Health and Community Services Department Advisory Board

Health and Community Services

Date: 25 January 2024	Time: 9:30 – 12:30pm	Venue: Main Hall, St Paul's Centre, Dumaresq St, St Helier, Jersey JE2 3RL

Board Members:		
Carolyn Downs CB - CHAIR	Non-Executive Director	**CD**
Anthony Hunter OBE	Non-Executive Director	**AH**
Dr Clare Gerada DBE	Non-Executive Director	**CG**
Julie Garbutt	Non-Executive Director (Items 1-11 only)	**JG**
Chris Bown	Chief Officer HCS	**CB**
Mr Patrick Armstrong	Medical Director	**PA**
Claire Thompson	Chief Operating Officer – Acute Services	**CT**
Andy Weir	Director of Mental Health Services and Adult Social Care	**AW**
Dr Anuschka Muller	Director of Improvement and Innovation	**AM**
Steve Graham	Associate Director of People HCS (outgoing)	**SG**
Bill Nutall	Director of Workforce (incoming)	**BN**
In Attendance:		
Cheryl Power	Director of Culture, Engagement and Wellbeing	**CP**
Obi Hasan	Finance Lead – HCS Change Team (Teams)	**OH**
Beverley Edgar	Workforce Lead – HCS Change Team (Teams)	**BE**
Cathy Stone	Nursing / Midwifery Lead – HCS Change Team (Teams)	**CS**
Emma O'Connor	Board Secretary	**EOC**
Daisy Larbalestier	Business Support Officer	**DL**
Dr Adrian Noon	Chief of Service Medical Care Group (Item 12 only)	**AN**

1	**Welcome and Apologies**	**Action**

Carolyn Downs introduced herself and advised that she would be acting as Chair for this meeting (noting that not acting as an interim Chair). Following the end of Professor Hugo Mascie Taylor's contract, the recruitment for the Chair continues and hopeful that a substantive chair will be in post for the next meeting.

All in attendance welcomed.

Bill Nutall was welcomed as the new interim Director of Workforce for HCS as this function has been transferred from People and Corporate Services to HCS. Steve Graham, Associate Director of People, was thanked for his contribution and support to HCS and wished well in his new job within Government of Jersey (GOJ).

Due to Purdah, there are items that cannot be covered during today's meeting and deferred to a future meeting.

The rheumatology item will be starting at 11:15am as advertised.

Apologies received from:

Jessie Marshall	Chief Nurse	JM
Professor Simon Mackenzie	Medical Lead – HCS Change Team	SMK

2	**Declarations of Interest**	**Action**

No declarations.

3	Minutes of the Previous Meeting	Action
The minutes of the meeting on 6th December 2023 were agreed.		

4	Matters Arising and Action Tracker	Action
Noting the length of the action tracker, it was agreed that where items are noted for a future agenda, the specific meeting would be identified to provide a clear view of the forward plan. No specific items to note from the action tracker.		

5	Chair's Introductions	Action
As above.		

6	Chief Officer's Report	Action
CB took the report as read and highlighted all the issues noted in the paper. Noting the time to first appointment is increasing, CG asked what action is being taken to address this. CT explained this was impacted by a higher number of referrals during October 2023 and loss of capacity during December 2023. However, good progress is being made in Trauma and Orthopaedics and Ophthalmology where 150 individuals were removed from the waiting list. Preliminary data for January 2024 demonstrates a reduction in outpatient number and those waiting over 90 days. During Q1 2024 the insourcing initiatives will yield further positive impacts with waiting list recovery schemes in diagnostics and ophthalmology (cataract), removal of 400 and 50 patients respectively. CG also asked how the delays in reporting of MRI scan (not access to the scan itself) were being addressed. CT responded that she is unaware of this particular concern regarding MRI but will review and feedback at the next meeting. ACTION: CT to feedback on timeliness of MRI scan reporting. TH noted that the breadth of staff engagement is encouraging and the creation of an environment for success is critical for the staff who are delivering care. ACTION: Non-Executive Directors to be receive the Monday Message and Wow Wednesday. Noting there is only one social work vacancy, this was highlighted as a very positive statistic. CD noted that the vaccination rates in Jersey are comparable to any in London and generally uptake is low. However, this does not mean that Jersey should be complacent and every effort should be made to continually improve the uptake. CD advised that the area of most concern is medical job planning. Noting that previous reports to the Board highlighted the importance of job planning to future clinical governance (also noting the link to rheumatology report) and that this was one of the most important issues for the Board to progress, the planned delay is very concerning. Job plans are not perfect in any organisation however, every Doctor has one and the British Medical Association (BMA) are very clear that every Doctor should have a job plan. With this in mind, CD asked firstly if the Executive Directors remain committed to job planning and if so, when will it happen? CB confirmed that job planning remains a priority for the executive team. PA confirmed this commitment and added that whilst a lot of job plans have been completed, it was during the review phase that issues were raised regarding quality and consistency. Time of in lieu (TOIL) is unique to Jersey in terms of the job planning process as individuals on low intensity but high frequency on-call duties will have up to 30% of their time as TOIL. In combination with other activities such as Supervised Professional Activities (SPAs), individuals will then only have 30-40% of clinical time within their job plan (based on 10 PA's). The root cause of this is the		

Consultant contract which is no longer fit-for-purpose for care delivery in 2024. There is commitment from the Consultant body through the Local Negotiating Committee (LNC) and States Employment Board (SEB) to potentially renegotiate the contract, noting that this will not happen quickly. However, there maybe opportunities through the LNC to work voluntarily in a different way to progress job planning.

Whilst noting this response, CD advised that the issue of TOIL and the out-dated contract must have been known about and therefore actions to address could have been started. CD asked if any other staff groups across HCS do not have agreed job plans. CB confirmed that allied healthcare professionals (AHPs) have job plans and whilst nursing staff and non-clinical staff do not have job plans, objectives are set and reviewed. However, HCS remains challenged to upload these onto the new Connect People system.

CD noted that it appears unfair that some staff have agreed job plans / objectives / targets and are expected to deliver against these, whilst one staff group do not. This does not create unity across the organisation and is potentially divisive. Concerns around provision of excellent clinical governance and also fairness.

ACTION: CD asked CB / PA to consider the comments and return to the Board in February 2024 with a robust action plan as to how this will be progressed.

PA in agreement and stated that the lack of fairness was identified as an issue as part of the lack of consistency. In addition, more robust information is required regarding activity that individuals are carrying out and without clear expectations of what staff are going to do, this is also a weakness (also from a value for money perspective).

Noting that data drives performance, CG asked PA if activity data is available at departmental levels. PA responded that some of the information needed is available for example, theatres. However, there is gap in individual activity data and HCS is working to get this to inform job planning. Individual clinician data is available through MAXIMS (this was not possible through the previous electronic patient record (EPR) system Trakcare). CG noted that in time, this level of data should be made available to the public.

CT explained that HCS has data including number of referrals and demand at speciality level and the theatre utilisation dashboard has been developed down to Consultant level. This level of data will inform discussions to drive productivity and efficiency and address waiting list issues. However, what cannot be done currently is articulating the impact of job planning that has been done.

CB in agreement with CG's point about the granularity of activity data as current activity drives future activity and resource requirements. For example, how many patients are seen in the ED per day and what does this mean in terms of how many are seen per hour per full time equivalent. This would enable the board members to understand productivity and for the people of Jersey to understand whether they are getting value for money.

OH explained that the financial recovery programme (FRP) team has been supporting the job planning work. Activity data is crucial to understand demand, where capacity is currently deployed and then allocate accordingly. It is the absence of this data and the systems available to the executive team that frustrates the work.

Accepting all the above points, CD stated this is about culture and having something is better than nothing. This sets expectations i.e. managers know what to expect from staff and what staff are going to provide the organisation. This is about a contract between employer and employee and when this is not in place, relationships break down.

In agreement with all the points raised, CB acknowledged that HCS is behind in job planning due to level of data available and out-of-date contracts, however, these must be addressed.

In summary, CD noted that by raising these issues, the NEDs are supporting the Executive Directors to achieve what they need to and through the Board to the people of Jersey, all productivity is transparent, open, understood and fair. ACTION: Following the issues raised, it was agreed that job planning would be a substantive item on the board agenda.	

7	Quality and Performance Report (QPR) Month 12	Action

CT highlighted the following key points from the report.

- *Total patients in ED > 10 hours* = 69 (point of clarification 69 patients not 69%). ED activity is increased during winter months and this is reflected in the data (more so January 2024). The conversion rate has remained stable between 16-18% which suggests that some of those waiting in the ED for extended periods are being treated and discharged. However, whilst there is a focus on making sure that those being admitted are transferred swiftly into the hospital, there will be patients who are delayed. During Dec / Jan, there has been an expected rise in admissions with specific viruses and the impact of this is often there is a wait for beds (gender and isolation cubicles). Whilst this ED metric has been controversial at times, it is very powerful in terms of patient experience.
- *Median time from arrival to triage.* The standard is 11 minutes and whilst this has not been achieved, the data show a year-to-date average of 15 minutes. It is anticipated that additional staff training will have a positive impact during Q1 2024.
- *% commenced treatment.* Performance is maintained in this area and there are actions in place to increase % commenced treatment for majors patients to green (from amber).
- *% inpatients discharged between 8am and noon.* There is a focussed piece of work to ensure that individuals are discharged in the morning which supports length of stay reductions and occupancy at midnight.
- Improvements are anticipated in the elective waiting lists as a further 28 hospital beds are made available on the opening of the refurbished Plemont ward in mid-February. This will have a positive impact on both medicine and surgery.

CB echoed the anticipated positive impact of the 28 additional beds. In addition, the outsourcing and insourcing schemes which will increase capacity to decrease the waiting lists. However, whilst HCS would like to continue to invest in schemes that will reduce waiting lists (in both acute and community care), the financial position is very difficult.

Noting the *percentage of new support plans reviewed within 6 weeks (ASCT),* CD asked AW how this will be addressed to improve. Commenting more generally about the Mental Health and Adult Social Care data, the following key points were made,

- The issues facing mental health services are fundamentally unchanged. However, there have been some data issues during December meaning that information is not available. These issues are being addressed with the assistance of data analysts and will be rectified for next month.
- *Access to psychological treatment*. Individuals are seen very quickly for an initial assessment which is good news (98%). However, 55% of individuals have waited longer than 18 weeks this month to be seen (referral to treatment). This related to capacity and recruitment is underway.
- *% of eligible cases that have shown reliable improvement*. This was one of the few outcome measures in place. Whilst individuals are waiting much longer than they should for treatment, once they are receiving treatment individuals are seeing good results.
- *% of referrals to Mental Health Crisis Team assessed in period within 4 hours* and *% of referrals to Mental Health Assessment Team assessed in period within 10 working days.* Due to a data issues, the position in December is better than reported, 90%, however, AW will confirm this at the board meeting in February 2024.

- The waiting time is deteriorating in the memory assessment service and this concerning. In addition, there are still significant waits in ADHD and autism services for diagnosis. This is a capacity issue. There is a finite number of psychiatrists and how the time of these psychiatrists is deployed needs careful consideration. The Mental Health SLT are having discussions about redirecting psychiatrist capacity into memory assessment service to support reducing the waiting list, however, this will have a negative impact upon another service and need to be transparent about this. Sourcing additional capacity has been unsuccessful for a year.
- Whilst delayed transfers of care have reduced with sustained reduction in the hospital, a significant increase can be seen in mental health services. 17 out of the 40 beds occupied during December were occupied by individuals who did not need to be in hospital. This is due to being unable to find placement for individuals with a dementia diagnosis (often complex needs) – one patient has waited for > 20 months. In addition, there is a high number of individuals that lose their housing at the point of entering mental health services – if detained and admitted to hospital, the housing benefit ceases and people lose their accommodation.
- The Mental Health Strategic Partnership Board met yesterday and set four system-wide objectives. One of these is objectives is concerned with a specific piece of work regarding housing and the creation of no fixed abode – looking at joint working to resolve this.
- *% of clients with a physical health check in the past year in learning disabilities services.* This position continues to improve and AW congratulated the team for achieving this standard.
- *% of new support plans reviewed within 6 weeks (ASCT).* This metric is under target because of a technical issue, not a practice issue. This is recorded from the point at which the support plan is agreed to 6 weeks later – however, there is a high % of cases where the support plan is agreed but cannot be implemented until week 4 or 5 due to delays in finding providers of agreed care packages. This metric is being reviewed to explore how it can be reported differently as it is doing a disservice to practitioners.

With reference to the infection control data, CD congratulated everybody as infection control across the UK is increasing. CS echoed this strong position, particularly in view of the recent comments regarding increased activity in the hospital. However, infection control is everybody's business (not limited to the microbiologist / infection control team) and this is an example of the hospital working together for the benefit of patients.

CG sought to clarify whether neurodevelopment services refers to adults and / or children, and AW confirmed adults. CG advised that waiting times for neurodevelopment services have increased globally. CG advised that when considered the reallocation of resources, must consider where the greatest impact will be for example, a diagnosis of ADHD at 45 is possibly not going to have a massive impact however, a diagnosis dementia will have a massive impact. In addition, CG advised caution against care of ADHD with GPs due to capacity, quality and safety issues. However, it may be worthwhile looking at a model where a GP and psychiatrist work together to develop a different model for this type of service provision. AW responded that a joint protocol has been developed with primary care in relation to shared care which addresses the issues raised by CG i.e. initiation always by the specialist, annual review by the specialist. Currently, there is one Consultant Psychiatrist who is doing all the diagnosis and prescribing for adults with ADHD (> 700 patients). Also, > 80% of activity in Child and Adolescent Mental Health Services (CAMHS) is neurodevelopmental and these children will be migrating into adult services.

ACTION: AW to provide a paper on neurodevelopmental services in May 2024.

JG declared a conflict of interest due to a family member accessing diagnosis services at this time. JG suggested that a review of this should include the voice of all services who are getting more involved in neurodiversity.

8	Workforce Report Month 12	Action
In addition to the workforce detail covered in the Chief Officer's report, CD asked SG / BN if there is anything additional to add? SG sought to assure the Board that even though 2023 has been successful, HCS is continuing to look for partners to support the organisation in brining in new staff i.e. different website and agencies. It is anticipated that in his new role, BN will be able to pull the activity into a single place rather than the disparate activity ongoing currently. In reference to the 'low' number of appraisal completed, CD asked for the figure. SG advised that HCS is the lowest department in terms of percentage of appraisal completed. CD commented that this is not acceptable and is creating issues in terms of individuals understanding what their responsibilities are and delivering against these. CB advised caution when considering the figure stated a there are know technical issues within HCS and not all appraisals are recorded on the Connect system. As an example, all nurses are being appraised as they should. Work continues with the Connect team to provide more training for supervisors and managers to move from a paper-based system of appraisal to Connect. CD stated her understanding of the bureaucracy of the system and requested more evidence of staff understanding what their objectives are. ACTION: Evidence of nursing appraisal (to ward level) will be presented to the board to provide assurance on a quarterly basis.		

9	HCS Annual Plan 2024	Action
Deferred to the meeting in February due to Purdah.		

10	Quality and Performance Report (QPR) Metrics 2024	Action
AM advised the Board that HCS reviews the list of key performance indicators annually to ensure that they reflect the organisation's strategic and operational priorities. This review was done in conjunction with the change team. This report details the proposed new list of indicators and a new format using statistical process control (SPC) for agreement. CD suggested that regarding the design, individual feedback can be given. JG commented on the loss of data items relating to planned activity and waiting times as this is an area which is very important to both the public and politicians of Jersey. However, it may be that the detail is reviewed at the subcommittee meetings and any exceptions are escalated to the board. TH noted that the indicators need to reflect the priorities of the Board so that there is a sense of progress to the public that the board is making. Consideration needs to be given as to how to measure more qualitative metrics such as quality of life and inequality of access to services. TH suggested some form of process to review and agree the indicators over the next month and also take into consideration any new Ministerial priorities. ACTION: Further work is required outside this meeting to agree the metrics. CT sought to reassure the board and public that the revised metrics are about being more transparent with the public by showing those that are waiting > 52 weeks, rather than the previous 90 days. Access to diagnostics (> 6 weeks) has been selected as this is crucial for pathways of care and cancer treatment access. These metrics in no way detract from the separate waiting list data which can be presented to the board as required. In addition, improvements are being made to the waiting list data available to the public (through the website) and anticipating this will be live in time for the February meeting. CD commented that CT's response provides reassurance and the proposed format is reflective of that seen in the NHS. However, CD advised caution against losing sight of adult social care metrics as a local authority Chief Executive you would expect to see a lot more data than proposed here.		

AM reinforced that HCS is committed to visibility and scrutiny of the waiting list data and currently exploring how the waiting list data on the public website can be accessed by service and individuals can view waiting times rather than total number of people on a waiting list. In addition, some of the data has not been deleted rather it has been replaced by a different standard that facilitates better benchmarking. AM also suggested that the data from Statistical Jersey can be used to review themes etc. Regarding the format, CD suggested that some form of symbol could be applied to each indicator which highlights those areas that are really positive or where significant concerns exist.	

11	Serious Incident Position Statement	Action
PA took the paper as read. In addition to the areas noted in the Chief Officer report, • Any massive obstetric haemorrhage that occurs is followed by a safety huddle to identify any areas of learning and also presented to the serious incident review panel (SIRP). Niche is an external company carrying out a thematic review of these cases and hopefully the final report will be received in the next couple of months. However, in terms of local learning, HCS compliance to the care bundle has significantly improved and there have no been no cases during Nov / Dec 2023 where this was not followed (not the case prior to this). Whilst MOH will always occur due to individual risk factors, it is the steps taken to minimise occurrence in the first instance and the management of MOH when it does occur that is important. • Work continues to address the themes identified from closed SI reports and includes the use of and compliance with the MUST Tool and the Recognition, Escalate and Rescue (RER) programme. A significant reduction in the number of SIs relating to failure to escalate can be seen. • Further improvements are required to improve timeliness of SI investigation and presentation back to the SIRP and work continues to address this. Both CG and CD noted the improvement that are being made. In response to CD's questions about 20 reported MOH SI cases combined into one, PA explained that whilst these were all individually managed as SIs, they have been presented to Niche to establish the themes. CS explained that combining individual SIs for a thematic revie is a common approach also taken in the NHS and there is a very clear audit trail and link to each of the SIs in HCS. The recently introduced care group clinical governance reviews allow a more granular review of each SIs, action against recommendations and evidence and trends. CD concluded that it is encouraging to see the work progressing and in future this will be overseen by the Quality Committee, chaired by Dr Clare Gerada and any escalations coming to the board. Any Never Events must be reported to the Board.		

12	Rheumatology Service Review	Action
Dr Adrian Noon, Chief of Service Medicine, in attendance for this item. Noting the sensitive nature of the report, CD highlighted the role of the board regarding this. The Board and NEDS are here to understand the governance structures that were not in place but now need to be to provide confidence to the board and more importantly, to the people of the Island that something of this nature could not happen again. There are separate employment issues that cannot be discussed in a public meeting as these are entirely confidential between the employee and employer (Government of Jersey). PA will be invited to speak, followed by AN and CB as Chief Officer for HCS. Members of the public will be invited to ask questions at an appropriate point and reminded those in attendance that employment issues cannot be discussed.		

Mr Patrick Armstong,

As you aware, earlier this week we published an independent review of the HCS rheumatology service. As the Medical Director of HCS I commissioned this review from the Royal College of Physicians England (RCP) as we will refer to them.

The review was based on a number of interviews conducted by the RCP review team and their in-depth review of the case records of 18 HCS rheumatology patients.

The RCP team's overall conclusion was highly critical. They said, "We found the standard of care to be well below what the review team would consider acceptable for a contemporary rheumatological service."

The RCP had criticisms of both HCS itself and of individual doctors.

With respect to patient notes prepared by clinicians working in the rheumatology services the RCP said:

- There was, "Little evidence to support a relevant patient history having been taken."
- There was "A lack of relevant imaging to support diagnoses."
- There was "Limited, and often absent, handwritten evidence of the clinical interaction with the patient". "Letters were brief and generally uninformative."
- In some cases there was "No evidence of clinical examination."
- There was, "An absence of reference to a specific diagnosis, and on occasions, an incorrect diagnosis."
- And "Despite a lack of clear diagnosis, biologic agents were prescribed, with frequent and multiple changes."

The review also concluded that patients were initiated on biological drugs which were frequently switched without giving enough time to determine their efficacy and noted that in some cases patients were treated with five or more biologics within a short period of time. The RCP also noted that in many cases the prescribing of these powerful drugs was outwith both UK and European guidance.

The review team also observed that many of the staff working in the rheumatology service at that time, including both medical and non-medical staff, were not formally trained in rheumatology. Neither Dr Y nor Dr Z, the two doctors identified in the review, were on the GMC specialist register for rheumatology.

This whole affair, this concern about the rheumatology service, emerged in January 2022 when a junior doctor raised some concerns about a more senior consultant physician who is referred to in the review as Dr Y.

As these concerns were wide ranging, HCS restricted Dr Y from undertaking any clinical practice and began an investigation. During this initial investigatory period it became apparent there was little regard for national or international guidance and there were anomalies in the prescription of drugs used in treating rheumatological conditions. These anomalies, and further concerns, were subsequently raised by another locum consultant. The further concerns included questions of record keeping and the clinical assessment of rheumatology patients.

Part way through their review the RCP review team were concerned enough about clinical practice in the rheumatology service that they wrote to HCS indicating that neither Dr Y nor Dr Z should work independently in providing rheumatology care until the RCP review was completed. The letter also recommended an audit of patients on biologic drugs to ensure their diagnosis was secure, or in other words, correct.

Now, for the public, this might be an appropriate moment to indicate that biologic drugs (or biologics as they are sometimes called) are a group of powerful drugs derived from natural sources such as human, animal, fungal or microbial cells. These drugs work by suppressing the immune system and disrupting the inflammation process that leads to joint pain and damage. They can be valuable drugs for rheumatology patients, but they should always be used with caution as they can also make patients more susceptible to life-threatening infections and can have significant other side effects.

In line with the RCP recommendation HCS has now completed the audit of every patient on biologic drugs and has gone further by reviewing the case notes of other patients seen by Dr Y and Dr Z over the three-year period prior to January 2022.

In a minute I am going to hand over to my colleague Dr Adrian Noon to explain what we have discovered while completing these audits and reviews but let me first address the question of what this means for Dr Y and Dr Z.

It is widely known in Jersey who Dr Y and Dr Z are. Dr Z no longer works in Jersey, but Dr Y remains an employee of HCS, and we owe him an important duty of care while he continues to be our employee, including a duty of confidentiality. We are therefore adopting the terminology used in the RCP report and referring to him simply as Dr Y.

However, it is also important that patients know whether it is safe to receive care and treatment from any given doctor anywhere in the UK, and in order to have that assurance they must be able to identify a particular doctor and check his or her registration on the General Medical Council register. It is therefore appropriate for us to confirm that the General Medical Council (GMC) has placed restrictions on what Dr Y can and cannot legally do and in this context they have publicly named him. A link to these interim restrictions on Dr Y can be found on the Government of Jersey website.

The restrictions include restrictions on his ability to prescribe drugs, a requirement to obtain the approval of the GMC before starting work in any non-NHS setting, a requirement that he does not undertake any rheumatology work and a requirement that he be supervised in any post by a clinical supervisor.

In terms of Dr Y's professional registration, we have sent the RCP report to the General Medical Council, and it will be for them to decide whether it has any impact on his ability to practice as a doctor.

With respect to his current employment with HCS we will be carefully considering this report and discussing it, and its implications with Dr Y. Dr Y is currently restricted to non-clinical work and is not therefore performing clinical duties.

Dr Z no longer works in Jersey, but we have sent the RCP report to his present employers, and it will be for them to consider the implications for him.

With that, I'll hand over to my colleague Dr Adrian Noon.

<u>Dr Adrian Noon</u>
Thank you Patrick.

Let me begin by summarising the results of the audit of biologic patients that we undertook. As Patrick explained this audit was an interim requirement of the Royal College of Physicians review. In total 341 Jersey patients were on biologics at the time of the audit. All of these patients have now had their notes reviewed by locum Consultants on the GMC specialist register for rheumatology. Those who are still living on Jersey have now been seen by a specialist rheumatologist and they are all now receiving appropriate care from our new rheumatology service, which is led by Dr Sofia Tosounidou, a consultant on the GMC specialist register for rheumatology. The clinical audit methodology we adopted was based on British Society for

Rheumatology audits, it was reviewed by three senior Rheumatology Consultants and approved by the RCP.

In over half the records reviewed, clinicians were not able to identify sufficient evidence to support the patient's diagnosis and approximately one in four of the patients reviewed had their biologic drugs discontinued because they were not felt to be necessary.

This audit of rheumatology patients on biologic medication raised such significant concerns about clinical practice and the consequential potential harm to patients that HCS decided to undertake further clinical reviews, covering every other rheumatology patient as well as those non-rheumatology patients who had been under the care of Doctors Y and Z referred to in the RCP review. These further clinical audits were also conducted by locum Consultants on the relevant specialist registers.

The first of these additional reviews covered over a thousand patients who had been prescribed Disease Modifying Anti-Rheumatic Drugs (or DMARDs). The clinical audit of case notes for this group has been completed and over 95% of these patients have now been reviewed in clinic. The few remaining patients are scheduled for a review appointment in January of this year. The review of this group of patients has resulted in the diagnosis of over 45% of these patients being changed and almost a third of these patients have had their DMARDS stopped.

The second additional review covered the case notes of 386 rheumatology outpatients who were under the care of Dr Y or Dr Z. This review indicated that approximately 50 patients should have their care reviewed at a clinic appointment and all of these patients have now been contacted to schedule such an appointment.

The third additional review involved 747 non-rheumatology inpatients who had been under the care of Dr Y or Dr Z. This review is approximately 80% complete and the main finding is that very few patients (less than 3%) have had their treatment changed as a result of the review.

The final additional review has yet to be started. This will be a review of any patient seen by Dr Y or Dr Z in the rheumatology clinic in the period since January 2019 and who has subsequently died for any reason at all. To be clear, this will include many patients whose cause of death had nothing whatsoever to do with their rheumatology care. This review will involve a clinical audit to be followed by a Mortality Learning Review (MLR) for any case where concerns are raised.

Before handing over to Chris Bown, the HCS Chief Officer, I should say that the wide-ranging review of patient care I have just described is a truly comprehensive review programme. We have gone way beyond the more limited review recommended by the RCP because we wanted to leave no stone unturned in our efforts to ensure patients in Jersey are now receiving the very best possible care. In total we have reviewed around 2,400 patients and we have recalled for clinic appointments any of these patients who needed a face-to-face clinic review.

The RCP review is highly critical of the practice of two doctors Dr Y and Dr Z. It is worth remembering the duties of a doctor which are detailed on the GMC website. They include the following:

- You should provide a good standard of practice and care.
- You should keep your professional knowledge and skills up to date.
- You should recognise and work within the limits of your competence.
- You are personally accountable for your professional practice.
- You must be competent in all aspects of your work.
- You must be familiar with guidelines and developments that will affect your work.

The GMC also says that if you assess, diagnose or treat patients, you must:

- Adequately assess the patient's conditions, taking account of their history and symptoms.
- Where necessary, examine the patient.

- You must prescribe drugs only when you are satisfied the drugs or treatment serve the patient's needs and,
- You must ensure that your clinical records are clear and accurate.

The RCP review touches upon all of these issues which are pertinent to the practice of the doctors concerned.

Having said this I think it is important to understand that the RCP review is not just a review of the practice of two doctors. It is also a review of the wider HCS rheumatology service and to explain this further I shall now hand over to Chris Bown.

Chris Bown

Thank you Adrian.

Yes, the RCP review clearly was not simply a review of the practice of Dr Y and Dr Z, it was a wider assessment of the whole HCS rheumatology service and in this context the review again makes a number of critical comments and offers a series of recommendations. It says

- The review team found no evidence of agreed pathways or standard operating procedures for most aspects of routine rheumatological care.
- It notes that both public and private patients were being seen in the same clinics and there was no meaningful explanation of how this overlap of private and public patients was managed or planned.
- It found no evidence of the provision of formal Multi-Disciplinary Team (MDT) meetings.
- It was concerned to hear there was no oversight of the prescriptions being dispensed to rheumatology patients.
- And it notes there was a lack of built in challenge to prescribing, particularly biologics, by the pharmacy team.

The review makes a number of recommendations including,

- The need to establish standard operating procedures.
- The need to standardised written correspondence templates to reduce the risk of missing key information within communications.
- The development of close links with another NHS rheumatology service to enable forums for sharing best practice and,
- A recommendation that the pharmacy team should review the arrangements they have in place for the prescribing of biologics.

A recurring theme through the RCP report is the lack of effective governance, not just in rheumatology but across HCS. In this context the RCP report is of course consistent with the findings of the review of governance and quality of care in Jersey that was completed in the summer of 2022 by Professor Hugo Mascie Taylor. That review made over sixty recommendations, and I can report that we are making progress on actioning these.

I think it would be helpful just to give a few examples,

- As Dr Noon says we have now appointed a new, specialist rheumatologist to lead the Jersey's rheumatology service.
- We have stronger governance frameworks and we mentioned earlier the monthly Care Group Governance meetings that have been in place over the last few months.
- In addition of course Jersey has established this Independent Advisory Board.
- We have made it clear to clinicians in HCS that they must now follow appropriate clinical guidelines such as the National Institute for Health and Care Excellence or other equivalent evidence based clinical guidelines.

- We are assuring that clinical specialities now take part in UK national audits to support benchmarking so that we and the people of Jersey can make judgements about the quality of service that we are providing.
- We have focussed initially on services where we have particular challenges such as the maternity which we have mentioned earlier and where we have been reporting the progress that we are making against the maternity improvement plan to this board in the past.
- And we have improved Serious Incident Reporting, and ensuring that lessons are being learned.

In its report the RCP review team notes this progress saying, "It was reassuring to hear from senior managers that steps were being taken to implement a governance framework." And the team went on to commend HCS and in particular the Medical Director, Mr Patrick Armstrong, for ensuring the concerns raised were appropriately investigated and taking forward the work of improving governance. This action was taken to ensure patient safety.

Now, one of the most important aspects of clinical governance is the commitment to openness and transparency and in the spirit of openness and transparency it is important for me to say that from the work we have done (which Adrian has just described) it is clear that a number of patients have had their diagnoses changed and / or their medication changed. It is inevitable that some of these patients will have been harmed clinically and / or economically by their earlier diagnosis or treatment.

We expect and hope that in most cases the level of harm will be minor or negligible but, of course, any level of harm is completely unacceptable and over the coming weeks we will be contacting any patient where we think harm may have been caused and we will be discussing with lawyers an appropriate approach to compensation.

Earlier this week we were in contact with the Jersey Arthritis Association, and I think the current position was well summarised by Maureen Parris, the Association Chair. She said,

"We welcome the publication of the RCP report, and we applaud the decision to commission this review in the first place. The task now is for everyone to learn the lessons. It is essential that the General Medical Council is made aware of any clinical practice that may impact on the right of a doctor to continue to practice medicine. And it is equally essential that HCS institutes a more robust and effective framework of clinical governance as rapidly as possible."

In conclusion, I would like to say this.

It is very important that healthcare staff feel free to speak up when they see something they think is not right. And when a junior doctor raises concerns about the practice of another doctor, even perhaps a senior and well-respected doctor, it is vitally important these concerns are taken seriously, fully considered and thoroughly investigated. That is what we have tried to do in this case.

What has emerged is a picture of a rheumatology service that none of us could be proud of. The people of Jersey deserve better, and we are deeply sorry that we did not provide a service that staff, patients and our community could be satisfied with. Our task now is to make the improvements recommended by the RCP and to ensure that HCS becomes a beacon of good governance, not just in rheumatology but across the full spectrum of our health and care services.

Nobody doubts the fact that our staff are well intentioned but that is not enough. Modern healthcare organisations must also have good governance and as this RCP report indicates the cost of not having good governance is far greater than the cost of getting it right in the first place.

CD thanked PA, AN and CB for their words and suggested that the commendation of the junior doctor who raised the initial concerns – this is a brave thing to do and they should be thanked for doing so. In addition, PA did the right thing in commissioning the review and acknowledged AN role in this. However, whilst HCS has responded in the right way, both HCS and the individuals

did not do the right things before this and it is the role of the board to address the issues regarding clinical governance or rather, the culture of good clinical governance.

Taking into account Professor Hugo Mascie Taylor report, CD advised this raises concerns regarding the culture of good clinical governance in HCS services and whether this culture exits. PA responded that in his view, there has not been a culture of good clinical governance in the past and this is one of the reasons why PA and his former colleague, Chief Nurse Rose Naylor, commissioned Professor Hugo Mascie Taylors report in the first instance.

For patients utilising HCS rheumatological services today, it does not resemble in any way the service that was provided in January 2022. The staff who have transformed the service are to be commended for their efforts and determination to improve the service. It is worth remembering that > 200,000 access services every year and the vast majority of these receive good care. As highlighted by Professor Hugo Mascie Taylor, this cannot always be evidenced and this is the improvement journey that HCS is on. Some of the practice identified within rheumatology is out with normal and the cast majority of staff across HCS do engage in good clinical evidence and strive to provide the best care possible (following appropriate guidelines). However, there is much work to do.

Likening this to significant reviews that have occurred in the UK (Mid Staffordshire), CG noted it is hard for an organisation to acknowledge failings. However, CG does not believe this is limited to rheumatology department and noted the role of pharmacy. CG went further to explain that the cost of the drugs involved is very high and the Island's economy would have been harmed (in addition to patient harm).

Secondly, CG noted reference to a report in 2016 where the RCP recommended a review of consultant adherence to NICE guidelines. However, this was not done as Consultants did not want this. Therefore, this is a system issue.

Thirdly, the reports refers to a mix of public and private patients and patients seen privately were issued with a public prescription. This would be viewed as fraud in the NHS – CB nodded in agreement.

Whilst respecting the need for confidentiality regarding employment matters, CG sought assurance that there will be a rapid process to address capability.

Finally, CG asked for assurance that this practice is not taking place within other HCS services and will be asking to review prescribing data. CG suggested that anyone with oversight of prescribing practices should have identified the amount of money being spent on biologic drugs within a very small population. As an example, are people being prescribed opiates appropriately?

CG concluded by stating that whilst it is regrettable that patients may have been harmed, it is good that this has been exposed and can only lead to improvements.

Noting CG's reference to pharmacy, CD thinks that this should have been identified by pharmacy. CD suggested that the audit of prescribing biologics should be broadened to include the connection between pharmaceutical companies, pharmacist and doctors across HCS. This should also include the issue of public and private prescriptions as the report has made it clear that this is not transparent.

PA responded that a biologic pharmacist has been appointed (due to start Feb 2024) to specifically oversee the prescription and use of these drugs. Noting that the leadership of pharmacy has changed since Jan 2022, the role of the Chief Pharmacist is unique in Jersey, however this has provided an opportunity to review the additional support required in pharmacy. The SLT has received proposal as to what the structure in pharmacy should look like.

Regarding the issues of public and private prescriptions that have been raised, PA would welcome an audit. However, as noted in the report, the mixture of public and private patients in the same clinic is not seen broadly across HCS. However, CG asked if the public prescription pad was being taken to private clinics and if so, this would be fraud in the UK – PA and CB nodded in agreement. Noting the growing Cannabis industry, CG asked if HCS maintains a conflict of interest. CB responded that the Executive teams are required to declare any conflicts and all senior meetings begin with any declarations of conflicts. EOC explained that all staff across Tier 1 to Tier 3 are required to complete the GOJ eForm to declare conflicts and in addition, any staff in tier 4 or below who are involved in placing or negotiating contracts or placing orders / raising invoices. HCS is mandating that all identified staff have to make a null declaration (where applicable). The register which is held centrally will be reviewed monthly to ensure that all declared conflicts are managed appropriately. PA also explained that there is clear guidance on the relationship between staff and pharmaceutical companies in that they should not be directly contacting clinicians directly and staff must not accept direct approaches. Acknowledging what is in place, CG advised the board is seeking assurance that the guidelines is adhered to, particularly the public / private split. AH supported the commendation of the junior doctor that raised this issue and acknowledged this is difficult. Whilst recognising this is not a substitute for good management, this should send a message across the organisation that individuals who have concerns should raise them. CB acknowledged that raising concerns is key to addressing poor practice and is part of the process of good governance. As recognised in the Professor Hugo Mascie Taylor report, staff need to feel confident to speak up. CB stated that the culture of good clinical governance is behind where you would expect to see it and work is required with clinicians to improve this, particularly in relation to following guidelines. HCS cannot let this happen again in Jersey as if appropriate guidelines were followed in the past, the rheumatology service would not have been in the position it was in January 2022. The Board has made clear it's expectations regarding following NICE guidelines however, work is still required with clinicians led by the appropriate executives and Chiefs of Service. The Board will bring the momentum required to ensure that such are addressed, particularly the culture of good clinical governance. DECISION: As the appropriate NED to oversee the issues of clinical governance, CG has been nominated and accepted. CD noted that this report highlights individuals acting outside their sphere of competency and links back to the issue of appraisal – if senior doctors are being regularly and properly appraised and therefore appropriate continual professional development and attending appropriate training courses on a regular basis, then this would have acted as a safeguard against this type of practice. The seniority of staff within an organisation is irrelevant, all staff should have a series of agreed objectives with training and development plans that are continually adhered to, monitored and evaluated in a supportive way. This will be regularly monitored / scrutinised through the People Committee and it will not be acceptable that either the employee or employer if people are not taking adequate professional development. CD asked if HCS has the capacity required to manage all the actions required following this report and if not, can the Board have a report detailing the capacity issues and how it will be managed going forward. CB advised that rightly the report has already consumed a great deal of capacity (clinical and managerial) already. HCS received £1.3million from Treasury during 2023 to support the work required and this was largely the use of specialist consultants to review the circa 2,500 patients under rheumatology service. A business case has been submitted to Treasury for 2024 seeking further resource. The Law Officers Department (LOD) are considering what may be required, including a compensation process.	

CB advised that HCS has limited capacity and resource to address the culture of clinical governance more broadly and there is already significant pressure on the budget. CB reminded the board that he has produced a paper regarding management capacity which is limited despite comment to the contrary. In addition, it is likely that as clinical governance improves, more issues may emerge which again will require additional capacity to address. However, the cost to not having good governance in place is far greater than having good governance – this will be reflected in the cost to the Island through levels of compensation following the rheumatology report. CD stated it is important that clinical governance is not seen as bureaucratic process, rather fundamental to maintaining patient safety. BN added that an understanding of the scope of work required is important to establish what can be achieved within HCS and identify areas requiring external support.

Noting the reference to appraisal in the Chief Officer's Report, PA advised the Board that the appraisal process was reviewed last year by the Southwest Higher Level Responsible Officers Group and all recommendations made have all been accepted by HCS. From March 2024 the current Responsible Officer will step aside and hand over the role to the Medical Director. We are actively seeking an external partner to support with appraisal and will move to a system where we have a mixture of internal and external appraisers. It is the intention of the GMC to audit the standard of our appraisals later in 2024.

ACTION: PA will advise the Board at the next meeting (February 2024) as to whether the external partner has been identified.

CG advised it is important to clarify the difference between medical appraisal and performance management. Performance management should be dealt with by managers on a daily basis and appraisal is about development of individuals as employees.

As the Medical Director for Primary Care, AN assured the Board that the management of appraisal is very different and lessons can be learned.

ACTION: To determine with the Chair (once appointed) and Dr Clare Gerada the frequency of board reports detailing progress against the actions to meet recommendations.

In summary, CD advised that this is a difficult issue and will continue to be. However, the Board is now committed to ensure that improvements are made for the benefit of Islanders.

	Questions from the Public	**Action**

Referencing CB's previous statement that a business case (circa £1million) has been submitted for additional finding in 2024, Member A asked how much this is likely to be. CB clarified that the request from HCS is for the implementation of ongoing clinical and managerial improvements. CB does not have the necessary expertise to assess level of compensation which is why the LOD and insurers are involved. £1.3 million was spent during 2023 (to support review of patients) and a further request has been for 2024.

Member B asked AN if the RCP will be undertaking the review of deceased patients (Tranche 5). AN responded that the rheumatology audit tool will be used initially and an MLR if required (internationally recognised tool for deceased patients) – this will be internal. HCS needs to decide what will be required if concerns are highlighted following this.

Noting the length of time that improvements will take, Member C asked the Executive Directors how they can assure citizens of Jersey that this is not happening in other specialities within HCS. CB referred to some of the improvement work that has already been taken (including audit, care group governance meetings, quality and performance reporting, avoidable harms, reestablishment of the board subcommittees). Where concerns are raised about other services, HCS will commission further external reviews. As with all other medical jurisdictions, provision of medical care carries an inherent risk, however HCS must provide a level of assurance that

services are as safe as possible. There are no performance indicators that currently identify issues on the scale of rheumatology. CD highlighted the role of public and should rightly demand good clinical governance from the clinicians providing care. CG supported this and using compliance with NICE guidelines as an example of how this sets expectations regarding service delivery. CG suggested that a Board of Governors should be considered for establishment in Jersey; CD noted this would be a matter for the politicians to decide. CB emphasised that many Doctors (and other clinical staff) do follow clinical guidelines and are committed to clinical governance, however this needs to be consistent across the organisation. PA clarified that HCS does not only commission reports when concerns arise, rather they are commissioned as a matter of routine to provide advice and direction on services – this will continue. Service user views are an essential part of these reviews. Member D sought to clarify whether the MRI waiting list has now increased from 11 to 14 weeks. CT explained that when the improvement work started in Oct / Nov 2023, the routine wait for an MRI scan was 52 weeks. This reduced to 7 weeks pre-Christmas and has increased to 10 weeks as of yesterday. However, whilst there is a slight increase, it has very much reduced from 52 weeks (starting point). Member D speculated that if the hospital services had received a Care Quality Commission (CQC) type inspection, the rheumatology services incident may not have happened and the absence of a qualified rheumatologist (until Jan 2022) was poor. Member D will be discussing the required legislative changes with the Minister for Health and Social Services (MHSS) required so that the hospital can be inspected and will also seek to address the appropriateness of one of the NEDs (previous Chief Officer). Member E asked if any action is being taken to assess harm to those who were waiting 52 weeks for an MRI scan and asked who was responsible for the waiting list. CT advised that a harm review policy has been developed. However, there is a process whereby the clinicians who triage the referrals initially, regularly review these and if necessary, bring appointments forward. CT provided assurance that all those with an ‘urgent’ or ‘soon’ referral for an MRI scan have been responded to appropriately, the extended waits have affected those triaged as ‘routine’ (where there is less clinical urgency). This is also addressed on a weekly basis when the waiting lists are reviewed across all departments. CB advised that the waiting lists are impacted by a number of different factors including demand and the level of resource that HCS has to invest (to influence productivity, clinical capacity, physical capacity etc). CD thanked everyone for their attendance and contribution at today’s meeting.	

	MEETING CLOSE	**Action**
Date of next meeting: Thursday 28th February 2024		