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

Health and Care Jersey

Date: 27 March 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**
David Keen	Non-Executive Director	**DK**
Executive Board Members (Voting):		
Tom Walker	Chief Officer HCJ	**TW**
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 (Item 10 onwards)	**ITe**
In Attendance:		
Cathy Stone	Nursing / Midwifery Lead – HCJ Change Team	**CS**
Mark Pugh	Medical Lead – HCJ Change Team	**MP**
Martin Carpenter	Chief Information Officer – HCJ	**MC**
Rachel Williams	Director of Strategic Planning and Projects	**RW**
Daisy Larbalestier	Business Support Officer	**DL**
Danielle Colback	Executive Assistant to Chief Officer HCJ	**DC**
Pamela Le Sueur	Associate Director of Quality and Safety (Item 9 only)	**PLS**
Professor Peter Bradley	Director of Public Health (Item 13 only)	**PB**
Margi Clarke	Head of Public Health Intelligence (Item 13 only)	**MCl**

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

CD welcomed all to the meeting. CD acknowledged the impact of EOC's absence on the preparation of board papers, which are lighter than usual. In addition both TW and RW have had periods of absence, contributing to the challenges faced. Given these circumstances, CD anticipates that the meeting may be shorter than planned.

Apologies received from:

Emma O'Connor Price	Board Secretary	**EOC**
Mr Simon West	Medical Director	**SW**
Julie Garbutt	Non-Executive Director	**JG**

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

No declarations.

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

The minutes of the previous meeting held on 30 January 2025 were agreed as accurate.

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

ACTION 159: AW provided an update on the exploration of an externally commissioned deep dive into ADHD services. The update reveals that monthly meetings with clinicians / clinical lead have been ongoing to address issues such as prioritising the waiting list and increasing capacity.

However, it was concluded that an external review is premature and should be reconsidered by the Board in three months.

CG expresses concern about the delay, emphasising the urgency due to the long waiting list and the broader issue of drug prescribing, including cannabis and ketamine. CG argues that immediate action is needed, whether through an external review or internal workshops, to address the seven-year waiting list and the high percentage of the population on these medications.

AW suggested the need to clearly define the scope of the review, distinguishing between a review of ADHD service delivery and prescribing practices (of cannabis and ketamine). Concerns are raised about the potential diversion of limited clinical time for a review that might only reiterate known issues.

AW to provide a detailed explanation at the next meeting to clarify the objectives and necessary actions.

ACTION 158: The discussion addresses concerns about long wait times for patients on the waiting list in the general medical cohort. This relates to 30 patients who are on a bariatric pathway requiring assessment for potential surgery. When this service was commissioned three to four years ago, capacity was allocated for the surgical aspect but not for medical outpatient services or allied health professional support. Consequently, these patients have been seeing diabetic doctors who have been busy with general medical activities, especially during this time of year. However, it is reported that 14 out of the 30 patients have appointments scheduled for the upcoming week, and it is not expected to be an ongoing issue.

5	**Chair's Introductions**	**Action**
See welcome (item 1).		

6	**Chief Officer Report**	**Action**

The Board received the Chief Officer Report providing a summary of strategic activities related to HCJ, recognitions for HCJ staff, feedback regarding services and other key issues.

Key highlights and discussion points:

Reintegration of the States of Jersey Ambulance Service

- Plans are underway to reintegrate the Ambulance Service into Health and Care Jersey, supporting a more unified healthcare system.
- The transfer is targeted for the second half of the year, subject to required approvals.

ACTION: Briefing on the reintegration of the States of Jersey Ambulance Service to be presented at the May meeting. Additionally, the Head of the Ambulance Service will be invited to attend for further discussion.

New Healthcare Facilities Program

- Funding for Phase 1 of the new healthcare facilities program has been approved in the 2025 budget.
- Planning approval for the acute hospital site was granted in February 2025, with strong departmental representation.
- The next key step is appointing a main works delivery partner for construction.

Jersey Cancer Strategy

- The strategy has had a positive start in 2025, but successful implementation relies on strong collaboration between secondary and primary care.
- Further board discussions are planned to explore how to strengthen this collaboration and support continued progress.

Staff Recognition and Achievements

- TW highlighted the achievement of Robin Boleat from the portering services, who was awarded International Porter of the Year, a well-deserved recognition for an often-undervalued service.

Areas for Improvement in 2025 (Executive Director five priorities)

- **Living Within Our Means:**
  Overspending has reduced since last year but remains slightly above target. The executive team is focused on returning to budget.
- **Patient Flow:**
  Discussed in detail under agenda item 8.
- **UK Tertiary Partnerships:**
  Progressing well, with a further update due in May.
- **Professional Standards:**
  Inconsistencies in care have led to serious impacts; work is underway to improve reliability across teams.
- **Staff Engagement:**
  Improvements noted, but ongoing efforts are needed to strengthen communication and the working environment.
- **Violence and Aggression Towards Staff:**
  Incidents—often medically driven—have occurred. Leadership, with Board support, is actively addressing the issue.

Discussion on Out of Hospital and Community Facilities
CD sought clarification on how the community facilities at Overdale and St Saviour's would complement hospital services and when the Board would be updated on the plans for these facilities. TW responded that the project team will turn their focus to the Kensington Place Ambulatory Site and the St Saviour's site.

ACTION: Update on the new healthcare facilities program, including Overdale and St Saviour's, to be provided by mid-year, with a detailed update in September.

Patient Experience and Feedback
TH highlighted the importance of reviewing the Patient Experience Team's work and the weekly patient feedback initiative. The Board considered that further attention should be given to improving the process and ensuring that feedback is fully utilised to enhance services.

ACTION: Review of the Patient Experience Team's initiative and feedback process to be taken up by the relevant committee.

Termination of Pregnancy and Legal Terminology
CG raised concerns about the use of the term "social abortion," requesting that the term be clarified and removed. In addition, CG also sought clarity on whether medical terminations are done on the island and whether terminations after 22 weeks are performed on the island or require travel off island.

Deputy Andy Howell (Assistant Health Minister) clarified that early medical terminations are being carried out on the island, including both medical (pill or pessary) and surgical terminations. CG further suggested that the terminology around "social " should be revised to better reflect the sensitivity of the subject.

Assisted Dying
CG suggested the need for a more thorough public engagement process on assisted dying, particularly given the implications it might have on organ donation, citing trends observed in other jurisdictions. The Board discussed the potential need for further engagement and education on this topic.

TW responded that the draft law on assisted dying is under development. The next stage will be lodging the draft law for the assembly to consider, likely in late summer 2025.

ACTION: Further discussions and updates on the draft law for assisted dying to be provided in late summer with a detailed board discussion in September.

7	**Acute Medicine improvement Plan**	**Action**
The Board received a report providing information and an update on the progress of the Medicine Improvement Plan (MIP).		

Key highlights:

Introduction to the MIP

- CT presented the Medicine Improvement Plan, stemming from a 2022 Royal College of Physicians review and internal learning from serious incidents.

Progress:

- Some recommendations have been closed, but consistent implementation is being monitored. Recruitment remains a key issue, with 11 medical ward posts unfilled (5 from last year).

Recruitment Focus:

- Efforts are ongoing via consultant networks and People and Corporate Services (PCS) support. Interest has increased, but securing appointments remains challenging.

Ambulatory and Same-Day Acute Care:

- Future focus is on enhancing these services. Previous attempts were hindered by inpatient pressures, but ongoing collaboration aims to drive improvement and address remaining recommendations.

Long-Term Work:

- A few recommendations, particularly around embedding new care models, will require sustained effort.

Discussion points:

CD raised a concern about ensuring that the processes and actions implemented are resulting in measurable improvements in health outcomes for the island's population and asked how the Board could assess whether these changes were effectively improving patient care.

CT responded, acknowledging the importance of health outcomes and noted that impact data is already being monitored through specific outcome measures. This includes pathways for long-term conditions, such as respiratory diseases, and other clinical effectiveness data, like the DVT (Deep Vein Thrombosis) pathway. CT suggested that as the services improve, clinical effectiveness data will become more robust, and this can be incorporated into future reporting.

CS suggested that the Board could track the 43 closed recommendations to ensure that improvements are being maintained. This would help demonstrate whether the team is consistently applying the right approach to close the recommendations and track the outcomes. CD agreed and found this to be a helpful suggestion.

CT sought clarification about whether the updates on the improvement plan should continue to be reported to the Board or directed to the Quality, Safety, and Improvement Committee. The Board members agreed that the MIP should now report to the Quality, Safety, and Improvement Committee, but it should remain a topic of discussion at the board level if any significant concerns arise.

TW suggested that tracking the health outcomes and improvement progress could be integrated into the transition to statutory oversight by the Jersey Care Commission. This would ensure that improvements and continuous learning systems are part of the statutory supervision framework.

ACTION: CT to work on providing clinical effectiveness data and integrate it into future reporting. CT to track the 43 closed recommendations and present progress to the Board in six months to ensure consistency and improvement.

ACTION: Medicine Improvement Plan updates to be redirected to the Quality, Safety, and Improvement Committee moving forward.

8	**Patient Flow**	**Action**

The Board received a paper providing an update on the work taking place to improve patient flow and the relationship with off island service provision. Addressing patient flow is one of the five key executive priorities.

Key highlights and discussion points:

Introduction and Overview:

- CT highlighted that the report focuses on acute bed capacity, particularly in medicine and surgery. This is because the availability of these inpatient beds has the greatest impact on performance.
- Acknowledged the ongoing ward refurbishments, which necessitate temporarily closing beds, limiting overall inpatient capacity even when staffing and budget are sufficient.
- Mentioned the vacancy of 11 posts in general medicine, further affecting the ability to maintain all acute beds open.

Bed Capacity and Configuration:

- **Details on Acute Beds:**
  - The hospital has 228 acute beds across various services. This does not include trolleys in the Emergency department (ED), day surgery unit, endoscopy unit, medical day unit (MDU), or specialist areas like paediatric units.
  - 181 adult inpatient beds are available, but not all are commissioned for use.
  - Funding for staffing and nursing workforce: £2.5 million investment at the end of 2023 to secure staff for beds like Corbiere, AAU, and Plemont (12 beds added).
- **Surge Capacity:**
  - There are 16 additional bed spaces for surge capacity.
  - Surge capacity also allows for ambulatory services in specific areas, such as AAU, which could alleviate acute emergency admissions by improving flow and reducing the strain on inpatient beds.

Challenges and Winter Surge:

- **Winter Surge Impact:**
  - In January, there was a rise in demand, especially related to infection control and higher acute care needs.
  - Critical care units and enhanced care areas were surging due to the increased demand.
  - The hospital managed to de-escalate medicine in early February, with no medical patients left outside the medicine wards.

Patient Flow Strategies:

- **Front Door Management:**
  - Focus on how Emergency Department (ED) and ambulance services interface, with the goal of reducing unnecessary admissions, especially for social care reasons.
- **Inpatient Management:**
  - Ensuring patients receive prompt clinical assessments, swift diagnostics, and efficient care. The Red to Green framework will be applied to improve patient management.
- **Discharge Management:**
  - Discharge planning should start on the day of admission. Close coordination with patients and families is essential, alongside timely social work assessments.
- **Performance Indicators:**
  - CT outlined performance indicators for patient flow, which will help measure the success of improvements. These indicators align with those used in other NHS trusts and healthcare organisations.
  - Continuous monitoring and benchmarking against best practices will guide improvements in the flow.

Community Services Impact:

- AW emphasised the role of community services in reducing hospital admissions and speeding up discharges. Key areas:
  - Social care admissions: A significant number of people admitted to the hospital do not need medical care but are admitted for lack of alternative accommodation or care options.

- The current model is being revised to ensure that social care needs are met more efficiently, reducing unnecessary admissions.
- Physiotherapy in ED: A pilot to have physiotherapists stationed at the ED to assess patients quickly and prevent unnecessary admissions.
- A trusted assessor model will be implemented to streamline assessments, reducing the burden of multiple assessments by different professionals.
- Discharge to Assess Model: under development.
- Telecare: Expanding telecare services (e.g., emergency alarms, activity monitoring) to help support people at home and reduce unnecessary hospital stays.
- Focus on frailty pathways and rehabilitation services that can be moved to community settings, allowing patients to receive care without the need for hospitalisation.
- Nursing and Residential Care: Addressing delays in discharge due to a lack of available nursing home placements, particularly for those with specialist dementia needs.
- These efforts aim to reduce the length of stay and improve community-based care.

CD thanked CT and AW for the comprehensive presentation, emphasising the importance of improving patient flow as a key component of hospital performance. CD suggested a six-month review of the indicators to monitor progress, with future reports clearly showing the targets and performance related to patient flow. The ambitious nature of some performance targets was recognised and CD expressed support for continued efforts in improving flow and reducing delays.

ACTION: A six-month review of the indicators to monitor progress, with future reports clearly showing the targets and performance related to patient flow.

AH highlighted the balance between urgent and long-term goals, stressing that while immediate performance is critical, there should also be a vision for the future that includes engagement and investment in community care, which not only improves health outcomes but also reduces pressure on the hospital system.

MP praised the clear description of a complicated process and raised concerns regarding frequent patients and how these admissions could be minimised.

CG thanked AW / CT and acknowledged the effort of work to make improvements.

CD suggested the importance of considering cost-effectiveness when implementing a discharge to assess model, particularly considering the financial strain on social care.

9	**Quality Account 2024 (Annual Report)**	**Action**

Pam Le Sueur (PLS) in attendance and began the discussion by presenting the Quality Account 2024 Annual Report, noting that this is the third year the report has been prepared. PLS emphasised that the report follows the same structure as previous years, focusing on the quality of care within HCJ, outlining areas of improvement, and identifying areas that still need work.

Key Points Discussed:

Report Structure and Framework:

- The report is structured around three core domains:
  - Patient Safety
  - Clinical Effectiveness
  - Patient Experience
- It adheres to the NHS Quality Account Framework, which has been maintained for consistency over the past three years.
- The report includes priorities identified from various data sources, including:
  - Complaints
  - Mortality reviews
  - Incident reporting
  - Serious incidents
  - Safeguarding issues
  - Litigation

- Cross-referencing with JCC standards

Annual Priorities and Stakeholder Engagement

- **Priorities Setting:**
  Data from multiple sources was used to align priorities across HCJ's annual plan and quality account, ensuring consistency and avoiding conflicting goals.
- **Review of Previous Year:**
  Most actions from last year were completed; outstanding items remain active priorities.
- **Stakeholder Feedback:**
  Feedback was sought from eight stakeholders; five responded (up from two last year), showing improved engagement. One stakeholder has not yet responded despite follow-up.

CG commended PLS and her team for their hard work and highlighted the demonstrable improvements in both the documentation and the outcomes of the quality initiatives (monitored through the Quality, Safety and Improvement Committee).

Publication and Next Steps:

- The final report will be published on the 31 March 2025 as per the required timeline.

In conclusion, CD thanked PLS and her team for their hard work and the comprehensive nature of the report. There was no further discussion on the report, as it was primarily the remit of the Quality, Safety and Improvement Committee who had reviewed the document in detail. The meeting was focused on providing the final sign-off.

10	Finance	Action

The Board received a paper providing an update on the month 2 financial position for 2025 and to discuss this position, noting the risks and mitigations, forecast trends and recommendations.

Key highlights and discussion points:

Financial Position for Month Two

- **Performance:**
  A £3.3 million deficit for the second month, with a monthly run rate deficit of £1.65 million, an improvement from last year's £2.3 million. After one-offs, the underlying deficit is £1 million, still a concern.

- **FRP Efficiency Savings:**
  £2.4 million in savings achieved, but £900,000 below the target. Improvement from last year, but still short of the required £1.7–1.8 million monthly savings.

- **Budget Balancing:**
  £28 million in savings needed: £14 million in budget cuts and £14 million from FRP savings. Focus on reducing waste and making tough decisions on recurring costs.

- **Quality Impact Assessments (QIA):**
  Initiatives impacting quality are assessed and revised if concerns arise.

- **Key Financial Risks:**
  Risks include social care and mental health activity growth, rising drug prices, and challenges with patient flow, discharge delays, and recruitment.

- **Staffing Costs and Recruitment:**
  £800,000 overspend on staffing, similar to last month. Recruitment delays may increase temporary staffing costs.

- **Winter and Emergency Costs:**
  Winter escalation costs adding unbudgeted expenses (e.g., £220,000 per month). Efforts to generate additional income through surgical activities and reduce non-pay costs.

- **Tertiary Care Activity:**
  Tertiary care referrals have risen by 15.6%.

- **Social Care and Insurance Pressures:**
  Delayed discharges and higher insurance premiums have led to a £600,000 income shortfall.

- **Mitigation Strategies:**
  Income generation, improving patient flow, reducing temporary staffing, and efficiency savings are key mitigation efforts.

AH sought assurance on how unexpected or "one-off" events are being anticipated and managed. OH responded that they are now in a stronger position to address such issues, with policies in place to manage specific costs and scrutiny of charge errors—some of which are still being resolved.

On emergency department (ED) pressures, CD raised concern over the feasibility of achieving an 8.6% reduction in operational spending given record-high demand—3,600 ED visits in January alone, equal to 3% of the population. OH acknowledged much of the demand is inappropriate for ED and should be redirected to primary care, with ongoing strategy work and MHSS support. CD and CG emphasised the need for a more integrated system, with CG suggesting the issue is less about inappropriate use and more about patients accessing care through the wrong “front door.” MC added that digital tools—such as a 111-style service and data integration—could help reduce unnecessary ED visits and direct patients to appropriate care but noted that adequate funding is essential for success.

Risk and Mitigation

- **Key Challenges:**
  High-risk budget reduction targets remain complex and require policy changes. Focus areas include demand management, structural funding, and social care policy updates.

- **Operational Strategies:**
  New actions include a high-cost drug funding scheme and faster recruitment processes. The executive team is driving improvements in patient flow and income generation.

- **Financial Outlook:**
  Despite the ongoing deficit, the organisation is better positioned to manage finances. Leadership is more proactive, confident, and accountable, with support across teams.

- **Leadership and Teamwork:**
  Strong collaboration and shared learning over the past two years are helping the team manage risk and build resilience for future challenges.

DK raised ongoing concerns about HCJ’s financial position, noting a £14 million savings shortfall and delays in delivering the efficiency programme (FRP), especially around staffing. Quality impact assessments were also delayed, limiting their usefulness this year.

DK stressed the need for stronger execution and agreed with OH on the seriousness of the situation, warning that without a clear plan, meeting the budget will be very difficult.

CD compared Jersey’s position to the NHS, highlighting similar struggles and asking whether early budget cuts to secure savings had been considered.

OH confirmed that COBRA-led FRP measures are in place but require broader collaboration and policy support.

TW acknowledged limited progress and emphasised the need for urgent executive action, given rising demand, limited resources, and increasing costs. The next few months will be critical to determining whether the budget can be brought back on track.

11	**Quality and Performance Report Month 2**	**Action**

The Board received the Quality and Performance Report Month 1.

Key highlights and discussion points:

- **Complaints and Patient Engagement:**
  Formal complaints are decreasing, though work continues to improve complaint handling and patient engagement. The Friends and Family Test is being enhanced to gather more meaningful feedback.

- **Pressure Ulcers:**
  Incidents are declining due to effective work by the Tissue Viability Team. Despite being understaffed (one nurse currently), prevention and post-discharge care remain a focus.

- **Emergency Department (ED):**
  In January, 3,626 patients attended ED; 2,465 were seen within the 4-hour target. Performance is steady but challenged by long waits and service pressures.

- **Elective Care:**
  Outpatient clinic performance has declined due to staff being redeployed to wards. Efforts are underway to reduce long-wait patients, especially in general surgery and orthopaedics.

CS highlights two key maternity care indicators: effective management of postpartum haemorrhage and timely, quality caesarean sections. These show positive outcomes and demonstrate the successful implementation of the maternity improvement plan, emphasising teamwork and patient-centred care.

Social Care Indicators:

- The social care indicators, which were planned for inclusion, are currently missing from the report for both Month 1 and Month 2. They are expected to be included in the Month 3 data.

Mental Health:

- The primary issues within mental health services are the waiting times for assessment, which are largely attributed to staffing shortages. There is also staff turnover in the autism service, which may impact service delivery.

Dementia Services:

- There are ongoing efforts to manage gaps in the dementia service. The aim is to prevent further increases in the waiting times, as the service had previously made great progress in bringing waiting times under target.

The Board noted that the emergency care performance issues discussed earlier were well understood, and no further comments were raised at this time.

12	**Workforce Report Month 2**	**Action**

The Board received the Workforce Report Month 2 2025. ITe provided a brief overview of the workforce report, with the usual disclaimer about data quality concerns, noting that the Chief People Officer is prioritising improvements in this area.

Key highlights and discussion:

Turnover:

- ITe clarified the current turnover levels, which are often reported by the press as being high, in fact remain low and should be understood in context.

Sickness Absence:

- ITe addressed the issue of sickness, particularly stress and anxiety levels among staff. ITe noted that the sickness rate is higher than desired, currently around 6%. This figure is an area of concern, and while reporting might be improving due to increased focus on the issue, it remains a problem that needs addressing.

- ITe shared a comparison with the NHS, where stress and anxiety account for 26% of sickness absences, while in HCJ workforce, it is only 11%. This context was provided to avoid misinterpretation of the figures.

Recruitment:

- ITe reported that there are currently 473 vacancies within the workforce, including nearly 200 in vet recruitment and about 100 roles covered by agency staff. He emphasised that there is ongoing work to reduce reliance on agency staff and increase the number of permanent staff hired.

The Board registered formal concern about the sickness rates, particularly in the context of its impact on costs and the overall wellbeing of staff.

The discussion on the workforce report concluded with no further issues raised at this time.

13	**Equity in Outcomes and Experience**	**Action**

The Director of Public Health, Dr Peter Bradley (PB) and the Head of Public Health Intelligence Margi Clarke (MCl) in attendance to discuss the equity / inequity in Jersey and factors affecting health outcomes and experiences across different demographics on the island. A series of slides were presented (addendum to these minutes) covering the role of Public Health, the importance of equity in health, measuring equity in outcomes and experience, barriers to equitable outcomes and experiences and strategies to improve equity.

Key Discussion Points:

CG emphasises that while healthcare plays a role in addressing health issues, 70% of health outcomes are influenced by environmental factors and genetics, which are harder to change, urging ministers to recognise that health systems cannot solve broader societal issues like housing and education. The conversation also highlights the long-term impact of living with illness and the need for better prevention, especially in areas like stroke prevention. CG advocates for more investment in prevention rather than focusing solely on healthcare spending.

PB agrees with CG's points, acknowledging Jersey's good life expectancy while noting the inequalities and external factors affecting health. Ministerial interest in prevention is strong, and efforts will continue in this area. PB stresses that addressing prevention is urgent, as projections suggest that without action, the situation will worsen, but there is still a chance to make a positive impact.

CD emphasises the need to shift focus from acute care to prevention, particularly in light of financial constraints, acknowledging that achieving this may require double funding, which poses implementation challenges. CD asks PB to identify the two most impactful initiatives. PB highlights smoking cessation and diabetes, noting that 80% of diabetes cases are reversible with treatment, making it a priority with potential for quick, positive outcomes. Targeting these areas is seen as key to improving overall health.
CD stressed the need for a whole-system healthcare approach in Jersey, integrating health budgets and strengthening out-of-hospital care., highlighting the island's unique opportunity to tackle these challenges but warns that swift action is essential due to concerns over financial sustainability. CD also concerned over bed projections, which could become a serious issue if not addressed.

MC inquired about a possible link between low income and the high number of ED visits in Jersey, aiming to understand how the island's health system finances might contribute to this, especially in comparison to the UK. In response, MCl noted that a major challenge in Jersey is the lack of integrated systems and data, making it difficult to connect ED usage with factors such as income or deprivation. Although Jersey does not yet have an indexed multiple deprivation measure, Public Health is working on one, with a recent feasibility study now complete.

AH acknowledges the complexity of encouraging personal responsibility for health while ensuring people do not feel unsupported by the state, stressing the challenge of balancing these two objectives effectively.

MP asked what aspects of the clinical strategy would be most meaningful or impactful to PB. PB emphasises the importance of fully embedding prevention into clinical management and placing a strong focus on supporting individuals in taking responsibility for their own health.

The MHSS outlines plans to propose substantial funding over the next 40 years to transition from a reactive to a proactive healthcare system and invites PB to discuss current actions and reporting related to this goal. PB explains that the MHSS has backed prevention initiatives, with significant progress made in developing a comprehensive strategy. This evidence-based approach focuses on conditions likely to rise in the future, offering cost savings for both healthcare and society, and targets those most in need of support, aiming to avoid a "hope for the best" approach.

In conclusion, CD emphasises that future success of HCJ depends on the success of the efforts being discussed, wishing good luck to everyone involved.

14	**Strategy Development Health and Care, Clinical, Workforce Strategy**	**Action**

The Board received a report on strategy development, which was escalated from the People and Culture Committee. RW presenting on behalf of the Director of Health Policy who was unable to attend.

Key highlights and discussion points:

- **Strategic Planning for 2025:**
  Focus is on aligning the Health and Care, Workforce, and Clinical strategies, alongside the Digital Strategy and new healthcare facilities development.

- **Need for Integration:**
  Strategies must be interconnected and aligned with broader system analysis, modelling, and prevention priorities, ensuring a whole-system, island-wide approach.

- **Partnership Board's Role:**
  The Board is key to driving integration. It was proposed that the Chair be invited to a future meeting to support ongoing strategy alignment.

Noting the timeline, CD suggests holding a comprehensive discussion later in the year (around September-November) about workforce, clinical, and out-of-hospital care, inviting relevant stakeholders. The goal is to have a holistic view of the system, and it is hoped that by then, the Partnerships Board will be established and its chair involved in the conversation.

ACTION: A future meeting should be scheduled to review the integration of strategies, ideally by September or November 2025. Invite the Partnership Board Chair to join this meeting for a broader conversation.

15	**Committee Reports**	**Action**

CD advised that the reports would normally be in written form; however, due to absenteeism, these are not available. The committee chairs were asked to highlight any items that had not already been covered in the meeting's agenda.

People and Culture Committee:

- The chair of the People and Culture Committee confirmed that all topics discussed in their meeting had already been covered in the current agenda. No additional report or updates were necessary.

Quality, Safety and Improvement Committee:

- No escalations

Finance and Performance Committee:

- No escalations

In conclusion, all key items from committee reports had been incorporated into the broader agenda for discussion.

16	Board Assurance Framework 2025	Action
The Board discussed the Board Assurance Framework (BAF), and CD clarified that the framework for 2025 had been reviewed by the Board the previous afternoon. **Key Updates**: • **Patient Feedback**: The primary issue raised in the BAF review was the need to use patient feedback more proactively in service development. In conclusion, no additional issues were highlighted within the framework that required immediate attention, and the Board reaffirmed that everything necessary had been placed on the agenda.		

17	Questions from the Public	Action
CD opened the floor for public questions and noted that none had been submitted in advance. **1. Question 1: Member A** • **Subject**: Financial Resources and Women's Health Strategy • **Summary**: Member A expressed concern about the financial limitations within the healthcare system, highlighting the lack of a dedicated women's health strategy. He questioned the effectiveness of current metrics, processes, and reviews, suggesting that they do not demonstrate clear outcomes or improvements. Member A mentioned that staff burnout, caused by understaffing and the need for permanent staff to fill gaps, is a key issue, leading to potential resignations. He referenced the impact of budgetary savings on healthcare quality, including the absence of an endoscopy nurse, resulting in significant external costs. • **Chair's Response**: CD acknowledged the concern about financial resources but clarified that sickness levels in the NHS are around 4%, with 26% of this is related to anxiety and stress. CG also emphasised that while the NHS is struggling, it is not 'broken' and disagreed with the notion that more money would solve the issue entirely, citing the social determinants of health as a significant factor. • **Further Discussion**: Member A raised concerns about the inefficiency of the review processes, questioning the return on investment for numerous reviews. CD agreed to explore the cost of these reviews over the past year and suggested the inclusion of this information in the minutes of the next meeting. **2. Question 2: Member B** • **Subject**: Emergency Services and Turnaround Team • **Summary**: Member B raised two points: 1. **Emergency Services**: She highlighted a significant information gap for the public regarding what to do in an emergency suggesting that public education through consultations could alleviate unnecessary use of emergency services by informing the public on alternative actions in emergency situations. 2. **Turnaround Team**: Member B questioned the status of the turnaround team, its costs, and its outcomes. She asked whether the team still exists, what it cost, and whether it provided a report. • **Chair's Response**: 1. **Emergency Services**: The Chair acknowledged the concern and agreed that public communication could help reduce unnecessary emergency visits. 2. **Turnaround Team**: CD clarified that members of the turnaround team, including Chris Brown and Obi Hasan transitioned to key roles in the health service. The Chair commended CS / MP work in improving clinical standards and safety. CD suggested that the cost and outcomes of the turnaround team would be provided in the meeting's minutes for transparency. **3. Question 3: Member C** • **Subject**: Hospital Safety and Patient Records • **Summary**: Member C raised concerns about hospital records, specifically regarding accessibility, correctness, and updates. They expressed frustration with the process of correcting records, receiving no follow-up or evidence that the changes had been made.		

The member emphasised that the process is not seamless, with emails often passed around without resolution.

- **Chair's Response**: JM acknowledged the concerns and noted that the Patient Advice and Liaison Services (PALS) team acts as the gateway for handling such issues. The Chair agreed to follow up on the matter with the Medical Director (SW), the information governance lead, and provide an update in the next board meeting.

4. Question 4: Member D

- **Subject**: Delayed Follow-ups and Wheelchair Services
- **Summary**: Member D presented two concerns:
    1. **Delayed Follow-up for Clinics**: Member D explained that she had been waiting for a follow-up appointment for six months, with no communication from the hospital. When she contacted the secretary, the appointment had not been arranged.
    2. **Wheelchair Services**: Member D raised concerns about the delay in wheelchair services. She mentioned that due to a lack of staff, there is an eight-month wait for an occupational therapist to assess whether her wheelchair is suitable.
- **Chair's Response**:
    1. **Delayed Follow-up**: CT acknowledged the issue and offered to speak to Member D directly after the meeting to resolve the appointment issue.
    2. **Wheelchair Services**: AW explained that the delay in wheelchair services is due to limited staff availability and not the transition to community-based care. AW reassured that addressing these delays is a priority, particularly to avoid unnecessary hospitalisations. AW emphasised the need to balance hospital care with community-based solutions to improve patient outcomes and reduce unnecessary hospital admissions.

	MEETING CLOSE	**Action**

Acknowledgment:

CD took a moment to thank Danielle Colback for her efforts in stepping in in the recent weeks, pulling the meeting together, and assisting with minute-taking.

Closing Remarks
CD thanked all attendees for their contributions and expressed appreciation for the hard work of all staff over the past months.

Date of next meeting: Thursday 29 May 2025