States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health and Social Security Scrutiny Panel

Health Services: Lessons Learnt

Witness: Former Clinical Lead, Health and Community Services Change Team

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:

Professor S. Mackenzie, Former Clinical Lead, Health and Community Services Change Team

[9:00]

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

Good morning. Welcome to this hearing held by the Health and Social Security Panel, in which we will be 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. 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. Secondly, 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 hearings is to listen to the experiences of our 3 witnesses and note any lessons learned that could be used to improve the service. The hearings will not be discussing any individual employment matter. Finally, before we get going, I am going to ask my fellow panel members to introduce themselves.

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:

Can you hear us all okay, Professor?

Former Clinical Lead, H.C.S. Change Team:

I can, yes. Can you hear me all right?

Deputy J. Renouf:

We can. So our first contributor is Professor Simon Mackenzie, who was until recently the clinical lead for the Change Team, in the Health Department. Perhaps I could begin, Professor, by asking you to tell us a little bit about your experience and your role when you came to Jersey?

Former Clinical Lead, H.C.S. Change Team:

I have been a doctor for just over 40 years. I qualified in 1983 from the University of Edinburgh. About the last 20 of those I have also had a role in medical leadership and management. So I have seen, as what people describe, as both sides of the fence. I do not think they are adversarial sides, I think they are complementary. I was appointed consultant anaesthetist in intensive care medicine in 1992, and I am a Fellow of the Royal College of Anaesthetists and the Faculty of Intensive Care Medicine. In 2012 to 2013 I had a year's full-time sabbatical as the Health Foundations' Quality Improvement Fellow where I worked at the Institute of Health Care Improvement in Boston, Massachusetts and at Harvard School of Public Health. I have published, lectured, chaired numerous committees in relation to healthcare improvement. My range of experience includes being medical director in both Edinburgh and in London and also chief executive of a hospital trust in London. Inside that and outside that I have led a lot of improvement initiatives, both for organisations and as a result of a scrutiny, done partly by me, of organisations for Healthcare Improvement Scotland, for N.H.S. (National Health Service) Improvement in England, and at the request of individual hospitals. So that is broadly my experience before I came to Jersey.

Deputy J. Renouf:

What role were you asked to do here? Could you just explain what "clinical lead" meant?

Former Clinical Lead, H.C.S. Change Team:

Yes. I prefer to use the term "medical lead" because it is one of these ... there was also a nursing lead and I think they are both clinical professions. Sometimes people mean doctors by clinicians, sometimes they mean a broader range. But I was a medical lead for the Change Team. The specification was they were looking for somebody who had been a medical director and bring that experience, and it was about improving clinical governance as part of the Government's response to Professor Mascie-Taylor's report, which was about clinical governance. At the outset, there was nothing in the brief about improving the quality of care, it was about introducing systems of clinical governance. However, when we arrived, it became clear that people did have concerns about the quality of care. I can talk a bit more about that. But I and my nursing colleague, Cathy Stone, shared those concerns about the actual quality of care and felt professionally obliged to do something to address those. Perhaps worth explaining that because I am mainly registered with the General Medical Council I have a professional obligation not to stand by if I see poor care, and that is actually a requirement for a doctor. At the request of some people in H.C.S., and with the agreement of the then Ministerial team, we agreed we would have to do some work on that.

Deputy L.K.F. Stephenson:
I was just going to say, do you mind me asking how long it took for those concerns to be raised with you to surface? Was it something very quickly as you arrived or did it take some time and start to come out slowly?

Former Clinical Lead, H.C.S. Change Team:
Concerns about maternity came out pretty much immediately because when we met the executive team, pretty much at introductory talks, and it was Chris Bown and myself, about what worries you. Just the way you would do trying to get to know a new team. They had maternity as a concern. When you just had a quick look at that and thought: "Gosh, I would be extremely concerned about that." The other area that was a particular concern during my time were the medical wards, and that took a little bit longer to emerge. In both cases, what I would say is this is not really a matter of opinion. These concerns were based on external reports from Colleges. I may have the dates slightly wrong for maternity, but in 2019 the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives did a report on maternity. There were then a number of specialist sub-reports and they had not been implemented, the recommendations. In medicine, there was a report, which was not actually available when I started, but from 2022 on medicine. Somebody kindly pointing out to me, which the executive seemed to be unaware of, there was also a report from the Royal College of Physicians in 2014. What concerned me was both reports made similar points and I could not find any evidence that there had been any action between 2014 and 2022. So it is not really a matter of opinion. It is certainly not a matter of just my opinion. This was objective evidence.

Deputy J. Renouf:

What steps did you take, or did you want to take, when you began to hear about these concerns?

Former Clinical Lead, H.C.S. Change Team:

We were obviously ... the first thing is, had the clinical governance system been working these concerns probably would not have arisen or would have been addressed. So they were kind of evidence of why we ought to be there but they were a bit diversionary. On the maternity side, a lot of the heavy lifting was done by Cathy Stone, because she is also a registered midwife and this required an expertise in obstetric and maternity care that I did not have. I was there as a medical director to help the overall system. We also, and this was me actually, re-engaged Dr. Devender Roberts, an obstetrician from Liverpool, who had been to Jersey before, at Jersey's request, H.C.S.'s request. But the work had started and a lot of it was about cultures and behaviours, but had not progressed for a variety of reasons. Partly that was due to the COVID pandemic, which obviously got in the way of everything but it was not entirely due to that. So we re-engaged Devender to come and do some work with the obstetricians. Cathy did a lot of work with the midwives and jointly we made progress on that, but I had very little personal involvement. It was about putting the right people in to make it happen. On the medical side I was more involved with trying to support Adrian Noon as the chief of service to achieve improvements there. It was pretty difficult because fundamentally a lot of the consultants did not accept the findings of the Royal College report. That was not the last time I encountered that at H.C.S. It is not something I have encountered elsewhere, where people say: "We just reject the report." One consultant said, in the open session: "The Royal College should never have been allowed to come. We know we provide a good standard of care", despite the Royal College saying most care is poor. So, that element of denial made it very difficult. I think we got stuck, if I am honest. Part of the problem again, as doctors, we all have our tribes. I am an intensive care consultant so if I go and speak to a consultant physician they will say that: "You do not do my job." So we initially approached a doctor from Brighton who turned out not to have the time. As I was leaving, I engaged with Dr Ian Sturgess, who is currently working at H.C.S., and he was a consultant physician and geriatrician who I have worked with in the past, and I believe that he is starting to make a bit of progress on this. But obviously I am out of the loop, but I think that may generate some improvement. The real challenge, though, is an attitudinal one. If people do not believe that there is a problem that needs to be fixed, they will not fix it. So you need to accept that there is a problem, and that depends on whether you think that the quality of care provided by H.C.S. is acceptable, not really of an adequate standard or, as some people appear to believe, is better than in most places. To be clear, I do not believe it is better than most places.

Deputy J. Renouf:

What is your assessment of the quality of care? Obviously it is a general point and it relates to when you were here, but in terms of your experience.

Former Clinical Lead, H.C.S. Change Team:

It is very difficult to generalise. It also depends what you compare it to. Because it is very common in Jersey to make criticisms of the N.H.S. The N.H.S. is used: "It is better than the N.H.S." The N.H.S. is a huge organisation with a large number of hospitals and the standard of care is variable. I would say, and again I am not an expert in every speciality, but I would say that the standard of healthcare in H.C.S. is generally lower than the standard I would expect to see in a similar-sized hospital. I have told both Ministers for Health and Social Services I have worked with, going back as far as July 2023, that knowing what I know, if I were a Jersey resident I would choose to have my healthcare elsewhere. It is not to say that you cannot get good healthcare in H.C.S. A lot of good people are doing a good job. But I would choose to go elsewhere. That is my personal view.

Deputy J. Renouf:

What do you think needs to be done? What were you trying to do, if we phrase it that way. What were the things that needed to happen to drive the change that you think needs to happen?

Former Clinical Lead, H.C.S. Change Team:

There needs to be a fundamental change. I know you are speaking to President Mascie-Taylor later, and I was flicking through his report last night.

[9:15]

I think he is right to say the ingrained attitudes, I think, among the senior medical staff, which percolates over into the population, that on the basis of no evidence but just "our self-belief that we are good". We are all of us, as human beings, really poor judges of our own performance. Sometimes, in fairness, we are too hard on ourselves, but we can rationalise things. Several things, in my view, need to happen. Again, these points were made in the summer of last year. I will start with the administrative arrangements. This is probably not going to be a popular view with very many people. The people of Jersey would be better served if you allowed managers to manage; there is not too much management in H.C.S. There is insufficient effective management. One thing I thought coming to Jersey, I thought it is a small organisation. It will be easy to make things happen quickly. A relatively small number of people need to be involved. It should be quite a short journey from making a decision to implementing the decision. It was anything but. I can absolutely get things done faster in a hospital in England, and there are a variety of reasons for that partly, it is the centralisation of services. So H.C.S. cannot decide how it wants to prioritise its H.R. (human resources) and I.T. (information technology) and finance resources. Everything has to be referred up to the Government of Jersey. So I would make it autonomous, like, say, the Ports of Jersey, and

have it run separately, and not part of the civil service. You could then have a chief officer who you could genuinely hold to account because they had all the authority to do that. It would also ...

Deputy P.M. Bailhache:

Can I just interrupt, Professor? One of your colleagues on the Change Team, is said to have said that the finances of the H.C.S. were effectively out of control. I am wondering if you consider that the changes that you recommend, in particular, bringing finance under the control of H.C.S. would be one way of mitigating that and making it better?

Former Clinical Lead, H.C.S. Change Team:

I think potentially it would because one of the things that the organisation lacks internally is an operational plan that says: "We have lots of challenges, but this year ..." So I have done this when I was the chief executive. I was the chief executive of a trust in big trouble. I could write a book of the things I wanted to do that were all highly desirable. We cut it down to a very short list of what are our priorities for this year and next year, which are important, urgent and doable. I said no to a lot of people who had good ideas. What this would do, Sir Philip, is it would make the position of politicians much easier by giving away power, because one of the problems that you have at the moment, and I appreciate it is very difficult in a community where everybody knows everybody, is a consultant has a great idea - and it is a great idea - for your speciality and knobbles somebody ... that is an unfair term, but discusses this, whether it is in the shop or at dinner or whatever. "So that is a great idea although, 'I think we should do this, chief officer'." So the chief officer suddenly ... well it is difficult to say no to the Minister. So that is another £100,000 gone on something, which frankly is not a priority in the big scheme of things. What H.C.S. lacks is a plan that says: "This year, for the sake of argument [take something really simple] we need to do X hundred hip replacements. Have we got the resources to do X hundred hip replacements?" "Yes." "Great." "No." "Right, now what are our alternatives to do that and what are the knock-on consequences?" You can, and most places do this for every speciality, and this is how normally you would do it. But it allows that ... the problem is what happens at the moment is everything takes a very long time. The other thing that would ... it obviously depends on the quality of management. We can come back to that if you like. What is it? I would, in terms of the clinical structure, you need to decide what the purpose of H.C.S. is. Leave aside your wider healthcare strategy, but you are going to need some sort of secondary care services, and my experience is much more on the acute side than on the mental health side. But you are going to need a secondary care service. You want one that provides high quality care. You do not want a local service that provides highly specialist care. There are things which thankfully are uncommon. They are best treated in large centres where the uncommon is common. That is why, if you think about the British Isles as an example, we have, I think, 3 centres who do paediatric heart transplants because thankfully very few children need heart transplants. You want somebody who does heart transplants every week. For adults, where there are more, we have a few more.

So I remember having a useful discussion with one of your consultants who said: "Well ..." And he was right. If we appointed a consultant to do that - I will not mention the procedure we are talking about because I will not link to individuals - they will get to do half a dozen a year. Even if they were good when they arrived, they quickly become de-skilled. It is better that half a dozen people a year get excellent treatment somewhere else. You know this, a large number of people do already go to the U.K. for treatment. The debate is not about whether it happens, it is where it happens. I believe that you are providing some services in H.C.S. that you should not be providing on the Island, because I do not believe you have the scale to do it and you have too many single-handed consultants. So they are the only consultant in their speciality or their sub-specialty. Some of the treatments that therefore have been provided are quite old-fashioned in the way they are provided. So you are not getting some of the better use of money. It is important. As a doctor, I am really interested in productivity and saving money because there is always more we could do with money. You, as politicians, will know there is no shortage of other things that people would like done for them, whether that is more of what we already do or whether it is things that we do not currently do. We always want to do things in the most efficient way. I would not want to have any consultants practising as the sole consultant in their speciality. There are 2 ways that we can achieve that. One is there are some specialities where you can have more than one consultant because there are enough people to ... there is enough work to make that a viable and sensible thing. That is tremendously helpful because somebody can then say ... suppose I am one of them and, Lucy, you are the other one, just because you happen to be sitting closest. You can say to me: "That was very interesting what you did yesterday, Simon, with that patient." By which you mean: "That seemed nuts to me." And we can have a conversation that you particularly ... it is often helpful for people from different generations: "Have you read that recent article, about 10 years ago, that says we do it differently now?" Or the alternative is to be well engaged with a U.K. centre. Some of your specialities are. Oncology is very good in this regard. Have a good matrix, in my view, of relationship with specialist centres, things they discuss, check that their treatment is up to date and provide it entirely on the Island, and the patient will probably hardly notice being discussed. Others where the specialist centre says: "This patient needs things that you cannot provide and we should basically manage the treatment" and others where there is a shared element. That is really how all your services should be run. While the consultants often tell me: "Oh yes, we have relations with such and such", when you dig down a little bit, it is all very informal and ad hoc. Modern medicine is very complicated. If I think back to what we could do 40 years ago, it does not seem like very much nowadays. Medicine can do far more than it ever could. Yet we are always told people are more dissatisfied than they ever were. It is the gap between what is possible and what gets done and the understanding. Because it is complicated, none of us know it all, which is why it is perfectly feasible with modern technology.[1] Your consultant should be working in networks with larger groups of

[1] Witness clarification: What was meant by this was: 'Because medicine is complicated, none of us know it all. Getting the best is perfectly feasible with modern technology'

consultants and hospitals, but most of it virtually by M.D.T.s. (multidisciplinary teams). I am not sure whether it was Professor Mascie-Taylor, but somebody certainly floated the idea that we should pay for consultants to have 2 weeks a year working in another centre and it should be the centre that they relate to, to build that expertise. Great, if you could persuade one of their consultants in return to come and work in Jersey for a couple of weeks and see how it is and get that relationship going. If I was redesigning your system, and I think your system does need to be redesigned, I would do one of 2 things. Option one is to align the services formally to a U.K. centre. It could be an N.H.S. hospital. The obvious ones would likely be Southampton or London because of communications. You want somewhere that is basically an air flight away. It could be a private sector organisation, such as the Cleveland Clinic in London. The reason I would prefer to move towards aligning to a single centre rather than multiple centres, is to develop a strategic relationship and have common standards of governance across, which I think would make it much easier for your managers and would give them expertise and insight, because at the moment your executives lack any level of peer support. I accept that, in theory, you can get the best for each speciality by contracting with lots of organisations. Frankly, what I have seen of H.C.S. admin around that is not very good and it is quite complicated. The centres we currently use are often based on personal connections, so it is all a bit chaotic. I would dispute the myth that you have bargaining power because of your additional income to these hospitals. H.C.S.'s entire budget is less than the divisional budget of many of these organisations.

[9:30]

If you are coming along with £1 million of business a year, you are not speaking to the chief executive, you are speaking to the middle level business manager, and frankly, they are not going to put much effort into it. So we do not have much bargaining power. That is probably the realistic thing to do, and you get better management that way. The second is what you might like to call the Norman Tebbit option, if you remember Mr. Tebbit, who thought that local council should meet once a year and issue a contract and then not meet again for a year. But you could, if you wanted to be really radical, contract it out to an organisation. I accept for political reasons you probably would not want to do that, and it would involve writing a very tight spec. But again, most healthcare can and should be provided on Jersey. Sometimes it has to be, the emergency stuff actually has to be. For most routine care and most care, which is really important to individuals because it happens to us once in our life, we hope, is routine for the people providing it, which you should be grateful for because you want people who actually do this all the time. But it comes back ... the reason I would like it to be that way is based on my experience. We have made some progress in the 14,15 months I was in Jersey with clinical governance, but it is largely about putting in place structures. My worry is, because Cathy and I constantly had to chase things up and find it had not been done and chased them again, but now I have left and whenever she leaves, that it will revert to type. There was a

letter from a very well-known consultant recently saying: "Well, N.I.C.E. (National Institute for Health and Care Excellence) guidelines do not apply in Jersey", although this was agreed by the executive team, by the medical staff committee, by the Ministers at the time. We agreed back in July last year that N.I.C.E. guidelines do apply in Jersey, not because N.I.C.E. had said anything but because we say they do. Now we have agreed mechanisms for varying from them where it is appropriate to do so. But it comes back to when I arrived, H.C.S. had a ridiculous, ambitious programme to survey the world for guidelines, which would be a never-ending task, then decide which ones would apply to Jersey. You have better things to do with your time. Most guidelines say the same things if they are based on the same evidence.

Deputy P.M. Bailhache:
I thought that was the default position.

Former Clinical Lead, H.C.S. Change Team:
Sorry?

Deputy P.M. Bailhache:
I thought that was the default position now is that the N.I.C.E. ...

Former Clinical Lead, H.C.S. Change Team:
It is the default position, you are correct.

Deputy P.M. Bailhache:
... guidelines apply unless there is some good reason for dealing with them differently.

Former Clinical Lead, H.C.S. Change Team:
Yes, that is exactly what we agreed. You are absolutely right, Sir Philip. But I say, when I had consultants I was disputing that was the case. I thought: "This is hard to get their hearts and minds." Part of the difficulty is your executive team, with a couple of exceptions, are inexperienced. They have not worked at this level before. Rightly or wrongly, they feel unsupported and are reluctant to make decisions that might displease people. I think these jobs are quite hard. They are hard to do anywhere. I think they are quite hard to fill in Jersey, because if you have people who hold these titles of executive directors and now board members, that comes with quite a lot of responsibility, but the size of the actual job, the size of the organisation, is tiny. So when you are trying to recruit a new chief officer in due course ... maybe you are already I do not know. I am not sure how long Chris Bown is staying, but I know he is interim in the end. It does not fit into a career progression for most hospital managers because in terms of the budget they are managing, it will be much smaller. So if you aspire to be chief executive of St. Thomas's in London or your University Hospital

in Maastricht or whatever, it does not really matter, you would be much better going to be deputy chief executive in some large organisation than coming to be chief executive in H.C.S., so how do you make it attractive. Which is why I think that if you had a strong strategic relationship with a larger organisation, and I would cut through all the waffle, it does need to be in England. That is where ... you speak the same language. That is where we require doctors to be registered with the G.M.C. (General Medical Council). That is where most of them got their qualifications. That is where the junior doctors come from are. You watch English television, there is some interest in the English election. That is where flight connections are. So it does need to be England, I say as a Scotsman. You would get support for both the clinicians and the executives because your chief nurse, your medical director do not *[currently]* have the peer network I had in those positions. The phone a friend, who will pick up the phone and who knows you. I would negotiate a contract with somebody that requires a certain level of support. That is roughly how I would restructure it. There needs to be a change of attitude in the medical community in my view, not universal, but there are some people who need to accept, like if we have changed, there is a reluctance to accept. I think that there needs to be ... I understand their frustrations with the management team, but the management team also have their own challenges and absolutely you need to bring them together. Again, I have written to both Ministers for Health and Social Services I worked with over the time saying the key that we need to achieve ... nobody disputes this, I do not think. But the key we need to achieve is a relationship of mutual respect between managers and clinicians. Because when you do not have that, it always ends in tears. Given some of the problems I have looked at and how long they have taken to arise, you just cannot hang it on any single generation of either clinicians or managers. So replacing the people is unlikely to give you much change, to be honest. The system that you have pushes people into this. My regret is, looking back now, after a month or 2, why did I not achieve as much as I had hoped to achieve? I think it is partly that the system is designed ... not deliberately, but the system produces what it produces. I think you have been round this loop a few times in Jersey, is my impression. Sorry, that was a very long answer to a question. I will stop now.

Deputy J. Renouf:
Did you see anything positive happen while you were in position? What were the stepping stones that did happen that were good?

Former Clinical Lead, H.C.S. Change Team:
There were some improvements. We did improve the way serious incidents are reviewed. There is still time scale problem. Deep down that reflects whether people really take it seriously. It is about getting people to actually do the work, but we got that better. People now actually do meet when they are supposed to meet. They do not necessarily meet the time scales, but we got that better. We agreed, at least in principle, that N.I.C.E. guidelines were the default, which has helped with the management of some emergency situations. I think that we have made some progress in maternity.

That was overwhelmingly due to Cathy Stone, and I think was helped along by the fact that there was going to be this inquest into the death of Amelia Clyde-Smith. When we arrived, the organisation was not in a position to realistically say it had addressed the issues raised by that case. It is terrible to say, but the pressure of having to face public scrutiny allowed us to put some force into that, but it required a degree of persistence that was surprising. I would have probably been more forceful, rightly or wrongly, with some of the staff than the executive team were. I think with medicine we were making some progress, but it was, to my mind, not quick enough. To be clear, the problem with medicine is that there is insufficient senior medical leadership on the wards, and that is giving you an unnecessary number of patients in the medical wards, which is then having an adverse impact on surgery. So by opening some more beds, by improving cover on the wards, albeit mainly with locums still, which is undesirable and expensive, we were able to get - I hope this is still true - but we were able to get the orthopaedic ward back to being an orthopaedic ward, which should help with that. Again, as I was leaving, this had taken a long time to organise, but we had the first visit from G.I.R.F.T., which is an acronym for Getting It Right First Time. It is an initiative that was started by Professor Tim Briggs, who is an orthopaedic surgeon by background, and more foreground as well. It is a very clinically-driven initiative about getting the right operation done the first time. They had a look at orthopaedics just before I left, and a quick look at ophthalmology. They are going to come back and do some more. I think that offers great potential. Tim's informal feedback to me was it is all fixable, and all your problems are fixable. The question is whether you accept that there is a problem and therefore have the will to fix it. There is nothing that cannot be fixed.

Deputy L.K.F. Stephenson:
I wonder if I could ask a question on that basis. You have alluded to it earlier in your answer. But when you mentioned about evidence but not everybody is accepting the evidence and where we are trying to bring people together around a common aim to try and move forward in a positive way and start tackling some of these challenges, and I think to refer to the maternity example, which you did, that took also a family fighting to get that case to the point that it did as well. So there are the families to think of in this.

Former Clinical Lead, H.C.S. Change Team:
Yes.

Deputy L.K.F. Stephenson:
What other evidence or is there more evidence beyond Royal College reports and similar that could be collected, sought out to try and bring those people together so we do not have to end up in a scenario like that, where a family has to go through an awful situation and then fight for justice afterwards for people to listen?

Former Clinical Lead, H.C.S. Change Team:

Clearly, that is what we want to do. This is why I come back to if we had good systems of clinical governance ... you cannot say we would never have incidents like that. That would be incredibly naive, but you would be less likely to have them. It is very interesting. When I was speaking to Dr Roberts about her report and her subsequent help that she gave us with maternity, she said "Simon, you need to see this in the context of, (this is actually before Professor Mascie-Taylor's report in 2019) I said[2] 'there is no clinical governance in the organisation so you cannot just blame the maternity service because they should have been guided by the centre'."

[9:45]

Again, nearly all the reports I have seen make reference to job planning for consultants, to appraisal for consultants. That is another thing I changed. The appraisal we had or the way consultants are appraised, it does happen but it is not good enough. So we have put in place an arrangement for the next 2 years with Wessex Appraisal Service, who already in fact do the G.P.s (general practitioners), and they will do that. That is important because it will keep H.C.S. in a favourable position with the G.M.C., which is essential. The other thing, I will come back to the question, is that we finally, and it took 10 months through the bureaucracy, have re-engaged with a series of national British Isles audits of various specialities. The question is whether we are using the information from those, and there is no evidence that we are. But to come back to your point, the days when a doctor, such as myself, can just rely on believing I am good and because I am an affable person and you like me, you believe it or you know no better are gone, we do need evidence. I remember medical staff complaining,... "now we need to show we are good". Well, actually, the answer is: "Yes, you do. That is what the General Medical Council requires you need to show." So part of it is about data. H.C.S. does have data. That is one that I disagree with Professor Mascie-Taylor on. It is not very good at using it. Your Informatics Department is quite high quality, but very small. You do not code your data properly. You have got a huge backlog, something like 18 months. You may say: "Well, why does that matter?" It is because literally you do not know what you are doing. When we have an argument about why has the length of stay of patients in the hospital increased, people will say: "Well, they are sicker." Well, are they sicker? We do not know because we do not collect the data. Now it would cost money. I helped support a plan *[to correct that]* that would cost about half a million pounds. But actually, for those of you who have run a business, it is like trying to run your business without knowing what you are producing. You do not know what you are actually treating. Therefore you are flying by the seat of your pants. You need to have a culture which accepts effectively benchmarking. How do you get there? To be honest, if I had been the medical director and had consultants come to me, and this happened in at least 2 departments where: "Well, we just

[2] Witness clarification: Dr Roberts said: I said 'there is no clinical governance in the organisation…'

do not accept the College report", and start muttering about N.H.S. *[I would have said]* "The College report, these are your peers. It is not the N.H.S. These are the Royal Colleges. They are independent bodies of doctors. You need to take those seriously". I would have pretty clear conversations with people. What the colleges will not ... the colleges will tell you what you need to do. They will not help you do it. That is why you need somebody to help make the improvement. Maybe you need somebody like me. I think what you probably need is to engage over other specialities with G.I.R.F.T. Now, G.I.R.F.T. started off as a private initiative, became part of N.H.S. England, but it also runs as a separate company. The bit we engaged with is the separate company bit. But they have access to the same data. I would use that for other specialities because, again, it is clinically led but it is data based. You want to have ... so what you actually need is people who work in the same area who understand the information and can have a sensible conversation based on information. They are not just looking at a spreadsheet and saying you are good, you are bad, which is ridiculous for something that involves people. But actually they can combine that data, intelligence and peer support. What G.I.R.F.T. will give you is help with actually making that journey of improvement. But you need to be willing to make the journey. I think the fundamental question is: does your committee, do the consultants, does the States Assembly accept that there is a need to improve? Much controversy in England at the moment about England's new Health Secretary saying the N.H.S. is broken. Somebody asked me: "Was that a good thing?" and I said: "Well, it is a bit dramatic, but in a way it at least helps to have somebody at the top say this is not good enough." It is clearly a danger saying something like that unless you have a solution. It is not and should not be seen as an attack on individuals. I found myself in the position of being dropped in as chief executive of a trust that had just been rated inadequate by the C.Q.C. (Care Quality Commission), that is why I was dropped into the position. So I had to say to staff: "You need to believe 2 absolutely contradictory things. You need to continue to turn up to work and be proud of what you do know. A lot of patients get good treatment from you and are very grateful to you. You need to also accept that the criticism in this report about the way we run these things are right, and as an organisation we need to change." You need to accept you have a problem.

Deputy J. Renouf:

Just to be clear, you would say that to Jersey, would you? Would that be ...

Former Clinical Lead, H.C.S. Change Team:

You need to accept you have a problem, yes. I think you absolutely do. But you then need to agree what the diagnosis ... there are people who will say the doctors are the problem. There are people who will say the managers are the problem. There are people who will say it is just there is not enough money. They all have a point and they are all wrong. It is a multifactorial thing. You need to believe ... you need to accept that what we expect of doctors has changed. We expect doctors now to participate in a system where it is not that their competence is being doubted, but they need

to demonstrate that they continue to be competent. You do that largely by peer comparison. We need to acknowledge that sometimes we will be able to learn from other people. Sometimes we will have things to teach people.

Deputy P.M. Bailhache:

May I ask a question, following on from that. Because it seems to me that much of what you are saying has been generally accepted. The Minister made a speech a few days ago where he said, if I could just read out a paragraph to you. He said: "Firstly, Jersey's H.C.S. has not developed as well as it should for a good number of years, mainly in the following areas. Governance, this has not been introduced progressively in the way that it should. Culture, this has been poor for some time and the problem seems persistent. Finances, these have not been managed as well as they might, resulting in important overall funding issues not being addressed. And finally, structural shortcomings and lack of autonomy in local terms, quite a complex organisation has evolved over the course of time, but very little seems to have been done to update the structure in order to improve efficiency." It does seem to me that that is a bit of a summation of what you have been telling us over the last half an hour.

Former Clinical Lead, H.C.S. Change Team:

Yes, a lot of that is true. What I have said today has been said to both Mr. Binet and Ms. Wilson. So I am really not saying anything that I have not said for some time. The question, therefore, is why it has not changed. I have to say the level of ... my time in H.C.S., and I say this with regret as a doctor, was sort of bookmarked at both ends by consultants fundamentally rejecting the need for any change on their part and everybody will need to change. What I do think would be good would be if doctors who, by their position, end up being major influencers and would step into positions of responsibility. So, for instance, there is an idea going around an element of the medical staff committee that "we should be able to sack the managers". It is an absurd idea, but there are very few doctors who are willing to do what I did, because I was frustrated in my hospital by things that I thought could be better, which is to step from being the critic to actually being into the leadership role, accepting that it means you will have to do things, make decisions that your colleagues will not like. Frankly, the position of those who have, the few who have, has been made very difficult. The thing that I found most difficult in Jersey was the way decisions were actually made is different to the way they are made, in theory. I do not know whether you can solve that problem in a very closed community, but it is the fact and this, again, is independent of the individual, that it is far too easy for a consultant to nab a politician and paralyse things. If the Government does not have faith in its management team by all means get a different management team. You just need to accept that you are going to have to pay them off. But they need to either have ... but the management team that you choose needs to have your support. The challenge I think that you now have is to put the principles of what I have said and what the Minister you say has said, which is gratifying to hear,

into actual action. I think that that will require this change in structure, because what I see is a recurrent pattern. So what I am told is that Jersey moved away from having so-called blended lists, allowing consultants to put private patients on public lists because of a conversation with a member of the public with a previous Minister for Health and Social Services. Because of pressure from the consultants on subsequent Ministers for Health and Social Services, H.C.S. now reversed that. I happen to think that is a really bad decision, by the way. I think you should keep private and public work separate. I think it is better for both groups, and I think it is actually better for consultants because otherwise they are vulnerable to the perception of conflict of interest. I think the challenge is to agree what the new structure should be. I said that I think that it needs to be, in summation - I know we are coming to the end of our time - it needs to be a network for both clinical and governance purposes, with a U.K. centre side. I do think it should be but it needs to be geographically sensible, so it has good geographical connections. It needs to be broad enough to do essentially everything you need to do for you. For instance, specialist care and support your generalist care.

[10:00]

Consultants will be away for 8 to 10 weeks of the year, probably. Actually, a fifth of your time you have not got your single-handed consultant. So actually again, if you have a network, you have a system of support.

Deputy J. Renouf:

What you are saying, just to be clear about that, Professor, what you are saying is that that is a contractual relationship; a single contractual relationship is what you would recommend. Although it could be multiple.

Former Clinical Lead, H.C.S. Change Team:

That is what I would recommend. Then you will need less of people like me coming in because you have got that kind of structural relationship. If somebody develops some wonderful new treatment and the question is: Can we do this in Jersey or not? You have got a group of 10 consultants who you can work with and actually we will do it on Jersey or we will not do it on Jersey, but we will make sure your patients get a fair slice of the action. But there is only going to be half a dozen of them so it does not make sense not to. That is what I would do. In the short term, I would get G.I.R.F.T. involved a lot more with the specialities that concern you. One other thing I would just like to mention is your auditors said a couple of years ago that the consultant contract needed revised. They were right, it does need revised ... you could be very radical. I suspect you probably should not be. The contract you have is based on the English consultant contract, but with some significant and unhelpful modifications. In terms of good use of public money and getting a service, you need to renegotiate your medical contracts. It is probably not difficult. In fact, before I left, it had been

suggested that I might lead on those because I was perceived as not having a conflict of interest in the way that any of the medical directors would, because I would not be a beneficiary. Candidly, you probably need to ... there are some things in it that are undesirable you probably need to buy out. You need to get your non-medical staff off civil service contracts, and on to a contract that is fit for hospitals to work seven days a week. There is quite a bit of stuff to do, but you could ... where you do have a freedom that you really ought to exploit, that no similar-sized population in the British Isles has, is because you can make different arrangements for social care, you should show that it is possible to get people who no longer need to be in hospital and are better off not being in hospital back to their homes really quickly. Whether it is by incentivising the market or by doing it yourself, you have the absurd situation where we keep people in hospital where they do not want to be, where they do not get the best care for them, but we do it in the most expensive way, and then we deny other patients' access to those beds because somebody who does not need it is ... actually, you do have a genuine opportunity there to show everybody how it could be done and how a better world could be. That would be really something to shout about to get that done.

Deputy J. Renouf:
That is a really optimistic note on which to end. I think we will have to end it there. We have used up our hour. But very much appreciate you taking the time to speak to us. Thank you very much indeed.

Former Clinical Lead, H.C.S. Change Team:
I wish you well.

Deputy J. Renouf:
Thank you, Professor.

[10:04]