Health and Community Services

Report to:	Health and Community Services Advisory Board		
Report title:	Rheumatology service: update on clinical audits and service improvements		
Date of Meeting:	25 July 2024	**Agenda Item:**	

Executive Lead:	Patrick Armstrong
Report Author:	Adrian Noon, Rachel Williams, Jessie Croke, Sophia Tosounidou, Darren Woodside

Purpose of Report:	Approval ☐	Assurance X	Information X	Discussion ☐
	This paper provides an update on progress since the HCS Board in January 2024, in particular regarding HCS' Duty of Candour regarding the outcomes of the assessment of possible medical harm, and the review of deceased patients.			
Summary of Key Messages:	• A report was presented to the HCS Advisory Board on 25 January 2024, outlining the recommendations from the Invited Review of Rheumatology undertaken by the Royal College of Physicians (RCP). The report outlined progress and outcomes of the HCS clinical audits and reviews of patients who had been prescribed 'biologics', those prescribed 'DMARDS' and/or steroids, outpatients, and inpatients, including the following outputs from HCS clinical audits: ○ 51.3% of cases reviewed had insufficient evidence to confirm the criteria for biologics were met ○ the diagnosis for almost 46.8% of patients was changed ○ 38% of patients had one or more medications discontinued. • The GMC subsequently placed restrictions on Dr Y, such that Dr Y is not currently practising in Jersey. As previously reported, Dr Z left Jersey some time ago. • As at 17 July 2024, three of the five clinical audits have been completed and closed. Of the remaining audits; one is complete and will be closed subject to receipt of some final information from Primary Care and the final audit relates to the review of deceased patients which is making good progress. The review of deceased patients is ongoing; this incorporates a clinical audit of all patients who have died since 2019, with a 'Mortality Learning Review' (MLR) for those where concerns are raised, and a Panel to consider the MLR outcomes. Any cases where the Panel agrees with concerns regarding diagnosis, treatment or care, such are referred to the Viscount for further consideration. To date, 20 such referrals have been made, with the relatives being invited to meet with HCS colleagues to answer initial questions and offer support. • To date, an assessment by a Consultant on the Specialist Register for Rheumatology has identified that the diagnosis, treatment and care of 33 patients was below expected standards such that it may have resulted in possible medical harm. 'Duty of Candour' letters are being sent to these patients, acknowledging this and apologising.			

	• The ongoing programme of Rheumatology service improvements is progressing well, with a number of RCP recommendations completed in full, and all other recommendations being progressed according to plan. Improvements have included the employment of a Biologics Pharmacist, evidence-based pathways, holistic working and a multidisciplinary team approach, with improved access to physiotherapy and podiatry for Rheumatology patients, and wellbeing support available as required. Links with UK hospitals are strengthened; a Shared Care Agreement has been developed for Primary Care; job plans are complete and professional development is supported; and progress is being made to enrol Jersey into national audits. • The medico-legal recourse remains under development. The intention is to adopt an approach that is patient-friendly, not overly protracted / complicated and respects a patient's right to seek independent legal recourse. Colleagues continue to work with a City of London law firm focusing on a pilot group of patients. Currently, stakeholders (including legal representatives acting on behalf of affected patients and the two Medical Defence Organisations) continue to carry out initial investigations of their own into individual claims brought forward by patients with responses due shortly.
Recommendations:	**The Board is asked to:** I. Note the actions undertaken to date in response to the RCP report, and the wider actions which have been progressed in order to review and assure patient safety II. Provide ongoing support for the Rheumatology review III. Note the actions which will be progressed in 2024, including rheumatology service improvements, Duty of Candour, a medico-legal approach, and completing the review of the care of deceased patients.

Link to JCC Domain:		**Link to BAF:**	
Safe		SR 1 – Quality and Safety	
Effective		SR 2 – Patient Experience	
Caring		SR 3 – Operational Performance (Access)	
Responsive		SR 4 – People and Culture	
Well Led		SR 5 – Finance	

Boards / Committees / Groups where this report has been discussed previously:		
Meeting	**Date**	**Outcome**

List of Appendices:
Report: Rheumatology service: update on clinical audits and service improvements

Health and Community Services

Health and Community Services (HCS) Advisory Board Report
Rheumatology service: update on clinical audits and service improvements

1. Introduction

A report was presented to the HCS Advisory Board on 25 January 2024, outlining the recommendations from the Invited Review of Rheumatology undertaken by the Royal College of Physicians (RCP). The report outlined progress and outcomes of the clinical audits and reviews of patients who had been prescribed 'biologics', those prescribed 'DMARDS' and/or steroids, outpatients, and inpatients. The report noted that a review of deceased patients was planned, that Duty of Candour would be enacted for patients in accordance with HCS policy, and that the Law Officers' Department (LOD) were considering medico-legal recourse.

This report provides an update; as at 17 July 2024, three of the five clinical audits have been completed and closed. Of the remaining audits; one is complete and will be closed subject to receipt of some final information from Primary Care and the final audit relates to the review of deceased patients which is making good progress. 'Duty of Candour' letters are being sent to patients and the ongoing programme of Rheumatology service improvements is progressing well, with a number of RCP recommendations completed in full. The medico-legal recourse remains under development.

Whilst Dr Y continues to be employed by HCS, GMC restrictions are such that Dr Y is not currently practising in Jersey. As previously reported, Dr Z left Jersey some time ago.

2. Background

On 20 December 2023, HCS received the final report of the RCP's Invited Review of Rheumatology. The RCP considered 18 case records and found the standard of care to be well below what the review team would consider acceptable for a contemporary rheumatological service. 17 of the care records were graded as 'room for improvement' or 'unsatisfactory'. A lack of evidence of pathways, multidisciplinary team working, professional development and clinical governance was also noted by the RCP.

The first of the RCP 'immediate recommendations' was that HCS should undertake an audit of all patients receiving 'biologic' medication. The clinical audit concluded that, of the 299 available case notes for patients first diagnosed in Jersey:

i. 46.0% had sufficient evidence for the clinical auditors to confirm that they met the relevant diagnostic criteria for their diagnosis
ii. 30.5% had insufficient evidence to confirm the relevant diagnostic criteria were met
iii. For 23.5%, the clinical auditors were unsure whether there was sufficient evidence
iv. 33.6% had sufficient evidence for the clinical auditors to confirm that they met the criteria for being prescribed biologic therapy
v. 51.3% had insufficient evidence to confirm that the criteria for biologics were met
vi. For 15.1% the clinical auditors were unsure whether there was sufficient evidence to support the prescribing of biologics.

The fact that in over half the records reviewed, the clinicians were not able to say there was sufficient evidence for the diagnosis raised a significant concern, because record keeping is a key part of medical

practice. Therefore, in addition to the clinical audit of case notes, patients were offered in-clinic review appointments, the conclusions from which were that biologics and/or DMARDs were discontinued for 38% of patients reviewed.

The clinical audit of Rheumatology patients receiving biologic medication (clinical audit 1) raised such significant concerns about clinical practice and the consequential potential harm to patients that HCS embarked on 4 further clinical audits and reviews, covering every patient in Rheumatology as well as all patients who had been under the care of the doctors cited in the RCP Invited Review. These clinical audits were also conducted by locum Consultants on the relevant GMC Specialist Registers:

Clinical audit 2: An in-clinic review of 1,066 patients who had been prescribed DMARDs[1], resulted in the diagnosis of almost 46.8% of patients being changed.

Clinical audit 3: The case notes of 386 outpatients who had been under the care of either Dr Y or Dr Z were reviewed by a relevant specialist (Rheumatologist or General Medicine). 50 patients were contacted to schedule a follow-up appointment.

Clinical audit 4: The clinical audit of inpatients who had been under the care of either clinician found that fewer than 3% of patients had had their treatment changed by a subsequent clinician.

3. Review of deceased patients

The report to the January HCS Advisory Board explained that a clinical audit of all patients under the care of Dr Y or Dr Z, who had died since January 2019, would be undertaken in 2024. This would be followed by a Mortality Learning Review (MLR) for any cases where concerns are raised.

The number of deceased patients since January 2019 has increased from 186 to 190, as more patients have passed away since the initial number was identified. The audit of deceased patients, as described in the January HCS Advisory Board report, is progressing to planned timescales. To date, c30% of cases have been identified as requiring an MLR. The MLR is conducted by an independent clinician on the relevant GMC Specialist Register, and the Review is considered by a Clinical Panel. Following MLR Panels, referrals are being made to the Viscount for further consideration if concerns regarding the quality of care warrant this. To date, 20 such referrals have been made to the Viscount.

The relatives of all the deceased patients in this review are being informed that the review has begun. Where a referral is made to the Viscount, the relatives are telephoned and offered a face-to-face meeting with the Chief of Service, a Consultant Rheumatologist and a wellbeing practitioner. This is followed by a further welfare call, with ongoing support, including psychological support where needed. This approach reflects and recognises the possible emotional impact on relatives of deceased patients, and the principles of putting patients and relatives at the centre of our work.

It is important to remember that these cases need to be dealt with thoroughly, carefully and sensitively. The work cannot be rushed, and therefore this audit of deceased patients is likely to continue through 2024. Information regarding the total number of referrals will be published, once the review is complete.

In discussion with the Viscount, HCS has decided to extend the timeline for the review of deceased patients to consider those who died before 2019. This work will commence once the current cohort has been completed.

4. Duty of Candour

Following the audit of patients on 'biologic' medication ('clinical audit 1'), DMARDs and steroids ('clinical audit 2'), outpatients ('clinical audit 3') and inpatients ('clinical audit 4'), every patient's care is being assessed by locum Consultants on the relevant Specialist Registers, to ascertain possible medical harm.

This independent assessment of possible medical harm is ongoing. To date, it has identified that the diagnosis, treatment and care of 33 patients was below expected standards and may have resulted in possible medical harm. 'Duty of Candour' letters are being sent to these patients, acknowledging this and apologising. These letters must be written in easily-understandable language, and be individualised so that the patient understands their diagnosis, treatment and care, why possible medical harm has been identified and what it might mean for them. Accordingly, the letters need to be carefully crafted and double-checked, in order to aim to reduce any further anxiety or ambiguity. The letters explain the information that has already been given to patients in their appointments with the specialist rheumatology Consultants. The first 'Duty of Candour' letters were sent to patients in June, and it is anticipated they will all be sent by the end of July.

5. Medico-legal recourse

Mindful that some patients may wish to seek legal recourse, HCS and legal representatives are working to consider the most appropriate approach for medico-legal matters related to Rheumatology. Our intention is to adopt an approach that is patient-friendly, not overly protracted / complicated and respects a patient's right to seek independent legal recourse.

The medico-legal recourse remains under discussion with colleagues in the legal profession, HCS insurers and Medical Defence Organisations.

Colleagues continue to work with a City of London law firm focusing on a pilot group of patients. Currently, stakeholders (including legal representatives acting on behalf of affected patients and the two Medical Defence Organisations) continue to carry out initial investigations of their own into individual claims brought forward by patients with responses due shortly. To date, two "Without Prejudice" meetings have been held with the legal representatives acting for the largest number of affected patients, with another meeting proposed. The pilot group should facilitate a greater understanding of the issues involved, including liability, and assisting the parties in mapping out an efficient resolution to these matters.

6. Rheumatology service improvements

Improvements continue to be made in Rheumatology. All 'immediate' recommendations had been completed before the January Advisory Board meeting. As at 17 July, nine of the of the 'short term' and three of the 'medium term' RCP recommendations have been fully implemented, and a further eight 'short term' and two 'medium term' recommendations are significantly developed.

Of particular note, since the January Advisory Board meeting, the Biologics Pharmacist has begun work and is reviewing prescribing practice and implementing improved governance. Evidence-based pathways, holistic working and a multidisciplinary team approach have all been adopted – including improved access to physiotherapy and podiatry for Rheumatology patients, and wellbeing support available as required. Links with UK hospitals are strengthened; a Shared Care Agreement has been developed for Primary Care; job plans are complete and professional development is supported; and progress is being made to enrol Jersey into national audits.

Further detail is presented in Appendix 1.

7. Communication and support

Patient-centred principles continue to guide the approach to the rheumatology audits. A dedicated, responsive and flexible PALS response continues to be available, with patients receiving case reviews by one of the Consultant Rheumatologists and invited to meet a Consultant to answer any questions where helpful. This is intended to reduce the levels of anxiety that patients may be experiencing, which can help manage the risk of psychological impact and negative patient experience.

Patients continue to be reminded of the additional wellbeing support that is available, and signposted to this support as appropriate; this provides a fast assessment and referral to a range of psychological support services, from self-help through to funded private therapy sessions, depending on the needs and preferences of the individual.

Mindful of the impact the review, and public announcements about the review, can have on staff, we have tried to ensure that staff are kept informed as the review proceeds. In particular, colleagues are informed prior to a media release and are reminded of the support available.

Regular communication has also been maintained with the GMS and JCC, and with HCS' insurers.

8. Wider learning

The review is also identifying lessons and improvements which could be applicable in other departments and across HCS and reflects the actions now being taken to respond to the Professor Mascie–Taylor governance report.

Clinical governance has been significantly strengthened across HCS, during 2023 and 2024, but it is not yet at the desired standard, and further improvements continue to be made.

The HCS Advisory Board supports and holds the HCS Executive to account for the delivery of the Mascie-Taylor recommendations, along with the Quality and Safety Assurance Committee, and there is ongoing challenge by the HCS Change Team, with monthly Care Group governance assurance meetings also having been introduced.

In 2023, a decision was made by the HCS Advisory Board, supported by the Minister for Health & Social Services, that all clinicians in HCS must follow evidence-based guidelines from NICE and Royal Colleges.

HCS has also directed that clinical specialties are to participate in national (UK) clinical audits to enable benchmarking. HCS has enrolled in the Healthcare Quality Improvement Partnership (HQIP) programme and will continue to adopt, wherever possible, entry to national audits to benchmark its services. It is also entering the National Joint Registry later in 2024.

Where appropriate, during the course of 2024 / 25, services will establish formal clinical networks with UK hospitals to increase resilience and support and strengthen clinical relationships, particularly in single-handed specialties.

A review of the HCS Pharmacy function and the role of the Chief Pharmacist, was presented to the HCS Senior Leadership Team (SLT) in December 2023. This has been further strengthened by an external independent review of Pharmacy services and HCS awaits the report from this review.

There will be a continuing focus on the recommendations from the Mascie-Taylor review, including those relating to clinical governance; this will be a key agenda for the HCS Board Quality and Safety Assurance Committee.

9. Finance / workforce implications

Funding of £1.3m was made available for 2023, with a further allocation of £1.17m for 2024. This provided for additional specialist clinical capacity to review the diagnosis, treatment and care for every Rheumatology patient and, in 2024, to undertake harm assessments and conduct the audit and MLRs for deceased patients. The additional funding also enabled an increase in capacity for physiotherapy and podiatry, and to employ a Biologics Pharmacist.

The Accountable Officer (AO) for HCS is the Accountable Officer for the Rheumatology review project. The Senior Responsible Officer (SRO) is the Assistant Chief Executive for GoJ, and additional project leadership has been secured from the Cabinet Office.

Oversight and direction is provided by a Co-ordination Group, and the work is led day-to-day by the Chief of Service (a consultant in emergency medicine) for the Medical Care Group, supported by a dedicated Project Manager.

10. Recommendation

The HCS Board is requested to:

I. Note the actions undertaken to date in response to the RCP report, and the wider actions which have been progressed in order to review and assure patient safety
II. Provide ongoing support for the Rheumatology review
III. Note the actions which will be progressed in 2024, including rheumatology service improvements, Duty of Candour, a medico-legal approach, and completing the review of the care of deceased patients.

END OF REPORT

RCP Recommendations – HCS progress and plans

'Immediate' recommendations
All four 'immediate' recommendations were completed in 2023, and reported to the HCS Advisory Board in January 2024:

i. **Commence an audit of those patients currently on biologics to assure their diagnosis is secure**. **COMPLETE**

As reported to the HCS Board in October 2023, the casenote clinical audit of all patients on biologics between January 2022 and April 2023[1] was completed and the emerging findings were placed in the public domain in early August. The casenote clinical audit was undertaken by locum Consultants on the Specialist Register for Rheumatology, and was quality assured by a separate specialist Rheumatology Locum Consultant.

The clinical audit methodology was based on British Society for Rheumatology audits, reviewed by three senior Rheumatology Consultants and approved by the RCP. The clinical audit concluded that, of the 299 available casenotes for patients first diagnosed in Jersey:

- 46.0% had sufficient evidence for the clinical auditors to confirm that they met the relevant diagnostic criteria for their diagnosis
- 30.5% had insufficient evidence to confirm the relevant diagnostic criteria were met
- For 23.5%, the clinical auditors were unsure whether there was sufficient evidence
- 33.6% had sufficient evidence for the clinical auditors to confirm that they met the criteria for being prescribed biologic therapy
- 51.3% had insufficient evidence to confirm the criteria for biologics were met
- For 15.1% the clinical auditors were unsure whether there was sufficient evidence to support the prescribing of biologics.

In addition to the casenote clinical audit, patients were offered in-clinic review appointments. All patients who currently live in Jersey and are on biologics have now been reviewed in clinic by the Head of Rheumatology. The conclusions from the in-clinic review is that:

- Biologics have been discontinued for 25% of patients reviewed
- DMARDs have been discontinued for almost 20% of patients reviewed
- A total of 38% had one or more medications discontinued.

ii. The two clinicians should not work independently in providing rheumatology care until such time that [this] Invited Review and other local processes are complete. It was recommended this was communicated with the relevant Responsible Officers, both in the private sector, where relevant, and the NHS. In addition, for the local GMC employment liaison officer to be informed of this action. COMPLETE

iii. Recommendation: Dr Y to be offered occupational health support. **COMPLETE**

Iv. Recommendation: Dr Z's Responsible Officer to consider the concerns raised by the clinical record review and create a framework that would allow Dr Z to continue to practice with relevant senior supervision (for example the British Society for Rheumatology (BSR) mentorship programme) and appropriate audits that would reassure that the concerns raised by our clinical

record review had been resolved. **COMPLETE**

'Short term' recommendations

i. Share the RCP report with the executive team and minister for health and social services, with oversight of an action plan by a Non-Executive Board member. **COMPLETE**
The RCP report was shared with the HCS Advisory Board at their meeting on 25 January 23024, along with a detailed progress update. The HCS Advisory Board nominated Professor Dame Clare Gerada to oversee the Rheumatology action plan going forwards, as Chair of the Quality Assurance Board sub-committee.
Progress reviews will continue until all recommendations have been completed.

Staffing and teamworking

ii. **Appoint consultants on the specialist register, specialist nurses and access to physio, OT, podiatry, pharmacy and psychology services. Secretarial and administrative support in order to provide a sustainable, contemporary rheumatology service**. **COMPLETE**
Dr Sofia Tosounidou commenced as Head of Rheumatology in July 2023. Dr Tosounidou is on the Specialist Register for Rheumatology and General Internal Medicine (GIM). A job plan is complete and clear objectives set.

The Biologic Pharmacist commenced in February 2024, and the Specialist Nurse commenced in April 2024.

Access to physiotherapy, hand therapy and podiatry has improved, with referrals increasing in 2023. An additional Physiotherapist and 0.5 FTE Podiatrist has been funded from the 2024 business case. Patients are also signposted to additional psychological support and are provided with a 'wellbeing' leaflet should the rheumatologist think this would be of benefit. The service is forward planning capacity and support requirements for 2025 as BAU.

Contemporary MDT working is proactive and where patients require additional psychology support they are signposted to services, and are provided with information regarding where they can access wellbeing services on island. We continue to work closely with our wellbeing team to ensure that wellbeing support for the department as well as patients is dynamic and responsive to change as part of BAU.

Service and delivery

iii. **Introduce job plans for Rheumatology consultants and clinical nurse specialists. COMPLETE**
Job plans for all staff working in Rheumatology have been completed; this includes the substantive Consultant Rheumatologist (Head of Rheumatology), Locum Consultant, Specialist Nurses, Senior Health Care Assistant and Biologic Pharmacist.

iv. **Review processes for personal and professional development of the rheumatology service staff, including weekly teaching sessions and annual appraisals. COMPLETE**
The Head of Rheumatology has had an annual appraisal and remains fully licensed with the GMC and on the specialist register. She is committed to personal and professional development; this includes attending regional, national and international meetings in accordance with RCP CPD guidelines. Dr Tosounidou continues to take active role in delivering and attending the monthly educational sessions (remotely) run by the Rheumatology Department at Sandwell and West Birmingham NHS Trust (SWBH); she also delivers educational sessions to help with professional development of the Rheumatology colleagues (including Specialist Registrars) and in the UK.

An 'Away Day' was held on 02 February 2024 for the Jersey Rheumatology service, and training for

colleagues has been delivered by the Substantive and Locum Consultant Rheumatologists, including basic rheumatology training to in hospital SAS Doctors and other trainees, and a presentation to GPs regarding shared care agreements and early inflammatory pathways.

Teaching and training opportunities have been circulated and there has been agreement at MDT that those attending such sessions will bring back learning outcomes to the MDT.

MDT meetings (which are held weekly) are a key element of professional learning and development. In addition, Jersey's rheumatology team will be invited to attend SWBH monthly educational sessions. The British Society for Rheumatology deliver a range of learning opportunities, including webinars and podcasts, which colleagues will be encouraged to participate in. The Rheumatology Specialist Nurses will be encouraged to apply for the British Society for Rheumatology (BSR) mentorship programme, and to attend BSR-led educational meetings for nurses, BSR conferences and/or EULAR (the annual European Congress of Rheumatology).

Supporting patients in their understanding and condition management is also being considered, along with invitations to learning sessions for members of the wider MDT and Primary Care, to provide the most appropriate holistic approach, further develop pathways and build relationships across the care system.

Medical and nursing staff are engaged in the annual appraisal process as advised by their relevant professional bodies. Training and teaching will have a 6 monthly review cycle as part of BAU.

v. **Embed MDT working into everyday practice and establish links with a mainland modern rheumatology centre. ON TRACK**
The Rheumatology Department Multi-disciplinary Team (MDT) is now held regularly. This includes discussion and management plan of patients' care and will be attended by medical and nursing staff with invitation to the wider MDT as clinically indicated.

During 2024, MDTs have become more structured with a log of attendees, patients discussed and outputs (following the structure of the oncology MDTs). The outcomes of the individual patient discussions in the MDT are communicated as required e.g. to the patient / GP etc.

vi. **Develop clear musculoskeletal pathways and SOPs, which include access to physiotherapy and pain services. ON TRACK**

A rolling programme of pathway and SOP development has commenced. New pathways will utilize NICE guidance as appropriate, and guidance from Getting it Right First Time (GIRFT) will be incorporated to design and deliver an improved, contemporary rheumatology service.

A dedicated Connective Tissue Disorder (CTD) clinic has been established to manage patients with complex systemic autoimmune diseases. This has been incorporated into the HCS Electronic Patient Record system, which will enable data to be submitted to the national Biologics Register audit programme BILAG/BR.

A virtual combined Interstitial Lung Disease (ILD) clinic has been established, to review and discuss challenging cases and identify the best treatments for those patients in a MDT forum.

A similar combined MDT with the renal team is planned.

The development of departmental protocol and treatment pathways for Rheumatoid Arthritis (RA), Psoriatic Arthritis (PsA) and Ankylosing Spondylitis (AS) are in progress.

Care pathways are being reviewed to ensure alignment with National Institute for Health and Care Excellence (NICE), British Society for Rheumatology (BSR) and European Alliance of Associations for Rheumatology (EULAR) guidelines for the management of patients with systemic autoimmune diseases.

SOPs for the provision of intravenous biologics and cytotoxic on the MDU (c 30 different kinds) have been reviewed, updated and established.

Work continues with Ophthalmology and surgical colleagues, aiming to introduce Giant Cell Arteritis (GCA) pathway by December 2024.

vii. Ensure all patients starting a biologic have a documented biologic assessment, an objective assessment of disease activity and infection risk, documentation of relevant co-morbidities and vaccination status, and confirmation that prescribing is in line with NICE/European guidelines. COMPLETE

The review of all Rheumatology patients on biologics is complete; new treatment plans have been established where appropriate. In order to assess patient applicability for biologics, nurses have been conducting assessments, which can include assessment of various areas such as vaccination status, co-morbidities implications and blood reviews.

A Rheumatology clinic letter template was introduced in January 2024. This includes:

- a list of medical conditions
- medications
- patient treatment / management plan
- recommendation to GP or other colleagues
- advice on vaccination, especially for patients on immunosuppressants
- a follow up plan.

Disease activity scores are documented in clinic letters for all patients who are about to be started on biologic therapy, and response to treatment for patients who have recently been prescribed biologics is assessed objectively using validated disease activities scores.

A wider MDT biologics program has commenced; the Specialist Nurse and Head of Rheumatology are actively involved, attending development meetings. The department is working closely with the Respiratory team to identify learning opportunities on governance processes regarding biologics, and with the specialist Biologics Pharmacist in order to develop a clinic template for rheumatology patients commencing biologics, which will include diagnosis, screening bloods results, disease activity scores and monitoring regime.

The Biologic Pharmacist is responsible for patient education on the use of biologics drugs and is actively delivering monthly Rheumatology clinics.

viii. **Service should adopt a more holistic approach with the involvement of therapies. ON TRACK**

Productive collaborative working is ongoing with the Physiotherapy department and Pain Clinic to standardise the referral pathway. The capacity and skill sets in Physiotherapy have increased, Psychology support is also available, and the Biologic Pharmacist is be an integral part of the MDT.

A more holistic approach has been introduced, including:

- Weekly MDT meetings
- Broadening MDT working, including with Respiratory colleagues for Interstitial Lung Disease (ILD) and Connective Tissue Disease (CTD).
- SOPs for the provision of intravenous biologics and cytotoxic on the MDU
- A dedicated rheumatology email address, to facilitate communication with Primary Care
- Shared Care Agreements (SCAs) for prescription and monitoring of all disease modifying drugs commonly used in rheumatology.

During the remainder of 2024, work will continue on:

- A referral pathway for Early Inflammatory Arthritis (EIA)
- A Giant Cell Arteritis (GCA) pathway
- Professional development opportunities.

ix. **Review the frequency of follow up. ON TRACK**

The Consultants now undertake robust triaging of new patients, and the Rheumatology clinic letter template includes the patient's treatment plan and follow-up plan. The frequency of follow-up will be determined by robust clinical assessment.

A Rheumatology helpline has been established, delivered by the nursing team, in order to further support patients.

The department has worked with Primary Care to develop the documents and process for a shared care pathway, and is working towards establishing an annual review clinic which will be nurse led and in work conjunction with Primary Care.

x. **Implement a standardized written correspondence template. COMPLETE**

The Rheumatology clinic letter template is outlined in vii above. This was sourced from a UK centre, and been adapted for Jersey practice. It provides patients with current diagnosis, previous diagnosis, current medication, treatment plan and follow-up.

xi. **Arrange a regular rheumatology MDT meeting with clear Terms of Reference. Record the MDT discussion and outcome in the patient's notes, with a copy sent to the GP and the patient. ON TRACK**

As outlined in v and viii above, the Rheumatology Department Multi-disciplinary Team (MDT) is now held regularly. The outcome of the MDT meeting will be documented in the patient's Electronic Patient Record, and a copy of the MDT decision will be sent to the GP and the patient as appropriate.

xii. **Discourage the sole reliance on pharmaceutical companies for drug information and training. COMPLETE**

Plans for a broad professional development programme are outlined in iv above. Pharmaceutical companies will be allowed to provide non-promotional educational /or training sessions on newly developed and licensed drugs, however, this will only form a part of the new programme.

The Head of Rheumatology's regular attendance at conferences and regional training days allow for discussion of new drugs and therapies with peer education.

Close working with senior Pharmacists, the Biologics Pharmacist and High-Cost Drugs Pharmacist has helped to ensure best practice and access to expertise, and removed the reliance on individual pharmaceutical companies.

Pharmacy

xiii. **Review the arrangements for the prescribing of biologics; incorporate processes for challenge and be more proactive in providing regular updates on rheumatology prescribing. ON TRACK**
As reported to the HCS Board in January 2024, the casenote clinical audit of all patients on biologics between January 2022 and April 2023 was completed by specialist Rheumatology Locum Consultants, using a methodology which was based on British Society for Rheumatology clinical audits, reviewed by three senior Rheumatology Consultants and approved by the RCP. All patients who currently live in Jersey and are on biologics have now been reviewed in clinic.

The Biologic Pharmacist is now in post. They are writing protocols for the prescribing of biologics across HCS, incorporating additional governance such that biologic medication dispensing must have the approval of a Biologic Pharmacist. An improved Pharmacy procedure has been approved and implemented, and the Biologic Pharmacist is an integral part of the MDT, with a key role in both challenging prescribing and in understanding and communicating the usage and cost of biologic drugs

The 'Blueteq' High-Cost Drug System will be introduced in Pharmacy in early 2024. This is a web-based software system for the approval and management of high-cost medicines. It will allow monitoring and prescribing of high-cost medicines and is designed to improve clinical and financial governance.

xiv. **Improve data collection and analysis in relation to dispensing rheumatological medications in order to assure patient safety prior to dispensing medication, maintain a record of the biologic therapy dispensed for audit purposes. ON TRACK**
Electronic Prescribing and Medicines Administration (EPMA) was introduced in Rheumatology in July 2023. The 'Blueteq' High-Cost Drug System will be implemented in 2024; this will allow monitoring and prescribing of high-cost medicines and is designed to improve clinical and financial governance.

Record keeping, data collection and analysis for biologic medications is the responsibility of the Biologic Pharmacist, who commenced in February 2024. The biologic pharmacist monitors, audits and reports on medicines management in Immunotherapy, including drug use, prescribing etc - and makes appropriate recommendations to support improvements.

The biologic pharmacist clinically reviews patients' medication, to assure compliance with medicines management policies, current legislation and local, regional or national standards and guidance (including NICE). This has included a review of all patients within HCS currently prescribed biologic treatment to ensure that it is in accordance with NICE guidance (not only rheumatology patients). The biological pharmacist reviews all new patients prescribed biologics to ensure that it is appropriate.

Additionally, they will liaise with HCS Clinical Audit to determine exactly the data which is needed for clinical audit purposes - to ensure the correct data is collected.

Audit and Governance

xv. **Hold a clinical governance meeting at least quarterly, including complaints, concerns, incidents, activity, staffing issues, audits and use of biologics. Document attendees and discussions, and report into the HCS clinical governance structure. ON TRACK**
Examples of good governance have been gathered, with improvement ideas being encouraged. This is informing planning for the QI meetings which will commence in 2024 and will be held every three months to discuss and approve pathways/protocols, complaints, concerns, incidents, activity, staffing issues,

clinical audits and use of biologics. Attendees and discussions during the meeting will be formally documented.

The meeting notes, along with an action tracker will be submitted to the Medical Care Group governance meeting every month.

xvi. **Regularly audit biologic therapies prescribing. COMPLETE**
Please see xiii and xiv above.

xvii. Use NICE guidance as part of the Rheumatology governance framework. COMPLETE
The Rheumatology Department now follows and applies NICE guidance as appropriate for the management of patients with rheumatic disease; this will be reflected on the local pathways and protocols. Furthermore, the Rheumatology Department follows guidance from Getting it Right First Time (GIRFT) to set up a contemporary rheumatology service.

The Medical Care Group is in correspondence with a Consultant Rheumatologist at Nottingham University Hospitals NHS Trust to arrange a visit the Rheumatology Department and review the improvement plan in line with GIRFT methodology.

6.4 'Medium term' recommendations

The six recommendations incorporate:

Rheumatology service design

i. **Foster relationships between primary and secondary care to develop more robust monitoring and develop shared care guidelines ON TRACK**
In close collaboration with Community Pharmacists, the Head of Rheumatology has produced Shared Care Agreements (SCAs) for prescription and monitoring of all disease modifying drugs commonly used in rheumatology, dermatology, gastroenterology and renal medicine. These have been discussed with the Primary Care Body, and are with the Primary and Preventative Care Group for ratification.

The Head of Rheumatology is developing the referral pathway for Early Inflammatory Arthritis (EIA) clinics. This will facilitate prompt referral and assessment of patients with suspected inflammatory arthritis. A dedicated email address has been set up for GPs, to improve the speed of communication. And Primary Care colleagues will be invited to key learning events, and/or the Head of Rheumatology will deliver educational sessions on the management of common rheumatic diseases if requested.

ii. **Develop close links with other NHS rheumatology services to enable forums for sharing best practice, and overall providing learning opportunities for the whole team. COMPLETE**
As outlined in response iv of the short term recommendations above Dr Sofia Tosounidou continues to take active role in delivering and attending the monthly educational sessions (remotely) run by the Rheumatology Department at Sandwell and West Birmingham NHS Trust (SWBH); she also delivers educational sessions to help with professional development of the rheumatology Specialist Registrar and colleagues in the UK.

She also attends a weekly MDT meeting with rheumatology colleagues at SWBH to discuss complex patients and share expertise.

The locum consultants maintain their links with other regional rheumatology centres, including London and Newcastle, and they attend regional training days and BSR and EULAR conferences.

Pharmacy

iii. **Support electronic prescribing and monitoring systems. COMPLETE FOR RHEUMATOLOGY**

EPMA has been implemented in the majority of inpatient areas, with Oncology (SOS patients only), Endoscopy, Day Surgery Unit, Medical Day Care, Depot Clinic and Renal unit due for implementation by the end of 2024.

EPMA has also been implemented in the majority of outpatient clinic areas, and more than 85% of outpatient prescriptions are now written electronically.

The future development of EPMA is being planned to allow the system to be introduced in Radiology and Theatres, as well as additional work to enable complex infusions to be prescribed and linked to SMART(er) infusion pumps, enabling the organisation to be fully electronic for all medicines processes. Electronic prescribing, preparation and administration for patients undergoing chemotherapy is also being planned through a separate project.

The 'Blueteq' High-Cost Drug System will be introduced in Pharmacy in 2024. This is a web-based software system for the approval and management of high-cost medicines. It will allow monitoring and prescribing of high-cost medicines and is designed to improve clinical and financial governance.

iv. **Appoint a pharmacist for high-cost drugs, to understand the usage and cost of biologic drugs and produce prescribing protocols. COMPLETE**
A Lead Pharmacist, Immunotherapy (Biologic Pharmacist) commenced in February 2024. In addition, a specialist High Cost Drugs Pharmacist is in post and is reviewing the usage and cost of drugs.

Audit and Governance

v. **Enrol in a regular rolling audit programme to provide reassurance about the activity and outcomes for patients and the use of expensive resources such as biologic therapies. ON TRACK**
The HCS Audit Manager is actively involved in planning for Rheumatology audits. The National Early Inflammatory Arthritis (NEIA) audit aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales. The audit generates service-level data across England and Wales, benchmarked to regional and national comparators against NICE Quality Standard 33 and other key metrics. Data is collected for patients with a diagnosis of Early Inflammatory Arthritis (EIA) across 12 months, assessing waiting times, time to treatment, clinical response to treatment and patient-reported outcomes. The audit now also collects data at diagnosis for some rare immune mediated inflammatory diseases (IMIDs).

The EIA referral pathways were presented to GPs in March 2024 and the early inflammatory arthritis EIA clinics have been introduced. The next step is to enrol the Rheumatology Department with the NEIA audit. The Head of Rheumatology and HCS Audit Manager are in discussions with the BSR with the aim of overcoming the challenges of enrolling in the audit whilst not being part of the NHS.

The Biologic Pharmacist and Specialist Nurse are now also enrolling patients in biologics and biosimilar registries.