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Deputy Beatriz Porée
Chair, Health and Social Security Scrutiny Panel
BY EMAIL

19 October 2026

Dear Chair,

Written Follow-Up Questions: Quarterly Public Hearing

Thank you for your letter following the recent Quarterly Public Hearing.

Please find attached my responses to the Panel's outstanding questions. I hope these provide the information requested and are helpful to the Panel.

Hospital Discharge Letters

Q. Can you please explain who first identified that approximately 7,300 discharge summaries were not being received by GP practices?

The issue was identified progressively through technical alerts and reports of individual missing discharge summaries, rather than through a single report that immediately established its full scale.

The earliest evidence currently identified is a production alert within the EMIS Keystone discharge pathway on 10 February 2026. This was followed by further alerts and reports of individual missing discharge summaries. By the end of April, technical investigation involving the Digital Health support teams and the system supplier had identified that some discharge files contained large data sizes but no correlation with Keystone was identified. At that stage, however, the full scale and potential clinical significance were not recognised.

On 9 July, the Digital Health team escalated concerns that the issue might affect several specialties and could result in GP practices not receiving information about medication changes, monitoring, investigations or follow-up actions. Further technical investigation involving the Digital Health team and the system supplier established the relevant processing failure on 10 July. It was discovered that some Discharges were causing Keystone processing errors and result in files being archived as suspect.

The Digital Health leadership team then initiated the formal incident-management process, alerted the clinical-safety leadership and requested a controlled recovery approach involving Health and Care Jersey, primary care and the system suppliers.

The initial estimate of approximately 8,000 potentially affected discharge summaries was subsequently reconciled to 7,324, which was communicated publicly as approximately 7,300

Q. Were there any missed opportunities to identify the problem earlier, given that affected records date back to February 2026?

Yes. The evidence indicates that there were earlier signals which, when considered collectively, could have led to the wider problem being recognised sooner.

These included one production alert from February and individual reports of missing discharge summaries in April. A support incident with the HCJ EPR supplier, IMS Maxims, relating to missing electronic discharge summaries was subsequently closed on 1 June without the underlying issue being confirmed as resolved, as no issue was detected by the HCJ acute EPR supplier. Further individual reports continued during June before the matter was escalated as an explicit clinical-safety risk on 9 July.

Two factors particularly complicated detection.

First, discharge summaries were facing an established pattern of delayed discharge summaries. GP practices could not readily distinguish between a summary that had not yet been clinically completed, one that had been completed but not transmitted and one that had been transmitted but had not reached the practice. The absence of a summary could therefore appear consistent with the existing pattern of delay, rather than immediately indicating a systemic transmission failure. The established pattern of delayed discharge summaries consequently masked the emerging technical problem and contributed to the absence being regarded as normal by receiving practices.

Secondly, the EMIS/Keystone alerting and monitoring arrangements did not clearly present the affected documents as failed deliveries. Files could be moved to a suspect area, but the monitoring produced alerts that were not clear and did not provide clear document-level reconciliation or reliable end-to-end confirmation that each summary had entered the intended practice's EMIS workflow. There was therefore no straightforward alert displaying the cumulative number of discharge summaries that had failed to reach GP practices.

The emerging review has also identified that individual reports were initially handled as separate technical cases, responsibilities across the multi-supplier pathway were not always sufficiently clear, and the support incident was closed before the wider clinical risk had been fully understood.

These matters are being examined through the Serious Incident Review. Its purpose is to establish the complete sequence of events, determine why the available signals did not result in earlier escalation and identify the monitoring, governance and supplier-management improvements required.

Q. Recent correspondence from the Minister to the Panel states that there is no evidence of widespread patient harm. Are any cases still under review through the clinical harm assessment process?

Yes. The statement that there is no evidence of widespread patient harm should not be interpreted as meaning that every individual case has completed clinical assessment.

The main incident was recorded as Datix B-83904. A related potential patient-safety case, Datix B-83989, concerned an AMU discharge summary dated 4 April that was received by the relevant practice on 21 July. The practice reported that requested repeat blood tests had not been completed and medication changes had not been actioned because the discharge information had not been available to the GP team.

That case required clinical review to determine whether the outcome should be classified as confirmed harm, a near miss or delayed care without identified harm. Additional Datix reports and concerns raised by practices were also included within the clinical-governance and harm-review process.

The latest evidence available for this response does not provide a final, formally approved outcome for every case. The appropriate position is therefore that there remains no evidence of

widespread patient harm, while acknowledging that individual concerns have been subject to clinical assessment.

Q. What criteria are being used to determine whether a patient has suffered harm due to delayed or missing discharge information?

Each reported concern is assessed clinically to determine whether the absence or delay of the discharge information caused or contributed to a delay, omission or material change in the patient's care.

The assessment considers whether:

- a medication change was delayed or not implemented;
- requested blood tests, investigations or monitoring were delayed or missed;
- a referral or follow-up appointment was delayed or not initiated;
- an action requested of the GP was not undertaken;
- the patient experienced deterioration, readmission or a need for additional treatment;
- the patient's vulnerability or clinical complexity increased the potential impact;
- the delayed information caused or contributed to the outcome; and
- the outcome should be classified as confirmed harm, a near miss or delayed care without identified harm.

The assessment draws on the hospital and GP clinical records, the full discharge summary, Datix reports, information supplied by the relevant practice and evidence of subsequent care or outcomes.

The interim reports provided to practices were intended to support prioritisation and reconciliation. They were not intended to replace the complete discharge summary or an individual clinical assessment.

Q. When does the Minister expect the Serious Incident Review to be completed, and will its findings be published?

The immediate operational recovery has been completed. The backlog was cleared, electronic Emergency Department discharge processing was restored, and the revised processing arrangements were reported as operating as expected. The incident then moved into formal investigation, clinical harm assessment, assurance and lessons learned.

The Serious Incident Review is continuing and is expected to conclude within one month. The review is considering the incident sequence, clinical harm assessment, validation and reconciliation of the affected cohort, supplier evidence, and the actions and controls required in response.

The Department will share the findings with the Panel once the review has concluded.

Any wider publication decision will need to take appropriate account of patient confidentiality, information security and legitimate commercial sensitivities. The immediate commitment is to provide the concluded review to the Panel.

Q. What assurances can the Minister provide that similar information-sharing risks do not exist elsewhere within Health and Care Jersey's digital infrastructure?

It would not be appropriate to provide an absolute assurance that no comparable risk could exist anywhere within a complex digital estate. The appropriate assurance is that the specific affected

pathway has been recovered and stabilised, and that the wider lessons concerning monitoring, reconciliation, governance and supplier oversight are being addressed.

For the affected pathway:

- the backlog was cleared;
- electronic processing was restored;
- separate processing arrangements were introduced for Emergency Department and non-Emergency Department discharge summaries;
- end-to-end and volume testing was undertaken;
- processing capacity was increased and monitored;
- reports were issued to practices to support reconciliation;
- practice-specific queries continued to be investigated; and
- later routine incident meetings reported that processing was continuing without new concerns being raised.

A central lesson is that confirmation that a document has left one system does not demonstrate that it has become available to the intended recipient. Future assurance must cover the complete pathway from clinical completion, through document generation and transmission, to visibility within the recipient's workflow.

The review identifies the need for stronger reconciliation, clearer alerting, improved architecture and configuration documentation, capacity testing, supplier assurance and clinical-safety oversight.

The evidence available does not establish that a review of every comparable interface across HCJ has been completed. The Department should therefore state that the learning is being applied to other safety-critical information flows and that further assurance work is continuing, rather than claiming that all comparable risks have already been eliminated.

Q. Has the Department considered whether contractual arrangements with EMIS provide sufficient accountability in situations where system failures affect patient care?

The incident has demonstrated that the contractual and supplier-management arrangements must be considered alongside the technical and clinical reviews.

EMIS provided senior operational and clinical-safety support, participated in the recovery and testing activities, implemented the technical enhancement and began its own root-cause work. The evidence also identifies matters requiring further examination, including the communication of processing constraints, incident escalation, access to technical evidence, service monitoring, capacity limits, and accountability for confirming that documents have entered the receiving GP workflow.

The review of the arrangements should consider whether they provide sufficiently clear requirements covering:

- clinical-safety incident notification and escalation;
- end-to-end delivery and acknowledgement;
- service monitoring and reconciliation;
- system performance and processing capacity;
- root-cause investigation and corrective action;
- cooperation and access to evidence during a Serious Incident;
- responsibilities where a service crosses several systems or suppliers; and

- appropriate remedies and accountability where service failure could affect patient care.

In parallel with the Serious Incident Review, the Department is reviewing the contractual implications with its commercial and legal partners. That work is considering supplier performance, oversight, accountability and any contractual implications arising from the incident. As this review remains in progress, it would be premature to state a final position on contractual responsibility or supplier liability.

Q. The Minister advised during the Hearing that the Connecting Care Programme is expected to provide NHS-aligned infrastructure during the first half of 2027. Can you provide an update on the programme's status and delivery timetable?

The programme is now commonly referred to as the Connecting Health programme, with the Single Patient Record describing its core patient-record ambition.

Work is progressing across several enabling foundations, including NHS connectivity, access to NHS-aligned services, primary-care data access, the Shared Care Record or Single Patient Record, and procurement of a Clinical Data Repository and open-EHR platform.

The Clinical Data Repository/open-EHR procurement and partner-selection timetable has been extended to allow for a final review, and additional time for bidder submissions, demonstrators and robust evaluation. The earliest contracting point is therefore February 2027, with capability releases following procurement, mobilisation, technical assurance and implementation.

It is too soon to confirm whether any platform capability releases will occur during the first half of 2027. In 2026, the programme objective is to open connectivity to the NHS Health and Social Care Network, unlocking early benefits associated with shared pharmaceutical prescription data.

“NHS-aligned infrastructure in the first half of 2027” should therefore be understood as phased implementation of enabling foundations, rather than completion of the full Single Patient Record by that date. The current confirmed near-term commitment is the 2026 NHS Health and Social Care Network connectivity objective; the timing of subsequent capability releases will be confirmed after partner selection and detailed implementation planning.

Q. What are the principal risks to successful delivery of the Programme, and is the project currently on time and within budget?

The principal risks currently identified include:

- availability and timely onboarding of specialist technical and programme resources;
- insufficient architectural capacity to complete detailed designs;
- procurement and evaluation timescales;
- dependencies on NHS connectivity, NHS permissions and external suppliers;
- access to data held in existing systems, including primary-care systems;
- data quality and patient matching;
- adoption and management of NHS numbers;
- information-governance and data-sharing approvals;
- integration across primary, acute, community, mental-health and specialist systems;
- and
- maintaining operational and clinical services while introducing significant change.

The September programme material specifically identifies incomplete resourcing and the absence of engaged resource to produce low-level designs for the Single Patient Record as risks capable of delaying critical-path milestones.

The programme is within its approved 2026 funding envelope but is not currently on time. Actual spend to 29 September 2026 was £1.87 million against a £7.86 million budget. Forecast total spend to the end of the year is £5.19 million, representing a forecast underspend of £2.67 million.

The current programme status is red, trending upwards. The principal drivers are delivery delays caused by recruitment restrictions during the early months of the programme, resource constraints among delivery partners across the organisation, delays to the platform procurement to allow wider engagement across Jersey technology companies and insufficient capacity deal with the project's requirements within the government's central IT department.

The path to green includes recruiting bridge resources to provide interim capacity ahead of permanent appointments; running foundational workstreams, including information governance and system integration, alongside platform procurement; implementing stakeholder and communication strategies; and adopting Agile delivery methods to accelerate capability releases once a platform partner has been selected.

Q. How will the success of the Programme be measured in terms of improving communication and information sharing between Health and Care Jersey, GPs and other healthcare providers?

Success should be demonstrated through measurable improvements in the availability, reliability, safety and usability of information across care settings, rather than solely by confirming that new technology has been installed.

The proposed measures should include:

- availability of agreed priority information through the Single Patient Record;
- successful matching of information to the correct patient;
- the number and range of participating providers able to access the agreed information;
- reduction in failed, delayed or unmatched clinical communications;
- improved end-to-end acknowledgement and traceability;
- time taken for hospital information to become available to authorised professionals;
- reduction in duplicate requests, investigations and manual information searches;
- reduction in administrative work needed to confirm whether referrals or documents have been received;
- professional confidence in the currency and completeness of the information;
- use across primary, acute, community, mental-health, ambulance and other participating services;
- clinical-safety incidents associated with missing or delayed information; and
- patient and professional experience of coordinated care.

The first Single Patient Record release is intended to be view-only and implemented incrementally, beginning with information prioritised for safe and effective care. Clinical prioritisation work has included patient identification, alerts, allergies, diagnoses, medicines, key results, treatment-escalation information, selected discharge information and others. An early enabling measure for 2026 will be whether connectivity to the NHS Health and Social Care Network is opened as planned and begins to deliver the expected benefits from shared pharmaceutical prescription data. Later measures should track the value and adoption of phased capability releases after a platform partner is selected.

A formal benefits framework is being established to provide a baseline, define each measure, assign accountable owners and report outcomes through programme and clinical governance.

Measures should be aligned to incremental capability releases and supported by the programme's stakeholder and communication strategies, so that the Department and the Panel can determine whether the programme has produced meaningful improvements for patients and professionals.

Health and Care Partnership Board

Q. Following reports that initial expressions of interest were lower than anticipated, was the Minister satisfied with the level and diversity of applicants, and were any additional recruitment measures required?

The deadline for expressions of interest was extended and more widely advertised, as the initial number of expressions received was lower than anticipated. Having taken these actions, there were numerous additional expressions of interest from across all health and care sectors, enabling me to proceed to appointment of Community Partners for the Board.

Q. Which sectors and organisations are currently represented on the Board, and are there any significant gaps in representation that still need to be addressed?

There are 11 Community partners are drawn from the following sectors:

- Third Sector Services
- End of Life Care
- Clinical Psychology
- Occupational Health
- Care Homes
- Allied Health Professionals (Occupational Therapy)
- General Practice
- Community Dental
- Community Pharmacy
- Community Nursing
- Home Care

There are currently no significant gaps in representation.

Q. Can the Minister provide examples of improvements, initiatives or areas of work that have emerged from the Board to improve integration between the Department, primary care, voluntary sector providers and other partners?

The Partnership Board has had two meetings to date, which have focused on providing an opportunity for Partners to get to know each other, to share information and discuss areas of intended joint working. It is too early in the formation of the Board to report on delivery as further actions are required to complete the operating framework.

Q. What feedback has the Minister received from Board members and healthcare providers regarding the effectiveness of the new arrangements?

The Minister has received positive feedback, with a few members having expressed some concerns about their role and anticipated outcomes. This is to be expected when setting up a new Board which is intended to help drive a new culture of whole system partnership working.

Q. Given concerns raised during the States debate regarding the evidence base for the Board, does the Minister intend to undertake any formal review or evaluation of its effectiveness during this Assembly term?

P52/2025 acknowledged that Partnership Board represents a new way of working in Jersey hence the terms of reference require:

the Board's terms of reference to be reviewed by the Board within six months of its establishment (end 2026)

the Board to arrange periodic reviews of its performance.

Subject to discussions between the Minister and Board members, it is envisaged that the first performance review will take place late 2027 (18 months post establishment)

Q. The Board was established to promote a whole-system approach to health and care. How does the Minister envisage it contributing to addressing major challenges such as primary care access, mental health services, hospital pressures and the sustainability of the Health Insurance Fund?

The Board will contribute to helping solve these complex challenges in the following ways:

- they will examine papers, information and proposals brought to them by me the department's officials and by the Board sub-groups, from their professional / sector perspective
- they will consult / liaise with others in their profession / sector bringing their insight and expertise to bear on those matters
- they will participate in Board sub-groups established to examine complex whole system systems (such as cancer pathways)
- they will provide me with professional / sector specific advice to help support decision making.

Yours sincerely,



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