Health and Care Jersey – Advisory Board
Part A – Meeting in Public
Minutes

Health and Care Jersey

Date: 29 May 2025	Time: 9:30 – 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	**AH**
Julie Garbutt	Non-Executive Director	**JG**
David Keen	Non-Executive Director	**DK**
Executive Board Members (Voting):		
Tom Walker	Chief Officer HCJ	**TW**
Mr Simon West	Medical Director	**SW**
Obi Hasan	Finance Lead – HCJ Change Team	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Emily Hoban	Head of Access deputising for Claire Thompson, Chief Operating Officer – Acute Services	**EH**
Andy Weir	Director of Mental Health, Social Care and Community Services	**AW**
Ian Tegerdine	Director of Workforce	**ITe**
In Attendance:		
Cathy Stone	Nursing / Midwifery Lead – HCJ Change Team	**CS**
Martin Carpenter	Chief Information Officer - Health	**MC**
Rachel Williams	Director of Strategic Planning and Projects	**RW**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Peter Gavey	Chief Ambulance Officer (Item 7 only)	**PG**

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

CD welcomed all to the meeting.

Apologies received from:

Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Mark Pugh	Medical Lead – HCJ Change Team	**MP**

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

No declarations.

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

The minutes of the previous meeting held on 27 March 2025 were agreed.

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

EOC reports there are two matters arising. Both issues were subsequently raised during the public question session at the conclusion of the previous meeting.

The first matter concerned the cost of external reviews conducted over the past twelve months. It was confirmed that the Board would receive a comprehensive report within the next two to four months, which will include detailed information on these costs as well as broader learning outcomes from the reviews. The second matter related to the cost and outcomes of the turnaround team. A one-off budget allocation of approximately one million pounds had been approved at the time. Additional information is available in a detailed Freedom of Information (FOI) publication, which was made accessible on the Government of Jersey's website in April 2025.	

5	Chair's Introductions	Action
CD opens the meeting by noting a couple of items to highlight. Firstly, an additional paper on medical job planning has been added to the agenda (item 15). For the benefit of members of the public, CD confirms that this paper is available on the HCJ Advisory Board website. Further clarity on progress will be provided when the report is discussed. Secondly, CD acknowledges that this is the final board meeting for two colleagues: Obi Hasan, Finance Lead, Change Team and Ian Tegerdine, Interim Director of Workforce. OH initially joined as part of the change team before being engaged as the fixed term substantive Head of Finance Business Partnering HCJ. CD commends OH for his exemplary work and significant contributions to HCJ and the Board. ITe joined HCJ approximately one year ago as Interim Director of Workforce. As Chair of the People and Culture Committee, CD expresses appreciation for ITe's substantial and positive impact on the People and Culture Committee and the wider Human Resources function within HCJ. CD extends sincere thanks on behalf of the Board to both OH and ITe and expresses regret at their departure. OH and ITe express their gratitude, and the Chair thanks them once again.		

6	Chief Officer Report	Action
The Board receives the Chief Officer Report which provides a summary of the strategic activities relating to Health and Care Jersey (HCJ), recognitions for health and care staff, feedback regarding the services, and some key issues, presented in more detail through the relevant board papers. The Board is asked to note the report. TW provides an update covering key strategic and operational priorities. TW begins by addressing HCJ's financial pressures, noting that the executive team has undertaken a detailed line-by-line review of the current forecast year end overspend. This work is ongoing and may lead to expenditure adjustments to stay within the agreed budget. All decisions will continue to be assessed through a quality impact process to understand potential implications. The Board is advised that this area likely requires continued focus and engagement. TW then outlines progress on professional standards of care, highlighting three workstreams. JM and CS lead efforts on inpatient hydration, which is progressing well. SW and MP work on 'modern ward rounds' to improve consistency in care; while AW works on enhancing how the organisation shares and learns from serious incidents. TW briefly references the reintegration of the States of Jersey Ambulance Service, noting this is scheduled for further discussion on the agenda. On infrastructure, TW reports that the New Healthcare Facilities Programme is moving forward with funding and planning permissions secured, and the site now cleared. Engagement with prospective main works partners is underway, with a partner currently expected to be appointed by autumn 2025. A new Suicide Prevention Strategy is also launched, led by AW and Director of Public Health, Professor Peter Bradley, and developed in partnership with stakeholders and people with lived		

experience. The initial focus is on encouraging men in Jersey to seek help. TW praises the quality of the work and suggests the Board review progress next year.

In terms of staff recognition, TW thanks Halil Metushev (Timeout West Café), Gary Beattie, and Maggie Wydro (Sterile Services) for representing HCJ in a public-facing campaign. TW also noted that 207 nominations have already been received for the annual "Our Stars" staff awards.

Following the report, CD highlights that, while much Board time is rightly spent on complaints and incidents, there were 300 compliments compared to 30 complaints in the last two months. This ratio reflects positively on frontline staff and deserves recognition.

CG raises a point regarding the Suicide Prevention Strategy, suggesting that the impact of gambling and gaming—especially on men—is under-addressed. AW responds that while gambling has not yet emerged in case reviews as a contributing factor, work has begun with local and national partners to strengthen awareness and support around this issue.

ACTION: Include the following items on the Board work plan for future agendas (late 2025): firstly, an update on the NHF Programme, secondly, progress on the implementation of the Suicide Prevention Strategy and thirdly, the results of the Our Stars Awards.

CD closes the item by thanking TW, noting that financial matters will be picked up again later in the meeting.

7	**Reintegration of States of Jersey Ambulance Service into Health and Care Jersey**	**Action**

The Board receives a paper providing a summary of the rationale for the reintegration of the States of Jersey Ambulance Service (SoJAS) into Health and Care Jersey (HCJ) and the progress made so far.

The HCJ Advisory Board is asked to note the reasons for SoJAS re-integration, progress to date and plans for engagement and communication.

Pete Gavey (PG), Chief Ambulance Officer, joins the meeting and presents an update on the planned reintegration of the SoJAS into HCJ, scheduled for 1 July. PG highlights key focus areas including leadership, governance, risk management, and staff communication throughout the transition. The most tangible operational change involves a shift in line management, with PG now reporting directly to the Chief Officer of HCJ.

In response to a question from CD about retaining operational autonomy, PG explains that although the service will be part of HCJ, it will preserve many of its existing governance structures. This includes maintaining its own oversight framework developed during its time under Justice and Home Affairs (JHA), while aligning with broader HCJ safety and regulatory requirements such as those set by the Jersey Care Commission (JCC). The aim is to strike a balance between integration and service-specific governance, particularly around patient safety.

When asked about anticipated benefits, PG reports reintegration supports closer collaboration with other health services, particularly in community care, restoring a level of integration that has been diminished in recent years. He notes the move allows the SoJAS to contribute more fully to Jersey's broader health and care strategy.

Board members welcome the reintegration, with some expressing personal satisfaction at the return of the service to HCJ. The process so far is described as well-managed, particularly in identifying and mitigating risks. PG notes that while no significant unmanaged risks have emerged, financial transition and initial staff concerns are closely monitored. Reassurances have been provided to staff that the change does not affect roles or terms of employment, except for PG's new reporting line.

There was agreement on the value of reviewing the impact of the reintegration after six months to assess whether the intended benefits—particularly for patient experience and service quality—have materialised.

ACTION: Include the following two items in the Board workplan. Firstly, integration of SoJAS performance reporting within the HCJ reporting framework. Secondly, a six-month post-reintegration review of SoJAS to assess impact and identify improvements.

PG is asked to share concerns that may require the attention of the Board post-integration and cites staffing and rota coverage, especially overnight, as a continuing challenge. While recent investments have improved response times—which exceed UK performance—there remain occasional delays that can be distressing for both the public and the service. A new demand and capacity review is planned to further align resources with service needs.

CD acknowledges the importance of tracking these issues and integrating ambulance performance data into HCJ's overall reporting framework to ensure a unified and transparent approach. The Board expresses strong support for the reintegration and looks forward to welcoming the SoJAS into HCJ. PG thanks the Board for their support before leaving the meeting due to other commitments.

8	**Health System Digital Transformation Plan**	**Action**

The Board receives a series of slides describing the Health System Digital Transformation Plan.

Presentation Overview:
MC presents the digital health transformation plan, emphasising the substantial benefits expected, including:

- Improved health outcomes for islanders
- Enhanced access to services
- Value for money and better system efficiency
- Attraction and retention of healthcare workforce due to better technology
- Critical importance of digitising systems alongside the new hospital program for its success.

MC references global consultancy McKinsey's estimates of a 15-20% productivity improvement through mature digital care coordination, and operational capacity gains (e.g., an 8% increase in operating room capacity). The plan outlines two options: significant investment (~£70 million over five years) or doing nothing, with the latter being clearly detrimental due to increasing patient safety events from fragmented data, a growing aging population, and workforce shortages.

A digital health advisory group is established with representatives from HCJ, Digital Jersey, and Primary Care, supporting the plan and driving its development.

Key Questions and Comments from Board Members:
CG:

- Asks if private providers are included (currently GoJ only).
- Queries about inclusion of e-prescribing directly to pharmacists and digital asynchronous GP consultations (not clearly included in the plan).
- Emphasises the importance of data sharing and data controller roles for patient assurance.
- Suggests including patient/public involvement and a Non-Executive Director (NED) on the Digital Health Advisory Group for governance and public trust.

DK:

- Supports the plan, noting the £70 million investment over five years (~£15 million/year) is reasonable for a program of this scale.
- Warns of "change fatigue" risks in long programs and stresses the need for clear management structure, organisational support, and ownership beyond MC alone.

CD:

- Echoes strong support and CG's suggestion for a NED on the advisory group.
- Highlights the massive funding gap between current investment (~£11.3 million) and the proposed amount.
- Notes Minister for Health and Social Services, Deputy Tom Binet's, public stance that the NHF cannot succeed without digital investment, which is not currently budgeted within the programme.

- Recommends the Advisory Board issue a **formal note of advice** to the MHSS strongly endorsing the plan as essential for patient benefit and system efficiency.

MC's Detailed Response:
Information Governance (IG) and Data Sharing:
- Established an IG subgroup in November 2024, with a signed memorandum of understanding between public and private health providers for data sharing.
- Developing appropriate IG frameworks around a **single patient record** system, proposed to be managed by an island partnership.
- IG is fundamental; without it, digital technologies have limited effectiveness.

Technology Scope:
- The current investment focuses on **foundational technology enabling digital integration** across care settings, not on specific e-consultation services.
- E-prescribing will be supported via integration with the UK's Prescription Delivery Service (PDS), enabling seamless prescription delivery directly to pharmacists island-wide.

Governance and Public Involvement:
- Supports having a **NED on the advisory group**; MHSS agrees this should be part of formal governance if funding is approved.
- The digital team consists of healthcare consumers themselves, motivated by personal experience of system challenges.
- Developing a communications and engagement plan to involve islanders for feedback and transparency.

Board Agreement and Next Steps:
- The Board agrees to draft a **formal advisory note to the MHSS**, stressing the critical nature of the digital transformation investment alongside the NHF.
- Recognises the transformational long-term benefits of a single patient record and digital infrastructure for the island's healthcare future.

ACTION: EOC and MC will coordinate to finalise and expedite the advisory note to the MHSS.

Closing Remarks:
CD thanks MC for his impactful leadership since joining HCJ and acknowledges the Board's constructive input and commitment.

9	**Learning from Deaths Framework**	**Action**

The Board receives a paper outlining the process used to ensure that all patient deaths are reviewed in line with local guidelines. It also explains how key lessons related to the care provided are identified and shared to support ongoing learning and improvement.

The HCJ Advisory Board is invited to endorse the proposed framework and support the strategic direction outlined, ensuring continued progress in learning from deaths and improving patient care.

Learning from Deaths Framework
SW introduces the framework as a high-level overview of how HCJ reviews patient deaths. The report outlines the structures and processes in place, developed over the past two years through significant work by the Quality and Safety team, particularly the Mortality Manager, Natalie Holt.

At the core of the framework are **Mortality Learning Reviews (MLRs)**, adapted from the UK's **Structured Judgement Reviews (SJRs)**. Each MLR involves two stages: first, a clinical review of the death using a structured framework; second, assessment by a Serious Incident Review Panel (SIRP). Based on scoring, the SIRP decides whether further investigation is needed.

In 2024, HCJ conducted 34 MLRs, roughly 10% of all deaths, aiming to double this to 20% by 2025.

Key learning themes from MLRs inform the 2025 quality improvement plan, including:
- Implementation of Do Not Attempt CPR (DNACPR) and treatment escalation plans

- Communication with families
- Early recognition of deteriorating patients
- Documentation quality.

Perinatal deaths and those involving people with learning disabilities are also reviewed. While HCJ would like to connect with the UK's **LeDeR** program (Learning from Deaths in people with a learning disability), current digital systems are not compatible. Instead, HCJ ensures all such deaths are internally reviewed.

Mortality review processes include dedicated meetings, both within care groups and organisation-wide, such as M&M (Morbidity and Mortality) sessions and inset days, to share learnings across teams.

Crude mortality is tracked annually, with improvement noted from 2023 to 2024. However, unlike the UK, HCJ cannot yet use tools like SHMI (Summary Hospital-level Mortality Indicator) due to limitations in coding and data infrastructure.

Looking ahead, HCJ aspires to establish a **Medical Examiner (ME) network** like the UK's, enabling comprehensive review of all deaths. However, this presents **financial and logistical challenges**, as MEs in the UK are appointed via the coroner's office, not health systems, and Jersey currently lacks such infrastructure.

Board members express **cautious support** for the direction but raise concerns about cost, impact, and whether MEs offer substantially more learning than existing reviews. It is noted that while the ME role is a recommendation following the Shipman Inquiry, its delayed implementation and operational challenges (particularly for GPs and in cremation/burial delays) suggest a need for further evidence of value before HCJ commits.

The Board concludes by endorsing the strategy and the move to increase MLR coverage to 20% of deaths, while requesting further information on the **impact and value of the Medical Examiner model** before any decisions on implementation.

10	**Finance Report Month 4**	**Action**

The Board receives the Finance Report Month 4 providing an update on financial position, an update on the Capital Programme for 2025 and an update on the status of Quality Impact Assessments (QIAs) and the governance and on-going monitoring process.

The Board is invited to discuss the financial position at M4 and FY25 Forecast noting the risks and mitigations and recommendations.

Finance Report – Month 4 Summary
OH opens with personal remarks, expressing gratitude to the Board, executive colleagues, and various teams for their collaboration and support during his tenure. OH emphasises that health and care are deeply personal sectors, and that sustainable healthcare funding—not efficiency alone—will be critical for the future.

Headline Financial Position (as of Month 4):
- **In-month deficit**: £1 million (improved from earlier trend of £1.5 million/month).
- **Year-to-date deficit**: £5.5 million.
- **Year-end forecast**: £18 million deficit (described as a *realistic but pessimistic* projection).

Maintaining the improved in-month performance will be challenging, as it depends on achieving ambitious FRP (Financial Recovery Plan) and stretch targets.

Financial Recovery Plan (FRP) Performance:
- **Year-to-date delivery**: £3.6 million (against a £5.2 million target at this stage).
- **Full-year FRP target**: £17.1 million, nearly double last year's delivery.

To contextualise the challenge:
- Benchmark efficiency improvements in comparable systems (e.g., NHS) are around 2–3% per annum.

- By contrast, to balance the budget, HCJ is required to deliver **8.6% total efficiencies** in 2025, of which **5.4%** relates to the FRP and **3.2%** to additional cost reductions.

Despite the shortfall, opportunities are identified to make further progress. Quality remains a priority, with a **well-established Quality Impact Assessment (QIA)** process in place to ensure that cost-saving measures do not compromise care.

Structural Pressures and Mitigation Efforts:
Key underlying cost drivers include:
- Workforce vacancies and associated agency spending.
- High health inflation (likely exceeding the assumed 2% annual rate).
- Demographic pressures, notably Jersey's ageing population.

Mitigation measures underway:
- Improved job planning and active recruitment (notably successful in attracting clinical staff to the island).
- Targeted procurement efficiencies and increased private patient revenue.
- Introduction of a **rigorous establishment control panel** (including clinical, operational, and finance input) to scrutinise all recruitment requests based on quality, safety, operational necessity, and budget availability.

Board Discussion Highlights:
- Recognition that the £18 million deficit is likely to be a floor rather than a ceiling unless active controls continue.
- Emphasis on **discipline** in delivering as many current-year benefits as possible (rather than deferring them to the next year).
- Importance of distinguishing between structural funding issues and any perceived underperformance in delivery.
- Calls for **greater transparency and assurance** around workforce grip and control.

ACTION: Committee reporting (Finance and Performance / People and Culture) on posts approved vs. rejected through the establishment panel (EVCP), noting the hurdles before a post reaches EVCP. Visibility of roles not submitted to EVCP due to internal reprioritisation (e.g., mental health service adjustments).

11	**Quality and Performance Report Month 4**	**Action**

The Board receives the Quality and Performance Report (QPR) for Month 4.

Elective and Urgent Care Performance
Elective Care:
- **Long Waits Reduction**: Significant reduction in patients waiting over 52 weeks for their first outpatient appointment.
- **Diagnostic Access**: Marked improvements in radiology diagnostics (endoscopy, ultrasound, MRI) wait times.

ED Performance:
- **Adults**: 80.3% seen within 4 hours.
- **Children**: 94.3% seen within 4 hours.
- This marks a notable improvement, particularly compared to winter months, and compares well with wider NHS performance.

Quality and Safety
- **Pressure Ulcers**: No grade 3 (or higher) pressure ulcers developed in care during April.
- **Island-wide Pressure Ulcer Prevention Framework**: Launched in collaboration with Family Nursing and Home Care, updating the 2021 framework.
- **Complaints**:
  - Remain low in volume.
  - **Themes Identified**: Attitude/behaviour and basic nursing care.
  - **Response**: New training launched for healthcare assistants, with initial completions this month.
- **Nutrition and Hydration**:

    - Comprehensive audit completed.
    - Improvement program underway starting May 2025, addressing patient meal quality and experience.
- **Infection Prevention and Control**:
    - Infection rates remain low.
    - All infections thoroughly reviewed by multidisciplinary teams.
    - No cross-infection cases identified.

Mental Health Services

- **Jersey Talking Therapies**: Concerning recent spike in waitlist; not necessarily a trend, under urgent review to determine cause as per usual practice.
- **Autism Assessments**: Waits increasing due to staffing shortages.
- **ADHD**: List continues to grow.
- **Discharge Follow-Ups**: Slight underperformance (75%) but based on small numbers (1 of 4 missed); each case investigated.

Social Care Indicators (first time reporting):

- **Annual Review of Support Plans**: 60% of service users reviewed.
- **Social Care Assessment Wait Time**: Average of 5 weeks; under review before setting a formal target.
- **Missing Indicators**:
    - Capacity assessment delays (to return next month).
    - Delayed transfers of care (currently 15% of beds).

Service User Feedback

- **Safeguarding**:
    - 60% report feeling safe and secure after intervention.
    - Plans to improve reporting and data presentation.
- **Learning Disability Services**:
    - 100% of service users report improved quality of life and functional ability in Q1 (up from 91% in Q4 last year).

Diagnostic Wait Times – Challenges and Concerns

- **Endoscopy**: Longest wait times due to limited capacity; additional doctors being recruited.
- **Ultrasound**: Currently at 26 weeks; expected to reduce to 12 weeks by August 2025 following new staff onboarding.
- **MRI**: Average wait of 6 weeks; 90th percentile at 13 weeks. Improvement trajectory expected.
- **CT and Cardiac CT**:
    - Cardiac CT specifically challenged by the need for both cardiologist and radiologist availability at the same time.
    - Sessions limited to two per week, exploring job plan changes and session rescheduling (e.g. Monday to Friday).

CG raised concerns regarding:

- Perceived overuse of diagnostics.
- Apparent disparity between MRI and ultrasound wait times.
- Call for education, performance management, and better use of advice/guidance tools.
- Suggestion for a dedicated diagnostics improvement report for the next Board meeting

Other Key Points

- **Radiology Review**: Planned review of radiology capacity, personnel, and service prioritisation.
- **Safeguarding and Learning**: Continued focus on making safeguarding more person-centred, with support from new designated doctor and partnership lead. Updates on serious case review learning to be reported to the next Quality, Safety and Improvement Committee.
- **Infection Control**: HCJ's near-zero hospital-acquired infection rate praised as an exceptional achievement, reflecting high compliance with hygiene protocols.

ACTION: The Board will receive an update on diagnostics, including measures being implemented to reduce diagnostic waiting times (July 2025).	

12	Workforce Report Month 4	Action

The Board receives a paper providing regular information on the status of the workforce. The Board is asked to note this report and the ongoing actions to develop a report that is more fit for purpose.

Key Workforce Highlights

Turnover

- There is a small **uptick in turnover** compared to the same time last year.
- Unclear if this is a trend or a **one-month anomaly** – to be closely monitored.

Sickness

- Sickness rates show **three consecutive months of reduction** since Christmas 2024.
- Still remain higher than last year overall, due to either increased incidence or increased reporting.
- Current total: **37,500 sickness days** over the last 12 months (~14 days per employee).
- Previous year comparison: ~11 days per employee.
- Concerns raised by CD about the **financial impact** and sustainability.
- Data issues limit granular analysis (e.g., trends by day of week or short vs. long-term sickness).

Recruitment

- Remains **patchy** month-on-month.
- Still **not confident** the organisation is recruiting as efficiently as possible.
- Working groups established for **medical and non-medical staff recruitment**.

Agency Staffing and Budget Controls

- Still reliant on **agency staff** across nursing, medicine, and AHPs – though numbers are decreasing.
- EVCP (Establishment and Vacancy Control Panel):
  - Used to ensure **budget adherence**, not cost-cutting.
  - Any agency requests must be justified against existing budgets.
- **Substantive staffing is underspent** per OH's finance report.

Performance Objectives

- Staff with objectives recorded in the system now at **63%** – best performance to date, although still short of stretch target.

Discussion and Comments

CD remarks

- Acknowledges improvement in sickness but emphasises:
  - **Sickness remains unacceptably high**.
  - Significant **cost implications**.
  - Need for **sharper focus** on tackling sickness.

TW

- Emphasised a **"hands-on" management approach** as key in HCJ due to generally smaller teams and managers knowing their staff.
- Suggests improvement is more likely through **active line management** than data alone.
- Advocates a **person-led** rather than purely data-driven approach.

AH

- Shares past experience:
  - Importance of **managerial compliance** with procedures.
  - Managers need **support and confidence** to address issues.
  - Need for **manager training** and possible **review of procedures**.

CG

- UK perspective:
  - National move to **reform the sick note system**.

- Notes higher sickness rates among **younger staff**.
- Emphasises breaking down **fear and HR barriers** that prevent proper management.
- Suggests **early contact with sick staff** is often avoided but essential.

Future Actions and Requests

- Further drill-down into sickness absence requested for next People and Culture Committee report:
  - **Service-area breakdown** of sickness.
  - Identification of **most-affected teams**.
- Continue tracking **long-term vs. short-term sickness**.
- Focus on **improving system capabilities** to support managers (e.g., automatic flags).

Closing Remarks

- ITe thanked for ongoing work.
- Recognition that **system limitations** are a major barrier, but **leadership and manager engagement** will be crucial.
- Sickness remains a **high-priority issue** moving forward, especially due to its impact on **financial and service sustainability**.

13	**Committee Reports**	**Action**

The Board receives a paper providing assurance on the work of each of the Committees and escalation of issues as necessary.

The Board is asked to note the reports.

a. People and Culture

CD wishes to draw specific attention to a key area of concern — workforce data quality. During the last meeting, the Committee held a focused discussion on the significant limitations in workforce data that are hindering effective workforce management. This includes challenges with managing sickness absence, monitoring trends, and holding teams accountable at an operational level. The current state of workforce data makes it almost impossible to manage some services in the way expected, particularly within the largest and most critical department within GoJ. This is considered unacceptable given the scale and importance of the workforce.

In response to these concerns, the Committee invited the Government of Jersey's Chief People Officer, along with colleagues from the workforce analytics team, to present at the meeting. They acknowledged the current deficiencies and offered a commitment to improve the system. Specifically, they have undertaken to deliver improvements within a six-month timeframe. However, it is also now clear that several previously expected capabilities have been withdrawn from scope and some data requirements will no longer be deliverable.

The Committee will continue to hold the relevant teams to account robustly over the promised improvements and intends to consider this issue further at future meetings — including the potential development of an advice note to the MHSS. Given the financial context, it is vital to reinforce that improved workforce data could unlock significant operational savings. Even a modest reduction in sickness absence — 1% — could potentially equate to as much as an estimated £1 million in savings. Lack of accurate, accessible data constrains the Board's ability to pursue such savings and undermines the commitment to good governance.

It was noted that while the NHS is also seeing increasing sickness absence trends, HCJ's levels remain comparatively high, and without appropriate data systems, local managers are left unable to identify and address recurring short-term absence patterns, which would otherwise be actionable in other systems.

Finally, the Committee reiterates the urgent need for investment in data infrastructure, and that this should be considered not just as a cost, but as a potential "invest-to-save" opportunity with material financial and operational benefits.

b. Finance and Performance

No issues to highlight (covered in item 10).

c. Quality, Safety and Improvement

Despite some public concerns about nursing staffing ratios, the Committee notes that HCJ meets the recommended ratios set by the Royal College of Nursing (RCN)—with appropriate nurse-to-patient ratios. Furthermore, there is a positive pipeline of trained nurses being onboarded, and agency nursing usage has significantly decreased, reflecting solid workforce management.

Additionally, while there has been some previous criticism regarding waiting times, the Committee acknowledges the considerable efforts of the access team and wider care groups in reducing these metrics, resulting in a more positive assessment of service quality overall.

No further questions are raised.

14	Board Assurance Framework	Action
Nil to note.		

15	Medical Job Planning Update	Action

The Board receives a paper providing an update on the current medical job planning process and looks forward with a proposed plan of actions to be undertaken prior to the next job planning round.

The Board is asked to note the excellent progress made on job planning in 2025 and the plans to move to prospective job planning for 2026.

SW reports that HCJ has made significant progress addressing the longstanding job planning challenges. Job planning, a mandatory annual process for all doctors that feeds directly into appraisal and revalidation cycles, has seen substantial improvement this year.

- **Consultants:** Approximately 82% of consultants now have job plans either in the first discussion, second discussion, or signed off stage. This figure rises to around 87% when including orthopaedics and gynaecology consultants whose job plans are temporarily on hold due to ongoing service reviews. This achievement marks the highest completion rate ever recorded in HCJ and is a testament to the dedicated efforts of MP, the FRP, and the medical staffing team.
- **SAS Doctors:** For SAS (Staff and Associate Specialist) doctors, 68% have progressed to first or second sign-off, with 32% still in discussion. Work continues to chase outstanding job plans, particularly within key specialty groups, with a target to complete this by the end of May 2025.

Looking ahead, there will be a review and “lockdown” of job plans at an ELT Cobra meeting to assess the impact of average caps on Programmed Activity Sessions (PAs)—12 PAS for consultants and 14 PAS for SAS grades. While reaching 100% completion is unlikely (consistent with NHS experience), further efforts will focus on improving the SAS completion rate.
Additional work from June to September 2025 will focus on reviewing the Allocate job planning system. As Allocate was originally designed for NHS systems, adaptations are necessary to fit HCJ’s unique contracts and working arrangements, including ‘hot’ weeks and on-call systems.

Diary card exercises are planned in specialties such as Emergency Medicine, General Surgery, Trauma and Orthopaedics, and Ophthalmology to better capture working patterns. The Board acknowledges the considerable improvement since the beginning of 2025 and commends the teams involved. While the anticipated savings were primarily attributed to the e-rostering system rather than job planning directly, optimised allocation of direct clinical player time is expected to yield around 500 PAs in savings.	

16	Register of Interests for Board Members	Action
Noted.		

17	Questions form the Public	Action
The meeting addresses questions submitted by members of the public. **1.** The first question was pre-submitted by email from Annetta Merritt, who was unable to attend in person. **Question from Annetta Merritt:** *In respect of PALS (Patient Advice and Liaison Service), what is the escalation process if no response is received to a request for information? Additionally, there is no information available on the PALS website regarding response times or escalation procedures.* **Response:** The PALS team handles enquiries within a 5-day timeframe. If a response or resolution is not achieved within this period, the concern is escalated to the Patient Feedback Team. Both teams conduct daily huddles to discuss outstanding concerns and complaints, enabling further escalation to the Patient Experience Manager as necessary. It was acknowledged that the PALS website currently lacks clear information on response times and escalation processes. ACTION: JM will undertake a review to update the website to ensure these details are clearly communicated (July 2025). A representative from PALS also clarified that the service primarily provides advice and support with complaints generally handled by colleagues in the HCJ feedback team. PALS would ensure that any query or complaint reaches the right HCJ team. **2.** **Question:** *You've spoken quite a lot about the digital system you're planning to implement. Will this make processes quicker? Recently, a consultant in the UK requested some information about me, and it took nearly three months for that information to be sent. Will the new system improve this?* **Response:** MC responded this would be the case. The intention is to integrate with the UK's digital system. Currently, if a GP in Jersey refers you to the hospital, the referral is sent electronically the same day. Similarly, if the hospital needs to make a tertiary referral to a UK specialist, it uses the same system. This means information flows in near real-time, avoiding long delays. This example highlights exactly why investment in a better digital infrastructure is so important. The current delays and poor quality of information sharing between providers are unacceptable. With the new system, patients will even have access to hold their own records, reducing dependency on paper or manual transfers. **Additional Concern:** *Regarding CT scan waiting times — I saw a consultant in March and was told my CT scan wouldn't be done until December. However, the CT department later informed me it's scheduled for June*	

18th. There seems to be a communication issue between departments, and the initial estimated wait times have fluctuated significantly.

Response:
The confusion and frustration around waiting times and communication between departments is acknowledged. The CT department indicated the scan was ordered as 'routine,' which may explain the longer wait estimates. However, the discrepancy in the information received is concerning, and will be investigated further to ensure clearer communication and more accurate wait time information going forward.

Concern:
My father broke his hip and getting him home was difficult. The hospital, physios, OTs, and social workers seemed to want to send him to a care home for convenience. The OT took an extra week to clear the house, delaying discharge. After discharge, there was no follow-up from hospital or therapy teams, only from the GP. This is frustrating and doesn't seem right.

Response:
Discharge planning should include follow-up based on individual needs, sometimes involving primary care or family nursing. It is acknowledged there may have been gaps here and the service manager will be asked to review this case.

The concern raised about older patients sometimes not receiving adequate attention are understood, but regular audits show efforts to improve care. Sometimes, decisions about residential care relate to patient or family choice, but unnecessary haste to residential care is not ideal.

Telecare services to support people at home are provided, including monitoring systems that alert safety issues. These services are subsidised for those on benefits and are gradually expanding.

Thanks given for sharing this experience; it highlights important system improvements needed.

3.
Question:
You mentioned remote monitoring, which is fantastic. We have a local company that offers a paid remote monitoring service. Would it be more cost-effective to outsource to them rather than setting up our own system with equipment and staff?

Response:
The focus is on having a central platform that integrates data from remote monitoring devices, allowing clinicians to view the information in one place. Some local companies provide devices, but clinicians often do not have access to that data, which remains siloed.

The goal is to adopt open international data standards so that any device or company contracted with can integrate data into our system. Cost-effectiveness and local partnerships will be priorities in procurement, but the key is to ensure clinicians get a complete, integrated view of patient health data.

Question:
Has there been any update on the neurology service review? Will there be a report?

Response:
The Royal College of Physicians conducted a review. Their initial feedback is positive, praising the service and the previous clinician (now retired). The final report is awaited, which typically takes 3–6 months. It is expected by autumn 2025.

Question:
When will there be an announcement about the new Director of Nursing?

Response:
The post has been filled. The announcement will be made shortly, once all arrangements have been finalised.

Question:
Data collection is crucial, especially for health. With recent Supreme Court rulings, should we require legal documentation of biological sex in records? This is important for clinical accuracy, such as prostate exams or cervical screenings, without negating self-identification.

Response:
The final guidance from the Equality and Human Rights Commission is awaited, like other UK health providers. Once issued, local policies will be reviewed to ensure compliance. This will balance accurate clinical data with respect for identity.

Clarification:
PALS is not for complaints but for advice and support. So where do people go to make formal complaints?

Response (PALS and Feedback Team):
PALS handle concerns and support but do not generally deal with formal complaints. Complaints are managed by the HCJ patient experience team's feedback officers. If a complaint is raised with PALS, they signpost or refer it to the feedback team. Both teams work closely and triage issues daily to resolve concerns quickly where possible.

The website information will be reviewed to make this clearer for the public.

Members of the public thanked OH and ITe for their fantastic work, acknowledging their contributions as they depart.

	MEETING CLOSE	**Action**
CD thanks all for attending today and for all those who contributed to the agenda. **Date of next meeting:** Thursday 31 July 2025		