Health and Community Services (HCS) Board (the board)
Notes of the meeting on Monday 19 October at 2:30pm – 5:00pm
St Paul's Centre, Dumaresq Street, St Helier, Jersey

Present:	Richard Renouf (Chair)	Minister for Health and Community Services	RR
	Steve Pallet	Assistant Minister / Quality, Performance & Risk Committee Chair	SP
	Hugh Raymond	Assistant Minister / Finance & Modernisation Committee Chair	HR
	Caroline Landon	Director General	CL
	Rose Naylor	Chief Nurse	RN
	Patrick Armstrong	Group Medical Director	PA
	Anuschka Muller	Director of Improvement and Innovation	AM
	Michelle Roach	Senior Finance Business Partner HCS	MR
	Ruth Brunton	CEO Brighter Futures	RB
	Judy Foglia	Director of Governance Regulation & Care, Family Nursing & Home Care (deputising for Bronwen Whittaker)	JF
	Adrian Noon	Associate Medical Director Primary, Prevention & Intermediate Care	AN
	Sam Lempriere	Management Executive Support Lead	SL
	Michelle West	Associate Group Managing Director (deputising for Robert Sainsbury)	MW
	(jointly referred to as the "Board")		
In Attendance:	Nicola De Jesus	Patient Experience Manager	NDJ
Minutes:	Emma O'Connor	Interim Board Secretary	EOC

Please note: *Some items may have been taken out of agenda order.*

Item no.	Agenda item	Action
1.	**Welcome and Apologies**	
	RR welcomed everyone to the meeting and introductions were made around the table. RR welcomed AM to the Board in her new role in HCS as Director of Improvement and Innovation. RR informed the Board that the meeting was not being filmed. EOC confirmed that this was due to the unavailability of staff following the late change of date due to the launch of the Government Plan. Apologies were noted as follows: Robert Sainsbury — Group Managing Director Sean Pontin — CEO Jersey Alzheimer's Association Isabel Watson — Head of Adult Social Care / Chief Social Worker Lauren Jones — Head of Finance Business Partnering Anne Robson — Interim Human Resources Director Bronwen Whittaker — CEO Family Nursing & Home Care Sarah Keating — Baby Friendly Initiative Project Lead Jeremy Macon — Education Meeting Commitment Dr Miguel Garcia-Alcaraz — Clinical Commitment (deputising for IW)	
2.	**Declarations of Interest**	
	No interests were declared.	
3.	**Service-User Story**	

S provided the Board with the service-user story. S recounted the experience of herself & her husband, J, following the diagnosis of an incurable cancer

The key points are,

- The diagnosis & prognosis were delivered in a blunt way using medical terminology; there was no humanity. Both S & J were left feeling shocked. From this point, J gave up & could see no future following the prognosis of up to 24 months survival following diagnosis. S stated that the nurse who was present at the time & remained with them after the clinician left showed care & compassion & acknowledged that giving this type of news could have managed in a better way.

  S suggested that clinicians should understand their patients before giving a life-changing diagnosis i.e. how their mental health is at the time, the language to be used. S stated that if diagnosis had been delivered differently & the support had been provided from this time then the following 21 months would have been different.

  PA apologised for the way in which the diagnosis & prognosis was delivered, stating that he would have expected better as all Doctors now receive training as to how to break bad news. AN echoed this & asked S if she would relay this experience to the junior Doctors. Had this bit been done better, would J have had a better quality of life during the 21 months following diagnosis until his death. S purported that he may even have lived for a little longer were it not for the fact that immediately following diagnosis J gave up, never returning to work or activities previously enjoyed as unable to see any future.

  ACTION: NDJ / AN to liaise to facilitate S delivering her story to the junior doctors.

- S informed the Board as to how shocked she was at the experience in the tertiary care centre in the United Kingdom (UK). S stated it was obvious that this was an underfunded provision & that the ward was understaffed. S acknowledged that the staff present on the ward were doing their best, however, meals were missed, drug rounds were missed. On speaking to others from Jersey in the same area, this was a regular occurrence. S stated that she was able to bring in food & speak for J where required but who is there to speak for those who are alone?

  PA noted that when HCS is commissioning off-island services we need to ensure the quality of these services is what we would expect here in Jersey. RR echoed this concern & stated that HCS needs to be assured as to the standard of care that is provided. MW stated that there is Channel Island Liaison Team based at this hospital but as the team is employed by this trust, it may affect the escalation of negative feedback. MW informed S that HCS now collects feedback on commissioned services for all those who travel off-island, but this was started after S & J's experience of off-island. MW will ensure that this is still in place.

- S spoke about the financial aspects. S states they were in a fortunate position as J received critical illness cover. In addition, they had a good family / friend network who were able to look after their children when both S & J were travelling over to the UK for treatment. What happens to families who do not have this financial or family support? Do they incur big debts as a result?

- Following the death of J, S stated that the volume of paperwork to be completed is overwhelming as everybody must be contacted individually. S stated it would be useful if people could be given some sort of an information pack which tells people what they need to do including bills / bank accounts,

as this type of information is not readily available. How does this happen for people who are not computer literate or are English speaking? S also highlighted how painful it was to continually repeat that J had died & how he had died – there must be a simpler way to do this?

RR asked if this could be referred to Citizens Advice. CL advised that Customer & Local Services (CLS) would be contacted.

- S stated that access to a wheelchair car in Jersey was very difficult. J's mobility deteriorated such that he needed a wheelchair & to enable the family to get out of the house, S required the use of a wheelchair car. As the need for this was only short term, S explored whether it was possible to lease or rent this type of car rather than purchase. S had to appeal on the local radio station & was able to use a car that is privately donated. However, if this is already in use there is no other option than to purchase. Should this be part of a centralised service?

- Following J's death, S was contacted by Jersey Hospice Care to come & collect J's possessions. S stated that at this time she did not want to go back to Hospice. Could there be somewhere to meet outside the place of death to do this handover?

- Supporting carers after death. S stated that Jersey Hospice Care offered support, but her GP was not aware of what had happened. It was only when S attended her GP sometime after J's death reporting palpitations that the GP was made aware by S herself. Could GP's be contacted with consent to alert them of carers who going through this type of experience so they can monitor, or can this be provided from within the Hospital?

- S stated that the care provided in relation to the physical aspect of the cancer was excellent but felt that the human side / mental health was lost. In addition, the mental health of carers felt neglected until JHC became involved. S acknowledged that this type of support was provided by JHC. RR asked how soon S & J had been put in touch with JHC? S confirmed that they had been referred early but only following a crisis.

  RN reported that the development of the cancer strategy had been put on hold due to the pandemic but would need to review how this work is recommenced as part of the modernisation portfolio to ensure this progresses. There are examples of speciality services that provide 'wrap around' care such as breast cancer care, However, what your experience is telling today is that we have not yet got this right & we do not do this consistently. The work of the Cancer Strategy should be to pull all of this together. RN advised that CP is recruiting to health psychology that would provide wrap around support – someone that would work with families to provide additional support.

  CL states this brings home the immediacy of what is needed. The Care Navigation programme will feed into the JCM & aims to treat people, not just the physical aspects. Hoping to have the start of the framework in place at end December 2020.

  S stated that anything that can signpost the care that is available will be worthwhile as her experience was that she had to find out & did not have the time to do this. It still seems that this information is gained by word of mouth & there should be a package from the hospital to signpost what is available.

  MW advised that HCS does work with McMillan to support specialist posts & this has recently been put in place for lung cancer. McMillan initially support

	the posts & this is then taken over by HCS. However, S's experience has highlighted that a gap still exists. RB asked if the care navigation provides a service beyond death. S confirmed that support is available in period immediately following death, but it is not necessarily needed at this point rather further down the line & at this point it is no longer easily accessible. AM asked S if she was ever in touch with people who were experiencing / had experienced a similar situation. S responded that this type of tumour was rare & normally seen in either the very young or older adults, consequently this type of support was not available. S stated that there were two others being treated in the UK at the same time but as they were treatable cancers, there was no common thread. Am also enquired as to whether the children received support. S confirmed this was offered by JHC. S stated the school had been very supportive. S had witnessed another scenario where a bereaved family were told that if the children wished to come to school that day then this would be OK. Following the death of J, S asked her children what they wanted to do & that day & the children responded that they wanted to go to school – S believes that this was an environment where they felt safe & provided normality for them. However, S acknowledged that had she not been aware of this from a previous family, she would not have sent her children to school so how would other know about this? SP acknowledged what a difficult story this must be to recount & asked S, how are you? S responded that she was fine & having children / family means that you must keep some normality. How do people without this cope? S stated that at times it would have been nice for someone to ask, how are you? SP asked if S felt it would have benefitted her husband to have had someone to speak to, S responded absolutely as he gave up immediately following his diagnosis. S feels that at the time of diagnosis someone should have been there from a mental health perspective to understand impact of the diagnosis. SP stated that there was a lot of work to ensure parity of physical & mental health. CL asked if this was S's first opportunity to feedback her experience. S responded that it was; having noticed a feedback poster, S contacted NDJ as she had been looking for an opportunity to share this experience. RR thanked S for her courage in attending the Board & telling her story; S was thanked by all Board members. S & NDJ left the meeting.	
4.	**Professional's Story**	
	This item has been deferred to November / December 2020.	
5.	**Minutes of the Previous Meeting**	
	The board reviewed the minutes of the previous meeting held on the 14th of September 2020, a copy of which was circulated with the agenda. JF highlighted that BW title was CEO FNHC rather than as stated, Director of Governance Regulation & Care. RB also requested a change of phrase from, *She added that BF is prioritising any children born in the last six months to ensure that they receive two face to face visits now these are allowed* to *RB suggested that no progress can be made to improve ……. She added that BF is prioritising any children born in the last six months but that all clients are now receiving at least two one-to-one support sessions now that these are allowed.* Subject to the changes, RR will approve.	

6.	**Matters Arising and Action Tracker**	
	There were no matters arising.	
a.	**HL to work with HR to get a better result with joint participation from our partners, Care Federation, CYPES, key workers etc. to create Island-Wide workforce Strategy.** - HL has confirmed that this will be included within tranche 1 of the Jersey Care model (JCM) & will be continues by the new HR Director. CL confirmed this was part of the workforce strategy piece. **IT WAS RESOLVED** to close this action.	
b.	**Director General & Ministerial Support to prepare a response to the points raised by Unicef & the discussion that followed.** - CL & RR confirmed this has been completed. The response will be circulated to Board members. **IT WAS RESOLVED** to close this action.	**EOC**
c.	**IW to work with PT (MIND | Jersey) in relation to the whole family life cycle system.** - IW has confirmed that this is an ongoing process rather than an action to complete. **IT WAS RESOLVED** to close this action.	
d.	**Deputy Director of Primary & Community Pathways to progress work in relation to the recovery & provision of support to the 65+ population in isolation to give them confidence to reengage with others.** - **IT WAS RESOLVED** that RN & EOC would discuss this outside the meeting.	
e.	**Head of Adult Social Care/Chief Social Worker to provide an update on progress with Jersey Talking Therapies (JTT).** - In IW absence **IT WAS RESOLVED** to carry this action forward.	
f.	**Director of Modernisation to provide CEO FNHC with map of current workstreams.** - In BW absence **IT WAS RESOLVED** that CL would carry this action forward & discuss with BW next week.	**CL**
g.	**Provision of HCS financial position** - This is an agenda item today, so **IT WAS RESOLVED** to close this action.	
h.	**RS to provide an update as to the progression of the Suicide Strategy** - RS sent his apologies for this meeting & **IT WAS RESOLVED** to carry this action forward. EOC to agenda this item for the next Board meeting.	**RS / EOC**
7.	**Chair's Report**	
	RR informed the Board that the Jersey Care Model has been lodged as a proposition before the States. This is accompanied by the PWC review which validates the JCM as the way forward for Jersey. Preparations are underway for the States debate on the JCM in two weeks' time. The Scrutiny Panel are also preparing their reports, the contents & any recommendations are yet unknown. Noting that this is a process, the intention is to engage with all stakeholders to develop what is right for Jersey, ensuring transparency. RR expressed the need to have GP representation on the Board. RR advised the preferred site for the new hospital has been announced in the States; Overdale Hospital. If this site is given approval by the States Assembly (due to be debated in November 2020) this will provide an excellent facility. There are issues relating to access. However, RR is confident it will deliver the hospital that is needed by Jersey. He noted the positive effect of the engagement & response from all involved in the process so far. RR congratulated Mr Patrick Armstrong & Dr Ivan Muscat who have both been awarded an MBE; thanking them both for all they have given to the Island.	

8.	**Director General's Report**	
	CL reiterated the positive news in relation to the preferred site for the new hospital. CL has been working with team around the submission of the Government Plan, which provides assurance for the continuity of healthcare services delivery of which the JCM is an integral part. CL also advised that work has been undertaken with primary care to understand how we can engage more effectively with these colleagues recognising that they deliver most of the care on the Island: this has been led by RS, working alongside AM & AN. CL will write to G. Callendar following this meeting to request nomination for representation & attendance at this Board. CL introduced AM & MR emphasising the positive effect that having these substantive postholders would have upon HCS. RR invited SP to inform the Board of any developments within the Mental Health Programme. SP stated from an Estate perspective, the refurbishment works at Orchard House (OH) are due to be completed, if not already. SP, RR & the HCS Senior Leadership Team (SLT) have recently conducted a tour of OH noting that it is now a vastly improved environment for care delivery. In addition, the standard of care has also improved as OH has now achieved green status according to the Jersey Nursing Assessment & Accreditation Standard (JNAAS). SP noted that this is an incredible achievement by the staff & the feedback received from service-users & families reflected this. SP advised caution as there is still a lot of work to do, much of which will be transferred into the Clinique Pinel (CP) development. SP confirmed that work had started on the CP site which is an incredible achievement following setbacks that have been encountered. He stated work was to be done with service-users and families in respect of moving some service users out of CP to alternative sites but that this was near to completion. The anticipated timeframe for the CP project is 72 weeks, with the hope that some of the buildings will be in use by at weeks. SP stated that it was important for the team to ensure this is delivered on time. Another important milestone which will hopefully be realised in a weeks' time is the reopening of La Chasse. SP stated that this achievement also needs to be recognised, having a fully fit for purpose environment for both staff & service-users. In terms of the service overall, SP advised that all areas of MH have improved, Children's MH has a business plan & a way forward to improve the services for young people. However, a robust governance structure needs to be in place. At present there are separate Boards & it needs to be agreed whether it would be appropriate to bring these together, having one Board that understands how the whole service works. However, this would entail changes to the TOR & membership of the Board to ensure representation from all services. SP stated it is important that there is agreement that this is the correct way forward before starting to consider how this may change. SP highlighted the importance of looking at Mental Health from each perspective; Adult, Child & Older Adult, noting that there are some gaps that need to be addressed within the provision of care to Older Adult MH. SP acknowledged the incredible amount of work that has been achieved within MHS over the last year & concluded by saying that all this positive work must continue as we are all now much more aware of the importance & parity of Mental Health.	**CL**

9.	**View from the Bridge**	
	Family Nursing & Home Care JF explained that as an organisation, BAU has now been embedded & noted that this was working well. The Senior Management Team (SMT) have recently reviewed the COVID-19 strategy & associated plans should there be a second wave / resurgence. Preparations are well underway for the annual Jersey Care Commission (JCC) inspection taking place Friday 23rd October 2020. Standards to be measured against include safer recruitment, statement of purpose and evidence of safeguarding, complaints, care planning & monthly / quarterly reports. JF's understanding is that an inspection of an organisation has not taken place, rather approved providers of care, until organisations such as FNHC have registered. It is anticipated that this will be a learning experience for both parties. JF stated that this is an opportunity to establish a baseline & what needs to be achieved in the future. JF stated that FNHC will report back to the Board next month. JF stated that the challenges around virtual meetings / TEAMS (that was raised by BW at the last Board) still exist, particularly when trying to arrange meetings with external agencies. Staff flu vaccination programme is in progress with a positive uptake noted. Extra dates have been put on & extra vaccines ordered to meet the demand. Normally a 33% uptake but this has improved. Child & Family Service still struggling with clinics & tending to do most of the work virtually. Efforts have been made to get clinics back into Church / Parish Halls but FNHC have been informed by Parish Halls that they will not be reopening until March 2021 at the earliest due to COVID-19 social distancing / cleaning requirements. NHC are currently looking at different ways of working. Pip's Place on Union Street has now opened. This venue also accommodates two other charities. Some of the clinics have been transferred to this facility. Immunisation programmes are in progress for schools, with a good uptake noted - this is near completion. District Nurses have resumed BAU & are expected to be at full recruitment within the next couple of months, noting that this has not been achieved for several years. Rapid response has experience challenges with HCS staff, mainly absence due to sickness. The service was closed to acute referrals last Friday, but this has since been resolved. Home care remains a challenge but on a positive note, successfully recruited a Manager & Clinical Coordinator due to commence employment Nov / Dec 2020. As experienced by many charities at present, fund raising is difficult. FNHC are currently looking at innovative ways to fund raise. However, it was noted that a lot of support had been received from external companies who have continued to provide funding. JF invited questions from the Board members. CL asked if there is a qualitative framework around the assessment. JF's understanding is that the assessment is like that of the Care Quality Commission (CQC) i.e. the lines of inquiry & the standards used by the JCC. JF states that FNHC have been able to provide the evidence requested by the JCC as good	

	governance structures and processes are in place. CL asked as part of the submission around metrics, are acuity levels being factored in acknowledging there is a difference around service provision? JF explained this is all included within the statement of purpose. CL stated it would be valuable for FNHC to share the report once available. JF stated that FNHC could deliver a presentation based upon this experience of regulation. RR referenced back to the challenges experienced by FNHC & virtual meetings, asking CL if HCS could assist. ACTION: SL to link in with FNHC & provide support re: TEAMS. SP asked if the report was a public document & this was confirmed by JF, stating that it would be on the website. SP asked if as part of the review recommendations are produced. JF responded that if areas within FNHC fall below that the JCC considers a reasonable standard and / or area for improvements are identified, then this is included within the report. CL advised that these types of reports are shared at Board level within other jurisdictions as meeting recommendations can often involve cross-working with other organisations. Moving forward, this could be considered as other organisations are inspected 7 this ensures transparency around healthcare systems. **Brighter Futures** RB stated that plans were being developed for the potential of a COVID-19 resurgence and the possibility of further restrictions being imposed. RB has reassurance so far that midwifery will be going into clinics & GP surgeries. RB stated that there was a general return to BAU within BF, whilst continuing to work within the guidelines. RB concerned that following screening, families are receiving letters from Speech and Language Therapy (SALT) indicating that there could be a 12 to 18 month wait, even if this is a red or amber referral. As these are pre-school children, waiting 12 to 18 months means that these children will start school before being seen. Consequently, these children could be behind their peers & could have lifelong implications. This concern was also raised at the Children's Cluster. There are additional time to talk sessions for those children who have been identified, some conducted on a one-to-one basis. There is also a trained member of staff who speaks Portuguese that has been supporting. RB Also voice the difficulties around fund raising but highlighted that they are looking at innovative ways to raise funds. RB acknowledged the continued support from businesses, organisations and corporate services. RB invited questions. CL stated that HCS could review SALT, acknowledging that the 12-18-month wait was not acceptable for pre-school children. CL stated both herself & RN to-date had not been informed that SALT was experiencing challenges with service-delivery. RB acknowledged that the service might be facing pressures for a variety of reasons but emphasised the point that this was a significant point in children's lives & failure to intervene could have a significant impact upon their lives further down the line. ACTION: CL will request a review of SALT. RR asked if any of the SALT staff had been redeployed. CL stated this was unlikely but as a starting point would like to understand the demand & the current capacity of SALT to meet this demand.	SL **CL**

	Referencing the last meeting & discussions around the resilience of the workforce in both FNHC & BF, RN asked in terms of moving forward & planning for any potential resurgence, how staff are feeling? RB responded that BF staff were generally OK, pointing out that regular checks are carried out on a team & individual basis. RB acknowledged that the team have been adaptable, flexible & very resilient. JF feels that some of the anxieties of staff experienced during the first wave have subsided substantially. TRiM is offered to staff. A meeting has been arranged this week & next with Health Visitors (HV) as concerns have been raised over their work pressures, particularly the potential consequences of the reduced face-to-face interactions. This meeting will facilitate an understanding of the staff's concerns, what can be learnt from COVID-19 so far and whether elements of practice need to be changed. District Nurses are also experiencing less anxieties & Rapid Response Service continues as normal. One of the Committee members teaches resilience & has offered to provide additional training if required. FNHC are also developing a questionnaire for all staff to determine what was done well during COVID, what could we have done better and what is the learning for the organisation (to be distributed at the end of this week). JF stated that FNHC staff surveys in the past have revealed that staff would like to be more involved in decision making. RB feels that as a smaller organisation, it is easier to have sight of all their staff and then identify when staff members are not OK. CL directed a question to PA in relation to children & the use of wearing masks, recognising that facial expression, verbal cues & lip reading are obscured by the wearing of a mask. Before Jersey moves to wearing masks in shops & other areas, is there any health messaging around schools as to why masks are being worn. PA is unsure of the available evidence but states that it has not been recommended that masks are warn in schools, although outside of school this will be seen a lot more. PA will discuss this issue at Scientific Technical Advisory Cell (STAC). SP directed a question to both RB & BF, if staff identify that any clients are experiencing mental health issues, how is this escalated / referred to the right professionals, ensuring that necessary support is provided? JF responded that a Helpline for HV was set up during the COVID period. Virtual meetings were provided to parents and an email address given. All parents were also given the contact number of their HV. The experience is that those parents who had babies during COVID have concerns / anxieties mainly due to the lack of access to face-to-face HV. SP asked what information / sign-posting that FNHC staff can provide to new parents who may be experiencing difficulties with their Mental Health. JF confirmed that clients are signposted to other agencies but would need to confirm which ones. The HV has always been the first point of contact to address emerging concerns from new parents. JF stated that FNHC does have a MH HV practitioner. In addition, Baby Steps (pre-natal) & MESH (postnatal) are service provided by FNHC to those parents experiencing difficulties. SP requested feedback as to the approach taken by FNHC staff in terms of addressing MH & identifying if any support is required. JF stated that the programme offered by HV is a universal programme but there is a universal plus programme if there any parents where there are concerns. SP seeking assurance that mental health is treated with the same importance as physical health & JF confirmed this.	

	RN added from recent personal experience there is a plethora of information provided in a variety of different ways & confirmed that the experience was that the mental health element is very well attended to. SP asked if people were more aware & open in their discussions of MH & consensus that this was the case. JF explained that key to this is forming a relationship between new parents & the HV & this has been difficult during Covid, explaining why those who had babies during lockdown are now coming forward with concerns. CL asked if there were any support groups – how are we identifying unmet need from lockdown? JF confirmed there is work ongoing with these parents on an individual basis, & these new parents have been identified as a priority. CL asked what provisions were made for those who don't reach out? CL highlighted that there is a wider piece of work that needs to be undertaken in relation to unmet need from lockdown. RN advised that the Safeguarding Partnership Board (SPB) are having a planning day tomorrow (Tues 20th) & one of the items for discussion is the challenge around safeguarding moving forward as agencies are not sighted on what has happened behind closed doors during lockdown. It was acknowledged that quantifying this unmet need is difficult. CL stated it would be beneficial to hold a workshop with all care providers around what is it we think we have missed during lockdown. RB stated there are 3 strands to the BF work: 1. Parent & child relationships 2. Mental Health & wellbeing 3. Second chance learning opportunities & learning development. Mental Health & wellbeing being the focus as it is known from client feedback that lower level domestic abuse has increased during lockdown. Doorstep checks were carried out for those families were concerns existed. SP asked if this approach was being continued at present, BF confirmed this. SP highlighted that we are not really recording the amount of support that is being provided to islander's mental health. SP suggested that it would be good to have round-up session with 3rd sector organisations to discuss what is currently being provided as this could otherwise go unrecognised. CL suggested that this work could link in with the work that RS is currently undertaking around learning from Covid with Care Homes & 3rd sector providers. CL suggested to MW that the work that SP is suggesting could be linked in with what people are currently offering & also work in relation to unmet need. RN advised a 'think family' approach as a lesson learned from the service-user story earlier on this afternoon. RR highlighted from a strategic perspective that a further lockdown would be a last resort, targeted measures would be used to manage outbreaks. **Alzheimer's Association** – Apologies **MIND | Jersey** – Apologies **Jersey Hospice Care** - Apologies	
10.	**Committee Report: Quality, Performance and Risk**	
	RN took the report as read & drew the Committees attention to the following points before taking questions. An options appraisal paper for the delivery of MAYBO training was discussed & a way forward has been agreed with two solutions; the first of which will address the immediate problem of recertification & a further comprehensive business case	

	has been developed to manage the longer term sustainability of MAYBO training delivery. MHS submitted a comprehensive paper to provide assurance which highlighted the volume of work that the team & partner organisations have achieved over a relatively short period of time in every aspect of MHS, not just within inpatient services but also early intervention services. An update will be provided to this Committee on a quarterly basis. RR asked RN how we ensure that we learn from complaints throughout the organisation, from the executives to frontline staff. PA explained that this was about developing the quality framework within the HCS to facilitate shared learning. Currently reviewing the meeting structure within Care Groups & services to ensure that items such as this appear on all agendas and all services are talking about the same thing, this includes the information expected to be escalated to the Executive & assurance Committees and also provides a mechanism within which to feed information on learning back down to service levels. Specifically around medical staff, clinical leads are being identified within each service and this role will be much more focused on the quality and safety agenda and the provision of time to fulfil this role. This is about supporting the human resources infrastructure within HCS and getting people in key clinical roles that will take responsibility for this element of the agenda. In relation to complaints, this Committee has asked from monthly reports to monitor performance. RN explained that looking to develop this into a wider piece of work around Patient Experience. In addition to identifying key people, there is the performance structure feeding into the assurance committees which include the care group performance reviews. These are not just about reviewing activity and budget but also the governance element which includes what complaints do we have open now? What stage of investigation there at? but more importantly what the learning is from these. By way of an example RN & PA attended maternity this morning as unannounced observers at the multi professional risk management meeting which is held for an hour every Monday morning. The agenda included discussion of any incidents that had occurred, the stage of the investigation of these and within the agenda was informal feedback that had been received from a patient who had attended an antenatal clinic. The meeting included Doctors & Midwives discussing what they were going to do in terms of changing practise to make sure this didn't happen again & also ensure that this individual received the care that she needs. RN described that's both herself and PA felt uplifted by observing this & highlighted that this is the kind of work that needs to be undertaken within every area of the organisation. RN stated the focus really does have to be on patient experience and make every contact with HCS count. RR asked if every member of the service was involved in this meeting & RN confirmed this morning's meeting was attended by clinical staff as there was a clinical focus and therefore you would not expect to see nonclinical staff here. There are broader meetings which include a wider range of staff groups. PA also received feedback that staff felt this meeting was very positive. There is a change of emphasis, shifting from blame to what can we do better? PA is confident that we are starting to see a change in culture from blame to learning. RR agreed & highlighted that it is important that a blame culture is not fostered and that the focus is on learning. RR appreciates the pressures of ensuring efficient service delivery & budgets but within this there must also be time for learning and for people to step back and reflect. RN stated that some work was done last year in relation to staffing and re-establishing the staffing base. Following this we were able to remove some of the funding that wasn't needed & the ward sister roles were made supervisory. The supervisory role means that when they come on duty they do not have to take a cohort of patients & their role is to support the team to focus on improving quality and safety, to role model good behaviour and support their team to develop; this work is currently being carried	

	out in mental health services. RN echoed what PA had stated earlier in that key to this is ensuring that staff have the time to be able to carry out this. SP stated that there hasn't been a consistent approach to managing complaints across GOJ which has been attributed to the silo mentality. SP asked what work is going on to stop this happening within HCS & ensure a consistent approach across all areas within HCS. RN responded and stated that an element of this is captured within thematic work. RN said that the focus now was improving performance around complaint management however in terms of the cross departmental working we have some early examples of some work done around incidents completed by EOC. A thematic review has been undertaken for low level incidents that do not have a big impact on patience but remains an issue across lots of different departments. Pulling this together as one piece of work to make or enable the changes across the system rather than individual departments making changes. This is something that will be discussed between RN and AM tomorrow, how this can be captured to demonstrate that we have organisational wide learning but also, we have a central repository for it. At present there is a focus on improving performance where gaps have been identified and then build on this. PA stated if we focus on what a high-quality service should look like in the first place hopefully, we won't get the complaints as HCS will have become more proactive rather than reactive. RN highlighted the value of listening to patient story's and that we need to get staff used to listening to these. JF agreed & stated this was about providing staff with the tools to enable them to approach service-users & ask if they are unhappy & what needs to be changed. JF purported that this early intervention will often resolve issues before they become formal complaints, but staff do not feel confident to be able to do this. RR stated that this will also be applicable to the learning from the serious incidents & how this learning is cascaded through the organisation. RR thanked RN for the report.	
11.	**Financial Position**	
	HR asked the Committee to note that LJ (Interim Head of Finance Business Partnering) will be leaving at the end December 2020. HR introduced & welcomed MR as the Senior Finance Business Partner for HCS. HR highlighted the key points from the report, noting that it has been a challenging year both operationally & financially. HCS has been working very hard with Treasury to ensure that the process of approval for funding for the provision of Covid and its related activities has been followed. Year to date, Covid spend is £21.1 million & there is a forecast year end position of £50 million. Excluding the Covid expenditure pressure, HCS finances marginally below planned year to date & we are now up to month 9. However, forecasting an overspend of £1.4 million. Mitigating actions are in place with a review of the nursing flexible workforce staffing expenditure which is now beginning to evidence a reduction in the run rates. MR added the year-to-date financial position at month 9 is currently 0.5 million pounds underspent. This does not include any covert expenditure. If this was added back in there would be an overspend of £10. 4 million. This relates primarily to the outstanding business cases of 10.9 million of Covid and we are assuming full funding will be given for this. In terms of the forecast, there is a £1.4 million overspend forecast however we are confident that with the work that CL and RN are doing around the efficiencies for staffing, that this will be met and we will break even at the end of the financial	

	year. This is being reviewed on a monthly basis along with all other budgets to identify whether there is anything that will change this financial position. In terms of the next financial year, zero base budgeting is being carried out and we are looking at the efficiencies that can be made here. This should be finalised at the end of October. Already, £5 million worth of savings have been identified. RR thanked MR & welcomed her to HCS. RR asked CL to confirm that thus far Treasury have supported all HCS Covid expenditure. CL confirmed this was the position at present. CL added a caveat explaining that it is the variable spend that is being managed not vacancies in nursing. This piece of work is managed by the Chief nurse, RN & a significant impact is already seen as a result of this in the run-rates. However, the run-rate is being very carefully managed according to safety. RR asked for clarity in relation to variable spend, CL explained this was the utilisation of overtime and bank / agency staff use. RN signs all overtime requests to ensure that we are using the budget effectively but within the parameters of safe staffing. RR asked when delivering the zero-based budgets & has this been thought about at base level where patient facing services have been considering exactly what they need. CL clarified that is about sitting down with the leadership team & going through all expenditure line-by-line to understand what is spent, why it is spent & why we need to continue spending it. CL invited MW to respond as she has been leading on this work. MW stated that weekly budget review meetings have begun to make sure that the position is aligned & to identify any expenditure we have had due to Covid. There is a plan to review medical staff agency expenditure & explore whether there is an opportunity to do anything differently. This is being monitored on a weekly basis. RN added that all her deputies have an improvement plan in place for each of their areas and they meet weekly to discuss progress against these. In relation to overtime and temporary staffing, it is about addressing the source of the problem rather than constantly spending money to manage it; understanding what is driving this. Therefore, a staffing establishment review is being undertaken in mental health services as there, until we understand the staffing establishment it is not possible to explain the overtime. agency / bank nurse expenditure. For all the areas where we have pressure points around staffing, improvement plans are put in place & scrutiny is applied to the process with clear justifications for spending. Already, spending has been driven down & no requests have been turned down. RN made clear that this is about safe staffing as a priority but also about getting to the root of the problem as it is in nobody's interest to have staff working extra hours on a regular basis. CL stated it is about understanding our people, understanding our activity, & understanding our money to make sure these are aligned & demonstrate the best use of taxpayer's money. MW explained vacancies drive a lot of the expenditure. HCS needs to manage recruitment where we have vacancies and recruit substantive people who are invested in working in Jersey rather than coming in for a fixed period. RR stated that should it not be the case that when an individual hands in their notice, an advertisement is immediately released. MW responded that it is not always as straight forward as this. At times, HCS can go out to recruitment but do not always attract candidates. There are difficult to recruit areas & now working with the new Associate Director of People about how we might look at a different	

	package to each these groups. RR asked if we capture data in relation to time taken to recruit to posts, MW stated this was difficult as the data would have to be extracted manually. MR added that a new integrated HR system should be in place by January 2021. CL stated that the piece of work that MW is leading on around capacity and demand informs this process as previously HCS has not always understood demand and understood what HCS has needed to staff to. MW holds a weekly Patient Tracking List (PTL) meeting & from this can see where the pressures are. These pressures are not always due to staffing shortfalls but what this work starts to do is give a picture of what demand is: if demand is understood then we can understand costs & how this needs to be resourced. Cl emphasised that this is an area where HCS is improving & it provides transparency around the information. HCS recruits for a variety of reasons but not always the right reason. RB stated that there is a fundamental issue across the whole piste around difficulties for recruitment & retainment & asked if there was any work being done across GOJ to address this? RN responded there is a piece of work that had been started before the emergency response to Covid around an island-wide workforce plan; this is being supported by RBI and Team Jersey. It is a cross industry piece of work including construction, finance, hospitality, health & education. All the major industries have been doing workshops around identifying what the workforce needs for the next 5 to 7 years. The first tranche of the work is to gather thoughts across different industries & explore the commonalities particularly in non-registered workforce. The second phase is looking around the enablers. The JCM work will also feed into this RR stated that we do not carry out exit interviews as often as we should do, and this would yield valuable learning as to why people have chosen not to stay within HCS. HCS should be the employer of choice. CL highlighted that HCS has lost several staff due to lockdown as they were unable to leave the island during this time. It is only when prohibited from travelling that the realisation of how far Jersey is and how this impacts upon family life. Covid has brought these additional challenges. CL feels that we should be investing in the people that are born & raised in Jersey & this is something that we do not appear to be doing well now. HR stated that a lot of the project work now is focussed on how the people of Jersey are going to be provided for.	
11.	**Any Other Business**	
	AN informed the Board that in relation to the flu vaccination programme, as of today 10,200 people in Primary Care have been vaccinated in 11 days. One thousand HCS staff have been vaccinated, 658 of these are patient-facing. Two thousand school children have been vaccinated with an average uptake of 73%, the average uptake last year was somewhere between 50 & 60%. This was highlighted & acknowledged by the Board as an incredible achievement. AN highlighted one of the challenges has been the supply of vaccines to meet demand. One thousand extra school vaccines have been purchased today and this may allow the vaccination of six formers who have not been included within the original programme (this cannot be confirmed). All public & private school teachers are being offered a vaccination for the first time this year and nursery workers will also be offered the vaccine. AN advised that this model of delivery will be used to inform the model of delivery for the Covid vaccination once available. What has been learnt so far is that the supply of vaccines from multiple pharmacies has caused confusion but with the Covid vaccine, it will all come from a central pint on the island which will have a positive impact upon the delivery of the vaccine.	

	RR asked if it was incumbent upon people to seek out a vaccination should they wish to have it. AN confirmed that this should not be the case but there have been some GP practices that have not written to their elderly and vulnerable but have opted for a different approach. RR asked for confirmation of this as a GP has suggested on local radio that that the population would know whether they wanted to be vaccinated and was expecting people to phone the surgery if they required it; the expectation was for the patients to take the initiative. AN explained many GP practises were doing very well although there were the minority that were not & this is being addressed. CL stated that if the vaccination numbers were not so impressive then there would be cause for concern.	
11.	**Date of the Next Meeting**	
	The date of the next meeting was confirmed as Monday 9th November in the Halliwell Theatre within the General Hospital. This will offer the TEAMS option for those not currently attending face to face meetings.	