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Health and Social Security Scrutiny Panel

Health Service: Lessons Learnt

Witness: Mr. Tom Hayhoe

Wednesday, 10th July 2024

Panel:

Deputy J. Renouf of St. Brelade (Vice Chair)

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter

Deputy P.M. Bailhache of St. Clement

Witness:

Mr. T. Hayhoe, former Chair of the Health and Community Services Board

[10:30]

Deputy J. Renouf of St. Brelade (Vice Chair):

Well, first of all, welcome. Welcome to this hearing held by the Health and Social Security Scrutiny Panel in which we are questioning 3 former senior leaders in the Health Department. They will all be appearing remotely and we have up to an hour for each session, although we do not have to use the whole hour. I am Deputy Jonathan Renouf. I am the Vice Chair of the panel and I will be chairing the hearing as the Chair, Deputy Doublet, has a medical appointment and sends her apologies. Before we begin, I would like to draw everyone's attention to the following points. First, this hearing is being streamed live and will be recorded. The recording and transcript will be published afterwards on the States website. Second, for those in the room, all electronic devices should be switched to silent. Third, I also want to make clear that the aim of the hearing is to listen to the experiences of our 3 witnesses and note any lessons learnt that could be used to improve the health service. The hearings will not be discussing any individual employment matters. Finally, before we get going, I am going to ask my fellow panel members to introduce themselves, so starting on my right.

Deputy P.M. Bailhache of St. Clement:

Deputy Philip Bailhache.

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter:

Deputy Lucy Stephenson.

Deputy J. Renouf:

Good. So our contributor is Tom Hayhoe, who was appointed as the first substantive chair of the Health and Community Services Board I think at the very end of February. He left the following month by agreement with the Minister for Health and Social Services. I thought perhaps we could start, Mr. Hayhoe, if you would tell us a little bit about your experience as it relates to running boards and driving improvements in healthcare.

Mr. T. Hayhoe:

Right. Well, I have chaired boards in the public sector, the private sector, the third sector and, for that matter, hybrid boards, which are a mix of public and private sector, in the U.K. (United Kingdom) for many years. My first career was in the private sector, as a management consultant with McKinsey & Company then as a retailer. But having studied health policy and economics while I was doing my M.B.A. (Master of Business Administration) at Stanford back in the late 1970s, in the mists of time, I had an involvement sitting on boards in the N.H.S. (National Health Service) and in the healthcare space going back to 1985, alongside the private sector career that I had, then progressively as we got into the new century increasingly into healthcare, both in the private sector and chairing 2 N.H.S. trusts. I also sat on the advisory board at N.H.S. Improvement and N.H.S. England and for the Care Quality Commission and chaired a regional committee making merit awards for the most senior N.H.S. consultants. I have also had 10 years working in professional regulations alongside the other things I was doing, first with nurses and midwives, for chartered accountants and for tax advisers. These days I chair the Legal Services Consumer Panel, which advises the Legal Services Board, the legal service regulators, and the Lord Chancellor on that as relating to the consumer interest. So that I think gives you the full profile in terms of background and I think things which are of relevance to the appointment that I briefly had in Jersey.

Deputy J. Renouf:

So you did not spend long here, but I wonder if I could wind you back a little bit to when you were applying to work here. It was obviously in the wake of the Mascie-Taylor report and I wondered what your impressions were, your first impressions were, when you came to Jersey in the light of that report.

Mr. T. Hayhoe:

Well, I think the things which I had to get my head round, first of all, is that Jersey is a small and proud nation, which consequently, not because of its independence or its size or its pride, but it does face some big challenges serving a population of 100,000, which is way below critical mass for all sorts of clinical services. Just by way of illustration, when I was at West Middlesex Hospital, we took over the maternity services from Ealing Hospital - which was in many respects viewed as being subscale, consequently not very safe, with the consequence that mums were voting with their feet and going elsewhere - which was operating at the level, if I recall, of maybe around 2,000 or 3,000 deliveries a year, getting on to 4 times the number of deliveries that there are on the Island. That just creates challenges being a relatively small place. Another thing which is really striking is that there are certain aspects of the way that healthcare is delivered in Jersey which ... you employ, albeit it is not part of H.C.S. (Health and Community Services), twice as many G.P.s (general practitioners) per head of population as we have in the U.K. Now, that is not necessarily on its own a bad thing, but it reflects and it actually represents some of the opportunities you face in the fact you are as generously doctored as you are. Coming into the post - and I have read the Mascie-Taylor report; I have read some of the other investigations from royal colleges over the years - I was acutely conscious that I was coming into a service which, on the face of it at least, has some major issues facing it around patient safety. That has been a major concern of mine for many years. There are clearly, and this did strike me over the relatively short time I was with you, some issues surrounding culture within H.C.S. By the standards of modern healthcare, massively hierarchical with, dare I say it, insufficient respect for the professions outside medicine itself.

Deputy J. Renouf:

Sorry, excuse me, Tom, what do you mean by that, insufficient respect for professions outside?

Mr. T. Hayhoe:

Well, I think that it is a ... the sense I received from nurses, pharmacists - and I would note there were some very tricky issues in pharmacy - from therapists is that they were not accorded the respect from ... partly from doctors in terms of where they sort of sit in the hierarchy and it does feel to me like a service which ... in many respects it feels much more like the service I first started getting involved with in a professional capacity back in the 1980s as opposed to what I would expect to see in terms of modern medicine.

Deputy J. Renouf:

What were the particular outliers, if you like? You obviously have experience in many different health settings and regulatory settings. What were the things that struck you as outliers in Jersey compared to what you would consider the norm?

Mr. T. Hayhoe:

Well, if we were to look at some issues, for example ... and I only had the opportunity to attend one because of the length of time I was there. It is kind of atmosphere, comments that came across in the medical staff committee, which is the consultants' committee. There were some other things which I think related to the degree of responsibility and autonomy given to people outside the medical professions, whereas the expectation in medicine was actually that the doctor was king as opposed to a professional with a particular skillset. So I think that is probably the issue that is in there. Yes, I think that is probably what I would want to particularly capture there. I also just did not have a sense - and again I was not on the Island for very long - of the respect for the sorts of things which - in fact, Hugo mentioned it in his report - add up to good clinical governance, things like attitudes to medical appraisal. One of the things that the G.M.C. (General Medical Council) requires in the U.K. these days is that there is some lay involvement in medical appraisals. I spent some years being involved personally in medical appraisal. There was a sense - and some of this hearsay but this is hearsay from the doctors - about the degree that more than lip service was paid to those sorts of things, and that, if one is looking at trying to create a culture of patient safety, is an important thing. It applies to all professionals, actually, the importance of high quality appraisal, feedback, adherence to standards of continuous professional development. I think alongside that the other thing that struck me just looking at the raw data, and this is something I have been pretty passionate about for many years, was having a culture in which it is okay to report clinical incidents and safety incidents and above all, actually, not just the things that actually happen but the near misses. My sense was, coming into it, an appetite and the convention was cover-up rather than saying: "Actually, look, something has gone wrong here. What are we going to do about it?" to the extent that ... now, this has been an issue in healthcare not just in the U.K. but elsewhere, that the tendency is for people to try and pretend that did not happen as opposed to say: "Look, actually, the surgeon on this case ..." - and this is a hypothetical example, not to do with Jersey - "... very nearly cut the wrong leg off, and had it not been for the scrub nurse saying: 'I am sorry, Mr. So and So, actually we are operating on the right leg, not the left leg'", that it is important to report the near miss and learn from it. Jersey, if I recall from looking at the data, has a relatively low level of incident reporting. If you look at industries like nuclear power, aviation, to name 2 industries where after some very high-profile disasters the standards of safety management in many ways set the benchmark for other industries, high levels of incident reporting are viewed as being a good thing as opposed to something that you feel vulnerable about reporting. Whistleblowing is viewed as being a healthy sign and that you approach it in a conscious and continuous learning. Now, that is not something that came across to me from my assorted meetings, albeit over a relatively short period, in H.C.S. in Jersey.

Deputy J. Renouf:

You say you read the Mascie-Taylor report before you came. Obviously, some time had elapsed after that report had been written before you arrived. Was your impression that either management

or politically these issues were being grappled with and addressed effectively or was your impression that there was still an awful long way to go?

Mr. T. Hayhoe:
I think the most important progress was actually recognising, which is clearly a political decision, that something had to change and the establishment of the advisory board. Now, I think as it has turned out - and it is in the public domain that not everyone was convinced that introducing a more robust and independent governance structure was the way ahead - my sense is that it has not been given the opportunity to really rise as it might do.

[10:45]

So yes, a big tick for recognising that something had to be done, but I would be very anxious that ... and there were some initiatives that I had tried to set in motion to try and improve both the input from the widest range of sources possible to inform the decisions of that board and also make sure that the board was engaging with both the patients and community and with the clinicians from all professions throughout the organisation. So it feels ... I would not say stillborn but it has not ... and given that my understanding is that it is about how the board is operating now without a substantive chair, without a full complement of non-executive directors, that it is not ... and, for example, some of the things that I had proposed shortly before I decided that there was not really a basis for going forward in the role have not been put in place. So I think that is the ... I think the thing which was in place was that some good people had been brought in to work and try and support and address some of the identified shortcomings in the service. So some of the interim appointments and consultants who were working alongside the service seemed to be doing some very good work. So, for example, things like trying to address that issue of the safety culture and improve the ... make people more comfortable with incident reporting were being pursued by the people who were working to support H.C.S. Alongside that, because one of the issues is there are some ... most organisations can find ways of improving the way they operate to improve quality, to improve efficiency, release resources which are being not as well used as they might be for other purposes. One of the things which was very clear was that the H.C.S. had moved to a position where it was ... I think the running deficit was of the order of 10 per cent a year. Now, there is nothing unique about that. There are hospitals in the U.K. which have operating deficits of that sort of level, but given the relatively generous levels of resourcing of healthcare in H.C.S. in terms of cash, which to some extent are necessary because of the lack of economies of scale, it was clearly important that people were looking at ways to do things better, which may be improving objective quality but equally well may be a matter of saying: “Can we actually save money here by doing this a bit better, which releases resource for doing other things?”

Deputy J. Renouf:

Beyond the governance issues, were there issues around, I do not know, the balance between private and public healthcare? You have hinted at issues around money and so on. What other things spiked for you as things that needed to be looked at?

Mr. T. Hayhoe:

I think one of the things which desperately needs to be looked at is how pharmacy is funded. So you have this issue about who pays for prescriptions in community pharmacy against what happens in the hospital, which results in things like costs which in other environments would be much better ... or services that would be much better delivered in community pharmacy coming back to the hospital. I think in terms of one of the really glaring challenges that the organisation faces - and I understand some of the sensitivities and that people appreciate some of the ways in which primary care operates, partly because there are quite so many G.P.s on the Island - is that the nature of the fee for service model in primary care and the relative cost of it means that there is significant ... I would not describe it as inappropriate but care that should be taking place in primary and community care ends up being addressed in the emergency department because it does not cost you to attend the emergency department, whereas it does if you attend your G.P. Looking forward strategically for Jersey, I think you have some really big, wider policy issues to consider. It is whether the current model is an appropriate model for a very rapidly ageing population, where the risk is that activity takes place in hospital rather than being addressed through a preventative agenda in primary care. Now, at one level, I have used the words, I know, but actually the numbers of G.P.s on the Island represent Jersey's "get out of jail" card in that you have the doctors there, which is a contrast to the picture we have in the U.K., but that the model needs to be moved away from quite the degree to which ... a fee for service model to one where it is more about ... I am trying to use a commercial metaphor because you have very commercial relationships in primary care, where you have an annual care contract with your G.P., which means that you create the incentives around preventative care, around regular monitoring, where actually in primary care you may end up with something of a shift in model so there is more input under the direction of the G.P. from physiotherapists, from the community pharmacy. A classic problem you find with older people, in which I might count myself, sadly, is where you end up with a problem which is known as polypharmacy, which is that you lose track of quite the number of medications that your patient is on because you pile one on top of the other and you need to then review should we be ... there are potential problems with patient X being on these 3 medications and we may need to look at moving from one to another. That is something which in well-run primary care ... so my local practice of which I am a patient in Hammersmith directly employs a pharmacist who is not there as the dispensing pharmacist but uses her skills to assess, to manage things like the repeat prescriptions reviews, but also regular reviews with patients whether or not, given the other medications they are on or how their healthcare is evolving, we should take you off medication X and maybe replace it with medication Y because of

the problems it has with medications A, B and C that you also take. So there is something about changing. Jersey needs to think strategically about how it changes its overall healthcare model. Alongside that, I think that then raises questions as to what is handled in primary care, how the relationships then work with the hospital. If I look at the vexed issue - I know that this is one which has been running for a lifetime - about the reprovision of the acute hospital, I am not sure and I am not suggesting for one moment that, given where you are, you should tear it all up and start it all over again, but if you were starting from scratch today you would say: "Do we need a hospital which has the number of beds we are putting in place?" because actually we should be doing more in terms of supporting the patients in the community, guided by primary care, not least because that is what ... certainly in my experience, patients want to be looked after in a community setting and hospitals are not, for a lot of conditions, the right places for patients to be.

Deputy L.K.F. Stephenson:

I wonder if we could go back to the board for a moment. Given your experience over many years on different boards, how do you see a board like this working effectively? What should its relationship be with the different parts of the health service and are we achieving that at the moment?

Mr. T. Hayhoe:

Well, I think one of the challenges with this, of course, is that the board itself as currently constituted is an advisory board rather than a classic corporate governance board. But with that caveat out of the way, my sense of the way in which you ought to be developing health and care services in Jersey is to look to have a board that has a responsibility for all parts of the health and social care system, and I would include the social care system as well as the hospital, but also oversight of primary care and pharmacy. There are 2 very different roles between running an executive board to running a small acute hospital, what the appropriate model is if you are trying to run just the mental health services, or for that matter have oversight of community care. One of the things that attracted me to this role was the fact it did at least, even if it did not have oversight of primary care and community pharmacy, bring mental health and acute services under one sort of virtual roof and also social care. Because a lot of the issues that we see in the U.K. around the challenges of discharging patients from hospital are to do with the social care provision that you provide for someone when they ... and again I am not suggesting that ... you have a fairly rich community of care homes on the Island, I understand, but there is someone that is at least able to pull together the various strands and facilitate when a patient, say an elderly patient who might, say, have had a stroke or some other condition which has meant that there is a step change in their care needs on discharge, that someone is able to pull that together. Similar issues can arise when you are discharging someone from a mental health setting. You will need to make sure there is appropriate social care as well as continuing mental health care for someone being discharged after an inpatient episode. So if I was given a free hand to design a healthcare governance system, it would be one that had a broader

remit than the current board and actively pulls things together. So we do it in the U.K., albeit that it is a case that there is not a consistent model to the introduction of integrated care boards, which is I think an appropriate move in terms of direction of travel. Now, we are talking for an integrated care board in the U.K. about populations in my patch that are 20 times the size of Jersey, but the ethos of trying to be able to have sight of the whole system and address the levers that mean that the incentives are appropriate and the relationships are appropriate is something that if you are looking to where you go in future in Jersey would be something I would encourage.

Deputy P.M. Bailhache:

Should the senior leadership team in the hospital have some measure of accountability, then, to what we call the advisory board?

[11:00]

Mr. T. Hayhoe:

Sorry, was that a ... that was a statement. Yes, they do have an accountability. My understanding was that ...

Deputy P.M. Bailhache:

No, it was a ...

Mr. T. Hayhoe:

... they were accountable to them, but one of the interesting things is it is in the name. It is explicitly described as an advisory board. Now, there is an executive structure which is in place. It is really not clear when something is given the title of advisory board whether it is there to advise, in which case who is it advising, and as opposed to being accountable for a budget, being accountable for the standards of service that are delivered. So in terms of the board structure, my feeling, and I tried to work within ... to some extent took the view that there was an accountability to the board and the board itself was accountable. But I think there is a severe confusion in what, if I understand it, was viewed as a kind of compromise outcome when it was designated rather than, as Hugo had suggested, being a board which is accountable for an organisation. Having spent a lifetime in governance in a whole wide variety of contexts and contributed to the evolution of governance models in the U.K., in the corporate sector as well as the private sector, it feels like a governance model ... no, I cannot find the right metaphor for it, but it is not a satisfactory model, the one that you have in place. It is clear that something needs to be in place. I think the recognition that there was merit from, in a sense, separating delivery, which is what it is there to do, what the board should be there to do, from policy, which is what politicians are there to address, was a missed opportunity or a mistake. One of the problems you have is that the board is due to be reviewed in March next year,

as I understand it, that there was an 18-month review point. I do not see how it will be possible to view this as having been ... the current exact models being appropriately delivered when it does not have a substantive chair, it does not have an appropriate quorum of non-executive directors. I have not followed things closely enough, but I am assuming that there still is not the financially qualified audit chair type person in place on the board, which had always been the intention. So I think there is a case of saying, look, actually, Jersey should consider reviewing whether it should go back a stage and say: "Actually, the advisory board motion was a mistake because it creates a huge confusion as to what the role was." It does then depend on ... if it is going to be an advisory board you need to expect it to provide advice, and again I do not think it is a matter of ... I am straying too far in terms of the employment issue, but there was a difference of view as to what the role of the chair of advisory board was between me and the Minister. I think that is something which needs to be clarified if you are going to put in place governance for healthcare, whether it is on the current boundaries or whether it is on the wider fully integrated model I described. Then I think that is something that you do need to give some very serious consideration to.

Deputy L.K.F. Stephenson:

In terms of the financially qualified board member, it is my understanding that there has still been a search on. Did you have any involvement in that? Why the struggle to find somebody to take up that role?

Mr. T. Hayhoe:

Well, it was described to me that initially there had been ... there is no shortage of people who are financially qualified and very capable people on the Island. It is something which I had heard somewhere or other that Jersey is actually quite good at. **[Laughter]** Chairing the tax advisory board, tax disciplinary board in the U.K., we are very conscious of the fact that lots of things go on financially in Jersey precisely ... it attracts very good people there. Now, one of the things that had been described to me is that when there was initially a search that no one on the Island - this is going back into last year - from the financial community viewed this as being something to which they ... it felt like H.C.S. was a sufficiently complex and difficult set of problems that they were not inclined to engage with it and say that I will put in my couple of days a month to try to do my bit for the Jersey community, deploying my financial knowledge and expertise. So when I arrived that was a post that remained vacant. My understanding, albeit I was not there for very long, was that there were people who were identified who felt that the changes which were in place and what little had been seen of me in your very extensive and very rich local media suggested actually this might be something which they would be willing to do but ... and I think one of the things which is desperately needed on that board is more people who are from the Island. I think it is a ... while I can think of good reasons for looking further afield for a chair and maybe one or 2 of the members of the board

from the Island, I find it extraordinary actually that it was not possible and I do not understand what the reasons were.

Deputy J. Renouf:

Tom, can I just interrupt just in terms of Lucy's question? You said that people did not come forward from the finance community. Were you given any indication as to why that was? What was it that they did not like about the job?

Mr. T. Hayhoe:

I think that they felt that ... the word used by one person who described it, they felt that H.C.S. was a basket case and that they did not feel it was going to ... they did not want to be tainted by being part of something which was a failing organisation. Now, I think there was a sense that the ... there was some very warm media coverage when I was first appointed and people felt that things were turning, there was a sense that maybe it might be different if they went out and tried again. Now, that is merely hearsay and I think there needs to be some sense that it is a really important job to be done, that there is a major positive contribution to be made. One of the things that I do wonder about, we had not got that far with the process of initiating a fresh recruitment round for the finance person while I was there, but my understanding is that Hugo as the interim chair was not involved in any way whatsoever and was actually explicitly excluded from the recruitment of the non-executives for the board. I think there is something about ... I certainly would not expect to find that when recruiting for any board that I have been chair of in the past, in that while the decision might still formally in terms of good public sector governance be handled by the Jersey Appointments Board, you would expect the chair to be involved in the recruitment process and probably be in a position to veto a candidate if they felt they were inappropriate, even if the ultimate decision was with, in your case, the Jersey Appointments Board.

Deputy J. Renouf:

If we move just to one other area, did you form any views about the relationship that H.C.S. might have with U.K. centres in terms of how the care might be provided, how much should be done on Island, how much might be done off Island? Did you take a view on that or was that not something that you had time to dive into?

Mr. T. Hayhoe:

It is certainly something I gave quite a lot of thought to because, albeit that I was not there very long, I was quite keen to use some of my network and relationships to open things up a bit. My sense is that Jersey has to take some really difficult decisions about what things are done on Island, what things are done off Island, and ensure that there is some real integration between services which are delivered on the Island and where there may be a need to escalate. I think there are also issues

if we look at things like clinical governance and the oversight of services, where there should be ... and the U.K. is the obvious one because of the issues of language and similarity, but if it was possible to do it with France as being the very near neighbour I could not see a good reason for not doing that either. I would expect if ... in an ideal world, I would like to see the clinical leaders on the Island, and here I am talking specifically about consultants, regularly spending a month on exchange with a clinician in another U.K. hospital probably, partly because it would help to keep them abreast of good practice. If part of it was that there was a backfill and there was an exchange, that, say, someone from Southampton came to do a month on the Island while a consultant from the Island was doing a spell in Southampton, it would be that the teams they were working with would also benefit from that sharing of experience. I think there are some very big issues and, without needing to go into how the problems with rheumatology blew up, that really good peer review, exposure to good practice, both bringing people on to the Island as well as people getting off the Island to do it, are the sorts of things that you need to do if you want to develop a service which, for a nation which on some welfare measures I think comes second only to Zurich in terms of places which should be desirable to live with high levels of income and good quality service, you do not have it in healthcare but you really ought to be in a position to do it. It would involve having some partnering arrangements with areas where really top notch healthcare is being delivered.

Deputy P.M. Bailhache:

Do you have a view on whether that is better done in terms of a single institution or whether it is capable of being equally well done by consultants having their own, as it were, ad hoc relationships with different hospitals in Oxford, Cambridge, London or wherever?

Mr. T. Hayhoe:

I would probably, given the scale of things, suggest it would be best done with a relationship with probably one but it might be in terms of ... no, actually, somewhere of the scale of somewhere like Southampton University or for that matter it might be one of the big London trusts. I think the issues about ... there are all sorts of challenging issues if you were the partner organisation because I am thinking about Imperial College Healthcare Trust looking after a patch or at least the kind of big beast on the local patch that I have, where just by way of illustration when I was at West Middlesex chairing the West Middlesex Hospital, we had quite a number of consultants who would have a joint contract between ourselves and Imperial and, in terms of professional networks, they have those things.

[11:15]

I suspect that the only sensible way of doing it would be to partner with a well-run large university institution in the U.K. where people would get exposure to the sorts of things that my erstwhile colleagues at West Middlesex would have had with their colleagues at Imperial. It also would mean

in terms of things like medical appraisal that you would be able to get input just to say: “This Mr. So and So or Dr. So and So, how were they doing when they were working with us?”, you know, input from a peer group or for that matter from senior members of other clinical professions, as well as simply getting feedback from their presence on the Island. It is a really big ... Jersey is in a very interesting position in that it is big enough to have what everyone would recognise as a proper hospital with a reasonably full range of services for all but the more complex of activities, but not really big enough to be able to get the benefits that you would have if you were an Island with a population 10 times the size.

Deputy J. Renouf:

In terms of the balance between private and public healthcare, Jersey has high levels of private health insurance, although it is not used as much as it could be potentially. Did you form any views about that balance between private and public healthcare and how it might develop going forward?

Mr. T. Hayhoe:

Well, I came to the Island with a pretty agnostic view about how you manage between private and public models. One of the challenges is that inevitably the public model ends up dealing with the problems of the acute emergency and for the elderly and for people on lower incomes. Having spent my early years studying healthcare in the States, one of the things which Americans are always a bit embarrassed about when you point it out is that actually there is more public money in absolute dollar terms spent per head by public agencies, veterans’ administration, Medicare, Medicaid, and so on, because of the enormous inefficiencies which are built into the U.S. (United States) private healthcare model, which ends up being picked up largely by employers, where decent health insurance is, in a sense, a condition of employment. In Jersey’s case, I think that you ... with an affluent population, many of whom can afford to make the choices about the things that you might not choose to provide in terms of the public care, I would expect to see a higher degree of ... even if you had a U.K. model in Jersey, you would have a bigger private sector component there. However, if I was living on the Island with the means or the insurance policy for anything with any acute health need ... routine like a hip placement is one thing, but anything more complex I am afraid I would go off the Island. There is a question about ... there is a bit of a belief in the Island that we have world-class medicine. I am afraid if I look at the ... compare at least the paper qualifications and records of clinicians in Jersey to the sorts of people that I was seeing on the Advisory Committee for Clinical Excellence Awards, there is no one I can think of who would be in the class of care that would be getting those sort of merit awards that the N.H.S. dishes out to the best and the brightest. That is not a criticism of anyone working on the Island. It is just that if you are not around that leading edge care, you are not going to be seeing and developing and being able to provide those guarantees of the quality that you might get, say, if you were, I do not know ... if I was thinking of hip revision because my first hip operation needed redoing for some reason or other, I would go to the

Royal National Orthopaedic Hospital at Stanmore. I would not go to my local D.G.H. (district general hospital). That is what people do if they have private healthcare.

Deputy L.K.F. Stephenson:

Without needing to go to the extreme of the example of like rheumatology reviews, how do you start to raise those standards?

Mr. T. Hayhoe:

Well, I think one of the thoughts is the approach that I suggested around partnering with a major academic hospital group. I mentioned Southampton because there are planes that fly into Southampton International regularly, but equally well it could be somewhere close to Heathrow, just in terms of the convenience. Because I think that things like that sort of exchange that someone does one month a year in the partner hospital, and likewise you have people taking responsibility the other way and coming into the Island to provide care and that benchmarking ... I believe, actually, talking to one of the regional directors in the N.H.S., that there had been openings of or discussions, exploratory discussions, of that sort coming outbound from here on occasions in the past, but they did not come to anything. I just do not know enough about the detail to know how much substance there was, but I think there would be ... I suspect an approach with ... there would be a prospect, I think, of someone being able to reach some arrangement of that sort. But it would also depend on the consultants themselves in Jersey being willing to engage with that process, and my impression was that while certainly there would be some who might well commit, there would be others who would find it ... would be resistant to change on that scale.

Deputy L.K.F. Stephenson:

Is adopting N.I.C.E. (National Institute for Health and Care Excellence) guidance across the board all part of that as well?

Mr. T. Hayhoe:

Absolutely. I cannot think of good reasons for not adopting N.I.C.E. guidance. Occasionally, N.I.C.E. guidance might be a year behind real leading edge practice, so that if a justify or a comply or justify ... so if it was because someone said: “Look, I am not following N.I.C.E. guidance here because I am reading these 2 really good papers which have just come out of Johns Hopkins or the Mayo Clinic and I know that there are people doing reviews of it”, but again that is a question about having decent medical ethics surrounding that. But I would have said that for a small hospital that ... I remember vividly, actually, where we took exactly that line when I was at West Middlesex Hospital around our orthopaedic surgeons who were not following N.I.C.E. guidance in relation to use of a particular preparation for the skin before going through an operation and took a view that they knew better. As it turned out, we were getting slightly higher infection rates, which, while not

directly attributable to that, they were certainly unable to say: “We want to use preparation X rather than preparation Y”. But we had a chief exec who had started her life as a scrub nurse and so was able to see down any orthopaedic surgeon. But that was an example where we took exactly that view. It is one thing being with an academically strong research team in a big university hospital or having something really exceptional. So Broadmoor, where I was, which is part of West London N.H.S. Trust, where, as you would understand, we had some really exceptional cases in terms of the nature of some people’s mental illness, we would be doing things which are an exception to the British National Formulary in terms of medication. But in each case there was very strong medical ethics around it in terms of the justification for why the medications in those cases were different. In terms of the patient group they were talking about, these were 2 of the 600 - because there were 3 similar high-secure hospitals - most damaged and most dangerous men in the mental health system. But that is not where Jersey is.

Deputy J. Renouf:
Thankfully.

Mr. T. Hayhoe:
I would have thought that it would be ... I cannot conceive of a good reason why you would not insist on N.I.C.E. guidance, and a departure from it would represent I think very serious questions about the safety of somebody’s practice.

Deputy J. Renouf:
We only have a couple of minutes left. I wanted to ask you about funding because it is a hot topic in the Island at the moment. The health system is running at 10 per cent, is basically wanting 10 per cent more on its budget. I just wondered whether you felt the system was well funded or whether there was a problem with efficiency. Where did that balance lie? Does it need more money or does it need to get its act together in terms of efficiency?

Mr. T. Hayhoe:
I think there is a question about what you do for H.C.S. to get its act together. So if additional funds were made available, I think they would need to be put in place against a very clear programme of change. But in terms of absolute benchmarking, it feels a relatively well-funded system but there are some elements of it which are ... it is a bit like that problem I described about overuse of A. and E. rather than primary care, where the structures you have in place undermine the obvious benchmarking against the U.K. system. You then have the issue of the big capital project because you do have a hospital which is ... I would not say falling down, let us not be unfair, but it is long past its best-by date.

Deputy J. Renouf:

Good. Any other questions? Is there anything else that you feel you have not had a chance to talk about?

Mr. T. Hayhoe:

No, I think you have probably covered an awful lot of ground there. I really wish H.C.S. and its people well. I think there is ... I did have a real sense of a challenge in terms of morale in the organisation and it would be nice for it to feel that it was on a path towards success as opposed to caught up in a bit of a political quagmire, which is I think where ... is the sense I have. It is not helpful when it feels like it is a bit of a political football. You have a challenge on your hands and I think some of the issues are some quite big structural things as well as how you get from A to B over the next few months.

Deputy J. Renouf:

Well, thank you very much indeed. I think we can stop there. We very much appreciate you taking the time to talk to us and thank you again. We look forward to seeing how we can get on with this, really.

Mr. T. Hayhoe:

I will certainly watch with interest from afar.

Deputy J. Renouf:

Thank you very much indeed.

Mr. T. Hayhoe:

Thank you.

[11:29]