Health and Community Services

Health and Community Services (HCS) Advisory Board Report

Report to:	Health and Community Services (HCS) Advisory Board		
Date of meeting:	25 January 2024		
Title of paper:	Rheumatology Service Review - Update		
Report author (& title):	Co-ordination Group	**Accountable Executive:**	Patrick Armstrong, Medical Director

1. Purpose

What is the purpose of this report? What is being asked of the Board?	To provide an update on the actions already taken and progress in relation to the Rheumatology Service Review, following receipt of the Royal College of Physicians Invited Review report. To outline how HCS has acted rapidly to ensure patient safety, including clinical audit and recall of Rheumatology patients.	Information	X
		Decision	
		Assurance	
		Update	X

2. Executive Summary

Background

Following concerns raised by a Locum Rheumatologist and a Junior Doctor, and in light of the potential harm which may have been caused to patients, the Health and Community Services (HCS) Medical Director commissioned an Invited Review by the Royal College of Physicians (RCP). The RCP sent an initial letter in March 2023 highlighting such significant concerns that remedial work commenced immediately, and an update was formally reported to the HCS Shadow Board in October 2023.

RCP Report in the Invited Review of Rheumatology

On 20 December 2023, HCS received the final report of the RCP's Invited Review of Rheumatology. The RCP's clinical record review 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 RCP final report contains 26 recommendations, of which four were 'immediate' (within 3 months), 16 had a short-term timescale (within 6 months), and six were recommended for completion in the medium term (6 – 12 months).

As at 18 January 2024, all four of the 'immediate' recommendations set out in the report have been completed.

Clinical audit of patients receiving biologic medication

The first of the RCP 'immediate recommendations' was that HCS should undertake an audit of all patients receiving 'biologic' medication. 'Biologics' 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. They can make patients more susceptible to life-threatening infections.

The clinical audit of patients receiving 'biologic' medication has been completed, and the emerging findings were placed in the public domain, in the spirit of openness and transparency, in early August 2023.

The clinical audit focused on evidence to support diagnosis and prescribing. It 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:

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 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 that 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 casenotes, patients were offered in-clinic review appointments. All patients who currently live in Jersey and are on biologics have now been reviewed by the new Head of Rheumatology (Dr Sofia Tosounidou). The conclusions from the in-clinic review is that:

- Biologics have been discontinued for 25% of patients reviewed
- Disease-Modifying Anti-Rheumatic Drugs (DMARDs) have been discontinued for almost 20% of patients reviewed
- A total of 38% had one or more medications discontinued.

Clinical Audits of other Rheumatology patients

The clinical audit of Rheumatology patients receiving biologic medication (clinical audit 1) raised significant concerns about clinical practice and the consequential potential harm to patients. Consequently, in addition to that clinical audit, 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 Invited Review. These clinical audits were also conducted by locum Consultants on the relevant Specialist Registers:

Clinical audit 2: Patients who have been prescribed DMARDs (1,066 patients). DMARDS are medicines that change or suppress the immune system. This can be very helpful in treating arthritis conditions, however they also suppress the bodies ability to fight infections which can be very dangerous. As at 18 January 2024, the clinical audit of case notes has been completed. Additionally, more than 95% of patients have been reviewed in clinic, with additional diagnostics and changes in therapies offered where clinically indicated. The remaining patients are scheduled for a review appointment in January 2024. The in-clinical review has resulted in:

- The diagnosis for almost 46.8% of patients being changed
- DMARDs medication discontinued for almost one third of patients.

Clinical audit 3: Other Outpatients who had been under the care of either clinician whose practice was reviewed as part of the RCP Invited Review. The casenotes of 386 outpatients have been reviewed by a relevant specialist (Rheumatologist or General Medicine). The casenotes of 50 patients indicated that an in-clinic review appointment would be advisable; all 50 patients have been contacted to schedule their appointment.

Clinical audit 4: Inpatients who had been under the care of either clinician whose practice was reviewed as part of the RCP Invited Review. This group comprised 747 patients. 587 casenotes have been reviewed, and the clinical audit of casenotes found that fewer than 3% of patients had had their treatment changed by a subsequent clinician. Casenotes for the remaining 160 patients in this group are being fully reviewed if they have not been seen by another clinician.

Clinical audit 5: Deceased patients (182 patients since January 2019). A clinical audit will be undertaken in 2024, followed by a Mortality Learning Review (MLR) for any casenotes where concerns are raised. The MLR will be conducted by three separate clinicians, and their assessment considered in a Clinical Panel. Any concerns will be reported to the Deputy Viscount for further consideration. The Deputy Viscount will then define any future review scope and/or processes to be put into place relating to historic deaths of Rheumatology patients.

Rheumatology service improvements

A number of service improvements have now been implemented, or are in progress, led by the new Head of Rheumatology. These improvements link to the recommendations of the RCP review but had commenced before the RCP report was received.

The Rheumatology service improvements are outlined in the main body of this report and explained in more detail in Appendix 1 (RCP recommendations). The improvements include multidisciplinary team working in Rheumatology, care pathway development and shared care, increased access to therapies for Rheumatology patients and improved monitoring of care quality and governance arrangements.

The new Head of Rheumatology clearly recognises the importance of implementing national best practice and following clinical guidelines in Jersey. This includes redesigning care pathways consistent with NICE guidelines and future participation in the British Society for Rheumatology national audit. A close working relationship has developed with Sandwell and West Birmingham NHS Trust (SWBH), which includes attending MDT meetings and seeking input and clinical opinions for complex patients. In order to comply with the GMC's Duties of a Doctor, professional development is now actively pursued and encouraged within the team.

Pharmacy improvements

The Chief Pharmacist has completed a review of Pharmacy and made a number of recommendations to the HCS Senior Leadership Team. These are summarised in Appendix 2 and, as relevant to Rheumatology, include the appointment of a Biologic Pharmacist who commences in February 2024 and implementation of the BlueTeq systems for high-cost drugs. This will increase the robustness and visibility of biologic prescribing, incorporating both challenge and governance.

Wider learning

At an organisational level, the HCS Board is committed to openness and transparency, and to significantly improving clinical quality, safety and governance. This includes:

- Recruiting a Deputy Medical Director in 2023, with a specific remit for clinical governance and quality improvement
- Requiring all clinicians to follow evidenced based guidelines from NICE and Royal Colleges except where HCS has formally agreed to follow other guidelines
- Ensuring clinical specialties to participate in national clinical audits
- Establishing clinical networks with larger UK services to increase resilience and support strengthen clinical relationships particularly in single handed specialities
- Introducing HCS Board Assurance Committees and ensuring that the receive adequate information to provide assurance, not simply reassurance.

Summary

The RCP initial review, and the subsequent clinical audits, have indicated that harm has most probably been caused to some patients. Since April 2023, HCS colleagues have pursued a multi-faceted programme of clinical audit, review, planning and improvement. The approach has been broader than was recommended by the RCP in their initial letter of March 2023. The HCS clinical audits and reviews have identified some areas of serious concern. Improvements for both individual patient care, the service, and colleagues working in Rheumatology have been and will continue to be implemented in order to improve patient safety, service quality and governance and deliver a contemporary rheumatology service in 2024.

3. Finance / workforce implications

A Letter of Comfort was provided by the Treasury Minister for up to £1.3m of expenditure in 2023. The funding provided for additional specialist clinical capacity to review the diagnosis, treatment and care for every Rheumatology patient. Patients for whom the casenote review indicated a possible incorrect diagnosis, prescribing or other care were then ‘recalled’ and seen by a specialist Rheumatologist in clinic – with additional diagnostic tests undertaken where indicated.

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. A weekly meeting has been held with the Interim Chair of the HCS Shadow Board who has experience in the management of similar situations, to provide guidance, and a regular update is provided to the Minister for Health & Social Services.

Oversight and direction is provided by a Co-ordination Group, which includes the Medical Director and Deputy Medical Director, Chief Operating Officer – Acute Services, Chief Pharmacist, medical staffing HR lead, communications, legal and information governance.

The work is led day-to-day by the Chief of Service (a consultant in emergency medicine) for the Medical Care Group, supported by the General Manager for Medicine and a dedicated Project Manager. Key operational colleagues are also involved in the project, including the Head of Rheumatology and HCS

Quality & Safety leads.

4. Risk and issues

Recognising the risks associated with the RCP Invited Review, HCS-determined further clinical audits and service improvements in Rheumatology and Pharmacy, the key mitigations put in place by HCS are:

- Patient safety:
    - A comprehensive review of all patients, starting with the groups most likely to be at risk – a broader review than the RCP recommended, comprising:
        - Clinical casenote audit of all Rheumatology patients, and other patients seen by the Rheumatology clinicians, undertaken by consultants on the relevant specialist register
        - Clinic appointments, with additional diagnostic tests, as directed by the clinical audit.
    - Service improvements being implemented, including in Pharmacy
    - Rheumatology being led by a Consultant on the Specialist Register for Rheumatology
    - Additional Consultants secured on locum contracts, to temporarily increase capacity in order to complete the clinical audit of casenotes and follow-up in-clinic appointments for Rheumatology patients
    - Engagement with the British Society for Rheumatology
    - Engagement with GMC and Jersey Care Commission.
- Possible reduced confidence in health services:
    - Communication relating to the breadth of the Rheumatology review, and progress to date
    - Information provided about the service improvements being made
    - Communication with patients, including Duty of Candour
    - A responsive PALS service, which provides call-back by a Rheumatologist where appropriate.
- Support for colleagues in Rheumatology:
    - Ongoing offers of support
    - Signposting to wellbeing services
    - Offering Occupational Health and Be Supported services
    - Informing Rheumatology colleagues in advance of media releases, and providing opportunity to discuss concerns.
- Capacity to complete the full scope of Rheumatology review and to fully implement service improvements in 2024:
    - A business case for funding in 2024
    - Plans to extend contracts for locum consultants, and to continue providing additional diagnostics and therapies
    - A Biologics Pharmacist, with a new Pharmacy system which monitors prescribing
    - Improvements in Rheumatology services, including multidisciplinary team working, evidence-based care pathways and participation in a British Society for Rheumatology audit
    - Plans to complete the review of deceased patients, with specially trained clinicians undertaking Mortality Learning Reviews.

5. Applicability to ministerial plan

Priority 1 of the Minister for Health & Social Services Delivery Plan is "Advancing the quality of Government of Jersey health and care services, ensuring they are well governed, safe and person centred."

The Rheumatology service review is contributing to this by:

- Delivering safe outcomes for patients by reviewing and improving the safety, effectiveness and patient centred care
- Implementing evidence-based practice
- Driving quality, safety, learning and continuous improvement
- Improving the performance of the service, delivering audit and information, data and evidence necessary to understanding and driving up standards of care.

6. Main Report

6.1 Background

HCS received the final report of the Royal College of Physicians' (RCP) Invited Review on 20 December 2023. On 20 December 2023, HCS received the final report of the RCP's Invited Review of Rheumatology. The RCP's clinical record review 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 RCP report contains 26 recommendations, of which 4 are 'immediate' (within 3 months), 16 have a short-term timescale (within 6 months), and 6 are recommended for completion in the medium term (6 – 12 months).

6.2 'Immediate' recommendations

All four 'immediate' recommendations were completed in 2023:

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

Action: 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. Recommendation: 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.

Action: This contains personal data relating to an identifiable individual and is appended in a confidential annex.

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

Action: This contains personal data relating to an identifiable individual and is appended in a confidential annex.

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.

Action: This contains personal data relating to an identifiable individual and is appended in a confidential annex.

6.3 'Short term' recommendations

The RCP report recommended that the report was shared with the HCS Senior Leadership Team and Minister for Health and Social Services, with oversight of an action plan by a Non-Executive Board member. The RCP report has now been shared; this report and associated detailed action plan is presented to the first HCS Board following the receipt of the RCP report - on 25 January 2024. The HCS Board are requested to identify a Non-Executive Director to oversee the Rheumatology action plan going forwards.

A further 15 recommendations were identified (further detail is presented in Appendix 1) covering four themes. Progress to date on the recommendations within these themes includes:

Staffing and teamworking in Rheumatology

The aim is to deliver a contemporary Rheumatology service in Jersey, providing evidence-based medicine tailored to patient needs.

Dr Sofia Tosounidou, who is on the Specialist Register for Rheumatology and General Internal Medicine (GIM), commenced as Head of Rheumatology in July 2023. The Rheumatology team has been further enhanced with a clinical manager, nurse consultant, and increased access to physiotherapy, hand therapy, podiatry and psychological support.

Service and delivery in Rheumatology

Job plans have been agreed, and annual appraisals will be delivered. In accordance with the GMC's Duties of a Doctor, professional development is now actively pursued and encouraged in order to:

- Provide a good standard of practice and care; and
- Keep professional knowledge and skills up to date.

Professional development includes weekly Multidisciplinary Team (MDT) meetings, attendance at regional, national and international meetings, monthly educational sessions (remotely) run by the Rheumatology Department at Sandwell and West Birmingham NHS Trust (SWBH), and accessing the British Society for Rheumatology learning opportunities including webinars, podcasts, mentoring and conferences. As well as enabling colleagues to remain 'current', this multi-strand approach also eliminates the 'reliance on pharmaceutical companies for drug information and training' which was identified in the RCP report.

Patient education is also being considered, with a view to delivering sessions for patients with rheumatic diseases. Members of the wider MDT and Primary Care will also be invited, to provide the most appropriate holistic approach and build relationships across the care system.

As noted above, the weekly MDT (which will include the biologic pharmacist) provides learning opportunities as well as ensuring patients' needs are discussed and care plans agreed. Rheumatology colleagues at SWBH will provide additional advice on complex patients.

A rolling programme of pathway and standard operating policies (SOP) development has commenced. Shared Care Agreements (SCAs) have been developed for prescription and monitoring of all disease modifying drugs commonly used in rheumatology, and a referral pathway for Early Inflammatory Arthritis (EIA) is being developed and annual review clinics (delivered by a Clinical Nurse Specialist) will be introduced for stable patients. New pathways will utilise and be informed by NICE guidance and Getting it Right First Time (GIRFT) and are being developed with colleagues across HCS.

Service improvements have already been implemented. For example, a Rheumatology clinic letter template was introduced in January 2024, which includes information on medication, treatment / management plan, advice on vaccinations and 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 will be assessed objectively using validated disease activities scores.

Pharmacy

A Biologic Pharmacist will commence in February 2024. They will be responsible for reviewing and improving prescribing, challenging prescribing and understanding and communicating the usage and cost of biologic drugs. Electronic Prescribing and Medicines Administration (EPMA) was introduced in Rheumatology in July 2023. Further improved governance will be enabled by the 'Blueteq' High-Cost Drug System, which will be introduced in Pharmacy in early 2024. The Biologic Pharmacist will monitor, clinical audit and report on medicines management, and will clinically review patients' medication, to assure compliance with medicines management policies, current legislation and local, regional or national standards and guidance (including NICE).

Audit and Governance relating to Rheumatology

As outlined above, the Biologic Pharmacist has a key role in clinical audit and governance for biologic medicines. Within Rheumatology, quality improvement meetings will be held every three months, reporting to the Medical Care Group governance meeting.

6.4 'Medium term' recommendations

Six recommendations were made:

Rheumatology service design

Progress and plans towards a more holistic approach to care – including working with Primary Care - are outlined in the 'short term' recommendations. In addition to MDT meetings, SCAs and pathways, new clinics will be introduced, responding to need and based on NICE guidelines and evidence - for example a clinic for patients with complex systemic rheumatic diseases.

Close links have developed with Sandwell and West Birmingham Hospitals (SWBH) to enable forums for sharing best practice, and overall providing learning opportunities for the whole team. The Head of Rheumatology continues to take an active role in delivering and attending the monthly educational sessions and attends a weekly MDT meeting with rheumatology colleagues at SWBH to discuss complex patients and share expertise.

Pharmacy

As outlined in the 'short term actions', electronic prescribing (EPMA) has been introduced. The Blue-Teq system will provide additional governance for the approval and management of high-cost medicines. The Biologic Pharmacist will lead the work on biologic drugs, including prescribing protocols.

Audit and Governance relating to Rheumatology

Once the Early Inflammatory Arthritis (EIA) clinics have been set up, the Rheumatology Department will enroll in the British Society for Rheumatology's National EIA Audit. The Biologic Pharmacist will enroll patients in biologics and biosimilar registries.

HCS-delivered departmental clinical audits will be considered during 2024, as part of the HCS clinical audit programme. In addition, opportunities and mechanisms to further assure the ongoing safety and quality of services will remain under review. This may include, for example, peer review or participation in a national Quality Review Scheme.

6.5 Additional actions

In addition to commencing the clinical audit of patients on biologics following receipt of the RCP interim letter in March 2023, a broader programme of actions commenced in early April 2023. As reported to the HCS Board, this is overseen by a multidisciplinary Co-ordination Group, which comprises many of the HCS Executive and is Chaired by the GoJ Assistant Chief Executive.

6.5.1 Review of all Rheumatology patients

The Co-ordination Group agreed that patient safety should determine all activities. The RCP initial review, and the subsequent clinical audits, have indicated that harm has most probably been caused to some patients.

Due to the significant concerns raised by the RCP in their initial letter, the Co-ordination Group directed that a wider review of rheumatology patients, and patient seen by rheumatology clinicians, should also be undertaken. In addition to the clinical audit and in-clinic review of all patients on biologics the additional clinical audits and patient reviews which have/are being undertaken, and their progress as at 18 January 2024, are:

i. Patients who are receiving Disease Modifying Antirheumatic Drugs (DMARDs) or steroids. The casenotes of all 1,066 patients have been reviewed by a Rheumatologist on the specialist register. As at 18 January 2024, more than 95% of patients have also been reviewed, with additional diagnostics and therapies offered where clinically indicated. The remaining patients are scheduled for a review appointment in January 2024.

As at 18 January, outcomes from the face-to-face review of the patients who had been diagnosed by either of the two Rheumatology clinicians were:

- The diagnosis for almost 36% of patients was changed
- Almost one third of patients had their DMARDs medication discontinued.

ii. Outpatients who are not receiving either biologics, DMARDs or steroids. The casenotes of all 386 patients have been reviewed by a relevant specialist (Rheumatologist or General Medicine). The casenotes of 50 patients indicated that an in-clinic review appointment would be advisable; all 50 patients have all been contacted to schedule their appointment. a as their notes indicated that this would be advisable, for example if their diagnosis is unclear. A further 17 will be referred to another service in January 2024.

iii. Inpatients who had been under the care of one of the Rheumatology consultants, but are not included in any of the other review groups. This group comprised 747 patients. 587 casenotes have been reviewed; no significant concerns have been raised - fewer than 3% of patients had had their treatment changed. Co-ordination Group decided that the 160 remaining patients in this group would only be fully reviewed if they had not been seen by another clinician.

iv. Rheumatology patients who have recently died. The casenotes of all 182 deaths of Rheumatology patients since January 2019 will be reviewed in 2024. The proposed methodology has been reviewed and approved by the RCP and incorporates a casenote review followed by a Mortality Learning Review (MLR) for any casenotes where concerns are raised. The MLR will be conducted by three separate clinicians, and their assessment considered in a Clinical Panel. Any concerns will be reported to the Deputy Viscount for further consideration. The Deputy Viscount will then define any future review scope and/or processes to be put into place relating to historic deaths of Rheumatology patients.

6.5.2 Communication

The review of Rheumatology services is being delivered with clear patient-centred principles. Communication is important, in order to ensure Islanders feel informed and are assured about progress, and to ensure patients understand the importance of attending appointments and know who to contact should they have questions or concerns.

Patients have received four letters providing updates and information about next steps as the Rheumatology service review progressed in 2023. A further letter has been sent to all Rheumatology patients on 19 January 2024, alerting them to the publication of the RCP report and the HCS Board report.

A speedy, responsive and flexible PALS response has been delivered, with patients receiving a call-back from Consultant Rheumatologist should this be appropriate. This helps 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 for whom possible harm has been identified will receive an individual 'Duty of Candour' letter which apologises and explains the medical harm that may have been caused, for example due to inappropriate prescribing. Mindful that some patients may wish to seek legal recourse, HCS are working to consider the most appropriate approach for medico-legal matters related to Rheumatology. The intent is to adopt an approach that is patient-friendly, not overly protracted/complicated and respects a patient's right to seek independent legal recourse.

Updates are also provided publicly via the media – in April , May, July and August 2023. Media is continually monitored (including on social media) and factual corrections provided. The next scheduled public update coincides with the HCS Board meeting in January 2024.

Mindful of the impact the review and public announcements can have on staff, colleagues, especially those in Rheumatology, have been updated during the review. 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.

6.5.3 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's governance report.

Clinical governance has been strengthened with the establishment of the HCS Advisory Board, who will support and hold the HCS Executive to account for the delivery of the Hugo Mascie-Taylor recommendations. This includes instigating monthly Care Group governance assurance meetings and ongoing challenge by the HCS Change Team. However, it is accepted that clinical governance is not yet at the desired standard.

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 now follow evidenced based guidelines from NICE and Royal Colleges.

HCS SLT has also agreed that clinical specialities are to be supported in participating in national (UK) clinical audits to enable benchmarking and where appropriate, during the course of 2024/25, services establish formal clinical networks with larger UK services to increase resilience and support and strengthen clinical relationships particularly in single handed specialities.

The Chief Pharmacist has led a review of the HCS Pharmacy function and the role of Chief Pharmacist, which was presented to HCS Senior Leadership Team (SLT) in December 2023. Appendix 2 presents the key findings, which resulted in a proposed phased improvement plan, to implement structural change to HCS Pharmacy, ensure fit-for-purpose reporting lines and responsibilities, and secure the resourcing required to meet both professional standards and the reasonable expectations of Islanders.

During 2024, there will be a continuing focus on the conclusions of the Hugo Mascie-Taylor review into HCS governance, including clinical governance. This will be a key agenda of the HCS Advisory Board and the new HCS Board Quality and Safety Assurance Committee.

7. Recommendation

The HCS Board are requested to:

I. Note the recommendations of the RCP Invited Review
II. 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
III. Provide ongoing support for the Rheumatology review
IV. Note the actions which will be progressed in 2024, including rheumatology service improvements, further Duty of Candour, a medico-legal approach, and completing the review of the care of deceased patients.
V. Identify a NED to overseeing the Rheumatology improvement programme

END OF REPORT

Appendix 1

RCP Recommendations – HCS progress and plans

'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**.
The RCP report has been shared; this report and associated detailed action plan is presented to the HCS Board. The HCS Board is requested to identify a Non-Executive Director to oversee the Rheumatology action plan going forwards.

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**.
Dr Sofia Tosounidou was appointed substantively as Head of Rheumatology, commencing in July 2023. Dr Tosounidou is on the Specialist Register for Rheumatology and General Internal Medicine (GIM).

A clinical manager has been appointed and is due to commence in January 2024. The clinical team will be further enhanced by a Nurse Consultant, who will deliver clinics in Rheumatology.

Access to physiotherapy, hand therapy and podiatry has improved, with referrals increasing in 2023; patients are also signposted to additional psychology support and are provided with a 'wellbeing' leaflet should the rheumatologist think this would be of benefit. Funding for this additional capacity, including an additional Nurse Specialist, has been requested for 2024.

Rheumatology staffing, including clinical capacity, administrative and secretarial support, will remain under review during 2024, and plans for 2025 will be developed.

Service and delivery

iii. **Introduce job plans for Rheumatology consultants and clinical nurse specialists.**
The substantive Consultant Rheumatologist (Head of Rheumatology) job plan was completed in August 2023 and clear objectives have been set. The Locum Consultant Rheumatologist's job plan was completed in September 2023; this is under ongoing review to meet service demand.

Job plans for the two part-time Specialist Nurses and the Senior Health Care Assistant were completed in October and November 2023 respectively.

Objectives for secretarial and administrative support will be agreed in January 2024, as part of the annual process for civil servants.

iv. **Review processes for personal and professional development of the rheumatology service staff, including weekly teaching sessions and annual appraisals.**
The Head of Rheumatology 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.

A dedicated workshop has been scheduled on 02 February 2024 for the Jersey Rheumatology service. This will include discussions regarding personal and professional development, and a plan will be developed which incorporates the RCP recommendations for service and professional development, best practice from other jurisdictions, and the Head of Rheumatology's experience of opportunities provided to colleagues who work in the NHS. The aim is to set up a contemporary rheumatology service in Jersey to

provide patients with evidence-based medicine tailored to their needs.

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, including delivering at least 4 education sessions per year for patients with rheumatic diseases. Members of the wider MDT and Primary Care will also be involved in and invited to these sessions, to provide the most appropriate holistic approach, further develop pathways and build relationships across the care system.

Medical and nursing staff should undergo an annual appraisal process as advised by their relevant professional bodies. The Head of Rheumatology will ensure this is actioned.

v. **Embed MDT working into everyday practice and establish links with a mainland modern rheumatology centre.**
The Rheumatology Department Multi-disciplinary Team (MDT) is now held every Wednesday afternoon. 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.
The Head of Rheumatology also attends a weekly MDT meeting with rheumatology colleagues at SWBH to discuss complex patients and share expertise.

The Head of Rheumatology is actively pursuing opportunities for broaden MDT working, including with Respiratory colleagues for Interstitial Lung Disease (ILD) and Connective Tissue Disease (CTD).

As outlined in iv, the Head of Rheumatology continues to have links with SWBH. During Q1 and Q2 2024, these links will be formalised and may include active participation from the rest of the rheumatology team to help with personal and professional development.

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

The Rheumatology pathway and SOP development programme is led by the Head of Rheumatology, and incorporates:

- Working with colleagues in the physiotherapy department and pain management service, with a view to standardizing the referral pathway
- Departmental pathways on the management of common rheumatic disease such as Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis - to be completed by September 2024
- SOPs on the use of intravenous biologics, chemotherapy and other intravenous medications on the Medical Day Unit - to be completed by May 2024
- Pathways and protocols for the use of biologics drugs in rheumatic diseases - to commence once the biologics pharmacist is in post in February
- A Giant Cell Arteritis (GCA) pathway – working with Ophthalmology and surgical colleagues – to be completed 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.
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. A standardized clinic template specific to patients on biologics will be introduced within the next 3 months. This will include diagnosis, screening bloods results, disease activity scores and monitoring regime. In addition, response to treatment for patients who have recently been prescribed biologics will be assessed objectively using validated disease activities scores.

viii. **Service should adopt a more holistic approach with the involvement of therapies**
A more holistic approach has been introduced, including:

- Weekly MDT meetings, for medical, nursing and the biologic pharmacist. Other healthcare professionals e.g. physio, podiatry, OT are invited to attend where there are specific, relevant patient needs to discuss
- Broadening MDT working, including with Respiratory colleagues for Interstitial Lung Disease (ILD) and Connective Tissue Disease (CTD).
- Developing a Giant Cell Arteritis (GCA) pathway – working with Ophthalmology and surgical colleagues
- Working with colleagues in the physiotherapy department and pain management service, with a view to standardizing the referral pathway
- Developing SOPs on the use of intravenous biologics, chemotherapy and other intravenous medications on the Medical Day Unit, and developing pathways and protocols for the use of biologics drugs in rheumatic diseases – working the colleagues in Pharmacy
- The biologic pharmacist will be an integral part of the MDT, and will be responsible for patient education on the use of biologics drugs
- A dedicated rheumatology email address will facilitate communication with Primary Care
- Shared Care Agreements (SCAs) have been developed for prescription and monitoring of all disease modifying drugs commonly used in rheumatology
- A referral pathway for Early Inflammatory Arthritis (EIA) is being developed
- Professional development opportunities are being scoped, and will be developed with, provided with and available to colleagues in relevant services across Jersey.

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

As part of the review of pathways and SOPs, annual review clinics will be introduced for stable patients. These will be led by a Clinical Nurse Specialist, using agreed evidence-based protocols.

x. **Implement a standardized written correspondence template.**
The Rheumatology clinic letter template is outlined in vii above.

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.
As outlined in v and viii above, the Rheumatology Department Multi-disciplinary Team (MDT) is now held every Wednesday afternoon. 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.**
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.

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.** As reported to the HCS Board in October 2023, 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.

Pathways and protocols for the use of biologics drugs in rheumatic diseases will be developed with the biologic pharmacist, who is due to commence in February 2024. The biologic pharmacist will also be an integral part of the MDT and will have 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.**
Electronic Prescribing and Medicines Administration (EPMA) was introduced in Rheumatology in July 2023. The 'Blueteq' High-Cost Drug System 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 will be the responsibility of the Biologic Pharmacist, who commences in February 2024. The biologic pharmacist will monitor, audit and report on medicines management in Immunotherapy, including drug use, prescribing etc - and make appropriate recommendations to support improvements.

The biologic pharmacist will clinically review patients' medication, to assure compliance with medicines management policies, current legislation and local, regional or national standards and guidance (including NICE). 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.**
QI meetings 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.**
Please see xiii and xiv above.

xvii. Use NICE guidance as part of the Rheumatology governance framework.
As noted in vi above, a rolling programme of pathway and SOP development has commenced. New pathways will utilise NICE guidance as appropriate, and guidance from Getting it Right First Time (GIRFT) will be incorporated in order to design and deliver an improved, contemporary rheumatology service.

6.4 'Medium term' recommendations

The six recommendations incorporate:

Rheumatology service design

i. **Adopt a more holistic approach to care, with allied health therapy groups contributing to the development of MSK pathways and patients accessing relevant treatments.**
Please see v, vi, viii and xi in the short term recommendations above.

New clinics will be introduced, responding to need and based on NICE guidelines and evidence - for example a clinic for patients with complex systemic rheumatic diseases.

ii. **Foster relationships between primary and secondary care to develop more robust monitoring and develop shared care guidelines.**
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 will be discussed with the Primary Care Body to agree an implementation plan.

The Head of Rheumatology is discussing a referral pathway for Early Inflammatory Arthritis (EIA) clinics with GPs in March 2024. 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.

iii. **Develop close links with other NHS rheumatology services to enable forums for sharing best practice, and overall providing learning opportunities for the whole team.**
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.

Pharmacy

iv. **Support electronic prescribing and monitoring systems.**
The majority of inpatient areas are live with EPMA, along with approximately 40% of outpatient specialties. Completion for Endoscopy, Day Surgery and Radiology is due in February, with Renal, Medical Day Care and the Depot Clinic, plus the remaining outpatient specialties, by the end of March 2024.

Additional work is required to enable complex infusions for ICU and for Theatres to be fully electronic. E-prescribing for intravenous chemotherapy is a separate project, which is in the scoping stage.

EPMA for Mental Health is complete for both inpatients and outpatients, however, some paper-based prescriptions will continue, as the system doesn't currently have functionality to deal with frequent repeat prescriptions for small quantities.

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.

v. **Appoint a pharmacist for high-cost drugs, to understand the usage and cost of biologic drugs and produce prescribing protocols.**
A Lead Pharmacist, Immunotherapy (Biologic Pharmacist) has been appointed, and will commence in February 2024.

Audit and Governance

vi. **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.**
Once the Early Inflammatory Arthritis (EIA) clinics have been set up, the Rheumatology Department will enroll in the British Society for Rheumatology's National EIA Audit.

The Biologic Pharmacist will enroll patients in biologics and biosimilar registries.

HCS-delivered departmental clinical audits will be considered during 2024, as part of the HCS clinical audit programme. In addition, opportunities and mechanisms to further assure the ongoing safety and quality of services will remain under review. This may include, for example, peer review or participation in a national Quality Review Scheme.

Appendix 2

Review of Pharmacy

The Chief Pharmacist conducted a review, referencing UK, HCS-wide and Jersey Pharmacy specific reviews, reports and audits, including:

- Review of Health and Community Services Clinical Governance Arrangements within Secondary Care – Prof Hugo Mascie-Taylor
- Royal College of Physicians Invited Review of Rheumatology
- External audit of Aseptic Pharmacy Services
- Internal Audit review of private patient prescriptions
- Internal review of HCS Pharmacy service provision against 'Royal Pharmaceutical Society – professional standards for hospital pharmacy services 2022'
- Royal College of Emergency Medicine position statement on Pharmacists and Pharmacy Services in the Emergency Department
- NHS benchmarking report.

A number of issues and pressures were identified:

- Regulatory, governance and assurance obligations associated with:
    - The growing number of licenced novel and high-cost drugs
    - Oversight of community pharmacies on-island
- The volume of outpatient prescriptions processed through the dispensary
- Advances in the prescribing and dispensary services and the rollout of corresponding digital interfaces
- The increasing complexity of medical presentations, coupled with the needs of an ageing population
- The significant governance burden resulting from the development of the medicinal cannabis sector
- Changes in national standards for qualifications and training, e.g. prescribing pharmacists
- Growth in demand for services, predominantly resulting from the increasing complexity of the medical presentations and the medicine needs of an ageing population
- Challenges with recruitment and retention, exacerbated by the pay differential in the community pharmacy sector
- Centralisation of Island-wide vaccination purchasing without an associated increase in staffing resources
- Unsustainable pressure on the Chief Pharmacist role due to an extremely broad remit of responsibilities.

The Chief Pharmacist is the Island's most senior advisor on all aspects of pharmacy practice and medicines related issues and policy. As head of the pharmacy profession, they are responsible for the leadership, performance and development of the profession in Jersey. Additionally, the Chief Pharmacist ensures compliance with statutory and regulatory requirements pertaining to medicines control and professional practice.

The role of Jersey's Chief Pharmacist is unusually wide when compared to other jurisdictions. For example, their role includes:

- statutory responsibilities and delegated authority in respect to the regulation, licencing, control, manufacturing and wholesale of certain drugs, including medicinal cannabis
- NHS England equivalent functions of:
    - Chief Pharmaceutical Officer – head of profession in England working at Government level to develop national policy and strategy; and,
    - Chief Pharmacist of a local or regional NHS trust (incl. hospital pharmacy functions, contractual community functions and all Trust medicines governance related functions).

The review proposed a three-phase approach:

Phase 1 – immediate actions, to address the most critical issues and lay the foundations to respond to the remaining issues and concerns, including:

- Implement changes recommended by the RCP, including biologic pharmacist and Blueteq system
- Recruit to critical new posts (within existing funding), including Associate Chief Pharmacist roles for medicines optimisation and regulation
- Changes to structures, roles and reporting – including a proposal that the Chief Pharmacist should be a member of the HCS senior leadership team and that there is appropriate representation and accountability to the HCS Advisory Board.

Phase 2 – 2024

- Develop business case for 2025 onwards

- Develop a medicines optimisation strategy including separate Island-wide strategy
- Bolster the medicines optimisation and digital teams, specifically in respect to pharmacoeconomics, high cost drugs and the implementation and support of related software for hospital prescribing of these medicines
- Introduce a regulation and policy team to assist with Island wide functions, including oversight and licencing of community pharmacies
- Provide compliance and licencing functions to support the medicinal cannabis industry
- Improve regulatory functions for the licencing, governance and assurance of controlled drugs
- Increased resources for aseptic services (which includes the production of intravenous chemotherapy for cancer patients)
- Ensure the provision of out of hours pharmacy services, including determining how the outpatient dispensary services may be redesigned and/or alternatively provided
- Subject to review and determination, bolster the clinical pharmacy teams supporting the emergency department
- Education and professional development to meet the updated professional training standards of new graduates entering the profession and to provide career development pathways for pharmacy professionals, allowing expertise to remain in Jersey.

Phase 3 - 2025 onwards. Based on review and learning from 2023 and 2024 developments, this may include:

- Implementation of a ready-to-administer injectable medicines service
- Development of a pre-assessment clinical pharmacy service and integration with digital services
- Further focus on cost savings through pharmacoeconomics
- Integrating capabilities of digital team with those of wider HCS information teams
- Business performance and support functions
- Improvements to capability and capacity
- Further enhanced workforce development, education and training.

The multi-phase proposals are intended to:

1. Provide an **immediate response to the most critical issues** that can be addressed using existing and reprioritised budgets.
2. Improve ability to develop and deliver the **strategic policy objectives of Government.**
3. Facilitate the **appropriate response to issues** identified within HCS Pharmacy, including those reports previously noted.
4. Advance the **quality, safety and effective use of medicines**, whilst providing **patient centred care** and ensuring value for money.
5. Improved **governance and assurance**, including ensuring **compliance with statutory requirements** pertaining to medicines control, as well as ensuring professional and regulatory standards are upheld.
6. Deliver **cost savings** in the use of medicines through dedicated pharmacoeconomics, high-cost drug pharmacists and adoption of digital solutions.
7. Improving **patient satisfaction** by ensuring 7-days-per-week dispensary services.
8. Promote **greater integration and collaboration** of HCS pharmacy teams with the wider health and care system – resulting in improved access to care and outcomes for patients.
9. Provide the resourcing required to implement new **digital solutions** driving both **medicines safety and service efficiencies.**
10. Increased ability to **leverage the significant expertise** of pharmacy professionals.
11. Provide **career development pathways** for pharmacy professionals, including **robust succession planning**, allowing expertise to remain in Jersey.
12. Provide adequate **regulatory and governance** support for the development of the Medicinal Cannabis industry (and other medicinal fungi / plants) in Jersey