STATES OF JERSEY

STATES OF JERSEY COMPLAINTS BOARD: FINDINGS – COMPLAINT BY MRS. X AGAINST THE MINISTER FOR HEALTH AND SOCIAL SERVICES REGARDING ACCESS TO TERTIARY CARE, COMMUNICATION FROM HEALTH CARE PROVIDERS AND THE ADMINISTRATION OF A COMPLAINT BY THE PATIENT EXPERIENCE TEAM

Presented to the States on 8th March 2024
by the Privileges and Procedures Committee

STATES GREFFE

REPORT

Foreword

In accordance with Article 9(9) of the Administrative Decisions (Review) (Jersey) Law 1982, the Privileges and Procedures Committee presents the findings of the Complaints Board constituted under the above Law to consider a complaint against the Minister for Health and Social Services regarding access to tertiary care, communication from health care providers and the administration of a complaint by the Patient Experience Team (Health and Social Services Department).

Chair, Privileges and Procedures Committee

STATES OF JERSEY COMPLAINTS BOARD

25th January 2024

Complaint by Mrs. X against the Minister for Health and Social Services regarding access to tertiary care, communication from health care providers and the administration of a complaint by the Patient Experience Team.

Hearing constituted under the Administrative Decisions (Review) (Jersey) Law 1982

Present

Board members –

G. Crill (Chairman)
G. Fraser.
D. Warman.

Complainant –

Mrs. X.

Minister for Health and Social Services –

J. Marshall, Chief Nurse, Health and Community Services Department
C. Evans, Patient Experience Manager, Health and Community Services Department.

States Greffe –

L.M. Hart, Deputy Greffier of the States
K.M. Larbalestier, Principal Secretariat Officer, Specialist Secretariat, L. Plumley, Secretariat Officer, Specialist Secretariat (as an observer)

The Hearing was held in public at 10:30 am on 24 January 2024, in the Le Capelain Room, States Building.

1. Opening

1.1 The Chair opened the Hearing by introducing the Board and setting out its remit. It was noted that the Board would only uphold a complaint if it felt that the decision which had given rise to the complaint was contrary to law, was unjust, oppressive or improperly discriminatory, was based wholly or partly on a mistake of law or fact, could not have been made by a reasonable body of persons after proper consideration of all the facts, or was contrary to the generally accepted principles of natural justice (Article 9 of the Administrative Decisions (Review) (Jersey) Law 1982).

2. Complainant's case

2.1 The Complainant's case followed on from a previous complaint against the Minister for Health and Social Services, which had been upheld (R.4/2019 refers). The current complaint centred around 3 issues - access to tertiary care, communication from health care providers and the administration of a complaint by the Patient Experience Team (PET).

2.2 The Board noted that Mrs. X had met Deputy K.M. Wilson of St. Clement, Minister for Health and Social Services in November 2022, to discuss issues she had experienced in relation to access to tertiary care and had understood that the Minister would contact her thereafter. However, Mrs. X had cause to contact the Minister shortly after the meeting as a result of an experience with a tertiary care provider - University Hospital Southampton (UHS), which had culminated in delays in the provision of care as a result of a failure to produce consultation notes/action appropriate referrals. An unreserved apology had been received from UHS with an undertaking to action referrals to appropriate departments. However, the Health and Community Services Department policy required the authorisation of such a referral by a Consultant in Jersey. Mrs. X understood that the relevant policy required the tertiary care provider to refer a patient back to the Health and Social Services Department in Jersey in order to access an outpatient appointment (and only if the required treatment was unavailable locally would a patient be referred to an external tertiary care provider). During this time, Mrs. X made several unsuccessful attempts to contact the Minister and ultimately received an outpatient appointment at UHS Ear, Nose and Throat (ENT) clinic for 2nd January 2024, which she believed fell short of the scope of acceptable early resolution offered by the Patient Advice and Liaison Service

(PALS) at UHS. This appointment was subsequently brought forward to June 2023, and whilst this was appreciated, the authorisation process appeared to fall outside of the Health and Social Services Department travel policy guidelines, having not been sanctioned by a Jersey consultant and relating to treatment which could be provided locally. Unfortunately, on arrival at UHS it became evident that whilst a referral/appointment had been made, no correspondence or medical notes were available. Mrs. X subsequently received an appointment for the ENT clinic in Jersey 2 weeks later. At another outpatient appointment in Jersey 4 months later no medical records or correspondence were available. In terms of travel to the UK for appointments, Mrs. X had been advised on several occasions that the travel policy precluded patients who were not suffering from cancer from being accompanied to appointments outside of the Island, albeit that this was not specifically referenced in the relevant policy.

2.3 As Mrs. X had yet to receive a response from the Minister she had contacted the Chief Minister, Deputy K. L. Moore of St. Mary, St. Ouen and St. Peter by electronic mail message on 23rd January 2023, in connexion with the matter. Mrs. X had been contacted by the PET, who had, in turn, been approached by the Chief Minister, who had requested that the matter be dealt with as a formal complaint. Mrs. X advised that she had been surprised to learn that the matter was being dealt with in this way as her initial meeting with the Minister for Health and Social Services had been motivated by a desire for change in the form of greater support for patients and an affiliated approach to tertiary care. A stage one response dated 13th February 2023, had been received from a staff member (who Mrs. X considered to be conflicted in the context of involvement with a previous complaint) and the matter subsequently progressed through the internal complaints process with various communication issues and errors arising which caused considerable stress and which left Mrs. X feeling that she was no longer in control. Furthermore, Mrs. X did not believe that stage 2 of the complaints process had been completed. During this period, it also became evident that an error in inputting Mrs. X's email address had led to the non-delivery of electronic mail messages from the Minister for Health and Social Services. A meeting with the Minister was subsequently scheduled for 30th March 2023, and this was preceded by an electronic mail message dated 29th March 2023, outlining the conclusions of stage 2 of the complaints process, which appeared to have been prepared in ignorance of correspondence from

UHS and which concluded that the case was now closed. Mrs. X stated that if matters were not progressed at stage 2 patients were left without support. Unfortunately, on the morning of the scheduled meeting with the Minister, Mrs. X was advised that the Minister was no longer available and that Deputy M. R. Ferey of St. Saviour would attend in her stead. It became apparent during the meeting that Deputy Ferey was unaware of the issues which Mrs. X and others faced in respect of access to tertiary care and the inconsistencies of approach which impacted on patient care. Sometime later Mrs. X had attended a drop-in session at the town hall in an attempt to discuss the issues she was facing with the Minister. The Minister had advised that she would be contacted by the Chief Officer but there had been no contact. In terms of her care, Mrs. X advised that tests at UHS which she had been informed would take 10 weeks had, in fact, taken 31 weeks. Mrs. X subsequently received an invitation to attend a multi-disciplinary team meeting on 24th April 2023, and a request for this meeting to be brought forward was denied. It was also not clear whether this constituted the third stage of the complaints process and the purpose and outcomes of the meeting were not clarified. Mrs. X was later informed that 3 clinicians (none of whom had been directly involved in her care) would attend the meeting and she feared that attendance at the same would not be in her best interests and that it was merely a 'damage limitation exercise'. Mrs. X ascertained that 2 of the clinicians were part of the Dietetics team and this caused her considerable anxiety due to previous experiences which had resulted in her feeling she had been 'bullied' into agreeing to certain treatments. On the morning of the multi-disciplinary meeting Mrs. X received a telephone call from a member of the PET advising that unless she attended the meeting the complaint would not progress to stage 3. Unfortunately, Mrs. X had learned of the sudden death of an immediate family member that morning and an offer to reschedule the meeting was made. However, Mrs. X attended the multi-disciplinary meeting on the scheduled date. At that meeting Dr. A. Noon agreed to take control of her 'fragmented care' and she was promised a copy of the minutes of the meeting. Mrs. X never received the minutes, in spite of the fact that Dr. Noon advised that these had been sent to her in August 2023. It was subsequently suggested that those present at the meeting (who had not been tasked with producing the record) generate their own minutes from recall. With regard to Dr. Noon's undertaking to oversee Mrs. X's care, she believed that he had failed

to fulfil his obligations in this respect and she referenced correspondence from him which appeared to focus on the care co-ordination role as opposed to health care or the outcome of the multi-disciplinary meeting. Dr. Noon had advised Mrs. X to contact the PET about her ongoing care but the PET did not deal with clinical care. It was understood that Dr. Noon had been contacted by Information Governance in October 2023, regarding inaccurate information in Mrs. X’s medical records but had yet to take the necessary action to rectify the matter. Mrs. X also referenced the content of certain communications, which appeared to illustrate a lack of awareness and insensitivity to individual circumstances and she stressed that previous complaints should not negate current experiences. Mrs. X advised that whilst an MRI appointment had been brought forward, 2 outstanding tests recommended by the tertiary care provider, both of which were to be carried out by the Health and Social Services Department, were not completed. Mrs. X had paid a private provider to carry out one of the tests.

2.4 The Board noted a full timeline of events from 22nd August 2022 to 23rd October 2023, which included details of interactions with the Health and Community Services Department. Mrs. X advised of the omission of the details of a meeting with the PET in October 2023, regarding access to medical records to address gaps in information. Mrs. X had been advised to contact Information Governance regarding this issue but had been unable to do so despite several attempts. She had sought assistance from the PET who had advised that they were unable to intervene due to the ‘seriousness of the case’. Mrs. X was concerned that clinical decisions were being made on the basis of inaccurate medical records. In response to a question from the Chair, Mrs. X concluded that it was impossible to separate the provision of ongoing clinical care from the complaints process.

2.5 The Board noted the contents of a letter to the complainant dated 1st June 2023, from the Interim Chief Officer of the Health and Social Services Department, who confirmed that onward referrals for tertiary care had to be authorised by a consultant of the Health and Social Services Department in Jersey to ensure oversight and that any care provided was clinically appropriate. This was standard practice across the United Kingdom National Health Service (NHS) and it was understood that miscommunications from the tertiary care centre had

led to delays. An undertaking to recommunicate the policy provisions with tertiary care centres had been provided. The letter also referenced the multi-disciplinary meeting, which it had been felt was necessary prior to the conclusion of the internal complaints process.

3. Minister's case

3.1 The Board noted the contents of a letter dated 13th July 2023, from the Interim Chief Officer of the Health and Community Services Department, which included a timeline for the complaint commencing on 23rd January 2023, and culminating on 5th June 2023.

3.2 The letter dealt with the requirements of the travel policy and other matters raised during the life of the complaint, which had led to the multi-disciplinary meeting. The letter noted that 3 formal responses to Mrs. X's complaint had been produced and that she had attended 2 in person meetings.

3.3 The Board's attention was also drawn to a letter dated 19th December 2023, from the Department which set out the steps which had been taken to address the complaint regarding access to tertiary care, communications by health care providers and the administration of the internal complaint by the PET.

3.4 The Department highlighted the fact that Mrs. X had submitted a total of 9 complaints dating back to 2011, all of which had been investigated and which were considered to have been concluded. The basis of the most recent complaint was considered to have evolved with time and the Board noted a comprehensive summary of the various stages of the complaints process, which had culminated in escalation to stage 3 – which involved the Interim Chief Officer.

3.5 Whilst it was recognised that the timeframe for the complaint exceeded that set out in the Government feedback policy, it was clear that the aforementioned policy recognised that some complaints required more specialist or wide ranging investigations and could take longer to conclude. In total the complaints process had taken just over 4 months, with initial concerns being raised in stage one and additional elements resulting in a multi-faceted complaint which required a different approach. Ultimately, it had been concluded that the internal complaints process had been exhausted.

3.6 Mr. Evans explained that he had joined the organisation in November 2023, as the PET Manager and that prior to that a number of processes had changed

during the pandemic. The PET had been organised in a similar manner to its UK counterpart and he confirmed that the PET dealt with non-clinical matters and much of the investigatory work was carried out by clinical teams. The PET acted as a point of contact and liaison. However, Mr. Evans added that there appeared to have been no clear distinctions between how teams worked and the implementation of UK models had caused confusion in the Jersey context. Weekly meetings were held between the PET and individual care groups to consider complaints. Mr. Evans accepted that the information contained within electronic mail messages received from the PET was confusing in terms of directing patients and some of the language appeared contrary to the aim of engaging for change. Mr. Evans also advised that maintaining a single point of contact for clinical matters was essential in order to avoid disparity. He informed the Board that stage one feedback responses would include the name of the care group lead in future, stage 2 responses would include his own name and stage 3 that of the Chief Officer. He believed that Mrs. X should have had access to a care co-ordinator and a clinical lead and undertook to campaign for the implementation of such arrangements, albeit that this fell outside of the remit of the PET.

3.7 Turning to the multi-disciplinary meeting, Mr. Evans advised that, in his experience it was unusual for patients to be involved in such meetings and this only occurred where care was complex and there had been ‘breakdowns’. He did not believe that multi-disciplinary team meetings involving patients should be arranged in response to complaints, as had been indicated to Mrs. X, and suggested that certain language which had been used had conflated matters. He stated that clear care outcomes should have been set out together with the appointment of a key care co-ordinator. He acknowledged that the PET should have been more involved in ensuring that communications were appropriate and any decisions were implemented. Oversight of clinical management was not undertaken by the PET. Mr. Evans accepted that issues could be raised at the weekly meetings with care group leaders and he advised that he was reliant upon the information provided by senior care group leadership. He also highlighted the fact that he was responsible for scrutinising information received in relation to complaints to ensure accuracy. Mr. Evans advised that in this particular case it appeared that a holistic approach had not been adopted and that the provision of co-ordinated care had been overshadowed by the feedback process.

3.8 Mr. Evans confirmed that clinical care should not be prejudiced by complaints. It was noted that complaints submitted by Mrs. X had been referenced during a medical appointment and Mr. Evans apologised for this.

3.9 Turning to the travel policy, it was noted that, whilst this was not means tested, to qualify for public funding, travel had to be booked through the Department's travel office and that consultants could request assistance for patients travelling to the UK. It was not clear whether patients were routinely asked by clinical staff whether they felt able to travel alone and the Chair suggested that this should be considered. It was also noted that the travel policy was currently under review. One of Mrs. X's concerns related to the fact that a patient's medical history was not considered in its entirety when they were required to travel off Island. She also believed that the travel office should offer to book flights for individuals accompanying patients with the chaperone funding their own travel costs where appropriate. Similarly, Mrs. X expressed frustration at the requirement for patients to attend outpatient appointments in Jersey to obtain medication recommended by a tertiary care provider, as opposed to receiving medication directly from the hospital pharmacy. However, it was confirmed that such an arrangement would give rise to clinical governance issues.

3.10 The Board was advised that a new information technology system had been installed in the hospital in May 2023, with a 3 year phased approach to implementation having been adopted. This system would facilitate the creation of electronic patient records meaning that clinicians would have access to records irrespective of the physical location of a clinic. Nurses would also use handheld devices to record information and the new system would provide the PET with 'the whole picture' and improved governance. Mr. Evans explained that each speciality would have oversight of individual cases with any issues being raised first with the care group, then a Board and finally a Non-Executive Director. In response to questions regarding Ministerial support for improved processes, Mr. Evans believed that facilitating a greater understanding of the day-to-day work at a political level would be beneficial but the involvement of the Minister should be viewed a last resort. Mr. Evans also suggested that sharing Mrs. X's experiences with colleagues would lead to learning but Mrs. X felt unable to commit to this at present. She went on to raise another issue she was dissatisfied with, which involved visiting locums applying NHS work

practices which resulted in prolonged waits. Ms. Marshall advised that locums received an induction but undertook to investigate this issue. Ms. Marshall advised of problems which had arisen when appointments had been moved over to the new system, with some patients receiving multiple appointments.

3.11 Mr. Evans stated that some of the issues discussed appeared to have arisen as a result of the language and tone used in correspondence and a lack of consistency in communication. The Chair suggested that communication should not take place 'for the sake of it' and that there should be a single point of contact. Similarly, any commitments should be followed through to their conclusion as the alternative resulted in distress and reduced confidence in the Department. Mrs. X referenced an independent report which had been prepared following a previous complaint to the Board and noted that the style and tone of correspondence had been highlighted in the report together with the lack of a proactive approach. She stated that the difficulties she had experienced suggested the recommendations arising from the report had not yet been implemented. Mrs. X believed that many issues which arose could be dealt with swiftly if the correct approach was adopted.

3.12 In concluding, Ms. Marshall extended an apology on behalf of the Department for the trauma and inconvenience Mrs. X had experienced. She believed that Mr. Evans' appointment would lead to improved processes and that progress was already being made to keep patients better informed. However, Mrs. X stated that she had received similar assurances in the past. Ms. Marshall assured her that Mr. Evans' professional experience would be of great assistance to the PET in moving forward with improvements and dealing with issues as they arose. However, Mrs. X wished to raise the issue of accountability and referenced the multi-disciplinary meeting and the lack of any tangible outcomes and suggested that Dr. Noon should be held accountable for this. She concluded by stating that she did not wish the past to be forgotten.

4. Closing remarks

4.1 The Chair thanked those present for attending and for their frankness and openness in discussing the issues raised. He also highlighted the limited scope of the Board's considerations but also advised that it was within the gift of the Board to make recommendations where appropriate. The Chair indicated that a

report of the hearing would be prepared in due course, which would be circulated to both parties for their input on the factual content.

5. Findings

5.1 The Board considered whether Mrs. X's complaint could be upheld on any of the grounds outlined in Article 9 of the Administrative Decisions (Review) (Jersey) Law 1982, as having been –

(a) contrary to law;

(b) unjust, oppressive or improperly discriminatory, or was in accordance with a provision of any enactment or practice which is or might be unjust, oppressive or improperly discriminatory;

(c) based wholly or partly on a mistake of law or fact;

(d) could not have been made by a reasonable body of persons after proper consideration or all the facts; or

(e) contrary to the generally accepted principles of natural justice

5.2 The Board upholds Mrs. X's complaint on the grounds of (b) and (e) above.

5.3 The Board was of the view that this case identified significant weaknesses and inefficiencies within the Department, to include a failure to place the patient at the heart of its processes. The Department must maintain a constant awareness of the fact that a patient is, by definition, unwell and this will have an emotional impact. It is essential for patients to have confidence in the oversight and management of cases. In practice, this means that a clear clinical plan with a timetable should be formulated and, most importantly, a dedicated point of contact should be established at the outset. Unfulfilled undertakings, the cancellation of meetings at short notice, inadequately briefed clinicians or Departmental officers and somewhat patronising unsigned correspondence did nothing to suggest practical progress in respect of ongoing care or treatment and were not positive indicators of the proper management and surveillance of a patient's case.

5.4 The Board was particularly concerned about the Department's complaints process. At the outset, Mrs. X appeared to have no desire to make a formal complaint, but merely wished to highlight what she perceived as generic inefficiencies, as well as shortcomings in respect of her own care. The Board was particularly concerned that once Mrs. X had been categorised as a

'complainant' this appeared to have a material effect on her clinical care. By the Department's own admission, no further steps could be taken until the outcome of the Departmental complaints process had been completed. The Board considered this approach to be indefensible and if this was indeed the Department's position, would require a full explanation as to what bearing the outcome of its consideration of the Department's complaint handling could possibly have in the context of the patient's clinical care. All patients were entitled to receive the best clinical care reasonably possible in a timely manner.

5.5 The Board considers that the Department did not follow its own complaints process. Mrs. X's complaint was escalated to Stage 2, which according to the Department should involve '*assessment and investigation of the complaint and decisions already made, a facilitated resolution process by request of the complainant (sic) (where a person not connected with the complaint reviews the matter and attempts to find an outcome acceptable to the relevant parties)'*. The Board was satisfied that no meaningful assessment or investigation of the complaint at this stage took place. Such investigation should have included an interview with the complainant, particularly as she had offered further documentary evidence in support of her complaint. Moreover, the Stage 2 process objective *('to find an outcome acceptable to the relevant parties'*) did not appear to have been considered as no such outcome was communicated to the complainant. The Stage 2 procedure further states that '*where a person making a complaint is dissatisfied with the outcome of a Stage 2 review, ... they may seek escalation to the Chief Officer* (Stage 3)'. The escalation of the complaint to Stage 3 is therefore entirely at the discretion of the complainant. However, in this case, Mrs. X was not aware that the complaint had been moved on to Stage 3. This demonstrates further a clear failure on the part of the Department to follow its own procedure.

6. Recommendations

6.1 The Board suggests that the Department review the nature and relevance of all communications to ensure that these focus on patient care and do not inadvertently adopt an unnecessary tone which could be misconstrued as patronising or condescending. All communications should advance or explain any relevant issues and patients should be able to respond directly to a dedicated individual responsible for managing the administration of their ongoing care.

The Department should also take patients' personal circumstances and health into consideration when communicating with them.

6.2 The Board was particularly concerned about the impact of the Departmental complaints process on clinical care. Mr. Evans (whom the Board understands has now left the Department after less than 3 months in post) tacitly acknowledged that complainants might be regarded somewhat differently in the context of the provision of clinical care. This would appear to be undeniable in this particular case, and reinforced by allegations that the publication of this Board's findings would likewise delay clinical care decisions. The Board considers this to be unacceptable.

6.3 Having established a PET, the Board recommends that patients involved with Departmental or other complaints processes should be allocated a dedicated liaison officer to ensure ongoing and clear communication between the Department and the patient, both in respect of the complaints process and the clinical care plan. This would ensure that clinical care was not adversely affected or disrupted by the complaints process. Whilst the role of the PET in the context of the provision of clinical care was understood, the Board was of the view that this should not preclude the team from keeping patients properly informed at each stage of the process and acting as a consistent point of contact for the patient.

Signed and dated by –

G.C. Crill, Chair, Chairman .... Dated: ....

G. Fraser .... Dated: ....

D. Warman .... Dated: ....