Health and Community Services Department Advisory Board

Health and Community Services

Date: 6 December 2023	Time: 9:30 – 1:10pm	Venue: Main Hall, Dumaresq St, St Helier, Jersey JE2 3RL

Board Members:		
Professor Hugo Mascie-Taylor - **CHAIR**	Fixed-Term Chair of the Board	**HMT**
Anthony Hunter OBE	Non-Executive Director	**AH**
Dr Clare Gerada DBE	Non-Executive Director	**CG**
Julie Garbutt	Non-Executive Director	**JG**
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong	Medical Director	**PA**
Jessie Marshall	Chief Nurse	**JM**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Steve Graham	Associate Director of People HCS	**SG**
Obi Hasan	Finance Lead – HCS Change Team (Teams)	**OH**
In Attendance:		
Beverley Edgar	Workforce Lead – HCS Change Team (Teams)	**BE**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (Teams)	**CS**
Professor Simon Mackenzie	Medical Lead – HCS Change Team	**SMK**
Emma O'Connor	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Dr Adrian Noon	Chief of Service Medical Care Group (Item 15 only)	**AN**
Dr David Hopkins	(Interim) Chief of Service Women, Children and Family Care (Item 16 only)	**DH**
Ashling McNevin	Freedom to Speak Up Guardian (Item 19 only)	**AMN**

1	**Welcome and Apologies**	**Action**
	Apologies received from: Dr Anuschka Muller — Director of Improvement and Innovation — AM Carolyn Downs CB — Non-Executive Director — CD	

2	**Declarations of Interest**	**Action**
	No declarations.	

3	**Minutes of the Previous Meeting**	**Action**
	The minutes of the meeting held on 1 November 2023 were agreed.	

4	**Matters Arising and Action Tracker**	**Action**
	ACTION 94: JM / CG met with the service-user on 5th December 2023. Agree **CLOSE**. **ACTION 89**: CG / CT formally introduced yesterday and will arrange this meeting. Agree **CLOSE**. **ACTION 86**: A paper is required for the HCS Senior Leadership Team to consider first and then Board in January 2024. In response to JG's question, CT confirmed that multiple discussions have been held with Customer and Local Services (CLS). Remain **OPEN** (for future agenda).	

ACTION 83: CP confirmed that meetings have been held with three NEDs and the fourth to be rescheduled. Agree **CLOSE**.

ACTION 80: JM confirmed that the required information has been provided to the NEDs. Agree **CLOSE**.

ACTION 79: JM confirmed that the current survey will close mid-January 2024, with preliminary information received during February 2024 and the final report in March 2024. The Picker Institute will attend the Board meeting during March (if requested) to provide feedback. In addition, this can also be presented to the Patient and Public Engagement Panel. Remain **OPEN** (for future agenda March 2024).

ACTION 31: It is anticipated that budget holders will have electronic access to their budgets in Jan / Feb 2024 (Q1 2024). To mitigate the risk, the finance business partners provide manual reports to the care groups monthly and accountable officers are held to account through the performance reviews. Remain **OPEN** (for a further update in February 2024).

5	Chair's Introductions	Action

HMT provided an update regarding appointments to the HCS Advisory Board.

1. A Chair appointment has not been made and HMT has agreed to extend his contract until end December 2023. As this will be his last meeting, HMT wished all well.
2. The process for appointing the fifth NED is underway and HMT hopeful that the successful candidate will be in post for the meeting of the Board in January 2024 (noting that HMT is not currently involved in the process of NED recruitment).
3. Whilst still under discussion, four assurance committees (previously three) have been proposed and each of these will be chaired by one or two of the NEDs. Reports from each of these committees will be provided to the Board.
4. HMT provided a reminder that this is not a statutory board, it is an advisory board that advises the Minister for Health and Social Services (MHSS). Substantial progress is being made to make clear the line of accountability from the people who work within HCS to the public (through the Executive Directors (EDs), NEDS, Chair and MHSS).

6	Chief Officer's Report	Action

CB provided a verbal precis of the Chief Officer report which is a summary of the key issues that HCS has experienced (and continues to experience) through the previous month (October). Most of these are covered in detail as separate reports on the agenda. In addition,

- Since writing the report, the Maternity Improvement Group (MIG) have established business as usual processes for a further 8 of the 127 recommendations, bringing the total to 88.
- The options appraisal paper for the proposed Medical Model was presented and discussed at the Senior Leadership Team (SLT) meeting and further work is required to understand the financial impacts.
- The demolition work at Overdale Site has started today.
- Interviews have taken place for Consultant Psychiatrists but unfortunately there was no suitable candidate to appointment.

Referring to the reference to attention deficit hyperactive disorder (ADHD) waiting lists, CG sought clarification as to whether this included adults and / or children – AW confirmed adults only. CG suggested that as there are other criteria in place, not to focus on the waiting list as any increase is likely to be related to increased demand.

Noting the 22 month wait for Ophthalmology, CG highlighted that those waiting are likely to be older adults who are at an increased risk of falling. CG sought assurance that the focus of waiting list initiatives are those areas that carry greatest risk to those waiting. CB advised that Ophthalmology is a key area hence the outsourcing contract. CT will discuss in more detail during item 8.

Noting the reference to General Practitioners (GPs) with specialist interests in Dermatology, CG asked if nurses are encouraged to develop additional / enhanced skills in this area. JM confirmed that there are specialist nurses in both Ophthalmology and Dermatology. In addition, the role of the Advanced Clinical Practitioner (ACP) has developed in Jersey and seeking to increase number of ACPs. ACTION: The board to receive a report indicating progress on increasing the number of ACPs (March 2024). Regarding the success of HCS in joining the National Audit Programme, HMT advised this is key step forward as it will allow HCS to understand how well it is doing compared to other organisations. ACTION: HMT asked for a report detailing those areas where comparisons will be made (through the National Audit Programme) – January 2024. Highlighting her support for benchmarking, JG asked if consideration had been made to broadening this to comparable organisations in the NHS and / or other Islands. CB advised this does happen and in particular, Jersey has had several discussions with Guernsey during 2023. CS also advised that links have been established with the Integrated Care Board (ICB) for Southampton, Isle of Wight and the partnership in Portsmouth. Not only does this provide data regarding rurality of an Island population, but this is also where most of the women and babies from Jersey will be transferred if they require intensive care and support. The newly developed maternity score care will reflect this benchmarking. SMK highlighted that benchmarking is important for driving improvement and directing resource. However, variance will occur but there will be acceptable / unacceptable variances across a defined range.	

7	Quality and Performance Report (QPR) Month 10	Action
	- Improvement can be seen in the *new to follow-up ratio* and *outpatient did not attend (DNA) rate*. The required improvements to IT system have contributed to this. - *Elective theatre list utilisation* is improving, and this is reviewed in the clinical productivity workstream as part of the financial recovery programme (FRP). - Better evidence to support more timely *commencement of treatment in the Emergency Department (ED).* - There will be additional bed capacity (18 beds) to allow HCS to respond to any surge in activity over the winter period. - *% day cases* is an area of focus, particularly a review of those procedures of low clinical value to ensure there are clinically effective pathways in place. - Additional focus on triage within the ED and *rate of readmission within 30 days of a previous inpatient discharge.*	
Regarding procedures of low clinical value, CG asked if this is mandated or does the surgeon decide – CT responded that this this varies, and surgeons can apply clinical judgement. CG further sought clarification as to whether clinicians can make a case for carrying out a procedure of low clinical value or are there are strict criteria in place. PA responded that HCS does not robustly apply the policy and must make this guidance clearer for clinicians to ensure that patients are offered all other appropriate treatments before being offered surgery. Noting the risk of patient harm by carrying out unnecessary procedures, CG asked if the Board could see a list of these procedures (low clinical value) at a future meeting (including numbers). SMK suggested that whilst this data would be useful, there may be more value in selecting a few procedures for a deep dive to understand to what extent any exceptions can be justified. CT advised that the Procedures of Low Clinical Value Policy has recently been reviewed and compliance with this is included in the clinical productivity workstream to understand capacity and clinically effective pathways. CB highlighted this is as an example where HCS is trying to ensure that good clinical practice is embedded, rather than sitting in a policy. HMT emphasised that the organisation must recognise that all processes to drive quality and safety (NICE		

Guidance, National Audit etc) must be followed. The first step is to make sure the policies are in place, which HCS is doing currently, and the second (more difficult) step is ensuring compliance.

ACTION: The Board is to receive a paper with the list of Procedures of Low Clinical Value, the number that are carried out and an audit of when these have been carried out. Areas of non-compliance should be listed – February 2024.

- The redesign of the Community Mental Health Services considered two areas of focus: firstly *access* and secondly, *review within 72 hours following hospital discharge*. Measurement of review within 72hours following hospital discharge is a key safety performance indicator (KPI) as there is evidence to demonstrate that if people are going to kill themselves on discharge from inpatient mental healthcare, they do so within 72 hours. Performance in this areas has improved significantly over the last two years.
- In addition, the Crisis Team are seeing 82% of people referred to the service within ten working days. However, work continues to establish why this is not 100% and initial findings indicate that this is due to patient choice.
- Whilst 98% of people are being assessed within target for psychological therapies, the wait relates to accessing treatment.
- Specialist diagnostic services (Dementia Assessment Service, ADHD, Autism) are subject to increased waiting times.
- Learning Disabilities – percentage of clients with a physical health check in the past year. The Learning Disabilities are reviewing this and have found that individuals are declining a physical health check from HCS as they are accessing other provider's i.e. primary care. This metric will be reviewed to understand if it is correct.
- The percentage of new support plans reviewed within 6 weeks (ASCT) is not meeting target (65% against 80%) but this is due to the diversion of social work attention to discharges from hospital.

AW confirmed that he is working with AH to review all the targets for Adult Social Care (ASC) to ensure the metrics are correct and measuring the things that really matter and support a fully integrated health and social care system. This suite of indicators will be presented to the board in January 2024.

AW stressed that additional KPIs are measured for both Mental Health Services and ASC, however, only the highlights are included within the QPR.

Quality and Safety

- VTE risk assessment is an area of concern. Prior to the introduction of MAXIMS, VTE assessments were completed through the EPMA, and treatments could not be prescribed if this had not been completed. This function was switched off following the introduction of MAXIMS. The current rate of assessment completion has been validated and falls well below acceptable. Whilst switching this back on through EPMA was considered, the EPMA has not been introduced across all areas of HCS and it only measures assessment of VTE risk (not subsequent management of risk). HCS is able to monitor prescribing VTE treatment and prescribing rates are higher than expected (higher than the assessment rates). This is assuring on one level; however, in the absence of a risk assessment, it is not known whether this is appropriate treatment. The dashboards will be introduced next week which will show both the assessment and prescribing rates. Staff in clinical areas will be asked to review this daily to ensure assessment compliance. The chair noted that the consequence of this process not working well has a direct effect on the lives of patients and asked how the Board could support increasing compliance, noting that there is a clear evidence base for this. JM confirmed that the nurse managers are involved with clear escalation processes. In response to HMT, it was confirmed that there are some areas that are better than others with significant differences across wards.

ACTION: Deeper analysis of VTE assessment (ward by ward) to be presented to the appropriate assurance committee (and subsequent board report) in January 2024. Areas of non-compliance to be listed.

- Infection rates remain low with two cases of C. diff identified. Whilst these occurred on the same ward, no link was identified following an investigation. - Reported pressure trauma has reduced during October 2023 and this is a consequence of the targeted educational work delivered by the tissue viability team. - Responses to complaints and communication with complainants is continuously reviewed to ensure that regular updates are provided. The response rate has improved and 50% are now outside timeframe. Whilst there is still much to improve, continual progress is being made. Feedback includes compliments and HCS is improving the recording of these. Further work regarding complaints will be taken back to the Patient Panel.	

8	Waiting List Report – Acute Services	Action
Paper taken as read. Key points, - The number of patient waiting for endoscopy has reduced to 815 (from 1170). - The procurement exercise for outsourcing Ophthalmology to provide additional capacity is complete. The impact on the waiting lists and patients will be included in the report to board in January 2024. - Trauma and Orthopaedics continues to be impacted by surge of medical patients into surgical beds. However it is anticipated that the substantiation of the additional 18 beds and the introduction of a new medical model will improve this. - The waiting time for a routine MRI scan has reduced from 52 weeks to 11 weeks. - The community dental waiting list has reduced following the commission of dentists in primary care. A paper will be presented to the HCS SLT to discuss funding options for continuation of service beyond 2023. - The dermatology waiting list is impacted by difficulties in recruitment. However, developing and diversifying the workforce is an area of focus. The impact of the additional workforce will be detailed in the paper for the board in January 2024. CG noted the vast amount of work to address the waiting lists and congratulated HCS for achievements to-date. JG sought to confirm that HCS has sustainable resources in place to maintain the waiting lists (and prevent further increases) following the waiting list initiatives. CT confirmed that the work to modernise patient pathways, use of technology (such as telemedicine in dermatology) and developing and diversifying the workforce will contribute to sustainable capacity. CB stated that the sustainability of the waiting lists must be considered as part of the FRP and that the HCS SLT are discussing how this can be achieved within the financial envelope. Noting that the procurement of some services to address the waiting lists has not been a quick process, JG asked if this is being addressed, particularly if additional schemes are required in the future. CB in agreement that the potential for speed must be maximised through the procurement process (whilst following the Government of Jersey (GOJ) process and ensuring value for money). However, when outsourcing and insourcing services, there are additional contractual consideration in addition to the finances such as governance arrangements.		

9	Finance Report Month 10 (M10)	Action
OH on TEAMS to guide the Board through the M10 report. Key points, - Year-to-date deficit has increased to £25.6 million. - The underlying run rate (an important measure) is slowing down (an improvement), by £0.2million. It is hoped that this will accelerate over the coming months. - The FY 23 year-end forecast has reduced to a deficit of £27.2 million with the forecast run rate reducing by £0.7 million to an exit run rate by year end of £1.7 million overspend. - Whilst Month 11 (M11) has not been officially reported yet, HCS in on target to deliver the saving agreed with Treasury. - There are still significant risks that remain in the underlying position causing HCS to continually mitigate further pressures moving forward. As an example, although agency spend has reduced, HCS is recruiting into substantive posts and from a financial		

perspective, if the timing of staff leaving and starting is not sequenced, this presents a short-term cost pressure.

- There are 470 vacancies (a reduction of approx. 30 since Sept 2023). Agency staff reduced to 191.
  Packages of care reman a significant pressure. There is a focus on financial opportunities when renegotiating contracts and this is an area of focus, however it will be next year before any benefits are seen.
- At M10, £16 million overspend against non-pay with a forecast year end overspend of £17.6 million. The main drivers of this are,
  - mental health off-Island placements,
  - social care packages,
  - tertiary care contracts (mainly NHS),
  - companion travel (a policy decision which presented a significant cost pressure)
  - estates compliance.

- Year-end forecast over achievement of £0.5 million in income which includes an under achievement in surgical private patient income due to lack of beds. However, this has been mitigated by over achievement in staff accommodation (through the Chief Nurse budget) and Long-Term Care (LTC) Benefit (received for additional activity done).

Noting the financial achievements are encouraging, AH asked if the impacts on services are understood, particularly regarding quality. CB advised that one of the principles of the financial recovery programme is that it is quality driven and quality impact assessments are carried out where required with engagement of Chief Nurse and Medical Director. The aim is to protect clinical services however, there is a significant financial gap and decisions will need to be made by the HCS SLT as to which services can be provided and which cannot; 2024 will be a difficult year for HCS. Discussions will be held with the Minister of Health and Social Services before any such decisions are made and presented to the board prior to enacting any decisions.

CG thanked OH for clarity of the finance report. Noting both the overspend across HCS and the underachievement of income, CG asked if a review of productivity is included in the FRP and whether it will be considered alongside any decisions regarding services. HMT and OH responded that a review of productivity is key, and this was identified as a driver for the FRP work that is within HCS's control. The FRP states that if HCS can do things better and more efficiently, not only will the quality of care and operational performance improve, but money is also released to reinvest in growing services or other things; productivity is the correct way to drive quality and improvement and the money is a measurement of this. Poor productivity equals poor patient care. Using delayed transfers of care as an example, SMK noted that people are in hospital unnecessarily and there are less beds available for elective capacity – neither group of patients are receiving good care.

AH observed that this underlines the need for a focus on commissioning (through an assurance committee) and what services do the people of Jersey want / need in five / ten years' time. This will direct how HCS works with providers over time to ensure the correct care is in place. Noting delayed transfers of care, JG stated that the solution rests in the community, either in care homes or in care in the home neither of which HCS can resolve itself. HCS's relationship with the care sector, third sector and GOJ departments would be reviewed at the proposed assurance committee with a report then featuring at the Board.

The year-end forecast position for HCS is £1.67 million (year-end). OH clarified that the reserves differ from more traditional models in that rather than individual departments building their own reserves, all reserves are held centrally by GOJ, and departments have to apply or bid according to need. The reserves referred to in this report include growth monies, capital and covid funding and HCS draws against this according to need. It does not mean that HCS does not have access to reserves as an application can be made to Treasury. The remaining £1.67 million will be used to mitigate cost pressures against the £26 million deficit.

The FRP was developed to deliver the £12 million savings for 2024. There are significant risks to this including the capacity and capability within HCS to deliver recruitment processes and contract renegotiations, whilst keeping the unexpected cost pressures at bay for next year.

Budget planning for FY 2024 is continuing at pace. The increased budget of £286.5 million agreed with Treasury for 2024 includes £15million of unfunded services and deficit HCS is exiting 2023 with (£26million). The budget planning cycle is due to complete at end-Dec 2023 however, significant cost pressures identified by the care groups during the early part of 2024 is a risk. The ELT are working with the care groups to balance within the financial envelope.	

10	Workforce Report Month 10 (M10)	Action
Paper taken as read. Key points highlighted, - Turnover rate remains stable at 4% which equates to approx. one hundred people leaving in a 12-month period. - Sickness rate remains stable at 5 to 5.5% - Recruitment activity data is developing, and the paper details the pipeline information available for recruitment into nursing roles. Other staff groups will be included in the future. - Connect People is rolling out several modules to provide support to managers and employees with automated processes (leading to efficiencies). JG asked if there was any comparative Information, either across other GOJ departments or similar healthcare jurisdictions. There was agreement that the turnover rate of 4% was particularly low (against an expected 10 - 12%) but this could be attributed to the Island context.		

11	Recruitment – Long Term Approach	Action
SG explained that the paper is not strategic, rather it lists the activities undertaken in the last 12 months to improve the recruitment process. There are multiple workstreams including targeting different markets, staff groups and demographics. Governance arrangements have been established to ensure compliance with processes and monitor outcomes. JG asked why HCS is unable to facilitate Objective Structured Clinical Examinations (OSCE), taken by overseas nurses to gain registration with the Nursing and Midwifery Council (NMC). SG responded that the reasons for HCS not being able to facilitate OSCE are not yet well understood and how similar jurisdictions do this is being explored. HMT suggested it may be resolved if HCS had much a clearer relationship with a single organisation in the UK rather than having relationships with several different organisations.		

12	Medical Job Planning	Action
Paper taken as read. HMT asked for a specific focus on medical job planning and productivity. PA explained since the last meeting, support has been secured from two job planning experts with an HR background, specifically medical staffing. This has provided an opportunity to review the job plans already signed off for quality and consistency. SMK has contributed significantly to this process. The conclusion reached is that there are significant discrepancies and lack of consistency across a range of areas. In collaboration with the Local Negotiating Committee (LNC) it has been agreed to pause any further sign off of job plans until these issues are resolved. Whilst there is an accepted policy in place, this has not been implemented consistently. Regarding productivity, greater detail will be included in the job plans to show what the organisation requires from individuals, and how they can be supported to deliver this. The aim is to complete job planning by end March 2024. ACTION: Monthly update to the board on progress towards the completion of job planning by March 2024. Noting that job plans would normally be completed at the time of annual appraisal, CG asked if annual performance appraisals take place. HMT advised that medical appraisal which supports the revalidation of doctors is a development process based on the premise that if individuals reflect on practice, practice will improve. Separate to this are performance management		

processes which have a more direct effect on productivity – these do not take place in Jersey. The first challenge for HCS is to get these in place to support revalidation.	

13	Winter Plan 2023	Action

Paper taken as read. Key highlights,

- Learning from winter plan 2022/2023 has been incorporated into this year's plan.
- Key focus areas from other healthcare jurisdictions have been reviewed and included where appropriate.
- There are eighteen additional beds this winter following the recent refurbishment of Plemont ward. Working with the Chief Nurse to establish staffing for these beds.
- The resultant cost pressures of any winter surge are well mitigated this year.
- The medical care group are progressing key pieces of work regarding Same Day Emergency Care (SDEC) service.
- The development of an ambulance handover area in the Emergency Department (ED).
- Operational flow processes are reviewed with further training provided.
- Weekly DTOC meetings are held with Director of Mental Health Services and Adult Social Care to ensure that patients are accessing onward care as soon as possible.
- Development of a Discharge to Assess pilot.

CT used this as an opportunity to thank both clinical and non-clinical staff particularly with the refurbishment of Plemont and Beauport ward this year.

AH asked what work is being done to prepare the independent home care sector for potential winter pressures. AW advised that meetings are held with providers. Regarding the weekly DTOC meetings, there is now a clear data set of why individuals are delayed, for how long and for what they are waiting. In the last three months positive changes have been seen such as providers being able to provide packages of care more quickly. The new brokerage system introduced by Customer and Local Services (CLS) will help to improve this further. Currently, the key reasons for delays are access to nursing home beds (majority) and access to residential beds – waits for nursing home beds includes a small number of specialised dementia care beds. Different ways of working need to be established for access to nursing homes (particularly dementia care) as this is causing the longest delays by far.

ACTION: Update on the success of the winter plan in Feb 2024.

14	Serious Incident (SI) Position Statement	Action

Paper taken as read. PA provided some key highlights,

- The position is improving but a lot of work remains to achieve an acceptable position.
- The safety huddles are timelier.
- Rates of post-partum haemorrhage (PPH) and massive obstetric haemorrhage (MOH) remain a concern and consequently, all MOH are reviewed by the serious incident review panel (SIRP). Of the last nine presented, seven have not been declared as SIs. Improvements seen include prompt escalation. An independent thematic review has been commissioned to understand why MOHs are occurring and identify any further improvements in the management of labour.

JG asked what assurance the Board has that learning from SIs is embedded in practice, particularly organisation-wide learning. PA acknowledged only limited assurance; however, a quality improvement function now sits within the quality and safety team to review all the recommendations for evidence of action and learning. JG noted that there may be a resourcing issue as additional audit of learning in six / twelve months following an incident would provide further assurance of continuing compliance. PA anticipates the investment in the quality and safety team which expanded during 2023 would have an impact in 2024 on this type of work.

CS advised that as part of the maternity cycle, a 30-60-90-day feedback has been introduced to make sure that actions have embedded, and a quarterly paper will be provided to the quality and safety team to provide continuing assurance.

ACTION: HMT noted the monitoring of compliance in maternity services is encouraging and asked that the Board receives an outcome of this work at a future meeting (February 2024). Noting that HCS oversees SI investigations in Jersey Ambulance Service (JAS) and Child and Adolescent Mental Health Services (CAMHS), JG asked if capacity is provided from these departments to lead / support investigations. PA responded that there are not many investigations from these areas but if so, the expectation would be that resource would need to be provided. In addition, JG asked who has accountability and responsibility for implementing and monitoring recommendations that arise from these investigations. It was agreed that it was unusual to see JAS and CAMHS positioned outside HCS, leading to a lack of clarity regarding what HCS is accountable for. ACTION: The lack of clarity regarding clinical governance of arrangements of JAS and CAMHS will be discussed at an additional meeting (outside of Board).	

15	**Acute Medicine**	**Action**
AN introduced himself to the Board and members of the observing public: Chief of Service for Medicine and ED Consultant. The paper details some of the actions taken in response to the Invited Review from the Royal College of Physicians (RCP). The immediate actions have been completed and the medium to longer term actions are ongoing. Work is required in relation to culture, governance, education and retention of staff. As this is a monthly paper to Board, CT stated that there may not be significant change in completed recommendations from month to month. However, key to supporting the care group is the additional improvement capacity. An experienced senior nurse in safety improvements has joined the team with an initial focus on evidence of completed actions which will feature in future reports. HMT specifically asked about Consultant input to acute medicine i.e. is there daily Consultant presence on the wards looking after acutely ill patients? Are nursing and medical staff of sufficient seniority seeing the patients sufficiently frequently as this has a direct effect on patient safety and productivity? This also links to job planning – is it clear whether there is the correct presence on the wards? This work may indicate that HCS does not have the correct number of doctors and nurses however, it is important to establish the current position. SMK confirmed that care of acutely unwell medical patients is not as it should be, and this is a long-term problem, dating back to at least 2014. There is not enough time in the Consultant job plans to cover the work, most of which is covered by locums. Consistently good care is provided by substantively appointed Consultants and relevant nursing staff. However, the medical model is progressing, and an update can be provided in January 2024. Recognising that the work will not be completed by January 2024, HMT asked for the report to state exactly what needs to be done to provide modern acute care. ACTION: The board is to receive an update on the medical model in January 2024. To include work that needs to be done to provide modern acute care. ACTION: The board is to receive the action plan for acute medicine clearly stating which Executive Director(s) is accountable for the action and timescales. JG stated that this issue is rooted in the specialisation of general physicians and so far, a sustainable model has not been found in Jersey. However, the proposed medical model to resolve this is likely to require a substantial investment and will require the endorsement of the Board before going to the States Assembly and States Employment Board (SEB). SMK noted this will require a cultural change as Jersey requires a good general medical service and some of the more specialist services can largely be contracted out and delivered in other ways. The RCP report is clear that this is what the focus of the medical unit needs to be, however this has not been the internal culture of the medical unit for some time. The Executive Directors will require the support of the Board through this culture change as it may not be welcome by all and is why the change has not occurred before now.		

CG advised the Board that the NEDS give their full support to deliver joined up healthcare in Jersey, particular acute medical care, in a different way to make sure that everybody receives safe care not only when acutely unwell but also when they have chronic morbidities. CG noted her commitment at interview for the NED post was that as a single Island, Jersey has the potential to be the best healthcare system in the world.	

16	Maternity Improvement Plan (MIP)	Action

As (Interim) Chief of Service for Women, Children and Family Care, DH in attendance. Paper taken as read and the improvement plan continues as previously presented at Board. Key points highlighted,

- Additional recommendations have been closed since this paper was submitted.
- Regarding exceptions, work continues to change the culture. Multi-disciplinary training sessions have been established, particularly around skills and drills and emergency pathways to provide assurance that all staff are working effectively in emergencies.

HMT noted that his two mains area of concern are acute medicine and maternity as these carry the biggest clinical risks.

Moving forward, CS stated there has been a positive move to report any form of safety incident in maternity and progress through to resolution. Noting that MOH is a consequence of high-risk pregnancy, the key issue is that these are identified early so steps can be taken to protect women and babies. The aim of the thematic review is to identify any outstanding key themes or trends. The MIP has shown that there are actions to be undertaken and these have been taken with processes to follow these through to achieve expected outcomes. The maternity newsletter ensures that all those in service delivery are aware of the plan and how it is progressing.

DH confirmed that the national guidance is being followed for the management of MOH and there is a much more proactive identification of risk earlier to prevent sequelae.

CG asked if there is 24-hour consultant presence on the labour ward as this is the gold standard set by the Royal College of Obstetricians and Gynaecologists (RCOG). However, due to the low number of births in Jersey this is not practical, and mitigations include the presence of an experienced middle grade doctor on site 24 hours day and a very low threshold for escalation so that senior staff are called in very quickly. Consultant presence is maximised (12-13 hours per day). CB stated that it is important to not only ensure there is an appropriate escalation policy in place but that the culture facilitates the escalation policy being followed.

The middle grade doctors are accredited in-house i.e. they are directly observed in practice by consultant through a large number of cases before they can work independently on the on-call rota.

HMT asked to what extent the Board can be assured that the mitigation in place is effective as the low number of births means that HCS must do everything possible to make maternity services as safe as possible. DH responded that good assurance is provided through exception reporting and the culture aspects are embedded in all training. CS asked the board to note that attendance on labour ward both routinely and in an emergency situation is monitored and escalated.

In response to questions regarding stillbirth reporting, DH advised these are reported both locally and nationally.

ACTION: Progress against the maternity improvement plan to continue monthly.

PA noted that the specialisation in either obstetrics or gynaecology could be a challenge for Jersey. However, the advice of an external expert is sought as to what the future workforce model could look like.

17	Infection Prevention and Control	Action
Paper taken as read. Key points highlighted, - The overall target rate is 75% in line with other UK organisations. - The vaccination campaign continues with both mobile and static clinics across various sites in HCS. - Weekly communications are sent to staff and information is provided at staff entrances to HCS sites. - Flu vaccination uptake has increased to 986 staff (31%) although there is still room for improvement. - Covid vaccination uptake is 815 staff (25%). This is an increase compared to the same period for last year when vaccination completion rate was 14%. - The vaccination programme has been extended from the end December 2023 into mid-January 2024. This will be subject to further review in mid-January 2024. Recognising that HCS is not responsible for childhood vaccination, CG advised she was informed yesterday that 98% of children in Jersey are vaccinated against MMR and acknowledged this must be one of the world's best rates and congratulated the GPs for this. The rate in CG's borough in London is 60% and measles is emerging. HMT suggested that the flu / covid vaccination rates are worryingly low, and JM confirmed that much improvement is required to reach the target of 75%. HMT asked JM if there was confidence that this target would be reached, and JM responded that a new Lead Nurse for Infection Prevention and Control (IPAC) is starting Monday 11th Dec and other ways to attract staff to get vaccinated will be explored. JG asked if staff are incentivised to have the vaccinations although recognised that doing the right thing to protect themselves and patients should be incentive enough. ACTION: JM will explore staff incentives to increase vaccination rates. Update on flu / vaccination rates to be provided at the Board in January 2024.		

18	General Surgical Rota	Action
PA advised that the terms of reference have been agreed for the Royal College of Surgeons (RCS) review and now waiting for the RCS to provide a start date. CB noted this highlights the ongoing subspecialisation that presents enormous challenges for small healthcare jurisdiction like Jersey, particularly when covering on-call rotas. It also highlights the need for networks and partnerships with larger centres to ensure that Jersey can provide high quality care. In practical terms, HMT noted Jersey is not that different to a small hospital in the UK and the way of managing this is well understood – by networking these services with major centres that allows well-functioning multi-disciplinary teams, expert views on sub specialised topics and rotation of staff. These possibilities must be explored as the idea that Jersey can provide standalone safe clinical care across a wide range of conditions is unrealistic. CG suggested it may be useful to explore some key clinical areas in board workshops (working with primary care), for example, stroke and diabetes. HMT in support of this, especially as the interface with primary care and social care ought to be easier on an Island. SMK advised that although there are not many people that require tertiary care, those that do require this level of care should go to a specialist who works within a specialist unit; there is good evidence to support this model, and this is normal practice in other places. ACTION: The board to see the RCS review terms of reference at the board meeting in January 2024.		

19	Freedom to Speak Up (FTSU) Guardian (FTSUG)	Action
HMT introduced the FTSU role as recently established (January 2023) and introduced Ashling McNevin as the FTSUG. It was agreed that this role should regularly meet with an independent		

NED (previously only the Chair). The initial focus of the work has been to lay the foundations and build the structure of what is needed for staff to feel safe to speak up.

- Sixty-three individuals have approached the FTSUG since Match 2023.
- Categories are reported in line with the National Guardian's Office and the themes emerging in Jersey align.
- To-date, forty cases have been investigated and closed with positive outcomes for members of staff and the organisation.
- Learning will inform the Culture Plan for 2024.
- Twenty-five cases are currently active.
- During the early stages of service development, all reports are escalated through to the Senior Leadership Team (SLT) so there is an understanding of concerns raised.

Reflecting on experiences from other areas, CG stated that the FTSUG function is the single most important function driving improvement across organisations. Further investment for other FTSUG / ambassadors should be a consideration.

CB noted it is very encouraging to see that staff are speaking up, particularly as many of the cultural challenges are long-standing.

HMT advised that the organisation is receiving clear feedback from this service with consistent themes, particularly around culture and the need for change in behaviour.

20	Cultural Change Programme: Improvement Plan	Action

Paper taken as read. Following the FTSUG report, CP reported that data from other sources (BeHeard Survey, Complaints, Listening Events, Wellbeing) confirms that HCS is facing significant cultural challenges. A list of actions has been compiled following feedback and a Cultural Change Plan developed incorporating both cultural and people elements (contributed to by the Associate Director of People). The plan contains measures that can be used to evaluate the impact of the plan. It is recognised that cultural work is difficult and will take time however, the start of this change can be seen in particular areas, for example maternity.

ACTION: Progress against the Cultural Change Plan to be reported to Board in 3 months' time (March 2024).

JG stated that this work and the work of the FTSUG are establishing a new way of leadership and behaviours across HCS. Noting that the plan is comprehensive, JG asked if it can be delivered without additional resource. Secondly, JG asked if the patient voice features as part of this. CP advised that the patient voice is not a strong feature of this plan but can be considered for inclusion. Currently the patient voice is captured through feedback, the Patient Panel and Picker Surveys. HMT will be speaking to the facilitator for the Patient Panel later this week to discuss the relationship with the culture work and for the NEDs to meet with the Patient Panel early in 2024.

BE suggested two metrics that should be straight forward to track. Firstly, the number of staff cases that have gone forward into more formal cases and secondly, the conduct (tone) of clinical investigations i.e. what are the circumstances in which this incident occurred, rather than who is responsible for this incident.

CB advised that the issues of clinical quality and finance are symptoms of the culture of HCS and wider GOJ and is therefore fundamental to driving improvements.

Having had discussions with CP, HMT is confident that the proposed metrics are sufficiently robust to track change in culture (change in behaviours). Secondly, the evidence is clear, if behaviours are poor, patient care is poor. Reflecting on a similar discussion at the recent board workshop, HMT advised that the Board has a responsibility to model good behaviour for the organisation as this will have a direct positive effect on the care of patients.

AH stated he would like to understand more about how managers are responding to this, noting it can feel threatening as there are likely to be some issues that have been raised that are not

appropriate. HMT in agreement that whilst not everyone speaking to the FTSUG is necessarily making a point that is fair and / or reasonable, what HCS must do is listen to and respond, even if the response is not to the reporting individual's satisfaction. In response to CG's query regarding anonymous reporting, AMN confirmed the opportunity to do this exists for individuals, but it has not been used so far.	

21	Questions from the Public	Action
No pre-submitted questions. HMT asked the members of the public if they had any questions relating to agenda items. Member one The turnaround team were thanked for their work as it is felt that they have all made a real difference. Whilst the team were initially recruited on a one-year fixed term contract, is there an update as to whether these have been extended? CB confirmed that currently looking to extend the contracts of the change team and how their skills could be deployed to best effect during 2024. The States Employment Board are supportive of this. Member two Member two asked why her emails and telephone calls have not been responded to. HMT confirmed that he will revert as to the specific issues raised (prior to the meeting) however, there is a broader issues as to the lack of perceived responsiveness. Member A to send all relevant correspondence to CB and a meeting will be facilitated with PA. Member three HMT was thanked for his contribution to HCS to-date. HMT responded with thanks for this feedback and stated that he was confident that those in HCS will continue the work required. HMT thanked member three for his attendance in supporting the board to improve the quality of care to people in Jersey. HMT noted that although this is the third meeting, there is a tangible improvement in the function of the Board and that staff across HCS are committed to improving care.		

	MEETING CLOSE	Action
Date of next meeting: Thursday 25th January 2024		