Health and Community Services Board Meeting Notes

Date: 14th February 2022	Time: 2:30pm-5:00pm	Venue: TEAMS

Board Members Present:		
Richard Renouf	Minister for Health and Social Services (HSS) - **CHAIR**	RR
Trevor Pointon	Assistant Minister for HSS / Chair of the Quality and Risk Assurance Committee	TP
Caroline Landon	Director General HCS	CL
Andy Weir	Director for Mental Health Services & Adult Social Care	AW
Cheryl Power	Director for Culture, Engagement and Wellbeing	CP
Claire Thompson	Deputy Chief Nurse deputising for Rose Naylor Chief Nurse	CT
Steve Graham	Associate Director of People HCS	SG
Anuschka Muller	Director of Improvement and Innovation (Item 1-9 only)	AM
Michelle Roach	Head of Finance Business Partnering HCS	MR
Adrian Noon	Associate Medical Director for Primary, Prevention & Intermediate Care also deputising for Patrick Armstrong, Group Medical Director HCS	AN
Claudine Snape	CEO Dementia Jersey	CS
Patricia Tumelty	CEO Mind Jersey	PT
Rosemarie Finley	CEO Family Nursing and Home Care (FNHC)	RF
Fiona Brennan	CEO Brighter Futures	FB
Mike Palfreman	CEO Jersey Hospice Care	GC
(jointly referred to as the "Board")		
In Attendance:		
Emma O'Connor	Interim Board Secretary	EOC
Mark Richardson	Ministerial Support	MR
Beverley Edwards	Head of Informatics HCS	BE
Nicola De Jesus	Patient Experience Manager (Items 1-3 only)	NDJ
Louise Journeaux	Head of Communication HCS (Items 1-3 only)	LJ

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 in attendance & acknowledged that TEAMS meetings can be more difficult than face-to-face, however this was necessary due to current guidance. Meeting etiquette explained.	
	Apologies were received from:	

Hugh Raymond	Assistant Minister for HSS / Chair of the Operations, Performance and Finance Assurance Committee	HR
Patrick Armstrong	Group Medical Director HCS	PA
Hilary Lucas	Acting Chief Operating Officer HCS	HL
Rose Naylor	Chief Nurse	RN
Matthew Doyle	General Practitioner	MD

Item no.	Agenda item	Action
2.	**Declarations of Interest**	
	No declarations.	
3.	**Service-User Story**	
	NDJ presented a video of a service user, Pat Bougeard (PB), sharing her experiences (both positive & negative) of accessing HCS services during COVID period as a deaf person. • Access to the Travel Office changed from face-to-face to telephone during Covid. At times, Pat was unable to book travel as unable to use the telephone & the office was closed. Pat described this experience as frustrating & upsetting. This was resolved by	

staff coming in on their day off, however what assurances are there that the email system is working for future bookings.

- Pat was contacted by mobile phone the day before a planned procedure but was unable to answer. The more the phone rang, the more stressful the situation became – had the procedure been cancelled? There was nobody to ask until the following day & Pat was informed that the ward had changed. For the future, Pat asked that she is sent an email or another alternative to a mobile phone. Pat pointed out that her medical records indicate that she is deaf & unable to use the phone.

  On arrival, Pat commented that both nursing & medical staff were fantastic with their communication.

- Pat commented that she has really good experiences & feels supported when accessing parts of the hospital such as audiology, ENT & PALS. This is because Pat knows that if she sends an email, she will receive a response. In addition, audiology offers a text meaning that Pat has a choice as to method of communication.

- Pat said that there have been issues with access & communication at Overdale as on more than one occasion, Pat's mother has been contacted. Pat said this makes her feel like she is a child & is very stressful as she aspires to maintain her independence. Pat suggested that the availability of more email (departmental) addresses could help to resolve this.

- Pat commented that the physiotherapy department at Overdale has been fantastic. Communication was mainly by writing & email, in addition, confirmation of understanding was always checked by both parties. Pat noted this as two-way relationship & how communication should always be: an understanding of each other.

- Despite being unable to participate in telephone consultation (through COVID), Pat stated that frustratingly some services continued to try & call. Pat then had to rely on other people to contact the services & remind them that Pat could not use the telephone.

- As Pat needed to have her COVID vaccine at home, she had to contact the Helpline to arrange this. Pat emailed the helpline but on three occasions, a call was made in return to her mother. Pat commented, *if I can email them, why can't they email me back?* Pat commented it is very stressful to be so heavily reliant on her mother when she wants to be independent. *What happens when my mother is not here?*

- Mask wearing: Pat said that some staff did remove their mask when she asked them to. Pat advised that being shouted at through a mask, noting eyebrow movements is not helpful to her, she was still unable to hear them. Being heavily reliant on lip reading, the use of masks makes this situation very stressful.

- Pat suggested there needs to be more awareness regarding hidden disabilities & that the telephone is not the only method of communication. Pat thanked all those who use alternative methods of communication as this helps Pat & makes things easier. Pat also noted the benefits to staff as communication must be a two-way process to build a relationship.

Pat gave her thanks for those listening to her story.

RR noted that Pat described both positive experiences & negative experiences where Pat was being unnecessarily failed. RR asked what action had been taken to provide assurances that we have learnt form Pat's story.

NDJ stated that the following action had been taken,

- Work has been carried out with different departments about the use of email addresses to provide better access to services & a preferred choice of communication for service-users.
- NDJ noted that there are areas that still need to adopt this as a method of communication.

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	RR asked why the use of email & other methods of communication cannot be consistent. CL responded that this can be consistent & the executive team need to collectively consider the best way to make this happen. CL emphasised the value of sharing patient stories at the HCS Board. Noting that the delivery of the patient story had been affected by COVID, CL asked if a library of such experiences could be built up to share if attendance affected again. LJ not assured that every HCS department has a monitored departmental email address. However, this would be simple to check & implement, meaning that service users are not always reliant on communicating with one individual. LJ highlighted that a culture change would be needed to embed this. CS asked if consideration had been given to offering deaf Islanders wider choice regarding the communication channels that suit them. In addition, has a video relay service been considered & also the use of clear masks? CT will discuss the use & availability of clear masks. Visors are an option, but masks do offer the required level of protection with the mask, where a visor may not. In response to CS, NDJ responded that all service users have access to sign video. However, whilst actions such as departmental emails can be implemented, this is about the culture change & being aware of the communication methods & needs. As highlighted in Pats story, her medical records indicate that she is deaf so whilst it is about having methods available, this needs to be complemented with training & information available to consider these needs from the outset. This is covered in the monthly Customer Care training. ACTION: CL noted that pre-pandemic, Jo Poynter (Associate Director of Improvement & Innovation), had been working with the Deaf Community & given CS's experience in this area, could a member of this team link with CS regarding this. CS in agreement to this. AM advised that NDJ is building up a library of patient stories. AM noted that these stories are also shared at the assurance committees & whilst there are specific details, these include generic items across all services within HCS & the wider Island (for all organisations). It is about how we use these information & seeing things from the service user perspective. AM thanked NDJ acknowledging the work & engagement required to prepare for these. In response to AM's question, NDJ explained that these stories were used as a learning resource on the HCS intranet but there is no reason why these cannot be shared more widely as consent has been given for this. RR asked NDJ to thank & show gratitude to Pat Bougeard on behalf of the HCS Board & that HCS has & will continue to act on the points raised.	
4.	**Minutes of Previous Meeting**	
	Subject to the following amendment the minutes of the previous meeting held on 8th November were agreed as an accurate record. • p. 15 (of 64), under Item 12. Committee Report – Quality and Risk Assurance, 2nd bullet point changed from *Term of reference for a number of subcommittees have been* ***improved*** to *Term of reference for a number of subcommittees have been* ***approved***. The slides from the professional story & the paper from Mike Palfreman, CEO Jersey Hospice care, noted to be annexed to the minutes.	
5.	**Matters Arising and Action Tracker**	
	EOC advised no actions on the action tracker. RF highlighted a matter arising from the minutes that was not noted on the agenda, *In response to RR's question, CL / HL advised that a breakdown of the readmission data should be available for the next HCS Board.* EOC apologised & will transfer to the tracker. CL unable to comment on the action detail at this time but will be added to the next agenda.	

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6.	**Chair's Report**	
	COVID-19 RR noted that Jersey has experienced the fourth wave & thanked Islanders for their response, acknowledging the anxiety this may have caused, returning to home working & the difficulties faced by those with young family & the impact of the spread through young children upon parents & carers. The plans in place for the hospital have been resilient & able to care for patients coming into the hospital without a significant impact upon other services. RR noted the statistics released which shows vaccination is key to protecting the community, whilst recognising that it does not provide a guarantee. RR pleased with testing rates as people become used to taking regular lateral flow tests (LFTs) & hopes that people do not become blasé as there is need to minimise COVID in schools where testing is crucial. As a government, trying to achieve some normality as we learn to live with covid & avoid a position where legal orders are necessary. Aiming for a position where we can react to covid in the same way as flu, exercising caution but it does not become a matter for significant government action. Our Hospital Pleased to note this is progressing. No reason that the recent planning decision not to authorise demolition of buildings has significantly set the project back. The planning inquiry will begin in the next few months & RR hopes that this will lead to the granting of a permit before this States term comes to an end. RR noted that the location of a new hospital is not the most important factor, it is about the care delivered & RR would like to see this as the focus of future discussions. Government Plan Since the last HCS Board, the States have passed the Government Plan which includes significant COVID recovery funds & fiscal stimulus, much of which will go towards health and social care. Rehabilitation Services There has been significant discussion regarding rehabilitation services. It has been rightly & readily acknowledged that we are not assured regarding the rehabilitation provision in the community & hospital. As the States have requested, HCS is working on a plan to improve the services, including the location of the rehabilitation services which includes the option of returning to Samares Ward for a period. If the planning permit is passed for the new hospital, plans have to be in place for transfer out of Samares. Options are being considered & RR will update States Members & members of the public in due course. Radiotherapy Provision There has been a recent debate regarding radiotherapy provision in the Island which is an interesting but complex subject. RR has received correspondence detailing both positive & negatives experiences of travelling off Island for treatment. RR noted that whilst it would be beneficial for Islanders to receive this treatment close to families, the achievement of safe outcomes & quality should be the determinants - a poorer outcome than currently achieved off Island is not favourable. The report is in progress. RR invited questions.	
7.	**Director General's Report**	
	CL extended RR's welcome to AW, the new Director for Mental Health Services & Adult Social Care. AW is working across all teams within HCS to be able to prioritise both mental & physical health for our patients. RS has undertaken a secondment role of Director General for Children, Young People, Education & Skills (CYPES). Claire Thompson, current Deputy Chief Nurse, is going to be covering RS's role for the next nine months, commencing 28th February. Cheryl Power has joined the meeting as the Director of Wellbeing, Culture & Engagement. CP will be arranging to meet with external partners. The long COVID clinics have commenced which have been successful, provisioning care for Islanders suffering from long COVID. The intention is to continue with these clinics.	

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	Work continues at pace to support an integrated care system, led by AM & the Improvement & Innovation team. Bed occupancy levels have been high due to increased admissions which is anticipated over the winter period. Teams have been kept informed through the weekly winter update which includes detail regarding occupancy levels, staffing and how many patients are accessing services (emergency & elective). This has been a busy winter period as patient have begun to access HCS services again following the onset of the pandemic. CL thank all staff for working through a very busy winter who are dealing with COVID whilst maintaining business as usual activity. CL also thanked all partners for their contributions care delivery would not be possible without this help.	
8.	**Quality and Performance Report December 2021**	
	RR commented that HCS Board members had just received the report & invited CT & BE to proceed slowly through the report. <u>Demand & Activity</u> • *Demand & Activity*: Increased activity can be noted through HCS, particularly during December 2021, with normal winter pressures & COVID demand. • Higher number of admissions seen in December 2021. • *Elective admissions*: during December there are normally eight days where Theatres are not operating a normal level of activity & therefore it is expected to see a decrease in elective admission rate. • *Stranded patients with length of stay (LOS) > 7 days*: Significant increase in number of patients staying within the hospital for longer than 7 days, i.e., patients who are medically fit for discharge but unable to access onward care needed. Daily rates have varied between 20-45 patients. • *Outpatient 1st Appointment Waiting List*: This data is a testament to all the hard work of staff in the significant achievement to reduce the outpatient waiting list. There has been a forward impact as some of these patients required ongoing treatment & planned care. This is demonstrated through the increase in the elective waiting list data. However, maintaining this position is a significant achievement whilst also managing significant emergency demand. <u>Quality & Performance Scorecard</u> • *% deliveries by c-section*: the number of c-sections has reduced. A significant proportion had a c-section previously & it is expected that a proportion of these would need a c-section for the second baby. There is a vaginal birth after c-section (VBAC) clinic to ensure that women who have had their first delivery by c-section, can discuss alternative birthing options. This will continue to be monitored. • *% Primary post-partum haemorrhage*: This is due to a change in medication during November 2021. Syntometrin is an effective drug for reducing PPH. However, recent NICE guidance has advised a move away from the use of this drug (due to side effects) to an alternative, syntocin. As a result, the PPH rates have increased Nationally & Globally. Month-on-month comparison is difficult as this metric will also fluctuate due to a number of variables. • *Induced labour*: a reduction noted from November to December 2021. The Women, Children & Family care (WACS) care group have introduced a new forum to provide confidence that challenging ourselves around the induction of labour, ensuring this is not done unnecessarily & understanding the reasons as to why this is being considered. • *Was not brought (WNB)*: CT plans to explore this metric further across all specialities.	

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- *% patients waiting >90 days for 1st appointment*: An increase can be seen but this metric has been significantly impacted by the Community Dental & Orthodontic waiting lists. If these subsets were removed, the overall metric would show as amber. There are a range of actions in place regarding the recovery of community dental & orthodontics which includes successful substantive recruitment & changing referral patterns. COVID had a significant impact upon dental waiting list due to the high-risk nature of dental care with aerosol generating procedures – work had to reduce & once able to open, capacity was reduced due to infection prevention & control requirements. The service was successful in receiving a significant COVID bid & working alongside partners in SPPP to commission community dental health care for children adversely affected by COVID. CT expects to see improvement through Q1 & Q2, 2022.

- *Total patient waiting >90 days for elective admissions*: a slight increase can be seen. The significant impact is from diagnostic services, particularly endoscopy. If the diagnostic element was removed from this metric, it would be sitting around 32% (amber). There are a range of activities in place regarding endoscopy capacity which includes additional sessions and exploring whether external support is needed.

- *New to follow up ratio*: benchmarking activity is ongoing.

- *Intrasession theatre utilisation rate*: BE reported that this indicator is only looking at in-patient theatres & does not include day surgery. Looking to include day surgery during 2022. However, the current patient administration system (PAS), does not have the up-to-date theatre module which enables data extraction. However, due to the introduction of the new PAS & EPR later this year, efforts are now focussed on getting this right for the new system, rather than explore the current system further. The analysis reflects the current position. A task & finish group is addressing this, of which data quality is a significant workstream – however this must be balanced with the preparation for the implementation of the new EPR.

Emergency (Unscheduled) Care

- Increase in acuity, frailty, demand for emergency care (particularly respiratory).

- The number of patients delayed at end of each period increased.

- *Rate of readmission within 30 days of a previously admitted discharge*: it is known that this data does not just describe those patients readmitted with the same concern (which would raise a quality concern regarding the discharge of patients too soon). NHS England publishes the rate of an equivalent metric at 14.4%. Whilst this means that Jersey is not outlying other jurisdictions, further understanding is needed regarding discharge practices, pathways & how to demonstrate a good length of stay across all specialities.

Quality Indicators

- *MRSA Bacteraemia*: this position has been achieved through the year & demonstrates good, consistent infection prevention control practices. There is a new Lead Nurse for Infection Prevention & Control who is progressing work to continually drive improvements.

- *C.Difficile*: there have been no recent cases but there is focussed work on antibiotic prescribing. Whilst this indicator is green, aiming to continually improve.

- *Category 2 pressure ulcers*: increase noted. This is not unusual with admission of elderly, frail patients & represents a mixture of heel & sacral pressure trauma. This continues to be monitored by the tissue viability team & a pressure area task force has commenced. A low level of Category 3 remains. Working to detect & prevent pressure damage at a very early stage (Cat 0/1).

RR asked when HCS will be able to demonstrate a reduction in Community Dental & Orthodontics waiting lists. CT responded that a dental task & finish group has been commissioned which includes modelling activity & demand to understand the establishment required to maintain the PTL. Following the capacity & demand modelling, a business case will

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be developed. This will also provide intelligence for orthodontic capacity. There is a locum in place & recently recruited substantively. RR hopes that with the additional staff member in post, the waiting list will start to reduce. CT explained that the nuance within dental care is that an individual can receive treatment for anywhere between 18-24 months. However, the follow up & recall rate can be evidenced. All of this work must link with the Oral Health Strategy.

RF commented that Public Health (PH) preventative work is required regarding dental & this would be of huge benefit. CT advised that the Oral Health (OH) Strategy is being developed & whilst preventative work has not been a feature of the COVID recovery, the preventative agenda is a very significant feature of the OH strategy. RR advised that the children's minister is in discussion with dentists in private practice who might be interested in joining a scheme to carry out dental health checks on young children with some government subsidy. CT further explained that there is a specific voucher scheme for children of income support families & the work seeking to commission with private dentists as part of the recovery programme will allow children to access a high street dentist for the first time. RR acknowledged that HCS cannot see every child & must use community resource & invite private practitioners to contribute. RF added that health visitors do see every child in Jersey on a regular basis & their involvement in this would be useful. AN advised that Jersey Smiles, an organisation that goes into all schools & provides health & dental education, have been commissioned for another 2 years (funded through PH). In addition, they will also provide some data regarding decayed / missing / filled teeth to provide the first epidemiological review. RR noted this was positive.

RR noted the average time in ED has increase to 182 minutes during December & asked if this is a matter of concern (acknowledging the indicator remains green). Following analysis of this, it is understood that this metric considers admission avoidance & patients waiting in the ED longer for admission whilst trying to establish if have covid. CL commented that the conversion rate has increased which demonstrates the increased acuity of patients. However, whilst delayed transfers are noted, occupancy is only at 70% which suggests increased acuity & trying to optimise people in the ED to avoid hospital admission.

RR invited Board members to comment as it is a concern that the hospital is unable to discharge patients who are medically fit for discharge. CT explained that aiming to establish an emergency care group to analyse this & support winter planning for next year. The winter planning this year was based on 15 medically fit (at any one time), in reality anything from 20-45 medically fit for discharge are within the hospital this winter. CT will be inviting system partners to work as part of this.

As the winter doctor, AN commented that he has had a unique view of both primary care & other services. Each COVID wave has affected the health system differently. For example, when there were no vaccinations there were large numbers of acutely unwell patients & during wave 4, whilst there have not been huge numbers of acutely unwell patient, there has been a rapidly changing effect upon the workforce. At times, 47% staff been off sick within the community (residential homes, nursing homes & community services) & continuing to see outbreaks within nursing & residential homes. The ability to discharge patients into the community is then severely impaired which impacts upon the acute services. The ED has seen increasingly complex medical patients with multiple comorbidities that have COVID who require a lot of time to stabilise before it is safe to transfer to other areas within the hospital. Echoing CLs point, this is not about a lack of beds but that patients required an intensive amount of care in the ED before transfer. All these factors have come together for the first time & this learning will be incorporated into future plans.

RF asked if this is not an issue of lack of beds, is it lack of staff? RF understands from the data that approx. 1/3 patients are clinically fit for discharge. CT noted that the occupancy figure does not describe flow, speed & availability of beds. Whilst staffing has been affected across all industries during COVID, HCS managed to open additional beds over the winter period whilst experiencing the impact upon staffing. It was acknowledged that this a whole Island system issue. RR suggested to achieve flexibility, the workforce needs to be regarded as a whole, so staff can be redeployed to areas of need.

CS asked if the memory assessment service waiting times had been included & were publicly available. AW advised not at the moment but reviewing the metrics for Mental Health (MH) & Adult Social Care (ASC) within this report as part of the overall MH services review. AW anticipates differentiation in these metrics in the future.

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CL asked CT for confirmation that the number of DNAs (was not brought) for children are being highlighted to CYPES. CT confirmed that *was not brought* is a focus for the next set of performance reviews & will notify CYPES.

Regarding the *% of complaints responded to within 28 days,* CL noted that performance inversely correlates with number received as during March 41 complaints were received against a performance of 90%. ACTION: CL requested further detail regarding this.

Mental Health & Adult Social Care
RR invited AW to guide the Board through the mental health & social care metrics.

- For inpatients services a significant positive shift can be seen since Sept across most of the range of metrics for working age adults.
- Concern remains within older adult inpatient services & issues of delayed transfers of care. Bed occupancy is high with significantly high percentage of individuals delayed with no apparent exit pathway, particularly those with complex needs (challenging behaviours & dementia). As described by RF earlier, this is a system issue as there is no capacity in the system to take this particular group of people out of acute care. This is being reviewed as a priority, with social care.
- There has been one admission of a young person under the age of 18 years to the inpatient adult facility. This was clinically appropriate & in the absence of any other available specialist bed, HCS will be admitting children into the inpatient service at times. Working collaboratively with CAMHS to ensure that the care is safe & appropriate to the needs of the adolescent(s).
- Within community services, pressure remain within psychotherapies. In future reports, Jersey Talking Therapies (JTT) & Psychological Assessment Therapies (PAT) will be presented separately as they are very different services. Both these services have faced a consistent high level of demand. In addition, there is reduced staff capacity, partly due to vacancy but mostly due to sickness absence & leave. There is also the backlog as the services closed for a period of time during COVID.
- For any service that has a significant sustained waiting list, now working jointly with the service to produce a formal recovery plan with a trajectory for delivery which clearly states the position over the next 12 months & what is needed to influence this. Need to work with services to appropriately prioritise, particularly diagnostic services as there is a balance between diagnosing & providing post-diagnostic support & care – this balance needs to be right.
- Also reviewing the metrics to consider what are the right things to measure & report.
- Of significance in ASC, there has been a sudden spike in the reported number of cases reopened within 90 days & this is inexplicable. Working through this in detail with the service & initial findings are that this is due to the way in which the discharge teams work in the hospital & changes to reporting. ACTION: There is no clear answer at the moment, but AW will report back next month with the action plan to address it.

RR asked if there is a backlog with the MAS that needs to be addressed. AW responded there is a backlog which has been reviewed in detail. The MAS received 321 referrals during 2021 & there is currently a backlog of 140 people waiting. The issues are that some monies were allocated for the service as part of COVID recovery but unfortunately no success in recruiting to any of the posts until this week. However, a recovery trajectory will be planned. In addition, this is a service where balance is needed between new diagnosis & post-diagnostic support. At present, a lot of the work is around post diagnostic support & need to understand whether this balance is correct. Looking to introduce some KPIs into the MAS which would be seen in other jurisdictions such as *first face-to-face assessment to commence within 8 weeks,* & *diagnosis to have occurred within 12 weeks.*

Regarding the work to separate the PAT / JTT data, PT asked who would be involved in this & will there be an opportunity for those with lived experience to be involved. AW advised the first step is to separate the data as conflating primary mental health care, counselling & complex psychological intervention as the same service is not helpful. Following this, clarity regarding the psychological interventions provided & how these are provided will be required. This should

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	happen as part of the review of the community model & AW would welcome those who use services to be involved. CS advised that Dementia Jersey have been having discussion with MAS to discuss how support can be provided & potentially provide a biweekly service where Dementia Jersey can offer dementia advisors to support families currently waiting (as an interim measure). AW advised he is used to a model of care where other partners provide a lot of pre & post diagnostic support. However, what this support will not do is provide a diagnostic assessment any quicker & the core function of a MAS is to give diagnosis. Clarity is required about how to ensure focus on the diagnostic pathway whilst working with other partners as suggested to do some of the other supportive work, acknowledging that early diagnosis is associated with better outcomes. Report noted & publication **AGREED** (following item 9 in the recording).	
	COMFORT BREAK	
9.	**View from the Bridge**	
	<u>Family Nursing & Home Care (FNHC)</u> RF took the paper as read & verbally summarised the key points detailed in the paper. In addition, • Having achieved UNICEF Baby Friendly Initiative (BFI) Level 2, now working towards level 3 accreditation & hoping to achieve this by end 2022. • Safeguarding capacity is a concern, particularly regarding children & young people. A gap analysis has been completed & an audit is taking place to understand the requirements to keep these groups safe within the Health Visiting Baby Steps & School Nursing service. • Participating in a small pilot regarding the discharge of 9 patients in one day with a 6-week programme of care who will be visited three times / day in their homes until they can access a long-term package. • Current caseload of approx. 34,000 people across Jersey, which is one third of the population. This is a year-on-year increase. Child & family has decreased due to the decrease in birth rate. RF invited questions. <u>Jersey Hospice Care (JHC)</u> Following the Minister's earlier point regarding a flexible workforce, MP asked if there is more that could be done to offer staff joint opportunities across two or more employers – JHC would be interested in this. JHC Annual Report & Impact Report will be forthcoming for 2021 - this will be shared shortly. • A successful workshop has been held & the findings from this will be incorporated within the draft strategy that will go to the partnership board by end March 2022. • Eight of 12 beds are open in the inpatient unit. JHC has experienced significant levels of staff sickness & vacancies. Looking at two years of significant deficits of expenditure against income. There are reserves but running at this deficit is not sustainable. Undergoing a full process of looking at all levels of expenditure & how income can be increased with the aim of achieving balance over next 2-3 years by a combination of cost cutting & income growth. • Reassessing how the needs of children & young people can be best met. • Confusion about JHC position on assisted dying so JHC have now made this position more public (included within the paper). MP invited questions. RR acknowledged JHC position & that of many charities in that their income streams have been disrupted over COVID. CT interested to understand how we capture an understanding of people's preferred place of death & is this part of the strategy. MP responded that preferred place of death should be captured at a	

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very early stage of someone going onto a palliative care pathway & JHC ensures this is initiated at the moment of referral. CT clarified that when people enter the last days of life, there is not necessarily the flexibility in the system to be able to respond to this (preferred place of death) & how is this articulated through the strategy because capacity could impact this. MP will review the strategy to ensure this is addressed.

RR thanked MP for organising the end-of-life (EOL) discussion workshops. MP advised that one output of the workshop is to make EOL services the best they can possibly be so that those considering assisted dying, realise they have alternatives.

MIND Jersey
PT took the paper as read. In addition,

- Key headlines regarding sustainable income & having to use reserves.
- Recently reaccredited with MIND UK.
- PT pleased to have received an invite from AW to feedback the report from the conference in November 2021 as part of the redesign of mental health services. However, often unspoken is the complexity of presentation of those with mental illness & that cannot easily be fitted into certain categories. Covid has highlighted these complexities & more important than ever to work with AMH & other MH charities to specifically look at ensuring people are signposted to the right place. Carer support is paramount. Also need to investigate specific places for people with long terms mental illness to have as their own, wellbeing hubs as cannot assume needs match across groups. Recovery College are interested in this & now liaising with HCS. Alongside this is recognising the voice of people with lived experience.

RR thanked PT & incited questions. No questions – report noted.

Dementia Jersey

- Experiencing increased demand which has resulted in recruitment of an additional dementia advisor. Also expanding service offer from resources & information to therapeutic services. CS will be speaking to colleagues & team members about to help disseminate this information – developing Tai Chi session for people with dementia & their carers, a gardening club, petanque, various guides & resources, including a carers pack, & the dementia pathway to help people signpost through the different stages of their journey.
- Working on the Dementia Strategy & working collaboratively with RF & McMillan on a briefing for States Members to think about how we can view improvement to health outcomes for Jersey's aging population through the lens of dementia & how this can be achieved through the strategy & an aging well agenda. This was planned for Feb 16th, but the format has changed, presenting a delay.
- Looking forward to meeting J. Poynter the Nominated lead for the Dementia Strategy. AM clarified that this is joint project & rather than being led by HCS & what role could other organisations play, for instance Dementia Jersey could assume a leading role.
- RR noted that CS will be discussing the MAS proposition with AW.
- Noting the request for more information regarding the MAS waiting times, AW confirmed the longest wait to-date is 7 months.

RR thanked CS & the reported was noted.

CL advised it was good to hear about the collaborative working with FNHC & McMillan to start looking at alternative ways of provisioning care & recognising there are different ways to be explored. This is the precursor to the work of the partnership board & this is very valuable.

Brighter Futures

- Ended 2021 with higher rates of referrals & started 2022 in the same way.
- Low staff turnover rate however, covid impacted groups which have started slightly later than normal (at request of parents /families) because of high rates at the start of the year.
- A number of new programmes are being offered & wellbeing programmes expanded to help to focus on the mental & physical health & wellbeing of the families. Working closely with other 3rd sector agencies to ensure no duplicity of services offered across these, whilst ensuring that parents / families have a good choice as to what is available to access. Offering walking groups, yoga, mindfulness, massage, family massage, breathing programme & programmes for children to support child mental health & offering a new

	perinatal programme for pregnant ladies (which starts in a couple of weeks). Also looking at a gardening project to support those who might struggle to get out to access this type of environment. • BF asked the Board as to who to approach regarding funding. • RF extended a general invitation to HCS Board members to visit BF to understand the work undertaken. RR thanked FB & advised that the Ministerial team had spent an inspirational morning at BF learning about work done & encouraged other members to visit. Noting that he would not be Minister for Health and Social Services after July & unable to commit to funding, RR put forward CL to help FB access the right person to further discuss funding. Government of Jersey recovery money has been used to start a project similar to BF & RR echoed BF's point that want to avoid duplicity in services, rather seek to compliment services. BF advised some families are much more comfortable accessing a voluntary service rather than statutory services, particularly those with complex backgrounds. There have been many conversations to ensure duplicity is avoided but choice is important. Demand for the service is demonstrated by the referral numbers. Constantly looking for ways to adapt the services according to the needs of families. CL confirmed she is happy to meet with BF, recognising the important. CL asked if increasing amounts of post covid trauma was being seen & FB confirmed this, advising that one of the biggest areas that covid hit was those families having babies during this period. Many individuals felt isolated & lonely & remain traumatised by this experience a year later. RB explained that most services have reopened & when families referred may want to attend courses that have already started, these have now been shaped so that programmes can be accessed at any time (including step off). ACTION: CL in support of flexible services & asked CT to discuss this with FB. AM left the meeting.	
10.	**Finance Report – December 2021**	
	MR took the report for the financial year end 31 December 2021 as read & highlighted the following key points, • Excluding Jersey Care Model (JCM) & COVID allocations, HCS achieved a £1000.00 underspend against the overall budget. This included 12.6 million of cumulative efficiencies from 2020 / 2021. This is an outstanding achievement considering COVID & other pressures experienced throughout the financial year. • JCM had an agreed underspend of 1.5 million which is now being deferred into 2022 due to slippage in the first year of the programme. • Considering JCM & COVID overall, the underspend was 5.68 million of which 4.18 relates to COVID, an underspend primarily against the Jersey Nightingale Hospital (JNH) where a full allocation for the year was provided (decommissioned June 2021). • All of the figures presented today are subject to final audit with a planned completion date 31 March 2022. MR invited questions. RR thanked MR for good outturn & financial acumen. Report noted.	
11.	**Committee Report – Quality & Risk Assurance**	
	CT took the paper as read & verbally summarised the key points. In addition, • Regarding E.Coli bacteraemia's: this is generally addressed by the whole system as approximately 75% of these will occur prior to admission to hospital. The setting of the IPAC agenda for 2022 will be key to this. • Tracking improvements within the care groups is key to managing complaints. • Pressure ulcer incidence reporting is increasing which is seen as positive (organisations with a maturing safety culture have high levels of reporting). • Working to ensure that any key learning from serious incidents (SI) are implemented & having a focus on this at the SI huddles. • An increase is noted in reported acts of physical aggression / verbal aggression. How staff are trained & supported is key, but it is important to see how this committee received assurance on MAYBO training which is a key element of supporting staff & providing them with skills & strategies to manage these situations.	

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	RR thanked CT & invited TP to comment. TP thanked the Committee members for the work over 2021 & support provided to TP as the Chair. Report noted	
12.	**Committee Report – Operations, Performance & Finance**	
	CL took the paper as read & highlighted the following, • The FIT testing is progressing well & is helping to significantly address the challenges in endoscopy. The teams are continuing to work across the whole organisation to reduce the waiting lists & improve access for patients. • Maternity estate programme continues which is a huge piece of work being undertaken to refurbish the Maternity estate & continues at pace. • The estates programme continues to be challenging for the JGH particularly during winter. The team are working hard to maintain the buildings. • Good outturn on the financial position. RR thanked CL & questions invited. Report noted.	
13.	**Committee Report – People & Organisational Development**	
	SG took the paper as read & highlighted the following, • Department HR Metrics: Headcount has increased through 2021 by 75 staff (against a loss of 161 during this period). The vacancy work continues. This does not underplay the areas where there are significant concerns. There is an international recruitment plan for Theatres & social media campaigns to tackle recruitment in radiography. • Wellbeing: quarterly discussions & heartening to see the drop in the number of staff absent with anxiety / depression over Q4 (decreased by a third - 30 staff down to 20). This morning, the number has further decreased below 20 for the first time in 12 months. Working with CP, Director for Culture, Engagement & Wellbeing to understand the effect of the wellbeing work. • Health & Safety: quarterly report presented by Health & Safety Manager & heartening to see & hear the engagement around the workforce with health & safety. This activity has increased & is a vital part of wellbeing & looking after the workforce. • CP advise the wellbeing work continues with a focus for next few months on programmes of work regarding developing a positive culture across HCS: civility & respect, psychological safety & understanding the culture required to support & sustain a caring workforce moving forward. RR stated this was positive to hear, acknowledging that staff have experienced a hard two years. Recognising staff as a wonderful group of people & glad to hear that they were being provided with this support. RR thanked SG & CP & invited questions. Report NOTED.	
14.	**Any Other Business**	
	Nil raised.	
	Date of the Next Meeting	
	RR thanked all in attendance for their contributions & noted this as a useful meeting. Date of next meeting: **Tuesday 3rd May 2022**.	

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