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Investigation of Clinical Governance arrangements relating to medical staff employed by the Health and Social Services Department of the States of Jersey

Supplementary report

Background

1. This investigation was undertaken at the request of Mr Colin Myers, Director of Health and Safety at the Health and Safety Inspectorate, on behalf of the Attorney General.

2. In July 2011, I submitted a report dealing with clinical governance arrangements at Jersey General Hospital after two Serious Untoward Incidents which occurred there. I indicated that, in my opinion, senior managers had prepared plans which should lead to significant improvements in clinical governance, but that the situation regarding implementation of the plans should be reviewed towards the end of 2011, particularly because of the importance of introducing mandatory appraisal to ensure that doctors were prepared for revalidation when it is introduced by the General Medical Council (GMC) towards the end of 2012.

3. I visited Jersey General Hospital again on 14 December 2011 and met Mr Andrew McLaughlin (Hospital Director), Dr Andrew Luksza (one of the two Medical Directors), Mr Tony Riley (Director of Human Resources [HR]), Mr Brian Jones (Medical Staffing Manager) and Ms Rose Naylor (Director of Nursing and Governance). I also spoke by telephone to Dr Susan Turnbull, Medical Officer of Health and Interim Medical Director for Primary Care because she had been in discussions with the GMC about revalidation for primary care doctors in Jersey.

Medical staffing

4. Eight Clinical Director positions exist, for Surgery, Medicine, Emergency Care, Paediatrics, Obstetrics and Gynaecology, Anaesthesia, Radiology and Support Services,

and these posts have been filled. The Clinical Directors meet every 2 weeks with the Hospital Director and the Medical Directors.

5. Consultants and their teams are now ward-based, which has improved communication between medical and nursing staff.

6. Divisional meetings are held monthly to review incidents, complaints, risk registers, activity, quality benchmarks and budgets.

7. The committee structure has been reorganised so that there is a clear chain of accountability. Terms of reference have been written for all committees.

8. There is now a consultant-based service in the Accident and Emergency Department.

9. There is more rigorous scrutiny of applications for the final three incremental points on the consultant pay scale, which are now awarded only if the consultant can demonstrate commitment and improvements in the quality of service.

10. Because of the large number of retirements of consultants expected in the next 10 years and the difficulty of replacing them with individuals with comparable skills, partnerships with two UK centres are being investigated.

11. Five high-quality consultants have been appointed recently.

Consultant job planning

12. Job planning has been rudimentary and medical staff do not have Personal Development Plans, which are necessary as part of the appraisal process as a means of ensuring that the Continuing Professional Development objectives are met. The Zircadian suite of software which facilitates job planning and appraisal has been purchased and is being implemented. It is anticipated that job planning of Clinical Directors will be complete by the end of January 2012, and of other consultants by the end of February 2012.

Appraisal

13. Apart from Foundation Year (FY) 1 and 2 trainees, who are appraised by the Wessex Deanery, appraisal of medical staff in Jersey has been sporadic. Appraisal is important for, principally, two reasons. First, the hospital is able to obtain reassurance that the consultant has an acceptable clinical record, has been keeping up to date and has been participating in audit, and compliments or complaints from patients are considered.

Health and probity are also explored. In the absence of regular appraisal, the hospital cannot know whether its consultants are acting within acceptable boundaries. Second, revalidation by the General Medical Council (GMC) is scheduled to start towards the end of 2012, and to be complete by 2015. Revalidation will be a requirement for doctors to maintain a licence to practise. The current advice from the GMC is that, for the first round of revalidation, a recommendation on revalidation can be made to the GMC by the Responsible Officer (a local senior doctor trained by the GMC to assess whether criteria for revalidation have been met by each doctor) on the basis of at least one strengthened appraisal. Subsequent rounds of revalidation will occur every five years, and will be based on five annual appraisals.

14. When I visited Jersey in May 2011, I was assured that mandatory annual appraisal at the General Hospital was planned to start towards the end of 2011 so that every doctor would have had at least one appraisal in time for revalidation starting at the end of 2012. At the time of my visit, no Responsible Officer had been appointed.

15. In December 2011, I was told that both medical directors would act as Responsible Officers because this was in their contracts of employment. However, my understanding is that only one individual will be accepted by the GMC as Responsible Officer for Jersey General Hospital. The identity of that individual has not yet been determined, the GMC has not agreed to an appointment and nobody has received training as Responsible Officer.

16. There has been no formal training of appraisers within the last few years. A business case has been made for a Clinical Leadership course, which would include appraiser training but at the time of my visit there was no timetable for its implementation,

17. It is proposed that the Medical Directors will appraise the Clinical Directors, and the Clinical Directors will appraise medical staff in their Directorate. The Medical Directors will be appraised by a clinician and the Hospital Director. The HR department estimates that appraisal of consultants will begin in mid- to late spring 2012 and would be complete by autumn 2012.

18. I was told that there was less urgency to complete appraisal because Dr Turnbull had been told by the GMC that it was unlikely that revalidation would start in Jersey until 2013 or 2014. However, having spoken to Dr Turnbull, I understand that this is not

guaranteed because the method of selection of doctors for revalidation has not yet been finalised. When the first attempt at revalidation was introduced, selection of the time of revalidation was based on the last digit of a doctor's GMC registration number, not on a regional basis. The delay in starting appraisal has been contributed to by the many changes occurring at the hospital and by finalisation of the middle grade doctor contract. However, it is noteworthy that all general practitioners in Jersey have already had two annual appraisals, while there have been no recent appraisals of doctors at Jersey General Hospital. Failure to achieve a satisfactory appraisal would mean that the Responsible Officer could not recommend revalidation and the doctor would lose his or her licence to practise. My impression was that there was a degree of complacency about appraisal which has led to a delay in appraiser training, a failure to identify and have approved a Responsible Officer, a delay in job planning and a delay in implementation of appraisal. In my opinion, any further delays would represent a significant risk not only because some doctors might lose their licence to practise but also because there is currently little knowledge about the practice, continuing education achievements and probity of doctors at the General Hospital.

'Middle grade' doctors

19. Because there are very few trainees, the General Hospital relies heavily on 'middle grade' medical staff, who were until very recently on old staff grade or associate specialist contracts. A new contract for these non-consultant career grade (NCCG) doctors, based on the contract used in the United Kingdom, underwent negotiation with the British Medical Association for 3 years and has now been implemented, including prospective cover for annual leave, resulting in a decreased need for locums. Few of the NCCG doctors have been appraised at all. Job planning, a prerequisite for appraisal, has started. A middle grade doctor has been made responsible for education and appraisal of middle grade doctors.

20. Five middle grade doctors were found to be underperforming. Three have left, attempts were made to retrain one in the United Kingdom (who has subsequently resigned and been replaced) and the fifth is working in supervised practice.

Exclusions/restricted practice

21. There is currently one consultant on restricted practice, who will retire in March 2012.

Locums

22. There is currently only a small number of locums in post.

Induction and assessment

23. An electronic induction and competency-based assessment system is being piloted in Jersey for job applicants.

Risk management

24. Two Associate Medical Directors have been appointed as clinical governance leads (consultants in Obstetrics and Gynaecology, and Paediatrics). The Head of Midwifery has been appointed to a hospital-wide role as Deputy Director of Operations – Governance, supported by a newly appointed Lead Midwife for Governance in the Women's and Children's Division. Rose Naylor told me that the appointment of Clinical Directors has markedly improved clinical governance.

25. Medical Audit programmes have been in place but lacked structure. This is now led through the clinical audit team working closely with consultants and other clinicians. Audit programmes are formalised through the audit committee which reports to the Care Quality Groups. Morbidity and Mortality meetings have been started. The allocation of consultants and their teams to wards has improved safety because nursing staff know who to contact if they are concerned about patients. New medical handover documents are used at the formal night handover with the night nurse practitioner and medical on-call teams. The ward rounds now occur with key staff (including nurses) at agreed times.

26. Mandatory training has been improved and each staff member keeps a 'training passport'.

27. The on-line incident reporting system has been upgraded and within the General Hospital reports are followed up after every incident. Incident reports and complaints are also reviewed at the divisional governance meetings. There is increasing support for the incident reporting system because feedback is given through Clinical Directors and the Operational Manager.

28. Complaints are dealt with by a Complaints Officer who reports to the Deputy Chief Officer of Health & Social Services. Complaints are usually responded to within 1 week.

29. New software (TrakCare) has been purchased, which identifies the location of all patients in the hospital and which tracks performance.

Leadership

30. With regard to the management of medical practitioners, the Hospital Director, senior members of the HR department, the Medical Directors and the Director of Nursing and Governance have, in my opinion, developed plans which would bring the General Hospital up to the level of best practice in the United Kingdom if implemented and achieved over the next few years. The HR Director has been appointed to a permanent contract but the Hospital Director is on a temporary contract. My impression is that, for a variety of reasons, none of the current senior managers will be in a position to take over the role of Hospital Director when he leaves, although to pre-empt this, he has tried to involve clinicians much more heavily in management on the basis that they are likely to be in post for longer than senior managers. He has made enormous and beneficial changes to the organisation but, in my opinion, his replacement needs to have a similar standard of organisation, drive and strategic foresight to continue the improvements which have been made in the last year.

Other matters

31. In November 2011, the Medical Defence Union (MDU), which indemnified three of the consultants in Obstetrics and Gynaecology, informed these consultants of an intention to increase their annual subscription from £80,000 to £800,000. The MDU has done this in a number of countries because the financial risk of litigation in obstetrics is incalculable. Litigation on behalf of a baby damaged at birth may not materialise for more than 20 years, by which time the financial liability could be tens of millions of pounds. At present, the other medical defence organisations have not increased their annual subscriptions to anything like the same extent. However, there is no guarantee that they will not do so, and all the medical defence organisations may seek greatly increased indemnity contributions from other high-risk specialists in future years. The strategy of the MDU in other countries has been to persuade the state to provide indemnity cover for civil claims by public patients, and this has been successful in the United Kingdom and the Republic of Ireland. Unaffordable indemnity payments by consultants could threaten

the continued delivery of high-risk services in Jersey. In my opinion, consideration should be given to provision of indemnity for civil claims by public patients in the States of Jersey.

32. I have potential conflicts of interest which I wish to declare. I am a member of the Council of the MDU; however, the Council is an advisory body only, and has no executive function. I also provide expert advice on civil claims for the Medical Protection Society and the Medical and Dental Defence Union of Scotland, which are the other two principal providers of indemnity for doctors in the United Kingdom.

Conclusions

33. On the basis of the information available to me, the importance of clinical governance has been recognised at the General Hospital and many steps have been taken to manage it more effectively.

34. Safety in clinical areas at the General Hospital is improving. Managers have developed commendable structures and plans which will improve safety significantly over the next few years, but, in relation to medical staff, a number have not yet been implemented.

35. In my opinion, the most important issue in relation to medical staff is the introduction of mandatory annual appraisal which will provide reassurance about many aspects of doctors' performance and which will be essential if doctors are to retain their licence to practise medicine.

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