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

Health and Community Services

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

Board Members:		
Tom Hayhoe - **CHAIR**	Chair of the HCS Advisory Board	**TH**
Carolyn Downs CB	Non-Executive Director	**CD**
Anthony Hunter OBE	Non-Executive Director	**AH**
Dr Clare Gerada DBE	Non-Executive Director	**CG**
Julie Garbutt	Non-Executive Director	**JG**
Chris Bown	Chief Officer HCS	**CB**
Mr Simon West	Deputy Medical Director deputising for Mr Patrick Armstrong MBE, Medical Director	**PA**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Bill Nutall	Director of Workforce	**BN**
In Attendance:		
Dr Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Obi Hasan	Finance Lead – HCS Change Team	**OH**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (TEAMS)	**CS**
Emma O'Connor Price	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Sarah Gunn	Senior Project Manager Picker Institute (Item 7 only) (TEAMS)	**SG**
Alex Rawet	Picker Institute (Item 7 only) (TEAMS)	**AR**
Washington Gwatidzo	REACH representative (Items 13 and 14 only)	**WG**

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

TH welcomed all to the meeting and advised that whilst he was present for the last meeting, this is the first meeting as Chair.

For the benefit of those attending, TH advised that the board members could be identified by a sticker on their name plate. However, the material impact of this is only regarding the issue of a formal vote (and in practice, a vote is rare).

Meeting is quorate.

Apologies received from:

Professor Simon Mackenzie	Medical Lead – HCS Change Team	**SMK**
Beverley Edgar	Workforce Lead – HCS Change Team	**BE**
Mr Patrick Armstrong MBE	Medical Director	**PA**
Jessie Marshall	Chief Nurse	**JM**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**

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

No declarations.

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

The minutes of the previous meeting held on 29th February 2024 were agreed as accurate.

4	Matters Arising and Action Tracker	Action
ACTION 128: Patient Advice and Liaison Service website has been updated detailing the scope of the PAL service. The service will be officially launched in the coming weeks to ensure clear signposting of how the team can help and support patients, relatives. We are continuing to work on the services provided and will be able to provide further updates in the coming months. We are looking into Martha's Rule and how that might look in Jersey, but we are at early stages of this work. In addition it was noted that Deputy Ward and other members of the Ministerial team visited the PALs service yesterday. Agree **CLOSE**. **ACTION 127:** CP confirmed that the culture dashboard will be presented to Board in June 2024. Remain **OPEN**. **ACTION 126**: Awaiting the ministerial priorities. Represent April 2024. Remain **OPEN**. **ACTION 125**: AW confirmed that meetings have taken place between Mental health And Acute Services. A summary of this can be presented to the board in April 2024. Remain **OPEN**. **ACTION 121**: Meeting between CG and CT to discuss remote physiotherapy opportunities to be confirmed. Remain **OPEN**. **ACTION 119**: EOC confirmed that the Royal College of Surgeons (RCS) Terms of Reference (ToRs) have been added as an addendum to the minutes of the previous meeting and are available through the website. Agree **CLOSE**. **ACTION 118**: Rheumatology reporting will come through the Quality, Safety and Improvement Committee. Agree **CLOSE**. **ACTION 103**: CB advised this is a complex issue and work is being considered. This will form part of the ELT programme work to ensure that the appropriate governance arrangements are in place. Agree **CLOSE**. **ACTION 96**: The number of ACPs is to be increased – currently there are a small number in post. However a Project Lead has been appointed with start date 1st July to the position of Practice Development, Advanced Practice and Independent Prescribing who will support the further development of Advanced Clinical Practice across HCS in line with new NMC regulations due 2025/26. Anticipate an update after July 2024. Remain **OPEN**. **ACTION 85**: The Theatre utilisation dashboard shows consultant level public / private split. This is monitored by the clinical productivity workstream. Agree **CLOSE**. **ACTION 31**: OH advised that Treasury have confirmed that budget holders should have access to the budget data by end April 2024. Remain OPEN.		

5	Chair's Introductions	Action
TH summarised initial plans for how the board will operate in the future, specifically addressing increased public and service-user engagement. - The introduction of a patient story at the start of future meetings as is common in other health care jurisdictions. This can include carers / staff story). The patient story helps to ground the board and remind board members of their purpose. Due to issues of confidentiality, this item will take place privately 30 minutes before the start of the meeting proper. A summary of themes can be provided afterwards. - The Quality, Safety and Improvement Committee and the People and Culture Committee will be meeting bimonthly rather than quarterly.		

- In the absence of a Non-Executive Director (NED) with a strategic / finance background, the Risk and Audit Committee has not been established. Recruitment to this role continues. - To reach as wide an audience as possible, a panel of the board will be taken to different communities around the Island at times to maximise attendance. In addition, organisations around the Island will be invited to host these. This has been discussed with the Minister for Health and Social Services.	

6	Chief Officer's Report	Action
CB advised that the paper is a summary of the collective papers and provides an overview of key issues within HCS from his CEO perspective. The paper was taken as read and all points were verbally summarised. In addition: - Attention is drawn to the achievement of Donna Murphy who won the National MyPorter Awards: International Porter of the Year Award. - All patients who completed the Picker Institute Patient Experience Survey are thanked for the time and effort taken to complete this. CG is keen to understand if there are further solutions to address the issue of queues in hospital pharmacy. During the last meeting, the funding streams for prescriptions were discussed and how current arrangements limit patient choice, an unacceptable but complex situation which is being examined by the ministerial team. Noting the reference to reducing the ADHD waiting times, CG asked what services have been reduced to fund this, particularly those that do not receive media attention. Is the media driving prioritisation of services? AW confirmed that there is no reduction to any other service in relation to the work that is being carried out regarding the ADHD waiting list. Work is being done within the current resource. The money is not the issue, but the difficulty of obtaining the specialist clinical resource required to do this work. In response, CG asked if funding is available to support other services such as the community stoma service. CB explained that there is limited financial resource and if funding is increased in one area, it must be reduced in other areas. There is no planned growth money from Government of Jersey (GOJ) for 2024. AH thanked CB for the report which provides a "view from the bridge" at the beginning of each meeting. It is encouraging to see the Jersey Care Commission (JCC) reports on social care services and provides a strong foundation to build the relationship needed with the care sector over time as we greater understand the population's commissioning needs over the next 5 -10 years. Working in close collaboration with partners across sectors will be a crucial element of achieving Jersey's ambitions.	

7	Patient Experience – Picker Institute Results	Action
Sarah Gunn (SG) introduced herself as the Senior Project Manager at the Picker Institute who led the team which delivered the 2023 Patient Experience Evaluation in Jersey. SG was joined by Alex Rawet (AR), Head of Service Delivery who had oversight of the evaluation. The Picker Institute is an International Charity working across health and social care and measures experiences to uncover incidence of excellent and poor healthcare delivery. Work is focussed on supporting organisations to improve the quality of care provided. A ten-minute presentation was delivered (slides are an addendum to these minutes) which includes details of the methodology of the evaluation. Outpatient users were included in this survey for the first time. Today, the internal benchmarking for the nine core questions included in all five surveys will be presented. The response rate is shown as a percentage and represents the proportion of completed surveys of the total invited to participate. Overall, there were 1486 respondents from a sample size of 5727 (26% response rate). This has declined from the 2022	

response rate which was 32% but this decline is not unique to Jersey. The Care Quality Commission (CQC) survey programme in England has recorded a downward trend in response rates across all surveys in recent years.

Additional information can be found in the publicly available report which will be published in the coming weeks.

TH thanked SG for the presentation and invited questions.

Reflecting on his experience as an NHS Chief Executive Officer, CB advised that he would have been delighted to have received this set of results which are extraordinary. CB asked if there is any formal benchmarking against the NHS in the formal report. SG advised that there will be a publicly available report published in the next couple of weeks which will include all 21 core questions with full internal benchmarking and top and bottom scores for service specific questions against the CQC.

CD suggested that benchmarking against similar healthcare organisations would be useful, such as Guernsey and / the Isle of Man. CD noted that the results are largely brilliant (noting some in the 90s) but HCS should not be complacent and there is always room for improvement. Noting the response sample of 28%, CD asked what a representative sample would be. In addition, is the general decline in response rates due to people feeling disheartened that they provide feedback but do not see any change as a result. Is there a better way to conduct surveys so they are more inclusive and representative?

AR responded that Isle of Man do not run this programme currently, so benchmarking is not possible. However, if this changes, Picker will ensure the relevant people are in touch. The reason for the decline in responses is likely to be multifaceted and part of it is most certainly where people provide feedback but do not see how this is translated into service improvement. To promote inclusivity, future iterations could include more digital options, but this will depend upon system functionality and data sharing (telephone numbers / email addresses). The Picker Institute utilises the same methodology as the CQC in drawing a sample of 1250 respondents. However, as the maternity population is much smaller (especially in jersey), a full census is done. For Maternity, this is representative in the sense that everyone was invited to take part. It is not realistic to survey all users of other services. A comparison has not been done between these results and the overall sample provided by HCS. This can be done, but Picker uses a random sampling method which produces a very high likelihood that the results will be very close to a representative demographic. This additional analysis can be done by the Picker Institute on request. CD noted that the results are a representative view of the community because of the methodology used and this is fine. SW noted that the number of respondents has increased from 2022 (1364 to 1486). AR stated where outpatients has been included, more people have had the opportunity to provide feedback across a greater range of services.

CG noted that the Picker Institute is a very well-respected organisation and will take these results at face value. Noting that those with a poor experience are more likely to respond by paper and those with a good experience are more likely to respond digitally, the results are likely to be better here. However, noting the dissonance between what patients are experiencing and what the Board is beginning to understand as the quality of care, CG advised caution. It may be the case that some patients are not aware of how poor a service they are getting in comparison to other places. As an example, if a patient receives a medicine they have asked for medicine which is note evidenced based, they are likely to be happy about this. Conversely, if they did not receive the medicine, they are likely to be unhappy. It is important that the Board reflects on this and for different patient populations, their experience may get worse as the evidence for their care gets better (as in Rheumatology).

Noting the imperative for any Board to spend time looking at where things have gone wrong, AH saw these results as very encouraging, especially the 99% favourable response regarding kindness as this is often what is remembered (over and above clinical quality). Nevertheless, AH

is looking forward to hearing where the opportunities for improvement are and how these results can be even better.

Reflecting on his experience as Chair of mental health services, TH noted that mental health organisations tend to experience lower patient satisfaction figures. However, despite being lower than the other services measured, the HCS feedback is good. Noting the question regarding staff contra-indicating each other, TH was particularly concerned regarding maternity services (38% favourable response) and advised this is an area of focus. Considering the challenges that are sought to be addressed through the Maternity Improvement Plan, CB advised this is a statistical reflection of the issues that exist within Maternity services.

TH thanked SG and AR for the attendance and looks forward to the benchmarking data. However, reflecting on previous experience in both the public and private sectors, this data is good. There are successes to celebrate, though equally areas that are not as good as they should be.

8	**Quality and Performance Report (QPR) Month 2**	**Action**

CT guided the board through key highlights in the report.

Elective Care

- Patient waiting >52 weeks (inpatients and outpatients): A decline can be seen in those patients waiting the longest. This is consistent with the recovery plans which have been presented at previous board meetings. There has been focus on some speciality waiting lists such as cataracts and patients have begun to receive off-island care. The feedback from these patients has been broadly positive. Within outpatients, there has been focus on the group of patients who have been waiting less than a year. A proportion of those seen as outpatients will convert to inpatients which has happened, and this can be seen in the data. The impact of the extra resource introduced in mid-February 2024 will hopefully be seen in the data during the next couple of months. During January and February 2024, 200 more operations were undertaken than in the same period 2023, these have been a mix of emergency and elective procedures.
- Access to diagnostics: this is a new metric for Jersey. Diagnostics is part of the whole pathway of care and numbers within this category have reduced by 100 in-month.
- New to follow-up ratio: This ratio is decreasing which is positive and has been a focus in the clinical productivity workstream.
- Outpatient Did Not Attend (DNA) Rate is reducing.
- Was Not Brought (WNB) Rate is reducing.
- Theatre utilisation is improving.
- The theatre flow improvement group have developed a dashboard and the impact of this is expected to be a reduction on the number of operations cancelled by the hospital on the day for non-medical reasons. There have been bed pressures during January and February 2024.

Emergency Care

- HCS has experienced winter pressures; during February and early March 2024 there was a particular issue with norovirus which increased the demand for isolation rooms. The ambulatory care unit has been co-located on the acute admission unit (AAU) and, whilst additional capacity was delivered, capacity was lost on AAU. However, this is part of the response to the Royal College of Physicians (RCP) report.
- % patients waiting in the emergency department for more than 12 hours has increased. However, some of these patients will have been discharged from the ED to avoid hospital admission.
- Inpatient movements between 22:00 and 08:00 for non-clinical reasons is reducing. This was a key concern raised for patients.

- Total bed days delayed transfers of care (DTOC): there is a data reporting issue, and a different data source is reviewed weekly by Chief Operations Officer – Acute Services and Director of Mental Health Services and Adult Social Care.

CD asked if the issue of harm reviews for those waiting for long periods has been resolved. CT responded that as part of weekly Patient Tracking List (PTL) meeting, the Head of Access, General Managers and clinical leads ensure that all urgent patients are listed and seen. In addition, a clinical review is requested for those who have been waiting to ensure confidence that no harm has occurred. SW added that within orthopaedics a group of patients have been reviewed in the long wait clinics, none of whom have come to harm.

Mental Health and Social Care

- In areas where there are significant waits, there is a meeting with the clinical team to understand the assessment pathway and the appropriate use of resources to ensure that everything possible is being done to speed the process up. This review was undertaken at the beginning of 2023 with the autism service and the outcomes of this are now being seen. It is pleasing to note this month that there is a reduction in waiting time for Jersey Talking Therapies (JTT) for both assessment and treatment. The assessments have always been carried out very quickly and the wait was for treatment. The autism waiting list is on a downward trajectory.
- An improvement trajectory has been developed for the Memory Assessment Service and some additional resource has been given to the service. The current forecast is the achievement of a steady run rate (assessment and review within 6 weeks) for dementia assessment by Oct 2024 (at the latest).
- Access targets continue to improve. 91% in crisis were seen face-to-face within 4 hours and this significantly exceeds the 85% standard.
- 93% of all routine referrals were seen within 10 day working days. In 2022, people had to wait 5 months for initial assessment, so this is a remarkable achievement for the Crisis and Assessment Team.
- Delayed discharges for mental health: unable to include the data this month due to a data quality issue.
- ADHD: The position continues to deteriorate month-on-month, the reasons for which are well known. There are a range of solutions being explored including additional clinical activity, review of the assessment pathway and a review of those on the waiting list. Conversations continue with primary care regarding shared care arrangements.
- Adult social care (ASC): the two metrics have been well achieved in February 2024. There are a number of other indicators for ASC which are being considered for inclusion within this reporting framework.

CG noted the hard work in achieving the improvements noted today and congratulated the teams involved.

Building on the improvements, TH asked when reporting will record those waiting > 6 months rather than > 12 months (52 weeks). Secondly, TH noted his concern regarding the % of adult inpatients who have had a VTE risk assessment within 24 hours of admission. CB is in agreement that the data is poor and reflects the position of the NHS 15 years ago. SW stated there is a difference between the assessment being carried out and the DVT prophylaxis being prescribed and administered. There is evidence to show that DVT prophylaxis is being prescribed and administered, i.e. it is the assessment / recording of the assessment that is not occurring. This is compounded by a mixture of both digital and paper-based assessments. One solution is to ensure that the digital assessment will not allow progression until the assessment is completed – this functionality is due to be switched on later this year. In the meantime, the requirement for this assessment is being communicated.

CB asked CT if the impacts of the insourcing and outsourcing initiatives will be seen in the Q2 2024 data. In addition, is there confidence that those initiatives that are not yet live, will have a positive impact reflected in the SPC charts – CT confirmed this.

SW highlighted that the increase in patient safety events per 1000 bed days is positive and means that staff are recognising and reporting incidents. The important thing is to compare this to the number of serious incidents which is decreasing. The promotion of governance across HCS is showing a positive impact. TH echoed this and advised that within high-risk industries who have implemented robust safety cultures, incident reporting is regarded as positive.

9	**Workforce Report (Month 2)**	**Action**

TH takes the paper as read and invited BN to highlight any key points.

- Vacancy rate remained the same.
- Turnover rate decreased, both in voluntary and in leavers headcount.
- Sickness rate increased with this categorised as gastrointestinal and cough / colds.
- The number of appraisals and objectives competed has increased from 8% in January to 15.2% in February (despite turnover and increased sickness absence).
- The medical vacancy rate has decreased from 16% in Dec 2023 to 12% in Feb 2024. There are still 34 vacancies medical vacancies to fill, some of which are in known hard to recruit areas such as Child and Adolescent Mental health Services (CAMHS) and dermatology. A proposal will be taken to the States Employment Board (SEB) in April 2024 which is part of a Workforce Attraction and Recruitment and Retention Package.
- Nursing vacancies have reduced from 155 to 143. Of these 143, 86 have been appointed and awaiting clearances. Therefore the net vacancy rate is 57. Between April – June, hoping to have cohort recruitment (10 per month) through specialist nurse suppliers and recruitment agencies.
- Entering discussion with a specialist medical consultant recruitment company.
- The recruitment initiative 'Refer a Friend' is live. This is a scheme where local people can refer a friend to HCS for a post and earn £1000.00 (50% payable at commencement of role and 50% on completion of the probationary period).
- The recruitment mapping process (non-medical recruitment) has reduced significantly, from 120 -140 days to 60 – 90 days.
- Looking to improve the onboarding process, including transitional accommodation and increasing engagement during the first 9 months of employment.
- The new Talent Acquisition System (hiring system) will be rolled out across HCS by 21st April 2024 and going live on 22 April 2024. A review of the pilot delayed this from end March 2024.

CG congratulates BN on the metrics that are improving. Recognising that the data may not be to hand, CG asked for the ratio of International medical graduate ratio to graduates from the UK / Jersey – i.e. is Jersey reliant on International graduates for nursing and medicine? BN responded that the data is not to hand but this an area that should be explored further as anyone looking to further their career in Jersey represents a good opportunity and links to colleges / universities should be strengthened. CG asked if primary place of qualification is recorded. BN estimates that most of the staff are from the UK but recognises this may not be accurate. SW advised that there is a broad cross section of staff with the vast majority of junior medical staff and Consultants coming from the UK. However, there are staff who have come from Holland, Germany and France.

CD echoed CG's congratulations on the improving metrics. Noting the reduction in recruitment time by a third which will be associated with a third reduction in locum costs, what reduction has been recovered as part of the financial recovery plan (FRP)? The reduction assumed in the FRP is phased as a continual reduction. There are two processes, time to hire and then onboarding. Over a two-year period, the FRP assumes an 80% reduction in agency through recruitment. Whilst acknowledging the two-year approach is sensible, there are savings to be made this year and the work required must be done quickly to bank the savings. CD asked if the £6 million (or part of) for this year is at risk and would it be sensible to consider taking a risk and investing to speed up the process, for example investing £200,000.00 with an achievement of £3miilion savings? Recognising this a decision cannot be made now (and may require Ministerial approval), CD asked whether this is a risk that may be worth taking.

OH confirmed that there is a risk to the FRP delivery and is due to the processes taking longer to reduce the time to hire and onboard people (which is fundamental to replacing the expense of agency staff). Consequentially there is a likely slippage delay to reducing over expenditure that HCS is currently incurring. It is important to note that this is a slippage and the opportunity to deliver is still there. The action suggested by CD is the type of ambitious and entrepreneurial action needed to change the current rate and pace. TH summarised that to bring forward savings, there are invest to save opportunities. OH confirmed this, particularly as most of these processes are out with the control of HCS.

CB confirmed that during 2023, ten vacant Consultant post were filled, and the number of junior doctors and clinical fellows were expanded, and the Deanery asked Jersey to take on more trainees. This increased the junior doctor tier by 35 FTE medical staff. This is a significant improvement although further work is required.

ACTION: Invest to save options to be explored and brought back to the next meeting (April 2024).

10	Finance Report (Month 2)	Action

OH advised that the report covers the year-end outturn for 2023, and the financial position for January and February 2024.

Outturn 2023 Position
The 2023 year end outturn deficit was £32.5m which is a £6.5m variance against the forecast. The main factors driving this were,

- Staff cost pressures during winter with exceptionally high agency spending *Nursing and allied healthcare professional (AHP)) in Q4 due to significant additional hours being worked than forecast.
- Higher activity resulting in additional spend on expensive oncology drugs.
- Late recognition of costs for travel and accommodation due to system processing delays.
- High inflationary costs of mental health placements and social care packages.

M1 and M2 2024 Position
The financial position for year-to-date (YTD) M2 is a £5.1m deficit versus budget giving a headline monthly run-rate of £2.5m. Adjusting for one-off items and non-recurrent costs, the underlying run-date is £1.2m.

The one-off items include back pay for Doctors following job planning and exceptional operations (Operation Crocus) although HCS is anticipating funding for this during 2024. There are also payment timing issues.

FY24 Year-end forecast
The current FY24 year-end forecast is a deficit of £18.0m before additional mitigating actions are taken. The key factors driving this deficit are,

- Cost pressures due to budget funding constraints identified when completing the FY24 budgets of £7.5m.
- Risk of FRP saving slippage due to delays in enabling support to ensure timely delivery of an estimated £6m. As highlighted in the FRP plan, which was published in Sept 2023, there are some key dependencies to ensure full delivery of the planned FRP savings of £12m. These include receiving dedicated central HR / recruitment and procurement / commercial contracts support and resources to deliver the key FRP schemes with large savings.

  Any delays in this support becoming fully functional by March 2024 is likely to result in slippage of achieved savings to the following year making it unlikely to be recoverable in year and so requiring additional savings this year to remain within the required budget

constraints. However this is a timing delay, and the savings still projected to be delivered in FY25. There are also additional cost pressures which materialised at year end in FY23. - Mitigations include getting the required resource into place (reference previous discussion in item 6) and requires direction from the Board. Noting that the board is not decision-making, the advice from the Board to Ministers is to support exploration of invest to save opportunities for HR to accelerate this resource. JG suggested a similar approach could be taken for required procurement resource and this was supported by the Board. In addition, increasing grip and control measures by implementing strict controls on pay and non-pay, driven and supported by monthly finance budget accountability meetings. Additional FRP mitigation schemes include income maximisation, enhanced bank to eliminate overtime, workforce attraction package, HR team leading on accelerating recruitment and time to hire and non-pay procurement and commissioning (the latter two require central resources to support). CG advised that best way to reduce costs is to reduce demand and empower Primary Care i.e. reduce upstream activity by increasing downstream activity. CG asked how far the FRP is engaging the Primary Care workforce. CB reflected that GP s have not been specifically engaged but there are opportunities to do so, for example through the Primary Care Board. Noting the procurement challenges, AH stated that this is not unique to Jersey and whilst recognising the work already underway, there is further work to do to develop relationships with the care sector.	

11	Quality, Safety and Improvement Committee	Action
Paper noted (this follows the verbal summary at the previous meeting). No questions.		

12	People and Culture Committee	Action
No verbal update provided as the meeting only took place yesterday - a summary paper will be presented to the Board next month.		

13	Cultural Change Programme	Action
WG in attendance for items 13 and 14 only as the REACH representative. WG is a member of the HCS SLT meetings. CB thanked WG for his commitment and work in the REACH programme which is in addition to his substantive role as an assistant general manager for Medicine. CP takes the paper as read. The main focus of the paper is leadership which is the engagement factor in the BeHeard Survey that had the lowest score. Consequently, the need to develop leadership at all levels within HCS is a priority. A GOJ wide leadership programme for senior leaders has commenced and this diversity strengthens learning and acquisition of knowledge regarding leadership. In addition to this, an additional programme will be developed for leaders sitting under the SLT. Engagement continues with staff using a number of different approaches/methodologies and engagement levels are increasing. Feedback from staff includes a perceived lack of action following issues being raise; one such change not noted in the paper relates to the lack of private breast-feeding facilities for staff to enable staff to return to work following maternity leave – consequently, a room has been refurbished in the outpatient area that can be used by both patients and staff to privately breast feed. There has also been a focus through Q1 2024 on diversity and inclusion. WG explained that following the Board meeting in October 2023, a working group was set up to support HCS to move to an organisation that embraces diversity and inclusion. The group also undertook an		

anonymous survey over a two-week period to understand racism experienced by staff working within HCS.

85 responses were received. The key headlines from the survey include:

- 49% believed racism was a problem in HCS.
- 30% had experienced racism in the last 12 months.
- 50% had experienced racism from clients/patients.
- 54% had reported these incidents to the employer when it had happened.
- Of those that had reported only 35 were satisfied with how the employer managed it
- 53% of those that responded to the survey described themselves as white.
- Staff with ten different ethnicities contributed to the survey.

A summary of the themes identified, and actions was provided (all detailed in the report).

CB thanked WG and advised that a key issue for the Board is to make this public anti-racism statement (Appendix 1) and for the Board to endorse this course of action.

ACTION: Board members asked to feedback any comments on the statement to CP by Tuesday 2 April 2024.

CD thanked CP and WG for this work and noted that the survey results are deeply shocking (noting this is not an issue specific to Jersey). CD advised that if HCS makes this statement, it is imperative that HCS delivers against this. In time, as the employer, HCS should make clear that prosecutions will be sought as the law permits this. CP responded that alongside the statement, a poster has been created which delivers the key messages, one of which is reporting to the Police. JG in agreement with all CD's points and advised that the board should formally endorse this statement (specifically the Board, the executive and the SLT). CG also in agreement and referring to an earlier point, it would be useful to understand the breakdown of International Medical and Nursing graduates. Next steps should also include some positive initiatives (to promote and foster diversity). In addition to the above, AH welcomes the Board being challenged appropriately, i.e. modelling what we expect of staff throughout the organisation.

DECISION: Subject to any feedback (regarding wording of the document), the Board endorses the anti-racism statement.

Referring to the Cultural Change Programme, JG expressed concerns as to whether HCS had the capacity to implement this (noting other change programmes underway). CB responded this is recognised, however, there are (limited) gift funds that can be used specifically for this type of work. As the change programme is likely to take a minimum of five years, recurrent funding will need to be considered.

BN noted that the leadership is very important as this has been identified by Professor Michael West as the single and most important influence on culture. HCS now has the opportunity to consider what kind of leaders are required at the various levels within the organisation. JG sought to confirm that the leadership programmes that are being pursued involve clinical staff. CB confirmed that the leadership programme is funded by central GOJ, and clinicians (both medical and nursing) will be participating. The majority of the staff within the leadership structure are clinicians. TH advised caution against losing sight of the real importance of frontline managers and also what can be learned from other professions.

AH advised that cultural change must start with the Board; we need to be visible promoting and modelling culture change, including challenging ourselves.

14	**Anti Racism Statement**	**Action**
As above – included in item 13.		

15	Maternity Improvement Plan	Action

SW advised that the paper serves to provide information and assurance as part of the continuing maternity improvement programme.

Since the last HCS Advisory Board, further progress has been made:

- A further three recommendations have been approved by Women and Children's Senior Leadership Team as complete. Topics from these recommendations cover fire audits, reporting processes and perinatal mental health 2024 training and education calendar.

- Picker Institute survey. The discrepancies noted for Maternity Services need to be reviewed as an Executive Team particularly where patients are receiving contradictory information from staff.
- Culture Improvement Plan events have been confirmed as part of a rolling programme within this service.
- The Maternity Improvement Plan was presented at the Women's and Children's Inset Day (12 March) and is due to be presented at the Maternity Away Days (14 and 21 March).
- The Maternity Dashboard has been developed further.

Of the 127 recommendations, 96 have been completely signed off. There is a programme of 30-, 60- and 90-day reviews to ensure that each recommendation is embedded within business-as-usual activities; to date, 70 out of 99 recommendations have completed 30-, 60-, 90- day follow-up reviews, evidencing ongoing embedment of recommendations. The remaining 29 have not reached the 30-day mark yet.

CS reinforces the points made by SW and the key issue is the ongoing improvement and commitment to the MIP evident through the 30 / 60 / 90-day review. CS attended the multi-professionally inset study day which is a very positive way forward.

16	Mental Health and Capacity Legislation	Action

AW advised that this paper is an assurance paper from the Mental Health and Capacity Legislation Oversight Group chaired by AW. It refers to activity for Q4 2023. Key headlines include the number of unlawful detentions, the use of Article 36, the use of restrictive practices, changes to relevant legislation and other issues (all detailed in the paper).

CB asked AW if he is confident regarding completion of Maybo training by staff. Noting the different levels of training, AW explained that the vast majority of staff are trained to release themselves. There are also staff who are trained to a higher level and finally the staff in the inpatient mental health service are trained to physically restrain individuals (to give medication) and this is the highest level of restraint. AW is confident that the highest level of restraint training is completed in areas required, though further work is required in HCS (including the general hospital). This work has started to look at which staff are trained and to what level and how do we ensure that there are always enough people who are appropriately trained to respond safely in an emergency.

JG welcomes the work regarding SROL as any delays in these assessments prevents individuals from moving to appropriate care settings, thereby creating a safeguarding issue. There are also registration implications for care settings. AW advised the current position is not unusual and when the legislation was introduced in the UK, there was a rapid increase in applications and the capacity to authorise these was limited. In addition, there are issues with the applications and currently more than a third of applications made are rejected on a basis that the application has not been made appropriately. JG offered continuing support. AW advised that a detailed plan is being produced by the Chief Social Worker.

17	Winter Plan 2023 Outcomes	Action

CT takes the paper as read and draws the Board's attention to some key points including the key metrics used to monitor performance and the reasons for variance in the KPIs. In summary, there has been learning which will inform winter planning 2024 and overall it has been a reasonable winter period. AW added that mental health services had a winter plan and the issues experienced are comparable.	

18	**Delayed Hospital Discharges**	**Action**
AW explained this paper is presented at the request of the Board. AW provided a comprehensive summary of what delayed transfers of care (DToC) means, the current position, the reasons and the actions underway (all detailed in the paper). CD thanked AW / CT for the paper. CD noted that discharge-to-assess has increased social care costs in the UK and if this is implemented in jersey, the budget needs to be considered. Secondly, noting the issues with dementia care, CD reflected on her own experience of running local government services in Shropshire and stated that the only way of managing care costs was to intervene in the market (building care homes and intermediate care beds). Step up / step down beds should be an immediate intervention and the longer-term financial implications of intervening directly in the dementia market should be considered. Referring to the financial pressures, OH in agreement. CB noted that finding the staff on-Island to care for these patients will be a challenge. JG declared an interest (runs two non-profit care homes in Jersey). JG makes the point that Jersey is not purely a commercial environment for care; developing the whole system approach should include the non-profit sector. Also, there is the absence of an island wide strategy for caring for older adults and keeping them well in the community (this includes access to appropriate housing) – this needs to involve housing policy makers and housing providers. AH thanked AW / CT for the report. In a meeting with some social workers yesterday, AH noted their reference to a need for a holistic approach to meeting individuals' needs, and that we operate too much as they put it "in silos". It is in this way that people can be helped early and prevent need for hospitalisation in the first place. Jersey has the opportunity to be an exemplar of how person-centred care can be planned and delivered. AW confirmed that HCS meets with colleagues in housing to explore ways of working together to help resolve some of the DToC issues. The Dementia Strategy (will be launched shortly) creates a whole Island focus on dementia, rather than just health and social care. On some days, there can be up to 16 individuals receiving 1:1 care from support workers and need to consider how this resource can be utilised differently.	

19	**Quality Account**	**Action**
The Quality Account is presented to the Board for endorsement. DECISION: The Board endorsed the Quality Account.		

	Questions from the Public	**Action**
Member A: *At the Panel meeting held on the 19th March it was said that discussions were to be held the next week with GPs representatives regarding compatibility of their systems with that proposed for the hospital. Please advise what progress was made, at whose cost will it be and when is the likely implementation of Primary Health Care within the system?* **Response**: The meeting took place on 26 April 2024. There will be further meetings with the project team over the coming weeks and ensure that the Patient Panel will be update with the outcome of these meetings. CG noted (as a GP) that she is not aware of any place with		

interoperability with secondary care systems. Whilst this is a good idea, the focus should be on individuals having access to their own notes through an App.

Member A: *It was the hospital that put forward the proposal for an electronic system which could be seen by patients and the people who put it forward said they were having these discussions with GPs so they could merge the two systems.*

Response: CB responded that he was unaware of the outcome of yesterday's meeting.

Member B: *Statement – the leadership development for cultural change. The simplest thing to change is that managers at all levels should answer emails of concern when healthcare workers / clinicians raise them. If they email you with a concern, you reply out of common courtesy. Secondly, for the FRP, procurement is a bureaucratic mess leaving the hospital without equipment on many questions. Thirdly, want to congratulate frontline workers despite the low morale of the hospital. Question – there is a rumour (that I would like to try and quash) that nurses who are asked to fill in gaps in the rota who are currently paid overtime may have overtime payment rates reduced. The effect of this will be to reduce morale further and increase reliance on agency staff which is going to cost even more. Finally, there is an advertisement for HCS of a grip and control manager with a salary of £70k. What is a grip and control manager?*

Response: CB in agreement that emails should be answered. However, need to bear in mind that some of these people will receive circa 300-400 emails / day. CB noted the balance between being visible on the shop floor, attending meetings and answering large volumes of emails is difficult to achieve. However, emails should be responded to. Managers also include ward manager, lead nurses and clinical leads.

Regarding the overtime, OH noted some misconception regarding the payment arrangements. The reason for incentivising substantive staff with an enhanced bank rate offer is that currently they do not get this. Most additional hours worked (one of the biggest cost pressures) are by agency staff; this is not a good position, as overtime payments should go to substantive staff, i.e. those permanent staff employed on a daily basis. The offer will made to everybody, rather than just a few people which is what currently happens. In doing so, the rate must be affordable (noting it is still an enhanced rate). Whilst there may be differing views, staff have been consulted and the feedback has been reasonably positive. Areas of concern are being addressed, particularly those areas where it is difficult to get staff. In summary, this is a positive way to incentivise substantive staff that currently do not get these additional hours. CT advised that good rota management (six weeks in advance) means that gaps can be filled much earlier with advantages given to substantive staff. The principles are reducing the amount of money spent on agency, increasing spend on bank staff and enhancing the rate offered to substantive staff.

Member B: *What about sickness which cannot be anticipated?*

Response: To ensure a balance between covering the shifts and controlling the spend, the order is bank, overtime and agency. Both CT and member B confirmed not looking to reduce staff morale.

Regarding procurement, OH confirmed these are historical issues and HCS has put an effective troubleshooting arrangement in place to manage these supplier relationships. There are still cases that arise, but these are much less frequent and are resolved very quickly.

Regarding the grip and control manager, this role is connected with the FRP and is detailed in the plan published during 2023. The frontline teams do not have the capacity and require support to deliver the improvements required which includes grip and control (roster management and all the disciplines required to control the spend on rosters). The Programme Management Team (PMT) is the resource agreed to work with frontline teams to deliver the improvement programmes. Noting his 25-year experience of delivering financial turnaround in healthcare settings, CB advised the level of resource that has to be committed (albeit temporarily) to deliver the savings. Of the total amount required to save, approximately 1-2%

need to be committed to the management of the FRP (also dependent on size of organisation, the maturity of an organisation to accept large scale change, and the sophistication of clinical leadership). Change will not happen without this investment. There is a level of skill and expertise required and the market for these skills drives the price. TH confirmed this is a fixed term post. CT referred to her experience in other organisations that have dedicated improvement capacity to support key pieces of work. This is a resource that HCS has not had until recently. This capacity allows progression of work to improve care and support financial turnaround. **Member C**: *Regarding the current situation in our pharmacy department following several resignations within the last week, could we please be advised if this has been logged on HCS risk register, how is this risk register categorised and how is this risk categorised and managed.* CB advised that there is a meeting this evening regarding pharmacy. SW advised that risks are scored according to likelihood and impact and scored out of 25. A risk of 25 is very high and is categorised as red – descends from here. There is no specific risk regarding pharmacy but there is a general risk regarding staffing in general i.e. the ability of the organisation to run due to availability to key staff. **Member C**: *There are now not pharmacists available on the wards and I would say that the hospital is running at what I would class dangerous level. Would this be given a risk score of 25?* SW advised that we do not yet understand why these staff feel that the hospital is running at a dangerous level and that there are patient safety risks. The most important thing is to meet with the staff (x 3) at 5pm and understand their concerns. If there is an immediate patient safety risk, then mitigations will be put in place straight away. If a risk needs to be recorded to reflect an ongoing risk, this will be done and scored accordingly. **Member C**: *Noting that pharmacy has been highlighted as a difficult to recruit to, we should be doing more surely to retain staff – there is obviously a problem. With exit interviews, some staff are reporting that exit interviews are not offered and that some are being offered by the staff with whom they are having difficulty with them. Exit interviews should be carried out independently.* **Response***:* It was confirmed that exit interviews are carried out through to Connect. CP advised that the freedom To Speak Up guardian is aware of issues in Pharmacy and will be attending this evening's meeting.	

	MEETING CLOSE	**Action**
TH thanked everyone in attendance, and, in the spirit of openness and transparency, it is important for people to be aware of the issues facing HCS. **Date of next meeting:** Thursday 25th April 2024		