Health and Community Services Department Advisory Board
Part A – Meeting in Public
Minutes

Date: 26 September 2024	**Time:** 9:30am – 12:30pm	**Venue:** The Grand Suite, Jersey Grand Hotel, Esplanade, St Helier, JE2 3QA

Non-Executive Board Members (Voting):		
Carolyn Downs CB - **CHAIR**	Non-Executive Director	**CD**
Anthony Hunter OBE	Non-Executive Director	**AH**
Julie Garbutt	Non-Executive Director	**JG**
David Keen	Non-Executive Director (TEAMS)	**DK**
Executive Board Members (Voting):		
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong MBE	Medical Director	**PA**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health, Social care and Community Services	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Ian Tegerdine	Director of Workforce	**ITe**
In Attendance:		
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Mark Queree	Deputy Head of Finance Business Partnering	**MQ**
Patricia Winchester	Chief Executive – My Voice Jersey (Item 7 only)	**PW**
Mike Palfreman	Chief Executive Officer – Jersey Hospice Care (Item 7 only)	**MP**
Chris Shelton	Chief Operating Officer – LV Care Group (Item 7 only)	**CSh**

1	**Welcome and Apologies**	**Action**
CD welcomed all to the meeting. Apologies received from: Dame Clare Gerada DBE — Non-Executive Director — CG Obi Hasan — Head of Strategic Finance HCS — OH		

2	**Declarations of Interest**	**Action**
No declarations.		

3	**Minutes of the Previous Meeting**	**Action**
The minutes of the previous meeting, 25 July 2024, were agreed as accurate.		

4	**Matters Arising and Action Tracker**	**Action**
No items identified for discussion at this meeting.		

5	**Chair's Introductions**	**Action**
CD introduced David Keen as the recently appointed Non-Executive Director for Strategic Finance. CD advised those present that today is CBs last Board meeting before a period of leave for an elective procedure. CB started working for the Government of Jersey as part of the turnaround		

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team in January 2023 and interim Chief Officer from April 2024. On behalf of the Non-Executive Directors, CD thanked CB for his help, support and kindness during his tenure.

On behalf of the Executive Directors, PA thanked CB, noting that he started in HCS at a difficult time but was leaving when HCS had an opportunity to spring forward, largely due to CBs leadership. The Executive Directors are grateful for his unwavering support and good humour (even through trying times) and wished CB a speedy recovery. All looking forward to having the opportunity to meet with CB when he returns in an advisory capacity.

CB thanked CD and PA for their kind words. In addition, CB advised that the following message will be communicated across HCS today,

"Mr Patrick Armstrong MBE has decided after five years in the role to stand down as our Medical Director as of 1 January 2025 to focus on full time clinical duties (orthopaedic surgeon). We will therefore start the process of recruiting a replacement with the Jersey Appointments Commission (JAC). I would like to thank PA on behalf of the Board for his dedication, commitment to patient safety, high standards of clinical governance and his integrity in addressing often very difficult and controversial issues during his appointment. We should also recognise his strong leadership during the pandemic for which he was recognised the award of an MBE. I and all the Board wish PA every success in this transition back to full time clinical practice".

CD also thanked PA and wished him all the best returning to clinical practice.

6	Chief Officer Report	Action

CB took the paper as read which provides a summary of key activities for Health and Community Services (HCS), an overview of HCS' performance since the last Board meeting, and a summary of key issues, some of which are presented in more detail through the relevant board papers.

Regarding leadership training (Cohen Brown), TH noted this is a good initiative and asked how this is progressing and how many more individuals will be attending? CB replied that there has been good representation across all tiers of leadership in HCS at each session, but the programme has now concluded. CP specified that 48 members of staff from HCS have attended, including the Executive Team and senior leaders; feedback has been positive. HCS have enquired as to whether the programme will continue as this is a GoJ led initiative.

Noting the community engagement events held by the Learning Disability (LD) service, TH advised that he spent a fantastic morning yesterday with staff and service users visiting Pine Ridge, Maison Jubilee, Klondyke and a further site. The LD service is very impressive and is comparable to some of the best services that TH has seen in local authorities / NHS environments – not only for the quality of facilities but more importantly, the highly personalised nature of the support provided by fantastic staff. CD responded that herself and JG had done a similar visit in June 2024 and echoed TH's assessment of the service.

CD asked CB / PA for an update regarding rheumatology. PA responded that the review of 2019 to-date cohort of deceased patients continues, of which there are 217. Of the 217, all those under the care of rheumatology services will be reviewed further. Of the 217, 67 are still to be reviewed. Of the 150 reviewed so far, 34 have been referred to the Viscount. The aim is to conclude the review of this cohort by end December 2024 / early 2025. Following this, deaths from previous years (prior to 2018) will commence. CB reminded the Board that the Viscount requested the extension to review deceased patients back as far as possible. CD asked if there is a timescale which the Viscount is working to, recognising that this process could take a long time. PA responded it is likely that this will take a long period due to the processes involved and the changes in medical leadership have been made in recognition of this i.e. Dr Noon released to focus on this. The length of time could also depend on any actions that both the Viscount and Police wish to take. Whilst it may take a long time, HCS has a duty to answer any concerns raised by patients and / or their families.

Noting there has been no cases of C. Difficile, MRSA and MSSA, CD highlighted this is an amazing achievement, particularly as infection control rates are deteriorating in the NHS; all staff should be applauded.

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All other items are presented in detail through papers on this morning's agenda and will be addressed at the relevant time.

CD thanked CB for his report and his support and hard work whilst working as interim Chief Officer.

7	Partnerships in the Health and Social Care System	Action

CD welcomed the following to today's meeting,

- Chris Shelton - Chief Operating Officer – LV Care Group (Listening Lounge)
- Mike Palfreman – Chief Executive Officer, Jersey Hospice Care
- Patricia Winchester – Chief Executive, My Voice Jersey

CD explained that the proposed Jersey Care Commission (JCC) standards include how HCS works with partners. Three partners have been invited to present for five minutes to discuss,

1. What do you value about the current system?
2. What could be improved in the system to improve benefit to service-users?
3. How can HCS / partners work better together for the benefit of Jersy residents?

My Voice Jersey
PW presented a series of slides including an overview of My Voice and the service provided (addendum to these minutes). Key themes are,

- Commissioning process described as fair and equitable, based on services provided (rather than who you know), flexible, ensuring accountability and facilitates moving forward together.
- Needs to address balance of risk due to inflation (not receiving inflation uplift).
- Financial reserves: disproportionate amount of time is spent negotiating finances which detracts from service development
- Need to consider economies of scale – IT requirements, human resource requirements, insurance.

CD thanked PW for the excellent and informative presentation.

Jersey Hospice Care (JHC)
MP provided a verbal presentation and advised that he has been in post for three years and during this time has been working with GOJ on the development of the first Palliative Care and End of Life Care (EOL) Strategy for Jersey. This strategy has been borne out of real collaboration and partnership with parts of GoJ, including an excellent relationship with the HCS Associate Director of Improvement and Innovation and her team.

The strategy has necessitated additional funding for EOL care and has also provided JHC with the opportunity for additional funding for existing services which were previously poorly funded by GoJ. This provides more sustainability for JHC. New services are being developed to further expand the strategy and anticipate that a 3-year contract where GoJ funding will amount to 44% of total service costs will be in place. This is a better balance than the previous 18% of GoJ funding. JHC will fund 56% through fund raising and retail activities. For every £1 invested by GOJ, there is > £2 value for an essential health service.

The success of the strategy is critical, particularly with the introduction of Assisted Dying and the need to provide a high-quality alternative. The partnership has been flexible with debate and negotiation regarding targets and key performance indicators (KPIs). It has been part of a detailed planning exercise with other stakeholders on the EOL Partnership Group and reflects genuine partnership.

However, there needs to be consistency in the process particularly regarding inflation. JHC bore the cost of inflation as this was not included in previous contracts. Inflation is now covered for JHC but this needs to be consistent across the voluntary and third sector; it is unfair and inappropriate to expect these to cover inflation.

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LV Care Group - Listening Lounge (LL)
CSh provided a verbal presentation and explained that the Listening Lounge began as a pilot in 2019 and was a collaborative piece of work with GoJ following identification of a gap in the market for early intervention in mental health. The service was launched successfully with clear, measurable outcomes and relieved pressure on Jersey Talking Therapies (JTT). Key points,

- The pilot (initially 1 year) has recently concluded and been through a full tender process. Again, this was felt to be very collaborative. LL approach is to be open and transparent, understand what is achievable, and the funding available to make this happen.

- Rising inflation posed a challenge to deliver same quality of service. However, the current experience is positive and facilitates building trust. The newly designed LL is slimmed down but not in terms of impact. LV is a Jersey Company founded by Islanders who have a desire to invest in the health of Islanders and improve their quality of life.

- Private sector is highly motivated with ethical people (as is GOJ) and there should be more trust between partners.

- KPIs and outcomes: there is a lot more that can be done to collate holistic data for the Island. The current data is small and could be so much better; this is a lost opportunity as there is potential for smarter working.

- Consistent messaging to facilitate planning. LV has invested over £60m in Jersey. If GOJ is looking for commercial entities to commit large sums of monies (as an example, LV has a large dementia facility that has received planning approval (cost of £35m) strengthened partnership are required to provide these entities with more confidence.

- Communication and mutual respect. Sometimes a feeling of 'them and us' but need to recognise that all partners have good ideas and valid opinions. There needs to be more collaboration and openness to achieve mutually agreeable outcomes.

CD stated the presentations were exceptional particularly referencing the choice of organisations to attend in terms of scale, type and funding model (private, wholly GoJ funded, partially GoJ funded). However, despite the difference between the organisations, there are consistent themes including inflation, consistency and fairness and trust.

CD commented that governments should not interfere in other sectors and there should be more collaboration. How to better collaborate and share to make better use of resource on a small Island is a worthy discussion that GoJ should either partner or lead.

Addressing CSh point regarding confidence, CD in agreement that any investment requires a return and therefore commercial entities need to be confident. As an example, the prior discussion regarding market intervention to allow private / community sector to flourish or direct provision, this requires direct and trusting conversations.

CD noted that the issue of inflation needs to be considered by the Board.

AM / AW invited to comment.

AM thanked PW, MP and CSh for attending and the feedback provided very much reflects the thoughts of the Associate Director of Improvement and Innovation and wider team. The process has been challenging but developed well over time. HCS is commissioning from a variety of providers of variable size and moving towards much more partnership work using partner expertise in service design. This is an exciting time to do more for the Island.

AM acknowledged the issue of inflation, and this requires further thought; it is also an internal issue for HCS. CD suggested that whilst consistency has been stressed as important, inflation may need to be approached differently depending on the size / scale of the provider.

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AM signposted the Board to the paper on wider partnership working which provides context and update regarding JCC standards. In addition, it demonstrated the breadth of partnership working including Guernsey and the / UK.

AW thanked PW, MP and CSh and their openness regarding their experience, particularly the challenges. During AWs 2.5-year tenure to-date, the partnership board took time to launch and there have been inherent tensions around collaboration versus competition. A characteristic of some of the best partnerships now is the ability to have significant difference of view. AW reflected that he regularly disagrees with Police and a negotiation is required to navigate this, however, the end point is reached as a result of open honest dialogue.

DK noted this was a really interesting conversation, particularly as new to the health system. The issues struck a chord with a lot of issues seen in the private sector in the UK and are not unique to Jersey. Strengthening shared services and efficient implementation of shared service and partnerships is crucial moving forward. DK also noted the issue of inflation and there is little that can be done to negate the impact on partners.

MP advised that himself and PW belong to a group of charity CEO on Island that meet regularly and was keen to stress that their views today are not representative of all partners. CD sought to reassure MP / PW / CSh that this was understood, and they had not been invited to the Board to represent anyone but themselves.

CB thanked PW, MP and CSh and spoke about the importance of good commissioning rather than contracting and building relationships is critical and requires equal contribution from both parties. Despite challenges, it is working to ensure good outcomes for service users. CB was sympathetic to CSh's point regarding confidence and stated that the annual budget setting process provides little certainty for commercial entities, particularly in the long term. Regarding inflation there are also levels imposed on HCS (tertiary care providers) that exceed the inflationary uplift provided to HCS. CB concluded by recognising that the process may not be perfect across the Island and requires further work.

CD concluded this item has been of great value to the Board. Whilst the three partners were not considered representative of the Island, there is no doubt that those who do not have such a positive relationship, would have raised the same concerns. Whilst partners take out what they put in, HCS must continue to commit to listening constructively to partners and demonstrate collaborative behaviour.

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8	Finance Report Month 8 – August 2024	Action

MQ, Deputy Head of Finance Business Partnering, introduced himself and advised the Board that he is in attendance on behalf of OH (see apologies).

Paper taken as read with following key highlights,

FY24 Month 8 Finance Position

- The Financial position for YTD Month 8 is an £18.9m deficit vs budget giving a headline monthly run-rate of £2.4m.

Underlying position and Run-rate

- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £2.2m.

FY24 year-end forecast

The current reported FY24 year-end forecast is £24m. However, this is after delivery of an additional £5.3m of savings that are required, over and above the FRP savings, to mitigate against further cost pressures identified and contain the overspend to the mandated £24.2m deficit funding. Without delivery of these additional mitigating savings the underlying forecast deficit is £29.5m. The £5.3m cost pressures for which additional savings are required include:

- Loss of income from closure of beds due to staff shortages and historic overbilling of LTCB income which has now been adjusted

- Increased costs of social care packages and mental health placements
- Reduction in surgical income due to loss of accommodation income from increased public activity and conversion of inpatient to day cases
- Increased costs in theatres consumables due to higher public activity but also in both surgical and medical services.
- Overperformance on acute care contracts in the UK, including our largest contract (Southampton) and inflationary impact at Oxford (Cardiology contract with tariff increase from April 2024).
- High-cost drugs pressures.

FRP savings delivery

FRP savings delivery YTD M8 is £5.4m vs £4.2m revised plan, made-up of £3.6m against original schemes and an additional £1.8m of mitigation schemes to recover slippage and additional cost pressures identified.

Forecast savings for FY24 are £7.1m vs plan of £5.2m, over-delivering by £1.9m. However, due to the £5.3m increase in the forecast deficit, a total of £11.9m of savings are required from additional FRP savings and Cobra actions. FRP over-delivery and additional Cobra actions are forecast to deliver £10.3m savings, leaving a further £1.6m of savings to identify. Financial Recovery COBRA group of the Executive Team has been leading delivery of these required savings.

Recovery Actions

Recovery actions being taken include:

- Financial Recovery Actions led by Cobra Executive Team – High impact mitigation actions to deliver £5.3m savings to reduce deficit to £24m. There is a £1.6m gap in the plan with 3-months to close.
- Intensive recovery support working with the Care Groups at the established Support and Challenge Meetings (SCMs)
- Service changes options- a list of options for service changes has been shared with the Advisory Board and MHSS for consideration to eliminate the forecast deficit. If approved this will require a quality impact assessment and a restructuring provision to be made available before implementation.
- Sustainable long-term funding – a paper has been submitted to Treasury and the MHSS for discussion which has been shared with the Advisory Board, making the case for a long-term sustainable funding settlement for HCS.

As Chair of the Finance and Performance Committee yesterday, CD invited JG to comment. JG reiterated that this is a challenging time and finding the savings required will require very hard work, however they must be found as overspend is not an option. This is indicative of the pressure on all heath systems currently with growth in demand. Investing in preventative measures whilst supporting ongoing operations is a challenge.

CD invited comments from DK and DK in agreement with JG's assessment of the current situation. The detail of transparency is good but with only three months to year-end, it is going to be difficult to close the gap. In addition, what is the impact on 2025, particularly as the FRP savings required are greater. CB advised that the 2025 budget setting process has commenced and a key figure will be the exit run-rate from 2024. Any major changes required to find the savings (to deliver £24m) will have an impact on the level (not quality) of service that HCS can provide. However, the FRP savings are positive, particularly the reduction in nursing agency costs which follows successful recruitment.

CD thanked JM for the work to achieve this and stated it highlights that with effort and focus, reducing agency / locum spend can be done. However, many of the pressures are non-pay (social care, contract costs, medicine costs) and HCS has limited ability to control some of these and require longer term strategies to address.

Noting the challenge ahead, CD advised that some difficult (immediate) decisions must be made which will impact provision of services. Reflecting on her other roles in the UK, CD stated this is a challenge in other organisations.

DRAFT

9	Quality and Performance Report Month 8 – August 2024	Action

Acute Services

- **Patients waiting for first outpatient appointment > 52 weeks:** An increase is noted, and this is related to key specialities. Key to note that these are patients waiting for routine appointments. There is confidence that the recovery plan in place for Ophthalmology will see a reduction in the waiting list. The recruitment in gastroenterology provides additional capacity for the end of 2024. The introduction of new software to the Clinical Genetics Service is also expected to yield reduction in the current waits by end 2024.

  The recruitment of a dermatologist will provide much needed capacity, especially as this is an area of higher risk. The Board received a paper at its last meeting describing the long-term plans for the service. An insourcing opportunity is being progressed with support from commercial services and CT confident that this will have a positive impact.

  There is a clinically led weekly PTL process to ensure that urgent patients are prioritised and confident that all urgent patients are seen within timeframe. There is balance to be struck between using the clinical capacity to review patients rather than conduct harm reviews, however, there is confidence that the current process is robust.

- **Patients on elective list > 52 weeks:** The greater the number of patients seen in outpatients, the greater the conversion rate to those waiting for treatment. Urgent patients remain the priority and consequently, those categorised as routine wait longer. A reduction in this cohort could be seen during the first part of 2024 and the slight increase over Q3 is due to loss of theatre capacity for planned annual maintenance.

- **Access to diagnostics:** this is a developing metric and a new monitoring tool. The variance is in line with the data development– monitoring performance and additional types of first diagnostics tests. This metric is used broadly in the UK and includes 15 key diagnostics.

- **New to follow-up:** This is monitored at specialty level. Exploring initiatives to reduce this.

- **Outpatient Did Not Attend (DNA) Rate (Adults only)**: The increase seen this summer is a pressure noted in previous years and is thought to be due to the holiday period. Towards the end of 2024 / beginning of 2025, individuals will be called to book their appointment (rather than receive a letter) – this will provide confidence that the allocated appointment suits the individual and therefore more likely to attend.

- **Elective Theatre Utilisation:** This is slowly improving although there has been on the day pressures due to equipment issues. Loan equipment should help to mitigate this.

- **% patients in the Emergency department > 12 hours:** Increase noted in the number of patients waiting > 12 hours. This is due to the availability of beds. However significant reductions in length of stay (LOS) can be seen in Acute Admission Unit (AAU) and Corbiere Ward.

- **% patients in the ED < / = 4 hours:** This benchmarks well with the UK. However, this will need to be managed through the winter period with a predicted increase in demand.

Noting the refence to patient initiated follow up, CB advised that from his experience, this is an initiative that has worked well elsewhere and asked whether this can be in place during Q1 2025? CT is confident of this and currently working with colleagues in Digital Services to progress this.

Referencing the success of nurse recruitment, CD asked why the recruitment of the Ophthalmologist has been delayed by four months, particularly as this is a pressured specialty. CT explained this is due to individual circumstances and locum staff are supporting in the interim. CD asked what impact this appointment will have if there are already locums in place. CT explained that the locum provides additional capacity and reductions should be seen in the cataract pathway.

Regarding individuals waiting for long periods of time on the waiting list, CD advised that whilst the Board is reassured that no one is experiencing harm, it would be useful for the Board to understand

DRAFT

how the harm analysis is undertaken (by who, for which specialities, methodology, actions taken and private / public split) to provide complete assurance.

ACTION: The Board to receive a deep dive of the harm review process including who undertakes these, in which specialities, the methodology, the management of those identified at risk or experiencing harm and the public / private split.

- **Delayed Transfers of Care (DTOC):** The DTOC position was lasted reported in detail to the Board in March 2024 and at this time there was an average of 28 individuals delayed. Whilst there has been a deteriorating position since March 2024, thankfully this is not to the extent of summer 2023 (average of 40-50 people delayed). The current position is 31 people delayed (21% of available capacity). The trend and reasons for the trend are significant. Of the 31,

    - 16 people waiting for a nursing home bed (do not need to be in hospital but cannot access a nursing home bed).
    - 6 people are waiting for specialist dementia provision in the community
    - 3 people waiting for a package of care. The discharge team have significantly accelerated access to packages of care and HCS continues to see a reduction in those waiting for home care – this has been helped by the brokerage system introduced with Customer and Local Services (CLS).
    - The remaining are either waiting for home adaptations, waiting for residential care or wait through choice until their preferred placement becomes available (do not accept alternatives).

    There have been bed closures at Sandybrook since October following a flood which required refurbishment. These beds will be opening in the next 2 weeks, providing additional nursing home capacity. However, across the Island there is increased reported reduction of nursing home capacity, particularly due to temporary closures and this is a contributory factor to the overall position. In response to this, a draft Discharge Policy has been developed to address the issue of choice i.e. when individuals choose not to leave the hospital. Work with CLS to look at the whole system (including commissioning and paying for community services) has almost concluded. However, the work to accelerate community care has resulted in a significant overspend on social care placements and packages of care (> £3m).

    Progress has not been made in creating additional specialist dementia care capacity, particularly those with additional complex needs. These individuals are those waiting the longest. Currently work at Rosewood House (St Saviours) which will provide some additional capacity, but this will not be completed until March 2025.

Noting the refence to the importance of a well delivered discharge policy and procedures, TH asked if AW had any thoughts on the capacity of the social work discharge team. AW responded that the capacity of the discharge team has been increased by one social worker and one assistant social worker. AW chairs a weekly meeting to review all those fit and nearly fit to leave the hospital - the current discharge team are able to identify what the issues are, it is the capacity issue that is the problem.

CD noted that in future years, sadly there will be more people with dementia, and it may only be possible to manage this through creating a market as the private and community sector either cannot afford or are not willing to do this themselves. The GoJ may have to intervene to create this as a longer-term objective. A priority of the proposed overarching integrated health and care system should be looking at where the market requires intervention. AW responded that these are actions in the dementia strategy published earlier this year, specifically redesign of the dementia care pathway and longer-term dementia care bed capacity. Support can be given to mainstream nursing homes where possible to manage individuals for longer. However, AW in agreement with CD that reached a point where state provision must be considered for those with most complex needs. Reflecting on the Learning Disability Services, CD stated this is an example of good, successful state provision, and GoJ should not be fearful of replicating this for other services.

CB echoed that market intervention is critical and highlighted the negative impact of DTOC for individuals who remain in hospital unnecessarily.

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Mental Health

- **% of referrals to Mental Health Crisis Team assessed in period within 4 hours:** > 90% individuals who present in crisis are being seen face-to-face < 4 hours.

- **% referrals to Mental Health Assessment Team assessed in period within 10 working days**: 87% of all referrals are being seen within 10 working days which is excellent.

- **% adult acute discharges with a face-to-face contact from an appropriate mental health professional within 3 days**: This is an important safety metric for mental health services, and it is pleasing to see this performance sustained.

- **JTT % of clients waiting for assessment who have waited > 90 days:** There is an ever-increasing demand with 150 new referrals received during August 2024. 97% individuals are assessed well within the 90-day KPI but there is a lag on treatment – 43% people are waiting > 18-week standard for treatment. However, this is an improving position and will be sustained by successful recruitment.

- **Dementia Assessment Service**: The waiting time for dementia assessment has now reduced to 53 days, this is a terrific achievement on behalf of the service over recent months. This has reduced to 53 days and is almost within target.

- **Median wait of clients currently waiting for ADHD assessment (days):** This continues to rise and there is a specific paper later in this meeting (agenda item 12).

- **Access to specialist tertiary psychological therapies**: Whilst not included in this report, the waiting list for this is increasing and is predominantly due to vacancies where 50% of posts are vacant. However, active recruitment is underway which if successful will improve the current position.

- The LD service have done well to recover the position regarding those who have an annual health check. The social work team continue to exceed the performance target regarding assessments completed and authorised within three weeks.

CS drew the Boards attention to the maternity dashboard and the improvements made in access to service, timely intervention and outcomes for mothers and children. This is very different from last year and commended the work of staff in embedding these improvements. CD echoed the significant improvements in this area and congratulated all staff involved in this effort, noting it is team effort.

Quality indicators covered in the Chief Officer Report (agenda item 6).

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Comfort Break

10	Workforce Report Month 8 – August 2024	Action

CD asked the Board to note that this report follows a differs format from previously and confirmed that ITe would share the reasons for this.

Before discussing the paper, ITe sought to highlight that there has been significant absence from key members of staff and acknowledged the support of the HCS Executive Directors and Chief People Officer GOJ for their support provided during this difficult time.

Secondly, ITe highlighted the relationship between nursing and HR in achieving the success in recruitment.

The workforce report was withdrawn from the previous Board meeting for a number of reasons. Firstly, ITe was relatively new in post and not had ample opportunity to undertake the due diligence on the data. Secondly, ITe wanted to avoid issuing a report with incorrect data (as previously).

This is the first report of what is anticipated will be an improvement in workforce data. The People Committee also receives this data. The main changes include the format (now a dashboard report), and it provides more information regarding where the data is derived from and what it means (data labels). Caveats include that the data is drawn from multiple sources, and this introduces risk of error, also discrepancies continue to exist between the finance and people ledgers – HR and finance continue to work to reconcile these.

New starters
This reflects the high level of recruitment since mid-2024. The decrease in August represents leave. Unfortunately, time to recruit has increased in 2024 compared to 2023 and this is thought to be due to the difference in the type of recruitment. Internal recruitment was the feature of 2023 whereas in 2024, much of the recruitment is external and this takes longer (DBS etc.). Whilst the metric has increased, this is in fact positive news.

Vacancies
The reduction in vacancies reflects the work in recruitment.

Turnover
Currently not able to express turnover specifically in HCS as the Connect system is GOJ wide and records the data as such. Working with business intelligence to establish HCS specific turnover.

Sickness
Sickness currently at approximately 6% and whilst this is not of specific concern, it will be continuously monitored. A review of all staff with long terms sickness has been undertaken, working with line managers to ensure that staff are properly supported.

Staff costs
The overtime spend is reducing in year but remains higher than previous years. The increase in basic pay reflects the increase in recruitment with the offset of reduction in agency spend. Reduction in agency spend has been significant and positively, many agency staff are looking to convert to a substantive contract.

Zero hours
Zero hours relates to bank staff, most of which are currently employed by HCS and do extra hours. However, there are staff that chose only to have a bank contract.

Connected performance
This relates to objective setting and mid-year reviews recorded on the Connect system. Completion rates are low and is an area that HCS needs to focus on. Contributory factors include competency in using the system and manager compliance.

My Welcome
My Welcome is the GOJ induction, rather than HCS specific induction. Work is needed to gather data regarding HCS and service-based induction.

A workshop has been held with representatives from other GOJ departments to review the data currently available and a series of workstreams developed to explore different data sets. As these workstreams deliver, this report will improve regarding the depth and breadth of information. This is not only important for the Board for assurance but also reporting at directorate and care group level, so managers are provided with the required information to allow them to manage operationally.

CD advised that there had been in depth discussions on the same report at the People and Culture Committee meeting yesterday. However, CD sought to highlight that this is the first time that the Board has received this quality of information and whilst there is still work to do, thanked ITe for the work involved in this.

CD described the data relating to appraisal as alarming, although recognised there may be staff having appropriate development / performance conversations and not recording them in the system, However, of the 19.3% staff that have completed the mid-year review, only 7.4% of managers have effectively responded to this. HCS must focus on improving this statistic. In

DRAFT

addition, the nursing appraisal data is very good, therefore this means that other areas are very poor.

In conclusion, whilst the system / administration of recording appraisal may be difficult, this does not mean that people are not having the appropriate conversations, however, there is no evidence to say they are.

CB in agreement and stated that Connect is the system to use (despite any difficulties) and the appraisal conversations must be recorded here. Difficulties in the Connect system were discussed and include competency and the inappropriateness for a clinical appraisal. Recognising that an appraisal process for the civil service is probably not appropriate for clinicians, the system should be flexible enough to allow for this difference. However, overall HCS must be improve.

PA confirmed that Doctors are not appraised through Connect system and use a different system due to regulatory requirements for revalidation. However, CD emphasised that when appraisal is a regulatory requirement, it is completed.

AW highlighted that 25.8% have completed the mid-year review and whilst cold comfort, this figure is 25.8% + 8%. AW supports receiving a more detailed report as reports for his portfolio indicate that managers are at 75-80% compliance.

ITe clarified that the Connect Performance data does exclude doctors but also manual workers (contract does not require them to have an appraisal). ITe confirmed he has requested reports that provide data at care group and service level, and this is underway. CD asked how manual workers have a development discussion with their line manager and ITe suggested they do not as this is a contractual arrangement. CD recognised that whilst it may be contractual, it is not contractual that they do not receive care from their line managers. ITe recognised that he is new to the manual workers contracts and in discussion with union representation and leaders of these staff groups, anything that looks like it may be an appraisal conversation is declined. CD asked whether they receive any development opportunities and ITe responded that they do but it will be carried out in an ad-hoc manner. CT sought to reassure that whilst there is no formal system, there is evidence of members of this staff group developing, having access to courses and progressing.

CD concluded that the report is moving in the right direction and thanked ITe.

11	**Out of Hospital Health and Care Services**	**Action**

Paper noted. TH advised that is an important issue for the Board, particularly regarding individuals receiving care in the right place and asked AW for an update on the work with Customer and Local Services (CLS).

AW advised the Board that there is a piece of ongoing work led by CLS to review arrangements around care packages, care in the community and how this is funded. HCS has been involved in this work, specifically the Chief Social Worker and it is near to completion. This will support thinking regarding standardised rates, need, and arrangements moving forward. However, on occasions, HCS could purchase much more expensive for individuals, but this would set a precedent around rate and manging demand which creates tension for HCS manging its own financial sustainability.

AW referenced earlier discussions regarding the work that needs to happen in terms of stimulating the market, particularly stimulating the market for the right group of people. For example, sometimes there are beds available, but they will not accept the people who need beds i.e. there is a clear unmet need for those with dementia and complex needs. This links a number of conversations that have taken previously at this Board morning and HCS needs to be clear about what it needs, how this is commissioned and how we engage with the market in delivery that is affordable.

12	**Neurodevelopmental Services Update – Attention Deficit Hyperactivity Disorder (ADHD) and Autism**	**Action**

Paper noted for information.

Firstly, TH asked if there is any work in other healthcare jurisdictions that could benefit Jersey and secondly, stated that updates on the work taking place regarding prescription of ADHD medication, potential joint working with private provider, introduction of electronic self-assessment tool and development of sessions with GP with special interest would be useful.

AW responded that regarding other jurisdictions, there has been a recent article in the Health Service Journal indicating waiting times of 7 years for outstanding mental health organisations with a longest NHS wait of 10 years (for an ADHD assessment). This is to emphasise the point that this is an international issue and Jersey is therefore in competition with all providers elsewhere who are seeking to solve this issue. For example, recruitment and specialist skill acquisition, there are many seeking to do this, making it more difficult. There is a piece of work being commissioned by NHS England, led by the Royal College of Psychiatrists exploring what can be done to address the ADHD waiting lists and AW pleased to report that the HCS ADHD Consultant is engaged with this work.

The issue of shared care remains unresolved. HCS could seek to commission private providers to undertake assessments (already being done in some areas in the UK). However, if HCS does this, there will be a consequential rise in the number of ADHD prescriptions required and there is no capacity to do this. Currently have 254 individuals who require monthly prescribing, and this has been worsened by the international shortage of ADHD medication. In conclusion, there is no easy solution. HCS will continue to work on the shared care arrangements as this would release capacity for the specialists to undertake assessments and provide specialist advice (rather than repeatedly write prescriptions). There is also a scrutiny review of the ADHD prescribing arrangement and HCS will await the outcome of this. HCS is also in conversation with a potential provider with an electronic self-assessment tool, but this is in very early stages.

13	Board Committee Report	Action

The People and Culture Committee and Finance and Performance Committee took place yesterday (25th Sept) and a written report will be provided at the Board meeting in November 2024.

Quality, Safety and Improvement
As Deputy Chair, TH raised the following from the meeting (in absence of the Chair, Dame Clare Gerada).

- Significant reduction in **pressure trauma** acquired in care which evidences real improvement.
- **Serious Incidents**: all open SIs have allocated investigators. Cross cutting themes have been identified from a review of multiple recommendations and where appropriate, recommendations are incorporated into improvement plans.
- **Central Alert System (CAS) Alerts**: The Committee is aware of the large number of overdue alerts currently but received assurance that the alerts are triaged on receipt and there are no serious issues not being addressed. PA advised that some temporary capacity has been allocated to this and significant progress has been made in addressing the backlog. Work is required to secure permanent resource to manage this.
- **Policies**: Approximately 50% of HCS policies are overdue for review and this is becoming a regulatory issue within Learning Disability (LD) Services. LD services are receiving recommendations for improvement as corporate policies are out of date.
- **Absence of a paediatrically qualified Designated Doctor:** JM explained that whilst the current Designated Doctor for Safeguarding is not paediatrically qualified, he does have the qualifications to undertake the role. Therefore, Jersey does have this role in place within safeguarding.
- **CAMHS Service**: There are currently 140 children held by CAMHS who should have transferred into adult ADHD services.
- **Pharmacy review** – makes recommendations which relate to Island wide issues and require other GOJ departments to engage in enacting change. Committee thanked those individuals in pharmacy that had the courage to speak up.

14	Jersey General Hospital Pharmacy (External) Review: Update and Action Plan	Action

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CD explained that whilst this report has been published publicly, this is the first opportunity to review the action plan.

PA took the papers as read. The action plan continues to evolve, specifically how HCS will allocate resources to deliver the work. Culture work has already started. The structure of pharmacy will be reviewed as part of this work as the report commented on the difficulties of fulfilling the strategic / governance aspects of the service and the operational service within the current structure. Unique to Jersey, pharmacy has a regulatory function outside HCS i.e. the Chief Pharmacist is responsible for inspection of community pharmacies, responsibilities regarding medicines law and regulation and licensing within cannabis industry. The HCS SLT will be receiving a paper in the near future for a decision regarding proposed structural change. Regular updates will be provided to the Board.

TH commented the action plan is comprehensive and noting the reference to challenges in terms of resources to address the recommended improvements, sought assurance that the action plan will deliver. Noting that 59 recommendations were made, CD emphasised that the Board would need to receive assurance on the implementation / outcomes of the action plan and suggested that HCS concentrates on the recommendations that will make the most difference (taking into account the other review and action plans).

Regarding resources CB stated that the budget setting process for 2025 will need to consider whether HCS can implement some of the actions as they are unaffordable. The EPMA system has led to improvements in quality and safety. The recommendations may need to be prioritised.

PA highlighted that the approach to publishing this plan has differed from previously and the action plan would normally be developed before the report is made public. Consequently, HCS is unable to provide all the answers about how it will prioritise and proceed with implementation of the action plan. CD suggested it would be useful for the Board to receive the prioritised list of actions in November 2024 and in six months' time, receive the monitoring against the prioritised list. Noting the number of recommendations coming from all the reports, CD suggested a prioritisation approach is required for all.

ACTION: The Board to receive the prioritised list of actions in November 2024 and in six months' time, receive the monitoring against the prioritised list.

ITe advised the Board that progress has started regarding the structural changes and the required HR processes are being followed. Regarding weekend working (of pharmacists), ITe reminded the Board that pharmacists are on civil servant terms and conditions and there is no contractual requirement to work weekends – currently this is done out of good will. CD suggested that contractual adjustments may be required. ITe advised that he is in discussion with the Chief People Officer about how the States Employment Board (SEB) could support HCS to look at terms and conditions however, the renegotiation of a significant contract is a large piece of work. The Consultant contract is scheduled for renegotiation next year.

15	**Royal National Orthopaedic Hospital / Getting It Right First Time (GIRFT) Report and Action Plan**	**Action**

PA took the paper as read and explained that GIRFT are a nationally recognised programme running for over 20 years to help organisations improve productivity and efficiency (which in turn leads to safer care). The report made 36 recommendations which sit with the care group to deliver and embed as business as usual. GIRFT will continue to provide support and will return to evaluate progress made. PA is looking forward to being part of this and delivering some of the changes in the New Year.

Whilst there is no confirmed plan, HCS will ask GIRFT to review other services.

CB clarified that this review was not commissioned due to any concerns regarding quality of care. GIRFT is concerned with improving productivity, use of resources and efficiencies.

PA also asked the Board to note two areas of clarification. Firstly, there was a misunderstanding from the report that the MRI scanner does not have the capability to detect prostate cancer. It does, rather that HCS does not screen for prostate cancer. Secondly, the report incorrectly suggests high

levels performance management in CSSD, this should have stated sickness management. These are very different, and an apology has been made to CSSD for this error. CD noted there are many positives in the report, and it also provided solutions and different ways of working, specifically a review of contracts to remove any limitations to weekend / out of hours working. Regarding theatre utilisation and public / private work, CD stated that HCS must ensure that public patients are not deprioritised for private work, despite intention to maximise private productivity. TH reflected that it is worth emphasising that good organisations encourage reviews of its services.	

16	Board Assurance Framework	Action
Paper taken as read. EOC advised that following the most recent cycle of senior meetings and committees the levels of risk are, • Quality and safety remains at 20 • Patient experience remains at 8 • Operational performance (access) remains 20 • Finance increased to 25. • People and Culture: the People and Culture Committee concluded that the risk is higher than stated but this will be reviewed, along with the actions by the Director of Workforce.		

17	Declaration of Interest	Action
For information		

18	Questions from the Public	Action
Member A *"At the HCS Advisory Board meeting held on 30th May 2024, and subsequently captured in the published minutes on page 11, a member of the public asked if a zero-tolerance approach would be adopted for bullying, either generally and/or of whistleblowers, as it had already been publicly stated would be applied for instances of racism. Chris Bown "confirmed that HCS has a zero-tolerance of bullying". He continued with the following statement: "there must be evidence of bullying and upon investigation, it is not always the case that bullying has occurred".* *His last sentence is perfectly understandable, however, if, following the completion of an independent investigation executed in alignment with the applicable policy, certain and specific allegations of bullying are indeed upheld and fully substantiated, then what does the application of zero-tolerance actually mean in practice?* *If your interpretation of zero-tolerance does not support a 'one strike and you're out' approach, then what lesser approach is applied to the guilty employee, and does the Board believe that the cessation, preferably, or curtailment, the next best outcome, of bullying and harassment will be adversely impacted and diluted if confirmed bullies are allowed to continue benefitting from their employment with the Government of Jersey, and not seen to have been suitably disciplined and penalised whatsoever due to the fact that any actions recommended as part of the investigation are required, in accordance with the policy, to be kept confidential?* *That sounds to me very much like the bully winning again! It is absolutely imperative that when allegations of bullying are substantiated following the completion of either an internal or external investigation, suitable and swift action must not only be done, but must also be seen to be done."* **Response** CB responded that this appears to relate to matters detailed in email correspondence between CB and member A. Due process will take place and CB stated he is committed to this. The process and outcome of any investigation is reviewed by a disciplinary panel and the process will be followed through. CB stated he does not intend and never will discuss individuals publicly.		

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CD thanked member A for the question and noted that the original question was asked by another member of the public and was answered by CB at the time. In terms of the wider implications, CD confirmed that the Board holds the view that bullying is inappropriate, unacceptable and harms performance. CD noted that CB has advised that due process will now follow, and this is required legally i.e. there must be an internal process between the employer and employee which will take place.

Member B (in writing)
CD stated that an email has been received this morning from an individual who cannot be here in person as is in hospital and asked for the statement to be read out.

"I would have attended your meeting at 09.30 today, were I not temporarily in the General so please can you use this email to put before the board today? Thank you!

Please use this email of my direct experience over the last 3 weeks to bring around change. Effective communication is essential and does not cost anything, but could this problem be as a result of pressure on your administrators as well as caring staff? Anyway, it does not need more money, just attention to the job in hand and training.

I have currently been at the General Hospital in Beauport Ward and now Plemont Ward, following a fall and under observation since Wednesday 4/9/24. I have had plenty of opportunity to observe how management of the Hospital operates and its part in bed blocking.

Firstly, I must give credit to extraordinary care and compassion I and my "roommates" have without fail received from the caring staff. They deserve every penny and more of their wages. The pressure they are under from not only the amount of work over long hours, but emotionally, cannot be under-estimated.

However as for Administration, the left hand does not know what the right is doing and that, from my observations has been a factor leading to the current bed-blocking of the 32 beds. I have not seen that listed as a contributory factor so far.

Example 1:
Last week, I was due to have an MRI scan "tomorrow": no timing or any indication of AM or PM, but I'm not going anywhere.

I did not dress that day as it is difficult for me and anyway, I needed to ensure I was not wearing metal, so no need to dress. I waited from 08.00 in anticipation until 12.15 when I dressed as I did not want to be in my nightie at lunch time. At 13.15 I was told I would have the scan at 14.00. So, I undressed (as usual with difficulty but I did not want to add to the staff's busy day and anyway I could do it myself). The porters came with a trolley at 13.45 when the junior doctor who had been in the ward all morning realised he had not inserted a cannula in me. This took 15-20 minutes. He could have done that at any time during the morning at leisure and not under pressure from the busy porters who chivvied him on. When we got to MRI, I was told they had been waiting for me and had been available earlier on, so their expertise and 2 porters had been wasted, and timely progress was interrupted.

Example2:
When I arrived on Portlet from Beauport on Saturday 15/9/24, there was a charming, bright roommate, about to be discharged that day. She told me after waiting during the day that they could not discharge as they had not got her prescription to the pharmacy by lunch time when it closed, so her discharge was delayed until Sunday. Everything at home had been arranged. On Sunday she was told the doctor had forgotten to sign her prescription, so she was delayed until a Monday. I don't know what happened on Monday, but she was eventually discharged on Tuesday PM, having been in the bed for an extra 3 1/2 days. Of course, it may be there were other reasons for her delayed discharge, but she was not told that.

Example 3:
Oh yes! Me! After 3 weeks under observation and being told I was due to have conductivity and EMG tests yesterday and setting great store by these tests for many days I was told yesterday morning that the list was too busy to accommodate me. I would be discharged today and wait for

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the tests and their results as an outpatient. Why was I not booked in a few days after my arrival here as it was obvious I needed these tests?

So, after 3 weeks of observation at the hospital, I have no diagnosis or prognosis, and my untreated condition has worsened.

I also have observations on end-of-life care and am now a signed-up member of Assisted Dying, but I will keep that for another day, but please let me know if you want to share in the experience.

And of course, there was also someone denied the care that comes from my hospital bed!

Noting the poor coordination between different parts of the hospital, CD advised that the process should be agreed at day one and timetabled accordingly to expediate discharge. CD thanked member B for sharing her experience and highlighting these issues, noting it was written well and kindly. However, member B undoubtedly deserves an apology for her experience and JM will make contact with member B.

Member C
Following member B's experience, member C stated,

- She has been pointing the communication issues between departments for years.
- Member C also advised the Board that she is currently undergoing various investigations but will not receive results until December.
- Doubts data presented.
- Has a friend with a six-year-old son who broke his arm in two places and alleged that they waited for four hours in ED reception on a Friday night (not children's waiting room).

CT confirmed there is a paediatric area available in the ED and whilst there are more people being seen within 4 hours, there are also people who are not seen within 4 hours. However, work continues to reduce this as quickly as possible. CT offered support to individuals concerned to learn from their experience of care.

Whilst follow up is booked for December, CT stated she would not expect that member c would have to wait this long for the test results. Again, CT happy to discuss further with member c.

Member C suggested that these issues were only being reviewed as they were raised at the Board and stated that there must be similar experiences for others. CD reminded member c of the previous discussion (item 9) and the request for a deep dive regarding the prioritisation of the waiting lists. CD concluded these were points well made by member c and they reflect issues raised by member b.

	MEETING CLOSE	Action
CD thanked all for their participation in the meeting. Thanks were conveyed to CB for his work and contributions to HCS and looking forward to working with CB in his advisory capacity. CD also reiterated her thanks and best wishes to PA. **Date of next meeting:** Thursday 28th November 2024		

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