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Ben Walker
Research and Project Officer
States Assembly

BY EMAIL ONLY

30 September 2025

Dear Mr Walker,

Consultation response: Draft Regulation of Care (Jersey) Amendment Law 202–

Thank you for the opportunity to contribute to the work of the Regulation of Care Sub-Panel and to comment on the proposals as set out under the Draft Regulation of Care (Jersey) Amendment Law 202-. As noted in our response, The Royal College of Physicians is not a regulator or an expert in regulatory matters and we have therefore addressed your questions from the perspective of having previously undertaken invited reviews of specialty services in Jersey General Hospital.

If not already done, we would encourage you to seek the views of the Professional Standards Authority for Health and Social Care as well as oversight bodies in other jurisdictions (The Regulation and Quality Improvement Authority, Healthcare Improvement Scotland, Healthcare Inspectorate Wales and the Care Quality Commission) which have expertise and/or experience in this area.

Yours sincerely,

Mustafa

Dr Omar Mustafa
Registrar, Royal College of Physicians

Enclosed: Consultation response

Consultation response: Draft Regulation of Care (Jersey) Amendment Law 202–

The Royal College of Physicians (RCP) is the membership body for physicians, that is, doctors who work in the medical specialties. We are the largest professional association for UK hospital doctors, supporting physicians to deliver the best healthcare possible for patients and improve standards of care. We represent around 40,000 members and fellows in the UK and internationally. The RCP Invited Reviews (IR) Service offers consultancy services to healthcare organisations which require independent and external advice and support. Reviews provide an opportunity to healthcare organisations to deal with issues and concerns at an early stage.

Thank you for the opportunity to contribute to the work of the Regulation of Care Sub-Panel and to comment on the proposals as set out under the Draft Regulation of Care (Jersey) Amendment Law 202-. The Royal College of Physicians is not a regulator or an expert in regulatory matters. Our response is therefore from the perspective of having previously undertaken invited reviews of specialty services, including of clinical records, in Jersey General Hospital. Our answers to the specific questions posed are set out below.

1. **The 2023 Review highlighted "Some interviewees voiced apprehension with regards to reporting incidents due to the possible consequences that they felt might follow". The draft Law proposes the introduction of a 'duty of candour'. What impact do you believe the proposals for the duty of candour as set out within the draft Law, will have on learning from serious incidents across the service?**

We welcome this move towards greater transparency and the intention to increase learning from serious incidents. However, in order to be effective, this measure needs to be introduced as part of a wider commitment to supporting and embedding a culture of safety, learning and improvement within healthcare services in Jersey.

The duty proposed mirrors that already in place in England on service providers and managers. It was not clear whether the Jersey Care Commission would have similar enforcement powers to the Care Quality Commission (CQC).

There is existing research into the effectiveness of the duty of candour on service providers and managers in England. For example in November 2024 the Department of Health and Social Care (DHSC) reported the findings of a review which identified some concerns in relation to:

- culture (of the health and care system)
- inconsistency (in understanding and applying the duty)
- training (the lack of it, the need for further training)

Notably, less than 1 in 4 respondents to the DHSC's call for evidence said that the duty is correctly complied with when a notifiable safety incident occurs. Some felt staff are reticent about complying with the duty for fear that it admits fault and liability and leaves them open to blame. Others reported

instances where staff were empathetic and aimed to follow the process, but senior management did not support them, and they feared not being protected if considered a 'whistleblower'. Some respondents also believed there to be a culture of covering up incidents, falsification of records and dismissal of complaints.

It is reasonable to consider that similar issues could arise in the context of Jersey and if so, this would potentially limit the intended impact of the new duty.

As well as introducing a duty of candour on providers, there are a number of other factors that will impact positively on the likelihood of healthcare professionals raising concerns and the extent to which there is learning from serious incidents. These include:

- having appropriate and varied forums/routes through which to raise and discuss concerns (governance meetings, freedom to speak up guardian/adverse incident reporting software etc.) which are both well understood by staff and effectively managed
- having an organisational culture in which staff believe that those in senior leadership roles will take appropriate action in response to concerns.

These were particular areas of weakness identified in our review of the rheumatology service. We therefore consider that there must be a focus on steps to improve this alongside the introduction of a duty of candour, if the goals of increased reporting of and learning from patient safety incidents are to be achieved.

2. The draft Law proposes that the General Hospital, including all 'satellite sites', be inspected independently by the Jersey Care Commission. In the 2023 Review, it was stated that the "A recurring theme was the lack of governance, not just in rheumatology but across the healthcare organisation". To what extent do you believe the independent inspections of the hospital and its satellite sites by the Jersey Care Commission, as proposed by the draft Law, will address these governance and accountability concerns?

We think that a move towards greater independent scrutiny of healthcare services in Jersey is positive and could be a means to measure the effectiveness of governance structures and hold service providers to account. However, we have reservations, based on our review of some Jersey hospital services, that the lack of governance infrastructure observed within Jersey General Hospital will make it difficult to effectively measure performance and quality without significant improvement.

We note that one of the tasks of the Regulation of Care Sub-Panel is to assess the readiness of the service providers in scope of the proposals to implement the changes and to evaluate transitional arrangements and stakeholder engagement. We consider that there is a great deal of work to do before services at the hospital are in a position to meaningfully participate in an effective system of inspection. This will require investment and strong leadership to drive a culture of transparency and focus on measuring and improving outcomes for patients.

It is not clear what standards healthcare providers will be required to meet under this proposal. If these are still being developed, we would encourage consultation with the medical specialty societies and associations and relevant royal colleges which have expertise in this area. Engagement with the clinicians at a service level as to what they consider may be reasonable quality markers of assessment for their service would also be beneficial. The draft legislation states that where local expertise is not available, the Jersey Care Commission will engage external agencies to carry out specialised

inspections. We welcome this commitment and consider that external expertise must be obtained through a standardised and transparent process.

2. a) Do you believe that the proposals for inspections across Health and Community Services, by the Jersey Care Commission, address the 2023 Review's concerns about the "absence of the expected audits and benchmarking processes" that would normally be found within a rheumatological service?

Our experience from the review of the rheumatology service was that there was little to no activity and outcome data being collected and a very concerning lack of appetite among some staff to change this.

Again, a significant amount of work will be required to bring about improvement in this area. Data collected via the type of audit programme that we recommended for the rheumatology service may form part of the evidence provided in the proposed inspection process. However, regulation and inspection are distinct from the service/specialty level auditing and benchmarking discussed in our report.

The form of inspection proposed is a regular, regulatory assessment to check for compliance with specific rules and standards. An audit is a more in depth, periodic and systematic evaluation of data and clinical outcomes to assess overall effectiveness, identify root causes of potential issues, and ensure continuous quality improvement. Clinical audits allow healthcare practices and outcomes to be reviewed and compared against both evidence-based standards and the outcomes of other similar services. Undertaking regular audits and service evaluation (at an island level) is important in demonstrating safety on an ongoing basis and also embedding the culture of safety in everyday practice. It was not clear to us that regulation of these services will facilitate similar comparison and benchmarking processes.

3. **The 2023 Review also stated that "The review team were troubled with the lack of built in challenge to prescribing, particularly biologics, by the pharmacy team". Do you feel that the provisions covering the regulation of the Hospital pharmacy services, under Regulation 22 of the draft Law, addresses the 2023 Review's concerns about the lack of challenge to prescribing pharmaceuticals?**

Again, it is not clear what standards pharmacy services will be required to meet, making it difficult to answer this question. The introduction of regulation and regular inspections may encourage pharmacy services to make changes in line with some of those we recommended in our review of the rheumatology service such as improving data collection and introducing effective monitoring systems.

Our review of the rheumatology service and our findings in respect of its interaction with the pharmacy service, if reflected across hospital services, would indicate that significant cultural and organisational change is needed to ensure that pharmacists provide appropriate challenge to clinical colleagues and work effectively with them to provide safe care in line with nationally agreed medication management frameworks. We do not consider that the introduction of a system of inspection is sufficient in isolation to address these challenges.

4. **Overall, to what extent do you believe the regulation of Jersey's hospital services and ambulance services will provide Islanders with assurance about the quality and safety of Government provided healthcare services?**

4. a) Do you feel that the draft Law has taken account of the independent review of rheumatological services in Jersey undertaken in 2023?

We have welcomed the opportunity to contribute to the work of the Sub-Panel and to support the proposed move toward greater transparency and accountability in healthcare services in Jersey.

We note that our findings in the review of the rheumatology service have been considered as part of this process. Based on our experience of conducting that review and those of other services at Jersey General Hospital, the proposed legislation is only one element of the significant work that is needed to achieve the overarching goal of improving standards of patient care.