Governance Arrangements for Health and Social Care – Follow up

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Summary

Introduction

1. Good governance is essential for good public services. It involves clarity, openness and taking into account the views of the public including service users.

2. Good governance is of particular importance for Jersey's health and social care because of the:

   - scale of States' expenditure in this area
   - substantial changes implemented and planned for implementation within health and social care
   - incidence of high profile failings in health and social care where governance arrangements were unsatisfactory, in Jersey and elsewhere; and
   - particular need for public confidence in the health and social care system.

3. In 2018 the then Comptroller and Auditor General (C&AG) undertook a review of the adequacy of arrangements for governance of health and social care.

4. In her Report *Governance Arrangements for Health and Social Care,* my predecessor found that:

   - the governance arrangements for health and social care in place at May 2018 were inadequate: at an overall level they were overly complex for a relatively small health and social care system but at the same time poorly defined and communicated
   - clinical governance was not fit for purpose: there was no strategy or plan and the body in place to oversee the clinical and care audit programme did not take an effective role
   - there was fragmentation of responsibilities: even with the planned implementation of the Target Operating Model, there was much work to do to rationalise, clarify, communicate and implement governance structures and arrangements; and
   - governance arrangements lacked a focus on the quality and outcomes of health and social services provided, including:
     - insufficient impetus to implement independent regulation and inspection of all health and social care provision, including that

provided by the States, as an essential means of securing quality and providing assurance

- patchy public reporting on how services perform
- no effective use of complaints and whistleblowing as tools of governance; and
- poor practice in the preparation, maintenance, review and challenge of risk registers relating to health and social care.

5. The Government accepted all of the 22 recommendations made by my predecessor and developed an action plan in response. The implementation of the action plan has been monitored by HCS using an action tracker to update progress made.

6. I have now undertaken a follow up review with the same scope as the original 2018 work. This review is not an audit of the development or implementation of the Jersey Care Model. Where relevant, I have considered the Jersey Care Model in making recommendations. I am planning a review of the Jersey Care Model as part of my 2022 work programme.

7. This review has considered 'business as usual' governance arrangements and has not considered any specific arrangements put in place in respect of the COVID-19 pandemic. I have undertaken a separate review of the *Management of the Healthcare Response to the COVID-19 pandemic* (April 2021). I am also undertaking a specific review of *Governance and Decision Making during the COVID-19 pandemic*.

Key findings

8. The key findings from my follow up work are summarised below.

- Since the 2018 Report there has been some progress in implementing recommendations made. Where progress has been made it has been focussed on the Health and Community Services Department (HCS) rather than the whole Government health and social care system or the wider Island health and social care system.
- Out of the 22 recommendations made in 2018:
  - six have been implemented in full (although there is scope for further improvements in implementing two of these recommendations)

    - 12 have been partially implemented with more work required for full implementation; and
    - four have not been implemented.

- A HCS Board has been established with supporting assurance committees focussed on HCS functions. The way the HCS Board operates has changed since its establishment. Over time, there has been more verbal reporting with little supplementary written performance information outside of performance presentations.
- At assurance committee level there are terms of references in place, good minutes, committee workplans and action trackers. From the evidence I have reviewed however the three assurance committees act as HCS wide management groups, rather than providing assurance to the HCS Board.
- HCS is not the only department within Government with responsibility for the planning and delivery of health and social care services. The current model of governance for health and social care is focussed on HCS and does not have a clear rationale in terms of other Government provided services and the wider health and social care system. As a consequence, there remain gaps, duplications and misalignments in accountability and governance for health and social care within Government.
- As the implementation of the Jersey Care Model progresses there is a need to clarify the link between the overall governance arrangements for the health and social care system on the Island and those established within HCS. In particular, the links between the Jersey Care Model Independent Board and the HCS Board need to be articulated to ensure clarity and avoid potential duplication or gaps.
- Since the 2018 Report, the Jersey Care Commission has been established formally and has begun regulating services.
- Significant progress has been made since 2018 in setting out an overall Jersey Performance Framework linking down through the Government Plan to departmental objectives and business plans for individual Government departments, including HCS.
- There would be benefit in documenting a longer term strategy for health and wellbeing including an analysis of healthcare needs and actions planned to reduce healthcare inequalities and improve health and social care outcomes. This longer term strategy for health and wellbeing would benefit from the identification of some 'mid-range' enabling targets and performance measures.

Such mid-range measures would fill the gap between the short term operational indicators and the longer term high level outcome measures.

- Despite an improvement in performance on complaints handling since 2018, there is still a significant volume of HCS complaints that is not responded to within the target timescales.

- Capturing patient views through complaints is only one aspect of obtaining feedback on services. Since 2018 a Patient Experience Manager has been appointed. This is not however the same as a Patient Advice and Liaison Service (PALS), seen as good practice in other jurisdictions.

- There is good evidence of improvements having been made to HCS performance reporting since the 2018 Report. However, the quality performance reports produced for the Quality and Risk (Q&R) committee have not been reported publicly until recently. On 17 August 2021, HCS published its Quality and Performance Report for June 2021. I welcome this development which moves Jersey towards best practice seen in other jurisdictions. There should be an ambition to extend further the scope and nature of routine public reporting of the performance of all elements of health and social care.

- HCS has developed a Quality Strategy. Performance against this strategy should be published. This should include a detailed Annual Quality Account, which should include Jersey Nursing Assessment and Accreditation System (JNAAS) performance, serious incident information, summary details of complaints and compliments themes as well as outcomes of audits, clinical outcomes, clinical audits and benchmarking exercises undertaken. The Annual Quality Account should also include a full list of all internally commissioned external clinical reviews, including a summary of findings and key actions.

- In order to achieve a culture of continuous improvement within health and social care services it is essential to embed a quality and safety mindset. The appointment of a Quality and Safety Director will be key to this change. The rollout of a strong quality and safety programme including training in improvement skills is an important next step.

Conclusions

9. Since the 2018 Report, governance within HCS has visibly moved forward. This is evidenced by;

   - the HCS Board, the supporting assurance committees and executive oversight; and

   - new and improved systems for standards, regulation, risk management, performance management, business planning, whistleblowing and handling complaints.

10. However, there remain recommendations from 2018, all of which were accepted by Government, that are yet to be implemented. What HCS now needs to focus on in the next stage of governance development are the capacity and capability of those involved in governance, including ensuring shared values, skills and culture.

11. The health and social care system on the Island includes HCS, other Government delivered services and non-Government service providers such as care homes, charities, doctors, dentists and pharmacies. Developments since 2018 have focussed on HCS despite many of the recommendations being system-wide recommendations.

12. The system-wide governance arrangements, encompassing this wider range of providers, will become more important as Jersey moves to a 'community based (out of hospital), person centred, integrated health and social care model' as intended by the implementation of the Jersey Care Model. Future governance arrangements will need to evolve to recognise this.

Objectives and scope of the review

13. This follow up review adopted the same scope as the 2018 review and has considered:

- governance arrangements in place across the Government departments involved in health and social care
- governance arrangements that relate to provision of health and social care that is not within the direct control of the States, including services provided by independent contractors, the private sector and the voluntary and community sector; and
- the adequacy of arrangements for proposed changes to the governance of health and social care.

14. In particular, the follow up review has evaluated:

- the arrangements established to manage, monitor and report on implementation of agreed recommendations
- the progress made in implementing agreed recommendations
- the extent to which the changes made have been evaluated to ensure they address the improvement areas identified in the 2018 Report; and
- the adequacy of plans for the implementation of any outstanding recommendations.

15. The 2018 review was structured around *The Good Governance Standard for Public Services* (see Exhibit 1).

Exhibit 1: Overall Structure for the 2018 report

Source: Developed from The Good Governance Standard, The Independent Commission on Good Governance in Public Services: Office for Public Management Ltd.

16. This follow up review has also assessed how health and social care services are developing, or are planning to develop, management information to support the Jersey Performance Framework. This Framework focusses on long-term progress rather than short-term intervention, and measures:

    - Community wellbeing - the quality of people's lives
    - Environmental wellbeing – the quality of the natural world around us; and
    - Economic wellbeing – how well the economy is performing.

17. Due to changes in departmental structures and roles since 2018, this follow up review has encompassed departments that were not directly involved with the initial work.

18. This review is not an audit of the development or implementation of the Jersey Care Model. Where relevant, I have considered the Jersey Care Model in making recommendations. I am planning a review of the Jersey Care Model as part of my 2022 work programme.

19. This review has considered 'business as usual' governance arrangements and has not considered any specific arrangements put in place in respect of the COVID-19 pandemic. I have undertaken a separate review of the *Management of the Healthcare Response to the COVID-19 pandemic* (April 2021). I am also undertaking a specific review of *Governance and Decision Making during the COVID-19 pandemic*.

Detailed findings

Overall arrangements

20. The 2018 Report found that responsibility for health and social care within the States of Jersey was unnecessarily complex for a jurisdiction the size of Jersey. At that time, responsibility was split between three Government departments with different Ministerial accountabilities. The arrangements lacked strong system-wide oversight to identify future needs, provide assurance on current delivery, maintain effective relationships with the voluntary and private sectors and drive change.

21. Since the 2018 Report, the responsibility for health and social care within the States of Jersey has been spread across further departments:

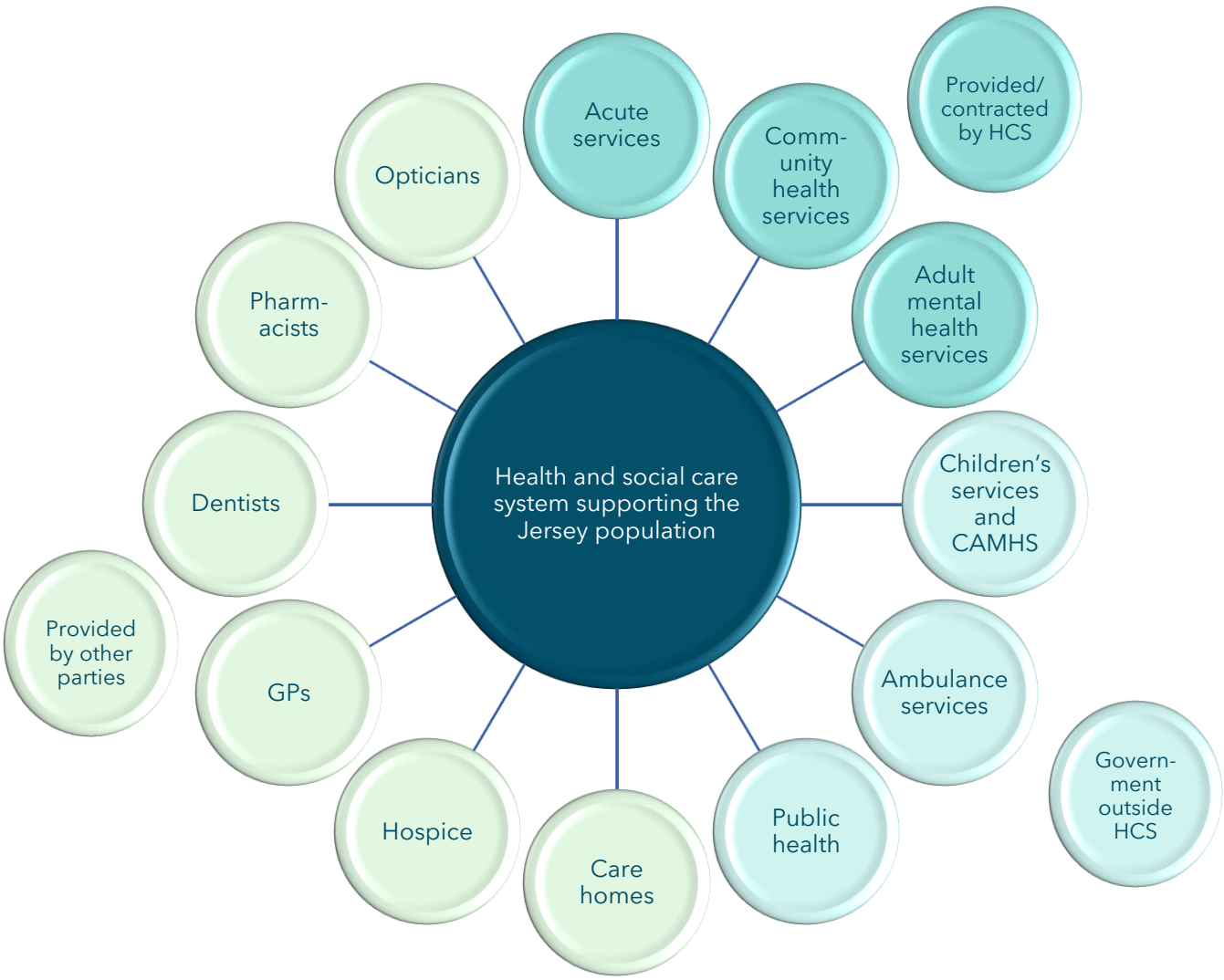
- HCS continues to have a key role in the planning and delivery of acute, community and adult mental health services. HCS has three distinct roles, all of which fall to a single Accountable Officer (the Director General of HCS):
    - Government department reporting directly to the Health and Social Services Minister
    - provider of services; and
    - commissioner of services
- Customer and Local Services (CLS) has a key role in handling complaints, including HCS complaints and continues to both manage the Health Insurance Fund payments for medical and pharmaceutical benefits and enable access to the Long-Term Care Fund
- Strategic Policy, Planning and Performance (SPPP) continues to be responsible for the public health function. SPPP also provides Island wide strategic planning, and performance management functions. HCS fits its arrangements into these Island wide frameworks
- Children, Young People, Education and Skills (CYPES) leads the management of children's services and youth services, including social work, child and family support and wellbeing. It is now also responsible for the Child and Adolescent Mental Health Service (CAMHS)
- Justice and Home Affairs (JHA) is now responsible for running the Ambulance Service; and
- in addition, two departments have key supporting roles:

- Treasury and Exchequer (T&E) – provides financial services into HCS and provides Government-wide risk management functions; and
- Chief Operating Office (COO) – provides people, organisational design, digital, information and procurement services for HCS.

22. Due to the population size of the Island and the consequent size of the health and social care system, both formal and informal ways of doing things have evolved. These each have an impact both on culture and on governance across the wider health and social care system on the Island.

23. The system of planning and delivering health and social care on the Island is illustrated in Exhibit 2:

Exhibit 2: Jersey health and social care system



Source: Jersey Audit Office analysis

24. In addition to Government delivered services, non-Government service providers such as care homes, charities, doctors, dentists and pharmacies are all involved in providing health and social care services on the Island. The system-wide governance arrangements, encompassing this wider range of providers, will become more important as Jersey moves to a 'community based (out of hospital), person centred, integrated health and social care model' as intended by the implementation of the Jersey Care Model (JCM). Future governance arrangements will need to evolve to recognise this.

25. The 2018 Report noted that although Government responsibilities were split between departments, the rationale for the model was not clear. It did not reflect:

- a commissioner/provider model
- a strategy/delivery model; or
- any other model drawn from best practice and adapted to the circumstances of Jersey.

26. This 2018 finding remains relevant to the structure and split of Government responsibilities across departments in 2021. The current model does not have a clear rationale and, as a consequence, there remain gaps, duplications and misalignments in accountability and governance for health and social care within Government.

27. The 2018 Report made five recommendations in respect of overall arrangements. Since the 2018 Report there has been some progress in implementing these recommendations as summarised in Exhibit 3. Where progress has been made it has been focussed on HCS rather than the whole Government health and social care system or the wider Island health and social care system.

Exhibit 3: Summary of progress in overall arrangements

Recommendation	Current position	Evaluation
R1 – Ensure that effective over-arching structures are in place to manage health and social care provision	A HCS Board was established in July 2019 and is chaired by the Minister for Health and Social Services. Committees, intended to be chaired by the Assistant Ministers for Health and Social Services, were created in August/September 2019. Over the past two years, the number and structure of the committees have changed. The assurance committees that exist currently are: - Quality and Risk (Q&R),	Partially implemented. The HCS governance arrangements are relatively strong in terms of performance oversight but are relatively weak in terms of the transparency of decision making. There is a lack of maturity in understanding of both the internal governance arrangements within HCS

Recommendation	Current position	Evaluation
	- Operations, Performance and Finance (OP&F) and - People and Organisational Development (POD) The current committee portfolios were revised in February 2021. All three assurance committees have an identified set of management sub-groups that appear to report directly into them. Separate governance arrangements have been established for the Jersey Care Model and for the Our Hospital projects. The formal governance arrangements that have been developed are focussed entirely on holding the HCS department to account.	and of how all of the governance arrangements relate to each other (including the governance arrangements external to HCS). The three committees act as HCS management assurance groups, rather than Board assurance committees.
R2 – Review the effectiveness of and rationalise the current groups supporting the governance of health and social care, ensuring that they are fit for purpose and have up-to-date Terms of Reference and clear accountabilities	The new HCS Board management arrangements were introduced initially in July 2019. The number and portfolios of HCS assurance committees have significantly changed since July 2019. The latest version came into effect in February 2021. Within HCS the Care Group structures have changed over time and the new Care Group arrangements only came into force in October/ November 2020. The Jersey Care Model proposition was approved by the States Assembly in November 2020. The current associated project governance arrangements were approved in March 2021. There is an interim Board Secretary who is also responsible for patient safety. All of the required consolidation and tidying up for a settled governance system still need to be completed.	Partially implemented. Some progress has been made within HCS in the rationalisation and documentation of up-to-date arrangements. More work is required to clarify how all parts of the governance system interact across a network of roles and responsibilities.

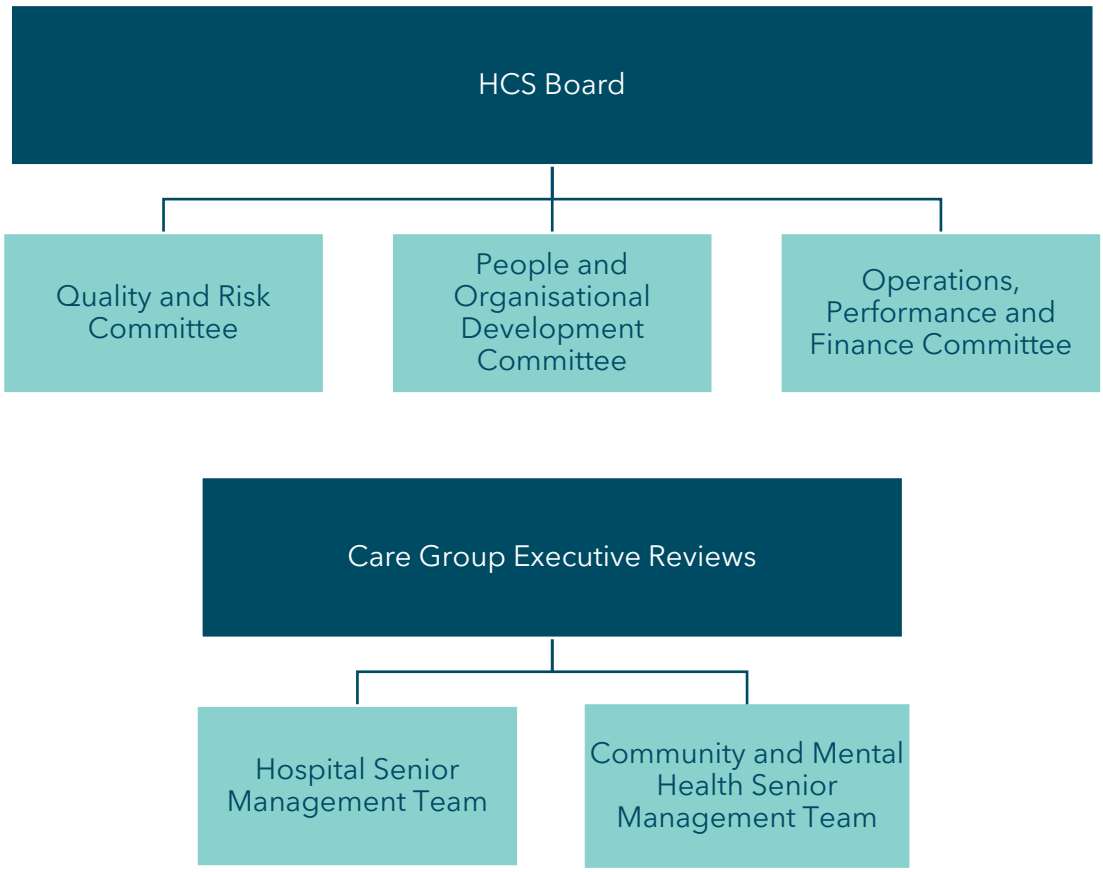
Recommendation	Current position	Evaluation
R3 – Publish a timetable for the extension of independent regulation and inspection of all elements of health and social care, including services directly provided by the States	There is a phased rollout of external Jersey Care Commission inspection and the key priorities have been Children's Services and Mental Health. Following a 2019 Government decision on the timetable of regulation rollout it will not be until 2025 that Jersey General Hospital, GPs, dentists and pharmacists will be fully inspected. In the meantime, HCS relies on: - the JNAAS tool developed in 2015 in conjunction with Salford Royal NHS Foundation Trust; and - a wide range of internally commissioned but externally provided service reviews.	Implemented.
R4 – Ensure that consultancy reviews leading to proposals for change include documented evaluations of alternatives against agreed criteria	There is reliance on a wide range of ad hoc external reviews commissioned by HCS and other departments (for example JHA). These reviews report to departmental Senior Leadership Teams and other groups as appropriate. The consultancy reviews have not consistently documented evaluations of alternatives against agreed criteria.	Partially implemented. I have made a further recommendation regarding the transparency of internally commissioned external reviews.
R5 – Thoroughly review the findings of the consultants that led to the proposal for the Strategic Partnership Board, determine actions in response and monitor their implementation	Both the HCS Board membership and reporting and the Jersey Care Model governance structure have implemented this recommendation.	Implemented.

Over-arching structures, groups and responsibilities

Purpose and remit of the HCS Board

28. The governance landscape that has been established for HCS since the 2018 Report is illustrated in Exhibit 4.

Exhibit 4: Governance structure for HCS



29. The HCS Board is support by three assurance committees. At executive level, the HCS governance structure is supported by monthly Care Group executive reviews of performance. Governance arrangements for key change projects such as the Jersey Care Model and the Our Hospital Project operate separately to the 'business as usual' structures. The governance structure for the Jersey Care Model includes a separate, independent board. The HCS Board has received periodic reports on progress with the Jersey Care Model.

30. The HCS Board met for the first time on 8 July 2019. The definition of governance included in the first HCS Board meeting was *'corporate governance is concerned with the structures, systems and processes by which the Health and Community Services Department leads, directs and controls its functions, in order to achieve organisational objectives and by which it relates to its partners and the wider community'.*

31. The stated role of the HCS Board is to *'demonstrate openly and transparently how HCS and their key partners are working to deliver the best health and social care services for islanders.'*

32. The purpose of the HCS Board is stated as:

- providing oversight
- shaping culture
- overseeing risk; and
- seeking assurance about the services provided by HCS and the experience and safety of patients receiving those services.

33. The terms of reference for the HCS Board state that *'The Board is a forum for the Minister for Health and Social Services to be transparent in the way s/he discharges his/her responsibilities as Minister. The Board therefore:*

- *leads Jersey's health and care system*
- *draws on evidence from HCS assurance committees to assure Islanders that:*
    - *HCS strategy and objectives are in accordance with government objectives and future health and care opportunities / threats*
    - *HCS is properly governed and well-managed across the full range of activities, and meets its regulatory and statutory responsibilities*
- *Holds the Management Executive Committee to account for the implementation of strategy and the day-to-day delivery of HCS activities'.*

34. The HCS Board, and its associated assurance committees, have been established with a focus on services provided by the HCS. The publicly stated remit of the HCS Board and the terms of reference for the HCS Board are however wider than HCS: there are frontline health and social care services and functions provided by other Government departments, in particular JHA, CYPES and SPPP. In addition, there are frontline primary care and other services led by parties outside of Government as shown in Exhibit 2.

35. The Ambulance Service sits within JHA. The Home Affairs Minister holds quarterly meetings with the Ambulance Service in which the performance of the service is discussed. The performance of the Ambulance Service is also discussed at JHA service and departmental leadership teams and at meetings between HCS and JHA. None of these meetings take place in public. In addition, there has been no public reporting of operational performance indicators for the Ambulance Service

since 2017, outside of the States of Jersey Annual Report. Neither the Director General for JHA nor the Head of the Ambulance Service have ever been asked to provide a report to the HCS Board or any of its assurance committees.

36. CYPES is responsible for the Child and Adolescent Mental Health Service (CAMHS). HCS retains responsibility for clinical governance for clinical services with a joint HCS/CYPES Governance Oversight Group in place. The role of the HCS Board in respect of CAMHS is not however clear and, similar to the Ambulance Service, the Director General for CYPES has never been asked to provide a report to the HCS Board or any of its assurance committees.

37. The public health function is the responsibility of SPPP. The COVID-19 pandemic has dominated the activities of the public health function during 2020 and 2021 to date. Oversight of the public health function during 2020 has therefore taken place through the governance and decision making mechanisms established for the COVID-19 pandemic. The role of the HCS Board in respect of governance and oversight of public health is not however clear: the Director General for SPPP, the Medical Officer of Health nor the recently appointed Director of Public Health have ever been asked to provide a report to the HCS Board or any of its assurance committees.

Operation of the HCS Board

38. The location of the meeting is publicised in advance. Agendas for the meetings are published in advance as well as the minutes of the previous meeting and other papers. As recorded in the minutes of the HCS Board meeting on 13 January 2020, 'the Chair informed all present that the HCS Board will continue to meet monthly and in public (Part A). However, there will be occasions in which the HCS Board will meeting in private (Part B) but only on occasions where patient confidentiality or commercial sensitivity requires the Board to meet in private.' Since then, up to the HCS Board meeting on 8 March 2021, there has not been a private (Part B) meeting.

39. The HCS Board is made up of:

- the Minister for Health and Social Services
- the Assistant Ministers for Health and Social Services
- the Director General for HCS
- the Chief Nurse
- the Group Managing Director for HCS
- the Medical Director for HCS

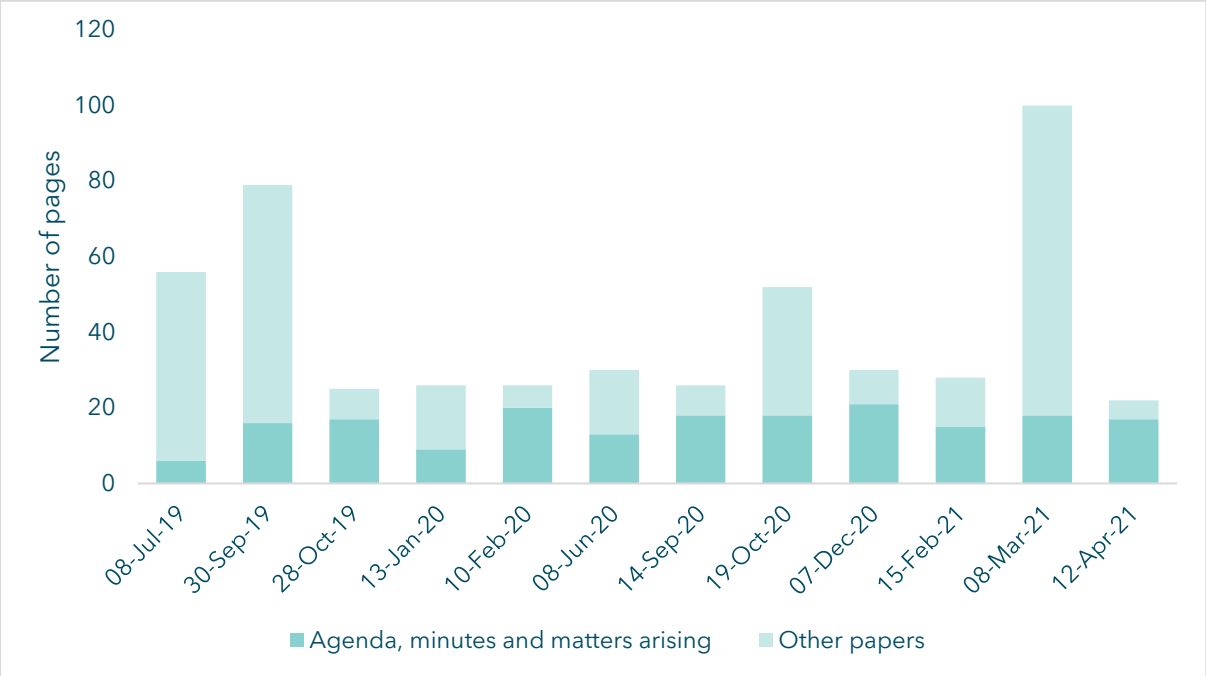
- the Group Finance Business Partner
- invited partners from the community and voluntary sector, and the primary care sector; and
- a patient representative.

40. Whilst the minutes of the HCS Board record who was present during each HCS Board meeting, they do not record clearly the membership of the HCS Board and who was there 'in attendance'. Additional officers participate in the HCS Board meetings in addition to those listed as members of the HCS Board on the Government of Jersey website. These additional officers are often listed in the minutes as 'present' rather than 'in attendance' and as such are implied to be members of the HCS Board.

41. The way the HCS Board operates has changed since its establishment. Over time, there has been more verbal reporting with little supplementary written performance information outside of performance presentations.

42. For a board to exercise its functions effectively there needs to be high quality written information provided to the board in advance, in addition to verbal information on urgent matters and in response to questions provided to the board at the meeting itself. Insufficient advance written information will inhibit the effectiveness of a board in fulfilling its functions. At times, the quantity of written information provided to the HCS Board in advance of its meeting falls short of the level I would expect for the HCS Board to fulfil its functions effectively. Whilst the COVID-19 pandemic had an impact on the capacity of management to produce written reports, there are other times when the size of the HCS Board packs demonstrates the limited amount of written information being provided to the HCS Board. Exhibit 5 illustrates the size of packs for the HCS Board over time. For half of the meetings in Exhibit 5, the agenda, minutes of the previous meeting and matters arising have made up over 50% of the Board packs.

Exhibit 5: Size of HCS Board packs



Source: Jersey Audit Office analysis

43. Since the 8 July 2019 up to 12 April 2021 there have been 12 HCS Board meetings. There has only been one written Director General report (8 July 2019) and no detailed public overview of risks since the 30 September 2019. After this the Risk Committee became subsumed into the (then) Quality, Performance and Risk Committee.

44. Exhibit 6 provides an analysis of the information provided to the HCS Board for its first 12 meetings.

Exhibit 6: Analysis of information provided to the HCS Board

	08-Jul-19	30-Sep-19	28-Oct-19	13-Jan-20	10-Feb-20	08-Jun-20	14-Sep-20	19-Oct-20	07-Dec-20	15-Feb-21	08-Mar-21	09-Apr-21
Standard items												
Agenda												
Minutes of previous meeting	N/A											
Matters arising and action log	N/A											

	08-Jul-19	30-Sep-19	28-Oct-19	13-Jan-20	10-Feb-20	08-Jun-20	14-Sep-20	19-Oct-20	07-Dec-20	15-Feb-21	08-Mar-21	09-Apr-21
Patient's story												
Professional's story												
Chair's report												
Director General's Report												
View from the bridge (partner organisations)												
New risks escalated to Board												
Performance report												
Management Executive/ Senior Leadership Team												
Quality and Risk												
Operations, Performance and Finance												
People and Organisational Development												
Governance items												
Governance Structure and terms of reference												

	08-Jul-19	30-Sep-19	28-Oct-19	13-Jan-20	10-Feb-20	08-Jun-20	14-Sep-20	19-Oct-20	07-Dec-20	15-Feb-21	08-Mar-21	09-Apr-21
Absence of Board Assurance Framework	written	written	written									
Clinical governance arrangements		written										
Advanced clinical practice framework											written	
Strategic items												
Jersey Care Model		presentation	verbal	verbal	verbal	verbal					written	
Digital strategy							verbal	presentation				
Ad hoc items												
EU exit		verbal	verbal									
Estates		verbal		verbal	verbal							
C&AG recommend-ation tracker and action log	written	written										
Letter from UNICEF						written						
COVID testing								presentation				

written report verbal report presentation

Source: Jersey Audit Office analysis

45. The reporting by the committees to the HCS Board has, in the main, been through written reports. However, the public reporting of performance to the HCS Board has been inconsistent in terms of quality and coverage. Since July 2019, performance reporting has sometimes been through the committee reports,

sometimes through a live PowerPoint presentation and sometimes through a more formal performance report.

46. Governance related items have always been reported in writing to the HCS Board. The overall governance structures depicted in Exhibit 4 apply to 'business as usual' HCS operations.

47. When the HCS Board was established it stated that a Board Assurance Framework (BAF) would be in place by the Autumn of 2019. A BAF brings together in one place all of the relevant information on the assurance being provided on the risks to strategic objectives and is good practice. To date however no BAF has been produced. In October 2020, a Government-wide risk management strategy was published which includes some commentary on the risk assurance framework. The Government-wide strategy does not refer to the assurance role played by the HCS Board and its assurance committees. In my view, a BAF would support the HCS Board and its assurance committees in discharging their responsibilities.

48. At the time of my fieldwork, a forward work plan for the HCS Board was being prepared but had not been published.

Assurance committees and other groups

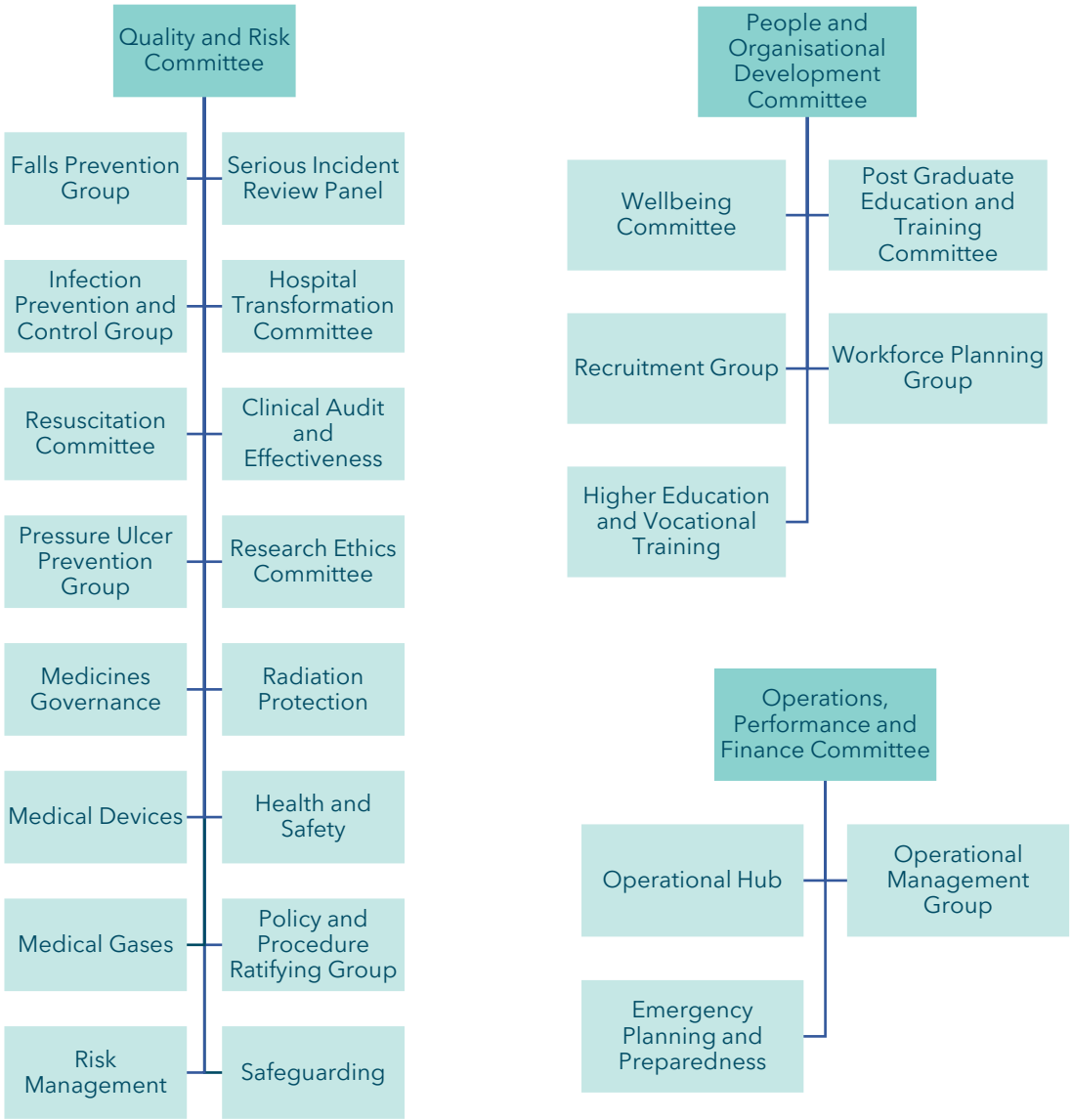
49. At the current time, three assurance committees sit below the HCS Board and are intended to be chaired by an Assistant Minister for Health and Social Services. These are:

- Quality and Risk (Q&R)
- Operations, Performance and Finance (OP&F); and
- People and Organisational Development (POD).

50. The committee structure was created in August/September 2019. There were originally four committees, but the structure has changed over time. The current committee portfolios were revised in February 2021. The fact that the number and portfolio of assurance committees has frequently changed since 2019, indicates that there has been much reflection on what is and is not working. However, it also means that there is little track record of settled assurance committee performance.

51. The assurance committees have always met in private although their reports to the HCS Board are public documents. The assurance committees have an identified set of management sub-groups that appear to report directly into them as shown in Exhibit 7.

Exhibit 7: Sub-groups supporting the assurance committees



52. There is a significant number of sub-groups reporting through to the assurance committees. In some instances, I would have expected these management sub-groups to formally report into the HCS Senior Leadership Team meetings rather than directly to the assurance committees.

53. The assurance committees are chaired by Assistant Ministers. Attendance at the meetings by the Assistant Ministers has however been limited, ranging from 33% to 42% of meetings in the period from August 2020 to May 2021. The vice chairs of the assurance committees are the 'relevant executive directors' who attend the committee. As noted in my 2020 Report *Management of the Healthcare Response to the COVID-19 pandemic*, it is not recommended practice for an executive director to chair a committee which has the main purpose of giving assurance regarding the quality of care given by the service. Recommended practice would

be for an independent lay person with an appropriate background to chair the committee.

54. From the evidence I have reviewed, the assurance committees act as HCS wide management groups, rather than providing assurance to the HCS Board. The challenge at the assurance committee meetings to Care Group Leaders comes from the Senior HCS Executives (rather than the Minister or Assistant Ministers who often do not attend). The HCS Board only sees escalation reports written by HCS Senior Executives or their direct reports and does not receive much, if any, routine primary sources of information on which to base its challenge.

55. The HCS Director General is held to account for performance by the Government of Jersey Chief Executive and by the Minister for Health and Social Services. The Government of Jersey website states that one of the purposes of the HCS Board is '*to seek assurance about the services provided by HCS…'* The terms of reference of the HCS Board further state that the Board '*holds the Management Executive Committee to account for the implementation of strategy and the day-to-day delivery of HCS activities'.* From the evidence I have reviewed however, neither the assurance committees nor the HCS Board are currently performing the role of holding the HCS Director General and Senior HCS Executives to account for performance.

56. Within HCS there is an executive led Senior Leadership Team (SLT), which is chaired by the HCS Director General. There are currently five clinical Care Groups and three Non-Clinical Care Groups. This Care Group configuration was revised in the Autumn of 2020 and leadership is based on a triumvirate model of a lead medic, a lead nurse and a lead manager. There are clear, formal and well structured performance management arrangements in place for the monthly review of the Clinical Care Groups, but there is less clear evidence for the review of the Non-Clinical Care Groups.

57. There is evidence of a HCS departmental wide risk management process based on the 'bottom up' identification of individual risks and input into the software risk management system called Datix. Risks are rated 1-5 for each of probability and impact. These ratings are multiplied to provide a risk score. Risk scores of 16 and above (and 12 for Children's services) are escalated to the assurance committees and are discussed in the monthly Care Group performance review meetings.

58. At committee level within HCS there are terms of references in place, there are good minutes, there are committee workplans and there are action trackers. The action tracker reporting does not include 'closed' actions and could be enhanced by including details of actions that have been 'closed' since the previous meeting.

59. In my view, there would be benefit in producing a comprehensive and publicly available Health and Social Care Integrated Governance Accountabilities (IGA) Framework. Such a Framework would include details of:

- terms of reference of all committees and groups
- relationships between the committees and groups
- memberships
- workplans; and
- frequency of meetings.

60. This Framework should include arrangements both within HCS and external to HCS. It should also include both the Jersey Care Model and Our Hospital project governance arrangements.

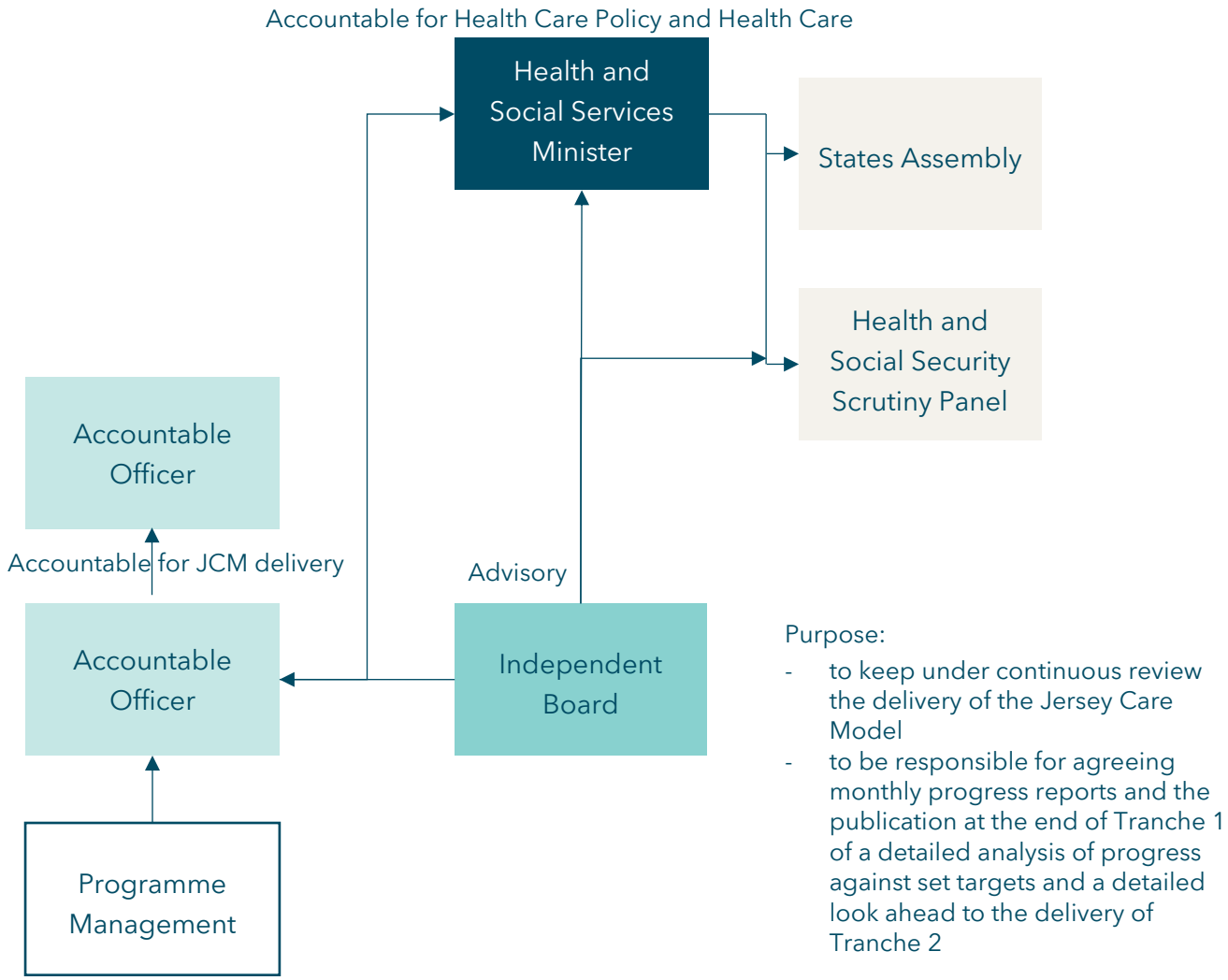
61. In the light of the production of an IGA Framework, the terms of reference of the HCS Board, its membership, forward work plan and operations should be reviewed. This review should ensure that there is more transparency in how the HCS Board meets its stated purpose and terms of reference, including in holding the HCS Director General and Senior Executives to account.

Links between overall governance arrangements and Jersey Care Model governance arrangements

62. The governance arrangements for the Jersey Care Model and the Our Hospital Project sit outside of the main HCS 'business as usual' governance arrangements.

63. The Jersey Care Model governance arrangements include an Independent Board as shown in Exhibit 8.

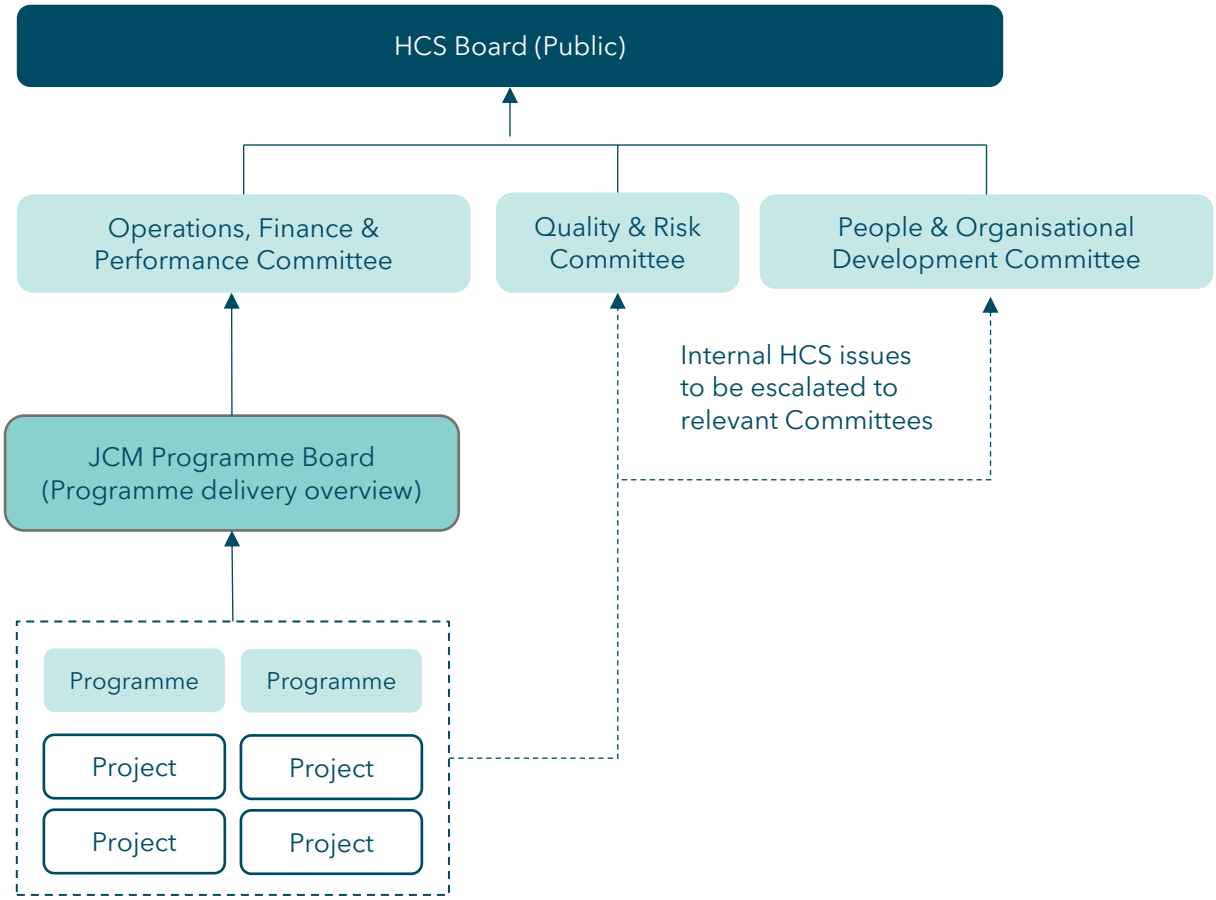
Exhibit 8: Jersey Care Model Governance



Source: Government of Jersey

64. A Jersey Care Model Programme Board sits below the Independent Board and is intended to feed into the 'business as usual' HCS governance arrangements in the way shown in Exhibit 9.

Exhibit 9: Current link between Jersey Care Model governance and HCS governance



Source: Government of Jersey

65. As the implementation of the Jersey Care Model progresses there is a need to clarify the link between the overall governance arrangements for the health and social care system on the Island and those established within HCS. In particular, the link between the Jersey Care Model Independent Board and the HCS Board needs to be articulated to ensure clarity and avoid potential duplication or gaps.

Link between HCS arrangements and overall Government-wide arrangements

66. Outside of the governance arrangements for HCS there is a Government of Jersey Risk and Audit Committee. The Risk and Audit Committee is a stand-alone body that provides oversight, advice, support and constructive challenge in order to help the Principal Accountable Officer and Accountable Officers to discharge their responsibilities for monitoring and reviewing governance, risk and control processes. The Risk and Audit Committee provides oversight of the work of external audit, Internal Audit and corporate risk functions.

67. The links between the HCS Board and its committees and the Government-wide Risk and Audit Committee have not been documented or clarified. There is therefore a risk of duplication or potentially gaps in the overall system of

governance and assurance. The documentation of a BAF could usefully consider the link between the HCS Board Assurance Framework and the Government-wide risk assurance framework.

External regulation and commissioned reviews

68. External regulation is extremely important in any system. Whilst the Jersey Care Commission has been established, it is not until 2025 that the main hospital is due to be inspected.

69. In advance of any external regulation of services, it is my view that HCS should build on its existing Quality Strategy and publish a detailed Annual Quality Account, which should include JNAAS performance, serious incident information, summary details of complaints and compliments themes as well as outcomes of audits, clinical outcomes, clinical audits and benchmarking exercises undertaken. The Annual Quality Account should also include a full list of all internally commissioned external clinical reviews, with a summary of findings and key actions.

70. The Ambulance Service has voluntarily commissioned an independent inspection of its services by the Association of Ambulance Chief Executives (AACE). AACE has shared the Framework it intends to use for this inspection with the Jersey Care Commission. The Jersey Care Commission does not have a statutory remit for the regulation and inspection of Ambulance Services.

Recommendations

R1 Document a comprehensive and publicly available Health and Social Care Integrated Governance Accountabilities (IGA) Framework. This structural document should include:

- terms of reference of committees and groups
- relationships between the committees and groups
- memberships, workplans and frequency of meetings
- arrangements both within HCS, within Government and within the whole Island health and social care system; and
- the Jersey Care Model and Our Hospital project governance arrangements.

R2 Review the terms of reference for and the membership of the HCS Board. This review should consider:

- the membership within Government and external to Government

- the responsibilities of the HCS Board in respect of all Government health and social care services (within and external to HCS); and
- the role and responsibilities of the HCS Board for the whole health and social care system on the Island.

R3 Review the way in which the HCS Board operates in order to:

- ensure that a more effective balance is struck between verbal and written reports
- ensure that the minutes record accurately who is 'present' as a HCS Board member and who is 'in attendance'
- require the HCS risk register to be reported to the HCS Board on at least an annual basis; and
- ensure that the Director General of HCS and other Senior Executives are held to account in an open and transparent way.

R4 Prioritise the finalisation of the Board Assurance Framework to support the work of the HCS Board. This document should be publicly available and be updated and publicised on at least a six monthly basis.

R5 Publish an Annual Quality Account for all health and social care services provided by Government. The Annual Quality Account should include, as a minimum, information on:

- a review of performance over the previous year across the domains of patient/service user safety, clinical effectiveness and patient/service user experience
- identification of and progress made in identified areas of improvement
- the outcomes of clinical audit
- the outcomes and recommendations from internally commissioned external clinical services reviews undertaken in the year
- action taken and proposed in respect of clinical audit and other reviews of services
- core quality indicators, including benchmarking of performance over time and against other health and social care systems where possible and appropriate
- the volume and themes from feedback including feedback from patients/service users, system partners, complaints and whistleblowing; and

- key themes from staff surveys with actions planned in response to staff feedback.

R6 Consider appointment of independent members to the assurance committees to ensure that there is appropriate independent challenge of and assurance over performance.

Focussing on service objectives and on outcomes for service users

71. Focussing on the purpose of a service from the perspective of those who use and fund it is at the heart of good governance of public services. The 2018 Report made seven recommendations for improvement. Some progress has been made in implementing these recommendations as summarised in Exhibit 10.

Exhibit 10: Summary of progress in focussing on service objectives and outcomes for users

Recommendation	Current position	Evaluation
R6 – Review and update documents setting out objectives for departments involved in health and social care in light of the new structures established under the Target Operating Model.	The Government's Common Strategic Policy 2018-22 (CSP) sets out the high-level Jersey wide priorities. In December 2019, the States Assembly approved the first ever Government Plan for Jersey setting out the activities to be delivered to support the achievement of the Government's priorities. Sitting below the Government Plan are departmental operational plans which set out clearly the departmental objectives and service performance measures.	Implemented but scope to improve further.
R7 – Adopt a clear timetable for the development of a Health and Wellbeing Framework for Jersey, supported by a work programme to deliver the Framework.	The Public Finances (Jersey) Law 2019 requires the Council of Ministers to take into account the sustainable wellbeing of current and future generations when it develops the Government Plan. The Jersey Performance Framework seeks to measure the progress being made towards achieving sustainable wellbeing. The Framework contains a number of indicators mapped to high level outcomes. The data supporting the Framework has not been updated on a consistent basis during the COVID-19 pandemic. A Health and Wellbeing Framework has been published on the Government website. The work programme to deliver the Framework is not yet clearly set out.	Partially implemented.

Recommendation	Current position	Evaluation
R8 – Develop a comprehensive, integrated approach to capturing and using patient views across all provisions of health and social care.	The Executive Response to the 2018 Report stated that a PALS would be established in early 2019. Whilst there is a Patient Experience Manager, a full PALS does not yet exist. A review for a future PALS is currently ongoing. A recent Scrutiny Panel review of maternity services noted the following: '*There is substantial evidence that women and families should be given the opportunity to have their voice heard in relation to maternity services. The Panel found that whilst work is being done to address this through the Maternity Voices Partnership, further work is required in order to improve this for women and their families*.'	Not implemented.
R9 – Develop a comprehensive programme for improving performance reporting across health and social care, including securing data quality and adoption of meaningful targets.	There is good evidence of improvements having been made to performance reporting. These include the Jersey Performance Framework and the HCS internal quality and performance report that goes to the OP&F committee. However there remain some gaps in the availability of public information on performance. There also remain challenges to improve the core IT systems, ensure adequate informatics staff capacity (particularly supporting Care Groups) and to develop a population health management approach to health information and health process and outcome reporting. The way that some of the information is presented could be improved. For example, there is no use of statistical process control (SPC) charts to explain variation in performance. In my 2020 Report *Management Information in Education: Follow up* I recommended the development and implementation of a Government-wide strategy for data quality to include: • corporate data quality standards	Partially implemented.

Recommendation	Current position	Evaluation
	• departmental specific standards; and • a data quality management and monitoring programme.	
R10 – Prioritise the development of benchmarking of the quality and outcomes of health and social care in Jersey against other jurisdictions.	The performance reports used by the Q&R committee and in the Care Group reviews were benchmarked against similar reports used in the NHS. HCS is a member of the NHS benchmarking network. However, there continues to be limited benchmarking of services at a granular level in comparison to other jurisdictions.	Partially implemented.
R11 – Develop a plan for the rollout of Jersey Nursing Assessment and Accreditation System (JNAAS) across all elements of health and care, including other publicly funded health and care providers, and monitor implementation.	The JNAAS was launched 2018 and covers aspects of patient care using 340 standards. HCS continued with full review assessments during 2020, with areas needing improvement being prioritised. There have been some delays in the programme during the COVID-19 pandemic. Update reports on JNAAS have continued to be provided to the (then) Quality Performance and Risk Management Committee during 2020. There is an expectation that progress with action plans be reported into Care Group Performance Reviews. The Learning Disability Service (LD) is currently developing a LD Assessment Framework, with a view of fully implementing JNAAS. The planned development of using the JNAAS outside HCS was suspended during 2020 due to the COVID-19 pandemic. There are plans to take JNAAS out to community providers including HMP La Moye and Family Nursing and Home Care. There is also the potential for the Ambulance Service to use the same methodology.	Partially implemented.

Recommendation	Current position	Evaluation
R12 – Operate a structured approach to identifying and implementing efficiency savings across health a social care, ensuring that savings are identified before the commencement of the financial year.	For 2021 there has been a top-down structured programme to identify cost savings aimed at catching up post Covid-19. This has been driven by the senior Government-wide Executive Leadership Team (ELT) supported by management consultants. There is not yet a bottom-up programme of innovation and improvement (including financial) driven by the Care Groups. There is a good approach and leadership supporting the implementation of a Person Level Information and Costing System (PLICS) and the information gathered is comprehensive. The quality of PLICS data is a function of the IT systems, culture of data recording and validation and commitment to clinical coding and resources, all of which are a challenge.	Partially implemented.

Performance framework and plans

72. Since the 2018 Report, significant progress has been made in setting out an overall Jersey Performance Framework linking down through the Government Plan to departmental objectives and business plans for individual Government departments.

73. Departmental plans and annual reports set out clearly the progress made and planned for individual departmental initiatives included in the Government Plan.

74. The Jersey Performance Framework seeks to measure performance over time against a series of sustainable wellbeing outcomes and indicators. By the nature of the outcomes, improvements may take a number of years to deliver. In addition, performance in any one year can be affected by new events (for example the COVID-19 pandemic).

75. Some data supporting the Jersey Performance Framework is only updated periodically on a multi-year basis by Statistics Jersey. Other data within the Framework has not been updated during 2020 due to resources being diverted from this activity during the COVID-19 pandemic. As a consequence, at the time of my review the age of the data supporting the indicators relating to health within the Jersey Performance Framework ranged from 2016 to 2020.

76. At the outset of the COVID-19 pandemic the public health function was operating at limited capacity and action was taken to re-deploy internal Government

resources to the function. Plans are in place in 2021 to expand the public health function to drive and deliver strategic public health initiatives. The SPPP departmental business plan for 2021 states that these initiatives will be driven across Government, health care services and key partners by:

- monitoring the pattern of disease in the community
- assessing the health needs of the population; and
- advising how these needs can be met to improve health and wellbeing and reduce health inequalities.

77. The Jersey Performance Framework contains long term high level outcome measures. Individual departmental plans contain short term operational indicators. There is however no coherent documented longer term strategy for health and social care to:

- support the health and wellbeing framework
- analyse healthcare needs
- identify the 'mid-range' enabling targets and performance measures to fill the gap between the short term operational indicators and longer term high level outcome measures; and
- document the actions planned to reduce healthcare inequalities and improve health outcomes.

Capturing patient views

78. The 2018 Report found that complaints were not used effectively to promote common values:

- although internal reports on themes and trends in complaints are prepared, these were not publicly available; and
- performance on handling complaints at that time was poor.

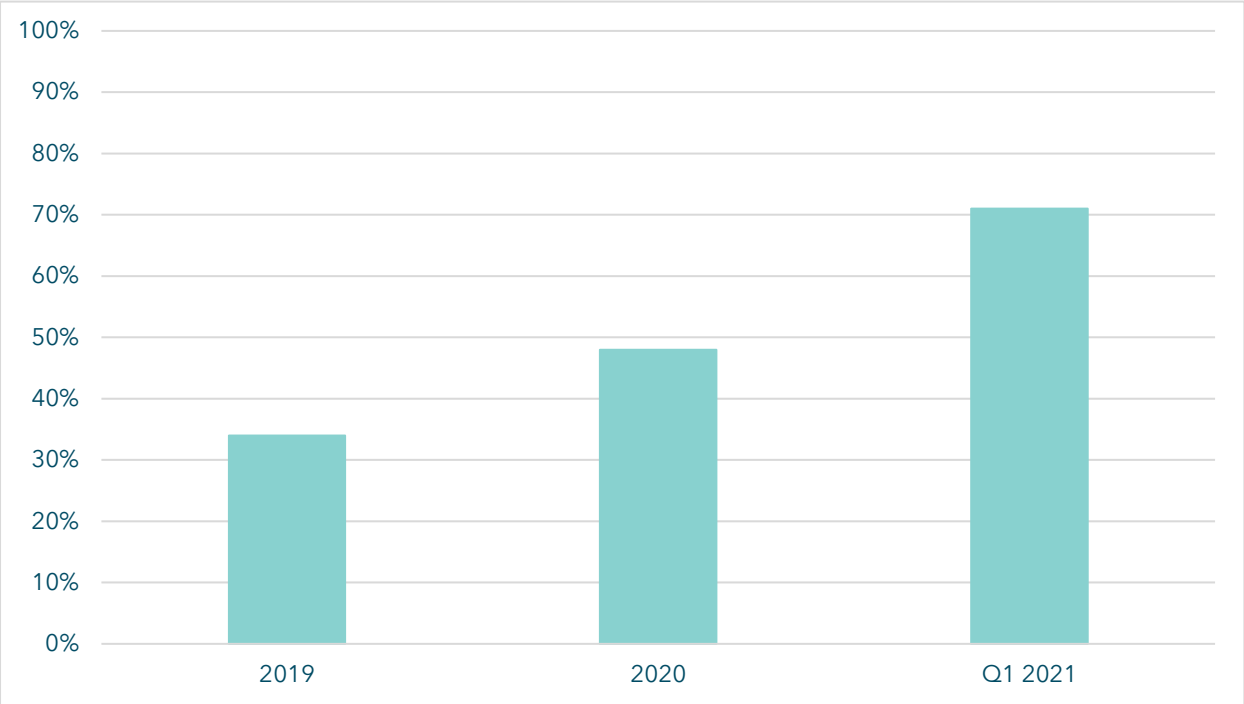
79. The 2018 Report noted that the target for responding to a complaint was 25 days. However in July 2017 compliance with this target was only 39% for complaints relating to the General Hospital and 25% for complaints relating to community services.

80. Towards the end of 2019, the Government of Jersey launched a new Customer Feedback Policy across all departments. The maximum response time for complaints, in line with this Customer Feedback Policy should be 25 working days.

The system used in HCS to record complaints is not yet fully aligned to the new Customer Feedback Policy timeframes: HCS reports on a timeframe of 28 days.

81. Since the 2018 Report, performance on responding to complaints within the HCS target timeframe has improved as shown in Exhibit 11.

Exhibit 11: Percentage of complaints responded to within 28 days



Source: Government of Jersey Freedom of Information response

82. Despite the improvement in performance, there is still however a significant volume of complaints that is not responded to within the target timescales. My 2020 Report *Handling and Learning from Complaints* evaluated the Government-wide arrangements for handling and learning from complaints. I found that more work was required to secure consistent handling of and learning from complaints and made 19 recommendations for improvement.

83. Capturing patient and service user views through complaints is only one aspect of obtaining feedback on services. Since the 2018 Report a Patient Experience Manager has been appointed. This is not however the same as a Patient Advice and Liaison Service (PALS), seen as good practice from other jurisdictions. A review for a potential future PALS is currently ongoing. Functions of a PALS can include:

- being an identifiable and accessible support for patients, their carers, friends and families

- providing on the spot help with the power to negotiate immediate solutions or speedy resolution of problems
- acting as a gateway to appropriate independent advice and advocacy support
- providing accurate information to patients, carers and families, about services, and about other health related issues
- systematically capturing views from disadvantaged groups and 'seldom heard voices'; and
- acting as a catalyst for change and improvement by providing information and feedback on problems arising and gaps in services and supporting staff to develop a responsive culture.

Performance reporting and improvement

84. There is good evidence of improvements having been made to performance reporting since the 2018 Report. However, the quality performance reports produced for the Q&R committee have not been reported publicly until recently. On 17 August 2021, HCS published its Quality and Performance Report for June 2021. I welcome this development which moves Jersey towards best practice seen in other jurisdictions.

85. Key changes are planned that are intended to enhance the availability and use of performance information to improve services:

- the Government is currently out to procurement for a new Electronic Patient Management (EPM) system. It is essential that the new EPM system meets the business needs of the future to provide high quality data for information intelligence
- appointing a new Quality and Safety Director. Successful health and social care organisations (especially clinically led ones) use quality and safety as the primary drivers for improvement. In essence, better outcomes are achieved by getting it right first time and reducing unwarranted variations in performance. By focussing on these clinically owned concepts at the outset, financial benefits are also typically achieved. The importance of a strong executive leader for quality and safety cannot therefore be overestimated; and
- a new Director of Public Health has been appointed and this provides an opportunity to develop a population health management approach to health information and health process and outcome reporting. Such reports can be integrated into the HCS and other Government department performance reporting.

86. Care Groups do not work systematically to identify savings and improvement within their Care Groups, across pathways and with partners. Care Groups consistently report a shortage of business support, including informatics support to understand their information better. Quality and safety programmes require excellent clinical data and clinicians are more likely to improve the quality of the data they capture if they are supported in a culture of using the data for clinical improvement.

Recommendations

R7 Ensure that robust arrangements are in place to update the data supporting the Jersey Performance Framework on a more regular basis.

R8 Document a long term strategy for health and wellbeing to be delivered across Government, health and social care services and key partners. Progress against the long term strategy should be reported publicly.

R9 Complete the review of a PALS and prioritise the establishment of a PALS or equivalent service.

R10 Review the level of business support provided to the Care Groups.

R11 Document a more formal programme of planned benchmarking and 'peer to peer' learning.

R12 Document and implement a formal action plan to rollout JNAAS to all community providers.

Performing effectively in clearly defined functions and roles

87. The 2018 Report made one over-arching recommendation in respect of the oversight of the governance of health and social care at that time. At the time of this follow up review, I have found that structures and systems have been put in place relating to HCS but that more work is required to:

- align these structures across Government and the wider health and social care system; and
- develop a consistent and coherent culture of improvement.

Exhibit 12: Progress made in recommendation relating to defined functions and roles

Recommendation	Current position	Evaluation
R13 – Develop and implement a plan for robust oversight of governance of health and social care including: • determining the appropriate groups, their membership, terms of reference and accountabilities; • developing underlying strategies and plans; • strengthening clinical and care audit and its oversight; • monitoring attendance at key governance groups; • ensuring engagement across health and social care; and • developing strengthened arrangements for engagement with community pharmacists, dentists and optometrists.	Structures and systems of governance and oversight are now in place for HCS delivered services. Engagement between Government departments takes place at an operational level rather than at a governance or oversight level. Attendance at key governance groups, particularly by Assistant Ministers, is weak. Oversight of clinical audit rests with the Q&R assurance committee. The duties and responsibilities of this committee include *'Ensure there is an appropriate and effective clinical audit programme'*. There are limited written reports provided to this committee on clinical audit. In my view this hampers the committee in discharging this responsibility.	Partially implemented. Progress has been made in the establishment of governance structures for HCS. These arrangements could be strengthened further to encompass all aspects of health and social care delivered to Islanders.

Recommendation	Current position	Evaluation
	Whilst there is engagement with community providers through the Care Groups and the Jersey Care Model, these arrangements could be strengthened further.	

88. As reported above, progress has been made in implementing systems and structures within HCS. More work is however required at a cultural level to embed better practice in governance and oversight. I consider this further in the next section.

89. More work is also required to develop and implement robust oversight arrangements to encompass all aspects of health and social care services delivered to Islanders. The acceptance and implementation of recommendations 1 and 5 in this report will be key in improving arrangements in the future.

Promoting values of good governance and demonstrating these through behaviour

90. As noted in both the 2018 Report and above, good governance depends not only on effective structures and accountabilities but also on a common understanding of and commitment to the values of good governance, driven from the top. In health and social care good governance is crucially dependent on a culture where speaking up and challenge by colleagues is promoted, respected and welcomed.

91. The 2018 Report made four recommendations in respect of values and behaviours. Some progress has been made in implementing these recommendations as shown in Exhibit 13.

Exhibit 13: Progress made in recommendations relating to values and behaviours

Recommendation	Current position	Evaluation
R14 – In developing new States-wide whistleblowing arrangements, reflect the statutory regulatory framework under the Regulation of Care (Jersey) Law 2014 and the obligations of health and care professionals to professional bodies	A whistleblowing policy was approved and launched in January 2019. The new policy makes reference to the statutory regulatory framework.	Implemented.
R15 – Develop and implement mechanisms for measuring the impact of "OUR Values OUR Actions" initiative on culture and behaviours	A Government-wide organisational development programme 'Team Jersey' is being rolled out. This programme is aimed at improving culture and behaviours. There are challenges in rolling out this programme to HCS staff who may have difficulty owning generic values and initiatives that do not use health and social care specific language.	Partially implemented.

Recommendation	Current position	Evaluation
R16 – Develop public reporting on complaints, including their incidence, nature, handling (including speed of handling), resolution and learning	There are Government-wide policies and procedures for complaints and these are performance managed. However as reported in my 2020 Report *Handling and Learning from Complaints* there are actions that the Government needs to take to improve processes further. Whilst there are monthly reports on patients experience complaints that go to the Q&R committee, there is little triangulation of the common themes from complaints. This in turn hinders identification of ways of learning from mistakes in a structured way. The public reporting on complaints remains limited.	Not implemented.
R17 – Extend the requirements for reporting on complaints to all primary care providers	The Government of Jersey does not have oversight on how complaints within primary care providers other than GPs are managed. Any changes to the oversight arrangements may require changes to the law. In terms of general practice, the complaints process is dictated by the Health Insurance (Performers List for General Medical Practitioners) (Jersey) Regulations 2014. There is no equivalent for other services and I recognise that some of these services are not publicly funded.	Not implemented.

Whistleblowing and complaints

92. Action has been taken in response to the 2018 Report in respect of whistleblowing. The new policy makes reference to the statutory regulatory framework, as follows:

'*For departments required to comply with UK regulatory and statutory provisions that apply to specific definitions of 'serious concerns' (for example, but not limited*

to, HSSD, Law Officers' Department and finance staff working with anti-money laundering legislation) departmental guidelines will apply in respect of who to raise concerns with.'

93. My 2020 report on *Handling and Learning from Complaints* found that the Government had taken important steps to improve complaints handling. The adoption of a Customer Feedback Policy, investment in a Customer Feedback Management System, recruitment of a corporate team and designation of departmental staff have shown a commitment to improving complaints handling.

94. My 2020 review found however that more work is required to secure consistent handling of and learning from complaints. In particular, there is a need for a focus on:

- ensuring that the staff handling complaints are people with the right skills, experience, training and supervision
- ensuring that there are appropriate processes, consistently applied, to facilitate the delivery of the Customer Feedback Policy
- ensuring that the Customer Feedback Management System is developed where necessary and its capacity fully used; and
- maximising the value that can be secured from the analysis of complaints and their handling.

95. My 2020 report made 19 recommendations, many of which are still to be fully implemented. To secure a more effective learning from healthcare related complaints it is essential for the Government-wide recommendations to be implemented. It is also essential for there to be a consistent and coherent process for learning from complaints across the wider health and social care system on the Island.

96. The Government of Jersey does not have oversight on how complaints within primary care providers other than GPs are managed. Any changes to the oversight arrangements may require changes to the law.

97. Whilst the complaints process is dictated by the Health Insurance (Performers List for General Medical Practitioners) (Jersey) Regulations 2014 for GPs, there is no equivalent for other services.

98. The Jersey Care Commission standards for the services they regulate include standards in respect of effective complaints policies and procedures.

Team values

99. Whilst progress has been made in the Team Jersey programme, HCS staff have difficulty in owning generic values and initiatives that do not use health and social care service related language. One way to address this would be to use the shared generic Team Jersey Values but redefine the expected behaviours into language that health and social care staff own.

100. In order to achieve a culture of continued improvement within health and social care services it is essential to embed a quality and safety mindset. Clearly the appointment of a Quality and Safety Director will be key to this change. The rollout of a strong quality and safety programme including training in improvement skills is an important next step.

Recommendations

R13 As part of the implementation of the Jersey Care Model, explore ways of sharing information and learning from complaints across all parts of the health and social care system, including from primary care providers.

R14 Redefine the expected behaviours supporting the Team Jersey Values into a language specific to the delivery of health and social care services for HCS staff.

R15 Implement a more comprehensive quality and safety programme across all health and social care services.

Taking informed, transparent decisions

101. The 2018 review considered the information available to the public at both a States-wide and departmental level. The review found that compared with health services in the UK, the Government of Jersey made very little information specifically available to the wider public about:

- the process of decision making; or
- the performance of Jersey's health and social care services against targets.

102. The 2018 Report made five recommendations and action has been taken to progress all these recommendations to some extent, as shown in Exhibit 14.

Exhibit 14: Progress in implementing recommendations relating to taking informed, transparent decisions

Recommendation	Current position	Evaluation
R18 – Extend the availability and scope of public performance reporting to increase the focus on the quality and outcomes of health and care services, including performance against targets	The availability and scope of public performance reporting has extended since the 2018 review. Performance against targets is reported publicly in the States of Jersey Annual Report. HCS also published its Quality and Performance Report for the first time on 17 August 2021.	Partially implemented. Scope to improve further.
R19 – Establish robust mechanisms to validate performance information before publication in the Annual Report	My 2020 Report *Management Information in Education: Follow Up* recommended the development and implementation of a Government-wide strategy for data quality.	Not implemented.
R20 – Extend the scope and nature of routine public reporting of the performance of all elements of health and social care, including through the States' website, taking into account performance reporting in other jurisdictions	The scope and nature of routine public reporting of performance has been extended. However there is significant scope to extend further.	Partially implemented. Scope to improve further.

Recommendation	Current position	Evaluation
R21 – Establish structured arrangements for monitoring, validating and reporting of action taken in response to agreed recommendations arising from internal and external reviews	A structured recommendations tracking system, that picks up the issues arising from all internal and external reviews (clinical and non-clinical) has been implemented.	Implemented.
R22 – Establish robust arrangements for the preparation, maintenance, review and challenge of risk registers relating to health and social care, including arrangements for escalation	Revised risk management arrangements have been put in place but there are gaps in terms of risk tracking, review and challenge of risk registers.	Implemented but scope to improve further.

Scope and availability of public reporting

103. Since the 2018 review, the scope and availability of public reporting on HCS departmental performance has increased. Performance is reported publicly using the following mechanisms:

- performance on key departmental indicators is reported in the Annual Report
- the Jersey Performance Framework indicators are reported on the Government of Jersey website; and
- waiting list information is now reported publicly for inpatient and outpatient appointments.

104. There remain gaps however in the public reporting of operational performance information in respect of health and social care services. There has been recent interest in the public reporting of operational performance by the media and by the Public Accounts Committee. HCS has a stated intention to publish more information in the form of an Integrated Performance Report publicly in 2022 after more work is undertaken in respect of data quality. On 17 August 2021, HCS published the Quality and Performance Report for June 2021. I welcome this development.

Risk management arrangements

105. A Government-wide risk management strategy was produced in 2020. There are comprehensive risk registers within HCS, with risks entered locally into a HCS Datix system. This HCS Datix system is not the Government-wide formal IT risk system, so risks are duplicated across two systems.

106. How the HCS Board assurance on risks fits into the Government Enterprise Risk Management (ERM) approach is not clear. Neither the HCS Board nor the Q&R committee have had a formal discussion on risk appetite.

107. There remains a lack of evidence of triangulation, grouping and learning from risks. There is also a limited audit trail through the assurance committees as to how risks have been managed on and off the risk register. Only new risks are presented to the Q&R committee in full risk register format. For all other risks the Q&R committee see a summary matrix.

108. Risks are discussed at Care Group meetings although there is scope to improve the information and support provided to Care Groups.

Recommendations

R16 Extend further the scope and nature of routine public reporting of the performance of all elements of health and social care, including through the Government of Jersey website, taking into account performance reporting in other jurisdictions.

R17 Improve the arrangements for the management of risks by:

- documenting the risk appetite for the key risks identified on the risk register
- ensuring that risk mitigation actions are aimed at managing risks within the identified risk appetite
- clarifying the interaction between the HCS approach to risk and the Government ERM approach
- improving the audit trail through the assurance committees and the HCS Board as to how risks have been managed on and off the risk register; and
- ensuring the HCS Board reviews the top health and social care system risks on a systematic basis at least twice a year.

Developing the capacity and capability of those involved in governance

109. Once governance structures and systems are in place it is important to develop the capacity and capability of those responsible for delivering governance in practice.

110. Since the 2018 Report, governance within HCS has visibly moved forward. This is evidenced by;

- the HCS Board, the supporting assurance committees and executive oversight of Care Groups;
- clinical leadership of Care Groups by Associate Medical Directors; and
- new and improved systems for standards, regulation, risk management, performance management, business planning, whistleblowing and complaints.

111. What HCS now needs to focus on in the next stage of governance development is the capacity and capability of those involved in governance including ensuring shared values, skills and culture.

112. The role of Board Secretary is a core part of the governance structure and steps should be taken to ensure a permanent appointment is made to this role.

113. There is significant evidence of activities aimed at incremental development. These include:

- leadership training being developed for Associate Medical Directors (ADMs) and Care Group staff
- informal coaching and mentoring activities
- the rollout of the Team Jersey values and behaviours programme
- the recognition by executive leadership of the need for additional managerial and support capacity in the Care Groups; and
- the recognition of the need for leadership and capacity in both PALS and Quality and Safety work.

114. These strands have not however been brought together into a robust programme of work.

115. In shaping this future programme of work, consideration should be given to the role that independent members may play within the governance structures. Independent members of key committees could help to coach and facilitate

improved performance and could help to mitigate risks at an earlier stage whilst still challenging and asking appropriate questions in a supportive way.

Recommendation

R18 Ensure that the quality and safety programme to be implemented includes a comprehensive strand of work aimed at developing the capacity and capability of all those involved in delivering governance across health and social care.

Appendix One
Audit Approach

The review included the following key elements:

- review of relevant documentation provided by the Government of Jersey; and
- interviews with key officers within the Government of Jersey, the Children's Commissioner and the Jersey Care Commission.

The documentation reviewed included:

- HCS Departmental Business Plans 2020 and 2021
- Adult Social Care Business Plan 2021
- Medical Services Business Plan 2021
- Surgical Care Group Business Plan 2021
- Business plan guidance and templates
- Jersey Care Commission Annual Report
- Jersey Care Commission 6 month report to the Government of Jersey June 2020
- Terms of reference and supporting papers for Children Strategic Partnership Board
- A sample of service contracts
- Jersey Care Model User Experience Panel terms of reference
- Jersey Care Commission complaints policy and how to make a complaint leaflet
- Agendas and board packs for HCS Board and supporting assurance committees
- HCS SLT minutes and agendas
- A sample of Care Group review and HCS management executive minutes and agendas
- A sample of papers and reports relating to the Jersey Care Model
- A Health and Wellbeing Framework for Jersey
- Government of Jersey Risk Management Strategy

- Whistleblowing Policy; and
- C&AG recommendations tracker log.

The following officers were interviewed or provided written input:

- Director General, HCS
- Director General, JHA
- Director General, SPPP
- Director General, CYPES
- Group Managing Director, HCS
- Children's Commissioner
- Chief Inspector, Jersey Care Commission
- Associate Group Managing Director Mental Health Services & Adult Social Care
- Chief Nurse
- HCS Interim Board Secretary
- Group Medical Director, HCS
- Associate Medical Director, Primary Care and Community
- Associate Medical Director, Social Care and Mental Health Services
- Associate Medical Director, Surgical and Scheduled Care
- Associate Medical Director, Medical and Unscheduled Care
- Associate Medical Director, Women's and Children
- Quality and Safety Lead
- Director of Improvement and Innovation, HCS
- Patient Experience Manager, HCS
- Lead for PLICS

Appendix Two
Summary of Recommendations

R1 Document a comprehensive and publicly available Health and Social Care Integrated Governance Accountabilities (IGA) Framework. This structural document should include:

- terms of reference of committees and groups
- relationships between the committees and groups
- memberships, workplans and frequency of meetings
- arrangements both within HCS, within Government and within the whole Island health and social care system; and
- the Jersey Care Model and Our Hospital project governance arrangements.

R2 Review the terms of reference for and the membership of the HCS Board. This review should consider:

- the membership within Government and external to Government
- the responsibilities of the HCS Board in respect of all Government health and social care services (within and external to HCS); and
- the role and responsibilities of the HCS Board for the whole health and social care system on the Island.

R3 Review the way in which the HCS Board operates in order to:

- ensure that a more effective balance is struck between verbal and written reports
- ensure that the minutes record accurately who is 'present' as a HCS Board member and who is 'in attendance'
- require the HCS risk register to be reported to the HCS Board on at least an annual basis; and
- ensure that the Director General of HCS and other Senior Executives are held to account in an open and transparent way.

R4 Prioritise the finalisation of the Board Assurance Framework to support the work of the HCS Board. This document should be publicly available and be updated and publicised on at least a six monthly basis.

R5 Publish an Annual Quality Account for all health and social care services provided by Government. The Annual Quality Account should include, as a minimum, information on:

- a review of performance over the previous year across the domains of patient/service user safety, clinical effectiveness and patient experience
- identification of and progress made in identified areas of improvement
- the outcomes of clinical audit
- the outcomes and recommendations from internally commissioned external clinical services reviews undertaken in the year
- action taken and proposed in respect of clinical audit and other reviews of services
- core quality indicators, including benchmarking of performance over time and against other health and social care systems where possible and appropriate
- the volume and themes from feedback including feedback from patients/service users, system partners, complaints and whistleblowing; and
- key themes from staff surveys with actions planned in response to staff feedback.

R6 Consider appointment of independent members to the assurance committees to ensure that there is appropriate independent challenge of and assurance over performance.

R7 Ensure that robust arrangements are in place to update the data supporting the Jersey Performance Framework on a more regular basis.

R8 Document a long term strategy for health and wellbeing to be delivered across Government, health and social care services and key partners. Progress against the long term strategy should be reported publicly.

R9 Complete the review of a PALS and prioritise the establishment of a PALS or equivalent service.

R10 Review the level of business support provided to the Care Groups.

R11 Document a more formal programme of planned benchmarking and 'peer to peer' learning.

R12 Document and implement a formal action plan to rollout JNAAS to all community providers.

R13 As part of the implementation of the Jersey Care Model, explore ways of sharing information and learning from complaints across all parts of the health and social care system, including from primary care providers.

R14 Redefine the expected behaviours supporting the Team Jersey Values into a language specific to the delivery of health and social care services for HCS staff.

R15 Implement a more comprehensive quality and safety programme across all health and social care services.

R16 Extend further the scope and nature of routine public reporting of the performance of all elements of health and social care, including through the Government of Jersey website, taking into account performance reporting in other jurisdictions.

R17 Improve the arrangements for the management of risks by:

- documenting the risk appetite for the key risks identified on the risk register
- ensuring that risk mitigation actions are aimed at managing risks within the identified risk appetite
- clarifying the interaction between the HCS approach to risk and the Government ERM approach
- improving the audit trail through the assurance committees and the HCS Board as to how risks have been managed on and off the risk register; and
- ensuring the HCS Board reviews the top health and social care system risks on a systematic basis at least twice a year.

R18 Ensure that the quality and safety programme to be implemented includes a comprehensive strand of work aimed at developing the capacity and capability of all those involved in delivering governance across health and social care.

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