Health and Care Jersey

Health and Care Jersey Advisory Board
Part A - Meeting in Public

27 MARCH 2025

Government of Jersey

Health and Care Jersey

AGENDA
MEETING: Part A (Meeting in Public) - Health and Care Jersey Advisory Board
DATE: 27 March 2025
TIME: 9:30am – 12:30pm
VENUE: Main Hall, St Paul's Centre, Dumaresq Street, St Helier, Jersey JE2 3RL

Non-Executive Board Members (Voting):		
Carolyn Downs CB	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**
Simon West	Medical Director	**SW**
Obi Hasan	Finance Lead – HCJ Change Team	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health, Social Care and Community Services	**AW**
Ian Tegerdine	Director of Workforce	**IT**
In Attendance:		
Martin Carpenter	Chief Information Officer HCJ	**MC**
Rachel Williams	Director of Strategic Planning and Projects	**RW**
Cathy Stone	Nursing / Midwifery Lead – HCJ Change Team	**CS**
Dr Mark Pugh	Medical Lead – HCJ Change Team	**MP**
Danielle Colback	EA HCJ Chief Officer	**DC**
Daisy Larbalestier	Business Support Officer	**DL**
Professor Peter Bradley	Director of Public Health	**PB**
Marguerite Clarke	Head of Public Health Intelligence	**MC**

Quorum requirements:
Three non-executive directors and two executive directors. At least one more non-executive director than executive director.

The Chair reminds members and attendees to consider equality, diversity and inclusion when discussing all items on this agenda.

	Agenda Item	Purpose	Presenter	Time
1	**Welcome and Apologies** *Verbal*	For **Information**	Chair	**9:30pm**
2	**Declarations of Interest** *Verbal*	For **Information**	Chair	**9.35am**
3	**Minutes of the Previous Meeting** HCS HCJ - Part A - Minutes 30012025.pdf	For **Decision**	Chair	**9.40am**

4	**Matters Arising and Action Tracker** PART A - HCS Board Meeting Log 2023.xlsx	For **Decision**	Chair	**9.45am**
5	**Chair's Introduction** *Verbal*	For **Information**	Chair	**9.50am**
6	**Chief Officer's Report** 06. HCS Chief Officer Report.pdf	For **Information**	Chief Officer	**10.05am**
7	**Acute Medicine improvement Plan** Medicine Improvement Plan - Cover Page.pdf Medicine Improvement Plan Exception Report.pdf Medicine Improvement Plan Monthly Poster.pdf	For **Information**	Chief Operating Officer – Acute Services	**10.15am**
8	**Patient Flow** Patient Flow.pdf	For **Information**	Chief Operating Officer – Acute Services	**10.25am**
9	**Quality Account 2025 (annual report)** Quality Account 2024 (Annual Report).pdf	For **Information**	Associate Director of Quality and Safety	**10.35am**
	Comfort Break			**10:50am**
10	**Finance** Finance Report M2 .pdf	For **Information**	Interim Head of Finance	**11.00am**
11	**Quality and Performance Report Month 2** Quality and Performance Report 2025 - Month 2.pdf	For **Information**	Chief Nurse	**11.10am**
12	**Workforce Report Month 2** HCJ Workforce M2 2025 Cover Sheet.pdf Operational People Dashboard.pdf	For **Information**	Director of Workforce	**11.20am**
13	**Equity in Outcomes and Experience (JCC)** *Verbal*	For **Information**	Director of Public Health Head of Public Health Intelligence	**11.30am**
14	**Committee Reports** *Verbal*	For **Information**	Non-Executive Directors	**11.50am**
15	**Board Assurance Framework 2025** *Verbal*	All	Chair	**12.00pm**
QUESTIONS FROM THE PUBLIC (Relating to Agenda Items Only)				
	Questions		Chair	**12:15pm**
	MEETING CLOSE **Date of next meeting**: 29 May 2025 9.30am to 12.30pm			**12:30pm**

Health and Care Jersey

*Proposed key for defining purpose of meeting papers / agenda items:

For Noting: These papers are provided to inform attendees about specific issues or updates. They don't require discussion or action but are important for keeping everyone informed.

For Information: Similar to noting, these papers provide detailed information on a particular topic. They might include reports, updates, or background information that attendees need to be aware of.

For Discussion: These papers are intended to stimulate discussion among attendees. They often present issues, proposals, or topics that require input, debate, or brainstorming.

For Decision: These papers outline specific proposals or actions that need to be decided upon during the meeting. They typically include recommendations and supporting information to help attendees make informed decisions.

For Approval: These papers seek formal approval from the meeting attendees for certain actions, plans, or documents. They often follow discussions and decisions made in previous meetings.

For Action: These papers outline tasks or actions that need to be taken by the attendees or specific individuals. They provide clear instructions and deadlines for implementation.

For Review: These papers are provided for attendees to review and provide feedback on. They might include draft documents, plans, or policies that need refinement before finalization.

For Endorsement: These papers seek the endorsement or support of the attendees for a particular initiative, project, or proposal. Endorsement papers often include arguments and evidence to gain backing.

For Assurance: These papers are provided to give confidence that certain processes, controls, or actions are in place and functioning effectively. They typically include audit reports, compliance reports, risk management updates, and performance metrics. Assurance papers help build trust and transparency within the organization by ensuring that key areas are being monitored and managed appropriately.

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

Health and Care Jersey

Date: 30 January 2025	**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	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	(Acting) Medical Director	**SW**
Obi Hasan	Finance Lead – HCJ Change Team	**OH**
Executive Board Members (Non-Voting):		
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health, Social Care and Community Services	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Ian Tegerdine	Director of Workforce	**ITe**
In Attendance:		
Cathy Stone	Nursing / Midwifery Lead – HCJ Change Team	**CS**
Mark Pugh	Medical Lead – HCJ Change Team	**MP**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**

1	**Welcome and Apologies**

CD welcomed all in attendance.

No apologies.

2	**Declarations of Interest**

No declarations.

3	**Minutes of the Previous Meeting**

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

4	**Matters Arising and Action Tracker**

ACTION 155: CT advised the Board that informatics will be able to support the required change (based on user feedback) during Q1 2025. Remain **OPEN**.

ACTION 154: TW advised that the relevant policy is clear and all patients transferring to the public waiting lists do so according to clinical priority and then chronologically. The policy will be published for transparency. The policy has been checked for consistency across other healthcare jurisdictions. In conclusion, TW assured that there is a robust policy in place however, there may be cases where patients are seen privately and their clinical priority changes. CD thanked TW and advised that it is important to endure adherence to this policy. Agree **CLOSE**.

5	Chair's Introductions

CD discussed several changes. Mr. Simon West (SW) was introduced as the new Medical Director. SW is an orthopaedic surgeon and will continue his clinical practice alongside his new role. He was appointed by the Jersey Appointments Commission, and everyone is delighted that he has accepted the role and started immediately. Congratulations and welcome, Simon.

HCJ is pleased to support the Government of Jersey (GoJ) with the secondment of Dr Anuschka Muller, Director of Improvement and Innovation, who will be working with the Cabinet Office on a government-wide strategic project. Congratulations, Anuschka.

Meanwhile, Rachel Williams (Director Public Health Delivery) will be working with TW to review the proposed integrated health and care system structures. This work is expected to return to the Board as soon as possible to help the Board understand the different roles within this system.

6	Chief Officer Report

Chief Officer Report Summary

TW, Chief Officer, highlighted key points from his report to the Board:

1. **Integration of Health and Care System**: The year began with the formation of Health and Care Jersey, aiming to create a more integrated health and care structure for Jersey. As of January, Public Health and health policy colleagues have joined Health and Care Jersey, with further integration opportunities expected throughout the year.

2. **New Health Care Facilities Program**: The States Assembly approved funding for the new health care facilities (NHF) program in December during the budget debate, marking an important milestone. The procurement process for the main developer is underway, which is crucial for the hospital's construction. Additionally, the planning application has been submitted and will be reviewed by the planning committee in February 2025, with hopes for a positive outcome.

3. **Progress on Assisted Dying**: The States Assembly has voted in principle in favour of assisted dying. The policy team will now draft legislation to implement this in Jersey. This development will have significant implications for health and care providers, including HCJ, and will be revisited later in the year once the assembly's decision is clarified.

4. **Top Priority Areas for Improvement**: The executive team will focus on the following areas during 2025:
    a. **Clinical Standards**: Enhancing clinical standards across the board.
    b. **Patient and Service User Flow**: Improving the flow of patients and service users through the system.
    c. **Budget Management**: Living within the budget allocated by the assembly.
    d. **Workforce**: Addressing long-standing vacancies and strengthening the workforce.
    e. **Off-Island Service Offer**: Rationalising tertiary care arrangements and taking a strategic approach to off-island services.

5. **Inspection by the Jersey Care Commission (JCC)**: This year, the department will prepare for its first inspection by the JCC, a significant milestone for the department and the service. This important piece of work will be revisited by the board later in the year.

ADHD Waiting List Concerns: CG raised concerns about the nearly 1,000 adults on the waiting list for ADHD assessments in Jersey, equating to about 1 in 50 adults. The current waiting time is approximately four years. Recommendations from the quality committee include:

a. **Prioritisation**: Focusing on those most affected by ADHD, such as individuals in prison, pre-sentencing adults, young adults transitioning from childhood ADHD, and those with drug and alcohol use issues.

b. **Impact Assessment**: Evaluating the financial and health impacts of addressing the waiting list by recruiting more staff.
c. **Review of ADHD Diagnosis**: Considering the ongoing review in England regarding the rise in ADHD diagnoses and potential misidentification with anxiety or stress.
d. **Deep Dive into High Diagnosis Rates**: Investigating why Jersey has such a high rate of ADHD diagnoses and involving patients and the public in this review.
e. **Patient Communication**: Finding ways to contact and support patients on the waiting list, including providing self-help materials and managing expectations about their likelihood of being seen unless they are in a priority group.

Tom Walker acknowledged the need to prioritise high-priority patients on the ADHD waiting list, similar to other clinical services. This issue will be further addressed by AW in the performance report.

TH thanked TW for the report and asked what aspects of the report were particularly notable, emphasising the importance of recognising achievements and having a sense of pride in progress. TH also inquired about the five priorities for the executive and what critical or complex issues were on his mind.

TW expressed pride in the dedication of both clinical and non-clinical staff across the services, noting their commitment to delivering high-quality support to patients and service users.

There are opportunities to enhance the flow of patients and service users through the system, from the emergency department (ED) to delayed transfers of care (DTOC). Improving this flow can significantly boost the resilience of acute services.

This year, there will be a particular focus on patient record keeping, which has been a recurring theme in serious incident (SI) reports. Ensuring accurate record keeping is seen as a lead indicator of adherence to good clinical standards.

TW highlighted the need to review and improve off-island tertiary care arrangements. While some relationships with tertiary care providers are highly valued, others are less so. By strategically reviewing these arrangements, there is an opportunity to enhance the quality of off-island care for Islanders.

ACTION: The board requested updates on the work being done on patient flow and off-island service offers at the next meeting in March. Additionally, a report on the digital agenda will be included. Regular updates on the five priorities will feature on the board agenda in addition to regular finance, workforce, and clinical improvement items.

7	**Environmental Sustainability**	**Action**

Ross Barnes (RB), Head of Non-Clinical Support Services and Jon Carter (JC), Head of Estates in attendance and presented a series of slides (addendum to these minutes).

CD thanked RB and JC for their comprehensive presentation and opened the floor for questions. CD asked how the Jersey Care Commission (JCC) might rate HCJ estates and facilities if they were to grade them, even though the JCC is not planning to provide such ratings. CD expressed uncertainty about the status of HCJ facilities and sought RB and JC's perspective.

JC responded by acknowledging that whilst there are some good facilities, there are concerns about areas that are part of the new hospital program for development or disposal, which may be slightly below par. In addition, some of the infrastructure dates back to the 1700s through to modern construction, which poses certain limitations. RB emphasised the need for continuous improvement and highlighted the importance of measuring against JCC standards, also noting that there are opportunities to improve communication and support for staff to adopt greener practices.

The World Health Organisation (WHO) emphasises sustainability not just in terms of reducing carbon emissions but also improving patient care. RB and his team focus on making facilities more sustainable by reducing the administrative burden on clinicians, allowing them to spend more time with patients. This approach aims to separate clinical and non-clinical tasks effectively with significant progress made in this area, continuing to support clinicians in becoming more sustainable. JC added that community care homes have undergone a trial period, and they are on the right path in terms of their built environment.

CG thanked both RB and JC and shared insights from the NHS in England, highlighting issues like dripping taps wasting water and the significant number of healthcare-related car journeys (circa 20%). CG emphasised the importance of accountability at all levels, including doctors and nurses switching off equipment and using digital tools to communicate with patients. CG inquired if the team would engage clinicians in audits to address wastefulness and other issues.

JC confirmed that they are already addressing these issues and use management tools to optimise engineer routes, reducing carbon footprints. In addition, water usage is managed in older infrastructure and implementation of new technologies to improve efficiency. The estate's compliance team also actively monitors and addresses issues, and there are efforts to promote greener travel options among staff.

The board thanked JC and RB for the presentation and offered their full support to enhance their efforts.

8	**Quality and Performance Report Month 12**	**Action**

CT provided a verbal summary of the following key areas for acute services.

1. **Outpatient Services**: Discussion regarding the recovery actions for outpatient services, particularly focusing on key specialties where patients have been waiting too long for routine appointments. However, there is assurance that patients with urgent clinical needs are prioritised and an improvement in outpatient activity across acute services noted. However, some pathways that remain a concern, especially in gastroenterology, where additional capacity is being utilised to improve services.

2. **Inpatient Services**: Inpatient activity impacted by theatre capacity due to ventilation and engineering problems, as well as bed pressures, especially during autumn and December 2024. These issues have affected routine surgeries, but urgent elective procedures are being prioritised. In addition, there is focus on those patients who have had their routine surgeries cancelled multiple times, ensuring they are also prioritised.

3. **Access to Diagnostics**: This is a developing metric for the board, with new modalities added for better oversight. The chief of service for surgery is focusing on managing capacity and demand in this area, making it a priority for 2025.

4. **New to Follow-Up Performance**: The speaker is pleased with the performance in this area, noting a reduction in Did Not Attend (DNA) rates due to actions like text reminders and phone calls to patients.

5. **Elective Utilisation**: This remains a priority, with varying improvements. Consistent improvement in late starts is noted, but further progress is needed.

6. **Emergency Activity**: Winter pressures and a rise in medical admissions, particularly respiratory infections, have impacted patient flow and 12-hour performance. Ensuring appropriate placement for patients requiring isolation has been challenging.

7. **Patient Movement and Safety**: The board has learned a lot about moving patients around the hospital to maintain a safe ED and manage handovers from ambulance services. Efforts to reduce inpatient moves, especially out of hours, have been successful, improving patient safety and experience.

CG expressed gratitude for the hard work and improvements seen in various areas, particularly in reducing the rate of rise in waiting times and improving mental health services, such as memory assessments. Acknowledgement of the challenges faced, including technical issues in radiology, building issues affecting scans, and staffing issues but despite these, there have been significant improvements in dermatology, attributed to leadership and the addition of a new consultant. CG emphasises the need for greater engagement from senior clinicians in innovation, both digital and in patient triaging, to continue improving services.

CT suggested the preparation of an assurance paper for the next Finance and Performance Committee which highlights the progress in reducing the over-52-week cohort of patients and move towards sustainability in key specialties (rather than interim recoveries). The focus is on maintaining sustained improvement in outpatient services and addressing challenges in elective care. As winter pressures ease, the aim is to concentrate on specific specialties to ensure continued progress.

TW thanked CT for the focus on diagnostics and the efforts to improve this area.

AW provided the following verbal summary of the Mental Health and Social Care indicators. Key points include:

1. **Jersey Talking Therapies Initial Assessments and Treatment Wait Times**: While initial assessments are conducted quickly, there are longer wait times for treatment. An 18% rise in referrals last year, particularly in November, has contributed to this issue. The service is exploring ways to manage the increased demand, possibly by reordering the process to balance wait times for assessments and treatments.
2. **Access Targets**: Despite a 28% increase in referrals to mental health services in 2024, the teams have maintained their access targets. Notably, 100% of crisis team referrals in December were seen face-to-face within 4 hours, and 95% of referrals are seen within 10 days. AW highlighted the significant effort of the team in achieving in achieving this.
3. **Waiting Times for Specific Services**: There has been a slight dip in waiting times for memory assessment, and autism services due to changes in ways of working. The memory assessment team is praised for their clinically led work in achieving waiting time targets and AW expressed gratitude for the hard work and dedication of the teams involved.
4. **Adult Social Care Indicators**: New indicators for adult social care will be monitored, with a focus on maintaining high performance levels (see item 9 on this agenda). There has been a decrease in the process indicator for assessments being authorised within three weeks, which returned to 100% compliance in December.

ADHD Waiting Times

The waiting time for ADHD referrals is currently four years, with 924 people on the waiting list (also a cohort of young people waiting to transition from Child and Adolescent Mental Health Services (CAMHS) to adult services. The service is struggling to meet the demand, with clinicians dividing their time between assessing and prescribing. The prescribing list is managed by a limited number of doctors, and drug availability issues exacerbate the problem.

1. **Prioritisation and Support**: The clinical team is developing criteria for prioritising patients on the waiting list. Psychological support and education groups have been introduced for those waiting, and a clinical nurse specialist has been budgeted for to increase capacity.

2. **Shared Care Model**: Discussions are ongoing about a shared care model with the primary care board, which could impact prescribing capacity. However, CG expressed concerns about the appropriateness of GPs prescribing ADHD medications due to their potential risks and urged HCJ / GPs to address this through a different route.

3. **Deep Dive into ADHD Diagnosis**: CG suggested a deep dive into Jersey has such high ADHD diagnosis rates. This would likely need to be commissioned externally to avoid overburdening the current service and conflicts of interest.

4. **Screening and Assessment Process**: The service screens referrals before assessment, which has led to a high positive assessment rate (90-95%). The process includes self-assessment forms and clinical screening to ensure appropriate referrals. CG highlighted the unusual 98% conversion rate from referral to diagnosis for ADHD, suggesting that this indicates a self-diagnostic identity rather than a clear clinical condition.

CG asked if consideration has been given to closing the ADHD waiting list, which currently has nearly 1,000 people, suggesting that the waiting list should only remain open for those meeting specific priority thresholds, such as prisoners pre-sentencing, transitioning young people, and those known to abuse cocaine or amphetamines. This is due to the unmanageable size of the waiting list and the need to send a clear message about prioritisation.

AW responded that the issue of closing the waiting list has been discussed twice before, and many NHS trusts have already closed their waiting lists for non-emergency referrals. Closing the waiting list would help manage the current demand and ensure that resources are focused on those with the most urgent needs. However, this is a complex and sensitive issue and closure of the waiting list is as a political decision that needs to be discussed with the Minister. CD concluded that this is a complex issue which requires very careful consideration and emphasised the importance of further updates at the board.	

9	Social Care Indicators	Action
AW advised the board of the development of new indicators for adult social care, created in collaboration with social workers. The goal is to ensure the indicators covered the responsibilities of the social care team and included outcome-based metrics, not just process indicators. Key performance indicators (KPIs) proposed include: 1. **Significant Restriction of Liberty Assessment**: Metrics related to mental health law and social care. 2. **Effective Flow**: Metrics to understand patient flow in and out of hospitals and whether people stay at home after discharge. 3. **Annual Health Checks and Care Plan Updates**: For people with learning disabilities. 4. **Qualitative Metrics**: Three metrics to be reported quarterly, asking people if the intervention made a difference, particularly in safeguarding. CD raised a concern about how to gather responses from individuals who cannot respond themselves, suggesting that friends and family might respond on their behalf. The team is considering how to best address this, especially in the learning disability service. Discussion ensued highlighting the importance of balancing the number of indicators and ensuring they focus on the right aspects. Some indicators will provide a comparative basis with the UK, while others are specific to Jersey. The shift towards outcome-based indicators and the emphasis on service user satisfaction were welcomed as they contribute to mental health and quality of life. CT added that the developing metric on keeping older people at home is crucial. By examining readmission rates, the effectiveness of procedures and pathways within acute care and support ongoing recovery at home can be assessed. This metric will provide detailed insights into performance, especially since a significant portion of readmissions involves individuals over the age of 75. Understanding these details will help drive improvements in other areas as well. The Board looks forward to seeing the results of these new indicators.		

10	Workforce Report Month 12	Action
As the People and Culture Committee reviewed the workforce indicators in-depth, the Board asked ITe for a focus on sickness absence rates. • **Previous Concerns and Improvements:** ITe reminded the Board that the People and Culture Committee received a paper on sickness in 2024, and significant work has been done since then. Initial concerns about the accuracy of sickness reporting have been addressed, leading to better reporting practices. • **Data Issues and Solutions:** Problems such as missing data have been identified and seeking to resolve. Efforts are ongoing to ensure managers' report sickness accurately, with a noted discrepancy in reporting quality between medical and non-medical staff. • **Current Sickness Rates:** The current sickness rate is around 6.4%, up from 5.3% previously. Comparisons with other regions show varied rates: Scotland and Wales report above 6%, NHS England around 5%, and the Isle of Man approximately 5%. • **Benchmarking Challenges:** Benchmarking against other jurisdictions is challenging due to differences in reporting and context. • **Focus on Well-being:** The primary goal is to understand the root causes of sickness absence and provide well-being support for staff, rather than punitive measures.		

- **Long-term and Short-term Sickness:** A review of long-term sickness cases is complete, with increased focus on identifying patterns in short-term sickness. The People and Culture Committee will receive a detailed statistical analysis in their next meeting (February 2025).
- **Data Refinements:** Further refinements of the data are needed to better understand sickness patterns, including average and mode durations of sickness spells.
- **Anxiety and Stress as Major Absence Reasons:** CD noted that anxiety and stress are the third most common reasons for absence, with 761 instances reported. This issue is seen as something that can be directly addressed and positively impacted by the board. There is a strong call for a concerted effort to reduce anxiety and stress among staff, as it is a significant concern, almost as prevalent as gastrointestinal problems.

Cross-referencing Surveys and Creating a Heat Map:

- **Creating a Heat Map:** The goal is to create a heat map to identify areas within the organisation with higher instances of grievances, vacancies, turnover, disciplinaries, and sickness levels. This will help pinpoint managerial and other issues. The heat map will correlate various data points, including Freedom to Speak Up issues and staff survey results, to provide a clear picture of problem areas. Although the timeline for completing this heat map is uncertain (aiming end Q1 2025), staff are actively working on it, and it remains a priority.

Anxiety and Stress:

- CG emphasised the need to change the narrative around anxiety and stress. The current metric for sickness due to anxiety and stress is seen as part of a broader issue where people feel they need to be 100% well to work. It was highlighted that work can improve mental health and well-being. The goal is not to make everyone happy all the time but to understand and communicate that stress can be beneficial in certain contexts.
- **Managing Emotions and Stress:** Efforts should be made to help individuals manage their own emotions and stress effectively.

Support for Workforce Mental Health:

- **Understanding External Pressures:** TH emphasised the importance of understanding how external pressures impact employees' mental health at work and providing appropriate support.
- **Low Utilisation of Employee Assistance Program:** It was noted that the HCJ workforce has a low uptake of the government-provided Employee Assistance Program (EAP), partly due to HCJ having its own initiatives. One of the targets for the year is to increase access to EAP services, which offer a range of support, including financial and commercial advice. The aim is to integrate these services more effectively within the health sector.

11	BeHeard Survey	Action

The BeHeard Survey, conducted by a third-party company, is distributed across the entire GoJ, including HCJ. HCJ achieved a response rate of circa 30%, which is lower than desired. Improving this response rate is a key target for the year. For comparison, the NHS achieves about 48%, Scotland around 59-60%, and Wales about 20%. Increasing engagement with the survey is crucial to better hear from people.

Despite the low response rate, the survey results revealed some positive news. Overall, more people are happy working within HCJ than are unhappy, and this positive sentiment has increased since the last survey.

Improvements were noted in various domains such as leadership, teamwork, personal growth, well-being, and feeling valued. However, there was a slight decline in how people feel about working in teams, which needs further investigation. The organisation is developing plans to address these issues and aims to drive further improvements. Key themes from the action plan include leadership and management, communication, teamwork, learning from errors, and supporting staff who report issues. The next survey will be conducted soon, and the organisation is committed to continuous improvement.

Additionally, the NHS uses the Friends and Family Test to gauge whether staff would recommend their workplace for care to friends and family. Understanding why staff in HCJ are not as positive as

those in other jurisdictions is important. This feedback will be incorporated into the corporate plan. Each care group is also asked to deep dive into their results and develop local plans to address any discrepancies. These plans will be scrutinised during monthly performance reviews from February 2025. The overall corporate plan is expected to be completed by the end of February, alongside the survey results for this year.

The 2025 BeHeard Survey has been brought forward to the summer, rather than the usual autumn schedule, giving less time to make an impact before being resurveyed. This change is likely due to the GoJ aim to find the best time of year for optimal responses. Additionally, HCJ plans to conduct its own Pulse Survey to check in with staff, potentially using the same structure as the BeHeard Survey. Despite the challenges, there is positive progress, and staff feedback indicates that HCJ is moving in the right direction. The focus remains on reflecting on these positive developments and continuing to improve.
Whilst CD emphasised the importance of recognising significant improvements and celebrating them (particularly in leadership), there are areas of concern, such as the lower recommendation rate for the service compared to the NHS (42% vs. 65%) and confidence in HCJ addressing concerns. CD suggested focusing the Pulse Survey on these issues and using listening events to understand and address staff concerns. The goal is to see real improvements by 2026, despite the current survey's limitations due to a low response rate and differences in survey scoring methods.

TH added that while the overview provides a general picture, it may mask significant differences between service areas. Understanding these differences is crucial for learning and improvement. TH further noted that changes in management can have a substantial impact on staff morale and happiness. The heat map discussed earlier will help identify these differences, and the People Committee will need to address them in an appropriate environment to ensure confidentiality and effectiveness.

12	Rheumatology Update	Action

Dr Adrian Noon (AN), Clinical Lead and Rachel Williams (RW), Operation Crocus Director (RW) in attendance and provided with a verbal summary (supported by papers).

RW summarised the background to the review. The Royal College of Physicians (RCP) was invited to review the Rheumatology department and the care received by its patients. This review was initiated due to concerns raised by an individual within Health and Community Services (now HCJ).

The RCP provided several recommendations, and significant progress has been made in addressing these recommendations, as well as additional issues identified by the department.
The RCP also recommended a clinical audit of all patients on biologic medication. During this audit, concerns arose, leading to an extended review covering all patients in the Rheumatology department. The review is nearly complete, with independent specialist clinicians reviewing various patient groups.

AN provided detailed explanations of the findings and ongoing actions, specifically noting the hard work of all staff involved. Key points,

- Approximately 2,200 patients have undergone some form of review, most of which were face-to-face with the clinical team.
- Harm assessments were conducted for all these patients, and when concerns about validity arose, the assessments were repeated to ensure accuracy.
- So far, 62 Duty of Candour (DoC) letters have been sent out, with a few more expected.
- Thirty-three cases were referred to the Viscount's office. Of these, meetings have been held with the families of 31 deceased patients. This process has been challenging, especially for elderly relatives and young children, necessitating the development of a comprehensive psychological support service, with significant contributions from mental health colleagues and Jersey Talking Therapies.
- There are still about 80 cases left to review among the deceased, and the process of contacting their relatives is ongoing.

The second paper focuses on the future, detailing the action plan initially developed under the guidance of the RCP.

- Significant changes have occurred in the Rheumatology department over the past 18 months, led by its clinicians and supported by a multidisciplinary team. Regular meetings, proper audits, and good clinical governance have been established. The department hopes to receive a review from the NHS's Get It Right First Time (GIRFT) team later this year for external validation of their progress and to identify further areas for improvement. The department has undergone substantial transformation due to hard work and organisational investment, making it almost unrecognisable compared to 18 months ago.

CD thanked AN and RW for the update and reminded the board that it has regularly received updates. CG suggested that this no longer needs to be a standing item on the board agenda, given the extensive discussions held at the Quality, Safety and Improvement (QSI) Committee. The board concluded that significant changes or issues should still be reported to the board via the committee's updates. Routine matters can be managed by the Quality Committee, with proper minuting to ensure the board remains informed. This approach balances the need for oversight with the recognition of the substantial progress already made.

13	Acute Medicine Improvement Plan	Action

CT presented the Acute Medicine Improvement Plan (MIP), which has been regularly reported to the board and is scrutinised by the QSI Committee. The plan is based on several internal and external reviews, most latterly, an invited review by the Royal College of Physicians (RCP) in 2022. The culmination of these reviews and internal learnings from serious incidents led to 61 recommendations, with 19 specifically from the RCP 2022 review.

All recommendations are progressing well, and concerns about the speed of implementation have been addressed. Many remaining recommendations focus on investing in and recruiting to the medical workforce. The workforce model described by the RCP has been resourced as part of the 2025 budget, providing a framework for future recruitment efforts.

CS thanked CT for the report and highlighted the synergies with the Maternity Improvement Plan, noting that a lot of work has been done. However, the success of the plan is due to embedded processes and inquired if the 30/60/90-day process is continuing within the MIP – CT confirmed this was the case.

TW asked CT about the challenges in filling some of the funded posts, particularly in difficult-to-fill specialties. CT acknowledged that while there have been successes in recruiting for respiratory and general/acute medical posts, frailty remains a significant challenge, and this post is crucial for admission avoidance services. CT mentioned that professional networking and efforts by Dr Matt Doyle, Chief of Service for Medicine, have generated interest in working for Jersey, which could help improve services. In conclusion, whilst there are challenges, there have been positive changes in some areas.

SW in agreement and emphasised the importance of selecting the right candidates for Jersey, given its unique and challenging environment. He noted that while there have been many applicants over the past 18 months, it is crucial to ensure they are the right candidates. Current vacancies have sometimes been due to candidates not adapting well. Despite these challenges, there have been recent successes in recruitment.

MP highlighted the difficulty of recruiting physicians, noting that 70% of advertised posts on the mainland do not attract a single appointable candidate.

CD asked about the status of recommendation 096, which referred to the 2023 job plans. SW confirmed that the 2022-2023 and 2024 job plans were closed down, and the 2025 cycle will open next Monday (.3 February 2025). The aim is to complete the cycle by the beginning of April 2025, with significant effort and resources devoted to this process. Learning events have been organised to help colleagues understand the job planning software and engage with the process. SW expressed his commitment to ensuring the plan is completed on time.

ITe acknowledged the progress made and emphasised the importance of starting the 2026 plans at the end of 2025. This effort, led by the Finance Recovery Programme (FRP) aims to eliminate the backlog and move towards prospective planning. Achieving these ambitious targets will place HCJ in a good position by the end of this year. Proper job planning is crucial for greater efficiency and productivity. OH expressed gratitude for the recognition of the FRP team's hard work.	

14	**Finance Report Month 12**	**Action**

2024 Year-End Position:

- The 2024 year-end financial position is a £28m deficit (forecast £28m),
- This indicates an improved understanding and management of financial variations.

Key Points:

- **Anticipation and Risk Management:** The organisation is getting better at anticipating variations and managing risks. This includes holding reserves and taking proactive recovery actions.
- **Movements and Predictions:** While there were some unexpected movements, these were predicted, and reserves were used to manage these effectively.
- **Cost Containment:** Rising costs and pressures were contained within the forecasted £28 million deficit, avoiding a potential increase to £31-32 million.
- **Savings:** Significant savings were achieved, particularly by care groups, contributing positively to the overall financial performance.

FRP Savings and Mitigation:

- The organisation delivered **FRP Savings of £8.95 million** last year, exceeding the planned £5.1 million. This helped mitigate additional cost pressures and contain the deficit.

Maintaining Momentum:

- The focus is on maintaining this momentum despite ongoing pressures.
- Strategies include proactive measures and learning from past experiences.

2025 Budget and Plan:

- The 2025 budget starts with a funding envelope of **£322.2 million**, an increase of £22 million from the previous year.
- The approach involves recognising efficiencies and demographic-related health pressures.
- Prioritising service provision within the allocated budget is key.

Quality Impact Assessments:

- Decisions are made using Quality Impact Assessments (QIAs), considering quality, operational delivery, and financial constraints which helps balance the budget while maintaining service quality.

Efficiency Savings Plan:

- An ambitious Efficiency Savings Plan of **£13.2 million** is set for 2025 and a further £9m for 2026.
- The organisation aims to deliver over **£39 million in savings** over a four-year period, exceeding the initial plan of £25 million.

Challenges and Mitigations:

- Balancing the budget is challenging, but the organisation is prepared to handle variations and pressures.
- The executive team is focused on proactive planning and mitigation strategies.

Accountability and Visibility:

- The budget is balanced but delivering it will be challenging.
- There is a clear mechanism for accountability and visibility, ensuring the organisation can be held to account for its actions.

Specific Risks and Mitigations:

- **Social Care Costs:** High rising costs in social care, demand-led mental health, and tertiary care contracts are major risks carried forward from last year.
- **Infrastructure Investment:** To mitigate these risks, infrastructure investments have been made to improve processes and control cost pressures.
    - **Examples:** Good buying practices and threshold management for care contracts to ensure fair charges and robust challenges to cost pressures.
    - **Team Investment:** £4 million of the £13 million savings depends on the infrastructure teams' ability to deliver and stop additional costs.

Strategic Initiatives:

- **Sustainable Healthcare Funding:** The organisation is actively supporting government initiatives on sustainable healthcare funding.
- **Integrated Health and Care System:** The vision of an Integrated Health and Care system is seen as a positive step towards financial sustainability and improved service delivery.

CT commented on the benefits of understanding of the cost of activity. Nearly 600 more inpatient procedures were performed in 2024 compared to 2023 with the same staff base, reducing waiting lists. Despite significant non-pay pressures, more care was provided, and resource prioritisation is improving.

Future Outlook:

- **Proactive Planning:** The organisation is focused on proactive planning and mitigation strategies to handle inevitable variations and pressures.
- **Accountability:** There is a clear mechanism for accountability and visibility, ensuring the organisation can be held to account for its actions.

Quality Impact Assessment (QIA) Process:

- **Purpose and Methodology:** The QIA process evaluates the impact of proposed changes on quality and operational performance. Established methodologies and forms are used to conduct these assessments.
- **Decision-Making:** When a decision is made to change a service, typically for cost savings or process changes, the QIA asks a series of questions about the impact on quality and operational performance.
- **Responsibility:** The assessments are completed by the care groups involved, not by the finance team. The finance team may identify opportunities for savings, but the care groups evaluate the quality and operational impacts.
- **Questions:** The QIA includes quality-based and operational impact questions, comparing the current baseline with the potential impact of the proposed changes.

TH asked OH to explain the QIA process further and how the board is assured.

- **Involvement:** Clinicians and managers complete the QIA process, which is then reviewed by a quality impact assessment board.
- **Board Composition:** The board includes the medical director, COO, chief nurse, and a finance representative.
- **Decision-Making:** The board reviews and signs off on the QIA. If the assessment fails, the scheme cannot be implemented without mitigation of identified risks.
- **Principle:** The focus is on ensuring that cost-saving measures do not compromise quality. Better quality of care is often aligned with more efficiency.
- **Assurance:** The QIA process ensures a balance between financial impact and quality maintenance. The executive team collectively reviews and makes decisions, ensuring all aspects are considered.

Strategic Focus:

- **Communication:** It's crucial to communicate with the public that cost reductions can lead to better outcomes and processes.
- **Out of Hours Work:** There is a strong focus on early intervention and improving overall health and quality of life to prevent the need for more expensive care.
- **Minister's Vision:** Aligning with the Minister's vision for an integrated health and care system to achieve financial sustainability and improved service delivery.

Referring to discussions as yesterday's QSI Committee, CG advised that the average cost of medicines on the island is double that of the UK, despite a healthier population. A tool called Blue Tech has been introduced to identify appropriate and inappropriate prescribing, potentially saving up to 10-20% of the £20 million prescribing budget.

Following TH's reference to out of hospital work, AW emphasised the redesign and development of services while managing demand and costs. The community services care group has a business plan focused on admission avoidance and reducing unnecessary hospital admissions. Efforts are being made to discharge patients more quickly and provide care at home, aligning with the five priorities for health and community services.

SW talked about the importance of financial leadership and the presence of a finance director within the executive team is crucial for maintaining financial control and governance. This role ensures a balance between financial management and quality of care. Secondly, the grip and control regarding off-Island Care is encouraging.

CD concluded that the board is working on improving processes and investing in tools like Blue Tech to achieve savings and better outcomes. There is a clear accountability for delivering savings and achieving financial targets which is a collective effort involving the entire team, not just the finance director.

15	**Annual Plan 2024**	**Action**

AM advised that the annual planning process involves creating a plan at the beginning of the year and then reviewing the year's performance against this plan at the end. This review includes various aspects, such as finances and quality performance indicators, which have already been covered. Other areas which receive less coverage are,

- **Recommendation Follow Up:** Although this area is not usually highlighted, it is important to note that recommendations are rigorously followed up in the background and included in the annual plan. Recommendations come from the Comptroller and Auditor General, Public Accounts Committee and Scrutiny Panels. 2024 started with **86 recommendations and b**y the end of 2024, the number of open recommendations was reduced to 25. By the end of Q1 2025, anticipating only two open recommendations remaining. Beyond the numbers, this progress reflects a positive message around service improvement.
- **Jersey Care Commission Preparation**: Significant efforts have been made in this area, and updates are included in the report.
- **New Hospital Digital Programs**: Various projects are listed, with some completed and others still ongoing. There has been some reprioritisation of these projects.
- **Quality Account Update**: An update on the quality account will be provided separately, but there is already a preview of achievements in this area.
- **Workforce Culture**: This aspect is usually covered and is noted in the report.

The board noted the annual report against last year's plan, highlighting the progress and achievements.

16	**Committee Reports**	**Action**

The board received a summary from each of the committees.

a. People and Culture:
The committee spent significant time discussing the BeHeard Survey. Workforce issue also discussed regularly at the Board, including this morning.

b. Finance and Performance Committee
Report taken as read.

c. Quality, Safety, and Improvement Report:
CG highlighted two areas of concern for the committee,

- **C. difficile Infection**: There is a significant rise in Clostridium difficile (C. difficile) infections, which are antibiotic-resistant and predominantly occur in hospitals. This rise is largely due to inappropriate prescribing of certain antibiotics. The new Blue Tech system will help identify which departments or individuals are prescribing these antibiotics. This monitoring is crucial as C. difficile infections can extend hospital stays and have serious implications for patient health.

- **Prescribing (Private and Public) - Medicinal Cannabis**:
  There is a notable increase in the use of medicinal cannabis, particularly in private prescriptions, which impacts the quality of care in other departments, especially mental health. The number of people on medicinal cannabis in the UK is around 0.04%, but on the island, it is significantly higher, estimated to be 150 to 200 times greater. This issue is being addressed by various committees, including those focused on the misuse of drugs.

For clarification, SW explained that whilst the Blueteq system was discussed yesterday, the system demonstrated was a Power BI dashboard has been developed to monitor prescribing patterns, which will help tremendously in managing prescriptions.

MP noted a concern about the lack of staff to manage ward-level prescribing, particularly antibiotic pharmacists who can oversee the prescription of antibiotics. The rise in hospital acquired infections (HAIs) is a consequence of this. Recruitment is underway to fill pharmacy vacancies which will allow pharmacists to work clinically on the wards, improving the overall pharmacy service.

17	**Board Assurance Framework 2024**	**Action**

The Board Assurance Framework has been reviewed, and the agenda has been assessed to ensure all issues are covered. Recent committee meetings in January 2024, deferred from the end of December 2024, have been conducted. The agenda for these meetings are structured to address key controls and assurances for scrutiny.

There has been learning from the 2024 process, which was the first iteration. This learning will be incorporated into the 2025 framework. The updated framework for 2025 is aiming for board presentation in March 2025.

18	**Risk Appetite Statement**	**Action**

TW advised that the risk appetite statement has been updated to reflect the current status, in line with normal risk management practices. A further review will be conducted in the next 12 months to ensure it remains current.

CD noted the risk appetite is generally moderate across most areas, with a low appetite for financial risk to avoid overspending.

CD thanked TW and the board looks forward to further iterations as risk appetite develops.

19	**Questions from the Public**	**Action**

The board received a presubmitted questions,

Question 1. *What measures are in place to stop a consultant in their private clinic prescribing medication to their patients on hospital prescriptions at the expense of the tax payer? The majority of hospital prescriptions are now prescribed using an electronic system. What is in place to prevent a consultant logging into the electronic system remotely and submitting a prescription to the hospital pharmacy?*

Response: SW responded that the public and private prescribing processes are distinct. The electronic prescribing system is used only for public patients. There is a separate paper-based system for all private prescriptions.

This clear demarcation separates the systems to ensure there is no confusion regarding how to prescribe for each pathway.

The majority of private scripts are directed to community pharmacies, but some are dispensed by the hospital pharmacy where the drug is only available to order by HCJ.

Occasionally a prescriber might make an error and prescribe a private script on the public system. On the rare occasions when this might occur, the prescriber would be reminded of process. Should it become a matter of persistent error, then this would become a matter for professional standards.

CD asked SW if there is confidence in the system described and does it stop individuals working the system to their advantage. SW explained that the systems are designed to give clinicians a clear choice. There is no evidence to suggest that clinicians are abusing the system.

Question: Reflecting on personal experiences, can a deep dive been undertaken so as to understand how many discharge letters are incorrect?

Response: SW responded that this is an area of constant review and errors are noted within discharge letters. SW will be meeting with the COO and Chief Nurse this week to review how discharge letters can be improved both from a quality perspective and timeliness. Ideally, patients should be discharged with the letter and with a digital solution, transferred electronically to the GP on discharge.

CG noted that the review of the role of the community pharmacist within the whole Island system should also lead to improvements in this area, specifically medicines reconciliation.

Question: The perceived lack of gluten free food available throughout the hospital is unacceptable.

Response: Gluten free food is a choice on all patient menus within HCJ. In response to a further question regarding the delay in patient menus, despite positive steps towards using local produce, JM explained that the dietician needed specific software to analyse the nutritional elements of the menus efficiently. This software has now been acquired, and the dietician will soon begin the work, which will expedite the process of reconfiguring the menus for patients.

Question: What is the most recent readmission rate?

Response: The information is available within the board papers; Month 12 position circa 14% with an average of 11%.

Question: Regarding the number of hospital beds, there used to be 240 which has reduced to 150 – how are the –90 accounted for?

Response: CT responded that there are >150 beds open currently, and ward-by-ward detail can be provided at the next meeting.

ACTION: CD suggested that the bed base could be included in the paper regarding patient flow planned for the meeting in March 2025.

Question: C*larification sought about the "general medicine" category, which currently has 55 people on the waiting list with a median waiting time of 96 weeks (almost 2 years). They are unsure what conditions or treatments fall under this category and are asking for more information about the patients on this list.*

Response*: T*he discussion revolves around the "general medicine" category, which includes patients referred by GPs for conditions that don't fit into specific specialties like rheumatology or cardiology. There are 55 people on this list with a median waiting time of 96 weeks. The referrals are made when GPs feel unable to manage the conditions, which might not be urgent but still require further investigation. The referrals are triaged by consultants who determine their priority. The lack of general physicians and the over-specialisation in medicine contribute to the long waiting times.

ACTION: The need for better prioritisation and more detailed information about these patients was acknowledged, and further details will be provided in the next waiting list report. **Question***:* The speaker raises two main concerns. First, they question whether all current consultants are members of their relevant specialist register and if other specialties prescribing biologics undergo the same pharmacy review as rheumatology. Second, they discuss the challenge of effectively using Supporting Professional Activity (SPA) time in consultants' job plans to address pressing clinical priorities. They suggest that the board might consider seeking advice on these issues to ensure SPA time is used efficiently and in line with concerns raised this morning. **Response**: SW confirmed that the current rheumatologist is on the specialist register. The Blueteq software, used alongside a biologic pharmacist, interrogates clinicians on their reasons for prescribing biologic agents. This software is not just for cost control but ensures appropriate use across various specialties, including neurology, dermatology, and paediatrics. The Medicines Optimisation Committee also regularly reviews prescribed medicines to ensure proper use. Thise not on the specialist register will be working under the supervision of those that are. Secondly, regarding job planning, the standard British Medical Association (BMA) allowance for Supporting Professional Activities (SPA) time is 1.5 sessions for revalidation, appraisal, and continuous professional development, with up to 2.5 SPA time allowed historically (specific in Jersey). The speaker emphasises the importance of knowing how SPA time is used to ensure it is valuable and suggests that it might be more beneficial for consultants to see patients if SPA time is not being used effectively. The meeting concludes with no further questions.	

	MEETING CLOSE	**Action**
Date of next meeting: Thursday 27th March 2025 9.00am – 2.30pm		

	A	B	C	D	E	F	G	H	I	J	K
1	**HEALTH AND COMMUNITY SERVICES ADVISORY BOARD - ACTION TRACKER (OPEN)**										
2											
3	**Action Number**	**Meeting Date**	**Agenda Item**	**Agenda Description**	**Action**	**Accountable Executive**	**By When**	**Progress report**	**Escalated to / when?**	**Action Closed Date**	**Status**
4	159	28-Jan-25			Explore the possibility of an externally commissioned deep dive into ADHD - update	A. Weir	Mar-25	Verbal update to be provided at Board			**OPEN**
5	158	28-Jan-25	19	Questions from members of the public	The need for better prioritisation and more detailed information about these patients (general medicine cohort) was acknowledged, and further details will be provided in the next waiting list report.	C. Thompson	Mar-25	Verbal update as part of the Quality Performance Review agenda item at the HCJ Advisory Board 27 March 2025			**OPEN**
6	158	28-Jan-25	6	Chief Officer Report	Regular updates on the five priorities will feature on the board agenda in addition to regular finance, workforce, and clinical improvement items.	T. Walker	Mar-25	The first of the five priorities, improving patient flow, is scheduled for consideration at the March Board.			**OPEN**
7	157	28-Jan-25	6	Chief Officer Report	Additionally, a report on the digital agenda will be included.	M. Carpenter	Mar-25	Digital Health Report included			**OPEN**
8	156	28-Jan-25	6	Chief Officer Report	The board requested updates on the work being done on patient flow (and impact) and off-island service offers at the next meeting in March. CD suggested that the bed base could be included in the paper regarding patient flow planned for the meeting in March 2025 (following a question from a member of the public). Also inlcude reference to available performance indicaitors and whether these are sufficient to drive the system.	C. Thompson	Mar-25	A Patient Flow Report submitted to the HCJ Advisory Board agenda 27 March 2025			**OPEN**
9	155	28-Nov-24	21	Public Questions	CT agreed to review and provide feedback on the availability of waiting list information at the next board meeting (January 2024).	C. Thompson	March 2025 ~~01/01/2025~~	28 Jan 2025 - CT advised the Board that informatics will be able to support the required change (based on user feedback) during Q1 2025. Remain OPEN. Being progressed with informatics. Extended opportuity to meet but declined with feedback however that we are encorporating. Change should be evident in Q1 publication.			**OPEN**
10	153	28-Nov-24	18	Pharmacy Improvement Plan – Prioritised Actions and Culture	Measurable outcomes to be included in future pharmacy reports.	S. West	May-25	SMART Objectives shared by Kevin Smith			**OPEN**
11	151	28-Nov-24	11	Finance - Month 10	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.	Finance Lead - Change Team	by Mar 2025	Verbal update to be provided at Board			**OPEN**
12	149	28-Nov-24	9	Harm Review – Patient Tracking List Management Process	The board to receive a harm review paper in June 2025 including a broader interpretation of harm.	C. Thompson	Jun-25	To be scheduled onto the June 2025 HCJ Advisory Board agenda			**OPEN**
13	147	28-Nov-24	7	The New Healthcare Facilities (NHF) Programme	HCS to prepare a series of reports during 2025 describing the preparatory work that HCJ needs to undertake for 2028 i.e. clinical strategy, digital strategy and workforce strategy. Each report is to include how this will be achieved (with timescales).	T. Walker	by end 2025	As agreed with the Chair (Feb 2025), the Board will receive a series of reports, starting with a Digital Report in March 2025. The Workforce and Clinical Strategy will be received at subsequent meetings during 2025.			**OPEN**

Report to:	Health and Care Jersey Advisory Board		
Report title:	**Chief Officer's Report**		
Date of Meeting:	27 March 2025	**Agenda Item:**	6.

Executive Lead:	Tom Walker, Chief Officer - Health and Care Jersey
Report Author:	Tom Walker, Chief Officer - Health and Care Jersey

Purpose of Report:	Approval ☐	Assurance ☐	Information √	Discussion √
	This paper provides a summary of: • 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.			
Summary of Key Messages:	The key messages arising from this report are: See below.			
Recommendations:	**The Board is asked to note the report.**			

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	√
Effective		SR 2 – Patient Experience	√
Caring		SR 3 – Operational Performance (Access)	√
Responsive		SR 4 – People and Culture	√
Well Led	√	SR 5 – Finance	√

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
Nil		

List of Appendices:
Nil

MAIN REPORT

Strategic Overview

Work is continuing to move towards further integration of health and care in Jersey. This will now include bringing the ***States of Jersey Ambulance Service*** (SoJAS) back into the Department from July 2025, as suggested during the consultation held in October/November 2024 regarding a more integrated approach to health and care. The re-integration of SoJAS will be progressed in a phased and structured manner to ensure continuity of services and I will be overseeing this process. The Board may wish to receive a briefing later in the year.

The ***New Healthcare Facilities Programme*** (NHFP) remains a strategic priority, guiding the development of modern facilities that meet Jersey's current and future healthcare needs. The States Assembly approved NHFP Phase 1 funding of £710m as part of the 2025 Budget.

Following the submission of the Planning Application in September 2024, the Planning Committee approved proposals for the Acute Hospital at Overdale in February 2025. Planning Obligation Agreements will be drawn up and signed over the coming months to complete the planning process.

The procurement process to secure a Main Works Delivery Partner (MWDP) for the Acute Hospital building and ancillary infrastructure is ongoing and is anticipated to conclude with the appointment of a MWDP anticipated to be in Autumn 2025.

The NHFP team continues engagement with HCJ clinical and non-clinical services with departmental and room layouts being discussed and agreed by the end of Spring 2025. Further work will also take place to ensure alignment of whole system health and care, workforce, clinical and digital strategies (as noted elsewhere in the Board agenda) as well as to progress transition planning. This work will help inform the Full Business Case for the NHFP Phase 1 that will be developed over coming months.

In cognisance of the activities at the adjacent crematorium, services will be temporarily relocated to the RJA&HS Members' Room in Summer 2025, with construction of the Acute Hospital set to start towards the end of 2025.

With key milestones being achieved for the Overdale Acute site, NHFP resource will be directed towards the Kensington Place Ambulatory and St Saviour Healthcare Village sites. This will include reinvigorating consultation within HCJ on the Functional Briefs for these facilities as well as refining the Development Control Plans previously devised as part of the Feasibility Study.

The emphasis on ***improving our services and organisation*** continues, including prioritising executive focus and making information available about the work being undertaken. As noted in my last report, we have enhanced the executive focus on five priority areas within the Annual Plan for 2025, as well as continuing preparations for inspection by Jersey Care Commission. One of these five priority areas is the need to improve patient flow across health and care to reduce the risk of harm, make the patient experience better and ensure that patients are cared for in the most appropriate setting. This work is presented to the Board as a separate agenda item. Other areas for improvement from the five priorities will be brought forward for consideration by the Board during the year.

The Public Accounts Committee (PAC) published their ***review of handling and learning from customer feedback and complaints*** on 14 March (P.A.C.1/2025)[1], which included examining HCJ processes to follow-up on previous recommendations. The PAC highlighted that the processes within HCJ now align with the overall Government processes within the Customer Feedback Policy and are now included within the Quality Assurance Framework for reporting and evaluation. The PAC also noted that the Board having opportunities to listen to a customer/patient's story was a positive development, which is also to be welcomed.

In addition, the number of complaints received has continued to decrease in February 2025, compared to February 2024. Within the Patient Experience Team, there has been recent recruitment to enhance nursing presence within the team, which will help to promote early resolution to immediate care concerns.

Strategy and Policy Updates

Progress continues on developing **assisted dying** legislation. A first draft of the law will be shared with key stakeholders, including the Jersey Care Commission and UK regulatory bodies, over the coming weeks ahead of lodging the law in late summer for debate before the end of 2025. In the meantime, the HCJ working group established to advise on matters related to the development of clinical guidelines and training for healthcare professionals has undertaken a survey of Jersey health and care professionals with a view to establishing whether professionals may / will not particate in the Assisted Dying Service. There have been 378 responses to date. A feedback report summarising the findings, and the implications for standing up the Assisted Dying Service, will be published alongside the draft law.

The States Assembly have determined that a draft, amended **termination of pregnancy law** should be brought forward before end 2025. In accordance with that decision, a 4-week public consultation on proposed amendments was launched on 17 March. The proposed amendments provide that social terminations will be legal in Jersey up to a 21 week and 6-day gestation period, noting that known workforce constraints and safe service considerations mean that HCJ cannot provide terminations up to this limit. If the proposals are adopted, there will be a difference between what is permitted in law and the service provided locally to Islanders. HCJ will not fund off-island social terminations that cannot be provided in Jersey but will fund off-island medical terminations, as it currently does. Allowing for later stage terminations in law removes associated stigma, creates potential opportunities for non-HCJ provision, or for HCJ service development if deemed a priority / safe.

Further to an Assembly decision to invest additional monies in **IVF**, new access criteria for funded IVF came into force on 1 January 2025. The Minister has committed to reviewing those criteria at end of Q1 2025 to determine whether they had struck the necessary balance between enabling access and managing demand. The results of that review will be made available by 1 April 2025. The investment of additional monies has enabled HCJ to negotiate new rates with UK IVF providers allowing HCJ to provide more treatment to more people.

Lastly, it is worth noting that the implementation of the **Jersey Cancer Strategy** has achieved significant milestones in its first year, with key advancements in screening, patient-centred care, and digital transformation. The transition to opt-out breast cancer screening, and the establishment of a nurse-led survivorship clinic, have enhanced early detection and post-treatment support. Additionally, the Holistic Needs Assessment has been fully integrated, and the launch of the Somerset digital platform has strengthened service coordination. Moving forward, priorities include accelerating digital integration, securing long-term financial sustainability, and enhancing public engagement to ensure continued progress through multi-sectoral collaboration.

[1] https://statesassembly.je/news/public-accounts-committee-delivers-findings-on-government's-handling-of-complaints

Staff Recognition and Achievement

Two HCJ porters from Jersey General Hospital - Maggie Hennessy and Robin Boleat - were shortlisted for International Porter of the Year at the My Porter Awards. Robin Boleat won this year's International Porter of the Year Award. Fabulous national recognition for Maggie, Robin and this essential hospital service.

Pharmacy Technician Trainees - Oliwia Wrobel and Goncalo Ruivoabd Fin Spillane - passed their exams towards their Certificate of Higher Education in Pharmacy Practice. A great achievement in growing our own pharmacy talent.

Also, the Faculty of Health Education held 2 drop-in sessions at the Santander Work Café for Islanders to find out more about a career in Nursing, building on our success in developing local nursing talent.

Lina Urbanaviciute, from the General Hospital Outpatients department, was interviewed by Bailiwick Express about her positive artworks, which she creates for the department in her spare time. Really positive recognition of the creativity that Lina brings to the workplace, which is greatly appreciated by staff and patients alike.

In addition, colourful murals were unveiled in Robin Ward, and local media outlets were invited to capture the opening and speak to HCJ employees and the Jersey Children's Charity who helped fund the artworks.

Chief Officer Visits to Services

I continued to visit our services to hear from and get to know our teams across HCJ. Recent visits have included the following services and partner providers:

- Physiotherapy Department (JGH)
- Acorn Jersey Employment Trust (Trinity)
- Sterile Services (Five Oaks)
- Le Geyt Centre.

Patient and Service User Feedback

Feedback continues to be received through various channels, including the gov.je website, social media, the PALS/Feedback inbox, and directly by colleagues on wards and in the different HCJ departments. Feedback is shared with the relevant colleagues, their managers and wards/departments. Additionally, feedback themes are discussed at monthly care group governance reviews to identify and share recurring themes, and to recognise good practices.

In February 2025, we received a total of 130 ***compliments***. The main themes identified were:

- Care provided
- Positive staff attitude
- Overall gratitude of patient experience.

Below are some examples of the many compliments from February 2025, received across services, and which reflect so well the compassionate care colleagues provide every day:

Respiratory Consultants:
"Thank you to Dr Hayat & Dr Alapati. Their kindness, care, attention to detail, gentle reassurance and total thoroughness have helped me enormously. We are very blessed having them in our hospital. Thank them both so much for me.

PALS – Patient Experience team:
"You and the team provide an excellent service in the very, I imagine, challenging role you have!"

Travel Service:
"I want to commend the Jersey Hospital travel desk team for their invaluable support. Thank you to everyone at Jersey Hospital for making such a positive impact on my health and overall well-being."

Samares Ward at St Ewolds:
"Husband of patient thanked all the staff from the bottom of his hear for meticulous care of patient and compassion in meeting physical and spiritual needs."

Learning From Feedback:

21 new complaints were received in February 2025; this is a reduction when compared to February 2024, when 24 complaints were received. All complaints were categorised for efficient tracking, prompt resolution, and trend identification. Our systematic approach and streamlining of the complaints handling process, is also providing insights into recurring issues, enabling targeted improvements. As such, themes of Attitude & Behaviour and Care Delivery Delays were identified in February. Each care group is actively working on these areas to ensure measurable improvements.

In addition, from February 2025 our Patient Experience Team began conducting weekly 'Patient Experience' audits. This initiative has enabled the team to assist inpatient wards in gathering patient feedback and identifying common themes. A recurring theme has been identified related to the discharge processes. As a result, the Patient Experience Team are working collaboratively with the Quality & Safety Team to thematically review discharge processes and will jointly feedback to each care group with highlighted areas for improvement.

END OF REPORT

Health and Community Services

Meeting Report

Guidance on completing this report	• Complete all parts of the report template • Ensure finance, workforce & risk implications are described succinctly • Limit this cover report to no more than 2 pages • Attach any additional relevant information as appendices • All reports & any pre-reading to be provided 5 working days before the meeting. Any material submitted after this time will be deferred.

Report to	HCJ Advisory Board		
Date of meeting:	27th March 2025		
Title of paper:	Medicine Improvement Plan		
Report author (& title):	Senior Change Manager/ Medicine Care Group SLT approved	**Sponsor (incl. Title):**	Claire Thompson Chief Operating Officer – Acute Services

1. Purpose

What is the purpose of this report? What is being asked of the HCS Advisory Board?	To provide information and update on the Medicine Improvement Plan. The Care Group remains committed to ensuring the completion of the recommendations within the Medicine Improvement Plan. The outstanding recommendations have long-term activities and external dependencies prior to their completion which are detailed in the attached exemption report. It has been agreed to pause the fortnightly meetings and monthly reporting whilst recruitment takes place to enable these final recommendations, to be reconvened on 23 April 2025.	Information	x
		Decision	
		Assurance	x
		Update	x

2. Executive Summary

The Medicine Improvement Plan was established on 1st November 2023, with the aim to deliver a comprehensive improvement plan following external reviews from:

1. Royal College of Physicians Invited Service Review 18 – 20 June 2014
2. Royal College of Physicians (RCP) in 2022 Letter
3. Royal College of Physicians Invited Service Review 3 – 4 November 2022

4. Royal College of Physicians Invited Service Review 28 June 2023
5. Dr Rob Haigh Review 21 - 24 August 2023
6. Serious Incidents

The recommendations have been collated and consolidated, totalling 61 recommendations to become embedded as part of the business-as-usual processes of the organisation.

Since the last report, the following progress has been made:

- In conjunction with the Culture, Engagement and Wellbeing team, a communication and engagement plan for the Medical Services Care Group regarding the Medicine Improvement Plan and cultural improvement elements in the Care Group has been established, to ensure there is continuous engagement with staff and lead into a series of culture and engagement modules. Current progress of the Medicine Improvement Plan is shared through a monthly poster.
    - December – Sessions held with Clinical Fellows and Middle Grades to gather opinions and feedback.
    - January – 2024 BeHeard survey results received, with Medical Care Group scored the same or higher compared to HCJ. The Care Group have also commenced daily Consultants meetings and scheduled quarterly Medical Care Group Team Meetings and developing a quarterly Care Group Newsletter.
    - February - The Care Group held their Inset Day on 10 February where the 2024 BeHeard survey results were shared in greater detail.
- The previous escalated recommendations are confirmed as closed at the Medicine Improvement Plan Monitoring Meeting on 29/01/2025, these are:
    - Rec.ID#004 Medical Model – Following approval of the Medical Model and full establishment file and budget this recommendation has been closed with recruitment to align with business-as-usual activities for these substantive roles and noted temporary workforce to be in place whilst this is undertaken. The approval of this establishment file, recognises and mitigates the concerns identified in the RCP report, and addresses any clinical safety risk.
    - Rec.ID#046 Imaging - Following this recommendation, the schedule for radiology slots has improved and no longer a problem. Time critical pathways are in place with dedicated slots available. As part of the organisation's strategy regarding ongoing improvements to ambulatory, the organisation will also consider the diagnostics requirements to support this. As part of the 2025 5 Executive Priorities, is operational flow improvement from red to green, which will further identify whether patients can be managed differently or any internal capacity issues for inpatient scans.
- The Care Group have 43 closed recommendations, with recent closure topics including; roll out of the Electronic Patient Record (EPR), nutrition champions and training, ERCP policy, NEW2 escalation procedures, NIV training, AKI policy and ongoing fluid balance quality improvement project.
- The outstanding recommendations have long-term activities and external dependencies

prior to their completion. These recommendations and dependencies are detailed in the attached exemption report. Following this, and discussion held at the Medicine Improvement Plan Monitoring Meeting on 12/02/2025, it was agreed to pause the fortnightly meetings and reporting whilst recruitment takes place to enable these final recommendations, to be reconvened on 23 April 2025.

Future key actions include:

- Ongoing delivery of the communication and engagement plan of the Medicine Improvement Plan and culture elements across the service. To consider for inclusion Executive and Senior Leadership Ward Visits and Diagonal Slice Meetings. The Care Group will also be commencing quarterly Medical Care Group Team Meetings and ongoing development of their quarterly Care Group Newsletter.
- Same day acute care review. A proof of concept is to commence for 4 weeks, with an admission avoidance area to be located in AAU. The Standard Operating Procedure and criteria for admission into this area is currently in development. Further to this, there is ongoing development of a proposal with endoscopy and MDU. The service is to be launched as part of the Plan-Do-Study-Act (PDSA) cycle, to identify and implement continuous improvements to the service, with the aim to develop a robust and definitive service model.
- Following approval of the Medical Model and establishment file within the Medicine Care Group, the team are to commence recruitment to these posts, and noted that temporary workforce may be in place whilst this is undertaken. The approval of this establishment file, recognises and mitigates the concerns identified in the RCP report, and addresses any clinical safety risk.

Progress to date

Currently 43 out of 61 recommendations have been identified by Medicine Care Group as complete (up from 17 in October QSI Committee), of which all have been confirmed as having robust evidence/ business-as-usual process. High level progress to date can be found below:

	December Advisory Board	**January** Senior Leadership Team	**February** QSI Committee
Total Number of recommendations	**61**	**61**	**61**
Complete signed off	26	34	43
Complete	3	8	0
Green	3	0	0
Amber	27	19	18
Red	0	0	0
Escalate	2	0	0

The RCP 2022 Report identified 19 recommendations to be implemented, these are broken down below:

Number of recs	Status	Reason
6	Complete signed off	These recommendations have been actioned and approved as implemented by Medicine SLT.
7	Amber	These have long-term activities and external dependencies prior to their completion.
4	Excluded from MIP	These are being progressed by service areas outside of the Medicine Care Group.
2	Out of scope	Not considered within the scope of the Medicine Improvement Plan, such as housing and staff upskilling.
19	**Total**	

3. Finance / Workforce Implications

Recommendations that have identified finance implications, such as recruitment to the Medical Model, have been reviewed and approved, with an establishment file and associated funding allocated to the completion of these recommendations.

Recommendations that have identified workforce implications, such as recruitment to the Medical Model, will commence substantive recruitment, aligned with business-as-usual activities.

4. Risk and Issues

The competing goals of delivering operational performance and evidencing against recommendations place a great deal of pressure on clinical department lead staff and Medicine Care Group Senior Leadership Team. To mitigate this, extra capacity has been sourced within the Care Group including extending Medicine Improvement Plan meetings to Clinical Fellow, Ward Managers, and Clinical Directors. A monthly newsletter is circulated, which hopes to identify further resource within the Care Group to support the plan.

It has been agreed to pause the fortnightly meetings and monthly reporting whilst recruitment takes place to enable these final recommendations, which will alleviate the pressure on Medicine Care Group staff to attend additional meetings.

Recruitment to vacancies remains a priority. Actions to shorten the time to recruit to allow for sustained pace to quality improvements also sit within the Financial Recovery Plan (FRP) due to risk of agency premium. It is hoped that the ongoing HR re-design will provide the service with more HR capacity, to support timely recruitment processes and establishment of a recruitment package.

5. Recommendation

The Medicine Improvement Plan members are undertaking long-term activities which enable the completion of outstanding recommendations. It was agreed at the Medicine Improvement

Plan Monitoring Meeting to pause the fortnightly meetings and monthly reporting whilst recruitment takes place to enable these final recommendations, to be reconvened on 23 April 2025.

Appendix
20240227 – HCJ Advisory Board – Medicine Improvement Plan – Exception Report
202501 – Medicine Improvement Plan – Monthly Poster – Approved 20250129

END OF REPORT

Health and Care Jersey

Medicine Improvement Plan Exception Report

19 February 2025

Government of Jersey

Purpose

The purpose of this document is to identify recommendations that are not progressing as planned and require further oversight and potential supporting or mitigating actions.

Introduction

The Medicine Improvement Plan was established on 1st November 2023, with the aim to deliver a comprehensive improvement plan following external reviews from:

1. Royal College of Physicians Invited Service Review 18 – 20 June 2014
2. Royal College of Physicians (RCP) in 2022 Letter
3. Royal College of Physicians Invited Service Review 3 – 4 November 2022
4. Royal College of Physicians Invited Service Review 28 June 2023
5. Dr Rob Haigh Review 21 - 24 August 2023
6. Serious Incidents

The recommendations have been collated and consolidated, totalling 61 recommendations to become embedded as part of the business-as-usual processes of the organisation.

Governance Arrangements

- Medicine Care Group SLT and MIP Working Groups
    - Fortnightly review of excel medicine improvement plan
    - Purpose is to review progress of actions and their tasks, support requirements and identify risks and issues
- Medicine Improvement Plan Monitoring Meeting – led by the Chief Operating Officer – Acute Services
    - Fortnightly presentation progress report and theme summary
    - Purpose is to review reds, ambers, decisions required, escalation of non-delivery of items, risks and issues and receive assurance on the completion of recommendations.
- HCS SLT
    - Monthly cover page and exception report
    - Purpose is to receive assurance and review any further exceptions or escalations.
- HCS Quality, Safety & Improvement Committee
    - Bi-Monthly cover page and report
    - Purpose is to provide assurance of progress against the MIP and embedding and sustainability of outcomes.
- HCS Advisory Board
    - Bi-Monthly cover page and report
    - Purpose is to provide assurance of progress against the MIP and embedding and sustainability of outcomes.

Escalation Standards

There is a process of escalation standards within the care group. Changes are overseen at a senior leadership team meeting that has a structure of an agenda and action points. This is followed by a review and approval at the Medicine Improvement Plan Monitoring Meeting. The governance process within the care group ensures that indicators, once they are complete (blue), can provide ongoing confidence in sustainability and evidence and these become business as usual.

High level progress to date

Total Number of recommendations	**December** Advisory Board	**January** Senior Leadership Team	**February** QSI Committee
	61	**61**	**61**
Complete signed off	26	34	43
Complete	3	8	0
Green	3	0	0
Amber	27	19	18
Red	0	0	0
Escalate	2	0	0
Not started	26	34	0

Not Started – Work to deliver against recommendation has not started

Escalate – To be escalated to Medicine Improvement Plan Monitoring Meeting or Medicine Care Group Senior Leadership Team

Red - Work to deliver against recommendation is off track and requires resource to mitigate

Amber - Work to deliver against recommendation is off track but recoverable by operational lead

Green - Work to deliver against recommendation is on track no escalation required, evidence is available to support this status.

Complete - The recommendation is considered complete; evidence is being gathered for approval by Medicine Care Group Senior Leadership Team

Complete signed off - The recommendation is considered complete by Medicine Care Group Senior Leadership Team with robust evidence and sustainability of BAU processes

The outstanding recommendations have long-term activities and external dependencies prior to their completion.

Number of Recs	Dependent On	Expected progression date
7	Medical Model & Recruitment	June 2025. Requires successful recruitment to Medical Model.
3	SDAC	Unknown. Requires approval of SDAC location by SLT.
2	Job Plans	June 2025.
1	Digital Services	Unknown. Alerts for radiology reports (note: not on Digital Services prioritisation list).
1	Tertiary Centre	Unknown. Regarding quorate MDT meetings with mechanisms for seeking second opinions within Standard Operating Policies including formal links with other centre(s).
1	Culture	Unknown. Engagement and recognition within Med Care Group.
1	Neurology Review	Unknown. Royal College review commenced in Feb 25. To implement recommendations from report.
1	Degenerative neurological conditions pathway - MND	Unknown. Noted RCP Neurology review 2025 and ongoing development of MND pathway.
1	Clinical Vision of Flow	Unknown. Requires capacity within Quality Improvement Team.

Medicine Improvement Plan

Health and Care Jersey

The Medicine Improvement Programme (MIP) was established in November 2023. The purpose is to deliver coordinated and sustained improvements within Medicine to address the recommendations from reports which have been received by the organisation, to ensure that responses become part of the embedded business-as-usual governance process of the organisation. Find out more by searching "Medicine Improvement Plan (MIP)" on MyStates.

December 2024 & January 2025 progress

Estimate Date for Discharge
Please ensure boards are up to date as this aids with discharge planning as an organisation

2024 BeHeard Survey Results
Reviewed with the areas we will look to improve are; giving something back, wellbeing and personal growth

Communication & Engagement
Sessions held with Clinical Fellows and Middle Grades to gather opinions and voice in their work

Endoscopic Retrograde Cholangio Pancreatography (ERCP) Pathway
New pathways live on MyStates. 30 day review to commence in February

Recommendation Priorities
34 closed with ongoing review of Medical Model, Same Day Acute Care and Clinical Vision of Flow

February

Communication & Engagement

- 2024 BeHeard survey results to be shared with the Care Group at our Day on 10 February, overall, the Medical Care Group scored the same or higher compared to HCS and we will look to continuously improve
- Commencement of daily Consultants meetings
- Commencement of Quarterly Medical Care Group Team Meetings
- Quarterly Care Group Newsletter commencing

Recommendation Priorities

- To review recruitment to the Medical Model and proof of concept of admission avoidance areas

Your voice

To get involved, please speak to your line manager for further information. If you have concerns, or if there is an issue stopping you from delivering the best possible patient care, please contact Ashling McNevin, our Freedom to Speak up Guardian, to ensure your voice is heard. Email: speakup@health.gov.je

Health and Community Services

Health and Community Services (HCS) Advisory Board Report

Guidance on completing this report	• Complete all parts of the report template • Ensure finance, workforce & risk implications are described succinctly • Limit this cover report to no more than 2 pages • Attach any additional relevant information as appendices • All reports & any pre-reading to be provided 5 working days before the meeting. Any material submitted after this time will be deferred.

eport to: *(delete as appropriate)*	Health and Community Services (HCS) Advisory Board		
Date of meeting:	27th March 2025		
Title of paper:	Patient Flow (including bed base capacity)		
Report author (& title):	Claire Thompson Chief Operating Officer Acute Services	**Sponsor (incl. Title):**	Claire Thompson Chief Operating Officer Acute Services

1. Purpose

What is the purpose of this report? What is being asked of SLT? *(brief statement & tick as appropriate)* *Any pre-reading*	To provide an update to the Board on the work taking place to improve patient flow and the relationship with off island service provision.	Information	√
		Decision	
		Assurance	
		Update	√

2. Executive Summary The report seeks to provide information on the bed capacity available for general acute adult inpatients. The report takes the opportunity to describe recent ward refurbishment activity delivered to the acute site in recent years. This refurbishment has reduced risk associated with the estate and improved patient experience. This necessary work limits inpatient capacity during this time, due to the need to decant wards during refurbishment. Detail is also provided on work being undertaken during 2025 to improve patient flow to help make care safer and the patient experience better.

3. Finance / workforce implications Improving flow is key to reducing both clinical and financial risk. Maximising use of available inpatient capacity is key to improving access to good quality emergency care, reducing waiting lists for planned surgery and improving patient experience by limiting the need for non-clinical transfers within the acute hospital, to maintain safe capacity in the emergency department.

4. Risk and issues There is currently no dedicated project management capacity to support the clinical productivity workstreams, which will limit the pace of improvement and impact. This is being actively considered across the suite of current active projects to allow prioritisation as soon as possible. The development of policy and access to care provision outside of JGH has been reported to Board including the risks and limitations of capacity

currently. Ability to recruit into General Medical Consultant posts will be key to improving performance on many of the listed key performance indicators.

5. Applicability to ministerial plan This is central to delivery of Ministerial objectives that ensures appropriate access to emergency and elective services for islanders that provide high quality care and health outcomes for the population of Jersey.

6. Main Report

6.1 Bed Capacity - Jersey General Hospital Physical Estate

There are 228 beds across acute services. This figure does not include trolley spaces in the ED department (resus and majors), DSU Day Surgery Unit, Endoscopy, Medical Day Unit as these do not constitute an *inpatient* bed.

Specialist areas are listed below:

Maternity including Delivery Suite (6) & Maternity Ward (16) 22
Critical Care 7
(JNU) Jersey Neonatal Unit 8
Robin Paediatric Ward 10

There are 181 physical beds spaces available to use across 8 adult general inpatient wards in the JGH site. Patients are placed onto the medical and surgical wards listed below as emergency or elective admissions. Medical admitting specialities include acute, respiratory, cardiology, gastroenterology. The surgical floor admits patients under the care of our general surgeons and surgical specialties including urology, breast, bowel, maxillo-facial, ENT to name some, with gynaecology and female surgery also.

Medicine Care Group (available estate) & speciality allocation
Bartlett 18 Respiratory (full refurbishment 2024)
Rozel 13 General Medicine Gastroenterology
Corbiere 28 Stroke (refurbished in 2020)
Plemont 28 General Medicine (full refurbishment 2022)
Neutropenic Beds 2 (within Sorel footprint)
Acute Admission Unit AAU 25
Total medical estate available capacity 114

Medicine Care Group operating capacity in budget 98 as below
Bartlett 18
Rozel 13
Corbiere 28
Plemont 12
Neutropenic Beds 2 (within Sorel footprint)
AAU 25

Operating budget 2025.

In 2023 additional funding was introduced to substantiate the required nursing workforce to maintain inpatient beds that had been open. These were predominantly beds on Corbiere and AAU (10 & 7) and then new, additional beds opened on Plemont (12). This allowed permanent recruitment to stabilise ward care delivery, reduce agency and maintain and extend the acute inpatient capacity. Therefore, at this point, for medicine, the inpatient footprint increased to 98 from 86. £2.5m of investment was provided for nurse staffing for these 29 beds as part of SLT approved paper in 2023. Additional medical workforce was provided by the medical model funding.

This leaves 16 physical bed spaces for surge capacity. These are not permanently funded but can be supported by HCJ central funding for escalation as required.

An operational plan is under development to establish a same day acute care area (SDAC) within AAU (as would be best practice). To enact this model in the JGH estate, we would need to adapt a current inpatient 6 bedded bay to an ambulatory care area (trolleys/chairs). The loss of inpatient capacity on AAU could be mitigated by increasing Plemont's operating capacity to 18 (12 in budget, funding for further 6 transfers from AAU so cost neutral). Best practice standard and impact regarding SDAC/Ambulatory pathways is a reduction of a third from the emergency medical take. A further 10 physical beds for winter surge/escalation remains on Plemont but would require funding.

Surgical Care Group 67 (including 13 Sorel)

Beauport Elective Orthopaedic and Trauma 28 (full refurbishment in 2023)
Surgical Floor 26 inpatient beds and Surgical Same Day Acute Care
(Portlet, Pipon & Rayner) Rayner and Pipon areas refurbishment planned April-November 2025.

Sorel ward is 13 cubicle historic private inpatient ward (redecorated May 2024). Post covid this ward was ring fenced for elective care (private and public activity to underpin waiting list recovery). Prior to 2022 was used for non-surgical public emergency.

6.2 Operational Flow

Good operational flow is achieved through targeted interventions across 3 dimensions:

- Front door - management of activity in ED, interface with Ambulance services and other referrers e.g. Primary Care and admission avoidance including ambulatory and (SDAC) Same Day Acute Care
- Inpatient management – efficient, clinically effective and prompt assessment, planning and delivery of treatment and high standards of operational processes and bed management
- Discharge – robust, patient centered, high quality discharge processes, capacity in market and policy development

The clinical productivity workstream, acute & emergency care, is developing a detailed work plan that will monitor and review key activities to drive the delivery of improvement. Clinical

productivity reports to the financial recovery oversight group with oversight by the Finance, operations and finance assurance committee. The below section aligns the associated key performance indicators with each specific dimension.

6.3 Performance indicators

Many of the below feature as part of the HCS Advisory Board Quality Performance Report, others will be monitored through the clinical productivity agenda and contribute to "Big 5" objectives delivery (of which are in bold and further context provided below).

Front Door

- **% of Patients in Emergency Department for less or equal to 4 hours (95% by end of Q3)**
- **% of Patients in Emergency Department for more than 12 hours (to <1% by end of Q4)**
- % of Patients in Emergency Department for more than 12 hours from DTA (decision to admit)
- ED metrics (time to triage, time to treatment major and minor)
- ED attendances
- ED conversion rate
- **Reduce social admissions from Q3**

Inpatient management

- Inpatient movements between 22:00 & 08:00
- Non-Elective Acute length of stay (days)
- **Rate of emergency readmission within 30 days of a previous inpatient discharge**
- Patients with stay >7 days
- **Red to green days-introduce reporting Q2 & reduction of % of red days per month by Q4**

Discharge and onward care & support

- **DTOC (delayed transfers of care) > 7 days reduce 2024 average by 50%**
- MFFD (medical fit for discharges)
- Referral to assessment hospital discharge (social work)

Many of these indicators are consistent with current NHS Trust board performance indicators about emergency care and patient flow and provide monitoring of the metrics that describe whether an acute hospital is providing efficient, safe emergency assessment and treatment and the proportion of patients who can access inpatient care without undue delay or waiting in ED. From the reporting suite the board will be alerted to the flow of patients into the broader care sector in Jersey, the demand and how this is impacting acute services. The correlation between surge in emergency activity or if demand is exceeding capacity will also be observed by progress to reduce waiting for elective care. It is noted that additional Ambulance Trust outcome measures are integrated into acute care reporting in the UK due

to the intrinsic relationship. This could be a consideration for HCJ Advisory reporting as integrations evolves here in Jersey/GOJ. In addition, there are process measures that drive and support attainment in the above which feature on appropriate care group scorecards that are reviewing monthly at Care Group Performance Reviews (CGPR) by the Executive team. These include:

In addition, HCJ Executive Leadership team's Big 5 for 2025 include developing the recording of Red to Green days and reduction of % red days per month. Red to Green is an NHS Improvement initiative launched in hospitals to provide a visual management system to assist in the identification of wasted time in a patient's inpatient journey. This places the person receiving the acute care in the centre, whose experience should be one of involvement and control and considers time to diagnostics, speciality review and discharge planning and links to the *Safer Patient Flow bundle* The SAFER Patient Flow Bundle | Fab NHS Stuff (framework for best practice). Clinical Productivity monthly oversight requires project management and analytical capacity to be identified and sits within the governance system of financial recovery programme terms of reference. Clinical Productivity has 2 areas of focus, emergency and elective pathways.

Over 2024 HCS Advisory board noted a reduction in non-clinical transfers of inpatient movements. This was a priority due to the impact of patient care and experience. This meant that at times ED performance was negatively impacted to prevent or limit the need to move patients. However, our mean ED performance continues to benchmark well with the UK. Non elective acute length of stay (LOS) shows variance often linked to seasonal drivers of health, but individual ward LOS is reviewed and has been shown to improve post substantive Consultant recruitment. This supported the expansion of the medical model and would be a highly likely impact of successful recruitment. The percentage of discharges that occurs before midday will provide a significant opportunity for HCJ to reduce patients waiting more than 4 hours in ED, especially those awaiting admission to ward (12-hour KPI) and this will be addressed through adoption of the Safer Care bundle framework and red to green initiative.

6.4 Off island service offers

Any patient who requires off island care is referred at the point of need e.g. as part of their emergency admission pathway if tertiary treatment is required such as cardiology or neurology. Daily flight transfers and repatriations to Jersey are discussed at the 4 times a day capacity and flow (bed) meetings so that any clinical impact is monitored, mitigated or escalated. There is no evidence currently to suggest that delays or lack of capacity in the mainland is impacting JGH operational flow performance. Contracts for planned care and the decisions HCJ wants to take in the future about these could impact elective surgical bed requirement (increase/decrease) as considerations into repatriation of some procedures could demonstrate improvements to the provision of island healthcare and opportunities for Channel Islands alliance. Attendance at the off island tertiary governance meeting by acute care general managers, Chief of services and other clinicians ensures that key learning and links between off island contracting, and daily operational performance is made and maintained.

7. Recommendation The board is asked to receive update and note contents. Consider opportunity to receive updates and assurance in regard to progress via assurance committee reporting or individual board paper quarterly.

END OF REPORT

Health and Community Services

Report to:	Health and Community Services (HCS) Advisory Board		
Report title:	Finance Report M2 February 2025		
Date of Meeting:	26 March 2025	**Agenda Item:**	10.

Executive Lead:	Tom Walker, Chief Officer
Report Author:	Obi Hasan, Finance Lead Change Team, Interim Lead of Finance Business Partnering HCS

Purpose of Report:	Approval ☐	Assurance ☒	Information ☒	Discussion ☒
	• To provide an update on the Month 2 Financial position for 2025. • To discuss the financial position at M2, noting the risks and mitigations, forecast trends, and recommendations.			
Summary of Key Messages:	The key messages arising from this report are: • The 2025 M2 Financial position is a £3.29m deficit vs budget giving a headline run-rate of £1.65m (vs last year exit run-rate £2.3m). Adjusting for one-off items and non-recurrent costs the underlying run-rate is £0.97m (vs last year £2.6m). • FRP savings delivery for the year to M2 is £2.4m vs £3.2m plan, under-achieving by £0.9m. • In addition to the initially planned FY25 FRP efficiency savings of £13.2m (4%), further 'stretch' savings and funding/cost-recovery schemes of £14.7m (4.6%) or a total of £27.9m (8.6%) have been required to balance the budget. As a result, the increased FRP savings target is £17.3m, including additional efficiencies of £4.1m. A further £10.6m of savings are planned from budget reductions, further re-prioritisation of service provision, and structural funding changes with other funds. • To ensure maintaining quality of care remains paramount, qualifying schemes require Quality Impact Assessments (QIAs) to be undertaken and fully assess the implications on service provision. The majority of QIAs have been completed, with the remaining planned by the end of March. • Key risks are the 'no growth' assumption necessitated to balance the budget against the reality of rising costs of social care and mental health packages, development of policies to implement demand management of tertiary care contracts, and the lack of specialised ring-fenced funding for high cost drugs and treatments. • Other challenges include delays in reducing recruitment time-to-hire, the high cost of escalation beds due to lack of patient flow from shortage of care home beds and internal processes, resulting in medical patients occupying surgical beds that should be ring-fenced for private patients income generation.			

	• Work is progressing in developing strategic partnerships with UK providers that can help stabilise the clinical model, workforce capacity, and generate further income opportunities.
Recommendations:	The Advisory Board is asked to discuss the financial position at M2 noting the risks and mitigations and recommendations.

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 - Quality and Safety	
Effective		SR 2 - Patient Experience	
Caring		SR 3 - Operational Performance	
Responsive		SR 4 - People and Culture	
Well Led	Y	SR 5 - Finance	Y

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**

List of Appendices:
Appendices 1-6

MAIN REPORT

Financial Performance

FY25 Month 2 Finance Position

	Current Month		Year-to-Date			Full Year			Full Year	Full Year
HCS Categorisation	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Staff Costs	19,881	19,889	39,583	40,337	(754)	239,778	240,778	(1,000)	(1.9%)	(0.4%)
Non Pay	10,658	11,566	22,033	23,823	(1,790)	120,987	120,987	0	(8.1%)	0.0%
Income	(3,051)	(2,457)	(5,208)	(4,460)	(748)	(28,973)	(28,973)	0	(14.4%)	0.0%
Grand Total	27,488	28,998	56,408	59,700	(3,292)	331,792	332,792	(1,000)	(5.8%)	0.0%

- The 2025 M2 Financial position is a £3.29m deficit vs budget giving a headline run-rate of £1.65m.

Underlying position and Run-rate

- Adjusting for one-off items and non-recurrent costs the underlying run-rate is £0.97m. See Appendix 1 for monthly run-rate trend.

The key drivers are:

- **Staff Costs** – M2 is in line with budget showing a minor variance. YTD is a £0.8m overspend made up of an agency overspend of £0.4m (no. of agency staff as at end of Feb: 93 - 29 doctors, 39 Nurses, 25 AHPs and Other), an overtime overspend of £0.5m, offset by a substantive underspend of £0.1m (vacancies at end of Feb: 473 FTE).

  The main variances are:

  - Surgical Services £0.5m overspend mainly due to doctors backpay, ICU and Radiology activity.
  - Medical Services £0.5m overspend due to bed pressures requiring opening unfunded beds capacity in Bartlett ward costing £0.2m per month (YTD £0.4m), A&E Nursing agency (£0.1m), Pathology (£0.1m), A&E Medical (£0.1m).
  - Mental Health £0.1m overspend relates mainly to Dec-24 additional hours and extra duty payments in Jan-25 with Feb in line with budget. Agency costs are £23k higher due to activity pressures with wards running at 120% of capacity, and recruitment delays. There is a good pipeline of candidates in the on-boarding process, which is expected to reduce the agency costs going forward.

- **Non-Pay** – M2 is £0.9m and YTD £1.8m overspend, including a £0.2m under-delivery on additional 'stretch' savings/funding schemes planned for delivery in future months but phased monthly in the budget.

  The main variances are:

  - Tertiary Care £0.6m overspend relates to last year impact of accruals (£0.2m), activity growth, Oxford University Hospital price increase which is being challenged with a possibility of a refund, and a contractually allowed retrospective rate increase applied by Cambridge University Hospital. To control this rising trend, demand management schemes are in development, which will require policy changes with Ministerial approval before implementation.

- Patient Access £0.1m - Travel and Accommodation costs relate to tertiary care activity growth.
- Medical Director £0.5m relates to insurance settlements for which there is no budget allocation, higher than planned costs of completing medical appraisals, and operation Crocus costs, awaiting confirmation of budget funding.
- Medical Services £0.3m is due to high cost drugs expenditure with no allowance for a specialised ring-fenced funding to manage these variations.
- Surgical Services £0.3m relates to higher consumables spend in Theatres due to higher activity levels with 502 more public patients seen compared to same period last year.
- Social Care £0.3m relates to the cost of Care packages mainly due to last year's costs.
- Mental Health £0.1m relates to UK placements, mainly due to 2024 costs with Feb-25 costs in line with budget. £50k per month adverse variance relates to Les Amis supplementary payments, which has continued from previous years for which there is no budget this year. This is currently under review for resolution by M6.

- **Income** – M2 is £0.6m and YTD £0.7m under-achievement due to:
  - Surgical Services £0.8m shortfall in Main Theatres and DSU income targets partly due to lack of surgical beds for income generation activity occupied by medical outliers.
  - Long Term Care Benefit £0.2m shows over-achievement across Community Services, Mental Health and Social Care.

See Appendices 2 and 6 for Financial Position by Care Group, Detailed Variances by Expenditure Type, Pay, Non-Pay, and Income detail.

FRP savings delivery

- FRP savings delivery for the year to M2 is £2.4m vs £3.2m plan, under-achieving by £0.9m. The planned FRP savings for the year are £17.3m (including additional stretch savings) vs re-profiled savings plan of £8m as per Gov Plan 25.

Workstreams	FY24 Savings Delivered	FY25 Planned Savings	Jan	Feb	Mar-Dec	Total 2025 Savings	YTD Plan	YTD Actual Saving	YTD Plan vs Actual Saving
			Actual	Actual	Forecast				
Clinical Productivity	-	955	133	100	722	955	159	233	74
Workforce	3,469	8,327	572	596	6,581	7,750	1,746	1,169	-578
Non-Pay and Procurement	1,559	3,081	221	229	2,543	2,993	538	450	-88
Income	1,322	4,942	248	253	4,156	4,658	786	501	-284
Other Budget Pressures	2,603	-	0	0		-	-	-	
TOTAL FRP SCHEME SAVINGS	8,953	17,305	1,175	1,178	14,002	16,355	3,229	2,353	-876

Additional 'stretch' savings to balance the FY25 budget

- The FY25 Budget allocated to Care Groups/Directorates is £319m after holding back £3m central reserves from the total £322m FY25 Budget funding available. In addition to delivery of £13.2m (4%) of FRP savings (vs target £8m), to balance the budget required stretching the required savings by a further £14.7m targeting:
  - Further Efficiencies £4.1m and budget reductions £1.5m
  - Further re-prioritisation of service provision £2.7m
  - Structural Funding Changes with other funds £6.5m

  Therefore, the increased FRP savings target is £17.3m, including additional efficiencies of £4.1m, with a further £10.6m of savings planned from budget reductions, further re-prioritisation of service provision, and structural funding changes with other funds.
- As reported in the year-end M12 Finance Report, the underlying exit run-rate at the end of last year was a deficit of £2.6m per month, which has required such a high level of savings equating to 8.6%, to balance the FY25 budget.

Risks and Mitigations

- Delivery of additional 'stretch' savings target in-year. These are complex high risk schemes with dependencies such as policy changes requiring Ministerial approval to enable demand management actions to be implemented, and structural funding changes, which require collaboration and agreement across GoJ departments. Work continues to progress these led by the Executive Team.
- Social care and Mental health budgets have not been able to accommodate any growth to balance the budget. This is against the reality of rising costs due to high growth as evidenced in FY23 and FY24.
- Development of policies to implement demand management of tertiary care contracts. Development of demand management policies are being worked on at pace for approval.
- Lack of specialised ring-fenced funding for high cost drugs and treatments. Proposal for specialised ring-fenced funding for high cost drugs and treatments in development.
- Delays in reducing recruitment time-to-hire leading to slippage in FRP savings delivery. Proposal for HCJ to acquire its own recruitment resources was developed last year and is under discussion again to tackle this ongoing issue.
- Lack of patient flow from shortage of care home beds and inefficient internal processes leading to opening of high cost additional/escalation beds capacity (e.g. Bartlett ward).
- Beds pressures resulting in medical patients occupying surgical beds that should be ring-fenced, leading to loss of private patients income generation. Beds are planned to be ring-fenced by end of March.

FY25 Year-end Forecast

The FY25 forecast will be revised in Mar-25 (Q1) in light of the income and expenditure run-rate trend, and assessment of delivery risks, mitigations and opportunities.

Reserves Position

The earmarked reserves balance is £7.7m (after draw-down of £0.38m). This is made-up of Maintaining healthcare standards £4.8m, Parental leave funding £1m, Infrastructure investment £0.99m, Pay awards £0.9m, and Cobra surplus £0.39m.

Conclusion

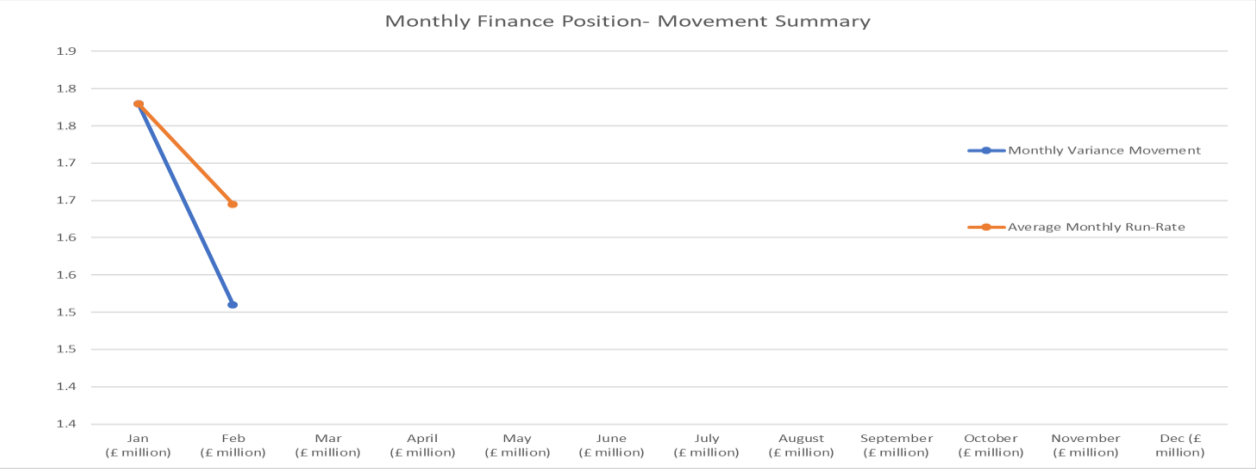
- FY25 M2 outturn is an overspend of £3.29m. Adjusting for one-off items and non-recurrent costs the underlying monthly run-rate is £0.97m.
- The FY25 year-end forecast will be revised in Mar-25 (Q1) in light of the income and expenditure run-rate trend, and assessment of delivery risks, mitigations and opportunities
- FRP savings delivery for the year to M2 is £2.4m vs £3.2m plan, under-achieving by £0.9m. The planned FRP savings for the year are £17.3m (including additional stretch savings)
- To balance the budget, additional 'stretch' savings are planned to deliver £10.6m of savings and funding/cost-recovery schemes.

Appendices

Appendix 1 - Monthly Run-rate trend

Monthly year-to-date run-rate

Monthly Finance Position	2025 Actual Jan (£ million)	Actual Feb (£ million)	Forecast Mar (£ million)	Forecast April (£ million)	Forecast May (£ million)	Forecast June (£ million)	Forecast July (£ million)	Forecast August (£ million)	Forecast September (£ million)	Forecast October (£ million)	Forecast November (£ million)	Forecast Dec (£ million)	Year-to-date (£ million)	Full Year 2025 (£ million)
Monthly Budget	28.92	27.49											56.41	
Monthly Actuals	30.70	29.00											59.70	
Monthly variance	(1.78)	(1.51)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(3.29)	
Operating Variance													0.00	
Pay	*(0.75)*	*(0.01)*											0.75	
Non-Pay	*(0.88)*	*(0.91)*											1.79	
Income	*(0.15)*	*(0.59)*											0.75	
Other														
FRP Delivery Variance													0.00	
Average Monthly Run-Rate	(1.78)	(1.65)	(1.10)	(0.82)	(0.66)	(0.55)	(0.47)	(0.41)	(0.37)	(0.33)	(0.30)	(0.13)	(0.30)	
Exceptional / One-Off Costs														
Medical Staffing Backpay	0.20												0.20	
Mental Health prior year impact	0.27	(0.12)											0.15	
Social Care prior year impact	0.17												0.17	
Medical Director- legal claim settlements	0.07	0.21											0.28	
Tertiary Care- prior year impact		0.20											0.20	
Medical Director- medical appraisal costs	0.08												0.08	
Medical Director- Operation Crocus unbudgeted	0.09	0.07											0.16	
Adjustments:														
Baby Steps income profiling (WACS)- budget reprofile required	(0.06)	0.06											(0.00)	
Baby Steps income profiling (I&I)- budget reprofile required	(0.15)	0.15											0.00	
Radiology income- understated for Jan	0.13												0.13	
													0.00	
Adjusted Variance	(0.99)	(0.94)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(1.93)	(1.00)
Year to Date Cumulative Variance	(0.99)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)	(1.93)		(0.08)
Underlying run-rate	(0.99)	(0.97)	(0.64)	(0.48)	(0.39)	(0.32)	(0.28)	(0.24)	(0.21)	(0.19)	(0.18)	(0.16)		



Appendix 2 - Financial Position By Care Group/Directorate

	Current Month		Year-to-date			Full Year			Year-to-date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	545	554	1,078	1,044	35	6,857	6,857	(0)	3.2%	(0.0%)
Chief Officer's Department	858	1,077	1,697	1,814	(117)	17,186	17,186	0	(6.9%)	0.0%
Community Services	1,300	1,088	2,728	2,505	222	15,569	15,569	(0)	8.1%	(0.0%)
Digital Health	103	87	379	345	34	1,440	1,440	0	9.1%	0.0%
Estates & Hard Facilitie	1,072	1,081	2,173	2,106	66	13,248	13,248	0	3.0%	0.0%
Improvement & Innovation	1,668	1,665	3,623	3,391	232	21,823	21,823	0	6.4%	0.0%
Medical Director	1,081	1,339	2,217	2,608	(391)	12,816	13,816	(1,000)	(17.6%)	(7.8%)
Medical Services	5,645	6,067	11,278	12,120	(842)	63,484	63,484	(0)	(7.5%)	(0.0%)
Mental Health	3,528	3,304	7,023	7,178	(154)	40,672	40,672	0	(2.2%)	0.0%
Non-Clinical Support Ser	1,558	1,422	3,210	3,075	135	18,128	18,128	0	4.2%	0.0%
Patient Access & Clinical Administration	721	897	1,687	1,935	(248)	9,222	9,222	0	(14.7%)	0.0%
Social Care	2,368	2,261	5,238	5,305	(67)	27,942	27,942	0	(1.3%)	0.0%
Surgical Services	3,690	4,436	7,361	9,061	(1,699)	45,837	45,837	0	(23.1%)	0.0%
Tertiary Care	1,445	1,943	2,891	3,484	(593)	14,511	14,511	0	(20.5%)	0.0%
Women Children & Family	1,904	1,776	3,824	3,729	95	23,058	23,058	0	2.5%	0.0%
Grand Total	**27,488**	**28,998**	**56,408**	**59,700**	**(3,292)**	**331,792**	**332,792**	**(1,000)**	**(5.8%)**	**(0.3%)**

Appendix 3 - Detail of Variances by Expenditure type – All Care Groups

		Current Month			Year-to-Date			Full Year			Year-to-Date	Full Year
HCS Categorisation	Subjective Category Detail	Sum of CM BUD	Sum of CM ACT	Sum of CM BUD vs ACT	Sum of YTD BUD	Sum of YTD ACT	Sum of YTD BUD vs ACT	Sum of FY BUD	Sum of FY FST	Sum of FY BUD vs FST	% Variance	% Variance
Staff Costs	Agency	818	875	(57)	1,668	2,082	(415)	4,411	4,511	(100)	(24.9%)	(2.3%)
Staff Costs	Overtime	115	332	(217)	230	706	(476)	1,390	1,390	0	(207.0%)	0.0%
Staff Costs	Substantive	19,031	18,759	272	37,852	37,827	25	239,097	239,997	(900)	0.1%	(0.4%)
Staff Costs	Unbudgeted	(83)	(77)	(6)	(167)	(278)	112	(5,120)	(5,120)	0	67.0%	0.0%
Staff Costs Total		**19,881**	**19,889**	**(8)**	**39,583**	**40,337**	**(754)**	**239,778**	**240,778**	**(1,000)**	**(1.9%)**	**(0.4%)**
Non Pay	Administrative Expenses	45	14	31	90	14	75	538	538	0	84.1%	0.0%
Non Pay	Clinical supplies	217	247	(29)	435	424	11	2,610	2,610	0	2.6%	0.0%
Non Pay	Drugs & Vaccinations	1,539	1,587	(48)	3,078	3,414	(336)	18,466	18,466	0	(10.9%)	0.0%
Non Pay	Financial Adjustments & Write-	11	(4)	16	22	9	13	134	134	0	59.0%	0.0%
Non Pay	Other Fees	0	0	(0)	0	1	(1)	0	0	0	0.0%	0.0%
Non Pay	Premises & Maintenance	568	578	(10)	1,119	1,183	(64)	6,618	6,618	0	(5.7%)	0.0%
Non Pay	Social Benefit Payment	3	0	3	7	0	6	40	40	0	97.0%	0.0%
Non Pay	Supplies and Services	8,483	9,144	(660)	17,699	18,778	(1,079)	97,561	97,561	0	(6.1%)	0.0%
Non Pay	Unbudgeted	(208)	0	(208)	(417)	0	(417)	(4,980)	(4,980)	(0)	(100.0%)	(0.0%)
Non Pay Total		**10,658**	**11,566**	**(907)**	**22,033**	**23,823**	**(1,790)**	**120,987**	**120,987**	**0**	**(8.1%)**	**0.0%**
Income	Course Fees	(6)	(8)	2	(13)	(30)	17	(76)	(76)	0	134.1%	0.0%
Income	Fees and fines	(4)	(3)	(1)	(7)	(9)	2	(42)	(42)	0	23.4%	0.0%
Income	Other Fees	(17)	(7)	(11)	(35)	(17)	(17)	(207)	(207)	0	(50.3%)	0.0%
Income	Other Income	(359)	(187)	(172)	(528)	(647)	119	8,096	8,096	0	22.5%	0.0%
Income	Patient Charges	(26)	(1)	(25)	(59)	(33)	(26)	(403)	(403)	0	(44.3%)	0.0%
Income	Sale of Goods	(17)	(14)	(2)	(33)	(26)	(8)	(200)	(200)	0	(23.1%)	0.0%
Income	Sale of Services	(2,622)	(2,237)	(385)	(4,533)	(3,699)	(834)	(36,141)	(36,141)	(0)	(18.4%)	(0.0%)
Income	Stamp Duty	0	0	0	0	0	0	0	0	0	0.0%	0.0%
Income Total		**(3,051)**	**(2,457)**	**(594)**	**(5,208)**	**(4,460)**	**(748)**	**(28,973)**	**(28,973)**	**0**	**(14.4%)**	**0.0%**
Grand Total		**27,488**	**28,998**	**(1,510)**	**56,408**	**59,700**	**(3,292)**	**331,792**	**332,792**	**(1,000)**	**(5.8%)**	**(0.3%)**

Appendix 4 - Pay Position

	Current Month		Year-to-date			Full Year			Year-to-date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Substantive	19,031	18,759	37,852	37,827	25	239,097	239,997	(900)	0.1%	(0.4%)
Agency	818	875	1,668	2,082	(415)	4,411	4,511	(100)	(24.9%)	(2.3%)
Overtime	115	332	230	706	(476)	1,390	1,390	0	(207.0%)	0.0%
Budget Pressure	(83)	(77)	(167)	(278)	112	(5,120)	(5,120)	0	67.0%	0.0%
Grand Total	**19,881**	**19,889**	**39,583**	**40,337**	**(754)**	**239,778**	**240,778**	**(1,000)**	**(1.9%)**	**(0.4%)**

	Current Month		Full Year			Full Year			Full Year	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	468	484	924	940	(16)	5,932	5,932	(0)	(1.7%)	(0.0%)
Chief Officer's Department	494	524	983	935	48	5,649	5,649	0	4.9%	0.0%
Community Services	1,335	1,223	2,620	2,528	92	16,002	16,002	(0)	3.5%	(0.0%)
Digital Health	100	87	201	172	28	1,091	1,091	0	14.1%	0.0%
Estates & Hard Facilitie	427	408	854	844	10	5,161	5,161	0	1.2%	0.0%
Improvement & Innovation	174	94	348	260	88	1,999	1,999	0	25.3%	0.0%
Medical Director	1,098	1,086	2,196	2,133	63	13,213	14,213	(1,000)	2.9%	(7.6%)
Medical Services	4,345	4,582	8,678	9,196	(518)	52,172	52,172	(0)	(6.0%)	(0.0%)
Mental Health	2,525	2,539	4,984	5,086	(102)	30,331	30,331	0	(2.1%)	0.0%
Non-Clinical Support Ser	1,335	1,265	2,667	2,638	29	15,934	15,934	0	1.1%	0.0%
Patient Access & Clinical Administration	523	591	1,046	1,173	(128)	6,352	6,352	0	(12.2%)	0.0%
Social Care	1,113	1,030	2,225	2,094	132	12,877	12,877	0	5.9%	0.0%
Surgical Services	4,205	4,322	8,390	8,867	(477)	52,008	52,008	0	(5.7%)	0.0%
Women Children & Family	1,740	1,654	3,466	3,469	(3)	21,058	21,058	0	(0.1%)	0.0%
Grand Total	**19,881**	**19,889**	**39,583**	**40,337**	**(754)**	**239,778**	**240,778**	**(1,000)**	**(1.9%)**	**(0.4%)**

Year-to-date M2 overspend 0.8m (1.9%), made up of:

- **Substantive pay underspend of £0.1m (substantive offset by budget pressure)** including an overspend in Surgical Services of £0.3m which includes backpay to Anaesthetists and a doctor in ENT, and overspends of £0.1m in both Medical Services and Patient Access & Clinical Administration, offset by £0.7m underspend from vacancies across all other areas (total vacancies at end of Feb: 473).
- **Overtime overspend of £0.5m**, with major overspends in Medical Services £0.2m, which mainly relates to ward areas and A&E, and Surgical Services £0.1m, which mainly relates to Theatres and Intensive Care.
- **Agency staffing overspend £0.4m**, with c 93 agency staff in post at end of February, mainly seen in Medical Services £0.2m and WACS £0.1m.

Appendix 5 – Non- Pay Position

	Current Month		Year-to-date			Full Year			Year-to-date	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Supplies and Services	8,483	9,144	17,699	18,778	(1,079)	97,561	97,561	0	(6.1%)	0.0%
Drugs & Vaccinations	1,539	1,587	3,078	3,414	(336)	18,466	18,466	0	(10.9%)	0.0%
Premises & Maintenance	568	578	1,119	1,183	(64)	6,618	6,618	0	(5.7%)	0.0%
Clinical supplies	217	247	435	424	11	2,610	2,610	0	2.6%	0.0%
Administrative Expenses	45	14	90	14	75	538	538	0	84.1%	0.0%
Financial Adjustments & Write-	11	(4)	22	9	13	134	134	0	59.0%	0.0%
Social Benefit Payment	3	0	7	0	6	40	40	0	97.0%	0.0%
Budget Pressure	(208)	0	(417)	0	(417)	(4,980)	(4,980)	(0)	(100.0%)	(0.0%)
Grand Total	**10,658**	**11,566**	**22,033**	**23,823**	**(1,790)**	**120,987**	**120,987**	**0**	**(8.1%)**	**0.0%**

	Current Month		Year-to-date			Full Year			Year-to-date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	91	74	183	124	58	1,096	1,096	0	31.9%	0.0%
Chief Officer's Department	372	553	728	879	(151)	1,346	1,346	(0)	(20.7%)	(0.0%)
Community Services	142	106	284	221	63	1,685	1,685	0	22.2%	0.0%
Digital Health	2	0	179	172	6	349	349	0	3.4%	0.0%
Estates & Hard Facilitie	644	673	1,318	1,262	56	8,087	8,087	0	4.3%	0.0%
Improvement & Innovation	1,642	1,571	3,437	3,293	144	19,986	19,986	0	4.2%	0.0%
Medical Director	210	476	476	949	(473)	2,328	2,328	0	(99.5%)	0.0%
Medical Services	1,809	1,916	3,619	3,885	(266)	21,712	21,712	0	(7.3%)	0.0%
Mental Health	1,042	844	2,085	2,180	(95)	10,858	10,858	0	(4.6%)	0.0%
Non-Clinical Support Ser	352	340	817	764	53	4,153	4,153	0	6.4%	0.0%
Patient Access & Clinical Administration	202	318	650	781	(132)	2,918	2,918	0	(20.3%)	0.0%
Social Care	1,758	1,795	3,516	3,777	(260)	21,097	21,097	0	(7.4%)	0.0%
Surgical Services	689	830	1,378	1,669	(291)	8,269	8,269	0	(21.1%)	0.0%
Tertiary Care	1,460	1,935	2,920	3,505	(585)	14,689	14,689	0	(20.0%)	0.0%
Women Children & Family	240	135	443	360	84	2,415	2,415	0	18.8%	0.0%
Grand Total	**10,658**	**11,566**	**22,033**	**23,823**	**(1,790)**	**120,987**	**120,987**	**0**	**(8.1%)**	**0.0%**

Year-to-date M2 overspend £1.8m (8.1%), made up of:

- Tertiary Care overspend £0.6m in relation to acute referrals to the UK, mainly due to impact of retrospective charges increase for Cambridge contract from April 2024, and additional costs for the Oxford contract.
- Medical Director overspend £0.5m, which includes an insurance claims settlements £0.3m, and an overspend against budget for medical appraisals, as well as costs in Pharmacy in relation to BlueTeq implementation.
- Surgical Services overspend £0.3m in relation to consumables mainly for Theatres £0.2m
- Medical Services overspend £0.3m in relation to drugs (£0.3m) across Respiratory, General Medicine, Clinical Haematology, and Oncology.
- Social Care overspend £0.3m mainly in relation to domiciliary care packages, of which the majority of the variance is attributable to 2024 expenditure, and well as Learning Disabilities commissioned activity and respite services.
- Patient Access overspend £0.1m mainly in relation to the Patient Travel Service.
- Mental Health overspend £0.1m in relation to off-Island placements and on-Island support packages, of which the majority of the variance is attributable to 2024 expenditure.

Appendix 6 – Income Position

	Current Month		Full Year			Full Year			Full Year	Full Year
Subjective Category Detail	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Sale of Services	(2,622)	(2,237)	(4,533)	(3,699)	(834)	(36,141)	(36,141)	(0)	(18.4%)	(0.0%)
Patient Charges	(26)	(1)	(59)	(33)	(26)	(403)	(403)	0	(44.3%)	0.0%
Other Fees	(17)	(7)	(35)	(17)	(17)	(207)	(207)	0	(50.3%)	0.0%
Sale of Goods	(17)	(14)	(33)	(26)	(8)	(200)	(200)	0	(23.1%)	0.0%
Course Fees	(6)	(8)	(13)	(30)	17	(76)	(76)	0	134.1%	0.0%
Fees and fines	(4)	(3)	(7)	(9)	2	(42)	(42)	0	23.4%	0.0%
Other Income	(359)	(187)	(528)	(647)	119	8,096	8,096	0	22.5%	0.0%
Grand Total	**(3,051)**	**(2,457)**	**(5,208)**	**(4,460)**	**(748)**	**(28,973)**	**(28,973)**	**0**	**(14.4%)**	**0.0%**

	Current Month		Year-to-date			Full Year			Year-to-date	Full Year
Care Groups & Directorates	Budget (£'000)	Actual (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)	% Variance	% Variance
Chief Nurse	(14)	(4)	(29)	(21)	(8)	(171)	(171)	0	(26.3%)	0.0%
Chief Officer's Department	(7)	(0)	(15)	(1)	(14)	10,191	10,191	0	(96.3%)	0.0%
Community Services	(176)	(240)	(177)	(244)	67	(2,118)	(2,118)	0	37.7%	0.0%
Improvement & Innovation	(149)	0	(162)	(162)	0	(162)	(162)	0		
Medical Director	(227)	(223)	(454)	(474)	20	(2,724)	(2,724)	0	4.4%	0.0%
Medical Services	(509)	(431)	(1,018)	(960)	(58)	(10,400)	(10,400)	(0)	(5.7%)	(0.0%)
Mental Health	(39)	(79)	(45)	(89)	43	(518)	(518)	0	95.4%	0.0%
Non-Clinical Support Ser	(129)	(183)	(274)	(327)	53	(1,959)	(1,959)	0	19.5%	0.0%
Patient Access & Clinical Administration	(4)	(12)	(8)	(19)	11	(48)	(48)	0	142.4%	0.0%
Social Care	(503)	(564)	(504)	(565)	62	(6,032)	(6,032)	0	12.2%	0.0%
Surgical Services	(1,203)	(715)	(2,407)	(1,476)	(931)	(14,439)	(14,439)	0	(38.7%)	0.0%
Tertiary Care	(15)	8	(30)	(22)	(8)	(177)	(177)	0	(27.2%)	0.0%
Women Children & Family	(75)	(14)	(85)	(100)	14	(414)	(414)	0	16.7%	0.0%
Grand Total	**(3,051)**	**(2,457)**	**(5,208)**	**(4,460)**	**(748)**	**(28,973)**	**(28,973)**	**0**	**(14.4%)**	**0.0%**

Year-to-date M2 £0.7m under-achieved (14.4%), made up of:

- Under-achievement in Surgical Services £0.9m due to increased private patient income deliverable not yet realised £0.8m. Budget evenly profiled inclusive of FRP delivery (Main Theatres, DSU and Private Patient Accommodation). £0.2m underachievement in Radiology.
- Medical Services income is showing an under-recovery of £0.1m, which includes an under-recovery of Oncology private income against the targeted level £0.2m, offset by over-recovery in Pathology and Gastroenterology.
- There are over-achievements across Community Services, Mental Health and Social Care of £0.2m in relation to Long Term Care Benefit.
- Non-Clinical Support Services is over-achieved by £0.1m in relation to Catering Services.

Health and Care Jersey

Report to:	Health and Community Services Advisory Board		
Report title:	**M2 Workforce data report**		
Date of Meeting:	**27th March 2025 (Data extract at 4/3/25)**	**Agenda Item:**	12.

Executive Lead:	**Ian Tegerdine Director of Workforce**
Report Author:	**Ian Tegerdine Director of Workforce**

Purpose of Report:	Approval ☐	Assurance √	Information ☐	Discussion ☐
	This paper provides the Board with regular information on the status of the workforce			
Summary of Key Messages:	The key messages arising from this report are: We continue to work with GoJ people services and with HCS informatics on improving these reports. We will introduce a new workforce finance report at the next People & Culture committee and this will then come to Board. People services analytics are managing a high workload at present and are working positively with us to improve overall workforce data reporting in the workforce data workstream and making changes to data structures across multiple systems to improve the structure of data reporting for us for the future. Putting aside our normal data challenges, which we are addressing in our workforce data workstream, then the following conclusions may be drawn (with the normal data warnings about how we have to compile reports from multiple sources): • Turnover remains broadly stable • Sickness levels continue to be higher than the same period last year, but stable compared with the previous month. Please see separate paper on sickness absence management. • Recruitment performance remains patchy month on month with the number of vacancies in recruitment is up to 186 (from 155 last month) and the number of new starters in Feb is half that of Jan. Work continues on the development of our dedicated HCJ recruitment team within people services at Union St. We propose to bring a paper on recruitment changes to the next People & Culture committee. • Connected Performance, the organisation has set an ambitious stretch target of 80% of staff having objectives set by the end of			

	Feb (one month later than the GoJ target to take account of winter pressures) but at the 4th of March this was at 49.3%. The ELT have been alerted and are undertaking actions to drive performance. For context the level of objectives set at the end of Jan for HCJ in the past three years has been 0.1% (2023), 10.3% (2024) and it was at 31.8% at the end of Jan 2025 • The Board will note that the report does not give the assurance on staffing that is needed and further work is needed in order to provide the Board and its committees (and the departments and teams in HCS) with the data required to effectively manage its workforce.
Recommendations:	The Board is asked to note the report and note the actions in train to develop a fit for purpose report.

Link to JCC Domain:		**Link to BAF:**	
Safe	**X**	SR 1 – Quality and Safety	**X**
Effective	**X**	SR 2 – Patient Experience	**X**
Caring		SR 3 – Operational Performance (Access)	**X**
Responsive	**X**	SR 4 – People and Culture	**X**
Well Led	**X**	SR 5 – Finance	**X**

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**
People & Culture Committee		

List of Appendices: