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Health and Social Security Scrutiny Panel

Health Service: Lessons Learnt

Witness: Former Interim Chair, Health and Community Services Board

Wednesday, 10th July 2024

Panel:
Deputy J. Renouf of St. Brelade (Vice-Chair)
Deputy P.M. Bailhache of St. Clement
Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter

Witness:
Professor H. Mascie-Taylor, Former Interim Chair, Health and Community Services Board

[11:45]

Deputy J. Renouf of St. Brelade (Vice-Chair):
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 are all appearing remotely and we have up to an hour for each session. I am Deputy Jonathan Renouf. I am the Vice-Chair of the panel but 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, all of us in the room need to remember to switch off our mobile devices. Third, I also want to make clear that the aim of the hearings 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. I will start this time with Lucy.

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

Deputy Lucy Stephenson.

Deputy P.M. Bailhache of St. Clement:

Deputy Philip Bailhache.

Former Interim Chair, Health and Community Services Board:

Hello Philip, good to see you again. I think I owe you lunch.

Deputy J. Renouf:

Our final contributor is Professor Hugo Mascie-Taylor, who was commissioned by the then Minister for Health to write a report on clinical governance in the Health and Community Services Department and he was subsequently appointed as the Interim Chair of the H.C.S. (Health and Community Services) Board, which he left earlier this year. I wonder if you could just - I have done this with all the people we have been speaking to - give us a little bit of a flavour of your background and your experience, particularly the bits that relate to the job you did in Jersey.

Former Interim Chair, Health and Community Services Board:

Yes, I will try to do that. I was trained and became a consultant physician in Leeds and then I was medical director in Leeds for a decade. After that I did a variety of jobs. I was medical director of the NHS Confederation; trust special administrator in Mid Staffordshire, which was quite a tricky job; I worked with EY for a while. Relevant I think to Jersey is probably most relevantly my international experience in this area. I have done quite extensive clinical governance reviews in Western Australia and the Middle East and looked at the organisation of healthcare in a number of countries around the world. That is an important point now because I am anxious that I am not seen as coming here in some way to push the N.H.S. (National Health Service), foist the N.H.S. on to Jersey, which is probably the last thing I would wish to do, but to try to bring my experience from around the globe to bear on Jersey. It does have, I think, unique challenges because of the geography but also unique opportunities.

Deputy J. Renouf:

Just in terms of the report you wrote, which was your first engagement with Jersey, what were the outliers for you? Relating to your experience in multiple other jurisdictions, what were the things that spiked as different in Jersey, good or bad for that matter?

Former Interim Chair, Health and Community Services Board:

Good is it is a delightful place to be, and of course we lived there pretty much for a year and thoroughly enjoyed it. I was largely treated with friendship. Even though my role was clearly contentious, people by and large got over the fact that the role might be contentious but treated me very well. In terms of what was striking about it, I suppose the most striking thing was the rugged individualism, the very assertive individualism that I encountered, particularly among my own profession but to some extent elsewhere, and the deep belief, it seemed, that what might be regarded around the world as total drivers of safety were less admired and less embraced by some in Jersey. That was very striking and, frankly, occasionally alarming. I can give you detail of the sort of things that were said if you wish, but it was that sense that was very, very clearly repeated to me that we in Jersey do not need to do those things that everywhere else I had worked thinks they do need to do. That was an abiding impression and saddened me because Jersey, because of its small size, in some ways needs to embrace those things more than large centres, but they were very firmly rejected by some and, in fairness, very clearly embraced by others. This was not everybody at all but there was a significant cohort who felt that the independence of Jersey, which is clearly important and desirable, should somehow mean that it did not have to embrace those things that have been accepted increasingly around the world since, I suppose, the 1980s.

Deputy J. Renouf:

What are the implications of that in your mind? Were they potential implications or were they real implications?

Former Interim Chair, Health and Community Services Board:

What an interesting question. Because of the way I went about doing the report, which was essentially to interview people, and because of the relative lack of organised outcome data, it was very difficult to be clear that the organisation was unsafe or, to put it the other round, impossible to give an assurance that it was safe. What I did see, though, were not only the cultural aspects that I have just alluded to but also it had many of the features of organisations which we know make it more difficult to be safe: a lot of people in lone consultant practice, in effect lone practitioners; a lack of multidisciplinary team working; again not everybody but some welcoming the isolation of their practice; a lack of job planning; a lack of clear lines of accountability; a lack of openness and transparency about what the organisation and individuals in it were achieving; relatively weak appraisal systems; in some a fierce rejection of guidelines. All of those things that one knows expose an organisation or a system to risk were there in number. That did not mean that it was definitely unsafe but it did mean that, as I say, I could not assure anyone that it was safe and I was deeply concerned it might not be. I suppose that was then evident as I moved into the next role where a number of specifics began to emerge and I imagine are still emerging - I am not familiar with the detail now - that demonstrated a clear lack of safety.

Deputy J. Renouf:

Did you notice any improvement? You produced a report in the summer of 2022, if I recall correctly, and you left earlier this year. Was there any sense of improvement? How well received was your message?

Former Interim Chair, Health and Community Services Board:

It was, I think, very well received by some and most people, perhaps understandably, when they talked to me about my report said: "Yes, it is absolutely accurate and you have captured the state of the nation", as it were. Some clearly did not like the report and rejected what I had said. In terms of what happened after that, then of course 2 things happened. I was asked to set up a board, which proved to be much more difficult than I had expected but nevertheless we did finish up with a board that met in public and that was, I thought, a significant step forward. The change team, who were individually and collectively very able, began to produce some change in the organisation. We had further reviews of services that said what needed to be done. We made a bit of progress on job planning, perhaps a bit of progress on appraisal, but they are hard yards because there is a very strong resistance among some - as I say, not by any means all - to any sort of change. We embraced at the board the use of clinical guidelines. We chose N.I.C.E. (National Institute for Health and Care Excellence) guidelines, but it does not really matter which ones you choose, and also the College Guidelines. So at organisational level - and that was supported politically, as I understand it - and political level, yes, that modern practice was embraced, years after it had been everywhere else, but I was not convinced by the time I left that there was an acceptance of it among all. In fact, I am quite sure there was a fierce rejection of the use of guidelines by some. I remember going to Guernsey, a diplomatic visit to Guernsey, and there was a discussion there about the use of guidelines where it was asserted that, yes, guidelines might be a good idea but we needed our own guidelines for Jersey, Guernsey and the Isle of Man because otherwise "it would not be fair". I could not help but think, well, fair upon whom? Who are these people that we have to be fair with, because it seemed to me guidelines are set up to be fair for the patients? So there was that sense, not just in Jersey but clearly also in Guernsey at the time, that somehow guidelines, we should develop our own. It is inconceivable that somewhere the size of Jersey or Guernsey could do that; it takes huge resource. Somehow then patients should almost expect a different standard of care, an idea that I rejected and I hope you will reject. I think that Jersey should aspire to the highest standards of care not mediocrity.

Deputy J. Renouf:

The future organisation of the health service is something that has been addressed by several of the people we have spoken to, the other 2 people we have spoken to today. There has been talk about the possibility of relationships with other centres, whether N.H.S. centres or private centres. Do you have a view about whether that would improve safety and the standard of care in Jersey?

Former Interim Chair, Health and Community Services Board:

Yes, I do. The great majority of patients in Jersey should be and could be treated safely in Jersey, so I think that is the first point. While we may not want to discuss it today, it is a view, I think, that a great deal could be done to improve the quality of primary care and the clinical pathways between primary and secondary care. If you were to do that, plus some more work on prevention, then the healthcare would be substantial. I think that the bit that you are talking about is, if you like, the link between secondary care in Jersey and tertiary-type care somewhere else. I think there are 2 types of benefit to that. The first is about specific patients. I was very struck by the fact that quite a lot of people in Jersey who can afford to leave for their care do so and do it privately but those, I suppose, who cannot afford it cannot or do not. The first benefit of having a clear relationship with another centre would be that specific patients with more esoteric or rarer illness would go to centres that see a lot of it. Medicine is no different to any other walk of life. If you do not deal with that which you are dealing with all the time, you are likely not to be very good at it. A lot of it is a skill and a lot of it is by pattern recognition. Those people in Jersey, which would be relatively few numerically, who have the more esoteric problems I think need to be managed, as they would be elsewhere in the world, in a larger centre. We could come, if you wanted, to what that centre might be.

[12:00]

The second benefit, though, that is certainly as important is if one could find a way of working very closely with these centres so that individual clinicians were part of their audit processes, so a combined audit process for Jersey and somewhere, combined multidisciplinary teams, so that patients would be discussed with a group of clinicians not just the bidding of a single individual, their education, maybe even exchanges. I think the benefits of linking with a specific tertiary-type centre are potentially enormous in those 2 regards. Equally, I think if it is going to carry on with the current lack of engagement with a major centre, which I have not seen anywhere else in the world that I can think of, in isolation, if it is going to carry on like that then I think the risks are substantial. I have no doubt from my conversations that again there is this interesting split between some clinicians who would really welcome such an engagement and some who really do not want it at all. Inasmuch as I can advise, I would say to you that you, if you like the politicians, should push that very hard, that there has got to be a link between Jersey and a major centre, and we could debate the nature of that major centre if you wish. All of these things. I mentioned, I think, the opportunity for Jersey. The opportunity is the system. Healthcare is like every other industry: quality and safety through systemisation, standardisation, following standard operating procedures. It does not matter whether it is the airline industry or whatever, it is all the same. That needs to happen within Jersey between social care, primary care and secondary care and outside Jersey between secondary care and tertiary care. Those relationships should be nurtured and formalised.

Deputy L.K.F. Stephenson:

Can I ask you, when you talk about the divide between those who are really up for that approach and those who are not, are there any patterns to where that division lies? Is it certain aspects of care; is it an age-generational thing? Are there any patterns there?

Former Interim Chair, Health and Community Services Board:

There is a huge danger of me getting this completely wrong and being unfair but I think there is a ... I was struck when I did the report and afterwards about talking with people, chatting, if you like, about why they had come to Jersey, the most prominent theme was to avoid bureaucracy. It was a love of personal autonomy. It was that rugged individualism: "I do not need anybody to tell me what to do and I know what is best for me and my patients." That did not just apply to doctors but most prominently it was some of the consultants who were split. I will not say who but I remember meeting a consultant who said: "One of the downsides of being in Jersey is I can no longer do some of the procedures that I used to do and enjoy doing because I simply do not do enough of them to be safe." That would be, if you like, one extreme. The other would be someone who said: "You have got to remember Jersey is rather like a tertiary centre and we do things here that only tertiary centres would do elsewhere", which filled me with foreboding because he could not do enough of them to remain competent. Does that answer your question? I think if one were looking at who would you look for, you would pick out the lovers of autonomy, lack of accountability, lack of transparency across the board and people who least liked ... who undoubtedly resist change. That is where your leadership, I think, is absolutely crucial.

Deputy J. Renouf:

Okay, so you are slightly throwing it to us there. My next question was going to be: how typically do you deal with those issues when you find them?

Former Interim Chair, Health and Community Services Board:

With difficulty. I am not pretending this is an easy task anywhere that I have ever been, but really by pretty assertive management, by which I do not simply mean the formal management of H.C.S.; because of the nature of Jersey in many ways the management of the organisation sits with the Minister and the States. Things are elevated more rapidly to politicians than anywhere else that I have seen and politicians - again I am generalising - are very happy to comment and to be involved in the detail in a way I have not experienced elsewhere. Frankly, I think that is understandable because it is a relatively small place and everyone tends to know each other, but I think it has got to be an assertion from the top, by which I mean the Chief Minister and the Ministers and the States, that Jersey will follow the path that improvement science tells you will improve patient care, not the N.H.S. but improvement science worldwide would give Jersey all the guidance that it needed. That has got to be ... and it will be opposed because people will see it as a threat to their autonomy. That

is why I think it would need consistent and persistent leadership over a period of time and a willingness to engage in a certain amount of structural change across the board, as I said, from primary care to tertiary care. Then I think the opportunity is hugely exciting. I think Jersey, again because of its geography, has an opportunity to do things in healthcare that will elude other countries. I think it could swing from being, frankly, not anything like as good as it could be to something really exciting.

Deputy J. Renouf:

What are those opportunities? Tell us about where you think the switch could come, if you like. What are the things that we could be good at?

Former Interim Chair, Health and Community Services Board:

Well, the ones that I am most familiar with, of course, are in the secondary-tertiary care domain and I have talked about those to some extent. First of all it is the cultural change, a recognition that if one is in a small centre, or even in a large centre, there is a necessity to follow best practice guidelines. It is not an option and that is a cultural change that is required and is then supported by a managerial process. That is to say: "You do not have any choice about this. This is the way we do things round here." That is the first thing. As I say, there is, I think, a clear need to link secondary and tertiary care in a formalised way and to develop that as strongly a possible, not just about moving individual patients but about a systemic approach to quality across those organisations. The area where I spent much less time and am probably less well informed would be I do think there is an opportunity in primary care in Jersey, which in some ways is constructed rather differently to elsewhere, to systematise that. I think one of the sad things is the lack of agreed clinical pathways again between primary and secondary care. It is arbitrary, based entirely on the whim of the individual as opposed to systematising it and saying: "This is the way we will manage this entity in this place." Those are the themes and I could go on for ever about them if you want. I suspect you do not.

Deputy J. Renouf:

Another thing that is talked about a lot is the role of private healthcare in Jersey and insurance and so on. It may be outside what you considered your orbit but did you form views about the role that private healthcare should play in Jersey? Should it be expanded, should it be changed, should it be less? Do you have any thoughts on that area?

Former Interim Chair, Health and Community Services Board:

Interesting. The way in which healthcare is funded around the world of course varies enormously and I always think one of the reasons it varies enormously is that people cannot come to the conclusion as to which is the best way of funding it. There is an issue here about how it is funded:

is it funded through the public purse or through private or whatever? I think it is unlikely that Jersey will move away from that mixed model and I do not think I would attempt to change that. I think it would be just too hard and arguably too expensive for the state. I would be nervous about trying to argue that particular case when I think there are other more important things to be done, so I would not get into that debate. Having said that, there has to be clear openness, transparency, accountability and probity. One of the things that was done was to separate public and private patients on operating lists and that does not mean that the situation was being abused but it did undoubtedly, in my experience, lead to a perception among some of the staff at H.C.S. that it was abused. So I would try to separate how you fund healthcare from the fact that it must be safe and good for all and conducted with due probity and that must be apparent to all concerned. I am trying to separate the 2, if you like. Then a final point is that one could be much more adventurous and say could Jersey arrange the delivery of its healthcare, not the funding of its healthcare, rather like the Mayo Clinic, which I think is a superb model. For what it is worth, I think the N.H.S. could well learn from the Mayo where, to some extent, the organisation rather than individuals provide both public and private care and their staff provide both. That, if you like, extracts funding from those that can afford to pay and, therefore, might help a little in what is an increasingly expensive business, but you have probity and clarity about who does what and to whom and when. I think the Mayo model has quite a lot to be said for it. There are other benefits to the Mayo model that I will not go into now unless you wish me to, but that might be a step too far too fast, you see. I am trying to think what is doable.

Deputy J. Renouf:

Yes, it probably is, but just for clarity I am not quite sure that I understand exactly what you mean by the Mayo model. Are you saying that essentially H.C.S. would contract the Mayo Clinic to provide all its services, for example?

Former Interim Chair, Health and Community Services Board:

No, sorry. I think there are 2 separate issues here. The first is with whom should H.C.S. and Jersey link as a tertiary centre. I was using the term the Mayo model to describe a model in which the organisation rather than the individual clinician accepted both private patients and public patients and the organisation had a responsibility to make sure they were managed by its staff as opposed to the mixed model, which can lead to all sorts of misunderstandings and difficulties.

Deputy P.M. Bailhache:

Do we not have that at the moment in Jersey? You have a private patient will come into the hospital and will contract with the hospital for the room that he occupies or the particular service that he obtains, so is that not the Mayo model?

Former Interim Chair, Health and Community Services Board:

That is absolutely correct. I think there is a bit just to mention that the organisation needs to be very clear that it is doing that in a financially sensible way. That is an aside. The Mayo model goes beyond that in that the organisation does not just provide the accommodation and the technology and all the staff except the doctors but in the Mayo model it employs all the staff and so the organisation as a whole is committed to providing both private and public care. My fear is that might just be a bridge too far and it is not necessarily where I would start because there are other things that I think are more urgent and can be achieved more easily. While I might have that in mind as a long-term objective, I would start with the more straightforward and more pressing things.

Deputy J. Renouf:

What about the question of funding in the sense ... since you left, the argument has been advanced and is being advanced that the health service needs another £24 million a year. Obviously last year it got extra money as well.

[12:15]

The question that I think people are interested in is knowing the extent to which the funding gap is a result of extra demand and genuine, legitimate demands on it and to what extent it might be that there is inefficiency within the system that needs to be addressed. Did you have thoughts on that efficiency versus demand sort of question?

Former Interim Chair, Health and Community Services Board:

Yes, although I must be careful not to go beyond that which I know to be true. I think Jersey is relatively expensive for the care that it delivers, but then you might expect that. It is small and there will be some diseconomies resulting from its small scale. I guess the area that I am more interested in is how do you provide the best possible safe care for the least possible cost. I think there is a great deal that could be done in Jersey to improve that across not just secondary care but primary and secondary care. It takes you back to chronic disease management, monitoring, prevention and chronic disease. There is an awful lot you can do in that area, but the detail of how you find the money to pay for it is clearly a fraught problem because there is no agreement across the world, as I say. I do not think I am particularly expert at that. What I would say is it is important not to muddle the 2, so whichever way you look at it with an ageing population and increasing medical technology, the cost of healthcare is going to continue to go up. How Jersey funds that, I just do not think I am well sighted on or sufficiently expert to comment in this arena. The second question, which is having agreed or decided how you are going to fund it, how you get the best out of the system, I think that is where I do understand that rather better.

Deputy J. Renouf:

In your time there, did you feel that there were major efficiencies that could squeeze more money to be spent on healthcare without having to increase budgets?

Former Interim Chair, Health and Community Services Board:

Almost certainly. The difficulty of being absolutely certain is the lack of transparency about what people do and when, so it is rather difficult to be sure because quite a lot of it is opaque in a way that you probably do not see in any other industry in Jersey. My suspicion is there is quite a lot that could be done. I have already said there is how people spend their time. I suspect there are some important skill mix questions to be addressed, not just in secondary care but in primary care. I think that prescribing is outside guidelines and, therefore, not tight. I think we all know that lack of safety costs a lot of money, as well as being unacceptable for other reasons, so that the moment you get complications you did not need to get, you are wasting a shedload of money. So, could you improve at all? Yes, you undoubtedly could across a range of different areas get a bigger bang for your buck, to put it ...

Deputy J. Renouf:

Yes. That all comes back to your points about transparency and organisation and rigour and so on. If you were to say what are the top 3 things or 4 things or whatever that you would do to drive the change we need in the organisation - and that could be across safety, it could be across efficiency - where would you concentrate your efforts?

Former Interim Chair, Health and Community Services Board:

I think I would try to get a shared vision among the leadership in Jersey and the leadership in the organisation about the direction of travel and I would be as assertive as I could be about stopping individuals having the right of veto. I never worked anywhere where the feedback loop between senior members of staff and senior politicians was so rapid and where some senior politicians were very prepared to intervene, if you like, on behalf of their friend or colleague. I suppose what I would try to do is to elevate the debate and say: "We in Jersey, without fear or favour, whatever our relationships and our friendships, will do that which is driven by what is well demonstrated in the area of improving science." I think having that, if you like, elevating the debate above personalities, would be the single most important thing in Jersey because so much, I found, was discussed about individuals as opposed to about systems, about who liked who, who got on with who. Some of that is inevitable. It is part of a democratic system, but I would try to move the debate a bit away from individual thoughts and discussion to how collectively can we design a system on Jersey that is above all that. That will undoubtedly run into all sorts of vested interest and that is why it would need to be an assertive approach, so strong leadership from the top I guess is the answer to the question.

Deputy L.K.F. Stephenson:

Just to go back to the finances briefly, do you see it as ... was it a concern to you and does it remain a concern that we do not have a member of the board in that role with a specialism in finance?

Former Interim Chair, Health and Community Services Board:

Both. I think that the board is a unitary board and therefore everyone has a fiduciary responsibility, so it is a shared responsibility. If I were to look at the board I think, as I saw it, it probably needs a greater non-executive presence from someone who understands the absolute detail of the way hospitals are run and it needs a strong financial presence, which somebody like Obi, who I guess you will know and who I think is quite outstanding, delivers. It will then require political will to both, I suspect, find new money but at the same time demand the sort of efficiency and effectiveness I have been talking about. It is not either, it is both. I really cannot sit here and say I can suggest a way in which you will spend less on healthcare but I do think I can sit here and say you would get a lot more for your money if you did some of the things that I am suggesting, and not just that I am suggesting but that every report I have seen has suggested. If you read back over all the reports, they all say pretty much the same thing. The challenge is not getting reports or even reading reports. It is enacting what is said in them and the reluctance to do that I think is a major difficulty for Jersey.

Deputy L.K.F. Stephenson:

With regards to finding a non-executive director with that financial experience, what are the barriers to finding those people? I understand there have been challenges along the way.

Former Interim Chair, Health and Community Services Board:

I am laughing because when I was asked to set up the board, as you probably all know, I thought my role was to try to find suitable candidates, and indeed I think I did that. Some of them were not shortlisted but nevertheless I thought I had found some people with some of the skills that I am talking about. What was interesting is that naively I thought the one group that we will have in abundance on Jersey would be very skilled, enabled people in the finance sector. When I set out recruiting non-execs, I thought the easiest one would be finance but it proved not to be the case because people in that industry - I am trying to find the right form of words - clearly did not wish to engage with what they saw as the difficult politics of Jersey in this domain. I will not name them but I talked to a number of leading lights in finance about the possibility that they might apply for the role I was seeing as potentially chairman of the audit committee. There was, among the people I talked to, a reluctance to be involved in what they saw as a very difficult political football.

Deputy J. Renouf:

Speaking more about the board, what do you think needs to happen with the board now?

Former Interim Chair, Health and Community Services Board:

I am not now familiar with the detail of it, as you know, so I have a bit of difficulty, but the board needs to have on it ... I think the people on it are, in my experience, very able and very committed and that is good. I think it needs specific experience, as I have just said, in terms of finance and probably a detailed knowledge of how hospitals run. It needs an effective chair in that the role of the chair is crucial and, as I understand it, there is not a chair. I may be wrong about that and if I am I apologise.

Deputy J. Renouf:

There is no substantive chair.

Former Interim Chair, Health and Community Services Board:

I think that is unfortunate. I think that the organisation does need that sort of leadership and indeed the non-execs need that sort of leadership. I can understand why it may be that given that the role of the board or the presence is going to be debated later in the year, I suppose there is a pragmatic approach that says we could not get anyone to be a chair for that short a period. I do not think I would agree with that. I would make every effort to get a substantive chair to signal intent unless the intent is, of course, to do away with the board, in which case there is no point in signalling that intent, is there? I think you will be sad if the board goes but that is not within my gift.

Deputy J. Renouf:

Your report recommended setting up a board, so you believe that a board is an important part of the change that is needed. Perhaps you should explain why that is the case.

Former Interim Chair, Health and Community Services Board:

Yes. Well, part of it is the case because that is what happens everywhere that I know and it happens not just in healthcare but it happens across many, many different industries. It has always seemed to me the key to it is the non-executive presence, which commands openness and transparency and is empowered to ask the right questions of executives and hold them to account. You will recall there was a board in Jersey in the past but it did not function, in my observation, as a proper board. It was more like a partnership group and I do think that any organisation in any walk of life, not just healthcare, is well served by having a group of people who are fearless and knowledgeable and ask the right questions. At the risk of being too blunt, that is a role that politicians, by and large, cannot fill because it is not their background. Politicians have a different role, a crucial role. The Minister should be setting policy, absolutely vital: what is the strategy for healthcare in Jersey? I think that is an absolutely crucial piece of work to be done because everything else would then have to fit into that framework. At the highest level, it seems me what is required is a clear strategic direction for

healthcare in Jersey. I have views on that and I will happily share them. I have shared them a bit but it is not my job to do that. That is what the politicians must do, the policymakers, and then the non-execs must deliver that and the chair should be very clearly accountable to the Minister. I just think that will give it the clarity and the openness and the certainty that it lacks.

Deputy P.M. Bailhache:
The uncertainty at the moment, it seems to me, lies in part in its title. It is called an advisory board and the question is whether it is an advisory board or whether it is an executive board of some kind and who accounts to whom. As you have rightly said, the chair should account to the Minister for political guidance and strategic direction, that kind of thing, but should the senior leadership team of the hospital not be accountable in some way to the board?

[12:30]

Former Interim Chair, Health and Community Services Board:
Absolutely it should. I would see the line of accountability as being, if you like, employee ultimately through to the chief officer or chief executive or director general, whatever you want to call them, and the director general, chief officer should be accountable to the chair and the non-execs, and the chair should quite explicitly be accountable to the Minister, the Minister to the States and the States to the people. When I became medical director in Leeds many years ago, quite a lot of my colleagues, and indeed some friends, rang me and said: "Now that you are our representative on the board, we would just like to bend your ear about this or that." I said: "Let us stop at that point because I am not your representative. I genuinely wish to work with you and I genuinely wish to hear what you have to say but my accountability is not to you. I am not elected. This is a democracy. I have been appointed and so I have been appointed by a board and my accountability is upwards to the board and through the board and through the chair to the Minister and everyone in that hierarchy has to fulfil their roles." Does that answer the lawyer's question?

Deputy P.M. Bailhache:
Thank you. That is very helpful.

Deputy J. Renouf:
One of the other things that is talked a lot about is management and the numbers of managers and the quality of management in the system. I think it is slightly amorphous in my mind what people are talking about when they say managers or management, but I wonder if you have views about are we over-managed in our system or under-managed or is it a quality issue or a combination? Where did you see that?

Former Interim Chair, Health and Community Services Board:
It is unquestionably under-managed. I am differentiating there between management and the number of managers, yes?

Deputy J. Renouf:
Yes.

Former Interim Chair, Health and Community Services Board:
When I did the report, the most senior manager was a director general and the next was a chief operating officer and beneath that 4 chairs of divisions, all of whom were doctors. Among the 6 most senior managers in the organisation, 4 were doctors. It was as clinically-led an organisation as I have ever seen, but when I talked to those 4 doctors they did not seem to grasp that they had a managerial role. That may not have been their problem, they had not been trained or whatever. I think what we have been talking about or what I have been talking about is a lack of what I would regard as management. So it is a lack of leadership and a lack of management. Leadership can be right from the top and the detail of management is within the organisation. I think there is every room there for a clinical involvement in that management but then the clinicians have to understand their managers. They are not there to defend the status quo or defend their colleagues. I do think the quality of management could probably be improved. There is a genuine difficulty in importing people to Jersey and one model - I am not advocating this but one could at least think about it for clarity - is you could offshore the management. I do not think that an N.H.S. partner would be prepared to try to manage a hospital in Jersey even if people in Jersey wanted that to happen, which I also think is highly unlikely. Somewhere like Cleveland Clinic might be prepared to manage it, but if you could have some model in which people rotated in and rotated out then I think it would be worth thinking really hard about that. One of the difficulties of becoming a senior executive in Jersey is that it may well be your last job in management. It is hard to get back from, rightly or wrongly, that it is not necessarily a good career move for someone in their early 40s or late 40s. I think when you look to recruit general managers it is more difficult because of Jersey's isolation and that is another potential benefit of working with a partner, which is that if there was a way in and way out, not only does that bring new ideas and fresh ideas but it allows people what would be a very exciting opportunity to go to a small hospital, as you might elsewhere in the world, and manage that. At the moment you would be better off, frankly, taking a deputy chief executive job in most healthcare organisations, not just in the U.K. (United Kingdom) but anywhere else. If I were advising a 40-year-old what to do, I would say: "Do not leave the main system, get yourself a deputy job and work up that way", whereas if there was a way of saying: "No, go off and work somewhere else and deal with the challenges of a different place" then I think that would be really helpful and it would be truly developmental. I found my time in Jersey to be a learning experience. I found it really, really

interesting and really helpful. It made me think about things I had previously not thought about. I think there is, again, every opportunity for Jersey but it has to embrace that partnership.

Deputy J. Renouf:

You mentioned earlier about strategic direction and said you had thoughts on the strategic direction that the Island should take in terms of designing its high level strategy for healthcare. What are the broad outlines of those things, accepting that you are not the person to do it but just asking an opinion?

Former Interim Chair, Health and Community Services Board:

Okay. Well, let us focus on the opportunities that Jersey has. It is small geographically. It has got a population of about 110,000 now, I do not know, with the challenges of an ageing population and chronic disease management, as they are everywhere in the world. I think the first thing I would focus on is the management of chronic disease in the community and that needs to be much better systematised than it is. That would allow the preventive element, secondary prevention as it is called, certainly primary prevention but secondary prevention: do you know everybody on the Island who has got type 2 diabetes? The answer is no. Do you know how often they are seen? Do you know what checks are undertaken when they are seen? Do you know what the preventive measures are? How frequently are bloods being monitored? All that stuff should be relatively easy to do with that population but it is not done. I am starting with the biggest numbers, so start with the elderly, chronic disease; how you organise primary care, systematise all of that. That is one area. The next one would be how do you then link primary care and social care with secondary care and that is through developing agreed care pathways. Fortunately such care pathways exist around the world so they do not all have to be reinvented in Jersey. They just have to be adopted: "This is the way we do things round here." So that link, primary care, social care, health and social care, a much more standardised approach with systematic linkage with the hospital and the things we have talked about, how you make that much safer than it currently is. We have rehearsed all those or some of those mechanisms. Then finally how you link that with a suitable major centre that can not only, as I said before, provide care for more esoteric and rare illness but also provide multidisciplinary team working, audit, all that stuff. That is where I would start if ... well, you have been kind enough to ask me. That is where I would start. You will have seen, as I have rambled on, the challenges that are going to be in every part of that because every bit of that has a whole series of vested interests that would need to be taken on but that, just to make the point, is why I think the importance of that sort of vision coming from Government is so important. That is the direction we are going in. I may be wrong about some of the detail, I am very happy to accept that and acknowledge it, but getting that really clear vision: how does a relatively small place go about delivering the highest quality of healthcare and simply adopt what has been adopted elsewhere? As I say, I would love to have a go at it. I am not going to, I recognise, but it is a really, really exciting opportunity that is theoretically

much more difficult to deliver elsewhere. There are examples from around the world that one could look at. For example, in Western Australia there are nurse-led clinics with the nearest doctor at least 500 miles away, telemedicine beamed back to Perth, the monitoring of disease beamed back to Perth. It is the same in Canada. The geographical isolation of Jersey is far, far less, far less, than I have seen elsewhere and modern technology allows you to overcome a great deal of that. What stops you overcoming it is attitudinal. It is not a technological challenge; it is an attitudinal challenge.

Deputy J. Renouf:

So there is great opportunity. When you left did you feel like the corner had been turned or were you feeling that there was a huge danger that things could slip back, and if they did slip back what are the implications?

Former Interim Chair, Health and Community Services Board:

I would like to have got further than I got, to be honest. On a good day I thought maybe I have helped a bit and maybe moved it on a bit, and on a less good day I thought I have just failed to achieve as much as I should have done. I did not leave Jersey with a sense that it had been a great success in my career. I did leave Jersey thinking I had really enjoyed being there and I had liked it and hoped I had made a contribution. I think the difficulty that I perceive is that the amount of energy that it takes to move things on is simply enormous. The amount of energy I found I had to pull in to even create the slightest change was extraordinary. My fear would be that unless that energy continues to be applied then things will slow down, stop and maybe revert to type, because there are so many who would quite like that to happen, to be blunt. I suppose that is why I am, as you pointed out at the beginning, trying to put the monkey on your shoulders. I am looking at you as the leadership in Jersey.

Deputy P.M. Bailhache:

That attitude, Professor, if I can assure you is not confined to medicine and to health. It runs throughout the community. Whenever you want to achieve something, you need to have the clearest of visions and an absolutely voracious appetite to see it through.

Former Interim Chair, Health and Community Services Board:

Indeed, and I know some of you well enough to know that you have that. I think, as I say, if the leadership could be a bit more coherent and I think you probably need expert help to help you formulate your vision but then you need to promulgate your vision because an outsider cannot do that. It is too hard and you are regarded inevitably as an outsider. I think you probably would benefit from expert help because you cannot be expert in everything with a population of 100,000, but having got a simple and straightforward vision for healthcare, then the drive to make that happen is from the top. No one else can do it.

Deputy J. Renouf:

I think we have come up to the end of our time. Is there anything else that you felt you wanted to ... any other points you wanted to make?

Former Interim Chair, Health and Community Services Board:

No, just to thank you for being kind enough to ask me. I do appreciate that. It was a privilege working in Jersey and, as I say, I enjoyed it, we enjoyed it. I am grateful for you being kind enough to ask me to do this and if I can help you in any way, you know that I will, formally or informally, and good luck. There is so much to be achieved. Good luck.

Deputy J. Renouf:

Thank you very much indeed, Professor.

Former Interim Chair, Health and Community Services Board:

Okay, very nice to talk with you.

Deputy J. Renouf:

We really appreciate your time. Thank you again and maybe we will see you back in the Island one day since you so clearly enjoyed it.

Former Interim Chair, Health and Community Services Board:

Well, yes, we will be back to visit, I am absolutely certain. I have already admitted I owe Philip lunch and that will be a delight. Thank you all very much.

Deputy J. Renouf:

Thank you very much indeed.

[12:45]