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

Health and Community Services

Date: 28 November 2024	**Time: 9:30am – 12:30pm**	**Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL**

Non-Executive Board Members (Voting):		
Carolyn Downs CB - **CHAIR**	Non-Executive Director	**CD**
Dame Clare Gerada DBE	Non-Executive Director	**CG**
Anthony Hunter OBE	Non-Executive Director (TEAMS)	**AH**
Julie Garbutt	Non-Executive Director (TEAMS)	**JG**
David Keen	Non-Executive Director	**DK**
Executive Board Members (Voting):		
Tom Walker	Chief Officer HCS	**TW**
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**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Paul Rendell	Chief Social Worker deputising for Andy Weir, Director of Mental Health, Social Care and Community Services	**PR**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Ian Tegerdine	Director of Workforce	**ITe**
In Attendance:		
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (TEAMS)	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Dr Clare Newman	Healthcare Lead, NHF (Item 7 only)	**CN**
Jessica Hardwick	Programme Director for NHF Programme (Item 7 only)	**JH**
Deanne Bratch	Interim Business Lead, NHF Programme (Item 7 only)	**DB**
Gary McGuire	Delivery Lead, NHF Programme (Item 7 only)	**GMG**
Sarah White	Digital and Engagement Lead, NHF Programme (Item 7 only)	**SW**
Ruth Johnson	Associate Director Health Policy (Item 17 only)	**RJ**

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

CD welcomed all to the meeting.

Dr Mark Pugh was introduced. MP will be working in an advisory capacity on medical governance and other medical issues more broadly.

Apologies received from:

Andy Weir	Director of Mental Health, Social Care and Community Services	**AW**

Quorate: Meeting is quorate.

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

No declarations.

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

The minutes of the meeting held on 26 September 2024 were agreed as an accurate reflection.

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

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ACTION 31: OH advised that budgetary information is now available, and the training programme is in place. Agree **CLOSE**.

a. Feedback on issues raised at the previous HCS Advisory Board meeting – externally commissioned providers.

The Board received a paper providing an update from HCS Senior Leadership Team (SLT) following direction from the Chair at the meeting on 26 September 2024 to consider the impact of inflation on externally commissioned services.

CD thanked the HCS SLT, specifically AM and the Head of Commissioning and Partnerships, Emma Polhill, for progressing this and the agreement in principle to pass on non-pay inflationary funding received by HCS to contracted providers, subject to States Assembly approval of the proposed Government Budget 2025-28 and HCS budget setting agreement.

CD stated this is a very positive outcome.

5	Chair’s Introductions	Action
Whilst acknowledged at the previous meeting, CD reminded the board that this is PA’s last board meeting and thanks were conveyed for all his contributions to the board over the last 12 months.		

6	Chief Officer Report	Action

TW stated it is privilege to be the new Chief Officer for HCS and a member of the board.

Since starting in post, TW has been meeting HCS colleagues and visiting staff in their services to understand their experiences of delivering care. There are still a number to visit in addition to a range of external providers.

Focus has been on the quality, effectiveness and safety of HCS services. A great deal of improvement work has taken place over the past couple of years. Good team working is now essential to ensure the continuation of improvements in a way that is consistent with public service values.

As senior responsible officer for the New Healthcare Facilities (NHF) Programme, TW has also spent time with the NHF Programme team as this will be an ever-increasing important part of the role to ensure delivery of facilities that meet the healthcare needs of the Island. Whilst there is a lot of focus on the Overdale site, the sites at Kensington Place and St Saviours are of equal importance (if not more) owing to their contribution to whole system working (referring to discussion taken place in item 7).

TW has also been supporting the Minister for Health and Social Services (MHSS) on the plans for integrated health and care in Jersey. These proposals are incredibly important for whole system working as a partnership of providers on the Island. This will be discussed in more detail later on the agenda.

Time has also been spent understanding the current position regarding digital technology. Martin Carpenter (MC) was welcomed as the Chief Clinical Information Officer (CCIO) for HCS.

TW drew the board's attention to the staff recognition work, namely the HCS Our Stars Awards where > 400 staff were nominated by their colleagues for their work. The winners are detailed in the CO report. TW emphasised the importance of recognising where we have stars within HCS.

The establishment of the freedom to speak up (FTSU) champions network is an important milestone. A speaking up and listening culture is going to be incredibly important for both HCS and the board and will require continual focus. Both the Chief Nurse as the executive lead for

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FTSU and Dame Clare Gerada as the non-executive lead for FTSU have been working hard to support the establishment of this network. CD thanks TW for the report and offered her apologies for not formally introducing both TW and MC.	

7	The New Healthcare Facilities (NHF) Programme	Action

The board welcomed,

- Dr Clare Newman (Healthcare Lead, NHF),
- Jessica Hardwick (Programme Director for NHF Programme),
- Deanne Bratch (Interim Business Lead, NHF Programme),
- Gary McGuire (Delivery Lead, NHF Programme)
- Sarah White (Digital and Engagement Lead, NHF Programme)

The aim of the presentation is to provide the board with an overview of progress of the NHF Programme, specifically how the public will be involved moving forward and the design of the interior. In addition, how this aligns with other services across the Island.

A series of slides was presented and are attached as an addendum to these minutes.

Noting that the need for acute care is likely to decrease over the next 10 – 15 years, CG asked if this has been considered as part of the NHF. JH responded that the multisite submission answers this is in part: acute services and ambulatory care provision. The modelling was based on the 'do nothing' option explored by a previous project, the Jersey Care Model (JCM) and forecasts demand and capacity to 2036. In addition to housing the mental health facilities, the Health Village at St Saviours will provide step down beds, rehabilitation and beds for those requiring care with dementia. The approach is to ensure that all facilities within the NHF are flexible to adapt to changing services.

Reflecting on a visit to Enid Quenault (EQ) Centre yesterday, CD commented that the refurbishment is very good, and it is encouraging to note the flexibility of facilities as EQ does not appear to be maximising its potential. Secondly, with an ageing population and the current rising social costs (particularly for off-Island services), there is a case for a review of the entire estate and intervening in the social care market more proactively to enable people to receive care in Jersey and reduce costs. Has this been considered? Thirdly, how has the ratio of single rooms to bays been calculated and what are the criteria for patients being placed in a single room versus a bay?

JH responded that the remit of the NHF Programme team is to engage with colleagues and understand the brief. The forecast and service modelling are a separate workstream to the NHF workstream, but the flexibility of design will address this in part. This programme is being delivered in the same way as new hospital programmes in the UK with the separation of the acute services from other services. CD advised that the creation of integrated care hubs in the UK are designed to prevent acute hospital admissions and suggested that EQ would be an ideal integrated care hub, sitting alongside and complementing acute services. JH stated that the EQ facility was initially designed to deliver services decanted from the Overdale Site, however it also provides an opportunity to reevaluate the types of services delivered at this site to adapt to need. As a word of caution, the conversion of the former school to EQ required a planning process and any future development of the site may be constrained by planning requirements.

CD concluded that all these issues must be considered strategically in the future to ensure that the NHF delivered are fit for purpose and address need.

CN clarified that the ratio of single rooms to bays. Each ward will have 30 beds split into 22 single rooms and two x four bedded bays. The criterion for use is an operational decision. CD advised that the NHS is directing only single rooms and in response CN explained that this decision was based on feedback that sometimes patients do prefer to be with other people and may require higher levels of observation that cannot be provided in a single room for safety reasons. The bays can also be split according to gender.

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Following an invitation for the HCS executive views on the NHF, CT advised there is good clinical engagement particularly with the Chiefs of Service and other senior members of the hospital team. Moving into next stage is an exciting time as staff will be able to see what specific working environments will look like. The environment for patients will be much improved and it is encouraging to see this work progressing.

OH asked what consideration has been given to the operational costs. DB responded that the outline business case introduced modelling for the running costs i.e. facilities management costs, capital lifetime cost and clinical costs. Clinical modelling costs to-date are based on functional brief, demographics and service provision, taking a theoretical view. Consideration has also been given to the multi-site vision and whether this introduces duplication. The importance of revising the workforce strategy, considering the impact of digital advancements and new ways of working was emphasised, highlighting the need for detailed planning and collaboration with HCS colleagues to move forward.

OH stressed the importance of working closely as the programme progresses, highlighting that integrated care can provide efficiencies and synergies if planned well, especially regarding the social care element.

Referring to patient flow across the whole system, PA commented that this will depend on the MHSS strategy, changes in technology and changes in healthcare delivery. The issues of most concern for staff include how they can cover all sites, and the skills needed. Emphasis on the need to develop a flexible workforce plan that maximizes the potential of all professional groups.

CD responded that workforce planning must be addressed soon and ITe advised that regular workforce meetings have begun, part of which is to look at how the development of workforce plans for both HCS and the NHF can be done in tandem. An island wide workforce plan is also a consideration. Noted that without a clinical strategy, creating a workforce strategy is challenging.

ACTION: HCS to prepare and present a report early 2025 outlining all the preparatory work that HCS needs to undertake for 2028 i.e. clinical strategy, digital strategy and workforce strategy. The report is to include how this will be achieved with timescales.

CD thanked the NHF Programme team for attending this morning and the board will be working to support the operation of the facilities once built.

8	HCS Annual Plan 2025 and Quality and Performance Report 2025	Action

The HCS Annual Plan 2025 provides the department and the board with key objectives and actions for 2025. The Annual Plan objectives and actions have been developed based on key themes arising from 2024 and through various workshops with colleagues. Wider staff feedback was gathered through a survey and has been incorporated in the tabled draft. A review of the key performance indicators has also been undertaken and is included within the papers.

Following feedback from the board last year, the following improvements have been made,

- planning for 2025 started much earlier this year meaning that the plan will be in place ready for the 1st of January 2025.
- the development of very specific objectives and actions which will facilitate monitoring and reporting throughout 2025.
- Inclusion of data definitions and data source under each metric in the Quality and Performance Report (QPR)

Noting these improvements, CG thanked AM for the work required to develop this, demonstrating real progress. These comments were echoed by CD and in addition, it is very encouraging to see a more focussed plan. CD further commented that the use of outcome measures is a good step forward, however some of these could be more specific to facilitate monitoring progress.

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AM thanked the board for the feedback which will be considered to further improve the plan. JG commented that it was encouraging to see the inclusion of commissioned services and related indicators. This reflects the interest that the board has in commissioning and also looking to the future regarding the MHSS's plan of whole system working. However, the board requires more assurance regarding purchase of tertiary services and asked if further consideration could be given to this. The absence of adult social care indicators was noted and PR advised these could be presented to the board in January 2025. ACTION: The board to receive the proposed adult social care indicators in January 2025 (AW). CD concluded that this is a real positive development from last year and the board endorses this plan for 2025.	

9	Harm Review – Patient Tracking List Management Process	Action
The board received a paper providing assurance around the process for harm review for patients with extended waits including clinical triage, monitoring and tracking, capacity and demand modelling, clinical oversight, incident reporting and the improvement work planned for the next six months. CT verbally summarised the report. Key point, • To-date, only one incident of harm has been identified and reported through Datix because of a patient long wait in 2024. The investigation took place through the serious incident process. The patient did not suffer any long-term harm. CG thanked CT for the report and asked how harm is assessed. CT responded that the Datix system was reviewed to establish whether any incidents of harm (both physical and psychological) related to long waits had been reported. CG stated that whilst reassuring, the low level of reported harm suggests that many individuals on the waiting lists may not need to be there. Noting the reference to patient-initiated follow-up, CG expressed an interest in whether this reduces follow-up rates. MP advised caution about relying on the Datix system as the sole indicator of harm and HCS should think of other more proactive ways to monitor this. Harm costs money and the key to eliminating harm is to eliminate the waiting lists. CD noted that waiting lists have been adversely impacted by capacity issues regarding estates and equipment, with no reference to this in the improvement section and asked if there is anything that can be done to help improve this. CT responded that the existing inpatient infrastructure has been improved. The issue in the paper is specifically related to an electrical panel in theatres, which is not part of the standard estate's refurbishment programme. Theatres were scheduled for routine maintenance rather than significant refurbishments. However, HCS is aware of the challenges of managing an ageing estate and has a planned maintenance approach in all areas. CD speculated that as the NHF approaches completion, there might be a tendency to do less maintenance on the current estates, potentially increasing waiting lists. Therefore forward planning is needed to reduce waiting lists by the end of 2026. ACTION: The board to receive a harm review paper in June 2025 including a broader interpretation of harm.		

10	Winter Plan 2024	Action
The board received a paper detailing the steps being taken to respond to bed capacity pressures inherent with the winter season due to additional demand associated with respiratory illness. Noting the key role that allied healthcare professionals have in admission avoidance, discharge and facilitating flow, CS asked if this staff group have been fully engaged. CT confirmed this. In		

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response to CD's question regarding whether HCS can afford the winter plan, OH advised this has been factored in.

The board noted the report.

11	Finance M10	Action

Paper taken as read. Key points,

- The Financial position for YTD Month 10 is a £24.7m deficit vs budget giving a headline monthly run-rate of £2.5m.
- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £2.3m.
- The FY24 year-end forecast is a deficit of £28m after delivery of additional savings to mitigate the underlying risk of £29.5 million deficit. The forecast has been updated to a £28m deficit, following a further detailed review of the deficit range previously reported of between £24.5m and £29.5m. This is due to the net impact of additional savings delivery from FRP and Cobra actions of £2.9m vs target £5.3m, and absorbing significant continued non-pay cost pressures, particularly from steeply rising costs of social care and mental health packages, tertiary care contracts, and high-cost drugs.
- FRP savings delivery YTD M10 is £7m vs £4.3m plan, made-up of £4.7m against original schemes and an additional £2.3m of mitigation schemes to recover slippage and additional cost pressures identified.
- Forecast savings delivery for FY24, including additional FRP and additional Cobra actions, are £8.1m vs plan of £5.2m, over-delivering by £2.9m, which mitigates against the above cost pressures reducing the underlying forecast deficit to £28m.

Recovery actions being taken include:

- Financial Recovery Actions led by Cobra Executive Team – Additional savings to reduce underlying deficit of £29.5m to the mitigated forecast of £28m or less.
- Sustainable long-term funding – a paper has been shared with Treasury and the MHSS for discussion and the board, making the case for a long-term sustainable funding settlement for HCS.

Risks and Opportunities

- Risks to the year-end forecast are from rising costs of social care and mental health packages, the high price and volume of tertiary care contracts, impact of high-cost drugs, and additional charges from accommodation voids.
- Opportunities that may benefit the year-end forecast are potential stock gain, long outstanding amounts to be written-off, and overprovision of PPE Stock.
- Agency nursing staff have reduced from 140 in January 2024 to 38 and < 20 by year-end.

Budget Planning 2025

- Budget planning and monitoring of expenditure for 2025 – budget planning for 2025 is underway, for budget sign-off and completion by the end of Dec-24. With new financial reporting tools, accountable budget owners will be able to monitor and manage their budgets actively and timely way.
- The overall budget amount for 2025 for HCS is detailed in the proposed Budget 2025-28. The Budget planning process for 2025 will ensure that planned income and expenditure fits within the allocated budget.
- Work is progressing on the development of a proper Operating Plan for HCS, starting with the 2025 budget planning cycle and for completion by 2026 that will allow HCS to determine each year the level of funding required to run a sustainable health service that fits within the available budget funding. The operating plan requires activity information at speciality level i.e. this is demand and this is the capacity (workforce, theatre time) and this is the financial impact of delivering that– this would then be compared to the financial envelope and what is achievable. However, these are not well developed.

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Noting the explanation of the operating plans, CD stated it is concerning that these are plans are not yet fully in place and therefore how confident can the board be about delivering against the budget? It is important for the credibility of HCS and the board to deliver services within the financial envelope as this has been extended considerably.

In addition, noting the three big risks i.e. social care costs, tertiary care costs and mental health costs - what is being done to mitigate these?

ACTION: The board to receive a report early 2025 detailing how these three risks are being mitigated.

As the NED for strategic finance, CD invited DK to comment. DK thanked OH for the reports, particularly the transparency of reporting. The year end position will be known in the next couple of weeks, and it is likely to be around £28m. The implication for 2025 is that HCS is starting with a run rate that leads to a further £28m loss, this does not fit in the budget envelope. It is key to focus on this now and this is addressed in part through the financial recovery programme (FRP). Very important to focus in 2025 on services, processes and products that can be adjusted immediately, and this may involve difficult decisions.

As one of the Chief Officer's priorities, CD invited TW to comment. TW reinforced that the States Assembly have decided to support HCS by moving more resources towards health and care as part of the budget 2025. This has not been an easy process and has impacted other parts of the public service. This makes it even more important that HCS meets this commitment to work within the revised financial envelope, but this will not come without challenges. The credibility of the board rests on being able to deliver within the envelope and the States Assembly has placed trust in HCS to deliver.

TH invited PR to comment regarding social care costs. PR informed the board that some productive work has been undertaken regarding domiciliary care and an engagement session was held last week with this sector. However, costs may rise further in 2025. There are two strands, firstly off island placements which collectively represent a significant cost and secondly, on-island cost which is significant and rising. PR in agreement with the CD's early point regarding the need to intervene in the social care market – PR highlighted two specific areas, nursing beds and EMI provision.

Calculating approx. 90 years of sick leave per year in a relatively healthy population (reflected in locum / agency staff costs) CG asked how the financial plan for 2025 is linked to workforce and whether this sick leave is long term or minor illness. The data indicates that each healthcare practitioner in Jersey takes > one day per month as absence. Reducing patient services will not address escalating costs linked to sickness absence leave. ITe responded that staff costs in the finance report are driving some of the overspend. Encouragingly, 11 more agency staff have been exited in the last month with an overall month-on-month reduction in numbers. Minimal agency staff are covering sickness absence as this is built into nursing rosters and covered by HCS staff.

The People and Culture Committee received a deep dive into sickness absence and HCS is average compared to the benchmark. Whilst this is an issue, driving sickness absence rates below average does not represent a significant opportunity. However, there have been changes in the way sickness absence is managed,

- Completed review of all staff on long term sickness to ensure appropriate support and care, Occupational Health (OH) engagement and supporting return to work.
- Current review of short-term sickness. This requires upskilling line managers to actively manage and support staff back into the workforce. Noticing pattens of sickness which can indicate distress.

CD concluded that HCS must deliver against its commitment to deliver within budget and be prepared for the work required in 2025 to achieve this.

ACTION: To drive delivery against the budget in 2025, the board is to receive more detail regarding risk and mitigations (for each board report). At every board meeting, where there is a variance to budget, a mitigation report must be presented. The board **NOTED** the report. JM clarified that sickness absence refers to all staff groups, not limited to nursing staff.		

12	**Workforce Month 10**	**Action**
Paper taken as read. CD asked the board to note the recruitment achievements and thanked ITe and his colleagues for this. The board **NOTED** the report.		

13	**Quality and Performance Month 10**	**Action**
Paper taken as read and questions / comments invited. TH informed the board that he had a meeting yesterday with members of the adult safeguarding team and was very impressed and assured regarding the focus and grip on safeguarding issues. All adult social care staff are fully trained, and it is good to see engagement with Police and General Practitioners (which is not necessarily the case in the UK). The ambition for integrated access to safeguarding within wider care is notable. The board **NOTED** the report.		

14	**Committee Reports:**	**Action**
a. People and Culture Committee Paper taken as read. No issues raised. CD explained it is a well-attended Committee with staff and trade union representation. Good discussions take place. **b. Finance and Performance Committee** CD invited DK to comment. The committee held lengthy discussion regarding finance and the issues raised during item 10 this morning. The committee also received a detailed report from the Head of Estates explaining the pressures of maintaining the current infrastructure within the budget. **c. Quality, Safety and Improvement Committee** CD invited CG to comment. CG sought to reassure islanders that the quality of care is improving, and significant improvements can be seen in maternity, pharmacy, medicines management, complaints and serious incidents. Whilst there is still room for further improvement, things are getting better. CD reflected on this and emphasised the benefit of giving focus to improvements already achieved.		

15	**Medicine Improvement Plan**	**Action**
Paper taken as read and CD invited comments. CT explained that one of the most significant issues in responding to the Royal College of Physicians (RCP) recommendations is the implementation the medical model and the board has held discussions regarding this, and the investment required. Inpatient acute care is very much the priority in budget setting for medicine and should resolve this recommendation. However, this may have an impact on delivery of other services.		

16	**Maternity Improvement Plan**	**Action**
Paper taken as read and CD invited comments.		

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PA highlighted that the improvements seen in maternity services are very encouraging and weekly monitoring is now covered as business as usual within the care group. The majority of the recommendations have undergone a 30/60/90-day review to provide assurance that the change has embedded.

Maternity won Team of the year at the Our Stars Awards.

PA asked the board to recognise the hard work and efforts of the care group in its achievements.

17	Integrated Health and Care System Proposals	Action

RJ in attendance and presented a series of slides detailing,

- the proposal of the MHSS for an integrated health and care system,
- the consultation that has taken place
- the feedback received (slides included as an addendum to these minutes).

Key points,

- The MHSS has made a public commitment to support health and care organisations to work better together. There is overwhelming evidence from other jurisdictions that when health and care organisations work together, it enables those organisations to make better use of resources including skills, staff and funding. It helps to deliver better outcomes for individual patients due to a joined-up care journey. It can also help to support improvements to the health and well-being of the whole population which can reduce the overall spend on health and care services.

- The ability to control the envisaged increase in spend on health and care services is very important because as the population ages and as health inflation continues to rise, the public are going to have to invest a greater proportion of the island's money into health and care.

- The MHSS developed some initial proposals regarding how providers could be supported to work better together, and this was consulted on during October and November, engaging GoJ health and care providers, Public Health (PH) and Jersey Ambulance Service (JAS). In addition, external providers of health and care services including 3rd sector, and also other key players within the health and care sector such as the Jersey Care Commission (JCC) and the NHF Programme Team. Following this an integrated health and care system has been proposed reflecting the feedback received.

- Proposal to set up a ministerial policy group which looks at the wider determinants of health and well-being.

- The health and care services board referred to is the HCS Advisory Board. There was overwhelming feedback that the board is delivering value and that it should continue.

- There is a proposal that the three core sources of public funding are brought under the control of one Minister; annual taxpayer budget that goes to HCS, the health insurance fund (HIF) and the long-term care (LTC) fund. This would help to support more joined up decision making.

- There was a proposal to establish a new partnership board which will include an independent chair and partners from across the health and care sector.

- Proposal to rename HCS as Health and Care Jersey. This signifies an important culture shift in the way that the GoJ views its role and responsibility towards health and care of islanders. The word department will no longer be used as the need to engage non-GoJ much more closely is recognised. There will be two core divisions, firstly the service division which is broadly HCS and has responsibility for delivering hospital services

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mental health services and community services. Feedback is very supportive of JAS moving back to Health and Care Jersey (currently sits in Justice and Home Affairs). The second division is the island division and will have the key officers and functions that focus on integrated health and care and working with partners across the system.

Feedback

The feedback received was qualitative rather than quantitative as people were spoken to in face-to-face meetings as opposed to surveys. A feedback report was published on the 22 November, and this is available on gov.je.

Key points,

- There was almost universal support for the principle of integrated and whole system working and for the proposed arrangements although this was subject to further detail and clarification.
- Some concerns were expressed by both GoJ and non-GOJ consultees regarding the ability of the GoJ to deliver meaningful change (based on previous experience).
- Consultees were clear that cultural change is required in addition to the proposed structural change. As examples, GoJ acknowledging the expertise and contributions of other providers across the system and all providers needing to prioritise Islanders, not the resources for their individual services.
- A principles-based approach needs to be taken to the work. If preventing ill health in the first instance is a core principle of the work of Health and Care Jersey, then we should not be seeking to disinvest in prevention to invest in treatments.
- Regarding the partnership board, feedback included establishing this as soon as possible. Partners who sit on this board should hold joint responsibility and ownership of decision making across the whole system. The GoJ should share authority, responsibility and accountability. The partnership board's key duties should include the development and oversight of the delivery of a whole system heath and care strategy and models of care. The partnership board should have statutory powers that would protect the board and the role and authority of board members from interference by the GoJ and States Assembly.
- The HCS Advisory Board must be maintained to focus on the quality and performance of health and care services, rather than on strategy across the whole system.
- An independent chair is essential to the partnership board. Partners should also be renumerated as this is essential for requiring standards of participation.
- There needs to be secretariat support function to the partnership board which requires investment.
- Partners would provide service specific information whilst avoiding individual business interests.
- Feedback generally supportive of the change of focus to whole system rather than services. However, steps need to be taken to protect non-service budgets and resources to ensure that the Chief Officer has capacity to operate across the whole system.
- Need to protect the PH function as a critical friend.
- Universal agreement that JAS should move back but this requires more detailed planning.
- Both PH and Health Policy should be part of Health and Care Jersey to drive focus on the whole system.
- The question of whether Children's Service (currently sitting in CYPES) should move has split opinion and can be considered later. It is not a consideration during phase one.
- Proposals to move environmental health were rejected.
- Universal support for improving commissioning functions within the department to ensure a whole system approach to commissioning, including the commissioning of services delivered by HCS. Need to develop a Jersey specific approach to commissioning.
- A lot of emphasis on primary care and the need to rebuild a focus on primary care, rather than just General Practitioners (GPs).

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- Patient complaints and suggestions should be decoupled from the GoJ system.
- The funding changes were supported in principle although this will require very clear proposals on how money for LTC and primary care will be protected.
- GoJ needs to accelerate work on health and care due to the evident need to invest more money in health and care systems.

Next Steps

- The MHSS will brief the Council of Ministers and States Assembly members next week (week commencing 2 Dec 2024). Following their support, a transition plan will be developed. It is intended to move towards the new arrangement on 1 January 2025.
- Bringing forth proposals to set up the new partnership board and seek the continuation of the HCS Advisory Board during Q1 2025.

CD thanked RJ for the presentation and stated it was encouraging to see feedback being considered and incorporated into the revised proposal.

RJ agreed that the transition plan can be shared with the board once developed.

CG sought reassurance that the Health Insurance Fund (HIF) would remain protected when moved. The plan, pending approval, involves a minor legislative change regarding the responsible Minister, with no other legal protections for patient funds being altered. CG thanked the Minister, and everyone involved for their efforts, especially in conjunction with the NHF Programme.

CD expressed the board's support for the proposals but highlighted the need for clarification on certain details, including the statutory powers of the board and the roles and accountability of the Island-wide positions (Chief Nurse/Medical Director) in relation to hospital roles.

ITe enquired about the inclusion of strategic workforce planning in the proposal. RJ explained that a workforce strategy will be a key part of the overall health and care system strategy, with the partnership board responsible for its development. It's important to integrate the GoJ workforce strategy with the Island workforce strategy, rather than developing them separately. Discussions with the NHF Programme team suggest these are more operational issues. The current plan is for the partnership board to develop a comprehensive health and care system strategy, which includes a workforce strategy. This strategy will cover the workforce needs for both government and non-government services.

CD enquired about HCS representation on the partnership board. The Chief Officer of HCS and the Finance Director will be voting members. The Director of HR, with an expanded role, will also attend. The partnership board will lead the development of the Island workforce strategy, including the new hospital's needs.

CG enquired about the representation of mental health and community services on the partnership board. The leadership structure within HCS is still being resolved. If there is a deputy chief officer responsible for service delivery, they will sit on the board. If not, the lead officers for the hospital and mental health services will be the representatives. CG emphasized that the board should discuss the proposed deputy chief officer role.

TH acknowledged the significant effort in developing the proposals, emphasising the importance of assessing the benefits of cultural changes and incorporating independent review processes. Regarding commissioning, TH highlighted the opportunity to evaluate current and future community needs and determine the best service providers within a clear partnership framework.

In conclusion, CD thanked RJ for the presentation and work to develop the proposals. The board looks forward to implementing the new system and continuing discussions on the issues raised. The proposals received support from the board.

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18	**Pharmacy Improvement Plan – Prioritised Actions and Culture**	**Action**

On the 26 September 2024, the board noted > 50 recommendations made in the report and asked HCS to identify priority actions which would have greatest impact. These have now been condensed into five themes.

PA took the paper as read and advised that the themes align with the subheadings of the original report: culture, workforce, workload, education and training. The paper describes the work taking place in each of these and the areas that have been identified as priorities. Whilst all the actions still exist and will be addressed, this paper describes the initial focus.

Firstly, CD advised she met with colleagues in pharmacy yesterday and generally feedback pointed towards improvement which is positive to hear. Secondly, whilst the paper references the resolution of private prescription (private referring to GP prescriptions rather than paid for hospital consultant services), feedback from pharmacy suggests this is not the case. Both inpatients and outpatients continue to be prescribed repeat prescriptions which should generally be done through their GP. In addition to the financial impact, this also prevents pharmacy staff from spending time on the wards focussing on medicine's safety; this requires further review.

Staff from pharmacy have been invited to the next People and Culture Committee (January 2025) to discuss the cultural change improvements and share their experiences; the executives were asked to encourage this.

CG remains concerned about prescribing, specifically the loss of ward pharmacists to dispensing which affects quality. CG suggested a deep dive into pharmacy at a future workshop.

ACTION: A deep dive into pharmacy to be scheduled for a future board workshop (EOC).

CD commented that the approach detailed is better than the 50+ recommendations but it is unclear as to how some of these will be measured.

ACTION: Measurable outcomes to be included in future pharmacy reports.

19	**Board Assurance Framework**	**Action**

All relevant issues have either been discussed at the board this morning or a previous committee.

20	**Board Performance Review**	**Action**

CD advised that it is good governance for the board to assess its performance and this process will be undertaken. This is also a requirement of the States Assembly.

EOC explained that the review will follow an established framework. Public engagement and feedback will be an important part of the process, and the communications team will be engaged to support this.

	Public Questions	**Action**

Member A:
Member A made three comments:

1. Assessment of harm should include those in pain.
2. Social media posts suggest people seek private consultations before transferring to public waiting lists, disadvantaging those who can't afford private care. Whilst declaring an interest as a consultant with a private practice, PA emphasized the need for a clear policy on this issue, to be developed with the Consultant body. The Chief Officer was asked to address this.
3. Patients at EQ must travel to the hospital pharmacy for prescriptions, which is difficult for those relying on public transport. PA noted this issue had been explored before EQ opened, but current funding mechanisms prevent hospital consultants from prescribing

DRAFT

medications dispensed in the community. The Chair asked HCS to consider possible solutions. ACTION: Chief Officer to address the issue of people being seen privately but then require further treatment and / or investigation as a public patient. **Member B** Concerns were raised about the waiting lists published on gov.je, noting they lack details such as the number of patients seen and added to the list. It was mentioned that 823 patients were added to the inpatient waiting list in one month. CT confirmed that both inpatient and outpatient waiting lists are detailed in the Quality and Performance report, and it is common to see a rise in inpatient lists as more outpatients are seen. CT offered to review the waiting list details with Member B and noted that between 700 and 900 outpatients are seen weekly, with inpatient numbers varying based on bed availability. HCS could improve public clarity on standard activity. CT suggested enhancing website data with member B's feedback. MP highlighted that patients want to know their personal wait times for appointments and surgeries. This information should be available in 2025, linked to the Somerset Cancer Registry development. CT agreed to review and provide feedback at the next board meeting. ACTION: CT agreed to review and provide feedback on the availability of waiting list information at the next board meeting (January 2024).	

	MEETING CLOSE	Action
Date of next meeting: Thursday 30 January 2025		

DRAFT

Government of JERSEY

Gouvèrnément d'Jèrri

Integrated Health and Care System: Consultation feedback and next steps

HCS Advisory Board

28 November 2024

Background

MHSS; public commitment to support health and care organisations to work better together

Evidence that doing so:

- enables jurisdictions to make better use of resources (staff, skills, equipment and funding)
- helps deliver better outcomes for individual patients though joined-up care
- can support improvements to the health and wellbeing of populations of people

➢ can, in turn, reduce the requirement to spend more money on services. IMPORTANT given known increase in future costs

MHSS developed proposed arrangements to support providers to work better together.

Undertook face-to-face consultation in Oct / early Nov 2024 with:

- GoJ providers: HCS, public health & ambulance invited
- external providers: third sector, pharmacy, GP, dentists, care homes / home care
- others: Care Commission / new hospital facilities team

Purpose: update Board on consultation feedback and next steps

Proposed integrated system structure (reflecting feedback)

Ministerial Policy Group: Determinants of Health and Wellbeing

Health and Care Services Board

Independent Chair & NEDS

Health and Care budget

Partnership Board

Independent Chair

GP	Community nursing	Care Home	Home Care	Third Sector provider	Community Pharmacy	Dental (?)	GoJ Children's Services	Occupational health / AHP (?)

Health and Care Jersey

Island Division	**Services Division**
Chief Officer	
Digital	
Finance	
Medical Officer for Health	Deputy Chief Officer / Managing Director
Island Chief Nurse Advisor (inc. AHP)	Director of HCJ Nursing
Public Health	Medical Director (GMC RO for HCJ medics)
Director, Primary Care (GMC RO for GPs)	Mental Health / adults social care / intermediate & community services
Chief Pharmaceutical Officer	Hospital Services
Commissioning and Partnerships	Ambulance
Policy, Strategy	HR

Feedback

- Qualitative, not quantitative
- Feedback report published 22 November (www.gov.je)

Key feedback

<table>
<tr>
<td>Support for:

• principle of integrated, whole system working

• proposed arrangements (subject to detail)

Some concerns about ability to deliver meaningful change due to previous lack of political support at Assembly level</td>
<td>Cultural change, not just structural change:

• GoJ STOP “putting its services first” / START “acknowledging expertise of others”

• all providers prioritise Islanders / not resources for their services

• principles based approach (prevention is core principle = don’t disinvest in prevention to treat)</td>
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Partnership Board

Establish Partnership Board ASAP: • partners have joint responsibility and ownership of decision making across the whole system • duties inc; developing / overseeing delivery of whole system strategy and model of care	Statutory powers in near term to: • protect from Government / Assembly • partners make decisions and held to account • share authority and responsibility with partners (not just lip service)

Maintain HCS Advisory Board (renamed Health and Care Services Board)	• Maintain focus on government's services (make statutory). Same configuration of NEDs v executives?

Clinical Governance	Both Boards provide opportunities for improved clinical governance across all services, but invest in systems that drive clinical governance, and associated assurance

Matters related to Partnership board • Independent Chair essential (different Services Board Chair) • Partners renumerated - basis for standards of participation • Secretariat and Partners support function (training; coaching) • Size: good presentation v. too big to be effective • Differentiate between members and attendees	Partners' role: • represent Islanders and system sustainability • providing sector information (avoiding individual business interests) • participate in decision making and 'own' decisions • liaise with other sector providers (require support to do so) Officer attendees inc: Director of Partnerships & Commissioning / Director of Public Health / representatives of New Hospital Facilities / Chief Pharmaceutical Advisor

Partner members	• Community AHP - instead of / in addition to occupation health? • Community dentists: ambivalence about the proposed arrangements (additional feedback anticipated)

Determinants of Health Ministerial Group: establish and link to Partnership Board
Islanders’ voices forum: provide effective whole system feedback & listening standards for Partners
Third sector forum: required

Department

Establish whole system Department (not just service delivery)	Focus on the system BUT risk services are 'burning platform': • protect non-service budgets and resources • ensure CO capacity to operate across system (Deputy Services CO) • need strong, clear leadership to address tensions • protect public health 'critical friend' independence but capitalise on benefits of public health ethos to drive prevention • invest in better data capture from across the whole system / invest in PLICS

Rename - Health and Care Jersey (tbc)	Remove 'services' and 'department"; culture shift to health and wellbeing / system not GoJ

Two divisions	• Island division; functions that support integrated services / whole system decision making • Health and care service division: delivery of GoJ hospital, mental health and community services

Include wider GoJ services?	• Ambulance: Yes, part of HCJ (subjected to detailed planning) • Public health and Health Policy: Yes, part of HCJ • Children's Services: Potentially at a future date but at request of Children's Minister • Environmental Health: No, due to links with natural / built environment

Commissioning	Support for: • whole system commissioning inc HCS services • more 'Jersey specific' approach • creation of Director of Partnerships and Commissioning role

Primary care	• Primary Care Directorate in Island Division (Director of Primary Care, Director of Public Health and key functions (e.g.: pharmacy; nursing; mental health) • hub and spoke model with Chief Medical Officer as hub • separate GP's GMC Responsible Officer from lead on contract compliance / standards

Department

Integrated care group	• hub and spoke model in Island Division • GoJ / non-GoJ services providers to plan care pathways, shared care agreements, discharge.

Patient complaints / suggestions	Decouple for GoJ system; straight to PALS

New / recast roles

- Medical Officer for Health (independence in law)
- Island Chief Nurse Advisor (new role)
- Chief Pharmaceutical Officer (lead professional)
- Director of Primary Care (GMC RO for GPs)
- Designated safeguarding Dr and Nurse – ensure whole system focus
- Director of Partnerships and Commissioning (lead on HIF contracts)
- Director of Digital health (whole system)
- Director of Finance (whole Jersey Health budget inc HIF)
- Deputy CO / Managing Director (to provide CO capacity to focus on system)

Funding

Support for single Minister responsible for health budget (in principle)	
Health Insurance Fund	Support shift to MHSS whilst protecting primary care budget
Long term Care Fund	Consider shift to MHSS (but retaining as a ‘benefit’ as opposed to universal service funding)
Health and care funding reform	Accelerate work to reform health and care funding across all services given current deficit / demand; health inflation and demographic changes

Cost of integrated arrangements: Some concerns about cost of Partnership Board and new staff post eg: Island Chief Nurse Advisor (internal only)

Next steps

- MHSS to brief COM and Assembly in early December
- Transition plan developed
- Roll out from 1 January inc:
    - move of Public Health and Health Policy
    - new Department name
- Assembly Partnership Board proposal: Q1 2025 (plus continuation of Health and Care Services Board)

Government of JERSEY

Gouvèrnément d'Jèrri

End

Jersey Health and Care System

A system that works together to:

- improve islanders' health and wellbeing through population level initiatives and seamless services that enable islanders to live happy, healthy, productive lives
- meet needs through delivery of safe, high-quality service that deliver value for money

Why two Boards?
Partnership Board members are not accountable for GoJ services

Two Boards:

- Health and Care **Partnership Board**; provides framework for partners to jointly have accountability, responsibility and ownership of decision making / leadership across the whole system; supports increased diversity of professionals involved in system wide decisions and planning
- Health and Care **Services Board**; focused on driving up standards and safety of government services delivered by a restructured department of government

A department of government (Jersey Health and Care Department) which:

- works to ensure integrated service delivery and one system approach / whole system commissioning function
- directly delivers a range of hospital, mental health and adults social services.

➢ Focus on Islanders (includes patients) as working at population level not just service user level

➢ Strategic priorities: prevention and wellbeing / population health / system productivity (inc digital) / productive economy

➢ Strategic approach: a whole system = a single Minister accountable for the health insurance fund and monies provided to Department via the annual Government budget – *the Jersey health budget*

Health and Care Partnership Board

- Non-statutory partnership Board held to account by MHSS
- Partners appointed through agreed, transparent, sector-based processes (except for where GoJ employee)
- Majority of partners are private / third sector providers
- ➢ Works on behalf of islanders
- Drives integrated care and health and wellbeing outcomes
- Oversees whole system strategy / plans
- Recommends spending priorities

Independent Chair (TBC)

Jersey Health and Care Department Chief Officer

Other Board members*					
	GPs	Community nursing	Community Pharmacy	Home Care	Dental
	Lead Finance Officer: Jersey Health budget	Island Medical Director (?)	Island Chief Nurse Advisor	Director of Digital Health (Health Chief Information Officer)	Group Director: Public health and intelligence
	Condition specific charitable providers	Care homes	Occupational health / AHPs (TBC)	GoJ Children's services (mental health & social care)	HCS Health and Care Services

*Community opticians as members in 2nd phase of development?

Health and Care Services Board

A non-statutory partnership Board held to account by MHSS
- Majority non-executive directors appointed through Jersey Appointments Commission process
- Works to drive up operational service standards

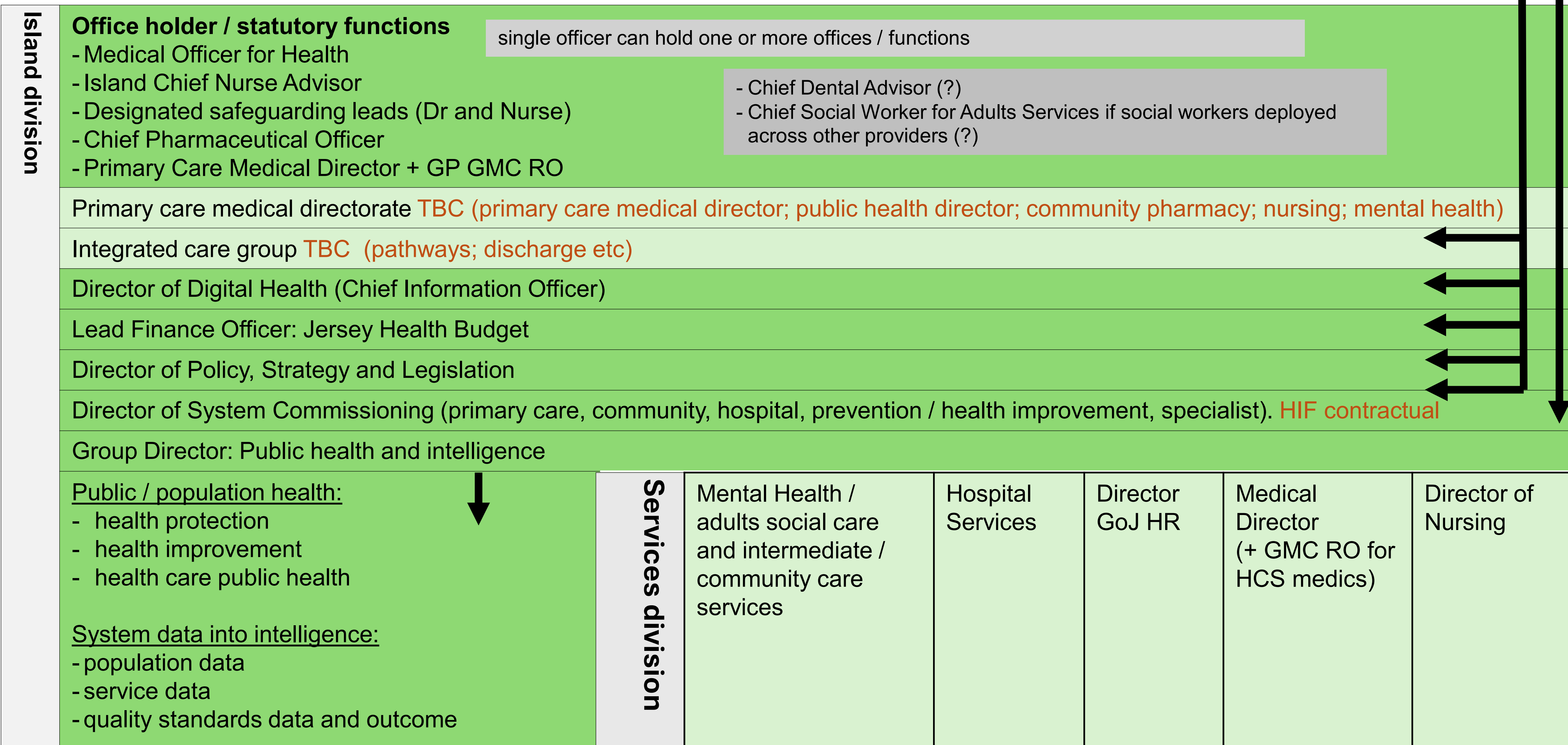
Independent Chair

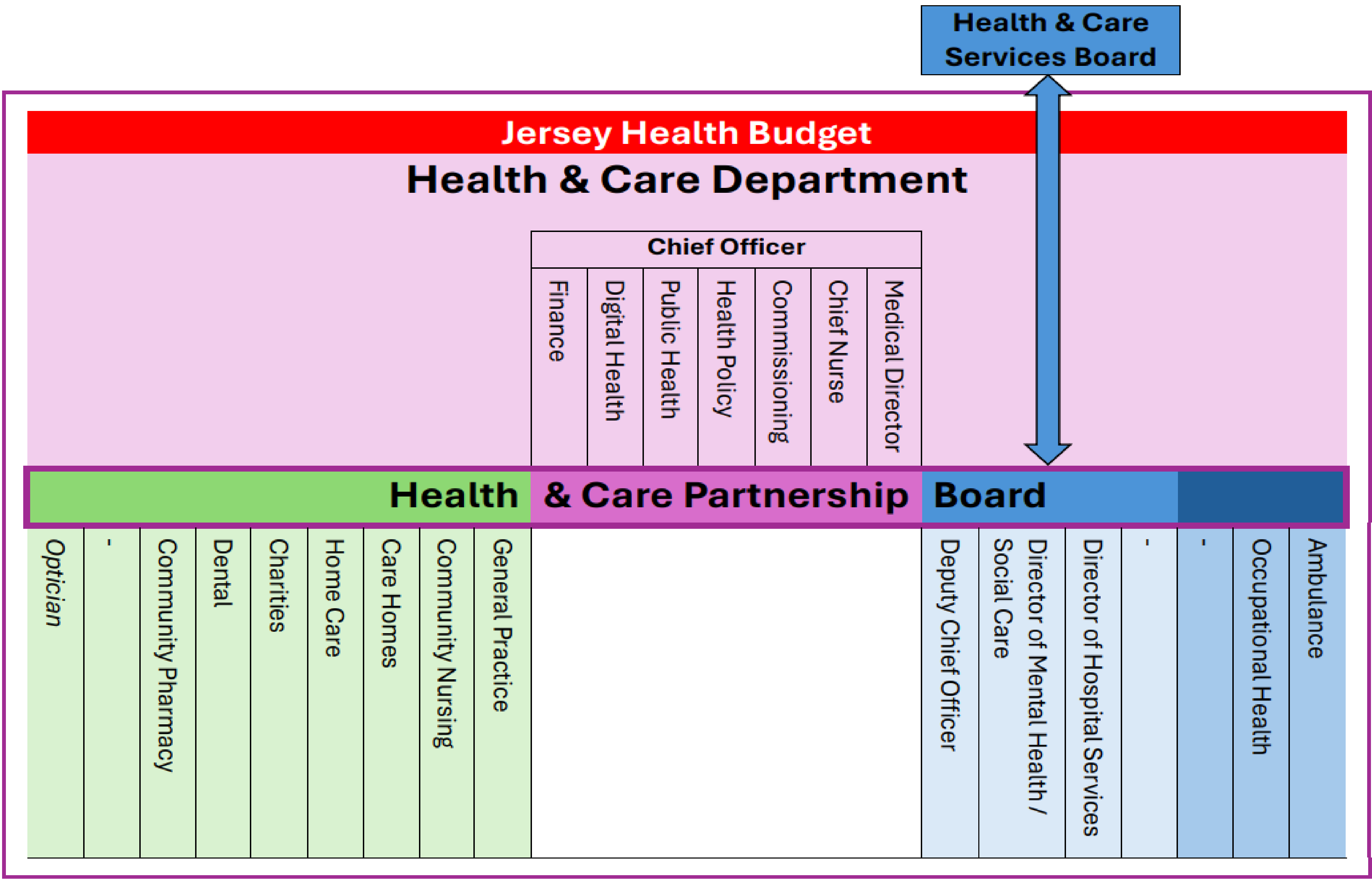
Jersey Health and Care Department Chief Officer

Non executives	5 x Non-Executive Director			
Island Health division executives	Lead Finance Officer: Jersey Health budget	Director of Digital Health (Health Chief Information Officer)		
Services executives	Hospital	Mental Health / adults social care and intermediate / community care	Director of Nursing Medical Director	Director GoJ HR

Key	
Non-executive	
Private / third sector provide partner	
GoJ provider partner	
Island Health executives	
Health and care services executives	

Jersey Health and Care Department (HCD)





Health & Care Services Board
Determinants of Health and Wellbeing Ministerial Group
Jersey Health Budget
Health & Care Department
Chief Officer
Finance
Digital Health
Public Health
Health Policy
Commissioning
Chief Nurse
Medical Director
Health & Care Partnership Board
Optician
-
Community Pharmacy
Dental
Charities
Home Care
Care Homes
Community Nursing
General Practice
Deputy Chief Officer
Director of Mental Health / Social Care
Director of Hospital Services
-
-
Occupational Health
Ambulance