



Date: 25 April 2024	Time: 9:30 – 12:30pm	Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL
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Voting Members:		
Carolyn Downs CB - CHAIR	Non-Executive Director	CD
Anthony Hunter OBE	Non-Executive Director	AH
Julie Garbutt	Non-Executive Director	JG
Chris Bown	Chief Officer HCS	CB
Patrick Armstrong MBE	Medical Director	PA
Obi Hasan	Finance Lead – HCS Change Team	OH
Non-Voting:		
Jessie Marshall	Chief Nurse	JM
Claire Thompson	Chief Operating Officer – Acute Services	CT
Dr Anuschka Muller	Director of Improvement and Innovation	AM
Bill Nutall	Director of Workforce	BN
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	CP
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (TEAMS)	CS
Emma O'Connor Price	Board Secretary	EOC
Daisy Larbalestier	Business Support Officer	DL
Becky Sherrington	Chief Inspector, Jersey Care Commission (Item 7 only)	BS
Ashling McNevin	Freedom to Speak Up Guardian (item 17 only)	AMN

1	Welcome and Apologies	Action												
	<p>CD welcomed all in attendance. It was communicated at last month's meeting that CD will chair the meetings but is not acting as Chair. The responsibilities of the Chair will be split between the current four Non-Executive Directors (NEDs),</p> <ul style="list-style-type: none"> - CD will lead on finance and workforce issues (until the 5th (finance) NED is recruited). - TH / JG will lead on out of hospital, mental health and commissioning - CG will lead on quality and safety. <p>The process for recruiting the fifth NED is underway and hopeful that this will be sooner rather than later. This NED will be responsible for finance issue.</p> <p>Regarding the appointment of a Chair, there is no benefit in starting the process again as the Board is due to be reviewed in April 2025. The Board fully supports the decisions made by the Minister for Health and Social Services (MHSS) on this matter.</p> <p>The Minister for Health and Social Services (MHSS), Deputy Barbara Ward and Deput Andy Howell were welcomed.</p> <p>Meeting is quorate.</p> <p>Apologies received from:</p> <table border="1" data-bbox="92 1742 1348 1886"> <tr> <td>Professor Simon Mackenzie</td> <td>Medical Lead – HCS Change Team</td> <td>SMK</td> </tr> <tr> <td>Dr Clare Gerada DBE</td> <td>Non-Executive Director</td> <td>CG</td> </tr> <tr> <td>Andy Weir</td> <td>Director of Mental Health Services and Adult Social Care</td> <td>AW</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Professor Simon Mackenzie	Medical Lead – HCS Change Team	SMK	Dr Clare Gerada DBE	Non-Executive Director	CG	Andy Weir	Director of Mental Health Services and Adult Social Care	AW				
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2	Declarations of Interest	Action
	No declarations.	

3	Minutes of the Previous Meeting	Action
	The minutes of the previous meeting held on 28 March 2024 were agreed as accurate.	

4	Action
<p>The actions were acknowledged as either being addressed through today's agenda or a future agenda.</p>	
5	Action
<p>As above.</p>	
6	Action
<p>CB took the paper as read and reminded the Board that this report is a summary of the key issues facing HCS and most are covered in further detail on the agenda. In addition:</p> <ul style="list-style-type: none"> - In reference to the recent success of the healthcare assistant (HCA) recruitment campaign, seven applications are being processed and there are more to follow. - CB advised the Board that this is BN's final Board meeting as he will be leaving HCS at the beginning of May 2024. BN made a personal statement advising that his decision to leave is based on private family matters (as opposed to any work-related issues) and added that it has been a pleasure and privilege working with the Board and serving the people of Jersey. - Regarding the increase in deep tissue injuries (DTIs), JM explained that these are currently being investigated and the results will be presented to the Board next month. For the benefit of those present, a DTI is a breakdown in the skin as a result of trauma (prolonged period in the same position, medical equipment). In response to CD's questions, JM explained that the increase has been from zero cases to seven cases and have occurred across several wards rather than one area. - The Jersey Nursing Assessment and Accreditation System (JNAAS) has been replaced by a programme of peer review which is multidisciplinary (both clinical and non-clinical). The reviews include discussions with both patients and staff. Following the first round of reviews, there have been issues requiring immediate action in addition to the identification of medium to long term actions. Noting that peer reviews are very good practice, CD asked if consideration had been given to including a lay person as part of the team. In addition, should peer review cover all services rather than limited to wards? CS advised that during this 'proof of concept' phase, lay members had been included as part of the team and JM is in discussion with the Assistant Ministerial team to further incorporate patient engagement. CS reassured the Board that any immediate concerns were raised at the time in the clinical area and also shared at the feedback session following the reviews, recognising there will be themes across all areas. CS sought to commend the Chief Nurse for the establishment of the programme and implementation across all wards (except for three areas). The peer reviews will take place monthly (as opposed to annual JNAAS) in an unannounced format targeting specific areas e.g. nutrition and hydration. CB in full support of lay member inclusion. CB also advised that the externally commissioned reviews are another example of peer reviews and are key to ensuring safe, effective and up-to-date services. <p>ACTION: Results of the DTI investigations to be presented to the Board in May 2024.</p> <p>ACTION: On completion of the first cohort of peer reviews, the Board is to receive a summary of the outcomes (including any issues arising).</p> <p>AH thanked CB for this overview. Reflecting on the Picker Survey results, it was important to share these results with staff and continue to focus on improving staff / patient experiences.</p> <p>Noting the reference to concerns about the prescribing of cannabis for people with known serious mental illness, CD asked for a report to go to the Quality, Safety and Improvement Committee clearly detailing the patient safety issues.</p> <p>ACTION: Following concerns about the prescribing of cannabis for people with known serious mental illness, a report is to be presented to the Quality, Safety and Improvement Committee.</p>	

7	Jersey Care Commission – Single Assessment Framework	Action
	<p>Becky Sherrington, Chief Inspector Jersey Care Commission (JCC) was welcomed to the meeting. BS advised it was encouraging to see members of the public, particularly as this consultation is a public consultation.</p> <p>The JCC regulates health and social care in Jersey and undertakes 107 inspections each year, including healthcare, day centres, care homes and home care providers. More recently, elements of social care have been included such as Child and Adolescent Mental Health Service (CAMHS) and children’s social work. Fostering and adoption will be undertaken soon. In the spirit of transparency, all reports are published and can be found on the JCC website.</p> <p>As the Executive Lead for the JCC, BS has a team of regulation officers and is governed by the JCC Board. The Chair of the JCC is based in Northern Ireland and as the previous Chief Inspector for the Northern Ireland Inspectorate, has a lot of experience in this area.</p> <p>The purpose of the regulator is to improve health and social care (not ‘catch services out’). Regulation services must be based on-Island so that the law can be used when required. The current consultation / proposal is that the JCC regulate and inspect the hospital. As a small regulator, the JCC recognise that this cannot be achieved alone and are working with other regulators to provide expert support (a contract has been signed by the Care Quality Commission (CQC)). This blended model will provide the required level of expertise and also strengthen the independence of inspection.</p> <p>There are currently two public consultations. Firstly, the Government of Jersey are consulting on an amendment to the Regulation of Care Law which will include the hospital, mental health services and ambulance services (also include private ambulance services – St Johns Ambulance and Normandy Rescue). The amendments will then be debated by the States Assembly. In anticipation of this, the JCC is preparing and have written the proposed set of standards. The standards have been written so that providers are clear about what they should be providing, and service-users are clear as to the level of service they should be receiving. All Islanders and staff are encouraged to respond to the consultation. The feedback received on the standards for Childrens Services resulted in amendments to the standards.</p> <p>The consultation is open until the end of May 2024. Two consultation events have been planned and will be held at the Library and in the St Helier Parish Hall. Translators will be available to support those for whom English is not their first language. Also working with learning disabilities services and the Childrens Commissioner.</p> <p>A series of slides was presented (included as part of the Board papers).</p> <p>The framework begins with the Key Elements of care which sets the expectation that services should provide an environment that is safe, effective, caring, responsive and well-led. Under this are 35 standards.</p> <p>CD thanked BS for the presentation and advised that following consideration, the Board will provide and publish its response to the consultation.</p> <p>CD noted that the standards are very good and clear and what this means for HCS. However, from a service-user perspective, the standards may be less clear – specifically regarding regulation of HCS services and the regulation of out of hospital services. BS responded that regulation services are underdeveloped in Jersey, and this is being addressed by a phased approach. There are some services that are not in scope of regulation such as General Practitioners (GPs) and community pharmacies.</p> <p>Reflecting on his experience of working in regulated services, CB advised the proposal is very much welcomed. Staff feedback from the Hollies and Sandybrook Day Centre suggest that staff view regulation as positive for focussing improvement work.</p>	

<p>BS noted the importance of feedback and explained that feedback from areas that have been inspected is sought annually through a survey. 55% services have responded to the most recent survey, and this will be published next week.</p> <p>Whilst acknowledging that feedback from inspection can be sometimes be uncomfortable for services, it is important to be transparent and ensure that any findings are based on fact and not anecdotal evidence.</p> <p>Various members reflected on their experience of working within regulated services and the importance of this to continuous service development.</p> <p>Regarding outcome ratings, BS explained this has been debated and a decision has made that the hospital will not receive an overall rating (which is the same currently for other providers). However, reports will detail areas requiring improvement. CD welcomed this decision, recognising that there will both good and bad areas of complex organisations and it is difficult to reflect this into one rating. OH asked if a rating will be applied across the five key elements of care to inform an overall view. Until the inspection methodology has been fully agreed, BS unable to answer this fully and will revert.</p> <p>Providing the amendments are accepted, it is anticipated that the legislation will be in effect from January 2025 and HCS will have 6 months to register. Likely that the first inspection will take place at end 2025 and will be announced. The focus of the inspection has not been decided.</p> <p>Noting the CQC has resumed inspection of Local Authorities, AH is interested to understand how the JCC will be looking at care and support needs (out of hospital). BS advised that the inspection of areas is guided by the Regulation of Care law. However, a whole system approach can be considered for the future.</p> <p>CD thanked BS for attending and reassured BS that HCS will be preparing for inspection.</p>	
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8	Quality and Performance Report (QPR) Month 3	Action
	<p>As the Board receives this monthly, CD invited CT to appraise the Board of any deviations. CT responded with the following,</p> <ul style="list-style-type: none"> - There is a slight change in the rate of progress to reduce those waiting > 52 weeks for 1st outpatient appointment. This is due to a larger cohort of patients waiting in the 180–300-day category and the impact of waiting list initiatives. However, as we progress through April, CT is confident that the rate of progress will increase particularly in dermatology and clinical genetics. - HCS received 500 more referrals during March than January 2024. However, whilst this does not impact those waiting > 52 weeks, it does impact how capacity is used particularly for those triaged as urgent / soon. - The work regarding inpatient capacity is starting to impact performance and reduce the numbers of those waiting for inpatient care. - Other elective performance metrics continue to improve with the work carried out around diagnostics. - The new to follow-up ratio is consistent with further detailed work in some specialities continuing through the clinical productivity workstream. - Pleasingly, on the day cancellations for non-medical reasons continues to reduce. - Elective theatre utilisation continues to improve. - Emergency Care: although more patients were seen, treated and discharged within four hours, patients have been waiting longer in the Emergency Department (ED). However, for those waiting > 12 hours, some of these patients will have been discharged and others will have been delayed admissions for isolation reasons. However, it can be demonstrated that capacity is being managed in a safer way specifically through the reduction in overnight transfers. - PA sought to provide assurance regarding massive obstetric haemorrhage (MOH). There has been a reduction in numbers. In addition, the externally commissioned thematic review has been received and a number of recommendations have been made. However, the vast majority of these have already been implemented. The findings of the 	

report will be included in the Maternity Improvement Plan (MIP) report for the Board meeting in May.

ACTION: The findings of the thematic review of MOH will be presented to the Board in May 2024 as part of the MIP report.

In reference to the outpatient waits > 52 weeks and *plans to increase the capacity within the service is ongoing with a long-term strategy proposal in its infancy*, CD asked for clarity. CT explained this refers to dermatology and the development of a service plan to address the waiting list and maintain current progress. Both nursing and medical recruitment has been made and the overall dermatology waiting list is starting to reduce.

CD also asked for the reasons in the increase in referrals (> 500) and has this continued through April. CT explained this is currently under review to help to develop future service plans. Whilst there are variations across any year, many of these referrals are for physiotherapy. In addition, Public Health campaigns such as community dental can result in increase in referrals. The current data states that the number of referrals has reduced to levels seen in previous months. CB noted this can also be discussed at the next Primary Care Board (PCB) meeting. CD stated that importance of understanding the impact of the wider health and care system such as the campaigns mentioned above to allow HCS to better prepare for any impacts.

9	Workforce Report (Month 3)	Action
	<p>CD wished BN the very best for the future and invited any key points.</p> <ul style="list-style-type: none"> - The vacancy rate is consistent at 17%. - The turnover rate is consistent but has reduced from 6.9 to 6.6%. The voluntary turnover rate is consistent. - Leaver's headcount has increased. - Sickness absence has increased. The current occupational healthcare contract runs out November 2024 and a review of these services will be concluded at end April 2024. - Objective approved shows a marked increase from the beginning of Q1 to end Q1 2024, from 8 to 27.5%. However, it is important that the outcomes of appraisal can be realised with individuals / teams and that the investment can be made to ensure improvements. - The reconciliation work to establish accurate establishment and vacancy data has not been completed. To mitigate this, a vacancy tracker has been created. - Since beginning of 2024, 151 new staff have joined HCS. There are 284 vacancies where recruitment activity has not started. However, there are 138 vacancies going through the onboarding process. - The recent HCA recruitment campaign captured 35 potential candidates. - A contract is now in place with an external company to carry out cohort nursing recruitment from May to July 2024. This series of planned recruitment is a positive change in HCS recruitment activity. - Hoping to recruit a Chief Allied Healthcare Professional who will play a role in the strategic recruitment of AHPs. - A reduction in the time-to hire requires further discussions with People and Corporate Services (PCS) as HCS not currently in control of some of the administration processes. Ideally, HCS should have its own administration team to support the activity of the recruitment team. - HCS has received a report regarding exit interviews and the feedback has been shared with the HCS senior leadership team to inform improvements. - Talent Acquisition system will help to align and streamline recruitment activity and processes. <p>Given the challenges regarding the systems that underpin data acquisition, JG thanked BN for the report. JG suggested that a piece of work should be carried out with other providers to look at how people are encouraged to work within healthcare and how healthcare can be made an attractive career. Noting the success of the recent HCA campaign, JG applied caution and noted that these staff could be moving around the healthcare system in Jersey and whilst this improved HCS's position, there could be impacts on other parts of the system. Could a joint initiative be</p>	

<p>considered to bring HCAs into the Island? BN responded that following a meeting with PCS, changes will be made to the GOJ website and partnership work will be promoted.</p> <p>AH noted the sickness rate has doubled from the same period last year and stated that it is important for HCS to understand the reasons for this. In addition, whilst the objective setting rate has improved, it still remains low and the Board needs to be assured that this is being actioned.</p> <p>ACTION: The People and Workforce Culture Committee to receive a detailed report on the sickness absence rates. The summary of this discussion will then be reported to the Board.</p> <p>Noting the reference to the action regarding improving the rate of completed objectives, CD asked what this action is and what will be different / change as a result of this.</p> <p>ACTION: The People and Workforce Culture Committee to receive a detailed report on the work being undertaken to improve the rate of completed objectives and the impact of this. This can be included in the workforce report.</p> <p>Noting the exclusion of manual workers from the agreed appraisal / objective setting process, CD sought assurance that this group of staff will be supported and developed. CB explained that there was an agreement between the GOJ and the Trade Unions that manual workers would not be subject to appraisal. However, even with this staff group excluded from the current data, the rate of objective setting remains low.</p> <p>CD noted the absence of the report detailing the outcomes of the exit interviews (as stated in the report) is disappointing and this report must be presented at the next People and Culture Committee meeting. BN advised that this had been discussed by the Executive Leadership Team and the report will be circulated to the Board members.</p> <p>ACTION: The People and Culture Committee to receive the Law at Work Exit Interview Report and a summary of action will be presented to the Board.</p>	
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10	Finance Report (Month 3)	Action
	<p>OH invited to highlight any key points from the report.</p> <ul style="list-style-type: none"> - The Financial position for YTD Month 3 is a £5.4m deficit vs budget giving a headline monthly run-rate deficit of £1.8m. Adjusting for exceptional items and non-recurrent costs the underlying run-rate deficit is £1.5m. - FRP savings delivery is £1.82m vs £1.0m plan at M3 (M2 £0.51m) over-achieving by £0.82m in Q1. - The current FY24 year-end forecast remains a deficit of £18.0m, The key factors driving the forecast deficit are budget cost pressures, risk of FRP savings slippage and one-off exceptional costs. - Working to put the enablers in place. Proceeding at risk is not entirely within the control of HCS as the approval of the States Employment Board will be required for some posts, causing delay. <p>AH feels assured by the effort that is going into understanding the financial position, the key drivers, associated risks and mitigations. The Board must be clear and able to assure the Ministerial team of the absolute drive for efficiencies that are not impacting on service delivery. Any impacts on service delivery become a political decision. Secondly, a large part of the long-term solution is appropriate out of hospital care to reduce demand on the hospital. JG and AH are looking to work with the Executive Directors to develop this work.</p> <p>CB advised the Board that quality impact assessments (QIA) are undertaken where necessary. The integrity of the FRP remains and many of the delays are out with HCS's control. As the Accountable Officer (AO), CB has a legal duty to deliver the financial plan and within budget. Options to mitigate risk will be brought forward to the Ministerial team and some of these will require very difficult decisions.</p>	

<p>CD recognised the situation that at this point in 2024, the £18m deficit has not changed and it is unlikely to do so. To uphold transparency, any QIAs should be presented to the Board. CD suggested that the board's view is that the £18m is not achievable without serious impacts to service and therefore there needs to be political conversations as to the implications and whether the deficit could be ameliorated by the GOJ. However, noting CB's fiduciary duty, this cannot be delayed. CD asked if there is anymore that Board can be doing to support. CB in agreement that the task at present is to ensure that the £18m deficit does not increase.</p> <p>In conclusion, the Board supports the MHSS's view that additional funding will need to be given in this financial year. However, this does not mean that HCS will not deliver every efficiency possible and that in the long-term we will not continue to seek better, more efficient ways of working. It would be irresponsible not to raise this formally and therefore the Board wishes to raise this formally and support the MHSS in progressing this.</p> <p>OH emphasised that belief in the FRP is required as it is a quality led financial improvement programme: it balances quality and balances the money. The FRP is key to long-term sustainability and describes a clear road map that balances quality care with the finances. However, the enablers must be in place. HCS cannot keep asking for permission to do the right thing. As an example, HCS could manage its own recruitment and is then held to account for this. CD noted that the Board does not disagree with this, but it could be month 8 before this is in place; the short-term (in-year) issues must be managed.</p>	
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11	People and Culture Committee	Action
Paper taken as read.		

12	Nursing Appraisal	Action
<p>JM took the paper as read and highlighted the following key points,</p> <ul style="list-style-type: none"> - The overall rate of completed objectives is 27.5%. This paper specifically focuses on Nursing, Midwifery and HCAs. - Some areas continue to complete the appraisals on a paper-based system, and this has been considered. - Recent peer review has identified when combining the paper-based appraisal systems with the existing connect system a compliance of 54% (both objectives set, and objectives agreed). - It should be noted that staff on long-term sick leave and paternity leave are included in the number of staff with no objectives set – this accounts for approximately 5%. - Challenges remain with misaligned reporting lines. Appraisals are given focus during the weekly Lead Nurse meetings and ensuring that managers are encouraged and supported to make the required changes. - Ward compliance varies between wards and departments of greater than 85% to less than 50%. The Lead nurses will be doing some targeted work to ensure staff are trained in the system and that paper-based systems are not used. - The aim is to continue to improve this position. <p>Whilst CD acknowledged the current position is not optimal, it is twice as good as HCS overall. CD thanked JM for this candid report and this practice should be repeated across the piste. The figures demonstrate that some senior nurses are doing very well, and others are not carrying out their leadership / management role as well as they should be. This should be managed as part of their appraisal. Those that take a leadership position must recognise that there are obligations, and these must be fulfilled. If not, the job is not being done properly. CD suggested that the Board needs to be robust in its approach to this, recognising this is not limited to Nursing and Midwifery.</p> <p>BN advised that objective / appraisal is now a standing item on both the Executive Leadership Team (ELT) and Senior leadership Team (SLT) agendas. BN suggested that those managers who have done this well should be invited to these meetings to share how they have achieved this. In addition, as HCS does not have its own training budget, we are unable to develop first line supervisory managers in the art of leadership and management. It cannot be taken for</p>		

granted that because staff are appointed into a position, they immediately have all the skills required.	
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13	Maternity Improvement Plan	Action
<p>Paper taken as read. In addition,</p> <ul style="list-style-type: none"> - Whilst no further recommendations have been signed off, continue to monitor progress weekly. - The SLT have had a particular focus on culture and the development of a Maternity Strategy. - Ongoing follow-up reviews of which 75 out of 99 recommendations have completed 30-, 60-, 90- day follow-up reviews, evidencing ongoing embedment of recommendations. In areas with limited assurance, a review is carried out at 120-days. - Picker Institute surveyed Maternity Services during December 2023 and January 2024, with results provided to HCS Executives in March 2024. These are awaiting final sign-off prior to distribution with the organisation, expected April. It is noted that Maternity Services received positive outcomes. - A Practice Development Midwife and a Maternity Governance Midwife have been appointed and are expected to commence in July 2024. <p>Noting the alignment with SHIP Integrated Care Board, JG asked if benchmarking with Guernsey and Isle of Man has been considered as similar healthcare jurisdiction. In addition, is there an update regarding Consultant recruitment. PA responded that the first round of recruitment was unsuccessful and due to readvertise imminently.</p> <p>Regarding the issue of benchmarking, CS responded that the Director of midwifery is in close contact with both Guernsey and the Isla of Man. It is worth noting that SHIP does include the Isle of Wight which is comparable to Jersey. To-date, 100 recommendations have been completed.</p> <p>CD suggested that the Quality, Safety and Improvement Committee now receives detailed reports on the MIP (rather than the Board) as business as usual. The report should expand on areas that would be reported in the UK such as still births, brain cooling etc. CB suggested that the MI group continues to meet weekly to maintain momentum with the improvement work. CS stated that Jersey is part of EMBRACE UK (National Reporting Data Base), and any poor outcomes are reported and followed up.</p> <p>JG suggested that the issues regarding clinical recruitment should be reviewed at the People and Culture Committee.</p> <p>ACTION: The Quality, Safety and Improvement Committee to receive a detailed report regarding the MIP. The Board will receive a 6-monthly report.</p>		

14	Medicine Improvement Plan	Action
<p>Paper taken as read. In addition,</p> <ul style="list-style-type: none"> - CT advised the Board that a review of the current action plan has been commissioned and will follow the same themed approach taken by the maternity improvement group. - May is a crucial month as it includes the onboarding of capacity to support quality and safety performance, operational performance and project management. - A meeting has taken place to address the recommendation regarding the model of care for the Enhanced Care Area (ECA). There was good representation from both intensivists and acute physicians. - Interviews are scheduled for Consultants which will provide substantive capacity and support the response to the concerns raised by the Royal College of Physicians (RCP). <p>CB advised this is a key priority and recommended that the Board continues to receive a monthly report. Acute Medicine is a core service for the people of Jersey, and it has to be right: the RCP position describing the provision of 'largely poor care' in this area is not acceptable.</p>		

<p>ACTION: The paper for the next board meeting (May 2023) to include the action plan and need to understand more fully how existing staff are being consulted regarding the service redesign, what are their views, how many staff are involved, how many of these staff are actively involved in the conversations and at what level? How are people being taken forward together to make this a success? Need to balance the recommendations of the RCP with what is practical within HCS's resource.</p>	
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15	Patient Experience	Action
	<p>Paper taken as read.</p> <ul style="list-style-type: none"> - The data provided demonstrates the positive steps the team are making by showing a reduction in the number of days taken to respond to a complaint from 54 days in Q1 2023 to 15 days in 2024 for the same period. This is due to the hard work of the patient experience team working with the care groups and senior leadership teams weekly. - Overall complaints are down 64% year on year for the same period. - The Patient Advisory and Liaison Service (PALS) will be formally launched in Quarter 2, with new branding, a uniform, and a media campaign to highlight the work that the service offers. The aim of the relaunch is to let patients, relatives and carers know that they can contact the PALS team for help. - Work is also being carried out within the team to ensure good engagement and communication with patients, relatives and carers who want to log a formal complaint. - Regarding lessons learnt a number of workstreams have been established including a working group to look at ways to improve patient experience for the dDeaf community within HCS, specific suggestion box to be set up in Emergency Department following feedback and suggestions from patients about the patient waiting area environment and targeted staff training following complaints related to attitude. - Establishing a consistent approach as to whether complaints are upheld, not upheld or partially upheld will bring HCS in-line with the GOJ policy. - JM asked the Board to note the contents of the report, recognising the work undertaken by the patient experience team to ensure timely resolution of complaints. <p>AH commended the work to-date and stated that where there are complaints related to attitude, this does require focus and understanding (although recognising that attitude can be misinterpreted if people do not like what they here).</p> <p>CD congratulated the team on the improvements made and stated it would be useful to see the number of complaints as a percentage of the whole to understand whether the current number is concerning. Also, in agreement with AH, staff attitude as a theme of complaints stands out as unnecessary and need to understand where and why this is happening. Linking this to appraisals, it would also be useful to know whether staff attitude is a theme on wards where staff have not had appraisals. This triangulation of data will provide a clear view of pockets of poor leadership and performance.</p> <p>CD stated she has received direct positive feedback regarding the current PALS service leader.</p> <p>CB stated that staff attitude is concerning and is about basic good customer care and good communication. Reflecting on his experience of other healthcare jurisdictions, poor communication is at the heart of most of complaints.</p>	

16	Board Assurance Framework	Action
	<p>EOC advised that this is the first Board Assurance Framework that has been developed for HCS. It is not a unique tool and is widely used in both the public and private sectors. Following the development of the board objectives (detailed in the Annual Plan), the key risks were identified which could prevent achievement of these objectives.</p> <p>The BAF is a proactive element of risk management, identifying and mitigating risks before they materialise. It is important to note that this will develop over time, particularly once the assurance committees establish their cycle of business. The assurance committees will request deep dives</p>	

<p>into the key controls and assurance to make sure these are fully understood and represented accurately.</p> <p>Key to the effective use of the BAF is making sure it becomes BAU. The paper details some prompt questions (sourced from a Board Secretary Network) that can be used in HCS meetings to ensure that the impact of any business on the BAF is considered.</p> <p>Further work will include linking operational risks to the BAF.</p> <p>Noting the importance of the BAF and as part of the Well -Led standards for the JCC, CD asked when the BAF will come to the Board and reviewed in greater detail. EOC explained that this should be part of every board / assurance committee agenda. In addition, it will be considered at the HCS SLT meeting.</p> <p>ACTION: CD asked for the BAF to be at the beginning of the next board agenda to provide a more detailed review.</p>	
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17	Freedom to Speak Up Guardian	Action
	<p>AMN was welcomed to the meeting. CD advised the Board that she had specifically requested this report as one of the specific standards within the JCC single assessment framework relates to people's freedom to speak up, and for HCS to be successful, there has to be absolute confidence in people's ability to speak up and do so confidentially. As a Board and a community, there is a need to support all efforts to make FTSU a success. If it is not success, there are not only immediate concerns regarding inspection, but it is also not good for staff or patients.</p> <p>CD asked AMN to clarify the issues regarding confidentiality, the line management of the FTSUG and the relationship between the FTSUG and the HCS Executive Team.</p> <p>AMN thanked the Board for the opportunity to talk about the role of the FTSUG. AMN clarified that the role of the FTSUG within HCS is independent and offers an impartial service to all employees. The FTSU reports directly to the Chief Officer for Strategic Policy, Planning and Performance (who sits outside of HCS). Fortnightly meetings take place.</p> <p>The role of the FTSUG in Jersey continues to evolve. The National Guardians Office (NGO) in the UK oversees FTSU in England. Whilst Jersey sits outside this, the role of the FTSU in Jersey is in line with practice of FTSUG in England. Strong relationships and mentorship have been developed with other FTSUGs and this has been beneficial regarding the setup of the service.</p> <p>The overarching aims of FTSU is that staff have a safe space to speak about things that are impacting on their ability to do their job and also enable the service provider to provide a safe service. The limits to confidentiality are explained before any disclosures once an individual approaches the FTSUG. The limits of confidentiality exist to protect individuals and ensure that any safeguarding issues or issues that harm or compromise safety can be addressed.</p> <p>If an individual is happy to continue, the FTSU makes notes during the discussion which are typed and sent back to the individual. Individuals are anonymised in the report. The reports are stored by number (rather than name / issue). A FTSU Datix form has been developed and provides another mechanism for individuals to raise issues. Once submitted, these forms are only seen by the FTSU. In addition, the information can be stored secured in Datix. Datix also facilitates the analysis of themes.</p> <p>The themes arising from FTSU disclosures (also including areas), must be reported back into HCS so that improvement can be made. Whilst areas may be identifiable, individuals are not.</p> <p>Since the last FTSU board report, the Chief Nurse has been identified as the Executive Lead for FTSU. An Executive Lead for this service is in-line with National Guardians principles and guidance. The role of the Executive Lead is to be the champion to support FTSU and cultural change.</p>	

<p>There are two aspects to the role of the FTSU. Firstly, the interpersonal meetings with staff and secondly, the more proactive side including what is speaking up, how can this be developed, how can staff be encouraged to approach their managers to speak up and empowerment of managers to be open to understanding and listening and learning from staff.</p> <p>The difference between confidentiality and anonymity were explained. Individuals are assured confidentiality. However Datix offers the opportunity to report concerns anonymously (identity would not be known by the FTSU). However, anonymous reporting means that feedback cannot be provided which can lead to feelings of futility.</p> <p>CB also advised that Board that some staff give their permission for the FTSU G to speak with the Executive Team about issues raised. However, the Executive Team will not be approached if permission has not been given.</p> <p>AMN noted that key to FTSU is trust, recognising the courage it takes for individuals to raise issues. In addition, when addressing the wider issues around FTSU, the FTSUG is placing trust in the organisation to work to resolve any issues. The only time an individual will be identifiable to anyone other than the FTSUG is when they have given their express permission to do so.</p> <p>CB recognised that FTSU whilst FTSU is an important way to raise issues, staff also regularly approach the Executive team directly to raise issues. In his 12 months at HCS, CB has a sense that more people are coming forward to raise concerns and some of the issues addressed daily are because of concerns being raised. It is an important part of improving the safety for patients and improving experience for staff working in HCS. The FTSU service in larger organisations will be led by a team of FTSUG so the ongoing peer-to-peer contact with other FTSUG is supported.</p> <p>CD advised that when FTSU was introduced in England, they were treated with cynicism regarding their independence which probably reflects similar behaviours in Jersey. However, this has been overcome with time and FTSUGs are seen as a positive. Reflecting on her observations as an NHS NED, CD noted the success of the relationship between the FTSUG working with the NED Lead for FTSU, providing direct support. The NED Lead for FTSU is Dame Clare Gerada. It is important that the FTSUG has enough support to enable the job to be carried out and protect the independence of this role. CD advised that the Board should be very vigilant to maintaining the independence of the role and seen to be independent.</p> <p>CD further advised that the Board should receive an annual report from the FTSUG. The FTSU Report at a Birmingham Hospital Trust resulted in the hospital being put into special measures (despite good medical outcomes) and the replacement of the Chair of the Board and senior executives. Recognising that this is unlikely to happen here, a culture and environment must be created for the FTSUG to operate in the same way as other FTSUG elsewhere.</p> <p>Recognising that the role of the FTSUG must have the trust of both staff and senior managers, AH stated that the Board needs to be assured that AMN is confident that the role can be carried out.</p>	
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Questions from the Public	Action
<p>No written questions submitted in advance.</p> <p>Member A: Regarding finances and pharmacy, member A reflected on a recent hospital admission where her own medicines were discarded and reissued from pharmacy. In addition, some medicines were missing. What a waste of money. In addition, there were two pharmacist on the ward and why are two required given the long queues for outpatient pharmacy?</p> <p>Response: PA agreed this sounds like a waste of money. CD noted that pharmacist have to be present on the ward and without knowing the detail, there could have been two as one of them was in training or a pharmacy technician. CD thanked member A for raising the issue of wasted medicines and this will be reviewed by CB and OH.</p>	

Member B: Mainly observations from today and previous meetings. Firstly there has been a lot of debate and discussion regarding recruitment process and recruitment, however there are a group of doctors who have entered the recruitment process who have advised that the advert was incorrect and six weeks into the process, the applicants are unaware of the outcome. Surely, efforts should be made to retain these staff?

Second observation is in relation to appraisals. Whilst it is good to see the work underway, a lot of clinicians / managers feel under a lot of pressure to get these done and feel it is a tick box exercise – the focus on individual performance is therefore not what it should be, and this undermines the appraisal process. Also the use of corporate objectives does not necessarily enhance an individual's development.

Thirdly, regarding finance, member B urged the Executive Directors to scrutinise the way in which overtime / locum shifts are authorised. Member B states that a couple of Consultants in specific areas have raised this and that often, the most appropriate resource is not used i.e. a higher grade is used when a lower grade could be used. These things can be managed through good operational management.

Response: Regarding recruitment and retention, CB noted this was unacceptable and asked BN to discuss member B after the meeting.

Regarding appraisal and objective setting, CB advised that the quality of an appraisal is hugely important, and it cannot be a tick box exercise with objectives that are meaningless to people. CB referred to the work that PA is doing to improve doctor appraisal.

OH advised that one of the key workstreams of the FRP is a focus on rota compliance. The rotas are scrutinised 6 weeks in advance to ensure that they are safe, appropriate and follow financial disciplines. CD advised that this may be the role of the individual Executive leads to ensure that the right people are being overtime and that there is no favouritism (which creates disharmony). PA aware of these issue raised, and this is being addressed.

Member C: Following the resignations in pharmacy last month, how will these people be replaced noting the current recruitment process (possibility of gaps in service).

Response: CB responded that additional staff for pharmacy have been agreed and any gaps will be covered by agency / locum until substantive recruitment has taken place. However, this is a known hard to recruit area.

Member D: Member D described her current recruitment process: an interview was held in May 23 and returned to Jersey (from Jersey) at end July with no rota / no contact / no job role. No accommodation arrangements had been made (luckily able to go to her parent's house). Several other doctors have taken a job elsewhere as they have received no communication regarding Jersey employment. In addition, member 2 had a further interview over a month ago and to-date has received no communication as to what the plan is from August 2024 onwards.

Response: CD invited member D to attend the People and Culture Assurance Committee in May to discuss her experience of going through the recruitment process. Also invited member D to bring anyone else along with a similar experience. CD wants to understand in detail what individuals are personally experiencing going through the recruitment process. CD acknowledged that a lot of this will relate to the broader system rather than HCS, however, the NEDs need to know the root causes so this can be raised appropriately.

CD emphasised that if these functions come back to HCS (HR / finance), they must be done really well. Therefore listening to people's experiences is very important. CB noted it may be worthwhile inviting the Chief People Officer to the assurance committee meeting.

Member E: Sought a point of clarification regarding the meaning of culture issues in maternity.

Response: PA responded this is predominantly about the way people interact with each other, both within professional groups and between professional groups. It is about respecting each other's skills and staff being able to feel that they have a voice to either raise concerns or relay

<p>their point of view. CD clarified that this is an issue in maternity units across the UK and not unique to Jersey.</p> <p>PA also advised that whilst this some of this is due to individual behaviour, it is also about the environment that HCS creates as an organisation within which they work. It is about what HCS provides and includes some of the issues discussed today such as appraisal and people feeling valued.</p> <p>CD reflected that people often say that middle managers are not fully capable in many organisations and questioned the role of leadership in creating an environment where middle managers can flourish. It is incumbent on everybody, particularly the Board, to make sure that HCS is an environment where people can thrive.</p> <p>CD thanked all those in attendance and for their contributions.</p>	
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MEETING CLOSE	Action
Date of next meeting: Thursday 30 May 2024	

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