Health and Community Services Board Meeting Notes

Date: 8th November 2021	Time: 2:30pm-5:00pm	Venue: Main Hall, St Pauls Centre, Dumaresq Street, St Helier

Board Members Present:		
Richard Renouf (Chair)	Minister for Health and Social Services (HSS)	RR
Trevor Pointon	Assistant Minister for HSS / Chair of the Quality and Risk Assurance Committee	TP
Hugh Raymond	Assistant Minister for HSS / Chair of the Operations, Performance and Finance Assurance Committee	HR
Caroline Landon	Director General HCS	CL
Patrick Armstrong	Group Medical Director HCS	PA
Robert Sainsbury	Group Managing Director HCS (Item 7 onwards)	RS
Rose Naylor	Chief Nurse	RN
Steve Graham	Associate Director of People HCS	SG
Anuschka Muller	Director of Improvement and Innovation	AM
Michelle Roach	Head of Finance Business Partnering HCS	MR
Adrian Noon	Associate Medical Director for Primary, Prevention & Intermediate Care	AN
Paul Rendell	Principal Social Worker (Adults) deputising for Isabel Watson, Associate Group Managing Director Adult Social Care & Mental Health Service	PR
Claudine Snape	Chief Executive Officer (CEO) Dementia Jersey	CS
Patricia Tumelty	CEO Mind Jersey	PT
Rosemarie Finley	CEO Family Nursing and Home Care (FNHC)	BW
Fiona Brennan	CEO Brighter Futures	FB
(jointly referred to as the "Board")		
In Attendance:		
Emma O'Connor	Interim Board Secretary	EOC
Beverley Edwards	Head of Informatics HCS	BE
Louise Journeaux	Head of Communication HCS	MWh
Sarah Keating	Baby Friendly Initiative Project Lead (Item 3 only)	SK
Hilary Lucas	Acting Chief Operating Officer	HL

Please note: *Minutes have been numbered in accordance with Agenda. Some items may have been taken out of agenda order.*

Item no.	Agenda item	Action
1	**Welcome and Apologies**	
	RR welcomed all to the meeting noting that, • CS attending the HCS board for the first time as CEO Dementia Jersey • LJ had returned to HCS as Head of Communications. **Apologies were received from:**	

Name	Role	Initials
Isabel Watson	Associate Group Managing Director Adult Social Care & Mental Health Service	IW
Dr Matthew Doyle	General Practitioner	MD
Mike Palfreman	Chief Executive Officer Jersey Hospice Care	MP
Mark Richardson	Private Secretary to Minister for Health and Social Services	MR

Item no.	Agenda item	Action
2.	**Declarations of Interest**	
	No declarations made.	
3.	**Professional's Story**	

	SK introduced herself as the Project Manager for the implementation of the Baby Friendly Initiative standards (BFI) who also provides the complex feeding specialist support service, based in FNHC, working with Health Visitors (HV) & Midwives. A series of slides has been produced (annexed to these minutes) & SK provided a reflection as to how the service has changed through COVID, how the work of the operational group has adapted & how this has impacted breast feeding rates in Jersey. • The Operational group is a group of Professionals (HV / Midwives) & mothers. There is no representation from fathers, but the group is open to all who wish to be involved. The group has a focus on the following, – Promoting & supporting the implementation of the BFI standards within the clinical setting. – The normalising & promotion of breast feeding within the wider community. – Exploration of alternative ways to support breast feeding following the suspension of Midwifery face-to-face visiting during the pandemic. – Maintaining communication in response to a rapid escalation in questions from parents: is it safe to continue to breast feed? What would happen if mother contracted COVID? Does milk contain the virus? Emerging information was discussed through the operational group & used as a conduit to disseminate evidence at pace, ensuring that midwives & HV had the most-up-to-date advice. Social media channels were also used. This work was supported through the clinical settings by BFI champions. – The assessment of breast-feeding in the absence of face-to-face visits: this was a challenge. UNICEF facilitated the delivery of education to enable midwives to assess this virtually (using a screen), increasing the skill sets of HV & midwives. – Supporting mothers & babies with tongue-tie to continue to breast feeding following the suspension of the frenulotomy service. – The breast-feeding buddies group moved to a zoom platform to allow parents to share experience & advice. – Unable to celebrate International Breast-Feeding week as previous years due to COVID restrictions. However, in collaboration with Sophie Darwin, 27 pictures & stories of staff & breast-feeding mothers were shared on social media. The campaign was a success with more than 50,000 views over the week. – A 5% increase was noted in the rate of exclusive breast feeding to 6 months (2020). This occurred during a period where face-to-face support was not available due to COVID & demonstrates how the adapted service has continued to deliver. RR thanked SK for the presentation, commenting it was inspiring to hear how the service successfully adapted during the COVID period. RR asked SK what the primary reasons are for a mother choosing to stop breast feeding. SK responded that there a variety of reasons including loss of mother's confidence regarding an adequate milk supply, lack of support & wanting to involve fathers by using a bottle. SK emphasised that work is required to empower mothers, providing tools for the mother to assess how well baby is thriving. RN thanked SK & asked how the figure of 75% (2020 initiation / total given any breast milk) compares to other jurisdictions. SK responded this is comparable to the UK, the Jersey rates at 6-8 weeks are slightly higher than the UK & the 1-year figures are much better (23% compared to the UK figure of 2%). RN advised that anecdotally the midwives on Maternity ward felt that they had more time with mothers to focus on breast feeding due to the impact of COVID on visiting. There is some work to build on how this good practice continues to be supported, acknowledging that BFI level 1 accreditation has been achieved & working towards level 2. AM asked if there was any data available for 2018 / 2019 & how this compares. SK responded that this is comparable & that a noted increase in 6–8-week breast feeding rates approximately five years ago may be linked to the introduction of the MESH Programme (an intensive HV Programme). RR thanked SK for the presentation & wished the initiative every continuing success. SK left the meeting.	
4.	**Minutes of Previous Meeting**	

	EOC advised that a correction was required in the December 2020 minutes. Rather than *the board reviewed the minutes of the previous meeting held on 12th October, which were agreed as an accurate record,* it should state *the board reviewed the minutes of the previous meeting held on 19th October, which were agreed as an accurate record.* This amendment was **AGREED**. The minutes of the previous meeting held on 9th August 2021 were **APPROVED**.	
5.	**Matters Arising and Action Tracker**	
	Matters Arising Referring to the minutes of the 9th August 2021, RR asked SG if the issue related to Junior Doctors has been resolved. SG responded that the new contract for Junior Doctors will be implemented on 1 January 2022 with NHS Gateway Doctors in place to support the rotas, ensuring compliance with the new contract. Regarding the *readmission rate* (refer to page 7 of Board Pack), HL advised that herself & BE have commenced a piece of work to look at the readmission pathways. For information, readmission is used to facilitate rapid discharge from the hospital, rather than keep individuals in hospital, those that can be discharged are & asked to return to an ambulatory setting: this is accepted as part of normal healthcare practice. However, this data is included within the *readmission rate* & must be extrapolated. CL commented that the *% discharges before midday* is good, however, the *readmission rate* is presented as being high. This raised the question at the last HCS Board as to whether individuals were being discharged too soon. However, the work done so far (including audit) has indicated this is not the case so able to provide the Ministerial team with assurance that individuals are not being discharged too soon. An area identified for improvement is the support provided following discharge & HCS will be commissioning this piece of work. In response to RR's question, CL / HL advised that a breakdown of the *readmission data* should be available for the next HCS Board. HL further commented that readmissions not related to the primary discharge are also included within this indicator. CL asked AN to comment on ambulatory services & pathways in place. AN commented that this reflects how Medicine is changing as many of the conditions previously requiring admission for a period, no longer do so. For example, Cataract surgery is now a day case procedure where previously a lengthy period of admission was required. The changes in technology mean that individuals can be managed differently & moving to ambulatory care pathways is more beneficial. Action Tracker **SL to link in with FNHC & provide support re: TEAMS** – RR advised that an update has been received & the Business Partner for Digital health has met with FNHC. There is a piece of work regarding the ITS programme with ongoing discussions taking place. RF advised that although not complete, progress is being made. On this basis, RR suggested that this is closed on the action tracker but advised RF to report back to Board if any further difficulties encountered. Agree **CLOSURE.**	
6.	**Chair's Report**	
	COVID-19 Ministers recently announced the Winter Strategy, recognising that cases are likely to rise over the winter & the imperative is to prevent hospitalisation. There is a focus to ensure that those eligible for vaccination do so. Vaccines will be made available in schools to make it easier for those eligible under the age of 18 years. Other measures continue including mask wearing, distancing where possible, hygiene measures & limiting places that are visited, particularly if mixing with large groups. Rather than impose mandatory measures, Islanders are being asked to consider the above. RR asked HCS Board members to encourage this.	

	Hospital Funding There has been an important debate regarding the funding of the new hospital & RR pleased with the result. RR thanked HCS Nursing & Medical staff who came forward with their letters of support which had a significant impact upon States Members, reinforcing the urgency of moving to a new hospital. Assisted Dying RR advised of the upcoming difficult debate regarding assisted dying. HCS & The Government of Jersey (GOJ) do not have a stated position. RR has provided his personal view as States Deputy but will not be adopting this position as Minister for HSS. RR advised this is something which requires very careful consideration. Government of Jersey Plan The following States session will see the discussion of the GOJ Plan. Fiscal Stimulus The fiscal stimulus is money provided by Treasury to support the COVID recovery. The Help at Home initiative has been launched to recruit individuals as carers into the domiciliary care market & support the development of additional skills to existing carers. Following COVID, there has been an increased interest in the care professions & RR hopeful that this initiative will be successful. This funding is also supporting work regarding long Covid & developing a system to address this & support people experiencing long COVID symptoms. Rehabilitation Services RR advised there has been local discussion regarding rehabilitation services, acknowledging there is a petition which remains unanswered as still exploring the detail of the service (including a visit to Samares Ward). RR advised seeking assurance that services continue to be delivered to the same standards as previously, not withstanding the venue change. Visits RR advised that he had visited CS at Dementia Jersey to further understand the work of the charity & the challenges facing those living with dementia. The work regarding the Dementia Strategy must be escalated. RR has also visited Brighter Futures with the Assistant ministers for HSS & thanked FB for the hospitality of the service. The increased demand for the service during COVID & how this was successfully met was discussed. Brighter Futures encouraged to develop a plan to meet this increased demand & RR hoping to see this in the future. RR invited questions.	
7.	**Director General's Report**	
	Our Hospital CL continuing to working closely with the Clinical & Operational group regarding Our Hospital. The group meets monthly to understand how the new Hospital will function clinically: there has been good engagement, particularly around pathways & ensuing the provision is appropriate for Islanders. The work of this group has accelerated following agreement of the funding. Jersey Care Model The Jersey Care Model is progressing with a robust project team in place, led by Dr Anuschka Muller (HCS Director for Improvement & Innovation). Building our own resource / knowledge centre means less reliance upon external consultants. Workstreams are in place across the Island health & care system which will be shared as these progress. Winter Planning Winter planning has been taking place & RS will providing an update later in this meeting. Anticipating this will be a difficult & all HCS staff have, & continue to be encouraged to have the COVID / flu booster to provide the greatest possible level of protection for staff & patients as we go into this period. BeHeard The response to BeHeard (staff survey) work continues as HCS aspires to be the employer of choice. The Executive Lead, Anne Robson, has now completed a 6-month contract issued to	

	initiate this work. Dr Cheryl Power (Wellbeing Lead) has taken over this piece of work, supported by Dr Adrian Noon. <u>Wellbeing Week</u> HCS held its first Health & Wellbeing week with a range of activities available to all individuals working in the care sector. This was welcomed by staff, however, feedback included that next time, staff need to have more notice with clearer communication regarding what is on offer. This was a good start & something HCS would like to host regularly as part of the Health & Wellbeing work, including all partner provider organisations. <u>Allied Healthcare Professionals</u> The first forum, led by the Chief Nurse, provided an opportunity for all therapists to get together & start working as a united professional group. This was a great experience & it was encouraging to hear all the work undertaken. This will be hosted every 2 months <u>Governance</u> Continuing to work on the governance structure & seeking to appoint a Director of Quality & Safety for HCS. <u>Digital</u> Time spent with Digital Jersey learning about the digital advancements being made across the Island, in particularl the workstreams that will impact upon how health & care is delivered remotely & responsively for patients. <u>Executive Walkarounds</u> The Executive team continue weekly visits around HCS. Staff are encouraged to discuss the impact of the pandemic, reporting that that they feel tired, how difficult the past two years have been & continue to be. HCS staff have not worked from home during the pandemic & continue to come to work every day, now dealing with the challenges arising from the pandemic. This is a reminder as to how fantastic that the workforce across the Island is. RF asked what HCS's position is regarding staff COVID vaccinations, specifically whether it is mandated for those caring for vulnerable people. RN advised that the current position is voluntary rather than mandated. However, colleagues are encouraged to take the vaccine which has been made available. In response to RR's question, there are statistics available as to the number of healthcare workers that have received a vaccine. RN advised it is approximately 98% uptake for 2 doses & AN advised approximately 60% for three doses. CL noted the concern of the community, but staff do have the choice & highlighted that there is very good PPE provision that all staff have access to. Staff will be protected as best as possible but need to be able to make this choice. RR supportive of this & noted that this is of interest due to the mandated vaccination position in the UK. However, as the data suggests a very good uptake in Jersey, it should remain voluntary.	
8	**Performance Report**	
	A slideshow was presented by RS, supported by the Group Medical Director (PA) & Chief Nurse (RN) regarding the quality indicators, BE supporting the technical questions & HL supporting the performance improvement initiatives. • Increased activity can be seen within services. The number of deliveries has increased compared to previous month. The Emergency Department (ED) has seen its busy period of activity over the last month, however this has not resulted in a significant increase of admissions to the ED department & the conversion rate for admissions remains relatively low (positive indicator). Staff have done well to manage this level of increase in pressure. • A slight increase in elective admissions has been noted with an increase in day cases, which is positive. • The number of patients stranded with a Length of Stay (LOS) over 7 days has slightly reduced but remains at a level that is starting to cause some issues regarding overall patient flow. • Outpatient referrals have slightly increased & also seen an increase in outpatient first appointment waiting list. • An 8.5% increase in patients attending the Emergency Department is seen. However, the admission rate & conversion rates remain low. There has been a focus on the readmission rate within the ED & working with Head of Informatics as the data requires further	

integration to understand whether this captures those who are not readmitted as a overnight stay, rather presenting to the hospital for an intervention (ambulatory care).

RN addressed the Quality Indicators & advised that further work has been done to determine the standards, some of which are based on 2019 (pre-pandemic) averages.

- The number of C-Difficile cases is red as a larger number of cases have been seen this year compared to 2020. A root cause analysis (RCA) has been done on each of these & findings in all cases include the appropriate prescription of antibiotic & no evidence of cross-contamination.
- The number of falls resulting in harm is also red. Work continues to address this & RN provided assurance that each of these cases resulted in low level harm such as a bruise or skin tear. This data includes all HCS services such as long stay wards & adult Mental Health Services, in addition to the General Hospital.
- Concerns remain regarding complaints performance. An improvement workstream has been set up with a meeting having already taken place.

Regarding outpatients, RR asked which areas are most challenging & what is in place to address this. RS advised that a lot of increasing activity is seen around community facing services: Community Dentistry, Orthodontics & Physiotherapy. RS asked HL to comment on the approach to this as targeted work has commenced, building on the general work across the waiting list management overall.

HL advised that the Patient Tracking List (PTL) for outpatients is being monitored in two separate cohorts: community pathways & acute hospital. Within the acute hospital, there are two specialities where waits have increased significantly during COVID: Physiotherapy, & Trauma & Orthopaedics. If the growth in these areas was discounted, the waiting list for outpatients would have reduced in the acute setting.

Firstly, targeted work has begun in Physiotherapy including a review of pathways & how these can be streamlined to release additional capacity to treat patients more quickly. RN is the Executive sponsor & now three weeks into a six-week rapid improvement programme. Significant opportunities have been identified to effect change & during this period, the waiting list has reduced in excess of 100 patients (approximately 10% of this service). RN advised that following the six-week Task & Finish, the staff involved are already planning the improvement reviews for early 2022.

Secondly, Trauma & Orthopaedics has seen significant growth. This pathway overlaps with the Physiotherapy service & the Improvement & Innovation team are reviewing how this can be radically transformed whilst working towards the Jersey Care Model. Inefficiencies have been identified within the current approach so reviewing the pathway & linking with wider primary care colleagues & digital opportunities to advance, anticipating this will be transformed swiftly for the benefit of patients. RR commented that the anticipated improvements are encouraging & thanked those involved.

Regarding the Maternity dashboard, CL commented it was encouraging to see the number of home births increasing which supports the position of only seeing complex births coming into the General Hospital.

Regarding the *new to follow up ratio,* CL noted that the position was declining & asked what plans are in place to address this. HL responded that data concerns have been identified through the PTL sessions. The Head of Informatics is reviewing this to ensure data is as robust as possible. However, Physiotherapy, & Trauma & Orthopaedics are significant contributors to this high first to follow up ratio & the pathways are being reviewed as above.

CL noted that ED is busier & this is impacting upon service-user experience: *time to triage / time to commence treatment,* & specifically those *waiting for more than 10 hours.* HL advised that the Clinical Lead for the ED & General Manager for Medical Services Care Group undertake a daily review of those service-users wating in the ED longer than ten hours with the aim to reduce this. A variety of reason have been identified including escalation & real time communication. There are also data changes & data requiring validation. For assurance, the Group Medical Director & Chief Nurse have asked their deputies to review these patients on a daily basis. CL asked AN if this was related to a delay in obtaining a speciality opinion or lack of senior decision-making. AN advised this multifactorial & relates to processes that need to be streamlined rather than a lack of capacity / capability. In addition to the admission pathway, there is also minors activity in the majors area & this requires process improvement.

	CL understood the data for falls would be split to show those falls observed / unobserved. RN responded that the capture of the data was under review & being progressed by the Falls group, in addition how the different levels of harm are presented. Regarding the increased numbers of those admitted under the Mental Health Law, PT asked if this is under review & if needed, MIND would be happy to support this. RS commented this support would be helpful & advised a review is underway. Early indication from October data is that the number of applications has decreased. RF advised that FNHC (Rapid Reablement Response Team / District Nursing) had a meeting with Ambulance Service this morning to understand how they could work together differently to prevent individuals being transferred to hospital following a fall, particularly those who have not sustained harm but require support in the community to prevent further falls. There are approximately 1600 calls / per year for falls which accounts for 19-20% of all 999 calls. This would reduce the pressure within the ED. CL commented that this is a collaborative piece of work & asked RN if there was external representation on the HCS Falls Group. RN advised that the focus of the work presently is the updating of the guidelines according to National Guidance but welcomed the support of FNHC in increasing the breadth of this piece of work. RN commented that the CAS alarm system previously meant that those who suffered falls in the community were well connected to the Occupational Therapy (OT) services & whether this could be reignited with the Therapies Lead. CL suggested this indicates the need for a more system wide quality dashboard as there is co-creation work towards finding solutions in these areas. RR welcomed this as it will continue to ensure that individuals are supported to be as independent & safe as possible within their home environment. CL advised this is a piece of work for the newly appointed Director of Quality & Safety (once appointed). HR's understanding is that any calls relating to falls transfer through to Ambulance / Police / Fire control room & noting the previous conversation, are the right questions being asked at the time of the call being made. HR advised that there are ongoing discussions as to whether this is Police / Ambulance matter. RS noted that the Jersey Ambulance Service (JAS) have highlighted that a large proportion of this activity should not be directed to the JAS & working with partners to explore how the correct referral pathways can be determined. RN advised that the alarm system is crucial as the first line of response. RR asked what the alternative is rather than the ambulance service responding to a fall, RS advised that as standard practice Care Agencies respond to alarm related calls. RR further enquired if these staff worked on-call & RS advised not, but arrangements are in place to ensure a response within certain hours, noting a gap in the unsocial hours when most of the calls then redirect to the 999 service. RF feels that the resource to manage this is available & need to reorganise to ensure working in a way that is responsive to need. Falls represent 5 calls per day (average) & there should be a rapid response to enable individuals to get off the floor & not rely on the JAS, which is what is happening at the moment. CL asked if further work is required to prevent falls & general agreement that this is the case. AN noted that often those who are admitted to the ED following a fall, have had preceding falls & there is more that can be done in the community to prevent admissions. RR noted that the Quality and Performance Report was published for the first time following the last HCS Board meeting & asked members if in agreement to publish this report. It was **AGREED** to publish this Quality & Performance Report.	
9.	**View from the Bridge (Partner Organisations)**	
	<u>Family Nursing and Home Care (FNHC)</u> As the new CEO, RF explained that much of the last few months has been spent understanding the service, getting to know staff & meeting with partner organisations. Time has been spent with Nurses & Therapists in the community to look at the care being delivered & identifying a needs-based approach to care. Also looking at how organisations come together to deliver joined up, more connected care. The CEO Charities Forum will be meeting for the 2nd time to look at the needs of the charities & how can highlight / raise awareness in a more effective way. Working with the Children & Young People's Service as to how to link with Paediatricians & hospital services to address issues such as BFI. As an example of a quality improvement initiative, if a mother was mix feeding but baby not weight gaining then paediatricians were prescribing formula milk for the baby but as baby discharged into the community, breast feeding	

reduces. Need to work together looking at a better solution to improve the breast-feeding uptake & prevalence without the need for prescribing formula.

Rapid Response Service is in its infancy & a lot of development work required, including hospital discharge & admission avoidance which will help to support flow through the hospital. Gaps have been identified within the workforce, largely around therapies & this has an impact upon rehabilitation / reablement work that needs to be delivered in the community. However, excellent practice & joined up working has been identified.

RR thanked RF for the report & work to-date & question invited. CL commented that the CEO Charities forum is much needed initiative. CL noted that the charities sector is very diverse & delivers a breadth of care but agrees that this is not joined up as much as it could be. RR noted this is a valuable section of health care provision in the Island.

Jersey Hospice Care
Apologies sent by MP (report appended).

MIND Jersey
PT summarised the main points detailed in the paper. In addition,

- A strength-based approach was taken to understand what is working well & what more is required.
- 48 recommendations came out of the report & it is important to roll out the areas of concern highlighted.
- One key theme relates to the need for services to become more humane again as there is a concern that the focus has been on effectiveness. However, this is a global issue within Mental Health / Mental Illness. There is now real opportunity as the Mental Health Improvement Board (MHIB) needs to be revisited & a new MH strategy needs to be developed: mental health partners are keen to progress these.
- One further theme is the need for a bridge between public sector & the community / voluntary sector. Good work occurring in both spheres, but it is not joined up.

RR noted it was disappointing to hear that the close connection between public & voluntary sector is missing & hopes that the structure can be put in place to improve this. PT in agreement & noted that there is so much good practice & learning to share. There is also the risk of duplication where work is not joined.

CL asked what the plans are for the MHIB. PT advised that her understanding is that this has been paused & Professor Peter Bradley has agreed to Chair when it recommences. Meeting with community & voluntary sector & also asked for representation from the voluntary sector. CL will discuss this with Peter Bradley. PT also welcomed advice / guidance about how to make the recommendations visible & talked about.

RN thanked PT & regarding the last point raised in the paper, *ongoing need to increase public awareness of the distinction between mental wellbeing, mental health & mental illness – we need a whole service / community action plan for this,* has this work started. PT advised this is part of an action plan that would come from the strategy, however, whilst waiting for the strategy, there is work that can be started. PT advised that there is a risk that individuals who are having a normal reaction to everyday worries are medicalised & those that really do need the help, do not get it. RN advised that a recent media interview wanted to focus on sickness levels. However, GOJ categorise stress / anxiety & depression as one category, but there are clear distinctions between these.

Dementia Jersey
CS explained that like RF, spending time during first 6 months understanding the dementia landscape within Jersey & thanked RS for his help to-date.

- There are double the number of people trying to book an apointment with a Dementia advisor. This could be due to brand awareness following the name change March, in addition a backlog of appointments for diagnosis at Memory Assessment Service (MAS). GPs are also referring to the service. A third advisor has been recruited to enable meeting this demand, but this will need to be monitored. CS noted that HCS had reviewed what could be done to reduce the delay at MAS & advised this was appreciated.

	• Trying to understand the economic impact of Dementia on Jersey including how carers are affected. However, this is a struggle due to the way data is captured (or not) in Jersey. Because of the emphasis (political) on dementia in the UK at the moment, there is a dementia strategy. Why is the approach to Dementia different in Jersey compared to the UK? Does this need to be escalated up the political agenda? There is a commitment to a Dementia Strategy within the Jersey Care Model & the work that started in 2018 has since paused. CS keen to understand who has the responsibility of taking this forward. AM advised that the dementia strategy is a key item for the JCM next year & whilst Improvement & Innovation team is not clinically leading on this, they will facilitate developing the strategy. AM / CS will meet to discuss the inclusion of CS within this piece of work. • RS noted that ahead of the work in 2022, further data analysis is needed. This is imperative as seeing a high volume of older adults admitted to secondary care who go on to long term institutional care & dementia is usually one of the primary reasons. HCS will work with CS & BE to start to think about how the activity can be understood. RR asked if the delays in the MAS continue & if this is covid related. RS advised that there are long delays within this service as it is an area of growing activity, however, there will be a focussed improvement plan. RS explained that this has been compounded by COVID but it is an area where rapid assessment is required. Like the conversation regarding Falls, need those older adult rapid access & frailty services to provide more timely assessment. In response to RR's question, RS advised there are good levels of staffing in terms of medical support for this service but looking at how additional capacity can be moved into this area. CL advised that a lot of this work is carried out by Primary Care in the UK & this is a timely piece of work as trying to avoid acute admissions into hospital due to the increased impact this will have upon a person with dementia. RR asked CS to continue to provide progress update on issues highlighted at future Boards. General Practice MD sent apologies. Brighter Futures • FB advised continuing to operate at increased levels of clients with an increase in MH / wellbeing issues within the families coming forward. This increase is linked to Covid. • Increase in professional users of the Bridge building which is causing issues as space is limited. RB thanked Minister / Assistant Ministers for their visit. For clients who are already struggling, the physical building presents additional challenges & individuals have been known to turn away due to difficulties in access. Currently exploring the possibility of an additional building to run services from as unable to continue to operate at the current level or expand to accommodate need at The Bridge. • Unable to run events due to COVID restrictions which this has affected funding.	
10.	**Winter Planning**	
	RS advised that there is an annual winter planning process which covers the period 1st November 2021 to 31st March 2022. The plan builds on previous winter experiences (incorporating learning) –approximately 5 years unscheduled activity which is reviewed. HCS working closely with Public Health (PH) colleagues to understand the Covid modelling expected & the impact predicted in relation to flu. The key objectives for this winter plan particularly going into the 2021-2022 period, is a drive to sustain & ensure continuity of the planned scheduled care function: there is a clear objective to sustain this activity going in to winter. Multiple different workstreams developed & presented on a slide. • One of the main objectives is to drive further admission avoidance which has been well supported by Primary Care & Community throughout 2021. AN has been working closely with GPs to develop & support different ambulatory pathways. For example, increased diagnostic provision to support respiratory management which is a key area of focus. There is a very skilled Community Specialist Team & looking to build on this throughout the winter period, supported by faster & easier single testing arrangements around respiratory viruses.	

- The hospital is operating at levels of occupancy which are below levels of concern. However, there are pressures within acute medicine with periods of high occupancy above 85%. A key target area is improved patient flow within acute medicine bed capacity going into winter. A winter task force will be set up with a focus on improving occupancy & the improved patient flow opportunity within secondary care system, rather than simply moving to the creation of additional surge beds.
- Critical care capacity has been a key area of focus during covid & there is a good understanding of the pressures & how these will be managed if any increased activity noted in this area. Looking at how can support the early identification of any patients with escalating need within the inpatient setting.
- Looking at how to build on the acute assessment unit. The bed reconfiguration has now been completed & this has enabled specialist need to be met. The winter taskforce will be a key component for this for both Medicine & Surgery.
- New Interim Head of Physiotherapy is exploring the levels of physiotherapy support for the inpatient areas in addition to Occupational Therapy (OT) & other allied healthcare professionals.
- Working with partners & community adult social work team to explore how we ensure an early assessment for discharge from the secondary care system, building on some of the previous key successes in this area.
- Continue to work with 3rd sector support
- Ensure maximum uptake of staff vaccination as this has a significant impact upon workforce resilience & there are plans in place to ensure business continuity if encounter pressures relating to workforce absence.
- Wellbeing is another key area of focus & learning from previous waves. The Wellbeing team is working hard to ensure that build up wellbeing offer within all services likely to come under pressure.
- Perfect week initiatives will be undertaken in January. This is a well known tried & tested approach to drive improvements in patient flow between acute secondary care system & the community system. It looks at how to drive better supported discharge, how we can have better planning for patient pathways & how can focus on estimated / predicted dates of discharge in a more robust manner.
- Continue with operational & clinical hub. In addition, there is a well-tested bronze to gold structure & a clear escalation framework in terms of system status from green through to black.

HL advised there were a number of discussions at the meeting of the winter task force this morning. There are a number of medically fit for discharge which is higher than usual & having conversations with colleagues in the wider healthcare system to understand how this can be supported. However, need to revisit every aspect within the hospital environment initially. CL commented that delays around those medically fit for discharge is a recognised pressure. Also reviewed Paediatrics to explore whether there is something that paediatricians can do to support staff at front door / or a Paediatric Assessment Unit (PAU) type function to help otherwise well children who have seen a GP but require a further opinion. There is also a review of ambulatory pathways to see what can be done within surgery / medicine / gynaecology. RN / PA looking to establish a core team within the hospital who can help support patients should they outlie. HCS has committed to ensure continuation of elective care pathways in addition to emergency care & exploring how this can be done, for example, extra day surgery.

Regarding MH discharge planning, PT commented that 3rd sector charities could be included as part of this. HL advised that this can be incorporated within discharge planning & wider conversation around longer length of stay, PA / RN & deputies will be joining reviews with partners to provide scrutiny & challenge.

CL asked for assurance regarding nurse staffing & resilience across HCS. RN responded that with the exception of the known hotspots (Theatre), vacancies within the general wards have reduced to single figures following a positive period of recruitment over the summer. An updated report from MH shows there are 7 x band 5 /6 vacancies which is an improving position with further CV's being submitted. CL commented that this improving position does not reconcile with the reported recruitment crisis within HCS. RN added further that a recently published article in the BMJ spoke about the global nursing crisis & each recommended action point for organisations to consider are already in place within HCS: training staff locally, return to practice & recruitment campaigns. The local nurses have a significant impact upon posts the year they graduate & provide a steady flow of staff into both the hospital & wider community setting workforce. There is also a Social Work programme & an Operating Department Practitioner (ODP) programme running. As reported through the Council of Deans for Health, there has been

	an upsurge in the number of people who have wanted to go into nursing & social care careers with all universities reporting a significant surge in demand for these courses. CL noted it is important to provide assurance regarding the winter plan but also provide patients with assurance that services are safe & well-staffed, particularly following reports that there is a nursing crisis.	
11.	**Finance Report**	
	MR noted that the reported position as at end Month 9. • Year-to-date position: 1.1 million overspend at end September 2021. However, this is a timing issue linked to pending allocations. There is no risk to the financial outturn. • The financial outturn position remains break even & early indicative figures from November continue to show this. This is a huge achievement as 12.6 million savings have been made, recurrent from 2020. • A further 6.2 million saving for 2022 must be found & budget setting for 2022 has begun with all departments using the zero-based budgeting (ZBB) methodology (bottom-up approach). This approach is about engagement, accountability & ownership to ensure that the available funding is manged effectively, producing value for money for patients. This provides a great foundation to start managing the budgets year-on-year. CL thanked all teams across HCS for delivering 12.6 million efficiency savings by working innovatively & responsively whilst continuing to deliver good care. This ongoing transformation work allows HCS to spend taxpayers money more effectively.	
12.	**Committee Report – Quality and Risk Assurance**	
	RN summarised that the committee has covered a range of reports: monthly reports / quarterly reports / terms of reference. Key points, • The Risk Management Committee has been established & held its first meeting in October 2021, providing the platform to discuss & challenge around risks, particularly high risks. • Term of reference for a number of subcommittees have been approved. • Service improvement reports are received monthly & there will be additional areas that have established programmes next month. • The main issue regarding Datix is that the system needs to be upgraded & assurance was received regarding the implementation plan which will start early 2022. • Progress has been demonstrated against all serious incidents being investigated within the specified time frame. At the time of the report, one remained outstanding, however this has since been presented to the Serious Incident Review Panel (SIRP). The focus will now be evidencing the learning from the incidents. • Jersey Nursing Assessment & Accreditation System (JNAAS) is continuing to catch up with unannounced reviews (delayed during COVID) & on-track to have these completed by year-end. • The Safeguarding reports are now integrated with Adult Social Care & the HCS Safeguarding team. This will continue to develop & the data used to drive improvements. • Improvement work continues regarding patient experience. • Health & Safety activity: assured around progress in all areas of health & safety by a month-on-month evidenced improvements. The Health & Safety Management Risk has decreased as a result & predicted to continue this trajectory with forward plans for all areas. RR noted the reference to a lack of cubicles & following the winter planning presentation, how much of a problem does this present to IPAC & what measures are being taken. RN able to provide assurance that whilst unable to provide cubicles on five occasions, good IPAC practice ensured that no-one came to any harm as a result. However, in times of pressure, patients need to managed carefully, particularly those that need to be isolated. Advice is taken from the IPAC team & beds / cubicles are managed on a shift-by-shift basis. RN highlighted this is not a new challenge, rather an ongoing challenge presented by the physical environment. In response to RRs comment, RN confirmed this position will be vastly improved by the building of the new hospital. In response to RR's questions regarding the establishment of the pressure ulcer group, RN advised that a cross system piece of work was carried out following the outcomes of a serious	

	case review & an island wide policy for pressure ulcer management, connecting to safeguarding response has been developed. The next phase of the response within HCS is ensuring that the policy is implemented & embedded whilst FNHC also work to implement. A point prevalence study was undertaken within HCS providing an accurate baseline position of pressure ulcer management. The focus is early prevention & early detection of any deterioration in skin integrity.	
13.	**Committee Report – Operations, Performance and Finance (OPF) Assurance**	
	AM summarised the key points detailed in the paper. RR commented that he attended the last meeting of the Operations, Performance & Finance Assurance Committee & it was encouraging to hear the Care Group leadership teams presenting their data, noting the transformation that has taken place & how this has further facilitated planning of services, identification of areas of improvement & measurement of this. RF commented that services are asked to review sustainability from an environmental impact perspective & asked if this work is taking place within HCS? MR commented that this is a GOJ led strategy. RR noted that the current estate makes this difficult but once we have a new hospital, we will be in a much better position to address this. CL asked where the trajectories for the delivery of the harm reviews are monitored to provide assurance that this risk is being managed. HL responded that this is discussed at the monthly Executive Care Group Performance Reviews & the amended Planned Care Group, established as a subcommittee of the OPF Assurance committee. AM confirmed this will be reported through the OPF Committee & RN confirmed that the quality impact will be reported through to Quality & Risk Assurance Committee. MR noted from a financial perspective, it is not about managing the overspend, rather the focus to manage the budgets effectively & mitigate the underspends. HL advised that a discussion has taken place, including recruitment & how to streamline this process. SG has met with the General Managers to understand the challenges regarding delays to recruitment & will be taking these forward.	
14.	**Committee Report – People and Organisational Development Assurance**	
	SG summarised the main points detailed in the paper, • The Committee received assurance on the BeHeard survey action plan, initially led by A. Robson. Action plans are in place & this will now be led by Dr C. Power. • Nursing & Midwifery Council (NMC) endorsement for the pre-registration programmes has been received. • Work continues around keyworker accommodation which is important when considering the recruitment of staff to the Island. • The main monthly conversations focus on the workforce reports & analysing the data. The dashboards are more robust & now provide the conduit for rich conversations. • At end September, there are 131 vacancies within HCS which has reduced significantly. This is a vacancy rate of 5.3% which compares favourably to the NHS with an average of 7.2 % • Within the three clinical staff groups (Drs / Nurses / AHPS), there were 20 leavers & 49 starters. This demonstrates that HCS is continuing to close the vacancy gap. • Turnover rate of 5% which has reduced. • Sickness absence: 102 people off sick (out of 2500). Of these, 38 people are recorded as absent with designation of anxiety / stress / depression / other psychiatric disorder. Within this classification there could be a number of reasons as to why people are off & it does not distinguish between the impact of home or work circumstances. Conversations are being held as to whether this can be separated out. This number has remained stable for the preceding six months & of these 38, 29 have been absent for less than one month which indicates that the previous staff are coming back within one month. SG suggested that the wellbeing initiatives are helping people to come back to work quicker than previously & working with the wellbeing team to explore how this can be evidenced.	
15.	**Any Other Business**	
	Terms of Reference EOC advised that the terms of reference & annual work plan to implement these are due for review. EOC will meet with the Chair to develop a plan for this.	

	RR asked the Board to note that this is RS's last meeting whilst he takes up the role of Interim Director General CYPES. RR congratulated RS on this challenging role & thanked him for his contributions to the Board, wishing him luck for the future. Meeting concluded.	
	Date of the Next Meeting	
	To be confirmed.	