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

Health and Community Services

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

Voting Members:		
Carolyn Downs CB - **CHAIR**	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director	**CG**
Anthony Hunter OBE	Non-Executive Director	**AH**
Julie Garbutt	Non-Executive Director	**JG**
Chris Bown	Chief Officer HCS	**CB**
Dr Adrian Noon	Chief of Service – Medicine, deputising for Patrick Armstrong MBE, Medical Director	**AN**
Obi Hasan	Finance Lead – HCS Change Team (TEAMS)	**OH**
Non-Voting:		
Jessie Marshall	Chief Nurse	**JM**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Emily Hoban	Head of Access, deputising for Claire Thompson, Chief Operating Officer – Acute Services	**EH**
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**
David Goosey	Chair of the Safeguarding Partnership Board (Item 8 only)	**DG**
Alison Renouf	Safeguarding Partnership Board Manager (Item 8 only)	**AR**
Roslyn Bullen Bell	Director of Midwifery (Item 14 only)	**RBB**

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

CD welcomed all in attendance. This will be the last monthly meeting and the meetings will take place bimonthly hereafter. The next meeting will be at the end of July 2024.

Meeting is quorate.

Apologies received from:

Mr Patrick Armstrong MBE	Medical Director	**PA**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**

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

No declarations.

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

The minutes of the previous meeting held on 28 March 2024 were agreed as accurate.

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

The actions were acknowledged as either being addressed through today's agenda or a future agenda.

5	**Chair's Introductions**	**Action**

As above.

6	**Board Assurance Framework**	**Action**

- CB advised that the Government of Jersey (GOJ) Risk Team welcomed the development of the Board Assurance Framework (BAF) and provided positive feedback.
- The BAF is included at the beginning of each senior leadership team meeting to ensure focus on risk as each agenda item is discussed.
- In addition, the BAF is discussed at the end of each meeting to determine whether any agenda items have a material impact on the BAF.
- EOC echoed CB's points in that the BAF must now embed as part of the business-as-usual risk management process.

CD concluded that the areas assessed as high risk in the BAF are all covered on today's agenda.

7	Chief Officer's Report	Action

CB took the paper as read and reminded the Board that this report is a summary of the key issues HCS faced during April and touches on some issues from May. In addition:

- Ian Tegerdine, the newly appointed Director of Workforce will be attending the Board meeting in July 2024.
- During a visit to both Sandybrook and the Hollies Day Centre, CB was very impressed with the motivation of staff and care delivered to service-users.
- CB thanked those involved in the opening of the refurbished maternity unit.
- A report will be provided to the Board (likely July 2024) on the outcome of the review of those patients who died whilst under care of rheumatology services, including any referrals to the Viscount.
- Unfortunately, the Workforce report does not include accurate data, particularly regarding vacancies and sickness absence (noted after the report was circulated). This will be rectified, and a report recirculated to the Board and uploaded to the website.
- HCS continues to face significant financial pressures with a risk of at least £18m in the year-end forecast. Possible mitigations have been shared with the Ministerial team, but these will not be implemented due to the impact on clinical services. The future of healthcare funding will need to be progressed politically.

CD thanked CB and invited questions, highlighting that questions can be asked by any member of the Board (not just the Non-Executive Directors (NEDs)).

CG asked how the recruitment gaps are being addressed in Mental Health Services. AW clarified that there are currently 92 vacancies in MHS, of these 17 posts have been offered. Psychiatrists are continually being recruited and following a series of interviews over recent months, two psychiatrists and three middle grade doctors have been recruited. Key to this is a focussed MH recruitment campaign and AW working with an advertising agency to explore this; it needs to be about getting people interested in the idea of working in MHS in Jersey and matching people's skills with what is available. In addition, looking at developing staff internally and two staff are being sponsored this year to undertake nursing training (this supports staff who want to develop and are unable to afford to stop working to do this training). This initiative is also being explored for psychology training. CG thanked AW and noted the reassurance that recruitment in MHS is being managed.

CD asked what percentage of people on the ADHD waiting list are then diagnosed with ADHD (to give an idea about the accuracy of referrals). AW responded that an initial screen takes place and the conversion rate for a diagnostic assessment is > 90%. The service clinician would say this is because those who are unlikely to receive an ADHD diagnosis are redirected following the initial screening. However, as the waiting list is so large, it needs to be reviewed in its entirety, thinking about prioritisation and to ensure that those on the list should still be on the list. A senior specialist nurse has been employed for two days per week to review this list. The current position remains that demand hugely outstrips clinical capacity. CD asked if the ADHD waiting list will ever reach a normalised position and if so when. AW responded that currently there is no clear path to reach a normal run-rate without significantly increasing diagnostic capacity. This is very different from the waiting list for dementia assessment services where a piece of work has been done with the clinical team that has led to a trajectory of achieving a 6-week referral to diagnosis by the end of 2024. There is no clear plan regarding ADHD as simply there is not the

diagnostic capacity. The Board recognised this is an International problem and in some places in the UK, services have had to close to new referrals.

Regarding young people who have not had a confirmed diagnosis, CD asked what happens to their educational and health and care plan. AW responded that the waiting list in Children Services is very different and is currently under one year. Childrens mental health activity regarding neurodiversity has increased greatly and accounts for the vast majority of CAMHS activity; this is very different from five years ago. Reassuringly, most children are being seen within a reasonable timeframe.

8	**Safeguarding**	**Action**

DG and AR joined the meeting by TEAMS for this item.

AW and JM presented a series of slides (addendum to these minutes) to provide the Board with an understanding of the current safeguarding arrangements in HCS and how these relate to the Safeguarding Partnership Board (SPB).

CD thanked DG for attending the meeting and asked the Board to note that DG has been the Chair of the SPB for only a month. Recognising that safeguarding is an element of the Jersey Care Commission (JCC) inspection, CD asked DG for his first impressions, particularly regarding what could be differently, what could be improved and / or what do we need to do more of. Key points,

- DG been in post since Feb 2024 and the post is a 27 day per year role.
- Appointed as the Chair of the SPB and to act as an independent scrutineer (the latter being a departure from the predecessor). The Independent Scrutineer is a fairly well-developed process in the context of safeguarding children and to some extent, adult safeguarding, acting as a critical friend to the system providing support and challenge to member agencies that make up the partnership. Over time, it is envisaged that the role will change to have more of an emphasis on this role (rather than the Chair role). Anticipating that the independent oversight and scrutiny will be helpful to present at future Board meetings.
- Initial observations (stressing these are just observations) include an underdeveloped statutory framework for safeguarding adults.
- The vast majority of the effort of the SPB needs to be placed in multi-agency, multi-professional communication.
- The role of the SPB could be split into two primary functions. Firstly, the coordination of safeguarding activity (children and adults) across the system and secondly, holding agencies to account for their contributions to this system. Initial observations are that neither of these functions are developed sufficiently.
- There is an Accountable Officer (AO) group for the safeguarding of children and HCS is represented. It was decided at the last meeting that there should be a similar group for adult safeguarding. This needs to be a strategic oversight group, setting the key direction of travel for safeguarding on the Island. The meeting frequency has been reduced from 6 times a year to 4 times a year.
- Data: the SPB has two subcommittees which deal with quality assurance for children and adults. Whilst there is some data available from member agencies, it is fair to say that the quality of the data needs to be improved to understand how the system works for those needing a safeguarding service.
- The SPB is a large Board and may need to be reduced to include only the key agencies that have the main responsibility for safeguarding and to focus on the key task of coordinating and holding to account.
- The system in Jersey is complex and requires streamlining to focus on safeguarding the needs of vulnerable children and adults.

CD thanked DG and noted that safeguarding as a remit of the Board is dealt with by the Quality, Safety and Improvement Committee chaired by Dame Clare Gerada DBE and Tony Hunter CBE (Non-Executive Lead for Safeguarding).

Noting the emphasis on partnership and holding to account, AH reflected this very much echoes from his experience. Three key points,

1. This is a complex, critical high-profile area.
2. Alignment of policy and practice. A question for every Board member is how we can be confident that the policies in practice are consistently implemented.
3. What is the learning? Is there a culture of sharing and learning whereby the safeguarding priority can developed in forward looking ways.

CG expressed concern at the number of safeguarding referrals and the emotional toll these can have on healthcare staff. In response to CG's question, AW confirmed these all relate to adults. CD asked what this high number of referrals represents and stated it is positive to see the amount of resource dedicated to safeguarding. AW thanked CD and noted that this is one of the advantages of an integrated health and social care system. AW confirmed that the conversion of referrals to formal investigations is not high. However actively encouraging referrals helps an understanding of what is going on in the wider health system.

CS asked JM / AW how confident they are that staff (irrespective of role / grade) would know how to escalate a safeguarding concern. JM advised that the second week of care rounding was held earlier this week with a focus on safeguarding and every staff member (multi-professional) spoken to had either attended Level 1 or Level 2 safeguarding and knew what to look out for and how to appropriately escalate concerns. All wards across the hospital were included.

CB reflected on his experience of attending the AO Group for safeguarding and has concerns regarding the disparity of focus on adult safeguarding (particularly in view of volumes of adult referrals). DG in agreement that this needs to be addressed urgently. DG shared a slide showing the framework for the oversight of safeguarding children in Jersey which is large and potentially detracts from operational safeguarding activity. It is likely that the framework for oversight of adult safeguarding is less.

DG surmised that the focus should be on who is doing the safeguarding activity in the first instance rather than the committees that oversee this activity. A piece of work to ensure parity between adult and children's safeguarding is required.

CD concluded that there is a huge amount of work and resource dedicated to safeguarding. However, it would be helpful for both the Quality, Safety and Improvement Committee and the HCS Safeguarding Committee to go through the JCC standards to make sure it is satisfied that every standard is being met as well as possible.

DG was thanked for his attendance at the meeting.

9	**Quality and Performance Report (QPR) Month 4**	**Action**

EH took the paper as read and highlighted some key points,

- It is regrettable that there are long waits within elective care services. For assurance, the longest waiting patients are constantly reviewed both clinically and through validation work. There has been no harm reported to-date.
- Improvement can be seen in some services, namely those that have received focus as part of the waiting list initiative schemes. The outsourced cataract pathway has received good feedback and patients have been requesting to go back if the other eye requires surgery.
- Continue to see an overall reduction in the outpatient waiting list.
- A recently recruited consultant has significantly reduced the waiting times in the Stroke and TIA pathway.
- A significant improvement can be seen in the inpatient waiting list, particularly for those waiting > 52 weeks.
- Theatre utilisation has improved for the 4th consecutive month.
- Those areas where less of an improvement can be seen (Gastroenterology) are those with a capacity issue (lack of resource). However, a gastroenterology Consultant will be commencing in July 2024 and until this time, the service is supported by some additional locum capacity.

- The new Gastroenterology Consultant will also provide additional endoscopy capacity. A waiting list initiative was undertaken for endoscopy services in November 2023 and March 2024 which significantly improved the waiting times. A slight increase has since been noted but this is expected to reduce once the additional Consultant is in post.
- The dermatology waiting list remains significantly high (both new patients and follow up) and this is due to lack of capacity within the service. Recruitment continues for a substantive Consultant dermatologist and hopeful that a suitable candidate will apply. Dermatology is a compromised service across the UK. In the short term, additional capacity will be provided. For assurance, all urgent dermatology referrals are being seen within the correct clinical timeframe (2 -4 weeks).
- An increase can be seen in diagnostic MRI. A pilot initiative concluded in January 2024 and reduced the waiting times to 6 weeks. Some additional capacity has been provided since this time (not as much as in the pilot), but the waiting times have risen. The pilot will be implemented as a sustained service in July 2024, and it is anticipated that the waiting times will reduce back to 6 weeks. For assurance, all urgent referrals are clinically prioritised and will be seen in the 2-week target.

CD asked about the impact of increasing services for private patients on the waiting list for public patients and sought a categoric assurance that private patients are not prioritised over urgent public patients. EH responded that all patients (irrespective of whether public or private) are clinically triaged and the most urgent patients are prioritised above all others. This is monitored daily. Whilst reassured by this, CD commented that if the number of private patients is increased, those non-urgent public patients must be waiting longer. EH responded that if the private patient throughput is increased, the private capacity should increase. The pilot showed that the impact of increasing the private throughout had a positive impact on the ability to deliver a better public service.

CG suggested that rather than continually focusing on the number of people waiting for an MRI, it would be better to understand why so many people are referred for MRI scans and how many of these are positive / false positive. CG speculated that the number of people referred for an MRI is high. CG reminded the Board that an MRI is a diagnostic test and whilst acknowledging there is no evidence, appears to be overused (reflecting on her own 35-year experience as a GP having only referred two people directly for an MRI). A paper from England's Emergency Departments showed that during 2023, £5 billion of unnecessary investigations took place through the ED regarding MRI and other diagnostic tests.

Acknowledging the validity of CG's point, AN (as an ED Consultant) responded that a negative test is sometimes more important than a positive test as this facilitates a safe discharge; negative tests do have value. However, an over reliance on diagnostic tests can result in loss of clinical judgment skills. Therefore it is important to use the available technology with the appropriate protocols and guidelines in place. CG noted that the MRI activity is not generated through the ED (otherwise they would not be on the list), but unnecessary diagnostics result in increased length of stay etc.

Regarding the quality impact on non-urgent patients from increased private activity, CS stated that the Medical Director and Chief Nurse have requested a patient-by-patient deep-dive through the monthly care group governance meetings (due to start June 2024). CD noted this is reassuring and asked the Board to be updated if any exceptions are noted.

Noting the absence of a comprehensive suite of social care indicators, AH advised the Adult Social Care Development Event in June 2024 will help to reinforce what a good social care system looks like, how this supports wellbeing generally and reduces demand over time on hospital services. Noting that the QPR is still very much hospital focussed, out of hospital indicators must be looked at in the round.

CD stated it is positive to see action being taken and the reduction in those waiting > 52 weeks. However, the public perception does not reflect this and asked why this data is questioned a lot – is there anything that can be done to give the public greater confidence in the data? CB commented that some of the public speculation may be because of personal circumstances however, there is no reason to believe the current information is inaccurate. CD thanked CB / EH

for this reassurance and remains hopeful that perceptions will change as the waiting lists continue to reduce.	

10	Workforce Report Month 4	Action

CB re-emphasised the need to correct the data regarding vacancies and sickness absence.

Other key points,

- Planned recruitment activity (noting the update provided by AW for MHS in agenda item 7).
- Law at Work Exit interviews – the reasons for people leaving. This will be reviewed in detail by the People and Culture Committee.
- Strategic Workforce Planning: anticipated progress for 2024 has not been made. CB is working with other senior civil servants across GOJ to discuss how to approach the development of strategic workforce plans. The New Health Facilities and changing demographics are just two examples that will drive workforce planning. JG endorsed the necessity of doing this work, firstly to prevent recruitment issues causing operational issues and secondly, creating opportunities around available skills. However, this work should be driven by an acute services strategy and the Board should mandate this as an opportunity to start to consider what an acute services strategy would like (under a whole Island Health and Care Strategy). CB noted the importance of the inclusion of MHS in this.
- Staff appraisal: objective setting has improved from 27.5% to 41.4% (excluding manual workers).

CG thanked the executive team for their hard work in this area. CG asked if the absence data relates to long-term sickness or large amounts of episodic illness. CB advised that this data is available but in the absence of a Director of Workforce at the meeting, unable to provide the specific split. AW confirmed that in MHS / ASC the overarching sickness data is significantly skewed by a very small number of long-term absences. In general, there is far more short term (1-2 days) absences.

CG asked if the lack of Occupational Health remains an issue. CB responded that this service is provided by the GOJ and People and Corporate Services are currently reviewing what the service should be in the future (as it is believed this service could be strengthened).

CD accepted the data is incorrect but asked why it is wrong. Incorrect data erodes confidence however the People and Culture Committee will start to deep dive into some of these areas when it meets in June 2024. CB explained that the data inaccuracies arise from trying to reconcile three different sources of workforce data: the Connect system, the Finance system and the operational services. The disparity between systems has been a long-standing concern for the Executive Team and unable to give an answer for why this is still occurring. CD acknowledged this must be very frustrating for managers.

Reflecting on the excellent nursing appraisal report provided by the Chief Nurse at the meeting in April, CD stated that this shows senior nurses taking serious responsibility to undertake these. CD directed that the best practice demonstrated within nursing should be transferred across the workforce to further increase organisational performance. Recognising the appraisal process is different for Doctor, CB stated there is a renewed effort (working with the Essex Deanery) to improve the quality of medical appraisal. This is not recorded in the Connect system.

Regarding the Law at Work Exit Interviews, CD commended HCS for commissioning the report and publishing the themes as it is not positive reading. CD noted that approximately 66% of people leave because of what could be classified as cultural issues. Whilst the GOJ undertakes larger surveys, HCS must start undertaking pulse surveys to understand how the workforce is feeling. CP advised that a Pulse Survey will be launched on the 3rd June 2024 with six statements. The purpose is to gain a quick understanding of how the workforce feels. A further Pulse Survey is planned for Sept, and this will be GOJ wide. CD advised that whilst the People and Culture Committee will look at these in detail, the results must be seen by the Board. It is very concerning that 66% of leavers are doing so because of cultural issues.

CP further advised that the Culture Dashboard will be presented to the Board in July 2024 which will include a spectrum of elements of culture.

ACTION: The results of the Pulse Surveys to be presented to the Board.

AH reflected that it is important to understand the experience of staff and whilst surveys provide some data, this does not replace having conversations with staff and sharing what we learn.

11	Finance Report Month 4	Action

OH took the paper as read. Key points,

- The Financial position for YTD Month 4 is an £8.3m deficit vs budget giving a headline monthly run-rate of £2.1m.
- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £1.8m.
- FRP savings delivered are £2.4m vs £1.84m plan, made-up of £1.2m of original schemes and £1.2m of additional mitigating savings delivered to recover slippage and reduce budget cost pressures.
- FRP savings will initially be recognised against the GoJ Value for Money (VFM) target for HCS of £3.986m which is included as part of the FRP target of £12m for FY24.
- Exceptional items include backpay, Operation Crocus, drug inflation costs and non-pay inflation which is higher than funded amounts.
- The current FY24 year-end forecast remains a deficit of £18.0m. The key factors driving the forecast deficit are budget cost pressures £7.5m, FRP savings slippage due to delays in enabling support £6m, exceptional one-off costs in-year, Tertiary care contracts price inflation, activity increases in high cost-low volume (HCLV) services, drugs and other non-pay inflation, WLI funding, and additional costs of implementing the recommendations of Royal College reviews into Medicine and Maternity Services. The response to this is to continue working on mitigating actions and proposals and ideas have been shared with the Board and the Ministerial Team. However, unless the budget envelope moves, additional savings must be made. Ultimately this will be a political decision.

CD noted that the financial position is not changing. The £18m of reductions has been shared with the Ministerial Team and discussions are now being progressed politically. The NEDs have met with the current GOJ CEO and expressed concerns regarding the budget situation and received assurance that this is being dealt with as a GOJ wide issue (rather than HCS). However, there will be implications for other GOJ services as the GOJ seeks to balance the budget. The Board will await the outcome and the NEDs were reassured that the position would be known by July 2024.

12	HCS Response to Jersey Care Commission Single Assessment Framework Consultation	Action

CB explained that following the JCC presentation at the last Board meeting HCS has consulted widely (internally) on the proposed standards. In summary, HCS remains totally committed to the introduction of regulation and overall fully supports the principles and standards. There are a couple of specific comments (Appendix A) which will be sent to the JCC with a covering letter.

In addition, the second consultation (on legislation that will require the Jersey Care Commission to regulate hospital and ambulance services) has been considered. There are a number of technical issues that have been sent for comment by the Law Officers Department. HCS remains concerned about the issue of Registered Managers as the suggestion is that each ward / service manager is the Registered Manager. HCS does not consider this appropriate, and this does not the follow the CQC model – this responsibility sits with Chief Executive Officer and the designated Executive (Chief Nurse). Having multiple Registered Managers, some of whom will be junior members of staff is not something that HCS encourages.

CD thanked CB for his response and suggested that the latter should be included as part of the JCC response.

AH noted that Jersey is unique, and it is important that this framework recognises and captures this. AH emphasises this is not solely a hospital inspection; it includes community services, and it is important the Board has a sense of how HCS stands against the standards and what this means for future improvement work. CB responded that a gap analysis is being undertaken.

AM suggested that each Board agenda should feature an area included in the standards to aid understanding and identify potential gaps. Partnership working has been scheduled for Sept 2024. CD in agreement and hoping that the Director of Public Health will be able to attend in July 2024 to discuss the wider prevention programme.

CD suggested that the points made in Appendix A could be expanded when the response is returned so there is no misunderstanding and also include the concern regarding the second consultation.

The Board agreed this as the basis of the response to the JCC.

13	Outcome of the Root Cause Analysis of Deep Tissue Injuries	Action

JM took the paper as read and reminded the Board that this was drafted following an increase in pressure injury experienced by patients in hospital during March. A root cause analysis was undertaken for each incident and the theme of the damage related to the incorrect sizing of anti-embolism stockings (also known as compression stockings). These stockings are specially designed to help reduce risk of developing deep vein thrombosis (DVT) or blood clot in the lower leg. In response, organisation wide training and education was enacted to ensure correct measurements are taken to ensure the correct size stockings are applied to prevent future recurrence. A check has also been carried which showed that the training put in place has been followed.

Whilst it is regrettable and deep tissue injury should not occur whilst in HCS care, the damage identified was minimal. In addition, staff identified the pressure damage early and interventions were undertaken immediately to prevent further deterioration. In all cases, a full recovery has been made.

In April, the number of reported deep tissue injuries has reduced significantly to three. Following investigation it was identified that the common theme related to the timely repositioning of the patient. This is now being addressed through ward manager leadership reviewing care plans, peer reviews and specialist tissue viability nurse (TVN) support.

At the time of writing this report the number of reported cases has reduced to one. This demonstrates the impact of ongoing learning and improvement.

Additional ongoing work to support the prevention of pressure damage includes participation in the National Mattress Audit (8th May), review of pressure relieving devices available, care review rounds, workforce training and the launch of the Pressure Ulcer Prevention and Management Framework.

ACTION: Pressure Ulcer prevention to be monitored through the Quality, Safety and Improvement Committee.

14	Maternity Improvement Plan	Action

RBB in attendance and took the paper as read. Key highlights include,

- The refurbished maternity unit was officially opened on 8th May 2024 (note the paper incorrectly states 5th May 2024).
- Working towards the publication of the Maternity Dashboard
- Ongoing linkage of the breastfeeding and perinatal mental health support services
- Assurance of ongoing progress of remaining open recommendations, some of these are long-term, such as Culture.
- The Maternity Strategy is on target to be delivered for publication at end of June 2024.

- First perinatal mental health training modules have commenced for all midwives, support worker and doctors.
- Whilst the outcomes of the Niche Report were planned for presentation at the Board today, these have not been through the HCS governance processes yet and is deferred until July 2024. The reason for the delay is Niche were unable to present until 31st May 2024. An action plan has been developed by RBB and the patient safety midwife and will also be shared with the Board. To note, the NICHE report has not highlighted any new concerns with a significant number of recommendations having already been completed.
- The culture improvement plan will continue through June 2024.
- Following reconfiguration of the SHIP Integrated Care Board (ICB), HCS to align with this ICB.

CD asked if SHIP Maternity Services are regulated by the CQC. CS confirmed that Portsmouth is rated 'Good', Southampton are 'Good', Isle of Wight are 'Good' and unsure regarding Hampshire. CD reassured that HCS is benchmarking against organisations that are largely 'Good'. RBB confirmed that SHIP is one of the best ICB across England. SHIP was selected for this reason and because babies from Jersey are transferred to these hospitals. CS advised the Board of the Maternity Incentive Scheme where maternity units receive insurance rebates if they provide high standards of care. All units within SHIP received this status.

CB explained that the Maternity Strategy has been produced in response to a scrutiny recommendation and represents a long-term view of maternity services in Jersey and the challenges that a small healthcare jurisdiction presents (with a reducing birth rate). The date of publication will be determined by the Ministerial team.

CD reminded the Board that as progress has been so good, this should now be business as usual with monitoring at the Quality, Safety and Improvement Committee with escalation of items of concern to the Board. In addition, maternity indicators are included within the Quality and Performance report.

CD highlighted that the issue most difficult to determine is of culture – even with all the processes in place, how will we know when the culture has changed? CD sought to confirm that maternity will be targeted through one of the Pulse Surveys. CP confirmed that the whole workforce will be invited to complete the Pulse Survey and results will be available for specific areas. However, additional culture work (including listening events) will be carried out with maternity services. CD stated that the Board should receive feedback from the listening events to be reassured regarding the culture change (in addition to process and system change).

ACTION: Maternity feedback to be included in the next culture report to the Board.

In response to CS's question, RBB confirmed that the maternity unit is viewed as a multidisciplinary team (midwives, doctors, support workers, anaesthetists). RBB confirmed this is the approach taken in the NHS.

From a strategic level, AM commented that the Board should see on a quarterly / biannual basis progress against the strategy and are services developing according to the strategy.

ACTION: Progress against the Maternity Strategy to be monitored by the Board every six months.

An additional area of concern highlighted by CD is how do the women who have been in the maternity unit feel, what does it feel like for them and how can we determine this more regularly (than the Picker Survey). RBB responded that the Maternity Unit works closely with Maternity Voice Partnership and Baby Steps. Other communities have been reached out to for inclusion, however this is an area for improvement work. CD also suggested inclusion of women who have experienced traumatic births.

CD thanked RBB for her attendance.

15	**Medicine Improvement Plan**	**Action**

AN noted the Maternity Improvement Plan as an exemplar that Medicine will replicating to progress their improvement work.

- The Medicine Care Group had a large number of recommendations from multiple reviews (some of which were duplicated). These have been collated and consolidated, totalling 70 recommendations.
- A Head of Governance (Interim), dedicated Project Management Support, external physician advisory support and an assistant general manager are supporting the medical care group to deliver against the recommendations.
- Engagement with staff is key. The first Mortality and Morbidity meeting for five years has been held with 64 in attendance.
- Care Group Governance meeting had over 9 Consultants in attendance at the last meeting.
- The fifth inset day will be held next Monday, and it is oversubscribed with a waiting list.
- First strategy meeting held.

There is a lot of activity, and it is anticipated that progress will pick up pace, especially with the additional resource to focus on governance.

There was a discussion about where the medicine improvement plan would be monitored. CD concluded that as progress has been slow, it should be presented to the Quality, Safety and Improvement Committee in advance of the Board. The QSI Committee can raise the serious issues of concern at the Board meeting.

CG thanked AN for the openness of the report and acknowledging that progress is slow. CG offered to meet AN to discuss how she may be able to support this work.

CB noted that a key issue is Consultant presence on the ward, attending ward / board rounds etc. which is standard practice in healthcare jurisdictions across the world. CB reflected on a recent discussion with Dr Ian Sturgess (external physician advisory support with expertise in patient safety and operational flow improvement) and felt reassured that progress is being made in this rea. However, additional issues were raised such as facilitating earlier discharges and there is significant activity within HCS's control to improve this.

- A second Gastroenterologist Consultant, a Stroke Consultant (frailty registered) and an Acute Physician have been recruited. The appointed Stroke Consultant is a well-respected lead for Stroke Services and is keen to develop a proper Stroke Service in Jersey (though investment may be required). The Consultant has also been able to clear the waiting list for those who have experienced a Transient Ischaemic Attack (TIA) (in a 3-week period).

Noting the reference to the Patient Charter, CD stated it would be good for the Board to have sight of this. This charter has been developed by the Patient Panel for use across the organisation.

CD asked what the difficulties are regarding blister packs. AN described the current process which takes up to seven days. CD asked why HCS cannot produce blister packs. AN advised that the work needs to begin with defining what the service needs to deliver and what needs to be done to deliver it. There are issues regarding pharmacy capacity and governance. CG noted that hospitals in the UK do not discharge patients with blister packs and this is complex.

CD thanked AN for the candidness of the report and stressed that more progress must be evident at the meeting July 2024.

16	HCS Annual Plan	Action
Noted for information. AM advised that the document has been updated following feedback and now includes commissioning and other items. The plan will be published on the HCS website and will be available to all staff. HCS is ahead of other GOJ departments who have not yet developed an annual plan. Reporting on progress will come back to the Board. In addition, AM		

suggested it would be beneficial to start discussions in July 2024 regarding the Annual Plan 2025 (approved by January 2025). ACTION: The Board will receive a Q2 report regarding the annual plan in Sept 2024.	

	Questions from the Public	**Action**
Member A: *The Health Minister was asked by Scrutiny Assisted Dying panel to publish an update and progress of the actions on the Palliative Care and End of Life Strategy before the Assisted Dying debate on 21st May. However this update was not available although the report (and action plan) was published in October 2023 due to the working group needing to approve it. It is now due to be published by the end of July.* *Does the Board think this should be part of this Board's action plan and monitored in the same way as the maternity improvement plan given that the Assisted Dying Route one has been passed in the Assembly?* AM in agreement. A paper will be presented at the HCS Senior Leadership Team meeting during May 2024, and this should then feed up to the Board (July 2024), so the Board has visibility of progress including what is in place, what is planned if any gaps identified. ACTION: Palliative Care and End of Life Strategy update to be presented to the Board in July 2024. **Member B:** *Over the last few months HCS has stated they have adopted a zero-tolerance policy on racism which is exactly as it should be. With the election looming in the UK, Heston interviewed the Shadow Health Secretary Wes Streeting last week on TV who stated that he was aware that there was a culture that silences brave NHS staff who act as whistleblowers and puts protecting the reputation of the NHS over protecting patients and that it has got to stop. He said that a labour government would put patient care first, protect whistleblowers and sack those who try to silence them. These people would face immediate loss of office with no pay-off and we would ensure that they were never employed in the NHS in any role ever again. Are you prepared to confirm as of today you will adopt the same zero tolerance policy on bullying as you do on racism including bullying by management especially when it includes bullying, intimidation, harassment and hostility towards whistleblowers. If possible, will you ensure that any such people are reported to the NHS so this would also preclude them from being employed there as well?* (intended for the Minister for Health and Social Services but redirected to CB in his absence). CB advised he was unable to speak for the MHSS. CB confirmed that HCS has zero-tolerance of bullying. There must be evidence of bullying and upon investigation, it is not always the case that bullying has occurred. The Junior doctor that raised concerned regarding rheumatology was well supported and hopefully this encourages other whistleblowers to step forward. The Executive team meet with whistle-blowers frequently and are provided with support as these people are identifying concerns in care. There is a zero tolerance of intimidation of staff who wish to speak up and any instance will be investigated with action taken as appropriate. This is common sense in healthcare as people need to feel safe and must be able to speak up. There was agreement that bullying can also occur amongst peers, from managers to staff and upwards from staff to managers. Deputy Howell confirmed it is a priority of the current Ministerial team that bullying will not be accepted and the culture of the healthcare service should be as good as possible. AN responded that culture and communication are key (noting that whistleblowing is a very emotive word) and makes himself available / approachable if staff want to speak with him. This begins to change the culture and whilst there is a long way to go, the culture in medicine is starting to change. Establishing the facts is very important before taking action. However, often it is about discussing concerns and learning from them. Member B acknowledged that bullying is subjective and recognised that some staff can mistake for performance management for bullying. However, the above is in relation to clear bullying. CB	

reinforced that any individual who is bullied and / or asked not to speak up, this is a very serious matter.

CD advised that whistleblowers must be protected and HCS should seek to do this on all occasions. In addition, whistle-blowers should be provided with more than one route to raise their concerns. Jersey does not have the legislative framework that the UK has to protect whistle-blowers.

CD concluded that the real issue is culture. Member B thanked the Board for the assurances given.

Member C: *Member C asked if the same principles apply if doctors bully patients, using a recent personal experience where it was alleged that a recent comment was made to her.*

CD advised that if a doctor or any member of staff has made a racist comment, this should be reported and suggested this is discussed with CB.

Member C went to further to say that during a recent hospital stay, there was no pressure relieving pump available for 2 weeks and the HCA was unaware of how to measure / apply TED stockings. Also 'difficult' patients are left to sleep rather than turned. In addition, the reason for the lack of confidence in the data is due to the messages communicated by frontline staff – member C indicated that she was told she would have to wait at least 6 months for her MRI scan. Member C also highlighted that she had remined in hospital unnecessarily for IV antibiotics which could have been administered in the community (putting her at risk of hospital acquired infections).

CB unclear as to why any member of staff would have informed her that there is a 6 month wait for an MRI scan – this is not true. This needs to be investigated with the department and the outcome fed back privately to member C. JM will pick up the issue with the TED stockings.

Member D: *Regarding the lack of confidence in the data, member D stated that an individual has been told that he must wait for 1 year (with a waiting list of 200 patients) and please can you explain what you intend to do about this as I understand that no-one should wait longer than 6 weeks for a heart scan (CTCA) – life is in danger.*

EH explained that some work has started on the CTCA waiting list. In part there is a lengthy wait for a CTCA, however as previously stated all urgent cases are receiving the CTCA within an urgent timescale. The cardiologists and AN (Chief of Service) are developing a business case to support CTCA capacity. The CTCA waits are not currently reported, and CB emphasised this is different from a CT scan. CG asked what the wait is for a private CTCA scan but EH unable to provide this during the meeting. EH confirmed that the target for all urgent referrals is 2-3 weeks. A member of the public suggested that the private wait is 2-3 weeks regardless of urgency but EH confirmed this is incorrect. CB confirmed that if the patient referred to in the question was an urgent referral, he would be seen within 2-3 weeks – the Board concluded that he could not been referred as urgent. The Board was reminded that all referrals are triaged by the cardiologists. More generally, all referrals are triaged clinically (specifically not managers or administrative staff). CD referred to her earlier point that regarding the data, this is not what the public believe they are experiencing on the waiting list, and this can only be resolved by reducing the waiting lists considerably. A general discussion followed about miscommunication leading to lack of confidence in the data.

Member D asked if HCS is not receiving enough money to deal with the waiting list.

CB explained that the allocation of additional funding means that HCS could see more patients and reduce the waiting list (as demonstrated through recent insourcing / outsourcing initiatives). However, this is also dependent on recruitment, and this will be difficult in some specialities i.e. ADHD.

CD concluded that the main issue is communication and speculated that it could be that the right message is communicated but people don't like the honesty of the communication (noting this is a different matter).

Member E: *You mentioned that MRI waiting times are back up, where are they at the MRI waiting times?*

EH responded that the current wait is approximately 20 weeks.

In addition, *as far as you are aware no harm is being caused to people on the longer waits of to a year. How do you measure this and what do you consider harm?*

EH responded this is a clinical decision. The clinicians will review their waiting lists – some patients will be invited back to a clinic for a review and others will be a review of clinical notes. However, it is always determined by the clinician. Potential harm will vary according to the speciality and used rheumatology / gastroenterology as examples.

Member F: *We have heard about resourcing in the stroke / TIA waiting times by appointing a stroke consultant that save approximately £100,000 / year in locum costs. It took 5+ years to make this appointment and this is why we are having problems with acute medicine. We have seen a reduction in MRI waiting lists by pump priming a waiting list initiative with £100,000 and doing a 70 / 30 split of public and private. The private income generated from this paid for the initial £100,00 and this was a fantastic initiative of balancing public and private. The waiting list for endoscopy reduced with a cost of £800,000 as despite the two of us (before I retired) the waiting list continued to go up and now just recently appointed a second, I don't think things will change that much despite the £800,000 expenditure. The £18 million pound overspend is mostly on costs of people /locum / agency costs and by appointing substantive posts (consultants, nursing, physios) will save a lot of money by simply making appointments. We have clearly seen patient lists are completely dependent on not only recruitment but also retention of staff and that's what we need to do in terms of cultural change, in terms of looking at why people are leaving using the exit interviews which have just started. Unfortunately the culture has been developing over the past 15 years in my personal experience and only with the inception of using exit interviews we have realised there is a cultural problem. If we can pinpoint the line managers responsible for the departure of those individual frontline workers, then they need to take responsibility and ownership and they need to be taught how to manage their workers. As already illustrated, the cost of healthcare is substantial, and for the Treasury Minister to ask us to save money is ludicrous because really healthcare inflation is way beyond retail price of inflation. Really, we should be given the £18million rather than asked to save the £18 million. I would urge the Advisory Board to help clarify with HCS politicians that we really need more investment, we need cultural improvement in order to reinforce the future of our islands healthcare particularly with extra costs incurred by the multisite new hospital facility.*

CD thanked Member F for the comments and advised that there was nothing which the Board would disagree. The point regarding investment relates not only to the immediate deficit but also consider the investment need for a different Island healthcare system which will focus more on prevention – however, this is political issue and will take time. In addition, the financial points reflect the discussions held with the GOJ CEO yesterday (Tues 29th May) and Ministerial discussions.

Member G: *Noting the points made about the recent consultant recruitment, what is happening with Primary care i.e. the interface and the impact that primary care can have on the waiting lists. Has the development of specialist nurses been considered as good examples exist within gastroenterology, cardiology and many other areas.*

CG responded that international healthcare systems will not be able afford its healthcare unless it starts to transfer care out of hospital and invest in primary and community care and prevention. This will be discussed further at the Friends of Our New Hospital Healthcare Conference on 27th June. The different budget lines in Jersey make it more difficult to move resources and start to redesign services, however it is not impossible. CG will be starting to engage with the Primary Care Community and holds the view that much of current activity could be better managed further downstream. There are gaps in Intermediate Care and the use of digital. Closing these gaps could start to recover the current inflation costs. CG feels the point is well made and hopes to bring back further discussions to the Board.

CB advised that HCS meets with the GPs as part of the Primary Care Board (monthly) where a whole range of issues are raised. Using the example of gastroenterology, the use of specialist nurses is effective and specialist nursing is encouraged as all professions acting to the top of their registration. If the funding was available, more specialist nurses (and other specialist professionals such as AHPs) would be appointed as a fundamental part of the multi-disciplinary team. Member G responded this is a good to hear and was also thinking about primary care working within the secondary care setting. CG responded that this should be approached with caution as GPs would rapidly become secondary care minded and start to behave like Consultants. GPs are used to dealing with risk and uncertainty. CG stated that this has not worked in the UK. **Member H**: Reflecting on the discussion about affording whistle-blowers protection, should the same protection be afforded to patients who make complaints. CB responded that patient should not be afraid to complain as they fear that they may be treated differently (worse). Patients that raise concerns need to be protected and if any patient believes that they are receiving poor care as a consequence of raising the complaint they must contact CB or one of the Executive Directors – this is completely unacceptable. Member H stated this has been her experience and has been in contact with the Medical Director who has been helpful. This is inline with recent press coverage of complaints. JM will progress this individual case.	

	MEETING CLOSE	**Action**
CB thanked everyone in attendance for their contributions and advised that she will be on leave for the next meeting; AH will Chair the meeting. **Date of next meeting:** Thursday 25th July 2024		

Government of JERSEY

Gouvèrnément d'Jèrri

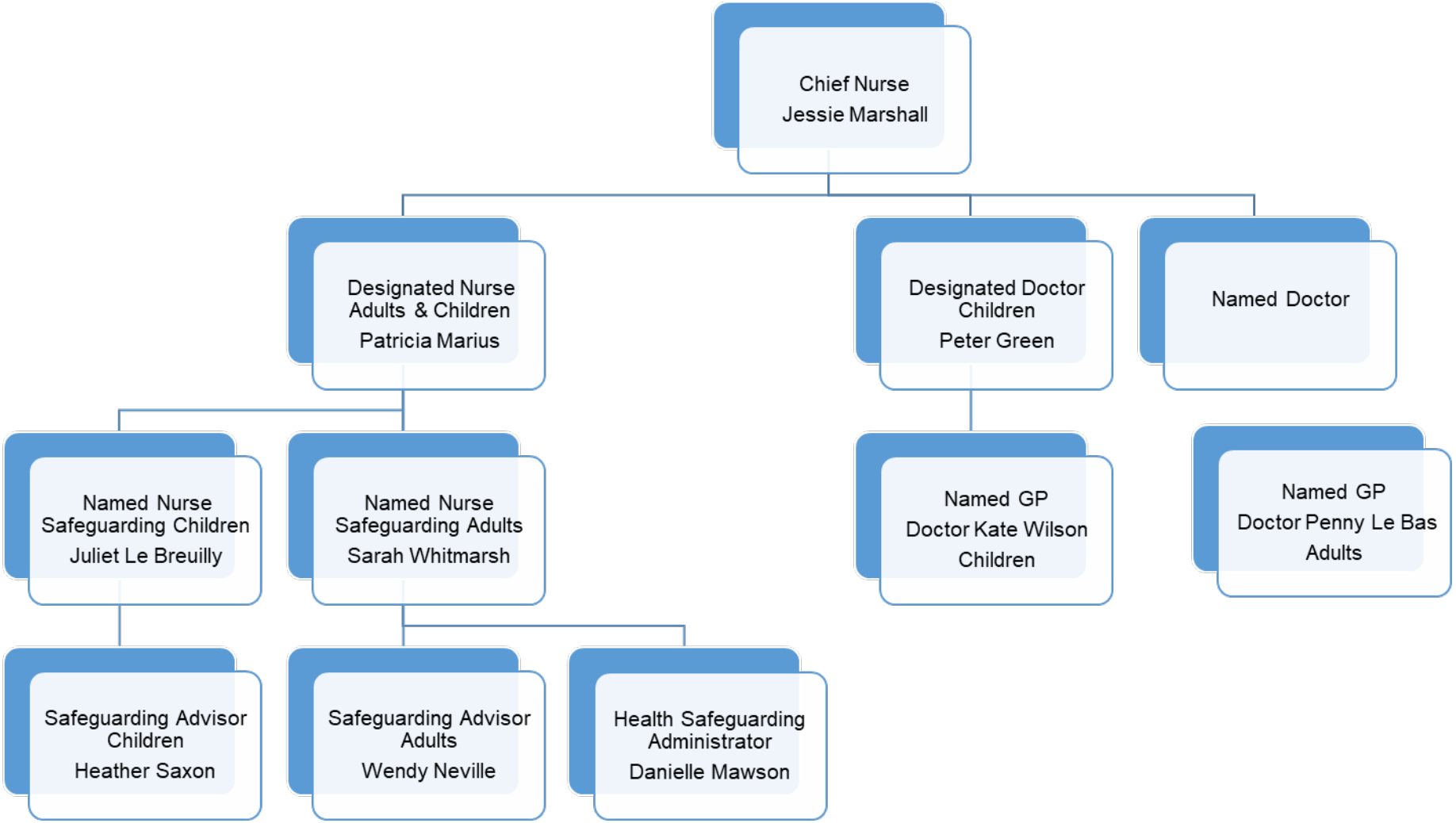
Safeguarding Overview – Children & Adults

Health Safeguarding Team

Vision Statement

To Safeguard and promote the welfare and wellbeing of babies, children, young people and adults at risk of abuse and neglect across the health economy. Health and Community Services is committed to safeguarding all patients, service users and staff emphasising safeguarding is everyday business and not a choice.

Safeguarding Team



Safeguarding Adults Team

Budgeted 3 posts – 1 team lead and 2 practitioners.

Reporting through Social Care General Manager to Director of Mental Health & Adult Social Care.

Due to level of demand / activity, additional 2 practitioner posts non-recurrently funded.

Team responsible for screening, investigation and coordination of all adult safeguarding referrals, including formal enquiry and large scale investigations.

515 referrals in 2022; 557 in 2023 ; 173 in 4 months of 2024 (with an additional 82 requests for advice)

- Key sources of referral are HCS, police and care agencies.
- High levels of physical health need, mental health need and cognitive impairment
- Main categories of alleged abuse (in descending order) are neglect, psychological abuse, domestic abuse, financial and self neglect.
- Need to review the Managing Allegations policy (as some identified gaps) and agree a self neglect policy
- Significant work undertaken on Making Safeguarding Personal; team now obtaining regular MSP feedback
- Current review of referral / front door process with SPOR and mental health services
- Significant pressures linked to SRoL processes & outstanding assessments

HCS Committee Structure

- HCS Safeguarding Committee established 2022
- Purpose of committee is to provide assurance across HCS on safeguarding activities and emerging trends
- Committee meets monthly the structure is divided into Bi-monthly meetings to:
  - Monitor and review actions/recommendations from Serious/Rapid case reviews
  - A multi- professional meeting focusing on training and development needs

Chief Nurse and Director MH&ASC both sit on Safeguarding Partnership Board

Safeguarding Children Accountable Officer Group in place across Government, which reports into Ministerial Safeguarding Group.

Children and Young People Law 2022

- The Children and Young People Law came into effect 2022
- The Law aims to promote and support the wellbeing of children and safeguard their welfare.
- The Law includes new responsibilities for all organisations who work with children, young people and their families.
- Requires all staff to complete training depending on their role

Training Modules	Training Numbers
Introduction to Statutory Guidance Training	1042
Working together	520
Information sharing	552
Corporate Parenting	290

Identified Risks, Challenges & Learning

- Lack of statutory framework (Care Act)
- Increased activity – both children & adults
- Self neglect
- Domestic abuse
- Complexity – working across agencies / boundaries
- Pressure on training resources (increased with mandatory training)
- Significant Restriction on Liberty Assessments
- Commissioned Royal College Looked After Children review
- On-going medical provision for safeguarding children
- Multi-professional / multi-agency communication