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Public Accounts Committee

Health and Social Care Review

Witness: Chief Officer, Health and Community Services

Monday, 10th July 2023

Panel:

Deputy L.V. Feltham of St. Helier Central (Chair)

Deputy M.B. Andrews of St. Helier North (Vice Chair)

Deputy T.A. Coles of St. Helier South

Deputy M.R. Le Hegarat of St. Helier North

Mr. G. Phipps, Lay Member

Ms. A. Trudgeon, Jersey Audit Office

Witnesses:

Mr. C. Bown, Chief Officer, Health and Community Services

Dr. A. Muller, Director of Improvement and Innovation

Ms. J. Marshall, Chief Nurse

[09:30]

Deputy L.V. Feltham of St. Helier Central (Chair):

Hello and welcome to this public hearing of the Public Accounts Committee. Today is Monday, 10th July 2023, and we are holding a public hearing with the Chief Officer for Health and Community Services as part of our review into performance management and our review into the governance of health and social care. I would like to draw everyone's attention to the following. This hearing will be filmed and streamed live. The recording and transcript will be published afterwards on the States Assembly website. All electronic devices, including mobile phones, should be switched to silent. I would ask that any members of the public who have joined us in the room today do not

interfere in the proceedings, and as soon as the hearing is closed please leave quietly. For the purpose of the recording and transcript, I would be grateful if everyone who speaks could ensure that you state your name and role and also speak clearly. If we can begin with introductions, I suggest that the committee introduce themselves first. My name is Deputy Lyndsay Feltham and I am the Chair of the Public Accounts Committee.

Deputy M.R. Le Hegarat of St. Helier North:

Deputy Mary Le Hegarat, District North of St. Helier, member of the Public Accounts Committee.

Deputy M.B. Andrews of St. Helier North:

Deputy Max Andrews. I am Vice Chair of the Public Accounts Committee.

Deputy T.A. Coles of St. Helier South:

Deputy Tom Coles, St. Helier South, panel member.

Mr. G. Phipps:

I am Graeme Phipps. I am a lay member of the Public Accounts Committee.

Deputy L.V. Feltham:

We also have representation from ...

Ms. A. Trudgeon:

Ann Trudgeon, Jersey Audit Office.

Chief Officer, Health and Community Services:

I am Chris Bown. I am the Chief Officer for Health and Community Services.

Chief Nurse:

Jessie Marshall, Chief Nurse for Health and Community Services.

Director of Improvement and Innovation:

Anuschka Muller, Director of Improvement and Innovation for Health and Community Services.

Deputy L.V. Feltham:

Okay. We will start with some questions into performance management and I will hand over to Deputy Andrews.

Deputy M.B. Andrews:

Thank you for attending our public hearing today. I would like to firstly ask you, Chris, what are your personal objectives for 2023?

Chief Officer, Health and Community Services:
I agreed my objectives with the then Chief Executive of the Government plus the Minister. I have a total of 10 broad objectives, broken down into multiple actions, but just to give some examples of those ... or do you want me to go through every single one?

Deputy M.B. Andrews:
If you could maybe just give us a rounding up of what they are.

Chief Officer, Health and Community Services:
Okay. So what you will see in my objectives that I have agreed with the Chief Executive are obviously the ministerial priorities, so things like the dementia and adult mental health strategies, private patient strategies, community framework, and also developing evidence-based standards such as N.I.C.E. (National Institute for Clinical Excellence) standards for guiding clinicians. Waiting list reductions is another good example of an objective; delivering the electronic patient record, financial recovery, which of course is a major piece of work, and also cultural change across H.C.S. (Health and Community Services), which is the fundamental of delivering any of the objectives that I have. So that is just a selection.

Deputy L.V. Feltham:
What we will do is we will ask for the rest of the list in writing.

Chief Officer, Health and Community Services:
Yes, I can send that, yes.

Deputy M.B. Andrews:
So in terms of having your personal objectives being set, how often have those objectives been reappraised with the Chief Executive?

Chief Officer, Health and Community Services:
Well, I only started at the beginning of April.

Deputy M.B. Andrews:
Oh, okay, right.

Chief Officer, Health and Community Services:

Yes, so none. **[Laughter]**

Deputy M.B. Andrews:

Okay. No, that is fair enough.

Mr. G. Phipps:

How often do you anticipate?

Chief Officer, Health and Community Services:

I would anticipate ... I meet the Chief Executive on a regular basis so we would always touch on the objectives, and certainly I would meet generally on at least a fortnightly basis with the Chief Executive. Clearly, we would not necessarily go through formally every single objective, but the topic of conversation will obviously focus on those key priorities and those key objectives. So while there has been no formal review it is sort of an ongoing process. I also obviously meet with the Minister for Health and Social Services and also now, of course, the shadow chair of the board. So there are a number of opportunities for people to appraise my performance outside of a formal appraisal process.

Deputy M.B. Andrews:

Could you maybe just explain the relationship, say, between yourself and the Minister and how things are then reported back to the Chief Executive in relation to the department and its performance?

Chief Officer, Health and Community Services:

Yes. So from the point of view obviously as accountable officer I am accountable through to the Chief Executive of the Government, but on a routine basis I meet with the Minister and also with the chair of the now shadow board. I would raise things of concern or interest to the Minister and clearly if there are things that I then need to speak to the Chief Executive about, particularly where there is a need for things to take place in other government departments and not under my control.

Deputy L.V. Feltham:

Just for clarity as you have mentioned it a couple of times, what is the current status of the shadow board?

Chief Officer, Health and Community Services:

It is shadow but I suppose from the point of view it does meet ... we do not have any non-executive directors at the moment other than the interim chair, Professor Hugo Mascie-Taylor, who you are meeting later, but we have been having shadow board meetings over the last few months as if the

board existed but recognising we only have one non-executive. So it will be a unitary board with executive and non-exec. So we are shadowing that process and also, of course, feeding into the board are the assurance committees that have always been in place, used to be chaired by a politician and will when the non-executives are appointed be chaired by a non-executive director of the board.

Deputy M.B. Andrews:

Okay. Also, Chris, I would just like to know how many officers are reporting back into you.

Chief Officer, Health and Community Services:

I am going to have to count them. **[Laughter]** I will go through them. We have the Medical Director, Chief Nurse, the Director of Clinical Services, Director of Innovation and Improvement, Director of Mental Health and Social Care and Director of Culture all report to me, so I have 6.

Deputy M.B. Andrews:

How often do you have one to one meetings with those officers?

Chief Officer, Health and Community Services:

I meet them all the time because we are based in the same offices. So I am trying to have them on a weekly basis but certainly fortnightly. But it is not as if we do not see each other every day.

Deputy M.B. Andrews:

What about having meetings where everybody is in the same meeting, does that happen on a regular basis?

Chief Officer, Health and Community Services:

It does. We have 2 key ... or 3 key meetings in H.C.S. One is the senior leadership team meeting, which is the decision-making body for H.C.S. that will report through in future to the board. That meets on a fortnightly basis and includes both the executive directors but also the chiefs of service. So these are the clinicians that run the clinical services also sit on that committee, including some other key staff such as the Chief Social Worker. So that is the key decision-making body; that is fortnightly. Also fortnightly we have our change programme board, which essentially is the S.L.T. (senior leadership team) but it is where we focus on the key change programmes that are facing H.C.S. We also have an executive leadership team meeting, which is essentially my team meeting with my direct reports, and that will happen in the weeks where we do not have a S.L.T. or a change programme board. So every week, in effect, I will meet with my team or the broader leadership team at H.C.S.

Deputy M.B. Andrews:

Yes. When we are, say, speaking about the objective setting across all those different areas, are some of those objectives similar or is there maybe, say, a differentiation among those objectives that are set?

Chief Officer, Health and Community Services:

Yes, my objectives clearly will cascade down to my direct reports. Those have been agreed. They are entered on to the Connect system, so that will happen. The chiefs of service who are accountable through to the Director of Clinical Service will agree the objectives, but the cascade will go down through the leadership team from the Chief Executive of the Government through me through to my direct reports.

Deputy M.B. Andrews:

Okay. Thank you very much.

Deputy L.V. Feltham:

I will hand over to Graeme.

Mr. G. Phipps:

Can I just dig a little deeper if I can into the process of the performance appraisal and related objectives? Given that you are fairly new and you have not had your own performance appraisal review yet, have you had any of these discussions with your direct reports? How do you draw the link between regular feedback and those specific goals that are set at the beginning of the year for your direct reports and the conversations you anticipate having with the Chief Minister or with the Ministers? How do you see that playing out?

Chief Officer, Health and Community Services:

Yes, I have diarised a formal midyear review with all my directors. That will be the formal process when I will sit down and go through each of the directors' objectives formally and provide feedback. So on a routine basis I am obviously aware of progress because I am on top of it all the time. So from the point of view of ongoing objective setting, there are times where we need to adjust those objectives because with the passage of time or things change or greater priorities emerge. So being on top of that on a weekly basis, on a daily basis, as I say, just running the H.C.S., will feed into that formal midyear review that I have when I return from annual leave.

Mr. G. Phipps:

Okay. You are well aware of the objectives of each of your direct reports?

Chief Officer, Health and Community Services:
Yes.

Mr. G. Phipps:
That is when you first established ...

Chief Officer, Health and Community Services:
They are my objectives basically shared out among the team to deliver.

Mr. G. Phipps:
How do you deal - can you give an example of process - with problem areas and performance issues? How do you see this playing out and how do you characterise how you would deal with it?

Chief Officer, Health and Community Services:
I think it is like all performance reviews. That quality of conversation, that quality of discussion when you are looking at individual performance, is important. I always need to consider and want to consider the circumstances that things have been delivered or not delivered against, whether there is a need for additional resources to make things happen that have not been available, whether individuals require more training or development or increased skills to deliver those objectives. Equally, if people are struggling to deliver what they need to deliver I would hope that people just do not wait until our formal performance reviews; in fact, I know they do not, we will have those discussions as part of business as usual.

Mr. G. Phipps:
So there is a pretty clear link between performance objectives and your routine discussions, you are saying? That is what I am picking up.

Chief Officer, Health and Community Services:
Yes.

Mr. G. Phipps:
Looking at the risk that you are responsible for, what are the top 3 risks that you would see for your department and how are you dealing with them?

Chief Officer, Health and Community Services:
So the top 3 risks, financial and financial recovery is obviously a major risk for us. We are forecasting around a £22 million deficit at the end of the year. We know we are not going to deliver a balanced position at the end of this year. We are looking to achieve £5 million worth of savings in year but we

are working to develop a financial recovery plan, a 2-year financial recovery plan, which I can obviously talk about in more detail. That work is ongoing but I can cover that. So financial risk is a significant one. The other is clinical standards and clinical governance, so the Hugo Mascie-Taylor report. There are many issues of concern that we are addressing around standards of clinical service and that is a clear risk in a number of areas. Thirdly, recruitment and retention is a big one. We are carrying about 480 vacancies at the moment and we rely heavily on agency and locum doctors, nurses and allied health professions, causing a significant part indeed of our financial overspend because of the high premium rates. So recruitment and retention is a risk. So you have the 3; the finance, the issues of recruitment and retention, and also around clinical standards and governance would be the 3 that would be at the top of my list and, indeed, they are at the top of the risk register for H.C.S. as well.

Mr. G. Phipps:
So 480, what approximate percentage of the total would that be, just to put it in context?

Chief Officer, Health and Community Services:
It is about 16 ... I am trying to think what sort of percentage. I have it here. We have 2,770-odd staff, so it is not insignificant.

Mr. G. Phipps:
It is big.

Chief Officer, Health and Community Services:
It is not insignificant at all.

Mr. G. Phipps:
You mentioned as far as following up on that that you rely on a process of filling these vacancies. To what extent do you personally oversee and manage and ensure this is being addressed versus looking to others to fill it?

Chief Officer, Health and Community Services:
The recruitment service is provided by the central H.R. (human resources) function. We know that the time to recruit is far too long, about 150 days to recruit a nurse or longer for a doctor. That is something that the Chief People Officer is very aware of, I am very aware of, and so are my colleagues. We are trying to address that and reduce the amount of time that it takes to recruit individuals. It is too long. So we have oversight of it, obviously, and we have just had someone seconded to us from the Government delivery unit to specifically work with the group H.R. function to reduce that period and also to improve the way that we advertise, recruit and, indeed, onboard

staff, because onboarding is not happening in the way that I would choose. So we are very heavily dependent on the central function. There is no H.R. director. I would be, as the chief executive in other jurisdictions, used to having my own workforce director or H.R. director and I do not have that.

Deputy L.V. Feltham:
Is that a recent change? Because I did think that Health did have an H.R. director. Am I mistaken?

[09:45]

Chief Officer, Health and Community Services:
Not since I ... I do not know, Anuschka, have we ever had an H.R. director?

Director of Improvement and Innovation:
Since the restructure, the wider restructure, the T.O.M. (target operating model) under Charlie Parker, all H.R. functions have been centralised, and while we have a lead H.R. business partner it is not an H.R. director owned by H.C.S., basically. The person is reporting into the central People Services function.

Deputy M.R. Le Hegarat:
Can I just quickly interject? So, therefore, the question that I would ask is: do you actually think that H.C.S. should have its own H.R. director?

Chief Officer, Health and Community Services:
Yes.

Deputy M.R. Le Hegarat:
Thank you.

Mr. G. Phipps:
So one last question, then I will turn it over to Mary to follow up. Looking ahead a year from now, looking back, how would you define what you would say was a fantastic year in retrospect, looking back? What would you ... what does success look like?

Chief Officer, Health and Community Services:
I would hope that in a year's time we will have a very clear financial recovery plan that is owned by the organisation or by H.C.S., that has been accepted by Ministers and the Treasury as a clear and sensible plan, and that we are making progress against that. I would hope that we had started to see a turn in the culture of the organisation, and I think when we look at the transformation of H.C.S.

in its broadest sense, this is not a 12-month effort, this is a 4 to 5-year programme of change. But in a year's time I would hope that we would be seeing some green shoots around improved culture and that the next Be Heard survey, so 2024, would start to demonstrate that. We are also going to be undertaking some Pulse surveys in between with far fewer questions, greater chance of people filling it in, just to measure whether we are making progress on culture. So I would hope to see that we are changing there. I would ...

Mr. G. Phipps:

Sorry, let me just intervene. What do you mean by culture? You are looking for some culture. Maybe try and be a little more specific so the audience in general can understand.

Chief Officer, Health and Community Services:

Yes. Staff feeling more valued, more listened to, more part of running H.C.S., feel that bullying and discrimination have started to reduce and have been tackled, that there are consequences for people that do not demonstrate the behaviours and values that we all in this room would expect. Now, as I say, we will not turn the culture around in 12 months but I would expect to see some green shoots around improving the way that people feel about being employed by H.C.S. The other thing I would expect to see is that very recently the senior leadership team made a decision that we would use N.I.C.E., the National Institute for Clinical Excellence, guidelines for its clinical services. Those guidelines were used by some clinicians and not used by others, and that now is a policy decision that we have made that we will follow where we can, because being an Island there are challenges. There will be resource issues associated, but as a default position we will follow N.I.C.E. guidelines and where we can follow N.I.C.E. guidelines we are very explicit and clinicians are very explicit about why that is the case and that the new board will take a view on that as well. But I would hope to start to see that that is embedded. It is one thing making a decision and having a policy; the other is compliance against that policy. So I would hope to see that we were seeing some compliance.

Deputy T.A. Coles:

Sorry, do you know why the N.I.C.E. guidelines were not previously being followed?

Chief Officer, Health and Community Services:

No. I think when we talk about culture there is a wider thing around the culture of H.C.S. and particularly how it has dealt with clinical governance or not dealt with clinical governance in the past. There is resistance from some to be held to account for practice. That is not widespread but there are pockets of that that need to be addressed. That is not good for the people of Jersey or, indeed, the clinician themselves because it puts them at risk.

Deputy L.V. Feltham:

In what areas are those pockets of resistance?

Chief Officer, Health and Community Services:

Well, what you will see is ... I think you have probably all read about rheumatology. Rheumatology I suppose is a classic example of where guidelines and appropriate clinical guidelines were not being followed. There are other areas where we need to ensure that where they are being followed or where people are saying they are following them that we see that through clinical audit and evidence. But if you look at a number of areas across H.C.S. there is cause for concern around the quality of those services and we have seen that in external reports on maternity, various. We have seen that in a report from the Royal College of Physicians on acute medicine. We have seen that in max-fax. So there are other areas, of course, that we need to explore to assure ourselves ... this goes back to the Hugo Mascie-Taylor report around can we be assured that the quality of services that Jersey people are experiencing are safe and effective, and that is part of the process that we and the change team that you will be aware of have been working on. We know that we have had to make some improvements, and Jessie as Chief Nurse notes that there are some of the fundamentals of care that we have had to improve and focus on to ensure that we are up to date and modern in the way that we provide care in Jersey. Compared to other jurisdictions we have probably slipped behind somewhat and we need to do some catching up to assure ourselves that we do have the right processes and guidelines in place, that we have effective serious incident reporting and, more important, investigation and timely investigation, that lessons are learned from those incidents and we use that as part of our continuous improvement in the quality of clinical services that Jersey people are having delivered for them through H.C.S.

Mr. G. Phipps:

So if things do not go according to plan and we do not get those 3 top objectives or goals you want, the risks that you identified are not being addressed, how do you plan to deal with that, you and your counterparts?

Chief Officer, Health and Community Services:

I think we will know whether we are going to feel that way in a year much sooner than the year is out because, again, we are constantly monitoring and auditing those processes. So we will have a sense. If things are not working, then we will try to mitigate that as we go along rather than just sort of wait and cross our fingers and hope for the best. But we know with the financial challenge, other things starting to emerge, cost pressures that have started to emerge in year potentially will often knock us off course and we will need to rethink again and look again at the plan. From the point of view of the culture, again our Pulse surveys, rather than waiting for the next Be Heard survey, will give us an indication whether some of the things that we are currently doing are working and whether they are not. So a good example is I started last month with a Chief Officer's listening event for staff

on Teams because you generally from my experience get a much broader and increased number of people that will attend those events than if you hold them at a lecture theatre where it is difficult for people, certainly on other sites, to come and listen. We had over 65 staff at that first meeting compared to probably 20 if it was face to face, and there has been positive feedback from that. We are going to continue to do that on a monthly basis. Well, through the Pulse survey if that is not working, then we will need to find a better way to improve our communications, but we will deal with that in year.

Deputy L.V. Feltham:

We will talk a bit more about culture and also performance management across the organisation in a minute, but just before we leave that I am conscious that what you have talked about today risk wise and some of the ... I think it would be fair to call it failings within the Health Department at the moment, how is that being dealt with at the highest level when it comes to performance management? Because obviously people will have to be held accountable for that. How has that happened in the past and what is changing now to ensure that it does not continue at that high level?

Chief Officer, Health and Community Services:

It is very difficult for me to comment on what has or has not happened in the past, but I think we have to put it into perspective. The challenges that we are facing now, from my experience these are challenges that have existed for decades and this is not something new. This is a problem of long standing around the culture and clinical governance. This is not something that you could look to an individual Chief Officer or an individual Medical Director to say: "It happened on your watch" because I think these sorts of things ... if you take rheumatology, it has been there for 30 years, so these are not new. So changing that position is a huge challenge. So now, through the objective setting and through the objectives, particularly those objectives that are set by the Director of Clinical Services to the chiefs of the clinical services, are a way that we can hold people to account for making those improvements that are needed. We ourselves, if you take the issue of serious incidents, we will review those on a weekly basis, complaints reviewed on a weekly basis by the senior leadership of H.C.S. If things are not progressing, then the relevant director will obviously deal with their direct reports where things are slipping or not happening. But this is more than just setting objectives. This is a whole cultural issue here. This is not just about setting that objective: "Oh, you have not done it, failed." It is a much bigger challenge.

Deputy L.V. Feltham:

But obviously the culture needs to start at the top.

Chief Officer, Health and Community Services:

Yes, it does.

Deputy L.V. Feltham:

So what is going to be different about the senior leadership team that we have now compared to what has happened in the past to ensure ...

Chief Officer, Health and Community Services:

As I say, I cannot comment about what happened in the past because I was not here, but I think all my directors know what is expected of them and what needs to be delivered, and if those things are not delivered, then that performance needs to be addressed with that individual, as you would in any organisation, any company. Now, I do not know whether that has happened in the past or not, but I do not think anyone - 2 of my colleagues here - are in any doubt that they are held to account for delivering what is required of them, and if that does not happen then there are consequences. I think one of the things with the Hugo Mascie-Taylor report is that staff do not feel there are consequences when behaviours are not as they should be. That is not, again, just at the senior level. Indeed, when you look at bullying and discrimination, we often think of this top-down bullying of managers. There is as much bullying horizontally between colleagues than there ever is that I have seen coming down from management. This is what I go back to. This is a much broader issue around the culture of H.C.S. that has developed over decades. So we should not consider that the bullying is just top down, it is not, because we are having to deal with inter-professional relationships as much as I am dealing with top-down bullying.

Mr. G. Phipps:

So how comfortable are you that a year from now the people of Jersey will be aware of and see the kind of progress that you are aspiring for and how will they know?

Chief Officer, Health and Community Services:

How will they know? Well, I think they will certainly know because the new board will be holding its meetings in public on a monthly basis. Reports on all these issues will come to that board so it will be very transparent. The performance reports will show whether there has been progress or not. The K.P.I.s (key performance indicators) will also be very public and we will be very transparent about everything that is happening, good and bad.

Deputy M.R. Le Hegarat:

I am going to ask a random question, as I do. It is to do with recruitment. You have just been recruited in the last few months. Following that experience, if you do not mind, what do you think ... in relation to that process, what would have made it better so that when you are looking to recruit other people your experience can improve that? Does that make sense?

Chief Officer, Health and Community Services:
It does and, as I say, I think my ...

Deputy M.R. Le Hegarat:
I know I put you on the spot a bit.

Chief Officer, Health and Community Services:
Yes, my experience was not that bad, but I have spoken to multiple members of staff, both senior and junior, whose onboarding experience has been poor. I know Jessie ... we have spoken about some of the nurses' experiences that would, quite frankly, make you weep. These are things that we just should get right, basic welcomes, people turning up knowing where they are going to live, being paid on time, basic stuff that we need to get right. Working with the people hub is something that we are working to improve that experience. I think the length of time - I talked about 150 days - is a big issue.

[10:00]

Now, whether that is just ... it is not just in Health, as I understand it, but we will lose doctors, nurses, physiotherapists, just because of the length of time it takes to recruit. They will find other jobs. The vacancy rates and the recruitment challenges that we are facing are global. We would be having this conversation in China as much as we would in the U.K. (United Kingdom) or Belgium or South America. This is a global challenge. So if we are not quick and slick as regards our recruitment, we will lose people and that is what has been happening. So, for me, the big thing is speed. I think we are improving induction. We have started a ... or refocused induction on having an H.C.S. induction. There is a Government one but many health professionals require their own induction. So improving induction, improving the basics, getting people paid, getting employment contracts to people quickly, are all things that I know the H.R. function is very aware of and we are working with them to make those improvements. But my particular experience, other than waiting a long time for an employment contract, was not that bad, but I know that there are many that we all speak to that have a far less positive experience.

Deputy M.R. Le Hegarat:
It is interesting, though, you say it was not that bad; you do not say it was positive.

Chief Officer, Health and Community Services:
I think speed is the issue, and again for me I suppose I had other options and opportunities. I was recruited to come to the change team, I think you might know that, to start with in January. There were other opportunities that I had, but I wanted to come to Jersey so it did not put me off. But I

think with some they might have taken those other opportunities that presented themselves more quickly, so it is something we have to improve on. As I say, I think everyone involved in the recruitment process knows that and are working to make sure that that happens.

Deputy M.R. Le Hegarat:

Is it a lack of resources or is it a lack of the ... I do not want to put this in the wrong way. Is it a lack of resources or it is that the people recruiting do not have the necessary experience?

Chief Officer, Health and Community Services:

I think it is difficult for me to tell because, of course, I do not run the recruitment process. That sits with the central H.R. function. I think it would be probably a mix, I would imagine, but I think it is resourcing. It is a disconnect between H.C.S. and H.R. At the H.C.S. end we are not necessarily turning things round as quickly as we need to so this is not pointing the finger at the H.R. function, this is a general problem around the speed with which we turn things round, short list, respond to queries. So there is a general improvement needed, both in H.C.S. and in H.R., to shorten that period of recruitment.

Deputy L.V. Feltham:

When it comes to recruitment, also the thing that people will look at is things like cost of living in Jersey, pay terms and conditions. So is that a big factor in recruitment?

Chief Officer, Health and Community Services:

It appears to be, and certainly if you look at the exit interviews that does feature. Many people leave to further their career. Remember we are a small jurisdiction so in many cases promotion and development comes from leaving the Island. But yes, the cost of living is an issue. Rent and childcare are 2 areas that are significant. If you are an agency, a locum member of staff, generally you will get your accommodation paid for, but if you commit yourself to Jersey and become a permanent member of staff, you do not get that paid for, obviously. So people can be working cheek to jowl with someone who is getting those benefits, a doctor, a nurse or something, and someone who is not. I think that must have an impact as well. So it is multifactorial but certainly the cost of living has to be one of those issues. H.R. have looked at the cost of living factors around nursing, for example. So if you are a nurse that lives or works in central London, then coming to Jersey with its tax benefit and its higher salaries than the U.K. is a benefit. If you live in Wigan, there is no chance you will be able to afford to come and live in Jersey. So it is a factor.

Deputy L.V. Feltham:

Given that you do not have control within your role of accountability with some of those things, you are also a member of the executive leadership team, so how does the executive leadership team work together to resolve issues that impact on very critical Island services?

Chief Officer, Health and Community Services:

Obviously, I work closely with Mark Grimley, the Group Director of People, on the issues that we ... in fact, I met him last week to have further discussions about that. So those relationships exist through the Government E.L.T. (executive leadership team) and obviously on a business as usual relationship with other Chief Officers where there is a need. We do not have our own finance director, for example, because services are provided by the Treasury. We do not have our own I.T. (information technology) function and that is provided by M. and D. (Modernisation and Digital). So those close relationships with other government departments are obviously very important if we are going to make progress on a number of the areas that we need to in Health.

Deputy L.V. Feltham:

Then does that flow through into adequate resourcing for what you need?

Chief Officer, Health and Community Services:

Yes, and I think from the point of view of the resourcing of those functions they also struggle to recruit. We have been out or Treasury have been out to find a head business partner for H.C.S. a number of times and have failed to be able to attract anyone. So those government departments, the same as Health, struggle to recruit to certain professions and jobs and that has an impact on us, obviously. So yes, resource is a challenge for everyone.

Deputy M.R. Le Hegarat:

Okay. We have talked already about objective setting. How many of your employees within your area of responsibility are in the scope for Connect Performance?

Chief Officer, Health and Community Services:

I was trying to find the number. Those that are not are doctors and they have an appraisal process. Certainly, consultants are attached to or linked to their fitness to practise. The manual workers, so people that work in the laundry, kitchens, portering, contractually for some reason are not part of the performance management process. Who else? Is there anyone else that does not get covered?

Director of Improvement and Innovation:

Manual workers.

Chief Officer, Health and Community Services:

Manual workers do not. Let us have a look. Yes, doctors, consultants, they have a separate ... manual workers, yes, the current contracts and terms and conditions do not require them to participate in performance management, it says here. So ...

Deputy T.A. Coles:

Do you agree with that, that they should not be under contract or is it something you would like to see?

Chief Officer, Health and Community Services:

I do not know the background to this. For me, I think all staff deserve to have objectives and an appraisal. It is about respecting those as individuals and this is not a punitive process. This is about respecting individuals, giving them clear objectives. Everyone wants to know what they are meant to be doing and what is going to make them look successful or be successful. So I have always looked at performance management as being something that we owe to our staff and the staff that I am responsible for, so I do not know why that is. It is obviously something in the past. From the point of view of doctors, this is the same as the U.K., the revalidation process and the appraisal is very different to what we might expect of an appraisal. It is very much associated with their clinical practice rather than, say, corporate objectives.

Deputy M.R. Le Hegarat:

So, effectively, you will have a doctor consultant at the hospital, so who actually appraises their performance then?

Chief Officer, Health and Community Services:

It will be through ... there will be 2 things. So you will look to the chiefs of service, who are doctors. They will look at their performance. But importantly, it is the responsible officer and those that undertake the appraisal of those doctors for revalidation that will look at their performance.

Deputy M.R. Le Hegarat:

So, effectively, that is not you?

Chief Officer, Health and Community Services:

That is not me.

Deputy M.R. Le Hegarat:

Surely that cannot be right, though, because the problem you have with that, surely, is the fact that you are responsible for delivering a health service that is suitable for everybody, but you have no

control over some of ... that is not the right word, control, but you have no way of highlighting ... or how would you highlight a poor performance then is the question maybe.

Chief Officer, Health and Community Services:

I think from the point of view of poor performance of medical staff, then that would come through the appraisal system. Of course, with doctors, and this is the same in the U.K., there are 2 issues. One is around performance around their clinical practice, and the other is around things that are non-clinical, so behaviours. Things that apply equally to me, to a nurse, to a porter, also applies to a doctor. But there is a whole set of issues that will be to do with their clinical practice and I think the appraisal system is obviously the same appraisal system as is being used in the U.K. It is required of doctors under their General Medical Council registration, and I think there are as many challenges in the National Health Service around doctor appraisal from my personal point of view as there is in Jersey. It is just the same. So the chiefs of service will expect doctors to play a part in and deliver what is required, so waiting lists, for example, but it is not as clear. It is not a direct line responsibility as clear as it would be between, say, a manager or a nurse and their ward sister or senior nurse. It is different.

Deputy M.R. Le Hegarat:

So how then - and I have had examples of this - do you deal with issues in relation to not the medical practice but the issues of bullying or cultural if you have no appraisal process?

Chief Officer, Health and Community Services:

No, you can deal with those things and those things are dealt with through the chiefs of service, the Medical Director if necessary if it needs to be escalated. So any poor behaviour around doctors, if raised - and it often is - it could be through the Datex system that we have or, indeed, I have met with a number of staff on a one to one basis because I have asked them to come to see me if they want to and have a coffee and talk personally and frankly and confidentially about their experiences of working in H.C.S., so if issues are raised. We also have the freedom to speak up guardian and again issues have been raised through the freedom to speak up guardian, which we then will take on and address.

Deputy L.V. Feltham:

Just for clarity, can I just ... you were saying that the heads of service do the appraisals. Are you saying that the Medical Director does the appraisals? How many tiers down are we talking?

Chief Officer, Health and Community Services:

Yes, so the appraisal of consultants is done by a colleague who has been trained in appraisal. So it is not a line appraisal in the way that we are used to. It is another doctor appraising a colleague, very different. I know it can be difficult to understand.

Deputy M.R. Le Hegarat:
Marking your own homework.

Chief Officer, Health and Community Services:
From the point of view of the chiefs of service, so these are the consultants, we have a chief of service for surgery, for medicine, for women's and children's, for example. The objectives and appraisal of those individuals are jointly undertaken by the Director of Clinical Service, who is their line manager, and the Medical Director, who is their professional manager. Their performance will be appraised because they are in leadership positions. Those will also ensure that the consultants, their clinical leads, so these are the people that run the specialties ... a clinical lead for radiology, for example, who is a consultant, will manage the doctors in radiology. We have some singlehanded consultant practices, so they are managing themselves because there is only one of them, but they will have an appraisal from their boss. But generally consultant appraisal is not a line relationship. It is by a colleague who has been trained in appraisal.

Mr. G. Phipps:
How do you ensure that the cultural changes you are trying to get across your organisation are similar and the same expectations then are in place for the cultural changes and expectations for doctors?

Chief Officer, Health and Community Services:
Because I talk about it a lot with doctors. I attend the medical staff committee. The expectations around the policies that we have and will develop over the course of this year will apply equally to doctors as it does to anyone else. Doctors are not exempt. Processes are being dealt with if they are bullying or bad behaviour. Now, let us just say this will be the minority. This is not the majority here.

[10:15]

But where that is necessary all the processes that we have as regards to cultural change will involve doctors. I think doctor engagement and staff engagement in general is a problem in H.C.S. Doctors find it, because of their clinical commitments, difficult to attend workshops, sessions, listening events. Certainly, we need to find a way in which we can engage senior medical staff more effectively. At the moment, their job plans mean that they struggle to attend meetings, for example.

They struggle to respond to emails. Their time is short, so we will not get that engagement unless we can provide time, particularly for the clinical leaders. The clinical leads who will be being paid to be the clinical lead for that responsibility, they also need to have the time to lead and to get involved in the changes that we need to make in H.C.S. That is a big challenge anywhere. It is certainly a challenge here.

Deputy L.V. Feltham:
When it comes to the skills required to lead and manage teams, what support structures are in place to ensure that those clinical leads, who might be very good and well-qualified clinically, have the right skills to manage?

Chief Officer, Health and Community Services:
Yes, I think there are 2 comments on that. There has been management development for clinicians. That was not there in the past. They have been to various programmes. That is fine, but if they do not have the time to put that into action, of course, it is meaningless. But the other, of course, is that we have a management structure and general managers that will support clinicians, so the chiefs of service, in the day to day management of the organisation, so professional managers who support clinicians. The managers are there to support the clinicians.

Deputy L.V. Feltham:
Just to give us a bit of a flavour and a picture, those chiefs of service, they are not clinicians themselves you are suggesting?

Chief Officer, Health and Community Services:
Yes, they are.

Deputy L.V. Feltham:
They are clinicians?

Chief Officer, Health and Community Services:
They are consultants, yes, medical consultants.

Deputy L.V. Feltham:
Okay. So where I am getting to is where do they get their professional management experience?

Chief Officer, Health and Community Services:
Oh, right. They will have ... I do not know about all of them but typically they would attend a management programme. There are plenty around. I think they have done in the past here, Jessie?

Chief Nurse:

Yes, the Faculty of Medical Management and Leadership.

Chief Officer, Health and Community Services:

Right, that is it. So they will have had some training. The clinical leads do ... sorry, the chiefs of service do have time because in their job plan they are primarily aimed to be leading. The level below that really struggle to get engaged, so what I call the specialty leads, the consultants that run their specialty. So training is important. Time, in fact, is more important. If they do not have the time, then they are not going to be able to do the job. They are also supported by the management structure.

Deputy L.V. Feltham:

When they are recruited, I suppose I am just thinking ... because you have admitted there is a cultural problem. We have talked about bullying and there is obviously lots to manage when it comes to people management. So when you are recruiting a clinician into a management position, what weighting does ... I suppose aptitude to be able to deal with some of that softer stuff and change culture, what weighting does that have when you are employing somebody into one of those leadership roles?

Chief Officer, Health and Community Services:

For me that is a hugely important part of that role because, remember, the cultural problems that we have are not unique. They exist in other jurisdictions as well. So being able to deal with people and colleagues is essential.

Deputy L.V. Feltham:

Okay. So we should expect to see that in the evaluations and the feedback that you are giving? Because obviously you did not recruit everybody that is in those positions now. It may well be that your stance on that is different to what it might have been in the past.

Chief Officer, Health and Community Services:

No, the expectation is that the Director of Clinical Services and the Medical Director will speak to those individuals if that is not what is being delivered. So yes, it is essential if we are going to make that cultural change because, as you say, it has to be led from the top.

Deputy T.A. Coles:

You were talking before about the clinical appraisals being done by another doctor, sort of sideways looking on. Do you get any sight of those appraisals?

Chief Officer, Health and Community Services:
No.

Deputy T.A. Coles:
No. So you do not know if anything has been told to improve or to ...?

Chief Officer, Health and Community Services:
No. I think if there were some serious issues obviously that would be escalated up through the system and I would get to know, but I would not routinely see a doctor's appraisal. It is a confidential appraisal between the doctor and their appraiser.

Deputy M.R. Le Hegarat:
Okay. Of those that are in scope, how many have completed the objectives within Connect Performance for 2023?

Chief Officer, Health and Community Services:
Well, it is 10 per cent at the moment, which is very low. It has gone up I think since the figures you might have seen recently, but it is very low. Am I surprised by that? No, not at all. Again, it is part of that culture around performance management culture. It is not there. We are not unique in that. It is difficult, for example, in the National Health Service as well. But when looking at it, I think what we have is a number of issues. You have the cultural issue of people being used to performance management. The other is when I met the ward managers, so the ward sisters, the other day with Jessie, they all said they have had their conversations with their direct reports and set people objectives. They just have not entered it on to the Connect system because they find it too time consuming. Now, if you look at ward managers, they will have ... how many direct reports?

Chief Nurse:
Up to 30.

Chief Officer, Health and Community Services:
So up to 30 people report, because of the different shifts, to the ward sister or the ward manager. So doing 30 appraisal and objective settings is quite a big task, then sitting down and putting all that on to Connect. So people tend to be reluctant about doing that. But we have to improve. We have agreed with central H.R. department we are going to have some bespoke training for staff about how to put the appraisals on to the Connect system because I think that is one of the problems we have, that people just really do not know how to do it. That programme will take place over the next 12 months. It is a cultural issue in Health around how people enter appraisals on to computer

systems is poor in many jurisdictions and it takes time for them to get used to that. But generally the management to staff ratios are quite large, particularly in the clinical areas, which makes it quite difficult.

Deputy L.V. Feltham:
Given what you have just said, and we know that you have thousands of staff and they are not staff that are going to be sat at a computer screen, that is just not part of their job, is Connect Performance fit for purpose for your areas?

Chief Officer, Health and Community Services:
It is difficult for me to say yes or no because I am just not familiar enough with it. I have put my objectives and my colleagues have put theirs and they may want to say something. I am not sure how intuitive it is. I am told it is. Maybe it is just my level of ability that has made it more challenging for me. I do not know. I am not used to the system enough to know that. I think people do have challenges with it.

Chief Nurse:
They do, yes. There have been challenges in accessing the system and also with managers being able to see their direct reports. So the systems do not align up all of the time, which makes it difficult. Nurses tend to want the paper copy of their appraisal because they need it for their revalidation folder as well, and we had a paper system before we had My Conversation, My Goals and then on to Connect. So it is getting people to change into the new system and then print off those objectives for their folders. Nurses tend to want that piece of paper. There have been issues with the alignment across, making sure that you have all your direct reports. You can have them on one week and then the next week when they go to do something with the objectives the direct reports have disappeared off the system. It has been challenging.

Mr. G. Phipps:
There is a case where consolidating is fine of services because they are centralised, they are the same, economy of scale, but then there are problems with conflicting objectives in different departments and the support then. So this sounds like a case where are you getting the support you need from H.R. centralised in this area?

Chief Officer, Health and Community Services:
I think we are going to because we have agreed for this bespoke training. I have some details somewhere about it. So that is going to start this month and we are hoping that will make a difference and increase ... because we need to increase the level from 10 per cent. That training we will monitor and see what difference it makes. It is something you can easily monitor because you can

gain the access to the data. So let us see where the training takes us. The question about is it suitable for Health, it is clearly not suitable for doctors. It just would not cope with that. I think there would also be a contractual issue about whether you would be allowed to do ... put it on a system like that. But I think we will need to look and see over time whether there are issues that we have because we are Health, particularly clinical. I think from a managerial point of view we have managed to sit down and do it. There are issues I suppose for me. I noticed you could only put a maximum of 8 objectives in and I have 10, so how do you ... the small things like that, but the training I am hoping will help.

Deputy M.R. Le Hegarat:

Clearly, there is only 10 per cent that is on the system. How then are you going to measure performance and undertake appraisals of staff if they have all fallen out of the system?

Chief Officer, Health and Community Services:

If you take the example I gave around the ward managers, they have set their objectives to their staff, they just have not put them on the system. So Jessie as Chief Nurse will be able to, through the cascade of nursing and the hierarchy of nursing, look at the performance of each ward manager, but yes, until it is on the system it will be quite difficult. I guess the question I have is: even if it is on the system, because I do not know the system well enough, it might be recorded but what does that actually mean? Because it is the quality of the conversation in the appraisal and the objective setting is the most important thing, whether that is on paper or on a computer system. I think what we have to avoid is a tick-box exercise where the objective is just to get it on to the system because that is how you judge ...

Deputy M.R. Le Hegarat:

I came from the police and so for 25 years worked on a paper system. The comment always is: if it is not written down, then it has not happened or it has not been recorded. I think for me fundamentally, listening to what you say ... because as a police officer, uniformed services, nursing, practical areas are very different to somebody who sits at a desk and may have the ability. Because as you rightly say, if you are managing staff and you are managing a ward of people who you are caring for, you might not have that time. What concerns me is the fact that you as the Chief Nurse not only need to know the objectives of the ward manager but need to know the objectives of all of the staff on that ward, 30 or whatever it is, but also their personal objectives as well. So how are you going to do that if the system does not work for you?

Chief Officer, Health and Community Services:

Yes, and I am hoping the system will work for us. We have not given up because we need the training to happen. So it does need to be recorded and our aim is to increase that percentage, no question about it. Jessie, it is a challenge, is it not, knowing without having a system?

Chief Nurse:
It is.

Chief Officer, Health and Community Services:
You are absolutely right, because trying to look at, say, the development needs of a particular ward, you cannot do it at the press of a button. That requires further work. Now, I think from my experience the ward manager will know through her objective setting what the requirements are on that ward and, therefore, can ultimately tell Jessie what they are.

Chief Nurse:
It comes up for the ward staff to the ward manager, who will know all of the objectives. That feeds into the lead nurses who know the objectives for each of their wards and their departments, which then feed into myself. We also have the Jersey national accreditation system as well that we monitor how many appraisals have been completed at ward level through the system on a regular basis. So the wards are assessed throughout the year, so that gives us an indication of how many appraisals we have that are not potentially on Connect but are on a paper system. Because, as you say, you are used to a paper system and the nurses are very much used to a paper system, where they would have gone off home, they would have written all their objectives out and then brought it back and discussed it with their manager and had that conversation. So that is still happening but it is just not being put on to the system.

Deputy M.R. Le Hegarat:
Out of interest, how long has Connect been with us? Because that I do not know.

Chief Nurse:
Since the beginning of the year.

[10:30]

Deputy M.R. Le Hegarat:
Okay. That is me because I am fairly new to this. Okay, so the beginning of the year. So we are now at the end of June. The worry I have is this, that I need to be from my own perspective clear in my mind that if there are any developmental issues with a member of staff that it has always been that it is a continual process because, as you rightly said, it is not a tick box, it is about ensuring that

staff all the way through the 12-month period, any positive performance or developmental issues are identified on a regular basis so that there is nothing that comes as a surprise at the end of 6 months, 12 months, whenever the appraisal process comes in.

Chief Officer, Health and Community Services:
Yes.

Deputy M.R. Le Hegarat:
Are you confident that if today my performance is not up to what you expect that you are able to say at that period that this person has not developed and this is what we now need to do? Do you know what I am trying to say?

Chief Officer, Health and Community Services:
Yes.

Deputy M.R. Le Hegarat:
What I am trying to say is that for me it is critical for all staff to feel confident that all of a sudden today I am not going to hand Max a piece of paper that says you are no good.

Chief Officer, Health and Community Services:
Yes. Certainly, for me personally, of course, I do because I set the objectives. I could not answer that question for the nearly 3,000 people that work in health, but I can certainly answer that question for my direct reports. I would expect my direct reports to be able to answer those questions for their direct reports and so on. Without it being on the system, and that is where we need to get to, of course, you could not easily prove that, but my expectation would be that in the same way as I know my direct reports' issues, that we do not get problems and where people are suddenly surprised by the fact that at the end of the year they are told that their performance was poor. I am not assured that that does not happen because that is all about the quality of that conversation and that regular feedback, is it not, about individual nurses or doctors or physiotherapists from their line manager? If their line manager is not trained ... and part of the training that we are seeing being offered by the central H.R. function is not just about how to use the system but how to have those conversations, because you need to be trained in having those conversations if you are a line manager. They are not natural. There is the technical aspects of Connect but also the developmental aspects of ensuring managers are equipped to have those conversations.

Deputy L.V. Feltham:
Can I ask a question, and I appreciate because of the length of time you have been here you probably will not be able to answer it, so it might be one for Jessie and Anuschka. Given that

Connect Performance is part of a multimillion pound major restructure of Government I.T. and given that I think I am correct in saying you are the department with the largest number of staff, how much engagement did H.C.S. have when it came to the people that were developing Connect Performance and how it might work practically on the ground for the 3,000 staff?

Chief Officer, Health and Community Services:
You are right, I cannot answer that question.

Director of Improvement and Innovation:
The programme was designed to have a senior officer as a representative for each department, so in that case I was representing H.C.S. just to make sure from a high-level strategic view - I think it was called like a change board - that you had these representatives from all departments and where key updates were shared. That was also the opportunity to raise any concerns. I raised a lot of concerns around it needs to be very much looked at around clinical staff. It is a very different environment, but also for our manual staff, so outside porters as well, so the non-clinical support services. Because it was not just the H.R. part, it was of course also the finance and the procurement and the States and lots of other areas. From a central project perspective they sent out individuals to liaise directly with affected areas. From a Connect Performance and Connect H.R. system perspective we did not have a lot of engagement from the centre in terms of specific sessions. There was not a detailed run through of clinical staff, how they do the assessment. There were some areas which we raised around revalidation, the clinical training, all the things that need to be recorded on an appraisal in order to, yes, feed into the clinical appraisal. Some of that has been addressed but not all of it is now included. Another area for us, very important, are D.B.S. (Disclosure and Barring Service) checks, so that had to be addressed, ideally all in one. There were definitely shortfalls in making sure the clinical side has been completely covered.

Deputy M.R. Le Hegarat:
On the back of that then, this started in January. What training or what input did both of you have in relation to what you said about training for those conversations? What did you call it?

Chief Officer, Health and Community Services:
The training, both technically how to use Connect but also how to have appraisal conversations with your staff, yes.

Deputy M.R. Le Hegarat:
Yes. What training did both of you have and the rest of the staff who are going to have to appraise people?

Director of Improvement and Innovation:

Yes. The training on the system was released relatively late, so that was released by the centre; I think it was mid-December for the beginning of January start. That was clear. Staff had not had a lot of opportunity to book themselves on the training and I think the I.T.S. (Integrated Technology Solution) project acknowledged that. That was definitely a shortfall that impacted on the rollout, definitely impacted on the ability to use the system. The training on how to have the conversations, how to have difficult conversations, how to have appraisal conversations, there have been ... they are called Team Jersey training sessions in place for a while. So I went through, for example, a number of those and these are on a rolling basis and they are constantly being updated. Some of it has been integrated into the world-class manager programmes. A number of managers have gone through those. This training has been in place for a while; however, people have to book themselves on to it through Virtual College. They have to actively go that way. It is difficult, of course, with the clinical schedule. If you roster people 6 weeks in advance, that is where it is more sensible to do a specific one for clinical staff to pick people and to integrate that into the roster.

Deputy M.R. Le Hegarat:

I fully accept people have to take some responsibility for their own going on the training.

Director of Improvement and Innovation:

Of course, yes.

Deputy M.R. Le Hegarat:

But did it come in before the end of last year? Was there a lead-up, a 6-month lead-up before Connect was introduced to have that training or not?

Director of Improvement and Innovation:

The difficult conversation, having appraisal conversations. As I say, it was a rolling programme available on Virtual College as part of being a manager, management support, but there was not a specific one. Now we are moving into a new system here as a specific push …

Deputy M.R. Le Hegarat:

What I am trying to get to is was it, do you remember, before the end of 2022? For me it is critical. If you are going to ask somebody to change a system and have the critical conversations which you think you are all aligned to the fact that the training needs to happen, was that training before the end of 2022?

Director of Improvement and Innovation:

It was, it was, yes.

Deputy M.R. Le Hegarat:
It was, yes, okay.

Director of Improvement and Innovation:
Because there was before was the - what is it called - My Conversation, My Goals?

Deputy M.R. Le Hegarat:
Okay, yes, yes.

Director of Improvement and Innovation:
That was in place.

Deputy L.V. Feltham:
You will have statistics because it was on the Virtual College of how many people undertook that training. Do you know?

Director of Improvement and Innovation:
We did not have access to that directly, so that will go to the central …

Deputy L.V. Feltham:
I suppose what I am trying to get to is we have already identified due to the nature of your work areas is, again, asking people to do training over Virtual College, is that the most fit for purpose process to get people onboarded on to this?

Director of Improvement and Innovation:
Yes. No, we are currently reviewing that, particularly for these reasons how to engage clinical staff better, how to use whatever booking system in the best way. Virtual College, again, works quite well for those with a desk-based job but how to enable those people who have maybe only one computer on the ward and cannot log in all at the same time or need to do most of that. We have just discussed that last week to have a look at how some of that training will be more customised without the need to go through Virtual College to book yourself on to it, rather than here is a list of dates, just send an email or just somebody going around and saying this is when there is a date and book yourself on to it.

Deputy M.R. Le Hegarat:
I think we have already identified probably about … I think we might as well move on to the next topic.

Deputy L.V. Feltham:
Yes, okay.

Deputy T.A. Coles:
We have also covered a lot of the questionnaires. Looking around the measure of the employee satisfaction, you mentioned the Be Heard survey and your Pulse surveys that you are going to carry out. Have you ever considered using 360 feedback?

Chief Officer, Health and Community Services:
I certainly have in other roles, other jobs. We have not considered it, so far as I am aware, recently here. Have we considered it in the past?

Director of Improvement and Innovation:
Not officially, but I do know that in Teams some do that unofficially. So particularly for management staff having that 360 review, it has been done but not officially.

Chief Officer, Health and Community Services:
As I say, I am not opposed to it. I think it is a good idea. Often it is trying to find the resources to fund it because some of these things are not cheap to do. But, yes, it is another option open to us, I think, and just, yes, no reason why we should not, other than resources.

Deputy T.A. Coles:
Speaking of resources as well, obviously you mentioned retention and recruitment as a big issue facing the department. Do you have any sort of idea where your turnover staff level is at the moment?

Chief Officer, Health and Community Services:
We do. It is just because I have the latest figure here. Let us have a look over there at turnover. It is not awful, compared to other health … it says 6 per cent, 6 point something per cent. Yes, 6 point something per cent. Working in, say, other jurisdictions that does not horrify me and that is reasonably standard as regards turnover or wastage, as some people call it, H.R. people call it. Yes, it could always be better but having some level of turnover is good and people do need to move on and develop. I would not want to see it probably, to be honest, that much lower.

Deputy T.A. Coles:
You have also mentioned that people are leaving for better opportunities, progression, because there is only finite …

Chief Officer, Health and Community Services:

The feedback that we are getting from the exit interviews is relatively limited at the moment for H.C.S. but asking for that feedback, it is a number of reasons. One of it is to progress and seek employment elsewhere, the other is because of cost of living, the other is - and not surprising because there is always one - not getting on with your line manager; it is a pretty typical one that you see in more or less any business in the world is a reason for people leaving. A whole range of reasons but, as I say, the feedback we are getting from the exit interviews, which, again, are run centrally, we are not seeing that on a routine basis, I do not think, at the moment. But turnover is what you might expect.

Deputy T.A. Coles:

Regarding your exit interviews, do you know how often these are completed or not completed?

Chief Officer, Health and Community Services:

There is a central system which is online and very recently the H.R. business partner for health has started to offer face to face. I have not seen the data yet personally feeding back, so I do not think we are seeing that. Have you seen it, Anuschka?

Director of Improvement and Innovation:

No.

Chief Officer, Health and Community Services:

No, so this is just purely verbal feedback to me from H.R. about the sorts of things that are happening. I do not know how many people are taking advantage of the online exit interview or not at the moment; that data is sort of invisible to me.

Deputy T.A. Coles:

Okay. You mentioned obviously that you are aware of your culture and how bullying might be coming down as well as crosswise. But as a general feeling, do you have any way of gauging what the current morale within your department is?

Chief Officer, Health and Community Services:

Yes, I think morale is poor in many areas and good and average in others, I think. Walking around, as I do, the different units, I was in the laundry that provides the linen to H.C.S. last week and talking to the staff. Morale seemed good.

[10:45]

You had some clinical services, rheumatology, for example, where morale is low. It often depends on the relationships between individuals in that department. It is mixed. It is not as good as I would want it. It is something that to me is not unexpected, as a health system where we are; it is not a shock to me. My experience has been working in challenged health organisations and whether you move into those organisations as a Chief Executive to address a financial problem or a clinical quality or performance problem, I say typically but not exclusively it is always a cultural challenge. It is the culture of the organisation; the finance and everything else is just a symptom of that. Culture, of course, is something that has been in some of these challenged organisations, say, in the U.K. for, again, decades. You will see pockets and some people I meet are really happy in their work and some are not.

Mr. G. Phipps:

How comfortable are you that a year from now you are going to make some of the positive progress in this domain that you are expecting?

Chief Officer, Health and Community Services:

Sorry, say again?

Mr. G. Phipps:

The actions you have in place, are you comfortable that a year from now when you look back you are going to be able to point and see dramatic changes or at least some changes?

Chief Officer, Health and Community Services:

Yes, I think we will see some changes. I am confident. I think from the point of view ... one of the things that I have sort of noticed here, compared to, say, doing this in the U.K. in the N.H.S. (National Health Service) is how my time is not completely devoted to running H.C.S., that I spend a good proportion of my time importantly servicing the democratic process of Jersey, whether that is briefings of Ministers, P.A.C. (Public Accounts Committee) meetings or Scrutiny meetings. We do not have an intermediate tier and neither should we because, of course, we are too small. But the roles of the intermediate tier, say for example, in the U.K. with the Department of Health and its agencies would mean that me as a Chief Executive running, let us say, a health trust in the U.K. would have 100 per cent of my time focused on addressing these sorts of challenges. Of course, because of the way that we need to operate I do not get 100 per cent of my time to do that because I do other things. As I say, between 30 and 40 per cent of my time is not running H.C.S.

Deputy T.A. Coles:

As I say, you are new to Jersey, so you probably missed the 2018 OneGov reform but maybe your colleagues can …

Chief Officer, Health and Community Services:
I have heard about that, yes.

Deputy T.A. Coles:
Yes. Initially you have also already mentioned the Team Jersey programme and maybe you could describe how that programme has had an impact on workplace culture.

Director of Improvement and Innovation:
Team Jersey programme, I have been in the Health Department for 2 years now, so since then we have run a number of kind of … trying to encourage people to take part in sessions. We had some specific sessions where it was specifically for teams, so for specific teams where a facilitator came in, ran some team sessions, so it was a mix of a variety of activities. Some more structured learning, people could attend courses, some more customised facilitation sessions, so that was quite good. Where the interaction has happened people reported back well, they said good feedback around these sessions. Some teams have tools and equipment to do some exercises as a team. I remember some teams did that and that was quite useful.

Deputy T.A. Coles:
Subject to the scheduling conflict and difficulties, do you find much take-up for Team Jersey?

Director of Improvement and Innovation:
Right, it is the same issue. But it worked quite well when it was integrated as part of a team meeting, when people had their team meeting. They were able to say, right, let us use a half an hour of our team meeting to do that specific team development exercise, which is quite nice if you do not have, as a team manager, to facilitate it yourself but you can use a bit off cards and activity sheet and say, look, let us think about these work priorities. It was different angles. Something was about culture, something was about objectives, something was about future thinking, and that worked quite well, rather than individuals being pulled out and have to attend meetings. I think this team approach, empowering teams and giving them the tools to do that themselves, worked quite well.

Deputy L.V. Feltham:
Given what we have discussed in relation to staff morale behaviours, what sense have you got - and I do not know if you have a figure - on how many staff grievances or disciplinary actions are currently in process?

Chief Officer, Health and Community Services:

Yes. There are some numbers, I think, somewhere in here; they have come down. What we have seen is what is known as case management, referred to as case management, but there were and still are to some extent some very longstanding cases, suspensions that are into years that is unacceptable, quite frankly, and we need to progress those to a conclusion. They are not right for the individual that is suspended or right for the organisation. But those numbers have come down from some figures I saw recently and this is probably in this pack. They are coming down. There are not great numbers. I think the concern for me was the length of time that these were left unresolved. Some of them are highly complex cases, particularly relating to clinicians. For me it is the speed at which we can investigate those issues and address those issues for everyone's sake. The numbers are coming down, or the last figures I saw, slightly.

Deputy L.V. Feltham:

What impact does having those open cases have on staff in general?

Chief Officer, Health and Community Services:

What it does from a financial perspective, we are obviously having to cover that absence by a locum or an agency. We cannot fill that post obviously because the case is unresolved. There is significant cost, particularly with doctors it would be hundreds and hundreds of thousands of pounds in locum costs. It also means that for the individual that is suspended it is obviously for their well-being. It is unacceptable that people are left suspended without a conclusion to any investigation, so that will have a detrimental impact on the individual that is suspended. Depending on the circumstances, the colleagues that work with that person may be pleased and relieved that they are not there or equally may be upset and unclear about why. Because I think one of the challenges that you always face because of the confidential nature of some of these investigations is people are not - and quite rightly - aware of the detail about those individual cases. People can be unsure and sort of fill in the gaps themselves, which is uncertainty but, of course, it is difficult. You cannot talk about those individual cases. It is a negative effect all around, but clearly if people have been removed from the workplace because of a serious issue, then that is right and proper and it should be investigated and progressed from there. That may require in some cases the retraining of an individual, it may mean that they can come back with certain restrictions, or indeed it may progress on to a formal exit.

Deputy L.V. Feltham:

Okay, thank you. I am conscious of time. We do have a number of other questions on specific P.A.C. and C. & A.G. (Comptroller and Auditor General) recommendations, which I will put to you in writing. But with the last few minutes I will move on to governance of health and social care and just a question. You said you were voted in as the head of the change team. Following the establishment

of the Health and Community Services change team, can you outline the changes that have been brought forward already as a result of the work of that team?

Chief Officer, Health and Community Services:

Yes, and I will sort of cover them off in the different sort of areas. We have a doctor, a nurse, an H.R. and O.D. (Organisational Development) specialist and a finance specialist as part of that change team. I will just remind myself where we are at. If you look around the clinical governance, I have mentioned the support that there had been to the adoption of the N.I.C.E. guidelines. We have a new serious incident policy now, a new complaints policy. We have developed a maternity improvement plan, which is an area of significant concern to me. The alignment of the J.N.A.A.S. (Jersey Nursing Assessment and Accreditation System) with the C.Q.C. (Care Quality Commission) standards introduced ward-based minimum safety standards. Those are just some of the examples around the clinical work that has been happening. We are developing an action plan regarding recommendations from a Royal College of Physicians report on acute medicine that particularly the professor doctor on the change team is helping the leadership team with and I know that Cathy Stone, who is the Chief Nurse, has been helping and supporting Jessie in her roles. From the point of view of the finance work, we have started a baseline financial review, including something called the drivers of the deficit. This work will establish, I suppose in simple terms, whether the budget that H.C.S. currently has is too much, too little or about right. It will also establish, when we look at the drivers of the deficit, those things that are in direct control of H.C.S., so through waste or poor productivity things we can do better at. But it will also, inevitably, identify things that accountants might call structural.

Deputy L.V. Feltham:

I am just conscious of the timeline of the government planning process. How does that sit?

Chief Officer, Health and Community Services:

That will probably be in 4 to 5 weeks' time, that baseline work, and the drivers of the deficit will be completed. We are getting support from an external consultancy to do that, accountants. It is a big piece of work.

Deputy L.V. Feltham:

So if these consider that you do not have adequate funding and resources within that piece of work, if that was the outcome ...

Chief Officer, Health and Community Services:

Yes, if that was the outcome.

Deputy L.V. Feltham:

... then you are confident you would have enough time and support to put a request in to the government planning process?

Chief Officer, Health and Community Services:

I am not confident, no. Because the government planning process is taking its course already, we are already submitting bids that I am sure will be over the ability of the Exchequer to cover. We started, for example, I think, as regards the requirement of around how many million, £60 million? This may not cover everything that we are going to identify. We will probably be lucky to get £7 million. That is what we are asking for now. There is going to be a significant challenge, and I say a challenge that is a difficult one for politicians, for you, is around the level of funding needed for the delivery of health care in Jersey. We will have a couple of options. We can either fund it to the level that is required to provide a modern health service or we will reduce the offer that is available to Jersey people. That will be a political and obviously not an H.C.S. decision, a very difficult political one. We are looking at, for example, the Royal College of Surgeons recommendation. It is likely to meet those recommendations we could be looking for at least another 10 consultant physicians; that is many millions of pounds in its own right. There are decisions to be made. But there are things that we will be able to reduce our costs so this is not ... through improved productivity. We have a number of work streams associated with theatre productivity, with outpatients, patient flow, income, medicines, management, where we believe we can reduce our costs; there is no question about that. But there will be things that will be structural and there will be things that through the work that the change team clinicians are doing and the external reviews that we have received from Royal Colleges where additional resources will be needed. Scoping that, of course, and understanding what those are is a bit more of a long-term piece of work because that needs to be associated with establishing a clinical strategy for health care in Jersey. These are not quick pieces of work, so I doubt whether it will fit into the Government Plan process. But they are with the Minister for Health and Social Services to look at the outcome of this work and see what that means for not only the current and future deficits, this £22 million forecast, but what it might mean generally for the funding of health services in Jersey. It is a pretty critical piece of work by anyone's standards. So that is the finance piece of work.

[11:00]

But we are making progress and we will make some savings, there is no question about that. There is opportunity to do so. From the point of view of H.R. and O.D., I think we have touched a lot on this. Recruitment is key. We are looking at a pilot to look at the harmonisations of terms and conditions. For example, our allied health professionals, our O.T.s (occupational therapists), physios, et cetera, are all on civil servant contracts. We just need to understand ... and it would be

far more appropriate if there was a harmonisation of terms and conditions across Health. There is a pilot just about to start on that. As I say, exit interviews have started and we are developing now a cultural programme, including something called Civility Saves Lives. This is a programme established by some doctors in the U.K. that recognises that bullying has a direct impact on individuals that has a direct impact on patient care. I think we know in Health that the reason to improve the morale of staff is that there is plenty of academic evidence that links poor morale and bullying to poor patient outcome. So there is every reason for patients that we need to do something about that, but this needs resourcing as well. So, a number of things on the O.D. and H.R. front, the clinical front and obviously finance that we are starting to move forward with. But, as I say, I think just to reiterate again that this is not a 12-month turnaround process; this is a long-term requirement. To move an organisation from its current state to a future best practice state I think for us will be 4 to 5 years of real, focused change, not just a 12-month hit.

Deputy L.V. Feltham:
Okay, thank you. We have come to the end of the time for this hearing. Thank you to the officers for attending and thank you to the supporting staff from the Greffe as well. There will be some further follow-up questions that the P.A.C. will send you in writing.

Chief Officer, Health and Community Services:
Thank you.

Deputy L.V. Feltham:
Okay, thank you.

Mr. G. Phipps:
Thank you very much for your candid comments, appreciate it very much.

[11:02]