Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care

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Summary

Jersey faces the challenges of a small island. (The same geography which make it so attractive). Its population is just greater than 100,000 and it is over 160 miles, by air or sea, to the United Kingdom (UK).

It is an affluent island and all the people and patients of Jersey, irrespective of their individual financial circumstances, need and deserve high quality, safe healthcare. They must be assured that this is being delivered by the publication of bench-marked clinical outcome and management information from a proactively managed accountable organisation which has adopted the systematic approaches to safety and quality seen in other industries, and in modern healthcare, across the World.

Sadly, it is not possible to conclude that this is the current situation, and the Government of Jersey, on behalf of the people of Jersey, must demand this service from HCS and its employees, and publicly and assertively support the organisation in achieving it.

HCS must respond to the challenge by becoming an exemplar of good clinical governance, driven by openness, transparency, and internal and external accountability, as well as by a strong managed approach to systematic quality improvement.

This represents a substantial change from the ingrained attitudes and behaviours of many years, probably decades. It is and will be difficult and change may be vigorously resisted. The current non-accountable and individualistic culture, at least of some groups of staff, firmly rejects, sometimes noisily and angrily, any move in these directions, seeing them as unnecessary, interfering, and bureaucratic, and certainly not required in Jersey.

However, the potential rewards of success in driving change are very substantial. They include not only a Jersey public that receives, and is assured that it receives, services of high quality, but also a professionally satisfying and attractive place of work for all employees, both present, and future.

Inevitably as more esoteric treatments of disease are trialled and implemented there might be the need to transfer more patients (along well-developed care pathways), but Jersey should be able to provide, on Island, most healthcare interventions required, performed safely and effectively.

In addition, there may be the potential to treat patients from other jurisdictions should it have a commercial wish to do so.

The challenge then for HCS and its employees is to be an organisation demonstrably at the leading edge of healthcare delivery, not just technically, but importantly operationally, - not only as individuals, but as an outstanding team. Although in recent times there has been a considerable effort, and some success, in moving the organisation forwards, there is a huge challenge to be met if HCS is to achieve its potential. It will need consistent and robust

support from Government to ensure the delivery of the quality of healthcare that the people of Jersey fund, deserve and should demand.

Clinical Governance

There are many ways of describing the components of clinical governance and making judgements about its effectiveness.

A simple but useful list of areas to consider and evaluate are these: -

- Knowledge and skills.
- Leadership, followership, and accountability.
- Information being widely disseminated within and out with the organisation, and including data analysis, comparative benchmarking, and an insistence on transparency.
- A culture of team working, embracing change and innovation. Placing the needs of the patients ahead of personal vested interests.
- Positive relationships including mutual earned respect, and deference to many forms of expertise. A lack of pointless hierarchy. Shared insistence on courteous professional behaviour and exposing and dealing with poor behaviour.
- Embracing of continuous quality improvement. Conformance with standardised and systematised processes which drive quality and safety (e.g., NICE guidelines).

Within the limits of the methodology and his own experience the author of this report attempts to make comment and recommendations in all these areas.

If the recommendations are enacted the quality and safety of healthcare in Jersey will unquestionably improve. This is not to say that there is any conclusive evidence that care within HCS is unacceptably poor, but there should always be a fierce ambition to make it better.

Unfortunately, however, the processes that provide assurance that care is good, or even acceptable, are not well-developed and need urgent improvement. The clinical governance is weak, and the risks are substantial.

Introduction to the Report

This report is written by Professor Hugo Mascie-Taylor whose biography is at Appendix 1. The Terms of Reference is at Appendix 2.

The report was commissioned by the Director General at the request of the Medical Director and Chief Nurse, and its purpose was to undertake a review of quality and safety in Health and Community Services (HCS). It has not assessed primary care services.

Professor Mascie-Taylor would like to thank all those who were prepared to be interviewed for their time, their courtesy and, in as far as he could tell, their willingness to be frank and open, whatever their views and however contentious.

The methodology used was a simple one. Professor Mascie-Taylor undertook 77 semi-structured non-attributable interviews, using open and closed questions, with 53 people during 7 visits to Jersey. In addition, he attended several meetings (see Appendix 3).

Notes were made immediately following the interviews and later re-read and evaluated.

This research was supported by a limited document review at the end of the interview process, including minutes of meetings and examining a series of external reviews (which had consistent and concerning themes).

1. Maternity Review – commissioned by the current Medical Director (Appendix 5)

2. Theatre review - commissioned by the current Director General (Appendix 6)

3. Mental Health Services Review - commissioned by the current Medical Director (Appendix 7)

A potential weakness of the methodology is that hard benchmarked clinical outcome measures were largely unavailable, and there is no individual Consultant clinical output or benchmark information in the public domain. This deficit needs to be addressed as a matter of urgency. The report therefore reflects as accurately as possible the collective, although often very disparate, views of those staff who provide care in HCS and were interviewed. The recommendations are those of the author although in many instances reflect a need articulated and advice given by interviewees.

The recommendations made are hopefully constructive and should be seen as an integrated package. Inevitably for this reason the same point may be repeated in the report.

A further important point is that before making or implying any criticism the author has triangulated the evidence. However, the evidence provided was taken at face value and no further investigation has taken place.

It should be clear that when any criticism is made, it is usually not a universal criticism. There is no doubt that many staff are making strenuous efforts to improve quality and safety and are frustrated by those who they perceive as obstructing change. Even those who may feel that they are being criticised may well be highly motivated and industrious.

There is not a universal view of the quality and safety of the care provided in HCS. Some members of staff believe strongly that care is of the highest quality and would compare very favourably with small hospitals anywhere in the World. Many others are deeply concerned about the considerable variability in the quality and safety of care provided and the lack of acceptance by some of a need for a systematic approach to safety and quality. This concern was particularly for the care of public rather than private patients, although not confined to them, and many of the relevant safety and assurance issues raised were said to apply to all patients.

Interestingly, even those who expressed concern, often deep concern, about the quality of care and safety of patients did not ascribe it to any lack of endeavour. The issues that they consistently described related to culture, behaviours, an antipathy towards multi-disciplinary team working and a rejection of systematic approaches to quality improvement. This was reported, and sometimes self-reported, as being allied to a strong belief in individual autonomy and a repudiation of any need for managerial process or governance.

A further point which again was consistently and repeatedly made was that the problems in HCS are deep seated and historic, and, some thought, reflecting longstanding wider societal traits. For those who had arrived more recently, in the last decade or so, there was surprise expressed that so little positive change had occurred before or since their arrival. Those who have been in Jersey longer expressed similar sentiments but sometimes saw the lack of change as a strength rather than a weakness. Whilst many did not welcome the situation, others did, or were resigned to it.

HCS does not appear to have been proactively managed in the past, perhaps for decades (and recent attempts to manage it more actively, in-line with healthcare organisations across the World, have sometimes been met with anger and hostility).

Many observed that the current executive team was making efforts to surface and deal with some of the problems, but there was little confidence expressed that they would succeed in the prevailing climate. Indeed, there was greater confidence expressed that they would lose their jobs if they pushed too hard to introduce management processes, accountability, and good governance.

Some employees, notably more recent arrivals, regretted that they did not perceive the same focus from the medical staff on the type of broadly based service improvement that had occurred elsewhere in their experience. They felt that this leadership would be a powerful driver for improving patient safety, as well as being professionally rewarding.

There is not a culture of transparency and indeed, resistance to it from some who view any form of governance with suspicion and any move towards assuring quality and safety with transparent accountability as, at best, unnecessary, and at worst, frustrating bureaucratic interference.

It is therefore safe to assume that driving change in HCS will encounter opposition, some of it substantial and noisy. The scale of ambition for change and coping with any fierce abreaction to it will necessarily and rightly ultimately be a matter for the Government of Jersey to both determine and assertively lead.

Recommendations arising from the introduction

Recommendation 1:

The lack of availability of clinical output and benchmark information placed in the public domain must be addressed as a matter of urgency. This should be at organisational, service, ward, and Consultant levels, and the information provided both at public meetings and on the website.

Recommendation 2:

The Consultant staff should embrace their professional role and leadership responsibility to drive system-wide (not just in their own practice) change to deliver improvement in patient safety, governance, and assurance processes.

HCS should be prepared to provide them with the necessary expert support to achieve this, notably in data gathering, analysis and benchmarking.

Culture and Behaviours

Holding to account

Most interviewees reported that historically the organisation has not held its employees to account.

Some (a powerful and influential minority) see this as a very welcome lack of bureaucracy and managerial "interference" with individual autonomy, and contrasting it very favourably with other health systems, notably the NHS. However, the majority perceived this culture as highly problematic and exposing patients to unquantified risk and exposing staff to poor behaviour.

There is no obvious unwillingness amongst the DG and Executive team to be held to account for HCS's performance and equally they understand the need for them to hold HCS and its people to account, both collectively and individually. To their credit and in the absence of an inspectorate, they have commissioned several external reviews, presumably aware that this may expose them to criticism.

However, the context in Jersey mitigates against accountability and assurance processes being robust, and consequently potentially undermines the Director General (DG) for HCS and the HCS Executive team. This benefits nobody, neither the patients nor most employees.

Jersey is a democratic Crown Dependency, and the line of accountability must therefore run from all employees and contractors to managers, to the DG, to the Minister, to Government and then to the people of Jersey and the patients who are served by HCS, and, of course, fund it, either through taxation or through their fees. This line of accountability is not well-developed.

The lack of robust governance at the highest-level, driven by Government not having the required architecture, capability, or processes to properly hold HCS to account, inevitably results in the most used phrase by interviewees during interviews being "there are no consequences." They were referring to the staff and not to the patients.

Within HCS there is also confusion among some about the nature of accountability. Several senior members of the Consultant staff said that they felt it was the role of the Medical Staff Committee to hold the Executive to account. They did not perceive that it is the necessary role of the Executive both to be held to account for the performance of HCS and, in turn, to hold them, the employees of the HCS, to account.

It does, of course, not deny the requirement for senior members of organisations to work constructively and creatively for the good of the organisation and its patients.

As Bob Garratt points out in the title of his seminal book, "*The Fish Rots from the Head*." If the leadership architecture is not in place from government (and the HCS Board) then there is a much greater chance of organisational failure. Leadership architecture throughout the organisation, as well as management, is essential.

Recommendation 3:

Structures and processes need to be in place to make the line of accountability of HCS and its employees to the Government and people of Jersey explicit and meaningful.

It will be difficult or even impossible to drive approaches to quality and safety if the architecture is not fit for purpose, widely understood, and accepted. Government must hold HCS to account, and then those who lead HCS would be empowered to hold its employees to account and to drive change.

For many this would result in an improved working environment as well as, most importantly, the assurance of safe patient care.

Power of Veto

Linked to the perceived lack of accountability was a feeling expressed that some staff (not limited to a single profession) have too great an opportunity to exercise a veto, or to enjoy undue influence beyond their legitimate sphere. This was described as sometimes the behaviour of individuals and sometimes that of groups. It is of course essential in a learning organisation that all have the right to express a view, and this should be respected and encouraged.

A characteristic of great organisations is a willingness to empower staff to take decisions but then hold them vigorously to account. Weaker organisations tolerate disruptive and obstructive behaviour and do not hold people to account.

Recommendation 4:

Individuals and groups must act responsibly in the interests of all patients and consider carefully what is within their legitimate remit. They must offer constructive input and expect to be accountable to HCS for the advice which they give, and for their behaviour.

Failure to fully investigate incidents and to learn from them

HCS needs to be open and willing to embark on independent and high-quality objective investigations wherever and whenever there is a strong imperative to do so, following a failure in patient care. This would usually be a serious incident but could be a complaint or a concern raised by staff.

Because of Jersey's isolation, there is a particularly strong case for HCS to seek the help of independent investigators, inviting them to bring constructive criticism and thus the potential for individual and organisational learning. This process might, in a limited way, compensate for the lack of external regulation of healthcare in Jersey (in the same way that the executive directors commissioned external reviews of services.) Any process which "shines the light" should be encouraged.

It was widely observed that incidents are not reported by staff because they are reluctant to be seen to do so. The reasons for this apparent reluctance are hard to determine but two concerning possibilities were raised by interviewees – first a belief that no useful learning would occur, only a protracted process and, secondly and alarmingly, a fear of some form of reprisal.

It should be understood that the investigation which follows an incident is not an investigation into the behaviour of an individual. The purpose of the investigation is to establish the facts of the incident and to make appropriate recommendations so that the organisation can learn from the errors made.

(Should an investigation indicate there may be a performance issue concerning an individual, then the initial investigation establishes a *prima facie* case for a formal investigation into the individual, who at this point needs to be advised that such an investigation is taking place. In the author's experience this occurs uncommonly but if indicated).

Following an appropriate management review, if this further investigation indicates the need for holding to account through an appropriate disciplinary process, then this should be done in a robust and proportionate way following the policies and procedures of the Government of Jersey and HCS.

Recommendation 5:

Staff should recognise that the reporting of incidents is a professional duty. If incidents are not reported, then opportunities to improve patient care are lost. The professions need to act with courage and with a strong focus on the patient, and not the protection of individual members of staff.

Recommendation 6:

Similarly, there needs to be a low threshold for commencing objective, fact-finding investigations, with relevant help and support being sought from appropriate external sources where independence, transparency and expertise are required. An independent investigation avoids any perception of lack of openness and transparency.

Whilst it is the role of the Executive and Serious Incident Review Panel (SIRP) to manage the process by which investigations occur and serious incidents are identified, the responsibility for enacting the change which must follow, needs to sit firmly at Care Group level. This process must be seen as an opportunity to improve patient care and not primarily a threat to individuals. Changing any current negative perceptions will require strong executive leadership to build trust in the process.

Approach to safety management and governance

HCS and particularly some of its employees,' approach to safety is to over-rely on individual competence, personal autonomy, and goodwill – some firmly rejecting any movement towards systematisation, standardisation, and good governance that has been widely and successfully embraced elsewhere.

This view is most evident and clearly expressed by some members of the medical profession but is present in all the clinical professions. The culture of the heroic individual, rather than the effective team, is supported by some in HCS more assertively than the author has encountered elsewhere in the world. It is sometimes seen as a major attraction to working in Jersey where "one can practise as one chooses" and enjoy a "collegiate" environment beyond criticism or accountability to the organisation or its patients.

A particular point that was repeatedly made was a reluctance by many to follow guidelines produced by authoritative bodies, for example National Institute for Health and Care Excellence (NICE) and professional organisations. This was expressed by some as an unfortunate consequence of constraints unique to Jersey (where, in fairness, there are inevitably particular constraints) and by others as something in which one could take pride. Several interviewees confidently asserted that "it might well work elsewhere but it would not work here," or "it couldn't work here."

National and College guidelines did not appear to be replaced by well-argued evidence-based and justified alternatives (which had been agreed at organisational level), but by a more random approach dictated by an individual at the time (creating an ad-hoc solution in the absence of policy or process). The result of this is that patient care risks being, and is, idiosyncratic. Staff are certainly confused, and this is potentially unsafe.

This bias against standardisation and systemisation also occurs at a very local clinical level where there is a paucity of care pathways and standardised operating procedures. The presence of these elsewhere makes lives easier for staff and safer for patients.

The author was puzzled by this apparent reluctance and sought explanations for it. The most proffered view is that there is a reluctance to enter private patients into such pathways, preferring more individualised approaches. If this is true, it should at least be transparent and agreed by HCS in consultation with the Government of Jersey, although the perceived benefit is not clear.

Recommendation 7:

In the absence of governmental policy, private and public patients should be managed employing identical policies, pathways, and procedures. (It would be most helpful if Government could be explicit about its wishes and policies in this regard). Clinical Leads should ensure that this occurs unless there are explicit exceptions agreed with their Professional Head.

It is a reasonable starting point to indicate that it is the policy of HCS to follow all relevant guidelines. If pressing reasons exist for not following them, and these reasons cannot be successfully mitigated, then the alternative agreed approach of HCS should be explicit. It should be argued and promoted by the Care Group leader, signed off by the relevant Head of Profession and then signed off in summary form by the HCS Board.

The new guideline or process must be recorded, be available and placed in the public domain (through and endorsed by the HCS Board).

This explicit and transparent process would protect both patients from harm and individual staff from an obvious source of criticism – potentially both reputational and legal. It may though expose HCS itself to reputational and medico-legal risk, so the process needs to be evidence-based and well documented so as to generate a defensible position.

Multi professional multi-disciplinary working

Healthcare is increasingly dependent on effective working in multidisciplinary teams, and it was reported by interviewees that there are good examples of this approach in HCS, but also some areas where this approach barely exists.

Throughout the patients' journey, several clinical practitioners are involved, and their activities must be conducted in an integrated and safe way. This may well commence during the diagnostic phase when professionals from different backgrounds come together to establish a diagnosis and formulate a management plan. This multidisciplinary, multi-professional approach needs to continue throughout the patients' journey. The more complex the patient's illness, the more this needs to be the case.

There has been much learning about safety in organisations. Conclusions include the need for respectful and honest dialogue, the need for any individual to be allowed to raise concerns, decisions to be as democratic as possible whilst not undermining individual accountability, effective teamwork, following well established safety processes etc.

For all of this to happen it is necessary that all members of staff feel valued equally and most importantly, must not be or feel intimidated. Sadly, several interviewees described clinical situations in which bullying, dismissive behaviour, autocratic behaviour, and lack of appropriate consultation had occurred. The areas most often pointed towards were theatres and some wards, but these were by no means the only areas where unhelpful behaviours are said to occur. There was a frustration expressed that some people were reported as immediately dismissing constructive advice. This behaviour is at best undermining and, at worst, potentially unsafe. (The experience of the airline industry in recognising that frequently prior to crashes, the causative problem may have been recognized but not reported to more senior staff, may well have relevance).

Most concerning was that those describing these examples of poor behaviour at interview felt that they were not reported because of the perception that no action, disciplinary or otherwise, would occur. In fairness it was also widely recognised that HCS is making tangible efforts to improve this situation but that changing a long-established culture is very challenging.

Recommendation 8:

HCS has a clear responsibility and duty of care towards its employees, and it needs to give this issue it's full attention and to act as assertively as it can to deal with poor and unprofessional behaviour. Such behaviour is a matter not only for HCS but should be brought to the attention of the relevant professional regulatory process. For example, for doctors, the Medical Director for HCS and the Responsible Officer for the GMC.

It is the responsibility of all the clinical professions not to tolerate, and to challenge and report poor behaviour.

Recommendation 9:

There appear to be areas of good multi-disciplinary team working within HCS. This approach needs to be extended to every area across the organisation, and no other approach tolerated.

Ensuring that this occurs must be clearly within the remit of Clinical Leads and is an approach that HCS leadership must insist upon.

Accountability for the quality of care of private patients

It was reported by some that there is confusion as to the accountability for the care of private patients. In private hospitals this issue is also debated although there is a clear trend towards holding the organisation as well as the individual consultant to account. However, the situation in HCS is that it, (as well as the Consultant), has a responsibility for the care of patients within its purview, be they public or private.

Recommendation 10:

HCS and its consultants must recognise that they have a joint responsibility for the safe care of all patients, both public and private, in the hospital. Linked to this must be the recognition that all the metrics which are needed to assure the safe care of patients apply equally to public and private patients.

Lack of openness and transparency

Whilst some individual clinicians commendably collect data about their practice and benchmark it against available data from elsewhere, there is an overall paucity of metrics about individual and collective performance. This is said to have improved, but more attention needs to be paid to this area with better information available to individual clinicians, their appraisers, groups of clinicians and the public.

An open and transparent culture within an organisation is a powerful driver for improvement in quality and safety.

Coupled with this marked lack of openness and transparency, both within HCS and external to it, is the failure to place performance information into the public domain. This neglects a powerful driver of safety and quality improvement – the most powerful driver of which is the collection and publication of good comparable metrics. This information should also be required for appraisal.

The introduction of the Quality and Performance report is a very welcome recent development that needs to be further enhanced.

The first requirement is that internally robust metrics are collected wherever possible about the working of HCS. This allows comparisons to be made between various wards, and the performance of clinicians and clinical groups to be monitored and longer-term trends observed.

The second requirement is that wherever possible the metrics are benchmarked against external organisations and individuals. This gives a meaningful comparison and allows the organisation and individual clinicians to know how well they are doing.

The third requirement is that as much information as possible is placed in the public domain. Arguments were advanced by some interviewees that the data is insufficiently robust, or that the public would be alarmed if the data were revealed to them.

Frankly, all of this is special pleading. The way to improve the quality of the data is to make it clear that it will be put in the public domain The public has the right to know about the quality of the services provided by HCS.

Recommendation 11:

More information about HCS and individual performance should be routinely placed on the website and put in the public domain through HCS Board meetings.

In fairness, a number of individual clinicians make strenuous efforts to monitor their own practice and to benchmark their results against other clinicians. This should be applauded and vigorously supported by HCS. The ownership of the data must be with HCS who are responsible for service, quality, and safety.

Patient and Public involvement

One of the striking features of the organisation is a lack of openness and transparency, internally and externally.

It is the case that positive moves are being made by the organisation to have greater public and patient involvement. These include the commitment to a fully functioning Patient Advisory and Liaison Service (PALS), the use of patient stories at the HCS Board and the development of the Ladder of Engagement tool.

These developments should be enhanced using every opportunity for exposing organisational and individual performance to scrutiny. This is the major driver of change available to healthcare organisations and undoubtedly leads to improvements in both quality and safety. Jersey lags far behind the best in this regard.

There is currently a limited involvement of the public and patients. There are several reasons for increasing this involvement as well as driving quality and safety. These include:

1. HCS is largely funded by the public out of general taxation and should account to it in an open and transparent way. The same principle applies to private patients.

2. Gaining the support and understanding of the public and setting realistic expectations for both the public and politicians.

3. To learn from the public about the quality and safety of the services that they receive and make appropriate changes in the light of this feedback.

Recommendation 12:

The developments briefly mentioned above should be enhanced as rapidly as possible. Clinical performance reporting is well developed in many areas of the World and Jersey does not need

to reinvent these processes but to adopt the best available. It may require technical support in doing this but the drive to do so must come from the Government of Jersey and the HCS Board.

Roles and Structures

The HCS Board and Assurance Committees

In July 2019, an HCS Board and Assurance Committees were established. The HCS Board meetings are held in public. These developments are a very welcome step forward and should be much applauded as a necessary step in the delivery of safe care by HCS, with assurance provided to the Government of Jersey.

However, further development and modification of these structures, building on the undoubted progress which has been made, is now necessary.

The Role of the HCS Board

The population of Jersey is just over 100,000 (103,267 census day, 21 March 2021). Its compact nature gives it many advantages in that people frequently know each other and there is the opportunity for good personal relationships to develop.

However, the potential disadvantages include lack of clear lines of accountability and an unwillingness to challenge each other. It was very frequently observed during interviews that any attempt by the Executives of the organisation to manage, to drive positive change or to hold employees to account was likely to be perceived as damaging to vested interests and subverted through the close, but not always transparent, social networks of Jersey. Many commented on the vulnerability of the senior managers, sometimes, but not always, sympathetically.

A striking number of interviewees, including some doctors, described a longstanding culture in which there is an unwillingness to manage and hold to account powerful and well-connected minorities, the presence and influence of undisclosed networks, and a lack of openness and transparency.

Many were very direct in their criticism and used the phrase "the Jersey Way" to critically describe the culture. Whether this is entirely fair the author cannot judge but the frequency of its use and belief in its existence is potentially highly damaging to patient care. It was repeatedly and forcefully described, and this issue must be assertively addressed by a far broader leadership than HCS, although the HCS Board must play its full part in leading the necessary cultural change within HCS. The first challenge therefore is to be clear about the line of accountability to the Minister for Health and Social Services (HSS). The DG accounts to the Chief executive and through the CEO to the Minister, Government and people of Jersey, and the staff of HCS account through the DG.

The HCS Board has the potential to be most helpful in both holding the organisation to account and "being assured , and in giving the Executives the authority and consistent support which they need to insist upon safe, high-quality practice. There is no doubt that the current HCS Board acts in good faith, but it has several impediments.

The first of these is that the Minister for HSS is the single lone figure (although Assistant

Ministers may attend) in holding the organisation to account. The result of this is that the Executive Directors give reassuring, but unchallenged accounts of the way in which the organisation is working. In fairness, some Executives do offer some challenge to their colleagues, and this is to be applauded, but a single Minister is ill-equipped to perform the task single-handedly, and nor should they be expected to do so.

The second difficulty is that the membership of the HCS Board is extraordinarily broad and in practice it works more like a partnership group rather than an effective Board, which would be characterised by informed non-Executives (NEDs) challenging the Executives.

If there is appetite to create an HCS Board along the lines widely adopted elsewhere in the World then this would result in the appropriate separation of policy makers (government) and providers of care. There are of course well-rehearsed reasons for the separation of policy making from operational issues. Policy makers can focus on their vital role, whilst allowing the HCS Board to direct and operational managers to manage and to be held to account for managing well.

The HCS Board could and should seek guidance from Government on essential policy matters.

By way of example, the HCS Board could seek guidance from the Minister for HSS on important policy issues such as:

- Should HCS adopt authoritative guidelines for safe patient management, and if it does not, explain publicly why it is unable to do so?

- Should public patients have the same access to consultants in the hospital as private patients, and should their care be equally safe, or is it acceptable that private patients are treated differently in this regard?

- Should clinical outcomes of the organisation and its consultants be documented, benchmarked, and published?

- Should statistics about serious incidents be placed in the public domain, along with actions taken to avoid recurrence, and details of follow-up audits?

- Should waiting list statistics be placed in the public domain, for both public and private patients?

These types of questions are policy issues for the Government of Jersey and active dialogue between Ministers and the Board could achieve clarity and dictate a clear direction for HCS, as well as an informed public.

The qualities that the organisation should seek to find in an independent Chair and NEDs include:

- A grasp of the difference between “directing” and “managing”.
- A sophisticated understanding of their topic area.
- Independence of thought.

- The capacity to be held responsible even when detached from the day to day operation.
- Being able to take the helicopter view and to deal with both the concrete and the abstract.
- Having a range of thinking styles to cope with the diversity of issues that they would confront.
- Being comfortable with developing and debating various scenarios without taking immediate action - a bias towards strategic thinking.
- An ability to make the connection between policies and strategic decisions, then being able to learn from results and to assess the quality of implementation.

The extent to which there is an appetite to change the membership and functioning of the HCS Board is not clear to the author, who recognises the potential need to fit with the existing architecture in Jersey.

The current HCS Board does function as well as a Partnership HCS Board. This is of some value and should not be lost.

Recommendation 13:

Consideration should be given to creating a conventional HCS Board with non-executive leadership and it accounting for the performance of HCS directly, or less desirably, indirectly, to the Minister.

This widely adopted model would allow the Minister (with the necessary policy support) to hold the organisation more effectively to account on behalf of the Government and people of Jersey, and to focus on leading the development of policy.

Other options which will allow the HCS Board to work more effectively, whether it remains constituted as it is currently or not, are set out below under "Assurance Committees."

Assurance committees

There are three Assurance Committees which function very loosely as HCS Board subcommittees. Having three such committees may well be a sensible approach and is a welcome step forward. However, their weakness is that there is no independent chair for each committee with the appropriate level of subject matter expertise.

In addition, the current chairs (Assistant Ministers) are the only people present from outside the organisation who are available "to be assured." The other members are the providers of assurance, and in practice "mark their own homework." If the Assistant Minister is unavailable, then an Executive Director must chair the meeting. In these circumstances a crucial piece in the assurance process cannot be in place.

When Executives do challenge, this may be done effectively but adds to the confusion between whether this is primarily a meeting to assure the Chair of the meeting (the Assistant Minister)

or whether it is an HCS senior manager meeting (at which one would expect more challenge of each other).

Interestingly, in questioning those who attend the assurance committee, this was almost invariably their view – that the meeting was seen as not being fit for its stated purpose in giving assurance to the Minister for Health and Social Services.

Recommendation 14:

The possibly emerging plan to have the assurance committees chaired by informed external experts could transform these processes and make them of benefit to all. Patient safety would be enhanced, and greater assurance would be provided to the Government and people of Jersey.

If the emerging model of one or three independent expert chairs were to be adopted, then an issue would be to whom do they account. In a pure model they would account to a non-executive Chair of the HCS Board, who in turn would account to the Minister (who accounts to the States Assembly and the people of Jersey). Other accountability models could be developed but this model would be the optimum.

The topics to be dealt with by each committee could include the following, (some of these topics are already covered by the current assurance committees). It is important to acknowledge that considerable progress has been made in recent times and that now these committees and their functions need to be further developed rather than discarded.

Operations, Performance and Finance Committee:

- Activity
- Waiting lists
- Exceptional issues e.g., pandemic
- Operational performance indicators by speciality / Care Group
- Estates
- Contract performance
- External review recommendations, action plans and progress
- Improvement reviews
- Information governance
- Strategic planning framework
- Dealing with regulatory processes
- Financial management

Quality and Risk Assurance Committee:

- Supporting or otherwise alternative guidelines when HCS is unable to meet National Guidelines – the reasons and the mitigation – before these are placed in the public domain

- Any deviations from the expected safe performance with action plans to manage the situations
- Staff survey
- Quality account / Indicators
- Patient experience
- Learning from deaths (Structured Judgements Reviews)
- Impact of staffing on safety
- Infection Prevention and Control
- Legal services activity (number / type of claims, themes, lessons learned)
- Jersey Nursing Assessment and Accreditation System (JNAAS)
- Health and safety
- Quality impact assessments
- Serious incident reporting and follow up of action plans
- Safety learning events and follow up
- Regulation of care/dialogue with professional regulators
- Avoidable harm (Pressure Trauma / Falls / Medication errors)
- Task and Finish groups (rapid improvement work)
- Audit of CPD (including SPA's)
- Signing off SOPs

People and Organisational Development Assurance Committee:

- Workforce indicators (including case management)
- Education and training
- Wellbeing
- Workforce strategy / planning
- Health and safety at work
- Job planning (including SPA activity)
- Staff surveys
- Staffing frameworks
- JNAAS
- Registration and revalidation
- Clinical supervision
- Organisational development
- People strategy
- Team Jersey and cultural change
- Rewards Review
- Internships / apprenticeships Recruitment

The benefit to senior management in HCS of being held to account by the Government of Jersey cannot be overstated. Their authority, including that of the DG, would derive directly from the people of Jersey through the Government, Minister, the Chair, the Chairs of Committees. and enable them in turn to hold the organisation to account.

The clarity brought to the situation would be of benefit to most employees.

Recommendation 15:

What should not be open to discussion is the need for the organisation to be held to account by Government of Jersey in a more rigorous and robust way, and importantly the authority of Government of Jersey transmitted downwards through the DG and Executives to bear on HCS and its employees.

Discussion needs to occur between relevant parties to design a more effective system building on the progress which commenced in 2019.

Internal Management of HCS

Role of the Director General (DG)

The most senior manager in HCS is the Director General (DG).

The role of the DG is unusual in that he / she is both acting on behalf of the Minister for HSS (who is seeking assurance) and at the same time is the Chief Executive Officer (CEO) of the organisation. These two roles are usually separated in other jurisdictions. This situation can possibly be turned to advantage with sufficient political skill, although it will remain a very challenging role.

The reason for the merging of the two roles is that there is no separate Department of Health which elsewhere in the World are the strategy setting, policy making parts of the civil service, and which hold healthcare providers (hospitals, primary care etc) to account. HCS performs both roles and this is understandable given the relatively small population of Jersey and only one hospital. However, it should be practical to have a health policy function sat within the Government of Jersey and to allow HCS to be a form of arm's length body, albeit with wider responsibilities, including health strategy and the management of primary care. (Reference to the Independent Review of the Isle of Man Health and Social Care System (2019).

The creation of a Board with a chair and non-executive function accounting to the Minister would aid both clarity and accountability. It would also facilitate an active dialogue between policy makers in Government and strategists in HCS.

Role of Group Managing Director

Given the breadth of the DG's responsibilities, the Group Managing Director has very substantial day to day operational responsibilities and would be described as a Chief Operating Officer (COO) in many healthcare organisations and with direct accountability to the CEO (and usually a seat on the HCS Board).

The Managing Director is required to manage the organisation on a day-to-day basis giving direction to his / her subordinates and holding them to account. This would require having a close working relationship with the leadership of the care groups.

Recently the Managing Director appeared to operate in a more strategic way but in this proposed model the key role is the day-to-day operational management of the organisation, leaving the DG and the NEDs to manage the external environment and provide direction to the organisation.

Recommendation 16:

The Managing Director role is crucial and the incumbent needs to be a highly competent and energetic operational manager (who can come from a variety of backgrounds e.g., general management, nursing, medicine).

Recommendation 17:

In the current HCS structure, the Managing Director should meet with the Chief of Service (currently known as Associate Medical Directors (AMD)) collectively at least weekly and more frequently at times of crisis. Individual meetings would also be required.

The Managing Director should chair the monthly Performance Review Meetings on behalf of the DG (this allows the DG to focus on the external environment and managing upwards). At these meetings, the Chief of the Care Group (AMD) and their teams should be held to account whilst receiving support and guidance.

The title of Group Managing Director is part of a wider Jersey model but is not a title used in hospitals. It may help understanding if the title were altered to Chief Operating Officer (COO).

Role of Care Groups

The organogram demonstrates that immediately beneath the Managing Director sit the Care Groups. Each of these is led by an Associate Medical Director (AMD) with a Lead Nurse (LN), and a General Manager (GM) accounting to them.

Surprisingly, some of the managers in these roles say that their accountability is unclear, and give different versions as to whom they account, often differentiating between 'on paper' and 'in practice.' This confusion cannot be helpful or accounted for as the organisation is clear that the LN and GM account to the AMD and the AMD to the Managing Director. It is for the AMD to hold the General manager and Lead Nurse to account.

It is not the case that managers can select to whom they account or who accounts to them.

Recommendation 18:

There is a need to make clear again, and make certain that it is understood by all, the accountabilities of all those in the triumvirate so that no lack of apparent understanding can occur or be expressed. Close working and positive relationships with regular meetings are essential.

Appraisals must recognise the line management relationships.

Whilst both the LN and the GM account managerially to the AMD (Chief of Care Group), the LN accounts professionally to the Chief Nurse, and the GM to the COO. The AMD (Chief of Care Group) does not account managerially to the Medical Director but accounts directly to the Managing Director (COO), and accounts to the Medical Director only in the professional sense as a doctor.

A further difficulty appears to be that some of the AMDs are said to not attend the monthly executive led performance review meetings regularly and that these meetings are not always chaired by the Managing Director.

This confusion risks 'everybody, somebody, anybody, nobody' being responsible and accountable – an undesirable situation in both a clinical and managerial context.

Recommendation 19:

The title of the Associate Medical Director is inappropriate and misleading. It should be changed to a suitable alternative. The title 'Chief of. . .' is used elsewhere.

The monthly performance review meetings should be chaired by the Managing Director (COO) and attended routinely by the AMD (Chief of care group). Both the COO and the Chief of the care group must require their immediate team to attend.

Accountability for safety and quality must be clear to all and the processes within the organisation must reflect the accountabilities. The accountability of the Chief of …… is for all aspects of the function of the care group, not just those that interest them. The role is that of a senior manager focussing on operational management and not on strategy.

There are several options for the leadership of the Care groups. By far the most common is that a care group, or its equivalent elsewhere, is led by a triumvirate of Doctor, Nurse, and Manager. There are choices available as to what the background of the individuals who undertake the lead management role should be. They all have advantages and disadvantages but the key to success is that whoever holds these posts fully understands that they are in a line management position between the Managing Director (COO) and the management structure beneath them.

Recommendation 20:

One member of the triumvirate should be accountable to the Managing Director (usually called COO) and the other two account to that individual. Sometimes the individual is the Doctor but not always – they are then often referred to as 'Chair.'

There are arguments to be made as to why the role should be filled by a doctor, but they only apply if the Doctor commits about 50% of his / her time to the role, is well supported, and fully understands the nature of their managerial responsibilities and their accountability.

Even if this – the current model - is preferred, it will not work unless the Doctor is competent to undertake the role or can be developed to the point where they become competent. The issue should therefore be addressed on a Care Group by Care Group basis and a doctor selected only if there is a suitable and enthusiastic candidate.

Recommendation 21:

The author's experience is that when the Doctor is placed in the Chair role and acts appropriately and competently, then this model is probably the optimum. It is an operational management role and usually requires at least 50% of the Doctors time.

The care group will continue to require business partners and expert professional advice in other areas, most obviously, but not exclusively, Finance and Human Resources, Health and Safety, Infection Control, Training and Development.

The fact that a range of skills is required to manage a complex group should not generate confusion as to who is accountable for all aspects of performance within the care group.

To discharge their responsibilities, the chief of the care group will need to meet regularly, at least weekly, with their teams and meet with them individually on a regular basis.

Clinical Leads

Clinical services are led by the Clinical Lead. The most striking feature concerning Clinical Leads was their lack of clarity about their role, although the organisational chart makes this clear.

There were varying accounts of their line of accountability and often no readiness to recognise any accountability for patient safety.

The language used tended to be about liaising with management rather than seeing themselves as a crucial part of the management of the organisation. Some went further and described their role more in terms of defending the vested interests of themselves and their colleagues.

In fairness, the lines of accountability at service level are unclear to many in the organisation and therefore it is unclear as to who is accountable for patient safety. This is a situation which creates unnecessary risks and needs to be resolved as a matter of urgency.

There are several available options, but the guiding principle must be clarity. The most rational model in Jersey is that the clinical lead accounts to the AMD / Chief of the care group. However, the most important requirement is that the post holder understands that they are employed in an important managerial role and that their accountability is to more senior management and not to their colleagues.

This does not mean that they should not have a constructive relationship with their colleagues, from whom followership is required.

Recommendation 22:

At service level there is frequently a similar triumvirate of doctor, nurse, and manager. If the doctor i.e., clinical lead, is the accountable manager, then the role will require at least one day a week. If either the nurse or the manager is in this role, then they may well be able to undertake the role in tandem with another service role or other managerial work.

The responsibilities and accountabilities of the role must be spelt out with clarity, understood by all, and then managed.

The author has seen examples of where every group of clinical staff is managed by their professional head. This is workable, but it generates a lack of multi-disciplinary team working and has the overwhelming disadvantage of the only point at which lines of accountability come together are the DG. It cannot be recommended.

Management Training and Development

A significant feature of some of the managers from all backgrounds was their lack of clarity about their role and their questionable ability to undertake it. It is a fact that healthcare

organisations often must recruit into a post and then develop the individual appropriately. Some indicated that they would welcome both uni-disciplinary and a multi-disciplinary management development programme, recognising their own skill deficit. Providing such development would benefit the organisation.

Recommendation 23:

All of those in management roles within the organisation need training and development consistent with and targeted at their current and future roles (as agreed with their line manager). Much of this could be provided in house.

For example, lead clinicians and most nurse-managers not at executive level do not need training in strategic management but in basic managerial competencies including finance, HR, holding others to account, and having difficult conversations with colleagues.

The drawing up of a series of competency frameworks could well be useful and aid selection and development processes.

Structure of Quality and Safety functions.

The organisation of the departments which have a remit in the Quality and Safety domain is not consistently described by those who worked within it. Whilst the various departments have different roles, no one from any of the departments would appear to understand the total picture, or to articulate an overall organisational approach to the issue. This is work in progress, but further rationalisation and unification of the functions would, at least in principle, be welcomed by interviewees.

Those interviewed indicated a lack of understanding of the role of other departments and a lack of integration between them. The reasons for this are unclear but possibly relate to the fact that there are several reporting lines. In addition to which there may be personality issues which need to be managed.

In addition to the corporate functions, some care groups have established, or are in the process of establishing, roles which work in the quality and safety domain. There is no obvious symmetry to these roles, and it remains unclear as to the extent to which their functions are integrated into any coherent organisational approach.

Whilst the author is not confident that he understands the current arrangements well enough, it is reported that the various quality functions account to four Executive Directors.

The Health and Safety Department which consistently articulated the most sophisticated approach and most impressive results is managed entirely separately.

Quality and Safety Team

The Quality and Safety Department is a small department concerned with the analysis and learning from serious incidents (SUIs). It also has other responsibilities, including running the library.

Its processes were often criticised as cumbersome and not timely. To some extent this department appears to feel that it has the responsibility for organisational learning (for which it does not have the necessary capacity). Its function needs to centre on providing timely and good analysis of SI's., and potentially other sources of information, for example, complaints.

The Quality and Safety Department accounts to the Medical Director.

Recommendation 24:

It should be made clear that the Quality and Safety function is to support the general management structure by organising investigations and audits. Enacting the recommendations is the responsibility of the AMD (Chief of Care Group) who is accountable to the Managing Director (COO).

Quality Improvement

The Quality Improvement Department adopts a facilitative rather than an analytical approach. However, the adoption of this facilitative approach does not seem to mesh with the work of quality and safety, and instead selects its own areas upon which to concentrate. In fairness these are not necessarily inappropriate, but not part of any coherent organisational strategy. The Quality Improvement function accounts to the Director of Improvement and Innovation.

Quality Assurance

The Nursing and Midwifery Quality Assurance Department is concerned with quality improvement in Nursing using the Jersey Nursing Assessment and Accreditation System (JNAAS) standards. The function accounts to the Chief Nurse and is well regarded.

Health and Safety

The Health and Safety Department has developed a coherent strategic plan for its function and accounts to the Managing Director through the Head of Non-Clinical Support Services. The progress made in this area is impressive.

Recommendation 25:

There is an innovative opportunity to bring the expertise in Health and Safety to bear on other quality and safety functions.

The author of this report suspects that he remained not fully sighted on the roles and relationships of all those within the organisation who have what could broadly be described as responsibility for the safety of patients and staff. However, there is no doubt that there is an opportunity to rationalise the current structures to allow them to work more effectively.

Recommendation 26:

HCS is a small organisation with limited capacity, and it must surely be the case that the overall strategic direction for Quality and Safety is placed in the hands of one executive director, preferably a new appointment of an individual capable of marshalling the available resources as effectively as possible, but if this is not achievable, then under an existing Executive Director.

The function of the collective resource should be to work through (not around) the core general management function, to improve overall quality and safety improvement. In this model, the leader of each care group is responsible and accountable for the quality and safety of staff and patient care in their areas, being very actively supported by a coherent corporate safety and quality function.

If a Director of Quality and Safety is appointed at Executive Director level, then the available resource should be placed at their disposal. The Director would need to collaborate closely with the Chief Nurse, Medical Director and Director for Improvement and Innovation but importantly work through the Managing Director (COO) in driving the agenda.

The organisation of how learning occurs from serious incidents, complaints feedback etc.

It is widely accepted that one of the important ways in which organisations learn, be they healthcare organisations or not, is from the analysis of errors and the promulgation of behaviours which reduces the chance of a similar error occurring again. The same type of learning can occur not only from the analysis of serious incidents but from patient surveys, analysis of complaints etc.

It was consistently reported by interviewees that the process in HCS failed repeatedly for several reasons. One of these is that there was a reluctance to report incidents and several interviewees said that they were aware of incidents which had not been reported and even that they themselves had been warned not to report incidents, although it is not clear by whom.

Enacting any learning from the analysis of SIs must be through the general line management structure. However, the quality and safety department appear to some extent to want to do this work itself (although lacking capacity), whilst the general management structure seems content to leave quality and safety to this small department.

This is most apparent when interviewing some of the AMDs who did not believe that they have the responsibility for ensuring organisational learning from the analysis of SIs and lack awareness of highly relevant information. Other members of the triumvirates were equally unclear about the role and accountability in this area.

Recommendation 27:

The HCS and Executives must make it clear that failure to report incidents is unacceptable to the organisation and is unprofessional. Sadly, there is a need to make it abundantly clear that those reporting incidents will be protected from any form of intimidation and that anyone attempting to stop reporting will find themselves in serious difficulty, both managerially and professionally.

It would be useful if those with professional regulatory responsibilities made this clear.

Failure to report a potentially serious incident is to directly undermine patient safety and staff should be held to account for this failure.

The triumvirate leadership of the Care groups must understand their role in this important domain and be performance managed in delivering it.

Nursing, Allied Health Professions (AHPs) and other non-medical specialities

This was an area where there was a relative paucity of evidence, and it is therefore difficult to be too dogmatic in appraising these professions, nor was it within the terms of reference.

The well-established JNAAS process (based upon the Care Quality Commission (CQC) standards) has attracted support but whilst it is likely to have improved the quality of care there is said to be no objective evidence to support this assertion. If this is true, then finding meaningful outcome metrics would be helpful.

The major concerns expressed by these professions was that the medical staff did not always take their expertise sufficiently seriously, and secondly that multidisciplinary team working was very patchy and poorly developed in HCS (as compared with other organisations in which staff had previously worked). There was also an observation made by some that nursing is less valued by the medical staff in HCS than in other organisations in which they had worked around the World.

Some reported good team working both with and between doctors. However, a disconcerting number reported poor working relationships including bullying by doctors or a lack of assertiveness of nurses, or both.

It was reported by some interviewees, often nurses, that an area of weakness in the organisation was in the monitoring of sick patients (when appropriate scoring systems were either not used or used incorrectly) and in the timely escalation of concerns when necessary.

There was also some concern expressed about the quality of communication with relatives.

Recommendation 28:

Further evaluation of alleged intimidatory behaviours is needed, and this should be followed by clear and measurable remedial action if indicated. It should be made clear to all the employees that bullying is unacceptable and will be vigorously dealt with by the organisation through appropriate processes.

Whilst most reported the quality of nursing to be usually acceptable, areas which require attention are effective communication with relatives (training for both doctors and nurses), and consistent and accurate monitoring of sick patients with timely escalation of problems.

A proactive auditing approach would be desirable to allow the scale of the problem to be quantified and, if necessary, remedial action to occur. The threshold for escalation may need to be lowered and then escalation met by medical staff with an understanding that it is in the interests of patients, even if it proves, in retrospect, to have been unnecessary.

Reference was repeatedly made to the difficulties of recruitment and retention of nurses and other professionals. It was suggested that to some extent this related to nursing being regarded as a less important activity and profession than it is elsewhere. It was also suggested that the cost of living/housing in Jersey was a significant problem.

Recommendation 29:

The author found it difficult to evaluate these points relating to recruitment and retention and would ask that Human Resources give a written report based on exit interviews and other intelligence. An expert external view might be helpful.

Medical staffing and Individual Specialities

It was reported that there are tensions with surgery driven by a reluctance of some (middle grade) doctors to see a patient until a particular investigation has been undertaken, sometimes followed by a reluctance by the service department to undertake the required investigation.

To admit patients from the emergency department sometimes requires protracted negotiation with doctors, in particular middle grade doctors. This effectively leaves the patient as a pawn in a debate between various groups of doctors and is unacceptable. During this time, a patient is being inappropriately, and potentially unsafely, managed in the emergency department.

Recommendation 30:

The solution to the difficulties in the admission from ED process is first to make it clear to all doctors that when they are asked to see a patient in the ED, then they must do so and failure to do so should be documented in the notes and the doctor held to account.

A second and highly effective approach is to give the unfettered right of admission to the hospital to ED consultants. The author has seen this work to very good effect despite fears expressed that ED consultants would be unable to differentiate between different clinical problems and would admit patients inappropriately. In practice they performed better than predicted by their peers and this was very rarely a problem.

The concern sometimes derives from a feeling that beds within the hospital are the property of doctors or groups of doctors. This is not the case. The beds belong to the institution which employs the doctors.

If a genuine problem arises over inappropriate admissions, then this is appropriately dealt with by constructive discussions between groups of medical and sometimes nursing staff but not by denying patients care.

It was reported by members of all professions that there is a lack of clarity about the variable availability of consultant staff. This was not a criticism of their lack of industry but an uncertainty about their availability. This was not a universal criticism but was a point made sufficiently to generate a concern about the safety of patients.

Recommendation 31:

The solution to any lack of clarity about the availability of consultant staff is straight-forward and long overdue. Robust job plans must be in place for all consultants and made widely available.

Not only would this facilitate the hospital running more smoothly it would also have a direct and positive effect on patient safety. Importantly it would end any unwarranted criticism of consultant staff whilst making explicit any gaps in the service.

Interviewees expressed considerable concern about several aspects of middle grade medical staffing. First there was concern about the long hours worked by some middle grade doctors. If this is the case, it is unacceptable and potentially unsafe. This needs to be remedied. Secondly it was pointed out repeatedly that some of the middle grade doctors are locums, the competence of which is unknown when they arrive. It was said that they work without direct supervision soon after their arrival in Jersey. It was also said that they are more likely to carry out procedures on public patients than on private patients thereby exposing public patients to a greater risk of unsafe care.

Recommendation 32:

Medical Staffing is an issue of some concern to many, and which is highly likely to have a direct effect on patient safety.

The role of middle grade doctors needs to be fully assessed in a joint piece of work between the Medical Director's and the HR departments. This must result in a written report for the HCS Board.

The report must include details of the hours worked by middle grade doctors, how their competence is assessed, and the extent to which the Consultants directly supervise them. (It may be that external support is required to do this piece of work).

If the concerns expressed prove to be upheld, then the solution will be to employ more consultants and move to a consultant-based Service.

Apart from the obvious direct benefit of having procedures undertaken by fully trained practitioners there are other benefits to this approach,

- A more comprehensive rostering will be possible without placing onerous demands on consultants.
- There will be more opportunities for a degree of sub-specialisation and the importing of techniques to the Island.
- Multi-disciplinary team working would be enhanced.
- There will be fewer lone practitioners.
- Consultants will be able to leave the Island for Continuing Professional Development
- Teaching and research would be improved, as would the quality of academic meetings on Jersey.
- Consultants would be available to take part in quality improvement initiatives.

Acute Medicine

There were several repeated reports about the lack of availability of Physicians to see acutely ill patients and the lack of clarity about which Physicians are available to see urgent referrals (from anywhere in the hospital). In the absence of any systematic approach, this poses risks to the patients and potentially an unwarranted criticism of the doctors. It was pointed out that the problem related to a lack of Physicians, rather than a lack of commitment.

This service requires immediate attention – it is a fact that, whatever their reasons for initial admission, most patients who deteriorate, do so for medical reasons.

An acute Consultant Physician is therefore needed to be always available to deal with sick patients throughout the hospital.

Recommendation 33:

There must be a physician of the day who is competent and available to manage or advise on the management of acutely ill medical patients on the medical wards, acute admissions unit,

emergency department, surgical wards, and the intensive care unit or indeed anywhere else. The rota must be published, and contact details made clear.

Intensive Care Unit (ICU)

Several interviewees reported some confusion as to whose care patients are under when they are on the ICU and at times, the absence of senior medical staff (Consultant Intensivists, Consultant Physicians, Referring Consultants,) from the unit.

Recommendation 34:

There are a variety of models available, but one solution to whom is responsible for the care of patients in ICU would be that patients are under the care of an Intensivist who should be immediately available at all times. The referring Consultant should visit at least daily and more when requested or wishes to do so.

Many of the patients on ICU have complex medical problems and the safety of care would certainly be improved by having a Physician of the day (see acute Medicine) who was available to provide a rapid consult service.

The Medical Director should ensure that ITU joins the national benchmarking process as soon as possible (Intensive Care National Audit and Research Centre (ICNARC)) and the results of this process placed in the public domain.

Access to ICU beds should be based on clinical need and no other consideration. This determination is the responsibility of the intensivist in charge who is, of course, accountable for their decision making.

Maternity

The maternity unit has less than a 1000 births per year and this is below the number recommended by the College to assure safety. However, for obvious reasons this situation will continue but what must be recognised is the potential challenge that it brings.

Recommendation 35:

The small number of births in Maternity makes the need for clear patient pathways and standard operating procedures very pressing, and the requirement to develop very precise benchmarks of performance. There would be benefit in a close linkage with a larger unit which could include joint audit, joint benchmarking, and a rotation of clinical staff.

The recommendations of previous reports should be enacted at pace.

Mental Health

A separate report has been obtained on Mental Health Services and therefore, no additional comment will be made except to observe that many of the themes are like those reported elsewhere.

Recommendation 36:

The recommendations of the Mental Health report should continue to be implemented as quickly as possible.

Theatres

Reference should be made to the report on Theatres and its recommendations continue to be enacted.

Issues which arose during interviews included inconsistent application of the "safe surgery" processes, variable MDT working, a lack of respectful behaviour and random start times.

Recommendation 37:

The recommendations of Theatre Review should continue to be enacted at pace.

However, there need be no delay in making it clear that lack of adherence to safety processes, failure to start lists in a timely way and bullying will not be tolerated and, if necessary, individuals held to account.

The issue most raised, particularly by non-medical staff concerned an assertion that private patients were prioritised over public patients and that their procedures were more likely to be undertaken by a consultant (both surgeon and anaesthetist). This is not necessarily unsafe but must raise significant questions about safety, and consultant supervision. This is even more the case when there are large numbers of locum middle grade medical staff.

It also raises important policy and probity questions.

Recommendation 38:

There is a need for HCS and Government to address the vexed question of the degree of advantage to be enjoyed by private patients – an issue which generates strong and divisive emotions. These divisions undermine team working and therefore inevitably impact on patient safety.

Recommendation 39:

It would be straightforward to conduct an audit to clarify whether the alleged focus of consultant staff on private patients is in fact the case.

If it is, then, apart from the policy decision outlined above, the quality of care given to those patients who do not receive consultant-based care needs to be closely monitored and transparent.

(To be clear this is not a criticism of middle grade medical staff but merely points out the greater degree of assurance required. The consultant must remain accountable for the quality of care delivered by those he or she supervises).

Surgery

Some of the features of the surgical service are addressed above. Other areas which were commented upon were a lack of MDT working and inconsistent timing and frequency of consultant ward rounds.

Recommendation 40:

The relevant AMD / Chief of care group needs to work with the lead clinicians to ensure less individualistic behaviour and greater systemisation in the management of surgical patients. Standard operating procedures, consistent timings etc. will make the management of surgical patients safer and easier for all staff groups.

The job planning process will address some, but not all, of these issues.

Radiology

Constructive discussions have occurred with Radiology about the need to either follow National and College guidelines or to develop and to have approved (by a formal process) alternative protocols. This would significantly improve working relationships with other departments and place individual radiologists and the organisation in a more defensible position.

Recommendation 41:

The recommendation is that radiology, in common with all other specialties, should follow National and College guidelines unless there are convincing reasons which cannot be mitigated. When this is the case, alternative guidelines should be developed as described above.

The constructive discussions between the lead clinicians which have commenced should continue.

Other Issues

Frequency and conduct of ward rounds

One of the most frequent concerns raised about the clinical specialities was about inconsistent timing and conduct of ward rounds, and insufficient MDT working. These are potentially safety issues.

Recommendation 42:

To reduce concerns about inconsistent timing and conduct of ward rounds, and insufficient MDT working, the first step is to introduce robust job planning and the second, to follow National Guidance on the conduct of ward rounds (see RCP / RCS / RCN) Modern ward rounds, RCP London.

If there is uncertainty about these processes, training might usefully be given as a mandatory part of CPD.

Continuing Professional Development (CPD)

An inherent disadvantage of HCS is that it is a small and geographically isolated organisation. This cannot be changed, and this means that there are small services and "lone practitioners." It is well-recognised that "the lone practitioner" from any professional background is at greatest risk of idiosyncratic or unsafe behaviours.

To their considerable credit, some lone practitioners recognise the dangers for their practice and therefore their patients, and they monitor their own performance as best they can. Indeed, some of them have recognised that they cannot continue to undertake some procedures because the patient volumes are simply too low to ensure that they remain competent. This level of insight might usefully also inform others within the organisation.

Recommendation 43:

The organisation should recognise its responsibility to assure itself that patient volumes are at acceptable and adequate levels. The RO should engage strongly with this area so that good professional practice is driven through the appraisal and revalidation process. Good metrics are essential and should be presented at appraisal.

Given the inevitability of its disadvantages then HCS and its employees must do everything possible to mitigate the potential problems which could emerge. Improved consultant staffing, as described above, would improve the situation.

At an Executive level, HCS should consider forming a closer relationship with a major centre. This would allow all forms of academic activity (which is a driver of quality and safety) to be undertaken in partnership.

Such a partnership may have other advantages both for training and service delivery, potentially to both parties.

For individual clinicians, the challenge is to keep up to date and have evidence that they are up to date. Many clinicians recognise this, but some do not. Individual clinicians CPD must recognise this challenge and address it directly. One way of doing this would be to routinely spend one or two weeks a year working in a relevant service at a major centre in the UK or elsewhere. Again, relationships which this would forge could have benefits for service delivery and training.

To be clear this is a challenge for all clinical professions and requires the development of suitable published strategies. This may well assist with recruitment and retention of staff.

Links to the tertiary centre

It is the case that there are links with a variety of tertiary centres, often based on personal links developed during a consultants training. These were reported as usually working tolerably well when the consultant was present, but less well when they were not.

Partly because of this pattern of clinical practice, the relationship with Southampton is patchy.

Recommendation 44:

There is a delicate balance between destroying current referral pathways to UK centres and creating more robust links with Southampton. Whilst a link with a single centre might remove some difficulties it could lose other real advantages, and so it is best to have a permissive approach but to ensure effort is made to mitigate the disadvantages of the current approach.

To facilitate this increasing linkage with a tertiary centre, similar to that seen across the UK and elsewhere in the World, the executives should engage in early and meaningful discussions with their counterparts in Southampton. This should lead to robust clinical pathways being developed and followed, ready availability of clinical advice, opportunities for training, audit, CPD, rotations etc. This would reduce the isolation currently experienced by HCS and its employees and so inimitable to safety and quality.

The author was struck by the very positive account of the links in Paediatrics between Jersey and Southampton. This might be a very suitable model.

Recommendation 45:

HCS should look closely at the paediatric model and evaluate its strengths and weaknesses. This potentially would further inform discussions with Southampton.

Certificate of Eligibility for Specialist Registration (CESR)

An effective way in which the organisation might recruit Consultants is through the CESR route and there is some enthusiasm for this approach (which has already proved successful).

Recommendation 46:

The Medical Director should assess the need to provide a more structured approach to support those wishing to go down the CESR route and, if indicated, HCS would be wise to place the organisation of this under an appropriate Deputy Medical Director and HR business partner.

There may well be similar approaches in the other clinical professions.

Mandatory Training

All organisations have mandatory training requirements of their employees. There is often a legal requirement to complete such training and certainly an organisational imperative.

(Interestingly when the author worked for one of the" big four," failure to complete mandatory training would rapidly result in a large fine and ultimately dismissal).

It is interesting to note that an Assistant Minister noted the lack of compliance with mandatory training and was understandably critical of it.

Recommendation 47:

HCS must develop and publish a mandatory training policy and insist that its employees complete their mandatory training.

If they fail to comply, they must be held to account.

In most organisations it is the responsibility of the local manager to ensure that this process occurs and is documented.

If the individual is within a regulated profession, then the failure must be reported to the regulator.

In Medicine it should be made clear by the RO that it is not possible to complete a successful appraisal whilst ignoring mandatory training requirements.

Supporting Professional Activities (SPA)

A specific point must be made about CPD for consultants. The productive use of SPA time is highly relevant to patient safety.

Currently within the consultant's contract (and should be made clear with specific timings in the job plan – see elsewhere) consultants are given time for CPD. For many, if not all consultants, this is 2.5 PAs.

This is a generous allocation and an expensive one. It needs to be fully understood that this time is paid for by the organisation to keep consultants and their patients safe. Consultants should be aware that they are available for recall to the hospital during their SPA time, and indeed the organisation is entitled to insist that the SPA time is done in the hospital, should it wish to do so.

The current arrangements with their lack of clarity are most concerning and potentially raise safety and probity issues for both the individual consultant and the organisation.

SPA time is contracted paid time and misuse of it is potentially a serious matter.

Recommendation 48:

Consultants should be open about the CPD work done in their SPA time, which should be defined in their job plans and are as such, a contractual commitment.

The organisation must insist that SPA time is used effectively and constructively. The activities undertaken should be documented and reviewed at appraisal.

Recommendation 49:

Mechanisms must be put in place to demonstrate that public money is being used to benefit patients.

One additional way in which SPA time could usefully be used would be to spend time working in a major centre in the UK or, with good reason, elsewhere. There is no doubt that some consultants would welcome this opportunity.

SPA time should also be used in a transparent way to attend clinical audit meetings, mortality and morbidity meetings, and other activities which drive quality and safety. Mandatory training should also occur during this time. This should all be part of the job planning process and performance managed.

Clinical audit

A number of interviewees indicated their concerns about clinical audit. The first of these was that performing clinical audit and attending audit meetings was reported as optional.

Recommendation 50:

Attendance at clinical meetings which drive safety and quality should not be optional and such meetings should be included in job plans.

The second concern was that private patients were sometimes excluded from the audit process. The author has no direct evidence of this, but it is so clearly undesirable that it deserves a mention.

Recommendation 51:

All patients, both public and private, should be included in audit processes.

Good audit processes conducted on all the patients within the institution would also assist in supporting the Consultant appraisal process in which there is an obligation to describe, in detail, a doctor's "whole practice."

Recommendation 52:

The RO should insist on a review of the audit of "whole practice" in guidance to appraisers and appraisees.

Specialisation

As the body of medical knowledge has increased, all healthcare professionals have become more sub-specialised. Overall, this is desirable but represents a challenge in a small hospital such as Jersey where there is self-evidently a need for generalists.

Recommendation 53:

The degree of sub specialisation versus generalisation needs to be constantly monitored and managed by clinical leaders. When subspecialisation is possible (to increase the volume of patients managed by doctors with skills in a particular area) it should occur.

It is legitimate to recognise that the opportunities for sub specialisation in Jersey are less than in larger institutions, but it is not legitimate to avoid sub specialisation to enhance private medical practice. Again, this needs to be actively managed by clinical managers and the RO.

Private practice

In HCS there is a mixed model of private and public practice. Most private practice is conducted in the public hospital by consultants who are also employees of HCS. It is only the Doctors that are fee paid and all other aspects of care provided by salaried employees of HCS.

(It is not within the remit of this report to establish whether the financial arrangements are such that the public purse benefits from undertaking private work or not. Clearly if it does not then there may be an impact on patient safety for both public and private patients. This is mentioned *en passant* because it was raised in several conversations).

Recommendation 54:

The financial arrangements of the management of private patients should be clarified and made transparent so that the benefit to HCS is clear and the public can be assured that care of public patients is not compromised, but hopefully is enhanced.

It is also not within the terms of reference of this report to become involved in any ideological debate but merely to point out the potential effect of a mixed model on patient safety and whether the quality and safety of care offered to public and private patients is the same.

It is a matter of policy as to whether it should be the same, but this decision should be explicit.

Theatre lists have historically contained both public and private patients. There has recently been some separation of the two categories of patients (and this remains very contentious). This issue was not explored in any detail.

It was the overwhelming view of interviewees that private patients are treated differently from public patients, and most interviewees said more favourably than public patients. Alleged examples of this include:

- *private patients being seen more frequently by their consultant,*
- *private patients more likely to be labelled urgent than public patients with the same condition (and therefore receiving treatment more quickly),*
- *the procedures being more likely to be undertaken by a consultant if the patient is a private patient and more likely to be undertaken by a less trained doctor if the patient is a public patient (which does not necessarily mean that it is unsafe),*
- *that consultants sometimes absent themselves from the care of public patients to provide care for private patients,*
- *Private patients are advantaged by being placed first on lists and are therefore more likely to be done by the Consultant and less likely to be cancelled.*

Whilst interviewees inevitably had differing views about the frequency of these difficulties there was little dispute that at least some of them occur some of the time.

It is not an ideological point to recognise that if some or all the allegations above are true, then there is a potential direct effect on patient safety and the quality of care. There may also be an undermining effect on teamwork.

Recommendation 55**:**

Allegations that the management of private patients is at the expense of public patients are very damaging – a point made by several consultants - and HCS must audit the situation thoroughly to assure itself that the management of patients within its purview is equitable and equally safe for all. (Assuming that this is the wish of the people and Government of Jersey).

If a robust audit is not reassuring, then the Government should make its position clear and HCS respond immediately to remedy the situation. This issue should also be a matter for the HCS Board, should it be reconstituted along more conventional lines.

Recommendation 56:

Many Consultants themselves were concerned not only about patient care but about the tarnishing of their reputation and it might be most helpful if the issues were discussed in an open and transparent way at the Medical Staff Committee (MSC). This is of course a matter for the MSC, which is not a management body but a representative body but can and should play an important constructive role.

A robust job planning process would provide consultant staff with protection from reputational damage.

A further point raised by some was a lack of clarity sometimes as to which consultant is responsible for the care of private patients.

Recommendation 57

A crucial point is that it should be always clear for all patients which Consultant is responsible for their care - at all times, and available to see them when needed.

Regulatory issues

There is some confusion in the organisation between the roles and responsibilities of the organisation and the roles and responsibilities of the regulator. This is most apparent in the medical profession.

Recommendation 58:

It is the role and responsibility of the organisation to provide safe high-quality care, and to be certain that its employees are doing this, as well as performing clinically and behaviourally to a satisfactory standard. This applies to both public and private patients, when these private patients being managed within its purview – in the hospital using hospital employees and facilities.

Equally, those employed by the organisation must understand that they are employees of an organization that is clearly accountable to the government and people of Jersey. To put it another way, they work *for* the organisation not *at* it.

It is the role of the regulatory bodies to regulate individual professionals. This includes the clinical competence of the professional, their behaviours and that they are conducting their affairs with probity.

The two roles are therefore linked and should be symbiotic, but the presence of a regulator does not remove the responsibility of the organisation to provide safe services and the accountability of its employees to it. When confusion exists about these issues then the danger is that the lack of clarity and accountability has a direct and damaging effect on the effectiveness of the organisation and patient safety.

The medical appraisal and revalidation process is well embedded in the UK and adopted in Jersey. It should be conducted to a high standard and the responsible officer should be rigorous in their assessment of doctors requiring revalidation (looking at and seeking evidence about all aspects of good medical practice including clinical outcomes, appropriate behaviours, organised and documented CPD and probity. These processes will clearly add value and a degree of assurance.

It is rumoured that Government in the UK may produce a more comprehensive picture of a doctor's performance which could be used at appraisal, and it would be worth monitoring this development.

In any event, HCS should seek to support the appraisal process by providing as comprehensive a picture of the doctor's performance as possible, including both public and private patient outcomes, details of complaints and compliments, use of SPA time, etc.

Whilst not diminishing in any way the role of the employer, the GMC and the Responsible Officer have a key role in maintaining medical professional standards and assuring the public that the requirements of Good Medical Practice are met in full.

An active dialogue between the Medical Director and RO would be useful in driving the recommendations of this report.

The informatics department should be of considerable assistance in this process and must also assist in obtaining good quality benchmarking data.

Job Planning and medical staffing

The author's understanding is that job planning for consultants is a contractual obligation. Given this, it is most surprising that in a small institution the process has not been routine and firmly embedded for many years (as it has elsewhere).

Its potential benefits are greater in an environment where this is a mixed economy of public and private work. It has the obvious benefit of allowing clarity as to where senior staff are at any given time. This facilitates the smooth running of the organisation and equally importantly removes not infrequently voiced criticism. Shining a light on this area would be a benefit to all.

Effective job planning, preferably linked to electronic rostering, would make transparent that safe patient care was being provided to the best of the organisation's ability. It would remove unwarranted criticism and allow firm action to be taken where criticism was justified. Importantly it would remove the much commented upon and divisive confusion about availability of consultants. Transparency would resolve the issue.

Recommendation 59:

The job planning process for consultants needs to be undertaken and completed as a matter of urgency by clinical line managers driven centrally from the Medical Director's Office. The Medical Director should chair a high-profile steering group charged with driving the process through the organisation at pace.

Job Planning could also be a useful process for other groups including middle grade doctors, some of whom are said to work excessively long hours of 15 PAs or more. There is a well understood argument about the effect of excessive hours on patient safety and these hours need to be reduced (with the appointment of more consultants to provide an increasingly consultant-based service), as is common elsewhere.

If the hours quoted are a true representation of the workload, then it is likely that more consultant appointments are required (see elsewhere in the report).

Staffing

Many interviewees described difficulties in staff recruitment because of the island nature of Jersey. This is clearly a challenge, and inevitably might affect patient safety.

The highest risk group with respect to patient safety are short-term locums in any clinical area or profession.

Recommendation 60:

The recruitment processes need to be both timely and robust. For both locums and lone practitioners, the best mitigation is good induction and then close monitoring of performance. The development of suitable metrics (many of which can be lifted from elsewhere) is central to this.

It may be worth obtaining external advice on recruitment and retention. It is not the author's area of expertise.

Signing off results

More than one interviewee had concerns as to where the responsibility lies for signing off results from radiology and laboratories. It was alleged that on some occasions, results are not signed off and may not have been seen. This has clear patient safety implications.

Recommendation 61:

The Medical Director should issue a clear statement as to where the responsibility lies for signing off results from radiology and laboratories.

The responsibility for ensuring that this is done, and appropriate action taken sits with the Consultant under whose care the patient is being managed.

This does not mean that those in service specialties should not continue to raise issues with clinicians directly and immediately if they are concerned about a result or a finding. Their expert opinion is invaluable in driving safety and good care.

Appendix 1. Professor Hugo Mascie-Taylor's Profile

"An experienced successful Clinician and Board level Executive. His career has, from early days, been characterised by being invited to take up newly created senior innovating roles, often to work in politically complex and highly emotive situations. He has worked as a healthcare provider, as a commissioner, as a regulator and as an advisor - in local, regional, national and international roles and settings"

Hugo Mascie-Taylor Consulting Ltd (2021 – present)

Invited by the Minister for Health to be a Cøpanellist of the Statutory Neurology Public Inquiry, Northern Ireland

Invited by the Deputy Prime Minister and Minister of Health to Chair the Independent Oversight Committee of the Sustainable Health Review, Western Australia

Leading EY to deliver the Clinical Governance Review, King Faisal Specialist Hospital. Riyadh

Qualifications and Professional Registration

F.R.C.P.(Lond.), F.R.C.P.I., S.F.F.M.L.M., A.Dip.C .(Henley)

- Fellow of the Royal College of Physicians of London
- Fellow of the Royal College of Physicians of Ireland
- Founding Senior Fellow of the Faculty of Medical Leadership and Management
- Advanced Postgraduate Diploma in Management Consulting (Henley)
- Interpersonal Mediation Practitioner's Certificate
- General Medical Council (UK) with full licence to practise (1740079)
- On Specialist Register- General (Internal) Medicine and Geriatrics
- Revalidated by General Medical Council (1740079)

Clinical Experience

- Training posts in General Medicine, General Surgery, Gastroenterology,Hepatology, Cardiology, Respiratory Medicine, Nephrology, Medicine for the Elderly, Critical Care, Anaesthesia, and Accident and Emergency
- Chief of Medical Staff, Mount Zion Hospital (UCSF), San Francisco
- Consultant Physician (General Medicine and Geriatrics), Leeds Teaching Hospitals NHS Trust
- Senior Clinical Lecturer, Leeds University

Other Chair and individual roles

- Chaired UK Government HSMR/SHIMI group
- Chaired a Department of Health review (see publications)
- Chaired an Academy of Medical Royal Colleges review (see publications)
- Chaired North Yorkshire Service Review (see publications)
- Chaired Clinical Advisory Committee in North Lincolnshire
- Co-Chaired AUKUH Consultant Productivity Bench Marking Group
- Co-Ordinator of trial site for the Consultant Contract
- Member - UK Revalidation Programme Board
- Member - Secretary of States weekly meeting
- Member - NHS National Quality Board
- Member - NHS Social Partnership Forum (National liaison group with public sector unions)
- Member - Leeds Acute Services Review - which led to the merger of two large teaching hospitals and the formation of the then largest Trust in the UK, and considerable service reconfiguration.
- Developed marketing strategy for Bristol Myers Squibb
- External Advisor to Aintree Foundation Trust Quality Committee
- Advised Goldsborough plc on their healthcarebusiness strategy
- Established and chairs a charity concerned with knowledge transfer to developing countries (OPTIN)

NHS Management roles

Local

- Clinical Director, Department of Medicine, Leeds UK
- Director of Strategy, Leeds Community and Mental Health Trust
- Medical Director, Leeds Health Authority
- Director of Commissioning, Leeds UK
- Medical Director, Leeds Teaching Hospitals NHS Trust
- Interim Chief Executive, Leeds Teaching Hospitals NHS Trust

Regional

- Commissioner for Specialised Services, Yorkshire UK

National

- Medical Director, NHS Confederation and NHS Employers
- Trust Special Administrator, Mid Stafford (appointed by and directly accountable to the Secretary of State)
- Medical Director, Monitor (NHS Regulator in England)

Board Experience

- For over 20 years served as an Executive Director on NHS Boards in acute and community organisations, teaching hospitals and district general hospitals, providers and commissioners, and at local, regional and national levels

Role at EY (2016-2020)

- Executive Medical Director (May 2016 – November 2020)
- Worked with EY in UK, Middle East, Australia and USA and advised on EY projects inother countries
- Led Clinical Governance review, Western Australia
- Invited by the Minister for Health to be a Co -panellist of the Statutory Neurology Inquiry, Northern Ireland
- Invited personally (by the Deputy Prime Minister and Minister of Health) to Chair the Independent Oversight Committee of the Sustainable Health Review, Western Australia
- Invited member of the International Expert Panel, Alberta Health Services
- Member of various EY teams involved in
  - Performance optimisation
  - Service reconfiguration
  - Safety and quality
  - Clinical and corporate governance
  - Board governance and development

Educational and Teaching Roles

- Visiting Professor, University of Leeds
- Visiting Professor, London South Bank University
- Senior Clinical Lecturer, University of Leeds
- Associate Professor, University of California, San Francisco (UCSF)
- Visiting Fellow, University of York
- External Examiner, University of Durham (MBA)
- External Examiner, University of Hull (MSc Gerontology)
- Teaching undergraduate and postgraduate Medicine and a wide variety of Healthcare professionals
- Educational and clinical supervisor for medical trainees
- Designed and delivered many development centres for doctors and senior managers
- Board level leadership of medical education and research in a major Teaching Hospitals group

Publications, reports, public speaking

- 30+ publications in peer reviewed journals
- Editorial BMJ, 4 book chapters, 2 books
- Recent invited chapter for The Academy of Medical Royal Colleges
- Clinical Governance Review for the Government of Western Australia
- Guidance on Consultant contract, British Medical Association/NHS Employers (Chair)
- Clinical Responses to the Downturn, NHS Confederation (Chair)
- Report on Remediation of Doctors with Capability issues: Department of Health (Chair)
- Report on Return to Practice after a period of absence: Academy of Medical Royal Colleges (Chair)
- The Acute Services Strategy Report, Leeds (SME)
- Strategy for Health Services in North Yorkshire: Yorkshire Strategic Health Authority (Chair)
- Verbal evidence to UK Government: both House of Commons and House of Lords Health Select Committees, Public Accounts Committee and also the Northern Ireland Assembly Health Committee

Professional and Public Engagement

- Extensive experience of television, radio, and print interviews, sometimes hostile
- Interviewed on "Hard Talk"- screened world wide by BBC News 24
- Professional Head of 1500 doctors (Leeds)
- Managed many professional performance issues both capability and conduct
- Undertook major disciplinary investigation in a large London teaching hospital
- Chaired and led many medical and multi disciplinary groups dealing with contentious an emotive issues
- Engaged successfully on many occasions with local, national and international politicians
- Led many public engagement and consultation meetings attended by up to 1500 people

Global Profile

- Spoken at over 40 Universities, as well as Royal Colleges, Learned Societies, and professional associations
- Spoken on healthcare topics in UK, USA, Australia, New Zealand, Qatar, Saudi Arabia, Oman, Bermuda, Madagascar, France, Switzerland, Spain, Portugal, Sweden, Germany, Italy, South Africa, and Ireland
- Co-led EY team producing a Clinical Governance Review for the Government of Western Australia
- Invited by the Minister of Health, Permanent Secretary and CMO to be a GP panellist of the Northern Ireland Statutory Neurology Inquiry - a governmental Inquiry into corporate and clinical governance following the recall of in excess of 3500 patients. (Current)
- Invited by the Deputy Prime Minister to Chair the Independent Oversight Group following the Sustainable Health Review in Western Australia. (Current)

Appendix 2. Terms of Reference

Terms of Reference
Review of Health and Community Services (HCS) Clinical Governance Arrangements within Secondary Care

1. Background

The Government of Jersey (GOJ) Department of Health and Community Services (HCS) is committed to provide safe and sustainable services that improve outcomes for patients and their families. As part of this ongoing commitment HCS wish to undertake an independent external review of clinical governance arrangements.

2. Purpose

An independent review of clinical governance within HCS will be undertaken to ensure that HCS has appropriate and robust clinical governance with clear roles and responsibilities, authority, and accountability to ensure the delivery of high-quality services for the Island community.

In reviewing the clinical governance arrangements, the reviewer will give particular attention to the following focus areas:

- Defining the current clinical governance structures

  What are the structural components, processes and culture that constitute the current HCS clinical governance structures? Are the roles and responsibilities, authority, and accountability clear? What oversight arrangements are in place?

- Lack of clarity / gaps / duplication

  Are there specific areas of unclear or absent clinical governance and/or duplication of clinical governance processes and, where these occur, what is the impact on the system?

- Fragmentation / Interface

  To what extent is the system fragmented in relation to clinical governance arrangements, and how well do the relevant governance partners (for example CYPES) interface, communicate, and engage to facilitate appropriate clinical governance and oversight?

- Effectiveness

How effectively does the current clinical governance structure facilitate decision making, clinical oversight and accountability, service management, achievement of clinical outcomes and the setting and monitoring of standards, to support HCS in delivering health services to the Island community?

- Efficiency

  How efficient is the current clinical governance structure in facilitating timely decision making and use of resources in managing and implementing clinical governance processes?

- Support for quality improvement and innovation

  How well does the clinical governance structure support, promote and foster quality improvement and innovation in the delivery of healthcare services? What improvements could be made?

- Opportunities for clinical governance improvement / reform

  What opportunities exist to improve / reform the clinical governance structure to enhance effectiveness and efficiency and embed a quality improvement focus to deliver best practice health services for the Island community?

3. Scope

The scope of the review will include, but is not limited to,

- Current HCS clinical governance in Secondary Care including, Clinical Effectiveness and Research, Audit, Risk Management, Education and Training, Patient and Public Involvement, Using Information, including that derived from Information Technology, Staffing and Staff Management.

- Overall HCS governance arrangements where these directly influence or impact clinical governance in secondary care.

- Other GOJ departments / Independent Agencies that directly impact secondary care clinical governance (for example Jersey Care Commission (JCC) and Children, Young People, Education and Skills (CYPES).

4. Methodology

This will be a triangulation of the following,

1. Document Review

2. Interviews

3. Survey

The process will be encouraging and supportive, providing honest and candid feedback even if that may be uncomfortable or difficult to hear. Good practice will be recognised, and any weaknesses or issues identified will be shared in a supportive and constructive way.

The reviewer will ensure that, during the process, staff understand the confidential nature of the review but that their reflections and information shared, may be used within the report, albeit in an unattributable way, and backed up by a number of other sources of evidence wherever possible.

Information gained from any review of patient notes used to support the review will be anonymised.

The independent reviewer will act independently of other external authorities to offer advice and recommendations confidentially, in an environment of trust.

Any amendments to the Terms of Reference will need to be agreed between the lead reviewer and the Director General for HCS.

Immediate issues of concern will be escalated to the Director General.

5. Sharing and Referencing Information

All documentation shared with the reviewer for the purpose will be indexed, referenced and a record kept in line with retention schedules.

A data sharing agreement will be in place.

Appendix 3. Interviewee list and Meetings attended

Clinical Governance Review 2021 / 2022 – Interviews and Meetings
Interviewees
Executive Leadership Team
Acting Chief Operating Officer (COO/)/Group Managing Director/ Director of Clinical Services Chief Nurse Director of Improvement and Innovation Group Medical Director Director for Adult Mental Health Services and Social Care
Associate Medical Directors
Associate Medical Director Surgery Associate Medical Director Medicine Associate Medical Director Women Children and Family Care (WaC) Associate Medical Director Primary Prevention and Intermediate Care
Workforce
Associate Director of People Head of Culture, Wellbeing and Engagement Head of Medical Staffing Health and Safety Manager
Quality and Safety
Associate Medical Quality and Safety Head of Quality and Safety Lead Manager Quality and Safety
Quality Improvement
Associate Director of Improvement and Innovation Head of Quality Improvement
Medical Profession
Consultants x 22
Nursing Profession
Deputy Chief Nurse Acting Associate Chief Nurse Associate Chief Allied Health Professionals Head of Midwifery (Acting) Lead Nurse Ward Manager x 2
General Manager x 3

Meetings attended

HCS Board
Quality and Risk Assurance Committee
People and Organisational Development Assurance Committee
Emergency Department Governance Committee
Care Group Performance Reviews
Medical Staffing Committee

Appendix 4. Summary of Recommendations

Recommendation 1:

The lack of availability of clinical output and benchmark information placed in the public domain must be addressed as a matter of urgency. This should be at organisational, service, ward, and Consultant levels, and the information provided both at public meetings and on the website.

Recommendation 2:

The Consultant staff should embrace their professional role and leadership responsibility to drive system-wide (not just in their own practice) change to deliver improvement in patient safety, governance, and assurance processes.

HCS should be prepared to provide them with the necessary expert support to achieve this, notably in data gathering, analysis and benchmarking.

Recommendation 3:

Structures and processes need to be in place to make the line of accountability of HCS and its employees to the Government and people of Jersey explicit and meaningful.

It will be difficult or even impossible to drive approaches to quality and safety if the architecture is not fit for purpose, widely understood, and accepted. Government must hold HCS to account, and then those who lead HCS would be empowered to hold its employees to account and to drive change.

For many this would result in an improved working environment as well as, most importantly, the assurance of safe patient care.

Recommendation 4:

Individuals and groups must act responsibly in the interests of all patients and consider carefully what is within their legitimate remit. They must offer constructive input and expect to be accountable to HCS for the advice which they give, and for their behaviour.

Recommendation 5:

Staff should recognise that the reporting of incidents is a professional duty. If incidents are not reported, then opportunities to patient care are lost. The professions need to act with courage and with a strong focus on the patient, and not the protection of individual members of staff.

Recommendation 6:

Similarly, there needs to be a low threshold for commencing objective, fact-finding investigations, with relevant help and support being sought from appropriate external sources where independence, transparency and expertise are required. An independent investigation avoids any perception of lack of openness and transparency.

Whilst it is the role of the Executive and Serious Incident Review Panel (SIRP) to manage the process by which investigations occur and serious incidents are identified, the responsibility for enacting the change which must follow, needs to sit firmly at Care Group level. This process must be seen as an opportunity to improve patient care and not primarily a threat to individuals. Changing any current negative perceptions will require strong executive leadership to build trust in the process.

Recommendation 7:

In the absence of governmental policy, private and public patients should be managed employing identical policies, pathways, and procedures. (It would be most helpful if Government could be explicit about its wishes and policies in this regard). Clinical Leads should ensure that this occurs unless there are explicit exceptions agreed with their Professional Head.

It is a reasonable starting point to indicate that it is the policy of HCS to follow all relevant guidelines. If pressing reasons exist for not following them, and these reasons cannot be successfully mitigated, then the alternative agreed approach of HCS should be explicit. It should be argued and promoted by the Care Group leader, signed off by the relevant Head of Profession and then signed off in summary form by the HCS Board.

The new guideline or process must be recorded, be available and placed in the public domain (through and endorsed by the HCS Board).

This explicit and transparent process would protect both patients from harm and individual staff from an obvious source of criticism – potentially both reputational and legal. It may though expose HCS itself to reputational and medico-legal risk, so the process needs to be evidence-based and well documented so as to generate a defensible position.

Recommendation 8:

HCS has a clear responsibility and duty of care towards its employees, and it needs to give this issue it's full attention and to act as assertively as it can to deal with poor and unprofessional behaviour. Such behaviour is a matter not only for HCS but should be brought to the attention of the relevant professional regulatory process. For example, for doctors, the Medical Director for HCS and the Responsible Officer for the GMC.

It is the responsibility of all the clinical professions not to tolerate, and to challenge and report poor behaviour.

Recommendation 9:

There appear to be areas of good multi-disciplinary team working within HCS. This approach needs to be extended to every area across the organisation, and no other approach tolerated. Ensuring that this occurs must be clearly within the remit of Clinical Leads and is an approach that HCS leadership must insist upon.

Recommendation 10:

HCS and its consultants must recognise that they have a joint responsibility for the safe care of all patients, both public and private, in the hospital. Linked to this must be the recognition that all the metrics which are needed to assure the safe care of patients apply equally to public and private patients.

Recommendation 11:

More information about HCS and individual performance should be routinely placed on the website and put in the public domain through HCS Board meetings.

In fairness, a number of individual clinicians make strenuous efforts to monitor their own practice and to benchmark their results against other clinicians. This should be applauded and vigorously supported by HCS. The ownership of the data must be with HCS who are responsible for service, quality, and safety.

Recommendation 12:

The developments briefly mentioned above should be enhanced as rapidly as possible. Clinical performance reporting is well developed in many areas of the World and Jersey does not need to reinvent these processes but to adopt the best available. It may require technical support in doing this but the drive to do so must come from the Government of Jersey and the HCS Board.

Recommendation 13:

Consideration should be given to creating a conventional HCS Board with non-executive leadership and it accounting for the performance of HCS directly, or less desirably, indirectly, to the Minister.

This widely adopted model would allow the Minister (with the necessary policy support) to hold the organisation more effectively to account on behalf of the Government and people of Jersey, and to focus on leading the development of policy.

Recommendation 14:

The possibly emerging plan to have the assurance committees chaired by informed external experts could transform these processes and make them of benefit to all. Patient safety would be enhanced, and greater assurance would be provided to the Government and people of Jersey.

Recommendation 15:

What should not be open to discussion is the need for the organisation to be held to account by Government of Jersey in a more rigorous and robust way, and importantly the authority of Government of Jersey transmitted downwards through the DG and Executives to bear on HCS and its employees.

Discussion needs to occur between relevant parties to design a more effective system building on the progress which commenced in 2019.

Recommendation 16:

The Managing Director role is crucial and the incumbent needs to be a highly competent and energetic operational manager (who can come from a variety of backgrounds e.g., general management, nursing, medicine).

Recommendation 17:

In the current HCS structure, the Managing Director should meet with the Chief of Service (currently known as Associate Medical Directors (AMD)) collectively at least weekly and more frequently at times of crisis. Individual meetings would also be required.

The Managing Director should chair the monthly Performance Review Meetings on behalf of the DG (this allows the DG to focus on the external environment and managing upwards). At these meetings, the Chief of the Care Group (AMD) and their teams should be held to account whilst receiving support and guidance.

The title of Group Managing Director is part of a wider Jersey model but is not a title used in hospitals. It may help understanding if the title were altered to Chief Operating Officer (COO).

Recommendation 18:

There is a need to make clear again, and make certain that it is understood by all, the accountabilities of all those in the triumvirate so that no lack of apparent understanding can occur or be expressed. Close working and positive relationships with regular meetings are essential.

Appraisals must recognise the line management relationships.

Recommendation 19:

The title of the Associate Medical Director is inappropriate and misleading. It should be changed to a suitable alternative. The title 'Chief of. . .' is used elsewhere.

The monthly performance review meetings should be chaired by the Managing Director (COO) and attended routinely by the AMD (Chief of care group). Both the COO and the Chief of the care group must require their immediate team to attend.

Accountability for safety and quality must be clear to all and the processes within the organisation must reflect the accountabilities. The accountability of the Chief of ..... is for all aspects of the function of the care group, not just those that interest them. The role is that of a senior manager focussing on operational management and not on strategy.

Recommendation 20:

One member of the triumvirate should be accountable to the Managing Director (usually called COO) and the other two account to that individual. Sometimes the individual is the Doctor but not always – they are then often referred to as 'Chair.'

Recommendation 21:

The author's experience is that when the Doctor is placed in the Chair role and acts appropriately and competently, then this model is probably the optimum. It is an operational management role and usually requires at least 50% of the Doctors time.

The care group will continue to require business partners and expert professional advice in other areas, most obviously, but not exclusively, Finance and Human Resources, Health and Safety, Infection Control, Training and Development.

The fact that a range of skills is required to manage a complex group should not generate confusion as to who is accountable for all aspects of performance within the care group.

To discharge their responsibilities, the chief of the care group will need to meet regularly, at least weekly, with their teams and meet with them individually on a regular basis.

Recommendation 22:

At service level there is frequently a similar triumvirate of doctor, nurse, and manager. If the doctor i.e., clinical lead, is the accountable manager, then the role will require at least one day a week. If either the nurse or the manager is in this role, then they may well be able to undertake the role in tandem with another service role or other managerial work.

The responsibilities and accountabilities of the role must be spelt out with clarity, understood by all, and then managed.

Recommendation 23:

All of those in management roles within the organisation need training and development consistent with and targeted at their current and future roles (as agreed with their line manager). Much of this could be provided in house.

For example, lead clinicians and most nurse-managers not at executive level do not need training in strategic management but in basic managerial competencies including finance, HR, holding others to account, and having difficult conversations with colleagues.

The drawing up of a series of competency frameworks could well be useful and aid selection and development processes.

Recommendation 24:

It should be made clear that the Quality and Safety function is to support the general management structure by organising investigations and audits. Enacting the recommendations is the responsibility of the AMD (Chief of Care Group) who is accountable to the Managing Director (COO).

Recommendation 25:

There is an innovative opportunity to bring the expertise in Health and Safety to bear on other quality and safety functions.

Recommendation 26:

HCS is a small organisation with limited capacity, and it must surely be the case that the overall strategic direction for Quality and Safety is placed in the hands of one executive director, preferably a new appointment of an individual capable of marshalling the available resources as effectively as possible, but if this is not achievable, then under an existing Executive Director.

The function of the collective resource should be to work through (not around) the core general management function, to improve overall quality and safety improvement. In this model, the leader of each care group is responsible and accountable for the quality and safety of staff and patient care in their areas, being very actively supported by a coherent corporate safety and quality function.

If a Director of Quality and Safety is appointed at Executive Director level, then the available resource should be placed at their disposal. The Director would need to collaborate closely with the Chief Nurse, Medical Director and Director for Improvement and Innovation but importantly work through the Managing Director (COO) in driving the agenda.

Recommendation 27:

The HCS and Executives must make it clear that failure to report incidents is unacceptable to the organisation and is unprofessional. Sadly, there is a need to make it abundantly clear that those reporting incidents will be protected from any form of intimidation and that anyone attempting to stop reporting will find themselves in serious difficulty, both managerially and professionally.

It would be useful if those with professional regulatory responsibilities made this clear.

Failure to report a potentially serious incident is to directly undermine patient safety and staff should be held to account for this failure.

The triumvirate leadership of the Care groups must understand their role in this important domain and be performance managed in delivering it.

Recommendation 28:

Further evaluation of alleged intimidatory behaviours is needed, and this should be followed by clear and measurable remedial action if indicated. It should be made clear to all the employees that bullying is unacceptable and will be vigorously dealt with by the organisation through appropriate processes.

Whilst most reported the quality of nursing to be usually acceptable, areas which require attention are effective communication with relatives (training for both doctors and nurses), and consistent and accurate monitoring of sick patients with timely escalation of problems.

A proactive auditing approach would be desirable to allow the scale of the problem to be quantified and, if necessary, remedial action to occur. The threshold for escalation may need to be lowered and then escalation met by medical staff with an understanding that it is in the interests of patients, even if it proves, in retrospect, to have been unnecessary.

Recommendation 29:

The author found it difficult to evaluate these points relating to recruitment and retention and would ask that Human Resources give a written report based on exit interviews and other intelligence. An expert external view might be helpful.

Recommendation 30:

The solution to the difficulties in the admission from ED process is first to make it clear to all doctors that when they are asked to see a patient in the ED, then they must do so and failure to do so should be documented in the notes and the doctor held to account.

A second and highly effective approach is to give the unfettered right of admission to the hospital to ED consultants. The author has seen this work to very good effect despite fears expressed that ED consultants would be unable to differentiate between different clinical

problems and would admit patients inappropriately. In practice they performed better than predicted by their peers and this was very rarely a problem.

The concern sometimes derives from a feeling that beds within the hospital are the property of doctors or groups of doctors. This is not the case. The beds belong to the institution which employs the doctors.

If a genuine problem arises over inappropriate admissions, then this is appropriately dealt with by constructive discussions between groups of medical and sometimes nursing staff but not by denying patients care.

Recommendation 31:

The solution to any lack of clarity about the availability of consultant staff is straight-forward and long overdue. Robust job plans must be in place for all consultants and made widely available.

Not only would this facilitate the hospital running more smoothly it would also have a direct and positive effect on patient safety. Importantly it would end any unwarranted criticism of consultant staff whilst making explicit any gaps in the service.

Recommendation 32:

Medical Staffing is an issue of some concern to many, and which is highly likely to have a direct effect on patient safety.

The role of middle grade doctors needs to be fully assessed in a joint piece of work between the Medical Director's and the HR departments. This must result in a written report for the HCS Board.

The report must include details of the hours worked by middle grade doctors, how their competence is assessed, and the extent to which the Consultants directly supervise them. (It may be that external support is required to do this piece of work).

If the concerns expressed prove to be upheld, then the solution will be to employ more consultants and move to a consultant-based Service.

Apart from the obvious direct benefit of having procedures undertaken by fully trained practitioners there are other benefits to this approach,

- A more comprehensive rostering will be possible without placing onerous demands on consultants.
- There will be more opportunities for a degree of sub-specialisation and the importing of techniques to the Island.
- Multi-disciplinary team working would be enhanced.
- There will be fewer lone practitioners.
- Consultants will be able to leave the Island for Continuing Professional Development

- Teaching and research would be improved, as would the quality of academic meetings on Jersey.
- Consultants would be available to take part in quality improvement initiatives.

Recommendation 33:

There must be a physician of the day who is competent and available to manage or advise on the management of acutely ill medical patients on the medical wards, acute admissions unit, emergency department, surgical wards, and the intensive care unit or indeed anywhere else. The rota must be published, and contact details made clear.

Recommendation 34:

There are a variety of models available, but one solution to whom is responsible for the care of patients in ICU would be that patients are under the care of an Intensivist who should be immediately available at all times. The referring Consultant should visit at least daily and more when requested or wishes to do so.

Many of the patients on ICU have complex medical problems and the safety of care would certainly be improved by having a Physician of the day (see acute Medicine) who was available to provide a rapid consult service.

The Medical Director should ensure that ITU joins the national benchmarking process as soon as possible (Intensive Care National Audit and Research Centre (ICNARC)) and the results of this process placed in the public domain.

Access to ICU beds should be based on clinical need and no other consideration. This determination is the responsibility of the intensivist in charge who is, of course, accountable for their decision making.

Recommendation 35:

The small number of births in Maternity makes the need for clear patient pathways and standard operating procedures very pressing, and the requirement to develop very precise benchmarks of performance. There would be benefit in a close linkage with a larger unit which could include joint audit, joint benchmarking, and a rotation of clinical staff.

The recommendations of previous reports should be enacted at pace.

Recommendation 36:

The recommendations of the Mental Health report should continue to be implemented as quickly as possible.

Recommendation 37:

The recommendations of Theatre Review should continue to be enacted at pace.

However, there need be no delay in making it clear that lack of adherence to safety processes, failure to start lists in a timely way and bullying will not be tolerated and, if necessary, individuals held to account.

Recommendation 38:

There is a need for HCS and Government to address the vexed question of the degree of advantage to be enjoyed by private patients – an issue which generates strong and divisive emotions. These divisions undermine team working and therefore inevitably impact on patient safety.

Recommendation 39:

It would be straightforward to conduct an audit to clarify whether the alleged focus of consultant staff on private patients is in fact the case.

If it is, then, apart from the policy decision outlined above, the quality of care given to those patients who do not receive consultant-based care needs to be closely monitored and transparent.

(To be clear this is not a criticism of middle grade medical staff but merely points out the greater degree of assurance required. The consultant must remain accountable for the quality of care delivered by those he or she supervises).

Recommendation 40:

The relevant AMD / Chief of care group needs to work with the lead clinicians to ensure less individualistic behaviour and greater systemisation in the management of surgical patients. Standard operating procedures, consistent timings etc. will make the management of surgical patients safer and easier for all staff groups.

The job planning process will address some, but not all, of these issues.

Recommendation 41:

The recommendation is that radiology, in common with all other specialties, should follow National and College guidelines unless there are convincing reasons which cannot be mitigated. When this is the case, alternative guidelines should be developed as described above.

The constructive discussions between the lead clinicians which have commenced should continue.

Recommendation 42:

To reduce concerns about inconsistent timing and conduct of ward rounds, and insufficient MDT working, the first step is to introduce robust job planning and the second, to follow National Guidance on the conduct of ward rounds (see RCP / RCS / RCN) Modern ward rounds, RCP London.

If there is uncertainty about these processes, training might usefully be given as a mandatory part of CPD.

Recommendation 43:

The organisation should recognise its responsibility to assure itself that patient volumes are at acceptable and adequate levels. The RO should engage strongly with this area so that good professional practice is driven through the appraisal and revalidation process. Good metrics are essential and should be presented at appraisal.

Given the inevitability of its disadvantages then HCS and its employees must do everything possible to mitigate the potential problems which could emerge. Improved consultant staffing, as described above, would improve the situation.

At an Executive level, HCS should consider forming a closer relationship with a major centre. This would allow all forms of academic activity (which is a driver of quality and safety) to be undertaken in partnership.

Such a partnership may have other advantages both for training and service delivery, potentially to both parties.

For individual clinicians, the challenge is to keep up to date and have evidence that they are up to date. Many clinicians recognise this, but some do not. Individual clinicians CPD must recognise this challenge and address it directly. One way of doing this would be to routinely spend one or two weeks a year working in a relevant service at a major centre in the UK or elsewhere. Again, relationships which this would forge could have benefits for service delivery and training.

To be clear this is a challenge for all clinical professions and requires the development of suitable published strategies. This may well assist with recruitment and retention of staff.

Recommendation 44:

There is a delicate balance between destroying current referral pathways to UK centres and creating more robust links with Southampton. Whilst a link with a single centre might remove

some difficulties it could lose other real advantages, and so it is best to have a permissive approach but to ensure effort is made to mitigate the disadvantages of the current approach.

To facilitate this increasing linkage with a tertiary centre, similar to that seen across the UK and elsewhere in the World, the executives should engage in early and meaningful discussions with their counterparts in Southampton. This should lead to robust clinical pathways being developed and followed, ready availability of clinical advice, opportunities for training, audit, CPD, rotations etc. This would reduce the isolation currently experienced by HCS and its employees and so inimitable to safety and quality.

Recommendation 45:

HCS should look closely at the paediatric model and evaluate its strengths and weaknesses. This potentially would further inform discussions with Southampton.

Recommendation 46:

The Medical Director should assess the need to provide a more structured approach to support those wishing to go down the CESR route and, if indicated, HCS would be wise to place the organisation of this under an appropriate Deputy Medical Director and HR business partner.

There may well be similar approaches in the other clinical professions.

Recommendation 47:

HCS must develop and publish a mandatory training policy and insist that its employees complete their mandatory training.

If they fail to comply, they must be held to account.

In most organisations it is the responsibility of the local manager to ensure that this process occurs and is documented.

If the individual is within a regulated profession, then the failure must be reported to the regulator.

In Medicine it should be made clear by the RO that it is not possible to complete a successful appraisal whilst ignoring mandatory training requirements.

Recommendation 48:

Consultants should be open about the CPD work done in their SPA time, which should be defined in their job plans and are as such, a contractual commitment.

The organisation must insist that SPA time is used effectively and constructively. The activities undertaken should be documented and reviewed at appraisal.

Recommendation 49:

Mechanisms must be put in place to demonstrate that public money is being used to benefit patients.

One additional way in which SPA time could usefully be used would be to spend time working in a major centre in the UK or, with good reason, elsewhere. There is no doubt that some consultants would welcome this opportunity.

SPA time should also be used in a transparent way to attend clinical audit meetings, mortality and morbidity meetings, and other activities which drive quality and safety. Mandatory training should also occur during this time. This should all be part of the job planning process and performance managed. .

Recommendation 50:

Attendance at clinical meetings which drive safety and quality should not be optional and such meetings should be included in job plans.

Recommendation 51:

All patients, both public and private, should be included in audit processes.

Recommendation 52:

The RO should insist on a review of the audit of "whole practice" in guidance to appraisers and appraisees.

Recommendation 53:

The degree of sub specialisation versus generalisation needs to be constantly monitored and managed by clinical leaders. When subspecialisation is possible (to increase the volume of patients managed by doctors with skills in a particular area) it should occur.

It is legitimate to recognise that the opportunities for sub specialisation in Jersey are less than in larger institutions, but it is not legitimate to avoid sub specialisation to enhance private medical practice. Again, this needs to be actively managed by clinical managers and the RO.

Recommendation 54:

The financial arrangements of the management of private patients should be clarified and made transparent so that the benefit to HCS is clear and the public can be assured that care of public patients is not compromised, but hopefully is enhanced.

Recommendation 55**:**

Allegations that the management of private patients is at the expense of public patients are very damaging – a point made by several consultants - and HCS must audit the situation thoroughly to assure itself that the management of patients within its purview is equitable and equally safe for all. (Assuming that this is the wish of the people and Government of Jersey).

If a robust audit is not reassuring, then the Government should make its position clear and HCS respond immediately to remedy the situation. This issue should also be a matter for the HCS Board, should it be reconstituted along more conventional lines.

Recommendation 56:

Many Consultants themselves were concerned not only about patient care but about the tarnishing of their reputation and it might be most helpful if the issues were discussed in an open and transparent way at the Medical Staff Committee (MSC). This is of course a matter for the MSC, which is not a management but a representative body, but can and should play an important constructive role.

A robust job planning process would provide consultant staff with protection from reputational damage.

Recommendation 57:

A crucial point is that it should be always clear for all patients which Consultant is responsible for their care - at all times, and available to see them when needed.

Recommendation 58:

It is the role and responsibility of the organisation to provide safe high-quality care, and to be certain that its employees are doing this, as well as performing clinically and behaviourally to a satisfactory standard. This applies to both public and private patients, when these private patients being managed within its purview – in the hospital using hospital employees and facilities.

Equally, those employed by the organisation must understand that they are employees of an organization that is clearly accountable to the government and people of Jersey. To put it another way, they work *for* the organisation not *at* it.

It is the role of the regulatory bodies to regulate individual professionals. This includes the clinical competence of the professional, their behaviours and that they are conducting their affairs with probity.

The two roles are therefore linked and should be symbiotic, but the presence of a regulator does not remove the responsibility of the organisation to provide safe services and the accountability of its employees to it. When confusion exists about these issues then the danger is that the lack of clarity and accountability has a direct and damaging effect on the effectiveness of the organisation and patient safety.

The medical appraisal and revalidation process is well embedded in the UK and adopted in Jersey. It should be conducted to a high standard and the responsible officer should be rigorous in their assessment of doctors requiring revalidation (looking at and seeking evidence about all aspects of good medical practice including clinical outcomes, appropriate behaviours, organised and documented CPD and probity. These processes will clearly add value and a degree of assurance.

It is rumoured that Government in the UK may produce a more comprehensive picture of a doctor's performance which could be used at appraisal, and it would be worth monitoring this development.

In any event, HCS should seek to support the appraisal process by providing as comprehensive a picture of the doctor's performance as possible, including both public and private patient outcomes, details of complaints and compliments, use of SPA time, etc.

Whilst not diminishing in any way the role of the employer, the GMC and the Responsible Officer have a key role in maintaining medical professional standards and assuring the public that the requirements of Good Medical Practice are met in full.

An active dialogue between the Medical Director and RO would be useful in driving the recommendations of this report.

The informatics department should be of considerable assistance in this process and must also assist in obtaining good quality benchmarking data.

Recommendation 59:

The job planning process for consultants needs to be undertaken and completed as a matter of urgency by clinical line managers driven centrally from the Medical Director's Office. The Medical Director should chair a high-profile steering group charged with driving the process through the organisation at pace.

Job Planning could also be a useful process for other groups including middle grade doctors, some of whom are said to work excessively long hours of 15 PAs or more. There is a well understood argument about the effect of excessive hours on patient safety and these hours need to be reduced (with the appointment of more consultants to provide an increasingly consultant-based service), as is common elsewhere.

If the hours quoted are a true representation of the workload, then it is likely that more consultant appointments are required (see elsewhere in the report).

Recommendation 60:

The recruitment processes need to be both timely and robust. For both locums and lone practitioners, the best mitigation is good induction and then close monitoring of performance. The development of suitable metrics (many of which can be lifted from elsewhere) is central to this.

It may be worth obtaining external advice on recruitment and retention. It is not the author's area of expertise.

Recommendation 61:

The Medical Director should issue a clear statement as to where the responsibility lies for signing off results from radiology and laboratories.

The responsibility for ensuring that this is done, and appropriate action taken, sits with the Consultant under whose care the patient is being managed.

This does not mean that those in service specialties should not continue to raise issues with clinicians directly and immediately if they are concerned about a result or a finding. Their expert opinion is invaluable in driving safety and good care.

Appendix 5: External Review: Review of Maternity Services Health and Social Security Scrutiny Panel (July 2021)

Report - Review of Maternity Services - 6 July 2021.pdf (gov.je)

1. EXECUTIVE SUMMARY

The Panel's review sought to access the current maternity services and whether they could be improved to help better support and assist women and their families through such a momentous stage in their lives. A vast number of individuals chose to engage with the Panel's review, which spoke volumes about the desire and need for women to share their experiences. The Panel found that, in the past, there has been a lack of real engagement with those who use such services and little opportunity provided to women to have their voices heard. The establishment of the Maternity Services Partnership (MVP) is a very welcomed development and will be an excellent vehicle for enhanced communication between maternity services and women. The Minister for Health and Social Services (the Minister) should therefore ensure that the MVP reports to the maternity services leadership team on an annual basis to provide feedback from women and their families as to their experiences of the service. The Panel's own survey demonstrated that women wish to have their say on their experiences of maternity care. An annual service user survey and maternity staff survey would be fundamental in shaping a new maternity strategy and setting a bar for acceptable standards of care. In line with recommendations that were made in the UK as a result of the 2020 Ockenden Review, we have proposed that an independent senior advocate role is created within maternity services to represent women and their families to ensure their voices are heard and any concerns considered and addressed.

During our review we found that whilst an overarching strategy for maternity services was due to be developed by Health and Community Services (HCS), there was currently no system-wide agreement to a single maternity strategy which describes agreed outcome and performance goals for maternity services. Such a strategy is vital to establishing a modern maternity service that meets the need of our population. We therefore recommend that a system-wide strategy is developed without delay which includes cultural values, the proposed model of care (including choices of maternity care and continuity of carer), the maternity care pathway, expected service outcomes and a performance measurement framework. In the meantime, establishing a dedicated Maternity Services project team to drive forward the necessary transformation in maternity services is recommended.

Evidence we received throughout our review overwhelmingly supported the need for an upgrade to the current maternity unit, with a large majority of service users and maternity staff recognising that the current facilities within the General Hospital are inadequate and highly unacceptable. The Panel is therefore extremely pleased that a commitment has been made to upgrade the facilities imminently, which will significantly improve the physical environment, and that it has been backed by substantial funding. Unfortunately, however, it became apparent that there has been little consultation with women who are recent or future users of the service, or with midwives providing the services, when developing the refurbishment plans. We therefore Review of Maternity Services 6 recommend that all maternity staff are given the opportunity to be involved at some point during the design stages of the refurbishment. We also believe that is vital that the MVP are engaged with to ensure that service user's views are taken into consideration as the project progresses. The upgrade is planned to take place in phases over a two-year period, whilst the Maternity Unit remains fully operational. We are extremely concerned that this timescale is too long and will lead to unnecessary disruption for women, their babies and for staff seeking to provide high quality care. For this reason, the Minister should engage

an independent estates expert to assess the options for the upgrade work to the Maternity Unit and provide a more rapid response.

As recognised by our advisers, when assessing the quality of a service it is important to consider not only whether it is 'safe' but also whether it is effective, caring, responsive and well led. Furthermore, international policy is increasingly affirming that physical safety on its own is not enough and that services need to ensure that women are also emotionally safe. Whilst Jersey's maternity services appear to be 'safe' when considered through the lends of major empirical measures (such as perinatal mortality or major physical trauma), they seem to be lacking the emotional component of quality. Our evidence suggests that a lack of emotional safety in the delivery of care is leaving women feeling unsafe, unsupported and with negative opinions of the service. We found that a women's emotional safety can be largely impacted by the continuity of care/carer and the level of compassion and kindness provided when receiving maternity care. Whilst many women undoubtedly have a positive experience, we received shocking testimonies from women who have had confusing and inconsistent advice, not had their wishes respected and have not been treated with compassion and respect.

Whilst we found that there is a clear intent within the maternity team to provide continuity of care, it is evident that there is still room for significant improvement. To help address this matter, we have proposed that a midwife-led model of care is defined, which incorporates, at a minimum, continuity of care in the antenatal and postnatal period, with the ambition of extending this to the intrapartum period. The main objective of this model should be to ensure that care is delivered as close to home as possible, to reduce inconsistency of advice throughout a women's pregnancy and to increase women's satisfaction with the service.

We found that positive and progressive steps were currently being taken by the maternity services leadership team to address cultural and communication issues within the maternity team and to help ensure that all women receiving care feel listened to, supported and respected. A Local Committee has been established with the objective of developing the basis of a culture and behaviour strategy, which will include organisational values. Furthermore, we were advised that the strategy would provide a framework that supports and promotes regular appraisals, improving communication and enhancing interpersonal relationships within maternity services. Without such a framework we believe it is very difficult to challenge behavioural problems and underpin poor culture and therefore agree it is vital to improving the confidence of women and Review of Maternity Services 7 their families in the care provided. We have recommended that the Local Committee includes multi professional and across sector representation and that the Culture and Behaviour Strategy is published as an integrated part of the Maternity Services Strategy. In addition, the culture strategy should be a statement of the overarching values of the service and the behaviours that will underpin those values.

Our review identified the need for a coherent Workforce Strategy to underpin the current maternity service and to support the new Maternity Strategy. Such a strategy would be vital for assessing whether the midwifery workforce is adequate to support a new model of midwifery led care. We also found that the current leadership structure is not appropriate for providing leadership to the work required and for ensuring both a consistent clinical model and robust system of governance in maternity services. Furthermore, under the current leadership model, the voice of midwives is not heard in the right fora. In light of these findings, we have made two recommendations. Firstly, that a Maternity Workforce Strategy is developed which considers future workforce requirements, assesses different roles to support all aspects of maternity care, and explores options for staff rotations with partner organisations. Secondly, that an appropriate leadership team for maternity services is created, including the appointment of a Director of Midwifery and an Associate Medical Director, who is also Lead Obstetrician.

Whilst the majority of women that engaged with our review felt involved in the decisions about their care, some reported feeling unsupported with their choices or coerced into agreeing to the type of care received. A particular area of concern which was raised by women was in respect to infant feeding. A significant number of women reported receiving either inadequate breastfeeding support or a lack of compassion and respect about how they wished to feed their baby. We found that it is vital that the promotion of breastfeeding is underpinned by women having ready access to well trained professionals, in both the hospital and home, who provide consistent support and advice. The achievement of Stage One accreditation of the UNICEF Baby Friendly Initiative Programme amongst Health Visitors and, most recently, Maternity Services, is commendable and the identification of five breastfeeding 'champions' within both services is a positive step. However, recent staff and resource constraints have meant that breastfeeding champions have been unable to be released to work towards the Baby Friendly Initiative. As a result, it is unclear when Maternity Services will be ready to progress to Stage 2 of the accreditation. We have therefore recommended that breastfeeding champions are given protected time to undertake the work and training necessary to fulfil their role. We also recommend that that the whole maternity system (Midwives, GPs, Health Visitors) demonstrate a commitment to achieving full accreditation (all 3 stages) by Spring 2023.

It is widely recognised that mental health problems are often associated with times of stress or change in an individual's life and that pregnancy and the first year after birth is a time where health professionals play a significant role in promoting mental health. Despite being advised that women were routinely asked about their emotional well-being and mental health at their Review of Maternity Services 8 first contact with primary care or their booking visit with the midwife, 21% of respondents to our survey reported that neither their GP or midwife had enquired about their mood or feelings during pregnancy. Therefore, the Panel has recommended that every expectant mother is routinely asked about her feelings and mood at every antenatal appointment to ensure that any issues are recognised and acted upon as early as possible. There are undoubtedly positive developments being made in the field of perinatal mental health within maternity services. During our review we learnt of the approval of a business case for a new perinatal mental health pathway which is intended to improve the referral route for new parents, making it clearer and more consistent. However, progress needs to be made quickly and the impact of the investment needs to be monitored. To ensure that the Panel is kept abreast of progress and the outcome of the new pathway, we have asked to be provided with quarterly updates from HCS for assurance that maternity and mental health are working collaboratively and delivering consistent care to women and their partners.

2. RECOMMENDATIONS

RECOMMENDATION 1 The Minister for Health and Social Services must ensure that all Maternity Staff are given the opportunity to be involved at some point during the design stages of the Maternity Unit refurbishment. The Minister must also engage with the Maternity Voices Partnership, and the public in general (including fathers/partners), to ensure that recent and future users of the service are able to share their views.

RECOMMENDATION 2: The Minister for Health and Social Services should engage an independent estates expert to assess the options for the upgrade work, including a standalone midwifery-led unit, to the Maternity Unit and provide a more rapid response.

RECOMMENDATION 3: The Minister for Health and Social Services must ensure that a midwife-led model of care is defined which incorporates, at a minimum, continuity of care in the antenatal and postnatal period, with the ambition of extending this to the intrapartum period. The main objective of the model should be to ensure that care is delivered in the home, or as close to home as possible, to

reduce inconsistency of advice in both the antenatal and postanal periods, and to increase women's satisfaction with the service.

RECOMMENDATION 4: The Minister for Health and Social Services must ensure that the Local Committee, developed following the initial Culture Summit, includes multi professional and across sector representation and that the Culture Strategy is published as an integrated part of the Maternity Services Strategy. Furthermore, the Culture Strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values.

RECOMMENDATION 5: The Minister for Health and Social Services must ensure that a system-wide maternity strategy is developed without delay which includes cultural values, the proposed model of care (including choices of maternity care and continuity of carer), the maternity care pathway (community/parish led maternity service), expected outcomes, performance measurement framework with KPIs/benchmarks and approach to oversee policy development.

RECOMMENDATION 6: The Minister for Health and Social Services must establish a system wide Maternity Task and Finish Group that is accountable to the Independent Jersey Care Model (JCM) Board. This should include a dedicated project manager. The remit of the Group should be to drive forward the development of the Maternity Strategy and to undertake the recommendations identified in the Panel's report.

RECOMMENDATION 7: The Minister for Health and Social Services must establish a comprehensive system of performance management, including an annual service user survey and staff survey, to enable benchmarking against other appropriate maternity services.

RECOMMENDATION 8: The Minister for Health and Social Services should establish a dashboard similar to the new National Maternity Dashboard to enable easy comparisons, such as Clinical Quality Improvement Metrics, with other maternity providers. The dashboard should be made publicly available.

RECOMMENDATION 9: The Minister for Health and Social Services should engage the Jersey Care Commission to support the maternity system to establish a robust and measurable quality framework, with suitable resources allocated.

RECOMMENDATION 10: The Minister for Health and Social Services must develop a maternity workforce strategy to consider future workforce requirements, assess different roles to support all aspects of maternity care and explore options for staff rotations with partner organisations.

RECOMMENDATION 11: The Minister for Health and Social Services should develop an appropriate leadership team for maternity services, including the appointment of a Director of Midwifery and an Associate Medical Director, who is also Lead Obstetrician.

RECOMMENDATION 12: The Minister for Health and Social Services must endeavour to complete all actions from the Royal College of Obstetrics and Gynaecology reviews of maternity services and have a complete set of key organisational policies in place by the end of 2021

RECOMMENDATION 13: All birthing women and their partners should routinely be provided with evidence and information concerning their options in respect of pain relief and birth choices, highlighting benefits and risks, and given the opportunity to discuss and understand these prior to labour. All information should be delivered clearly and in a non-judgemental way.

RECOMMENDATION 14: The Minister for Health and Social Services should consider opportunities to better link breastfeeding and perinatal mental health support services together and train volunteers locally to provide peer support services.

RECOMMENDATION 15: The Minister for Health and Social Services must ensure that breastfeeding champions are given protected time to undertake the work and training necessary to fulfil their role.

RECOMMENDATION 16: The Minister for Health and Social Services must ensure that the whole maternity system, including GPs, Midwifery, Neonatal and Health Visiting services, demonstrates a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 is owned by every service, adequately resourced and closely monitored.

RECOMMENDATION 17: The Minister for Health and Social Services must ensure that the utmost priority is given to appointing a specialist breastfeeding support midwife by the end of Q1 2022 to champion the UNICEF standards and mentor/upskill staff whose breastfeeding support skills require refinement.

RECOMMENDATION 18: The Minister for Health and Social Services should ensure that relevant information about infancy feeding and, specifically, how to deal with breastfeeding issues, is provided to women and their families routinely during their antenatal appointments.

RECOMMENDATION 19: The Minister for Health and Social Services should ensure that the "Pregnancy and birth' page on the Gov.je website is regularly updated and that women are made aware of the website during the very early stages of pregnancy.

RECOMMENDATION 20: The Minister for Health and Social Services must ensure that every expectant mother is routinely asked about her feelings and mood at every antenatal appointment to ensure that any issues are recognised and acted upon as early as possible.

RECOMMENDATION 21: The Minister for Health and Social Services must appoint a specialist perinatal mental health midwife by the end of Q1 2022.

RECOMMENDATION 22: The Minister for Health and Social Services must ensure that, when recruited, the Perinatal Mental Health Midwife organises and encourages education and training of all midwives in perinatal mental health and the delivery of care to make sure there is a consistent assessment and referral across all services.

RECOMMENDATION 23: The Minister for Health and Social Services must introduce guidance which ensures that all fathers/partners are routinely asked about their mental health (either directly or through the mother) during pregnancy and following the birth of the baby. The Minister should ensure that as part of the pathway, access to mental health support for fathers/partners should be expedited.

RECOMMENDATION 24: The Minister for Health and Social Services should consider the recruitment of a bereavement midwife, or the training of a current midwife into this position, in order to better support families going through baby loss.

RECOMMENDATION 25: The Minister for Health and Social Services should ensure that the de-brief service following birth is universally offered to women and adequately resourced. Women and their families should be made aware of the service postnatally whilst both in hospital (if the women had a hospital birth) and at home. The Minister should ensure that adequate mental health support is available to diagnose and treat women with birth-trauma-related Post Traumatic Stress Disorder (PTSD) symptoms.

RECOMMENDATION 26: The Minister for Health and Social Services should provide quarterly updates to the Panel in respect of the new perinatal mental health pathway for assurance that maternity and mental health staff are working collaboratively and delivering consistent care to women and their partners.

RECOMMENDATION 27: The Minister for Health and Social Services must ensure that the Maternity Voices Partnership reports to the maternity services leadership team on an annual basis to provide feedback from women and their families as to their experiences of the service.

RECOMMENDATION 28: The Minister for Health and Social Services should request feedback of families on their experiences of maternity care. This could be an annual or a bi-annual survey and/or during the six-week and two-year checks.

RECOMMENDATION 29: The Minister for Health and Social Services should create an independent senior advocate role within maternity services which reports to the Health and Community Services Executive Team.

Appendix 6: External Review: States of Jersey Health and Community Services, Theatre Service Review (June 2021)

States of Jersey Health and Community Services, Theatre Service Review (gov.je)

1. EXECUTIVE SUMMARY

The review found that the Health and Community Services States of Jersey are committed to providing safe and sustainable services that improve outcomes for patients and their families. This review is a testimony to its commitment to ensure that the people on its Island are in receipt of good quality and safe care. The position of The Health and Community Services States of Jersey is clear. What the review has found is that in its current arrangement the theatre service requires immediate improvements in a number of areas.

- It is my recommendation that the board sets up a Task and Finish group to set up a plan of action to draw up and agree on the best structure, process and outcome measures to use when evaluating the quality of care you provide.

- The current organisational leadership model is not in a good shape to meet the challenges of the service moving forward. Therefore, this report recommends that the organisational structure is re-designed to make it easier to identify inefficiencies and problems.

- The third recommendation which needs immediate address is an establishment review to set up specific roles and responsibilities. The focus should be on professional accountability and making sure that the staff are sufficiently competent to carry out their duties.

These are the three most pressing areas which require immediate action. A further review will be carried out in 3 months' time from the date this report is published. There are several other recommendations that have been made. It is up to the executive board to look into them and delegate responsibility on how these are going to be enacted.

I would like to thank the wonderful theatre staff of Jersey Hospital. It would not have been possible to write this report without their contribution. I was impressed by their optimism and professionalism and I am sure they truly believe in their work. I hope that this report has managed to capture in its true essence the changes they would like to see to improve patient care and their welfare.

RECOMMENDATIONS

Terms of Reference (TOR) 1. Examine the Leadership capacity and capability and consider whether the current systems of accountability are effective and support high quality and safe systems of work.

Staff Appraisal process

Senior management should establish a robust monitoring process for compliance with the process.

Management should ensure that everyone has an opportunity to discuss performance and development needs with line manager.

Utilise the process to ensure that staff understand their role and responsibility, and how they contribute to the performance of the organisation.

Review individual performance at least once a year and identify any training or development needs to undertake role to improve performance.

Immediate performance concerns should be acted upon sooner rather than wait for the appraisal process.

Appraisals should not be used to pursue personal vendettas instead the process should be used to support and encourage.

Sickness and Attendance management

Re-establish consistent management of sickness absence in line with the hospital's policy.

Senior managers should regularly monitor and evaluate the process for its application and compliance.

Utilise the policy to find ways on how to support staff well-being. Work related stress should be acknowledged and alternatives sought to support staff.

Move the recording of sickness from paper to electronic Health Roster to enable accurate monitoring.

Managers should always seek advice from occupational health.

Hold regular Human Resource meetings to seek advise on ongoing department sickness management.

Annual Leave Allocation

All annual leave management and allocation should be moved to the Electronic Health Roster.

There should be monitors in place to make sure that it is done so fairly.

No application for annual leave should be refused without good reason.

If annual leave is refused then reason must be recorded.

How is the Leadership?

The senior management needs to be visible and provide an authoritative but caring presence.

The management team needs to be all-encompassing making sure equality and opportunity for promotions follow a transparent process.

The nursing management needs to establish a culture of caring and continuous improvement through clear standards of behaviour and zero tolerance to gossiping and tolerance of poor care.

Provide a clear organisational chart and empower all staff grades to be part of the decision making process.

Give independence to individual theatres to manage their workloads, including sending for patients and allocation of breaks.

Give individual teams a voice and the professional independence to ensure they take ownership of the care they provide.

The coordinator's role should be rotational to allow others to develop.

Incorporate visual management to make performance and problems visible and to enable effective team communication.

Place large, clear and highly visual displays of daily targets and performance.

Establish a problem solving standard approach used to deal with issues that affect performance, systematically eliminating the barriers to progress.

Evaluating Information

Use information you are currently collecting to find out current trends/what needs improvement to make effective plans for future. Examples are:

- Waiting list
- Patient experience /lack of it
- Late theatres start
- Incidents reported investigated/not investigated
- Staff absences reasons/causes
- Underutilised theatre sessions
- Seek opportunities to collect information

Clinical Responsibilities for Registered staff (Nurses and Operating Department Practitioners)

Establish clear clinical responsibilities for all staff from the theatre attendant to Divisional lead.

Consent and Refusal of Consent

There should be zero tolerance to intra-operative altering of consent forms.

Encourage reporting of discrepancies between listed procedures against consent forms.

Safer surgery processes (Five steps to safer surgery)

Carry out regular audits to monitor compliance

Establish staff educational programmes to raise awareness

Monitor all incidents (near miss no harm/low harm related to non-adherence to the process.

Theatre Environment

Replace rusty equipment.

Replace Day Surgery Unit Recovery room multi-use curtains with disposable curtains.

Get a fire safety inspection to review the storage arrangements of the trolleys in the corridor for reassurance.

Sterile Services

Standardise instruments sets for day surgery and main theatres. Review the process for replacing instruments to make less bureaucratic.

Medical Devices Management and Safe Use

Review your medical devices management policy.

Establish a process for Reviewing Medical Devices Management

Put in place process for Monitoring Compliance and Effectiveness

Provide medical devices training to all staff and keep accurate records

Put in place a medical device checklist user responsibility

Make sure all equipment has clearly labelled

- Service due dates
- Organisation's equipment number

Datix (Reporting and Learning Culture)

Resources and readiness relook at the organisation's purpose of incident reporting.

- Allocate appropriate financial and staff resources
- Objectives must be clearly articulated
- Establish a culture around safety

Uptake and Usage should focus on the user experience with the reporting system.

- Provide training for staff
- Clear definitions of what should be reported
- Direct feedback loop
- Make sure that anonymity is guaranteed for staff

Information Capture should be meaningful to the relevant departments.

- Establish regular reports that show actual number of reports and categories
- Make sure reports are done in a timely manner
- Collaborative reporting to ensure data supports action

Analysis and Publication

- Making sure data is analysable
- Data must be understood by staff responsible for acting on it

• Managers should have immediate access to data
• All staff encouraged to participate in the analysis Generating learning and Improvement through effective feedback mechanisms.
• Prioritisation of efforts prior to designing improvements
• Establish system for monitoring improvement • Innovative approaches to engaging staff in improvement

Infection control

Put in place a process of monitoring surgical site infections. Challenge bad practices such as the wearing of wrist watches and bands in the clinical areas.

The impact of list scheduling utilisation and start and finish times

The review recommends that the theatre planning meeting agenda should focus on;

• Review of sessions that are being used / released / awaiting surgical cover
• Confirm any changes to be made to lists, who will action these and the associated deadlines
• Review of lists that are empty or significantly underutilised, in order to clarify whether or not they will still run.
• Discuss and agree any requests for extensions or additional ad-hoc sessions
• Review of the cancellations data from the previous week and look into the reasons why
• Discuss any estates or equipment issues

Additionally, the review recommends that a further list review meeting should be established to look at the following:

• To review lists for the next two weeks to ensure full bookings
• Review x-ray requirements to avoid clashes
• Review HDU/ Bed requirements
• Review equipment and implant queries

The issue with the high number of under-filled private lists

What happens in turnaround?

Establish a surgical arrivals lounge for on the day anaesthetic review and consenting.

Alternatively, share the 4 consultation rooms on Reynar ward for the first part of the morning with obstetrics.

Establish a definitive start session start time and monitor reasons for late starts.

Give individual teams control over how the list are run, sending for patients managing breaks.

Scrub and Anaesthetic ratios

The current staffing ratios are in line with recommended guidance on theatre staffing.

However, a list planning review should be put in place to determine staffing requirements based on clinical need.

It is recommended that a skills need analysis is carried as matter of urgency to determine the department needs.

Following that a clear staff development and rotational programme should be put into place to address the skills issues.

Senior staff should take an active role in the training and development of staff.

The role of the coordinator should be re-evaluated and clearly defined.

The recovery start times need to match the activity, therefore staggered start times are recommended in order to provide cover for the later part of the day.

Inside and outside staffing (Theatre Support Services)

Establish a theatres stores team to manage consumables and loan equipment.

Emergency lists and staffing

Keep the current arrangement however, identify and only allocate staff with the right skills to these shifts.

Bring back the theatre attendance on the on-call roster to cover shortfalls as they possess the right skills.

Value and efficiency

Establish metrics and measures to determine value. The focus should be quality, collect data to demonstrate your clinical outcomes.

It is recommended that an economical component to these metrics is also put in place.

Currently, the political perspective is very clear and in the absence of a patient voice this may be the closest you could get to patient representation.

Patient experience and outcomes

Measures should be put in place to ensure that there is an improvement of patient experience and to ensure positive outcomes of care.

The service needs to adopt a model that puts at the centre both private and public patient engagement and starts capturing patient experiences.

TOR 2. Appraise how well patient needs are assessed and if care and treatment are delivered in line with modern operating department standards and evidence-based guidance to achieve effective outcomes.

Consent and Refusal of Consent

There should be zero tolerance to intra-operative altering of consent forms.

Encourage reporting of discrepancies between listed procedures against consent forms.

Safer surgery processes (Five steps to safer surgery)

Carry out regular audits to monitor compliance

Establish staff educational programmes

Monitor all incidents (near miss no harm/low harm related to non-adherence to process

Theatre Environment

Replace rusty equipment.

Replace Day Surgery Unit Recovery room multi-use curtains with disposable curtains.

Get a fire safety inspection to review the storage arrangements of the trolleys in the corridor covered with highly combustible sheets.

Sterile Services

Standardise instruments sets for day surgery and main theatres.

Review the process for process for replacing instruments to make less bureaucratic.

Medical Devices Management and Safe Use

Review your medical devices management policy.

Establish a process for Reviewing Medical Devices Management.

Put in place process for Monitoring Compliance and Effectiveness

Provide medical devices training to all staff and keep accurate records

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- Service due dates
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Analysis and Publication

- Making sure data is analysable
- Data must be understood by staff responsible for acting on it
- Managers should have immediate access to data
- All staff encouraged to participate in the analysis

Generating learning and Improvement through effective feedback mechanisms.

• Prioritisation of efforts prior to designing improvements
• Establish system for monitoring improvement • Innovative approaches to engaging staff in improvement

Infection control

Put in place a process of monitoring surgical site infections.

Challenge bad practices such as the wearing of wrists watches and bands in the clinical areas.

TOR 3. Assess the efficacy of scheduling within the main theatre and specifically. The impact of list scheduling

- **List utilisation and start and finish times**
- **Speciality lists v generic – staffing and productivity**
- **What happens in turnaround**
- **Scrub and anaesthetic ratios**
- **Inside and outside staffing**
- **Emergency lists and staffing**

The impact of list scheduling utilisation and start and finish times

It is recommended that the theatre planning meeting agenda should:

- Review sessions that are being used / released / awaiting cover
- Confirm any changes to be made to lists, who will action these and the associated deadlines
- Review of lists that are empty or significantly underutilised, in order to clarify whether or not they will still run.
- Discuss and agree any requests for extensions or additional ad-hoc sessions
- Review of the cancellations data from the previous week and look into the reasons why
- Discuss any staffing or equipment issues

Additionally, it is recommended that a further list review meeting should be established to look at the following:

- To review lists for the next two weeks to ensure full bookings
- Review x-ray requirements to avoid clashes
- Review HDU/ Bed requirements
- Review equipment and implant queries.
- The issue with the high number of under-filled private lists

What happens in turnaround?

Establish a surgical arrivals lounge for on the day anaesthetic review and consenting.

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Establish a definitive start session start time and monitor reasons for late starts.

Give individual teams control over how the list are run, sending for patients managing breaks.

Scrub and Anaesthetic ratios

The current staffing ratios are in line with recommended guidance on theatre staffing.

However, a list planning review should be put in place to determine staffing requirements based on clinical need.

It is recommended that a skills need analysis is carried out as a matter of urgency to determine the department needs.

Following that a clear staff development and rotational programme should be put into place to address the skills issues.

Senior staff should take an active role in the training and development of staff.

The role of the coordinator should be re-evaluated and clearly defined

The recovery start times need to match the activity therefore, staggered start times are recommended in order to provide cover for the later part of the day.

Inside and outside staffing (Theatre Support Services)
Establish a theatres stores team to manage consumables and loan equipment.

Emergency lists and staffing
Keep the current arrangement however, identify and only allocate staff with the right skills to these shifts.

Bring back the theatre attendance on the on-call roster to cover shortfalls as they possess the skills.

Value and efficiency
Establish metrics and measurements to determine value.

The focus should be quality, collect data to demonstrate your clinical outcomes.

It is recommended that an economical component to these metrics is also put in place.

Currently, the political perspective is very clear and in the absence of a patient voice this may be the closest you could get to patient representation.

Patient experience and outcomes
Measures should be put in place to ensure that there is an improvement of patient experience and to ensure positive outcomes of care.

The service needs to adopt a good model of patient engagement and start capturing patient experiences.

TOR 4. Assess the efficacy of the relationship between theatres, TSSU and the wider organisation, including maternity.

The proximity of Theatre Sterile Services Unit and turnaround time

This has been looked at previously under Terms of Reference (2) under the subheading (Sterile Services).

Emergency Theatre Cover for Maternity

This has been looked at previously under Terms of Reference (3) under the subheading (Emergency lists and staffing)

TOR 5. Consider the relationships amongst staff teams to determine if these enable them to work collaboratively, share responsibility and resolve conflict quickly and constructively. Assess the culture within the service in response to incidents, establishing whether this enables openness and honesty at all levels amongst staff and patients.
Establish clear and specific performance goals for people's jobs. • Communicating is the link between a team's daily work and the organisation's strategy. • Set challenging yet realistic goals for others to inspire peak performance by connecting people to their work emotionally and intellectually. • Regularly review overall individual performance. • Encourage people to initiate tasks and projects. • Recognising superior performance helps employees grow and obtain their career goals. • Conduct team meetings that serve to increase trust and mutual respect.
TOR 6. Judge what a modern theatre service should look like for an island such as Jersey and advise on the plans for the future theatre modelling for the new Hospital build.
The future theatre modelling should take into account the patient journey. Admissions lounge should be on the same floor and the first point of arrival. This should include enough assessment rooms to cater for the number of theatres. The sterilisation unit should ideally be situated within the same complex. A consultation of the current users view would be useful in contributing to the theatre design.
TOR 7. Identify how an island such as Jersey could link into a network to help enhance and support the quality and safety of the on-island services.
It is recommended that all specialties connect to networks on the mainland. Individual leads need lead on the process. The hospital management create an office to look into needs and the benefits. Allocate resources to promote the cause

Appendix 7: Independent Review of Adult Mental Health Services in Jersey – which are part of the Health and Community Services (HCS) (October 2021)

R Independent Review of Adult Mental Health 18112021.pdf (gov.je)

1. EXECUTIVE SUMMARY

This review was undertaken at the request of the Health and Community Services Department's Executive Team and was tasked to give a judgement on the overall safety of the service and how it was led and managed together with other key objectives as described.

The reviewers had access to a number of documents and information from the service and undertook field visits to services across both community and in-patient services and interviewed several staff between the 29th of September 2021 and the 2nd of October 2021.

This was then collated and, where possible, tri-angulated to provide evidence guiding the report. The reviewers found the following key issues within Adult Mental Health Services:

- There is a lack of senior management leadership and direction.
- A lack of a system of MDT working such as the Care Programme Approach or an equivalent.
- Within Adult Mental Health, there are inadequate systems to learn from Serious Incidents.
- Silo working professionally and within teams.
- Lack of a system to ratify, manage and implement policies and procedures.
- Poor management supervision structures.
- Within Adult Mental Health on a positive note, the reviewers spoke with many professional staff who had a real motivation to develop and improve the service and have the potential to achieve positive change. Inpatient services have made some recent improvements, but further work is required.

The reviewers have identified several recommendations which focus on the key issues which it is hoped can be used as a springboard to help develop the Adult Mental Health Service that Jersey deserves.

2. RECOMMENDATIONS

The list of recommendations is not meant to be exhaustive but to focus on the key issues facing Adult Mental Health Services.

Adult Mental Health Senior Management Structure

- Review the senior management structure within Adult Mental Health Services to ensure it is fit for purpose.
- Make sure that Adult Mental Health Services have clear objectives that are regularly reviewed.
- Define and ensure measurable mental health outcomes, such as improvement in symptoms or functioning of patients. This might initially have to be process driven, for example by introducing the Care Programme Approach) introduction, and the number of MDT reviews undertaken.
- The Adult Mental Health Service is in the process of integrating with Adult Social Care –

Consideration should be given to putting this on hold until such time the Adult Mental Health Service is considered safer.

CPA or Equivalent

Adult Mental Health Services must introduce a system of CPA or an equivalent, acknowledging that this is more than a policy and requires a clear project plan that must include training for staff. It is important the staff group are involved in the development of this along with patients. The aim is to ensure good communication between clinicians, teams, patients and relatives.

This must include a clear method of MDT working.

Utilise best practise from other services in the context of an island service.

Jersey Care Model

Jersey has an ambitious plan to develop services in line with its model of care.

Adult Mental Health Services need to develop in the context of this with a clear model of care that is understood across the whole Jersey Health Service. Adult Mental Health Management structures should follow from the chosen care model and objectives that ought to be clearly defined with measurable outcomes.

Initially the current model needs to be articulated as a whole system so that each component part is understood as part of a whole system rather than a silo.

Adult Mental Health Management Roles

The management roles within Adult Mental Health Services should be reviewed to ensure that they receive regular management supervision, have clear objectives, and understand their role as part of a holistic Mental Health Service. The meeting structure should be reviewed as part of this to ensure it is fit for purpose and effective.

The Mental Health Nurse Consultant should have a clear link into the Chief Nurse Office and hierarchy, which influences and monitors the job plan. The role of the Mental Health Nurse Consultant should be reviewed and defined in line with the Jersey Care Model and best practice.

Consideration should be given to having the legislation department under the remit of a general manager within Adult Mental Health Services, rather than the current structure which reports to an adult social services manager.

Policies and procedures

There must be a clear process for developing and agreeing policies within the Adult Mental Health care group, and where there are delays, there must be an escalation process to the Mental Health leadership team.

An overall Clinical Risk Management Policy is a priority for Adult Mental Health.

We were told that there is currently a protracted process to deliver Electroconvulsive Therapy (ECT) for patients in Jersey, which does not allow for urgent ECT to be commissioned. There should be an agreed pathway for Electroconvulsive Therapy. As a matter of urgency, emergency ECT provisions need to be planned and commissioned, which should be in line with best practise guidelines.

Other immediate policies have been flagged earlier

Community Mental Health Team (CMHT)

The CMHT should consider that its staff should work across clear catchments areas on the island. This will allow coherence and fair distribution of workload.

Further consideration should be given to ensure that in particular, mental health nurses and social workers undertake community visits as appropriate.

Consultant Psychiatrists

The consultant job plans should be reviewed to ensure they facilitate MDT working and are in line with point 6 above.

Job plans need to be in line with Royal College of Psychiatrists recommendations. This will have to include management time for the senior management team.

Also, there should be a clear process that audits the use of polypharmacy to ensure it is in line with best practise. The role of the pharmacist could help facilitate this.

Adult Mental Health Inpatient Services

The model of care in the Adult Mental Health inpatient wards should be reviewed to ensure effective MDT working, continuity of care between inpatient and CMHT services, and to ensure there is a clear emphasis on safety and therapeutic interventions.

The inpatient services would benefit from an overall improvement plan linked to recommendation 9.

RCP accreditation/Best practise

Consideration should be given to joining the RCP (Royal College of Psychiatrists) networks across a range of specialities in mental health and working towards accreditation in each area as well as using the networks to maintain best practise and share learning. Consideration should be given as to how key personnel within Adult Mental Health can receive adequate support and guidance to help them develop mental health services and understand best practise.

Communication

There needs to be a clear communication process in Adult Mental Health that informs and allows staff to feel involved in the development of services.