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

Health and Community Services

Date: 25 July 2024	Time: 9:30 – 12:30pm	Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL

Non-Executive Board Members (Voting):		
Anthony Hunter OBE - **CHAIR**	Non-Executive Director	**AH**
Dame Clare Gerada DBE	Non-Executive Director (Item 8 onwards)	**CG**
Julie Garbutt	Non-Executive Director	**JG**
Executive Board Members (Voting):		
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong MBE	Medical Director	**PA**
Obi Hasan	Head of Strategic Finance HCS	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Emily Hoban	Head of Access deputising for Claire Thompson, Chief Operating Officer – Acute Services	**EH**
Andy Weir	Director of Mental Health Services, Adult Social Care and Intermediate Services	**AW**
Jo Poynter	Associate Director of Improvement and Innovation deputising for Dr Anuschka Muller, Director of Improvement and Innovation	**JP**
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 (TEAMS)	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Professor Peter Bradley	Director of Public Health and Medical Officer for Health (Item 7 only)	**PB**
Dr James Grose	Chair of the End of Life Care Partnership and palliative Care Consultant (Item 8 only)	**JGr**
John Gavey	Health and Safety Manager (Item 11 only)	**JGa**

1	**Welcome and Apologies**	**Action**

AH welcomed all to the meeting. EOC provided some housekeeping information including location of fire exits, comfort break arrangements and minimising distractions during the meeting.

Apologies received from:

Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Carolyn Downs CB	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director (late arrival)	**CG**

2	**Declarations of Interest**	**Action**

No declarations

3	**Minutes of the Previous Meeting**	**Action**

The minutes of the meeting held on 30th May 2024 were agreed.

4	**Matters Arising and Action Tracker**	**Action**

ACTION 123: EH confirmed that both the inpatient elective and outpatient new referral waiting lists are fully validated and this is a continuous process of validation. Agree **CLOSE**.

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ACTION 114: AW advised a paper will be presented in Sept 2024. The Quality and Performance Report for Month 6 demonstrates a plateau as a consequence of the work to review the waiting lists and reprioritise referrals. In addition, the clinical team are changing the pathway for assessment. Remain **OPEN**. **ACTION 76**: AH explained that the policy required for Article 36 has been prioritised ahead of progressing the Prosecution Policy and provided a preliminary delivery date of 2 -3 months. Remain **OPEN**. **ACTION 31**: OH advised this is not complete, feedback has been provided to the central team. There is still no confirmed date when budget holders will have access to budgetary information (through the Connect System). Remain **OPEN**.	

5	**Chair's Introductions**	**Action**
As above.		

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. Firstly, JG suggested that the Dementia Strategy could be presented at a future Board meeting with invites extended to key stakeholders. Secondly, JG welcomed the introduction of the Florence Nightingale Foundation Leadership Course for nurses and asked what training opportunities are available to doctors moving into or looking to further develop leadership skills. CB responded that senior staff across all Government of Jersey (GOJ) departments have been invited to attend the Cohen Brown Leadership training and this includes those in medical leadership roles. In addition, PA explained that the Faculty of Medical Leadership and Managers (FMLM) provided multiprofessional training (Doctors, Lead Nurses and General Managers) approximately 18 months ago. ACTION: Medical leadership training opportunities suggested for inclusion on the People and Culture Committee agenda.		

7	**Public Health**	**Action**
AH welcomed Professor Peter Bradley (PB), Director of Public Health and Medical Officer for Health, and emphasised the need for the Board to understand the importance of Public Health in Jersey and how HCS can contribute and support this agenda. The population of Jersey is getting older and as people get older, they live more years in poorer health; the ambition must be to make people well for longer in their lives and reduce the period of poorer health. This will also reduce the burden on the healthcare system. PB presented a series of slides (addendum to these minutes). AH thanked PB for the presentation and highlighted the linkage with HCS and the vision of the Minister for Health and Social Services (MHSS) for health, quality of life and prevention in Jersey and the range of services that will support this transition. JG thanked PB for the interesting and thought provoking presentation, in particular the reference to 61.4 years for females in good health and 23.7 years in poorer health. Also that the estimated cost of lost productivity to the Jersey economy due to preventable ill health has been estimated to be nearly £108m per year. JG echoed AH's observation that this Public Health agenda reflects the MHSS vision for the need of an integrated health system and the part that prevention, health promotion and wellbeing has in this. Healthy people are happy people, happy people are productive people and productive people contribute more to the economy that can be reinvested in health services. JG asked how HCS (which is predominantly engaged in the provision of services for the unwell) can support Public Health to move progress their agenda. PB responded		

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the main issue is advocacy for investment as services are not currently well-developed, particularly when compared to other health jurisdictions (Jersey spends approx. 1/5 to a 1/4 of that seen in other jurisdictions). In addition, strengthen existing services such as vaccination to ensure efficiency. JG noted that the need to double fund services i.e. fund the prevention and wellbeing services at the same time as funding the ill health services. This is a debate that needs to occur with both the GOJ and the public to understand how this can be progressed as it is critical to establishing a healthy population and funding healthcare in the future.

CB advised the Board that he meets regularly with PB and PA to discuss the issues described above. In addition, CB noted that governments in most other healthcare jurisdictions have difficulty with the issue of double funding and that HCS will support as much as possible.

AH thanked PB for his attendance and advised that work will continue to align HCS with the Public Health agenda. PB thanked Dr Matt Doyle, Chief of Service and Sarah Evans, General Manager for Primary and Prevention, Therapies and Community Dental for their contribution to this morning's presentation.

8	Update on the implementation of 'A Palliative and End of Life Care Strategy for Adults in Jersey'	Action

Dr James Grose (JGr), Chair of the End of Life Care Partnership and Palliative Medicine Consultant was welcomed to the meeting.

JP provided an introduction including the funding of the service and the development of the strategy. Key factors to the provision of a good service for everyone in Jersey include increasing community awareness, early identification of those on an end of life pathway to support them to have a good death and supporting preferred place of death (see paper). To deliver against the strategy, a partnership group has been set up.

JGr thanked JP for the introduction and thanked the Board for the opportunity to talk about the progress of the strategy. The Board was asked to recognise that there has never been a Palliative and End of Life (EOL) Care Strategy for Jersey and the publication of this in November 2023 was a huge advancement in terms of provision of service for this cohort of people. It recognises and benchmarks against International frameworks the key quality criteria to resemble a good palliative care service i.e. delivery of patient centred care, understanding patients expressed wishes, equal provision of service for non-cancer disease, and meeting physical symptom needs in addition to psychological, spiritual and social needs.

The EOL Partnership Group was formed shortly after the publication of the strategy with strong representation across all stakeholders (HCS, Jersey Hospice Care (JHC), Family Nursing and Home Care (FNHC), Jersey Care Federation (JCF), Jersey Ambulance Service (JAS), patient representatives and charities including MacMillan and Age Concern). This recognises that there is no single organisation in Jersey that can meet all holistic needs for this groups of patients. The partnership set about to explore priority aims against the strategy and concluded that the core of what needed to be delivered must be based on knowledge (clinical, medical, scientific) and well-grounded evidence to support quality in the service.

The first workstream focussed on education and a robust education strategy has been produced by the partnership group that identifies the key areas in which education and dissemination is core.

The well-developed specialist palliative care team is a finite resource that looks after individuals in their final stage of the disease journey or those with complex symptoms prior to being at EOL. A gap was identified for those individuals who are not in the final stages of life or do not have complex symptoms but have a life-limiting illness – these patients still have needs. The second workstream's focus is looking at how we make sure that those patients who do not currently fulfil the criteria for specialist palliative but equally have needs from a palliative care service, have the right coordinated care. Key roles in supporting this group of patients have been identified as navigators, or 'care coordinators'. These individuals are professionals from a nursing background who can guide patients through a complex system of multiple stakeholders providing all different types of supportive services for patients with life limiting illness who do not meet the

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threshold to be under specialist palliative care team care. One of the roles of this coordination service is to look at access to care and making sure that mechanism for funding is in place to rapidly increase a package of care for someone with a life-limiting illness who is starting to deteriorate at home. In addition, rapid access to equipment and mediation as these are often factors that can limit patients from being able to maintain their care at home.

The importance was noted of making sure that patients have the opportunities through skilled professionals to have conversations about their wishes when it comes to EOL and the role of care coordinator to make sure these wishes are documented and importantly, shared and disseminated (to increase the chances of these wishes being met).

JGr advised the Board that he is proud to Chair the partnership group and the investment in Palliative Care in Jersey is world class and exemplary. JGr noted he has never worked in an area (whether NHS or wider) that has invested and recognised the worth and importance of caring for those with complex specialist palliative care needs and also those with life limiting illness without complex needs who are currently missed in many jurisdictions. JGr is proud to be part of this work with all the stakeholders who are doing incredibly good things to realise this strategy. JGr thanked the Board for opportunity to share this.

Noting the reference to improvements in technology to facilitate better integration between services, CB asked JGr if an integrated care record would improve the coordination of EOL care across Jersey. JGr agreed and noted that digital infrastructure would support the dissemination of care plans. Having a well-educated workforce with the skills, knowledge and ability to have difficult conversations with patients about their wishes when it comes to dying is of limited benefit if these wishes cannot be communicated across services: the whole pathway falls. Positively, progress has been made with the electronic dissemination of ‘do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions and there is now a pathway to communicate DNACPR decisions electronically to the hospital. However, there is further work to explore how the wider decision making of patients is communicated.

CS commended JGr for the work of the group and asked JGr if he was confident that the strategy is reaching hard to reach groups. JGr recognised that there is a need (as part of the access workstream) to understand what is being done to support BAME groups in terms of access as currently there is under representation. The message must be that the specialist palliative care team and the partnership group will provide general palliative care regardless of ethnicity, religion or background. This work is not part of a current workstream, but it will be part of a future workstream.

Noting that much of the palliative care would be provided in the community until such time as specialist palliative care services are needed, CG asked if the community representation of the partnership needed to increase. JGr responded that it is important to recognise that everyone provides palliative care, and the partnership group represents a core groups of people that attend regular quarterly meetings; additional invites are sent when appropriate. AH suggested that JGr and CG could meet to discuss further outside of this meeting if required.

AH extended the Boards thanks to JGr for his attendance and presentation.

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9	Patient and Service User Charter	Action

JM advised she is presenting the Charter on behalf of Carl Walker, Chair of the Patient and User Panel. The Charter represents the work of the panel. The HCS Senior Leadership Team has approved the Charter for presentation to the Board.

AH noted the Board’s appreciation to Carl Walker and the Panel in producing this.

AW noted that HCS includes a range of community and social services and commented that the language may need to be changed to reflect this. CB extended his thanks to the Patient Panel and whilst the SLT is supportive recognised the point made by AW to ensure the language is appropriate for all services across HCS. It is then important to ensure the Charter is communicated across all sites and services in HCS.

CS sought to clarify that the voice of the child is included in the development of a children's / young person's charter and JM confirmed that this will be a collaborative piece of work.

The Board approved the Charter in principle.

10	Outcomes of the Ward Based Peer Reviews	Action

JM took the paper as read and verbally summarise the key points detailed in the paper, including areas of good practice and areas for ongoing improvement.

The Quality, Safety and Improvement Committee will be receiving quarterly assurance reports.

CS noted the regular (weekly) visibility of senior nursing leadership is very important. These reviews provide real-time information and allow for real time improvements where indicated. The reviews form a critical part of continuous improvement.

AH noted this represents a robust process of assurance and is open regarding the improvements that must be made. As a new member of staff within HCS, ITe endorsed and supported this process, stating this approach is not often seen. As an advisor to CQC inspections, ITe is aware of different practices, and this is one that a provider would be congratulated for. Specific areas highlighted include the senior nursing leadership and the multiprofessional approach to these reviews.

11	Health and Safety Q1 2024 Report	Action

John Gavey, Health and Safety Manager for HCS, was welcomed to the meeting and took the paper as read. In addition,

- The approach to Health and Safety is that of risk control and mitigation (rather than compliance). This is how the Health and Safety team are led and engage with all staff across HCS: the ability to mature Health and Safety culture is owned by Managers and Team Leaders in the operational teams.
- The Health and Safety team in HCS delivers specific training interventions which is unique to HCS.
- The Health and Safety Management System refers to the way in which HCS manages health and safety throughout the estate, and how it can demonstrate its due diligence of an effective implemented approach (rather than a software system). It is based on Plan, Do, Check, Act or HSG 65 from the health and Safety Executive. This risk entry is the collective of the other twenty-seven risks identified.
- >10,000 training certificates were issued for Health and Safety in HCS during 2023.
- 2,204 hours of face-to-face training were delivered by the Health and Safety Team.
- 91 HCS specific sample audits were completed.
- Whilst the report refers to Q1, during Q2 a Corporate audit (classed as external) of radiology against the Ionising Radiation Minimum Standard and achieved 100%. It is very rare to achieve 100% and JGa asked the Board to note the work of the radiology department in achieving this. Further detail will be provided in the Q2 report. This achievement has also been included in the report to the States Employment Board (SEB).

AH thanked JGa, particularly for reminding the Board that health and Safety is the responsibility of all employees.

CG asked for clarification regarding the risk of violence and aggression and who it relates to i.e., against staff, between staff. JGa explained that this relates to incidents as described by JGa and also includes members of the public and visitors as HCS has a duty to non-employees under the Health and Safety Law. The risk is representative of HCS as a whole but there will be different across services. It is concerned with the provision of tools to manage all types of abuse, not just physical / assault.

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CB advised the Board that he meets regularly with the JGa and that a steady trajectory of improvement continues within HCS. HCS is seen as an exemplar across GOJ with a maturing culture and thanked JGa and his team for their work.

In response to JG's questions, risk turns green below 4. However, in Health and Safety risk management, the mitigations often reduce the likelihood but not the impact. Therefore, it is unlikely that a 'green' will ever be achieved.

EOC confirmed that People and Culture Committee will receive future Health and Safety reports with the Q2 2024 scheduled for September 2024.

ITe thanked JGa for his report, noting the intelligent and thorough approach to Health and Safety. The Unions have raised the issue of violence and aggression in their regular meetings with HCS and suggested it would be beneficial for ITe and meet ahead of the People and Culture Committee to prepare. CP reminded the Board that an audit had been completed last year with a subsequent programme of improvement.

12	Royal College of Radiology Report including a Review of Mammography Service	Action

Before progressing to the key areas from the report, PA noted the following,

- Apologies to all patients and their relatives who have been affected by this report. Whilst the number of people affected is not large, this is not acceptable to any individual.
- Thanked Mr Simon West, Deputy Medical Director, who has led this piece of work.
- There are two parts to this work – firstly, the Review by the Royal College of Radiology and the Review by the British Society of Breast Radiologists. The review was commissioned following a concern raise through the Freedom To Speak Up Guardian regarding the performance of a Radiologist.

The Royal College of Radiology Report focussed on five different areas: patient safety, service planning and delivery, team working, clinical governance and managing concerns. There has been a focus on the team-working / relationships within Radiology and improvement work is ongoing. The reference is to some members of staff, it is not universal. Of most concern is the description that young, female doctors were not spoken to professionally and one doctor was told not to go to the department. PA assured the board that this incident was managed in the expected manner.

Tensions between different professional groups are not unique to Jersey or Radiology. PA suggested that HCS are behind the curve in supporting nurses and Allied Healthcare Professional in working to the top of their registration and moving away from the medical model in Jersey would help culture. In addition, this would provide improve retention and provide resilience to many services.

There are gaps in clinical governance however, item 11 highlighted some very good practice. It is important to note that the report did not state that there was no clinical governance, rather that improvements in clinical governance are needed. Radiology is a highly regulated area.

There is a programme of action to address the recommendations, all of which are detailed in the report.

The British Society of Breast Radiologists report led to the development of an action plan and all recommendations made have been accepted. Whilst avoiding focussing on individuals, PA highlighted that the Radiologist concerned has acted in an exemplar manner following concerns regarding their practice. It is important to note that this relates to one area of practice and HCS has good evidence that the same individual performs very well in other areas of radiology.

The review did not recommend a mass review / recall on the basis that many patients had already been seen and would likely be seen over the ensuing few months. However, HCS took the view that this period (5 months) was too long and commissioned an external review of patients. Key findings from this,

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• Of circa 3,500 patients, 650 had already been rescreened. Therefore circa 2,800 mammograms were reviewed. Of the 2,800, 23 needed to be recalled – 3 had already been seen which left 20 patients. In addition, a delay in diagnosis was identified for 14 patients and a duty of candour has been undertaken. In summary, this has been a distressing time for patients and staff. PA assured the Board that the findings of the reports have been acknowledged and HCS will implement any required improvements. AH thanked PA for the report and stated that the Board and the public will require ongoing assurance of the improvements delivered. AH noted the importance of the Freedom To Speak Up Guardian for all staff. CG stated she was unclear as to the level of harm to the 34 individuals affected. In addition, this represents a very low error rate (0.4 – 1%) and asked if the error rate for this service is known. In addition, did the initial concern raised through the FTSU refer to skill or behaviour? Thirdly, the frequency of screening (yearly) appears to be more than the UK which is every 3 years. Is the cumulative effect that the public are being worried unnecessarily? PA responded that the error rate is low and, in all probability, falls within what could be considered a normal range. However, the issue is that concerns within Radiology had been raised over a three year period and had not been acted upon. The BSBR has not been published as it contains personal information that would be inappropriate for the public domain. However, HCS acknowledges that no screening programme can provide 100% assurance, but HCS had a duty to act upon the concern raised. In response, CG suggested that concerns raised in the future could be brought to the Quality, Safety and Improvement Committee to discuss and decide how these should be managed; context is important. CB re-emphasised the key point that the concerns had been raised for three years within Radiology but had never been escalated from Radiology to senior management. The FTSU Guardian provided the opportunity to raise concerns through the system. The culture that fostered this failure to escalate is being addressed with all other recommendations. CB echoed PA's earlier point that behaviours do not relate to all staff within Radiology and the difficulties across professions are reflected elsewhere, for example within Maternity Services. However, HCS has a duty to manage all these issues head on, and despite a range of error, one patient harmed is one too many. HCS had to undertake the review (with expert opinion) to establish the number of patients involved. Whilst acknowledging that context is important, the report has raised significant issues that must be addressed and t is important to get an external view, particularly for small departments. Following the outcome of the reviews, CP advised that a Psychological Safety in Healthcare Teams Programme has been developed, particularly for managers to provide them with the skills to have difficult conversations and foster a culture where people feel safe to speak up. JG asked when the new mammography units are expected. EH suggested it is Q4 2024 but will confirm. AH thanked PA for the report and advised that the Board will require assurance of the improvement delivery. CG wished to emphasise that the public cannot be given the impression that the healthcare has a zero error rate.	

13	Rheumatology Update	Action
Reflecting on item 12, AH stated that it is difficult to strike the balance between addressing concerns with an appropriate and proportionate response. However, this should not indicate complacency, rather realism. PA advised this is an update for the Board, primarily regarding the review of deceased patients. The focus will be on the improvements made within the rheumatology service. PA stated it is		

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important to acknowledge and apologise to those patients and relatives who have been impacted by what has happened in this service. It is hoped that this report demonstrates the steps that HCS has taken to improve the service. PA also sought to acknowledge the tremendous effort of the staff in the rheumatology service for the improvements made in the service – this is now an exemplar service within HCS.

- The review of patients has been approached in different tranches and all previous audits have been completed. The most recent tranche has focussed on those patients who had been under the care of the rheumatology service and have died for any reason during the period Jan 2019 to Jan 2022. This period has been extended to patients who have died more recently.
- From Jan 2019 to-date, 190 patients were identified for review and 120 have been completed. The process includes the use of an audit tool to decide whether there are concerns regarding the care they received. Concerns existed for approximately one third of patients. These patients were subject to a Mortality Learning Review (Structured Judgement Review in the UK) followed by a panel review consisting of an independent general physician, a GP, an independent rheumatologist, Chief of Service Medicine and the Deputy Medical Director to establish if there was a possible or definite link between the care they received and their death. Under Jersey Law, HCS must notify the Police if further investigation may be required.
- In discussion with the Police and Viscount, it has been agreed that patients will be referred to the Viscount. HCS's part in the process ends here.
- To-date, 20 such referrals have been made.
- Of the 190, the remaining patients will be reviewed, and the Viscount has asked HCS to look back as far as possible. It is therefore likely that this process will take a long time (years).
- A Duty of Candour has been undertaken and they will be informed if there relative has been referred to the Viscount.
- All patients under the care of the service in recent years have been written to inform them that there is a process to establish whether they have come to harm as a result.
- 33 patients have been identified where it was felt that care has fallen below expected standards and may have resulted in possible medical harm.
- The medico-legal recourse remains under discussion and a pilot scheme is being piloted.

The following improvements have been made,

1. Commence an audit of those patients currently on biologics to assure their diagnosis is secure – **complete**
2. The recommendations made regarding the two Doctors involved – **complete**
3. Share the RCP report with the executive team and minister for health and social services, with oversight of an action plan by a Non-Executive Board member - **complete**
4. Appoint consultants on the specialist register, specialist nurses and access to physio, OT, podiatry, pharmacy and psychology services. Secretarial and administrative support in order to provide a sustainable, contemporary rheumatology service - **complete**
5. Introduce job plans for Rheumatology consultants and clinical nurse specialists - **complete.**
6. Review processes for personal and professional development of the rheumatology service staff, including weekly teaching sessions and annual appraisals - **complete**
7. Embed MDT working into everyday practice and establish links with a mainland modern rheumatology centre **- on track**
8. Ensure all patients starting a biologic have a documented biologic assessment, an objective assessment of disease activity and infection risk, documentation of relevant co-morbidities and vaccination status, and confirmation that prescribing is in line with NICE/European guidelines – **complete**
9. Service should adopt a more holistic approach with the involvement of therapies - **on track**
10. Review the frequency of follow up - **on track**
11. Implement a standardized written correspondence template – **complete**
12. Arrange a regular rheumatology MDT meeting with clear Terms of Reference. Record the MDT discussion and outcome in the patient's notes, with a copy sent to the GP and the patient - **on track**

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13. Discourage the sole reliance on pharmaceutical companies for drug information and training – **complete**
14. Review the arrangements for the prescribing of biologics; incorporate processes for challenge and be more proactive in providing regular updates on rheumatology prescribing - **on track**
15. Improve data collection and analysis in relation to dispensing rheumatological medications in order to assure patient safety prior to dispensing medication, maintain a record of the biologic therapy dispensed for audit purposes - **on track**
16. Hold a clinical governance meeting at least quarterly, including complaints, concerns, incidents, activity, staffing issues, audits and use of biologics. Document attendees and discussions, and report into the HCS clinical governance structure - **on track**
17. Regularly audit biologic therapies prescribing – **complete**
18. Use NICE guidance as part of the Rheumatology governance framework – **complete**
19. Foster relationships between primary and secondary care to develop more robust monitoring and develop shared care guidelines - **on track**
20. Support electronic prescribing and monitoring systems **- complete for rheumatology**
21. Appoint a pharmacist for high-cost drugs, to understand the usage and cost of biologic drugs and produce prescribing protocols – **complete**
22. Enrol in a regular rolling audit programme to provide reassurance about the activity and outcomes for patients and the use of expensive resources such as biologic therapies - **on track**

PA hopes that this reassures the Board and the public that a huge amount of work has been undertaken to realise these improvements.

Whilst acknowledging the distressing nature of this, AH stated it is now right to focus on the actions and continued assurance regain the service. CG gave her thanks for the improvements being made. CB highlighted that the Quality, Safety and Improvement Committee will continue to monitor the assurance regarding the improvements. In addition, CB provided an apology to all patients and relatives who have been harmed in any way. The distress to staff was also acknowledged and support is being provided. However, this is a powerful example for the need for strong clinical governance, the need for following evidence based guidance, participation in National Audits and linkage with a tertiary centre to ensure modernisation and sustainability in services.

14	**Medicine Improvement Plan**	**Action**
As the Medicine Improvement Plan (IP) is monitored by the Quality, Safety and improvement Committee, AH invited CG to comment. CG commented that despite the absence of outcomes, the improvement work continues. CG escalated the issue regarding the funding for the Consultant posts for the full implementation of the medical model which is critical to the Medicine IP.		

15	**2024 HCS Annual Plan - Q2 Progress Report**	**Action**
AH took the paper as read.		

16	**2025 Annual Business Planning Approach**	**Action**
AH took the paper as read.		

17	**Quality and Performance Report Month 6**	**Action**
AH invited exceptions only. No exceptions to highlight.		

18	**Dermatology Sustainability**	**Action**
EH advised the Board that the paper provides a very brief summary of the current service. CB highlighted that a second dermatology Consultant has been appointed and EH confirmed they		

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will be taking up the post before end 2024. Following this, the Consultant will consider how to progress the service. CG commented that her understanding is that the existing Consultant will only see pigmented lesions, and this means that the new Consultant will be overwhelmed with the large number of patients currently on the waiting list (circa 1500). The development of new care pathways has been requested although recognised that this will involve moving budgetary resource and empowering primary care practitioners. More can be done (in addition to recruitment) and if done well, there will be learning for other services. EH in agreement but CG advised this must be done as a matter of urgency due to the length of the waiting list. EH responded that work is ongoing to recruit to other vacancies and there are two GPs with specialist interest, one of which already works in the department and the other due to start January 2025. The use of teledermatology is also being explored.	

19	Finance Report Month 6	Action

Key headlines from the finance report (month 6).

- FY24 YTD M6 deficit is £13.9m giving a headline monthly run-rate of £2.3m. This is a deterioration on previous months. Drivers include tertiary care contracts (experiencing a 50% increase in tariff), mental health placements and social care, recharge from the accommodation service and medicine 9oncology and medical day care).
- FRP savings of £3.6m have been delivered vs £4m plan at M6 made-up of £2m savings from original FRP schemes and £1.6m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- The year-end forecast is £24.2m deficit after delivering £5m of FRP savings, with further downside risks from cost pressures that may materialise during the year, before additional mitigation actions are taken.
- Recovery actions include intensive recovery support, further cost reduction actions and sustainable long-term funding.

OH highlighted that the HCS Ministerial meeting have been very supportive while trying to work through this.

CB advised that the Executive Leadership Team (ELT) met yesterday to explore additional actions to further mitigate the risks. Weekly meetings have been scheduled to ensure delivery of these plans and monitoring current spend. Other measures include reviewing management costs and management of overtime more effectively. The aim is to ensure that the current forecast deficit does not increase.

CG asked if it is possible to obtain a comparison of the department based on tariffs available. Whilst costs are higher in Jersey due to economies of scale, significant differences would be evident. OH stated that this is possible, and work has been going on regarding the patient level information consisting system (PLICS) – the cost base for 2022 has been completed. CG stated that understood that doctors and nurses are not routinely coding activity meaning that the data is not available – is there a way of mandating coding? OH responded that the issue is one of resource – there are not enough coders. CB advised the Board that historically this is a skilled but low paid, in addition, these are not licensed posts and staff require intensive training. Consequently, this is a hard to recruit area.

AH advised that the Board will require continued assurance of the risks and implications of any additional savings. CB reassured the Board that quality impact assessments (QIAs) would be completed. In addition, could any of the increased pressures have been reasonably foreseeable. OH responded that HCS is well aware of where the pressures are coming from, it is the size of the pressure. Whilst HCS can enter negotiations regarding tertiary care contracts, there is not much bargaining power as Jersey has limited alternatives.

CS emphasised the benefits of substantive recruitment and in addition to saving money, permanent staff are more invested in the organisation and deliver good care. The Board heard that there are pockets of increasing recruitment.

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20	Proposed Future Workforce Report Structure	Action
AH noted that this was covered in the Chief Officer report. ITe advised the Board that the paper details the five priorities for ITe. In addition, the proposal for the workforce report is aligned to the Jersey Care Commission (JCC) domains which will provide the Board with information against these criteria.		

21	Committee Reports	Action
The Committee reports were taken as read. The Quality, Safety and Improvement Committee noted some escalations for the Board, 1. **Medical Model** - previously discussed under item 14. 2. **Central Alert System** – the lack of a central purchasing system leading to probable overspends and inability to manage safety alerts effectively. OH responded that a key action for the FRP is that HCS has its own central buying team – the aim is to have this set up in the next three months. CB echoed this and does not feel assured that HCS can be assured regarding safety alert management. 3. **Cannabis prescribing** – the prescribing of cannabis in the private sector is impacting the public sector due to the rise in mental illness and the lack of governance etc. CG will provide feedback to the Committee.		

22	Board Assurance Framework	Action
EOC took the paper as read and informed the Board that following review of the risks by the relevant committee, there had been some movement in risk level (detailed in report). Each Committee will continue to draft its agenda according to the key assurance to ensure these are effective.		

23	Questions form the Public	Action
Member A: Member A commented that it is very good that the areas requiring improvement are becoming apparent. However, why was this information not available previously – for example by the Pharmacy Department (cost of biologics) and Medical Director. PA responded that the issues are now being exposed. Radiology was actioned as soon as it was highlighted. In addition, as soon as the Rheumatology issues were raised with PA, these were acted upon. The culture is beginning to change and HCS is being open and transparent (as it should be). CB commented that these are 'old issues coming out in a new environment'. In part, the transparency has also been enhanced by the creation of this Board and its way of operating. CB referred to Professor Hugo Mascie's Review as to why Jersey faced these problems. AH commented that whilst it is distressing when incidents occur, it is important to generate confidence by managing these effectively i.e. acting appropriately and proportionately. However, it remains critical the issues are exposed – this is the open and accountable culture that that Board aims to foster. It is good that HCS is addressing historical problems in this open way. CS commended the Medical Director and Chief Nurse for managing the issues that have surfaced, noted it is work in progress and putting clinical governance systems in place meets resistance. However, patient needs must be placed in the centre of everything. Further support was provided by a member of the public who stated that changes had been implemented as a result of feedback. **Member B**: Member B used his own experience as a service user to highlight the following issues: lack of challenge amongst Doctors (resulting in expensive use of external), lack of recognition of previous medical history, treated with disregard and disrespect and unfounded		

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diagnoses / reports. In addition, Perceived unreasonable questioning of taking photographs during the Board meeting. AW responded that whilst it is reasonable for the Board to expect to have their photograph taken, it is not reasonable for members of the public attending the meeting to have their photograph taken without their consent. Member B sought to reassure the Board that members of the public were not in any of the photographs. AW advised that the repeated concerns specified are complicated, but AW will meet with member B outside this meeting to discuss. **Member C**: Member C stated whilst there are people in the room that are trying to help manage individual concerns, a culture of keeping issues hidden continues. **Member D**: Noting the Advisory nature of the Board, there are seven items for information, two for a decision, one for discussion, two for approval, ten for assurance and zero for advice to the Minister for Health and Social Services – why is this? CB / EOC advised that the agenda provides a balance of agenda items that would typically be seen in other healthcare jurisdictions and promotes accountability in an open and transparent manner. The MHSS meets regularly with the NEDs and will be advised where necessary during these meetings. AH noted the benefits of these debates occurring in public.	

	MEETING CLOSE	Action
AH thanked all those in attendance and closed the meeting. **Date of next meeting:** 26th September 2024		

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Health and
Community Services

Public Health
Jersey

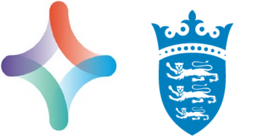
Healthy Jersey – Prevention in the right place

Making Jersey the healthiest place in the World

27th June 2024

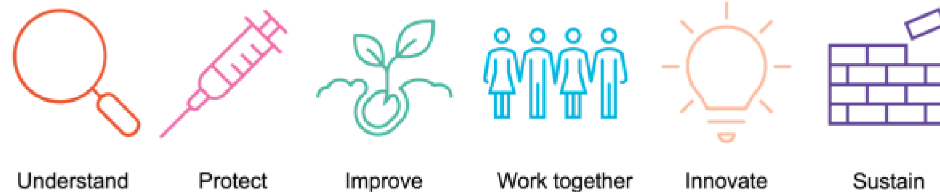
Gouvèrnément d'Jèrri

Six Strategic Priorities of Public Health



The 2023-27 Public Health Strategy "Seizing the Opportunity: A Population Health Strategy for Jersey" was published in summer 2023.

The strategy contains six strategic priorities:



Understand: To develop our understanding of health on the Island, of differences in health between Islanders and communities and our ability to assess the impact of interventions, so that we can advise from a position of deeper knowledge of Jersey's specific context.

Protect: Improve protection for Islanders from infectious diseases, environmental hazards and extreme events.

Improve: Make improvements to preventive services and health-promoting environments so that it is easier for all Islanders to be healthy.

Work together: Take a leadership role in coordinating the many people and organisations who work to improve Islanders' health through prevention, so that these efforts are as effective as they can be.

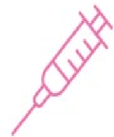
Innovate: Make skilful use of new approaches to improve our ability to tackle longstanding and challenging issues, like adolescent mental health.

Sustain: Sustain a highly skilled, appropriately resourced and well-supported Public Health team that can work effectively with a huge range of partners to deliver our ambitious agenda.

Public Health Workstreams 2024

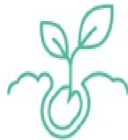
Understand

- COVID-19 Recovery
- Joint Strategic Needs Assessment
- PH Intelligence Reports
- Reporting and Surveillance



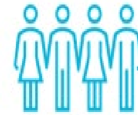
Protect

- Pandemic Planning
- PFAS
- Public Health Law / Civil Contingencies Law
- Nuclear
- Vaccination



Improve

- Alcohol
- Food and Nutrition including School Meals
- Health in all Policies
- Physical Exercise
- Suicide Prevention Strategy

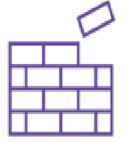


Work Together

- Public Health Alliance
- Substance Use Strategy
- Screening Programmes

Innovate

- Behavioural Change
- Sustainable Health Improvement Model



Sustain

- Expert Medical Advisor to Government

State of Health - Life Expectancy

Life expectancy in Jersey compares favourably to other jurisdictions, ranks just after China and Japan globally

Life expectancy at birth in Jersey was approximately **2 years** higher than in England

Life expectancy at birth in Jersey was approximately **1 year** higher than in the South West of England

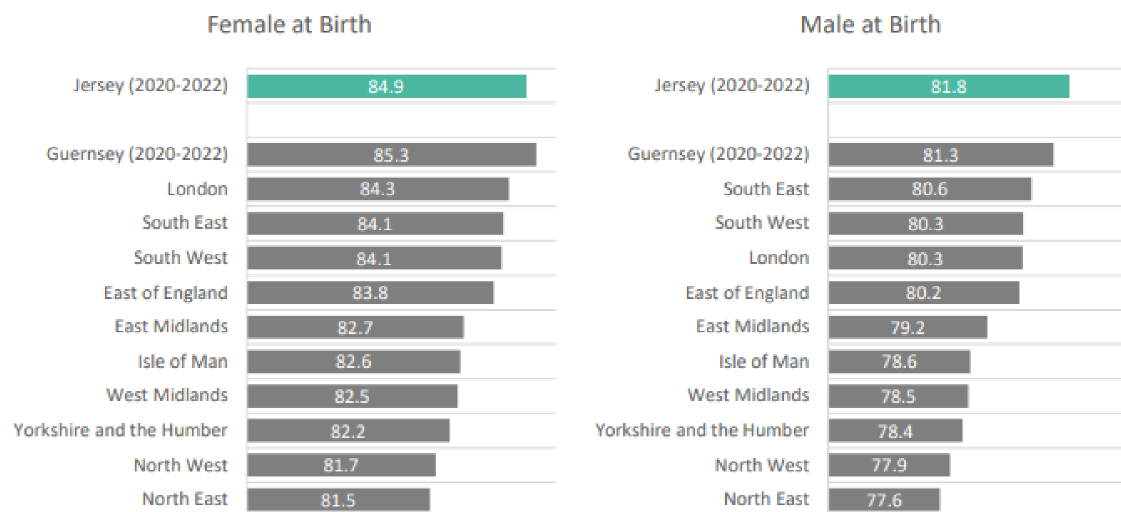
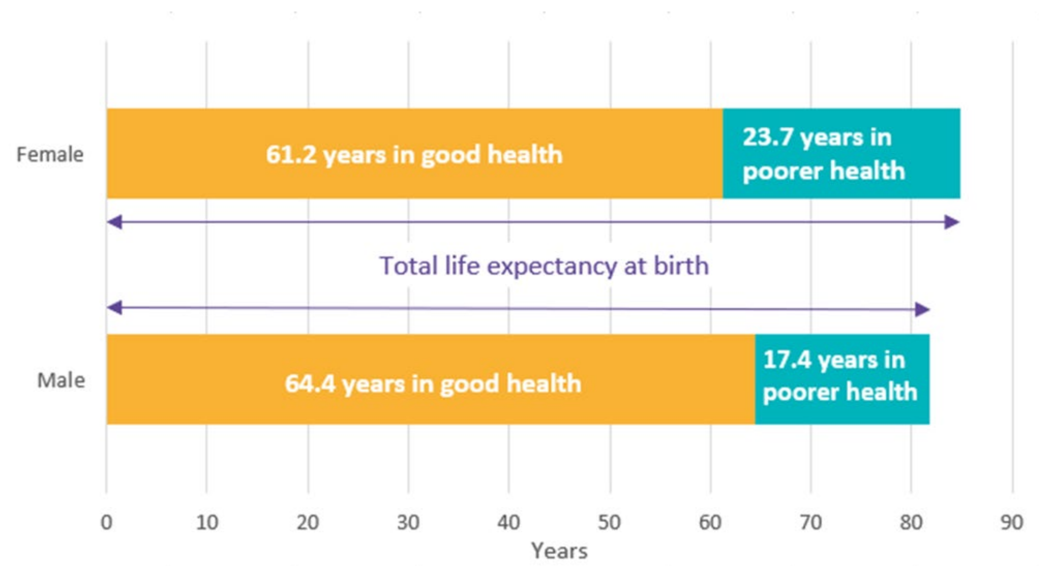


Table 4.3. Life expectancy at birth, top 10 world countries ranking and other countries of interest (2018-2020)

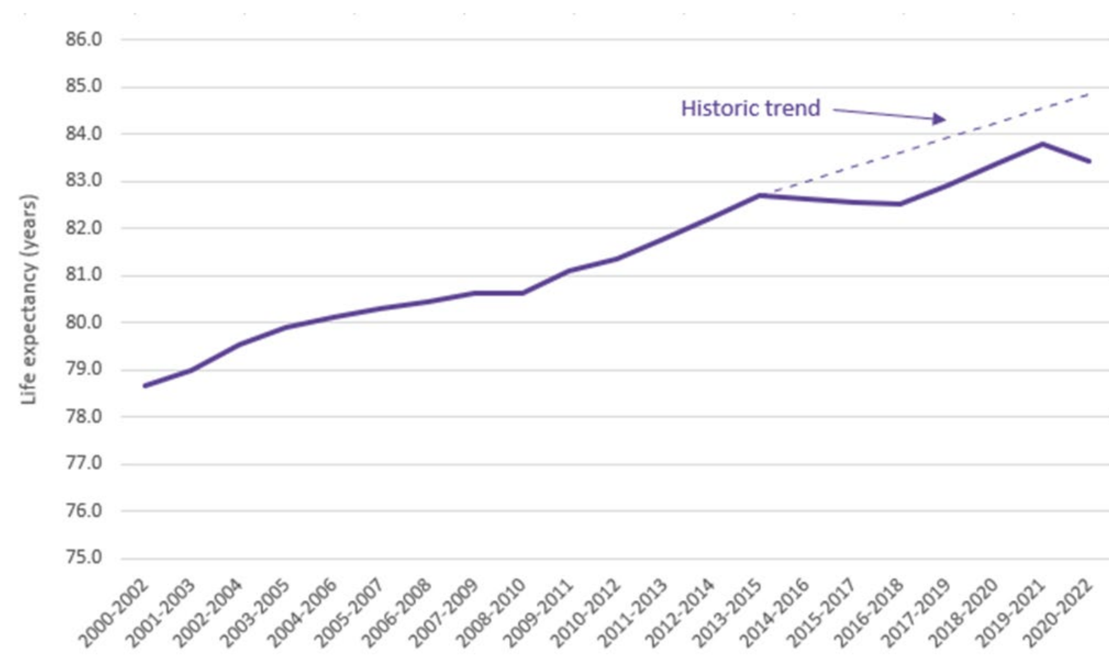
Rank	*Top 10 World*	*2018-2020*
1	Hong Kong SAR, China	**85.1**
2	Japan	84.4
3	Macao SAR, China	84.2
-	**Jersey (2019-2021)***	**83.7**
4	Switzerland	83.6
5	Singapore	83.5
-	Guernsey (2019-2021)**	83.5
6	Spain	83.2
7	Korea, Rep.	83.1
8	Italy	83.1
9	Iceland	83.0
10	Liechtenstein	83.0
30	Portugal	81.3
33	United Kingdom	81.1
37	High Income Countries	80.6
66	Poland	77.4
90	Upper Middle-Income Countries	75.9
178	Lower Middle-Income Countries	69.1
213	Low Income Countries	63.7

Link: Latest Life Expectancy Report & Health Profile 2022

What is the effect of our current lifestyle?



Differences in life expectancy and healthy life expectancy at birth for males and females, 2020-2022



Period life expectancy at birth, 2000-2022

Source: Public Health Intelligence, 2024

Big Health and Wellbeing conversation: public priorities

Gardening Jersey Yes Project Medecine Exercise Kindness Friends Parents Holidays Running Pets Therapy Jersey Heritage Healthy lifestyle Meditation Family Teachers Carers Time for self Exercise Mind Empathy Being outside Being outside Alcohol Affordable fashion School Volunteering Acorn Community organisations Mindfulness Nature Social connections Drinking water Listening Lounge Pedestrian zones Oreos Education Arcadia Stress management Games Cycling Diet Dogs Hobbies Teaching assistants Multivitamins Aquafit Diet Music Grandchildren Feeling included Family Cinema Faith Sleep Reading Highland College Art Swimming Baths Work-life balence Active travel Cleaning Not smoking Social connections Children Money Feeling safe Gym Sea swimming Support networks Yoga Health Visiting Service McDonald's Brighter Futures Autism Jersey Golf Salvation Army Walking Fun Work Text Friends Fresh air TV Walking Travelling Beaches Benefits Healthcare Homemade food Mencap Not drinking Football Natural environment Sanctuary Trust Independence Brain breaks Tea & coffee

Bad government decisions Family illness Not expressing emotions Coca-Cola Landlords Loneliness Food costs Deadlines Staff shortages Drugs Poverty Negativity Stubbing toe Crowds Wages Weather Money Taxes School Disability Overcrowding Lockdown Laziness Housing Healthcare Nothing Harassment Society Health issues Cost of healthcare Moving Activities for teenagers Exams Homelessness Activities for kids Social media Family Seasonal work Diet Rent costs Pain Smoking Work Accessibility Mental Health issues Teachers Family living abroad Energy prices Boredom Noise Alcohol Grief Long hours Hospital Discrimination Poor internet Corruption Travelling No time Ageing Waiting times Anxiety Vaccination Jersey Tax Office Pensions Worried about others Transport Caring duties Traffic Junk/processed food Depression Sleep Dust Cost of living Isolation Work permits Dog poop Cyberbullying Bullying Parking Climate change Cinema Construction Siblings Homework Screen time Being indoors Teaching The News Gambling Childcare Stress Pressure No support People Pollution Fuel prices Politics Own mindset Weight problems Feeling unsafe Social exclusion Activities for young adults

Oct 2022

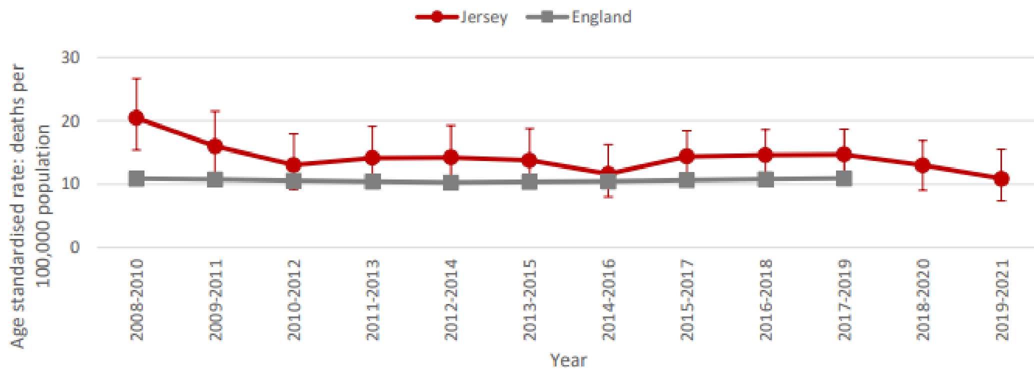
Key opportunities to reduce healthcare demand

- **Plan for increasing burden of ill-health as our population ages**. Projections show e.g. by 2043 heart failure increase by +42% and dementia +52%. A projected +2,860 people will be living with multiple long-term health conditions by 2043.
  Link: Latest Disease Projections Report
- **Reduce the high prevalence of many preventable conditions**, including some cancers (and subsequently we have preventable deaths).
  Links: Latest Multimorbidity Report and Latest Mortality Report
- **Support people to adopt a healthier lifestyle eg to drink less alcohol** (1 in 4 drink at levels considered harmful/hazardous to health), with serious health impacts.
  Link: Latest Alcohol Profile

Data on key opportunities

The number of hospital bed days is projected to increase by 30% by 2043

Figure 28. Alcohol-specific deaths rate: all people, Jersey and England (2008-2010 to 2019-2021)



Link: Latest Alcohol Profile

Approximately **14%** of individuals in Jersey are living with multiple morbidities

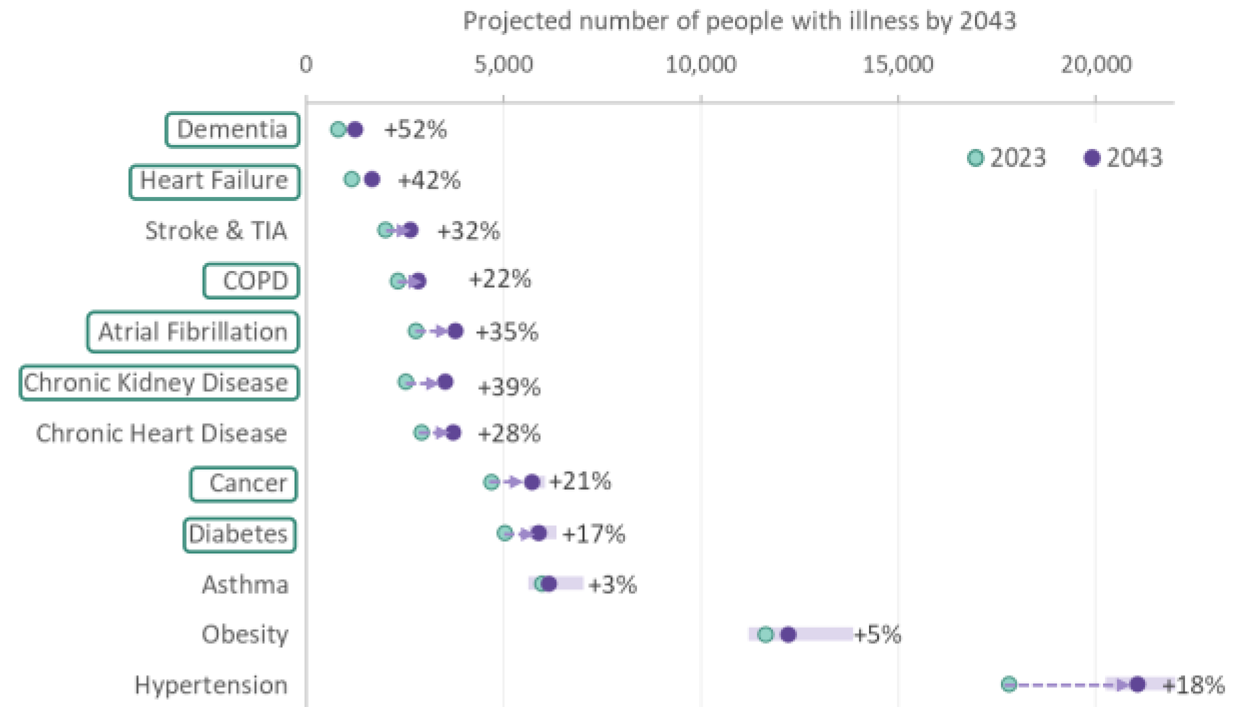
Hypertension was the most common morbidity, affecting **17%** of the population

Morbidities become more common with age

By age 85, over half of the population is suffering from **2 or more long-term conditions**

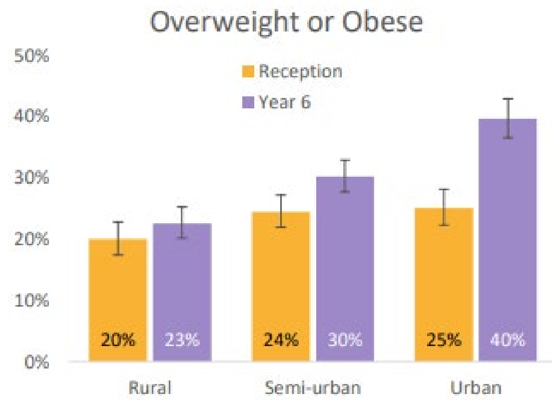
Links: Latest Multimorbidity Report

Figure 7. *Projected number of people with different illnesses by 2043 (with purple shading showing range depending on population projection scenario). % change shown in labels. Illnesses appearing on the Health Foundation's top 10 high impact conditions list boxed in green. Figure includes cancer projections (see section 4).*



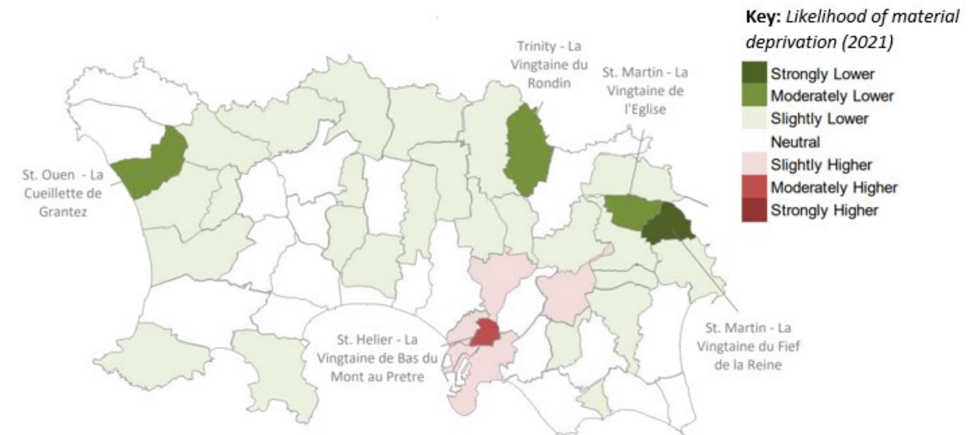
Link: Latest Disease Projections Report

Data on key opportunities – Tackle Inequalities



Link: Latest Child Measurement Report

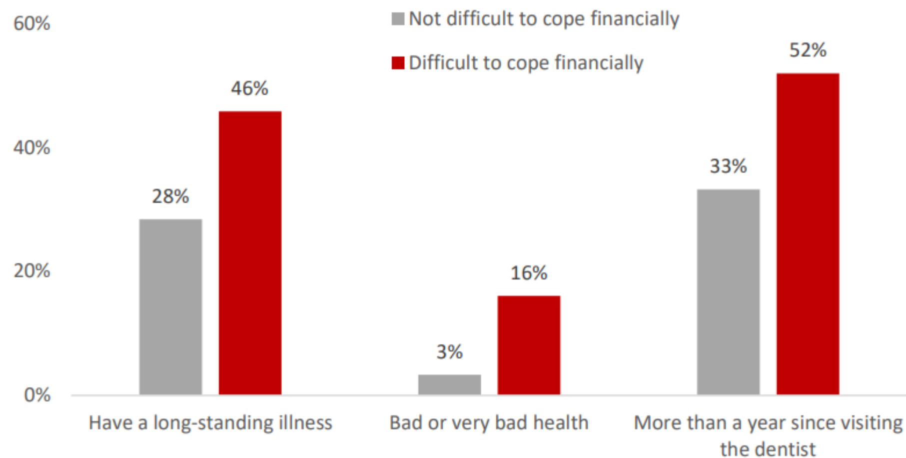
Figure 11.12. Combined index of deprivation (2021)



Source: Indicators of Deprivation by Parish Vingtaines Report

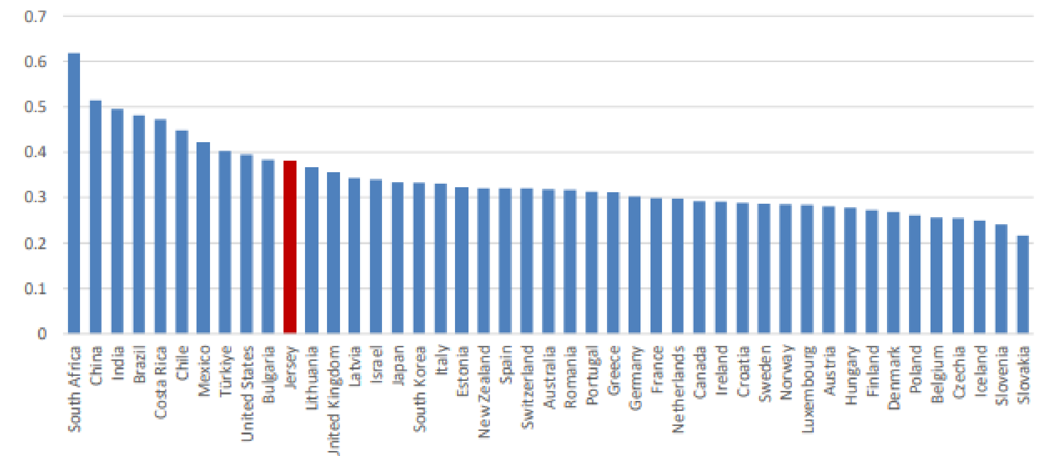
Link: Indicators of Deprivation by Parish Vingtaines

Figure 33. The percentage of people reporting a long-standing illness or being in bad health, split by whether they found it difficult to cope financially.



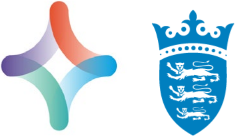
Link: Health Activity and Wellbeing Survey 2021

Figure 7: Gini index Jersey (2022) and OECD countries (2022 or nearest available)



Link: Latest Better Life Index

Prevention the right way



Investing in the upstream by embedding healthy lifestyles and support from childhood

Integrate tier 1 and tier 2 public health services throughout life

Supporting the downstream with rapid diagnostics, intervention and onwards referral

STRATEGIES

UPSTREAM

COMMUNITY IMPACT

TACTICS

Improve Community Conditions

Laws, policies, and regulations that create community conditions supporting health for all people

Addressing Individuals' Social Needs

MIDSTREAM

NEIGHBORHOOD IMPACT

Addressing community-wide social factors influencing health

Connecting individuals with services and systems of care

Addressing and supporting the needs of community-based organizations directly supporting social needs

Providing direct medical or clinical care services

DOWNSTREAM

INDIVIDUAL IMPACT

Medical interventions

Current spend

Tier 4

Acute/Complex

Tier 3

Specialist Support & targeted interventions

Tier 2

First line support: brief interventions, lifestyle coaching, exercise referral

Future expectations

Tier 1

Population-wide: healthy environment, active travel, public realm.

Most population benefit

The vision for Prevention Hub: Comprehensive, embedded in communities, proactive not reactive, free at the point of access

Single site of excellence

‘One stop shop’ for triage of high-risk patients for;

- Diabetes
- Dementia
- Cardiovascular disease and stroke
- Respiratory issues

- Screening hub;
    - Cancer: Bowel, breast, cervical
    - Diabetic retinal
    - Horizon scanning:
        - Aortic Aneurysm screening (UK; evidence base conflicting)
        - Lung Cancer screening (UK; currently in pilot)
        - PSA screening (TRANSFORM trial, currently recruiting, completion 2027)
        - GUM POC screening (Wales; currently running)

- Lifestyle advice (smoking, alcohol, weight, nutrition, exercise)
- Signposting to vaccination services

Embedding across government and wider community support system

Prevention initiatives to link other existing GoJ or third sector services to have a more comprehensive approach to improve mental wellbeing and physical health. These include:

- Income and housing support
- Workforce development and new job opportunities
- Leisure services
- Social prescribing
- Actions on children’s health
- And work with third sector to support to specific communities

Asset Based approach to Primary Prevention

- Optimising investment in assets in the community as well as supporting islanders to live well for longer
- Builds on existing programmes and evidence-based approaches to healthy, sustainable places and community resilience
- Healthy schools (extending the school day) and holiday activity provision
- Builds on use of existing assets in island community for health and wellbeing
- Spaces and places people trust, in the heart of their community

Reduction in demand

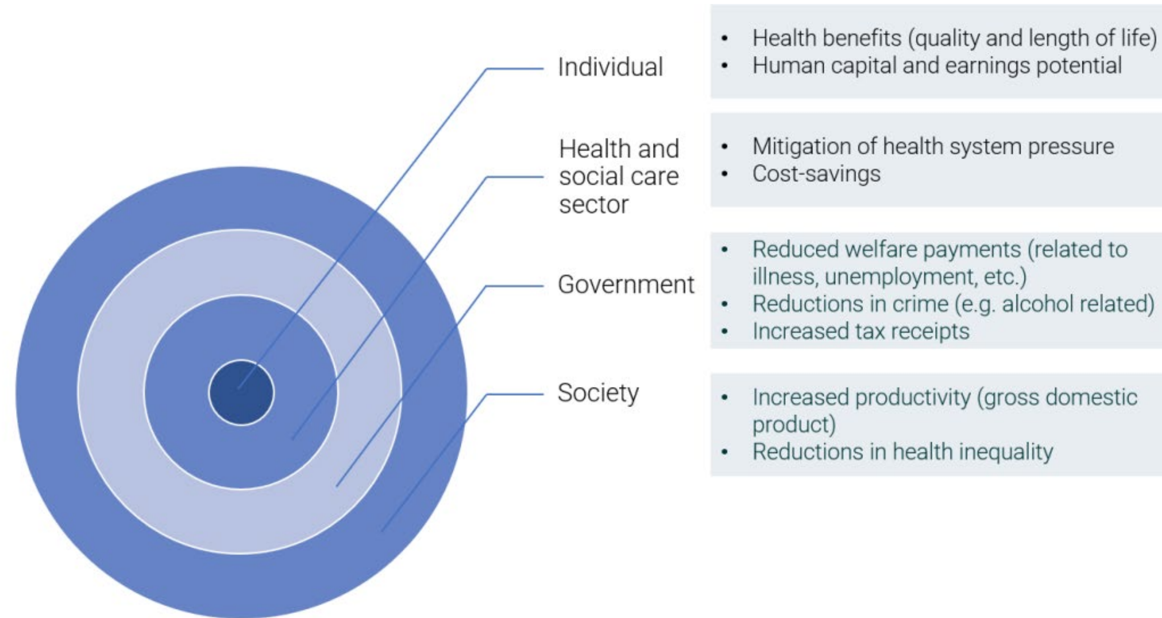
- 1% reduction in common long-term conditions would avoid about £5m additional healthcare costs
- 10% reduction leads avoids about £45m additional costs
- 20% reduction leads avoids about £90m additional costs

We estimate the following timeframe

- 1% reduction could be achieved in a year or two.
- 20% might take up to a decade

Wider economic impact

For government, reductions in preventable ill health could **increase tax receipts**, **reduce welfare payments**, and **generate savings to the police and criminal justice** system. For example, we estimate a reduction of 10% in obesity prevalence could **reduce annual spending on unemployment benefits** by £615k.



'For society, we estimate the **cost of lost productivity to the Jersey economy** due to preventable ill health has been estimated to be nearly **£108m** per annum'

Overall return on investment prevention measures

	Median ROI	# of studies	Median CBR	# of CBR studies
Overall	14.3	34	8.3	23
Local level	4.1	18	10.3	11
National level	27.2	17	17	10
Health protection	34.2	8	41.8	10
Legislation	46.5	2	5.8	2
Health promotion	2.2	12	14.4	3
Healthcare public health	5.1	6	-	-
Wider determinants	5.6	6	7.1	6

Source: Masters R, Anwar E, Collins B, Cookson R, Capewell S. Return on investment of public health interventions: a systematic review. J Epidemiol Community Health. 2017;71(8):827-34.

Health and
Community Services

Appendix

Public health in 2023

Making Jersey the healthiest place in the World

27th June 2024

Gouvèrnément d'Jèrri

Public Health in 2023

1 – JANUARY 2023
- Changes to COVID response take effect
- Cervical screening campaign goes viral

2 – FEBRUARY 2023
- Jersey Health Profile published
- First Director of Public Health Report released

3 – MARCH 2023
- Public Health Alliance with Guernsey
- Births and Breastfeeding Report published

4 – APRIL 2023
- Health and Wellbeing Priorities project launches
- Spring Booster campaign launches
- Alcohol Profile published
- More changes to COVID response

5 – MAY 2023
- IslandLiving.OrchaHealth.com launches
- Multi-morbidity report published
- Suicide Prevention Strategy consultation
- Food Systems Mapping workshop with Cambridge University
- Health Improvement Delivery Model work started
- PFAS Panel formed

6 – JUNE 2023
- Cervical Screening campaign
- PFAS Panel formed
- COVID vaccine primary offer ends
- Major Incident Psychological support available to all Islanders

7 – JULY 2023
- Substance Use Strategy Published
- Health Protection Review Published
- Healthy Life Expectancy report
- Jersey Breastfeeds initiative launches
- End of COVID emergency response

8 – AUGUST 2023
- Jersey Breastfeeds event
- Major incident free health checks launched

9 – SEPTEMBER 2023
- Winter Vaccine campaign launches
- Influenza Report published
- Mortality Report published

10 – OCTOBER 2023
- WellFest 2023
- Public Health Strategy Launch
- PFAS Panel visit Jersey
- Child Measurement Report published
- Life Expectancy Report published
- Immunisation Report published

11 – NOVEMBER 2023
- First Behavioural Science workshop with Influence at Work
- Changes to Covid Status Certification system

12 – DECEMBER 2023
- Notifiable Diseases System launched
- Love to Ride Winter Challenge launches
- Last rock up clinics for Autumn Booster