STATES OF JERSEY

REGULATION OF CARE LAW: PROPOSALS

Presented to the States on 7th May 2013
by the Minister for Health and Social Services

STATES GREFFE

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REPORT

EXECUTIVE SUMMARY

As we grow older, or if we have or develop a disability, we expect to maintain our quality of life, but may need some form of care to enable us to do this.

For many, good quality of life means aspiring to continued good health and to leading an independent and active life. With an ageing population, increasing numbers of people may need a degree of support either at home or in a supported care environment in order to maintain their quality of life and many of us may also from time to time require hospital care.

As the Health and Social Services White Paper – *Caring for each other, Caring for ourselves*, published in June 2012 (R.82/2012) sets out; care services in the future are likely to be not only increasingly in demand, but delivered by a wide range of providers. Islanders want services to be holistic and expect high quality person centred care delivered in the community and not just in hospital and institutions. The essential expansion in the provision for these services will be part funded by the Long-Term Care Insurance Scheme set out in the 2010 Social Security White Paper, which proposes long-term care benefit should include payment for care at home.

It is essential that there is effective, fit for purpose regulation of care provision if the States is to be satisfied that services provided as part of this new system will command public confidence and be value for money. As part of the toolkit to ensure quality services and high standards of care, an effective independent regulatory framework has an important role to play.

For some time, it has been acknowledged that the current legislation regulating health and social care is outdated and no longer fit for purpose and consequently in 2006, the then Council of Ministers approved drafting time for new legislation.

The reasons why we need much improved, up to date legislation, and why the current legislation is no longer fit for purpose, are set out further in Section 1, the next section of this report. Key objectives of what new legislation would achieve are explored in Section 2. Section 3 of this report explores what the new Law would include.

In January 2010, the Health and Social Services Department published the response to a Green Paper Consultation which offered providers of health and social care in Jersey an opportunity to comment on the current Laws and offer their views as to how health and social care should be regulated in the future. Those who responded were in favour of updating the legislation and strongly supported independent regulation and the inclusion of home care and services provided by the States of Jersey in the new Law. Stakeholders continue to be involved in the development of the legislation and support the detailed policy underpinning the proposed Law.

The purpose of this report is to update States members by summarising the policy, which is expected to inform the drafting instructions for a Regulation of Care Law. This report proposes that the existing legislative framework for the regulation of health and social care in Jersey is replaced with a single enabling Law, supported by specific regulations and codes of practice.

The regime would address the deficiencies in the existing legislation by providing clear, modern definitions of regulated activities and by providing for the comprehensive regulation of nursing agencies, domiciliary and primary care, including care provided by the States, within the same framework. This new regime will require those managing services or working with people in need of health and social care to have appropriate qualities, skills and expertise to be safe and competent practitioners. It will also enable clear, comprehensive and enforceable standards to be set for the provision of different types of care to be set. Furthermore it will establish a new independent Commission that will command public confidence to regulate the provision of health and social care and promote improvements in standards of care.

There will be a number of benefits to creating this new regulatory regime. In particular, individuals using care services or accessing them for family members will benefit from the knowledge that they should receive consistent standards of care from appropriately skilled and competent staff wherever care is delivered. They will also benefit from there being safeguards in place to protect against the risk of inadequate or negligent care being delivered to themselves or their loved ones.

SECTION 1

INTRODUCTION

Why do we need new legislation?

At present, the principal pieces of legislation covering the provision of health and social care in Jersey are the Nursing and Residential Homes (Jersey) Law 1994 ("the 1994 Law"); and the Nursing Agencies (Jersey) Law 1978 ("the 1978 Law"). The principle provisions of these Laws are summarised in Appendix 1 to this report. The Political accountability for both Laws lies with the Minister for Health and Social Services. In very broad terms –

(a) the 1994 Law is concerned with regulating independent residential care homes, nursing homes, mental nursing homes and private hospitals; and

(b) the 1978 Law is concerned with the licensing of businesses that supply nurses, midwives and auxiliary nurses.

The 1994 Law came into force in Jersey in May 1995 and was based on UK legislation from 10 years earlier and the 1978 Law is even older than that. Over the intervening years the structure of health and social care changed significantly and the expectations of those using services have increased. There is now much greater emphasis on the use of domiciliary care, the safety and quality of provision and a requirement for good governance and transparency. The inspection and regulatory regime in the UK is also focused more proactively on encouraging the incremental improvement of services rather than solely on regulatory enforcement. As a result there are a large number of deficiencies with the provisions contained in and made under these existing Laws. Of the upmost importance, these laws leave domiciliary care (i.e. care provided to support people in their own homes) and care provided by the States of Jersey unregulated.

They also –

- lack clear, modern definitions of regulated activities;
- they don't provide a basis for imposing sufficiently tailored and robust standards with regard to the quality of care provided in care homes or elsewhere;
- there is insufficient provision as to the background checks or the governance arrangements that care services should adopt to protect patients from abuse; and
- they don't provide for a sufficiently independent, risk based, transparent system of inspections or regulatory action.

The nature of these deficiencies is described in more detail below, but put simply the current system is incapable of commanding public confidence. As Jersey's population, like that of many western European countries, ages these deficiencies will be of increasing concern to an ever greater numbers of islanders. Further, as has recently been seen, failing to regulate the provision of domiciliary personal care can result in the, perhaps avoidable, neglect and mistreatment of vulnerable persons[1].

In May 2006 the Council of Ministers acknowledged that the legislation regulating the provision of health and social care in Jersey was no longer fit for purpose. A stakeholder consultation on proposals for reform was issued in November 2007[2] and invited views about what should be included in a new Law. A range of stakeholders responded to the consultation process including representation from independent care homes, domiciliary care and home nursing, general practice, service managers, acute hospital clinicians, voluntary sector and service users. The findings of the stakeholder consultation indicated that a majority of respondents (69%) thought that the legislation required updating; only 6% did not think this necessary. A report setting out the outcome of the consultation and some initial policy proposals, agreed by the Minister for Health and Social Services, was published in January 2010[3].

Specific Problems with the Current Legislation

Unregulated domiciliary care

The existing Laws don't reflect the reality that modern health and social care services are increasingly focused on domiciliary care, which is currently unregulated in Jersey. Such agencies supply care workers to support vulnerable people in their own homes, currently without any checks or balances in place to ensure that the staff are safe, competent and the quality of care is adequate.

The Public Health Department are aware of numerous concerns about existing unregulated local personal care agencies. These concerns include issues relating to

[1] In *AG v Breen*, 14th March 2011 – the Royal Court considered a case in which a person suffered serious neglect by their carer who was providing unregulated personal care for a person with dementia in their home.
[2] Regulation of Care (Jersey) Law 200- Stakeholder Consultation
www.statesassembly.gov.je/ScrutinyReviewResearches/2008/S-35164-48106-10122008.pdf
[3] Regulation of Care (Jersey) Law 200-, Report of Stakeholder Consultation –
www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R%20RegulationofCareResponseReport%20201001%20MC.pdf

unsafe handling practices, lack of confidentiality with client information, carers taking their children into clients' homes for their working shift including one incident where there were potential child protection issues. The Department is aware of complaints of carers regularly not turning up for shifts leaving people without any care, neglect of individual personal care needs, carers employed without proper recruitment checks, lack of induction training, new employees supplied to clients to undertake intimate personal care and administer medication without any training, carers lacking competence and appropriate experience for the clients' needs, lack of consistency in carers provided to individuals. The Department is also aware of allegations of an agency not paying their staff and people being over charged or charged for services not provided. Further, as already noted above, a recent Royal Court Judgement highlighted the potentially tragic consequences for an individual in receipt of negligent unregulated personal care at home.[4]

These examples are likely to be the tip of the iceberg. As domiciliary care is unregulated and the Public Health Department has no power or locus to investigate complaints about such care, many concerns about the standards of domiciliary care will doubtless fail to come to the attention of the Public Health Department.

Care Services provided by the States

A key limitation of the current legislation is the exemption of States operated services from regulation. An overwhelming 90% of respondents to the consultation indicated that the new Law should include Health and Social Services and other States department provision. This was further supported in the 2007 report of the Social Affairs Scrutiny Sub-Panel (Overdale Review) which examined the closure of McKinstry and Leoville wards at Overdale[5] and recommended that the Health and Social Services Department wards should be "subject to the same expectations and inspection process as privately – owned wards".

Safeguarding

Safeguarding vulnerable people from abuse is increasingly a major aspect of health and social care however there is little or no mention of the need to safeguard individuals from harm or abuse in the current legislation.

Acute Hospital Services

The nursing homes legislation makes provision to regulate any private hospital services including acute hospital care, operating theatres, x-ray facilities, endoscopy services and medical/cosmetic laser treatment. However, the Law gives insufficient powers to ensure safe practice is followed.

Modern acute hospital and health services are expected to have appropriate clinical governance arrangements in place; however history has shown that this is not sufficient to ensure patient safety. Evidence of poor governance and ineffective regulation is apparent in the recent findings of the Francis Inquiry into Mid

[4] AG v Breen, 14th March 2011
[5] S.R.1/2007 Overdale: The Closure of Leoville and McKinstry Wards, Education and Home Affairs Scrutiny Panel

Staffordshire NHS Trust[6]. The findings of this inquiry confirm that no acute hospital service is beyond criticism or can be immune from complacency about poor standards and clinical practice and that effective independent scrutiny is an essential safeguard to protect patient safety.

Lack of Regulatory Independence

Existing health and social care legislation is the responsibility of the Minister for Health and Social Services. The Minister through the Health and Social Services Department is also responsible for provision and commissioning of health and social care. There is an inherent conflict of interest in this arrangement with departmental pressures to provide and fund care at the lowest possible cost in services that it also regulates to improve and maintain standards. This dual function would become untenable in the event of Health and Social Services Department's services being regulated as the Minister would effectively be regulating services that he or she was also responsible for delivering. The stakeholder consultation confirmed this view with only 6% of respondents indicating that regulation should continue to be the function of Health and Social Services.

If a regulatory body is to be effective and to command public confidence then it must be independent, competent, and accountable and perform its functions in a transparent manner.

Fees

The regulatory fees charged by the Public Health Department at present are nominal and not related to the size and complexity of the service or the level of associated regulatory activity undertaken by officers. For example, at present a new care home provider applying to register a large 60 bedded dual registered care home in Jersey would pay an initial registration fee of £506.64[7]. The equivalent registration fee with a UK regulator would be £5,600[8]. Further, currently Jersey care homes pay an annual flat fee to remain registered of £86.50 irrespective of the size of the home or number of beds. This can be compared to £162 per bed in the UK. In practice, this means that the costs of regulating social care are currently being borne almost exclusively by the taxpayer and that the contribution of those providing regulated services, in many cases for profit, is minimal. It would be fairer to the taxpayer to re-balance the way in which regulatory costs are covered so that a greater proportion is borne by those providing the regulated services.

SECTION 2

KEY POLICY OBJECTIVES

Underpinning the proposed regulatory framework is an ethos of regulation and inspection for improvement as opposed to a compliance monitoring and enforcement model. This requires the regulator to engage with and support providers to meet regulatory requirements and encourage ongoing improvements in standards with

[6] Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, Chairman Robert Francis QC, February 2013
[7] Health and Social Services (2013 Fees) (Jersey) Order 2012
[8] CQC, Provision for Fees, 2012

enforcement as a last resort. Although it is not underpinned by existing legislation, to some extent this approach has been taken by current regulatory officers and has had some success in improving standards within the independent sector.

The key objectives of the proposed legislation are to –

1. Streamline existing Laws and include additional provisions to provide a single consistent legislative framework for the regulation of health and social care in Jersey.

2. Create a regulatory body in the form of a Commission that will be independent of strategic policy makers, providers and commissioners of health and social care.

3. Remove the exemption from regulation of health and social care provided by the Health and Social Services Department, other States of Jersey departments, district nursing services and premises operated by medical and dental practitioners.

4. Include nursing agencies, domiciliary and primary care within the same regulatory framework as other health and social care provision.

5. Ensure that the health, safety and welfare of individuals are protected.

6. Ensure that those managing services and working with people in need of health and social care have appropriate qualities, skills and expertise to be safe and competent practitioners.

7. Set clear, enforceable standards in the form of approved codes of practice, based on identifying and meeting the needs of individuals with a focus on outcomes for the individual.

8. Ensure premises offering health and social care are fit for purpose and conform to best practice standards and guidance.

9. Require health and social care services to develop robust quality assurance and governance arrangements.

10. Publish reports on the outcome of inspections and investigations and make these easily accessible to the public.

11. Establish a fee structure that is proportionate to the size and complexity of the service.

12. Enable a flexible risk based inspection regime that maintains public confidence.

There will be a number of benefits to creating this new regulatory regime. In particular, individuals using care services or accessing them for family members will benefit from the knowledge that they should receive consistent standards of care from appropriately skilled and competent staff wherever care is delivered. They will also benefit from there being safeguards in place to protect against the risk of inadequate or

negligent care being delivered to themselves or their loved ones. Making these changes should also benefit those providing services by setting standards that are fair and equitable across all sectors and providing a consistent regulatory framework for long-term nursing and residential care.

SECTION 3

WHAT WILL THE LAW INCLUDE?

The Regulation of Care Law will be primary legislation broadly setting out the regulatory function and how it operates. It is proposed that the legislation will therefore include the following elements:

Independent Regulatory Oversight

The legislation will provide for the establishment of a non-departmental independent statutory body in the form of a Health and Social Care Commission to fulfil the functions of the regulatory authority under the Law.[9]

With an increasing number of examples of shared regulatory functions between Jersey and Guernsey[10] there is an opportunity to create a joint Channel Island Health and Social Care Commission. As Guernsey are in the process of developing equivalent legislation in parallel to our own, there is ongoing collaboration and discussion to explore the feasibility of appointing a single Commission providing regulatory oversight in both islands.

Definitions of Health and Social Care

The types of care, services and activities that are to be regulated will be defined in the Law; this will give clear guidance both to service providers, care commissioners and the public about the difference between the services available. In particular, the new law will ensure that there are separate clear definitions of health, nursing, social and personal care.

Registration of Regulated Activities

The registration process will set out how those providing regulated services and those managing regulated services will be registered. The process will also enable the regulatory body to apply a greater variety of conditions to the registration, conferring a degree of control over the particular service provision. A registration will be able to be refused or cancelled on a number of grounds including where the applicant has not demonstrated that they are a fit person and are capable to provide the service, has not complied with the legal requirements, or has a conviction for a relevant offence.

Improvement Notices

The legislation will enable the regulatory authority to serve an improvement notice at any time to a registered provider indicating that unless significant specified

[9] Appendix 2
[10] Channel Islands Competition and Regulatory Authorities, Channel Island Independent Aviation Security Regulator, Joint Data Protection Commissioner

improvements are made in the provision of the service within a specified timeframe the authority will consider cancellation of the registration.

Inspection

Inspection to monitor the quality and standards of care will be a core element of the legislation. The purpose of inspection however will not be limited monitoring compliance, but will also include supporting and encouraging service improvement.

Where local expertise is not available external agencies will carry out inspections of specialised activities on behalf of the regulatory authority.

The arrangements about the frequency and type of inspection will be determined on a risk basis.

Following an inspection a report of the findings will be sent to the care provider. The purpose of this report will be to inform the provider of evidence of non-compliance with conditions of registration, the regulations and standards and the action the care provider should take to comply. It will also include, where appropriate, recommendations for improvement.

A copy of the inspection report will be available to the public; however information of a confidential nature relating to individuals using the service will be excluded from the public report.

Complaints and Matters of Concern

The Law will give the regulator a role in ensuring any complaint, incident, event or cause for concern about a service is properly investigated and where necessary will carry out their own investigations.

Provision of Services, Facilities and Management of Regulated Activity

Requirements as to the qualifications and character of those managing care services will form part of the registration requirements. These will also include an obligation on the registered person to ensure that services are well conducted with high standards of care. The care provider will be required to provide proper facilities and a safe and appropriate environment. They will also have a duty to employ sufficient appropriately qualified and competent staff and to maintain adequate records.

Standards and Approved Codes of Practice

To provide greater clarity and transparency about what is specifically required in terms of the services and facilities provided, standards in the form of Approved Codes of Practice will be produced and published. These standards/approved codes of practice will give practical guidance on complying with the Law and will be used in any enforcement action.

Fees

It is intended to introduce a fee structure comparable to other jurisdictions. This will include increasing the initial registration fee to an appropriate level that reflects the

responsibility and accountability of providing such a service plus an annual fee based on the size of the service. The increases will be phased in over 5 years.

SECTION 4

IMPLEMENTATION OF THE LAW

Provisional Legislation Timetable

The drafting instructions for the primary legislation are already in progress and it is expected that initial instructions could be sent to the Law Draftsman in April 2013. The Minister's aim, subject to pressures on drafting resources, is for the draft Law to be progressed with the first complete version being delivered to the Minister for Health and Social Services before the end of 2013. It is anticipated that a stakeholder consultation on the draft Law might then take place at the beginning of 2014 with a view to the possibility of lodging the draft Law with the States, for debate in July 2014.

Phased Implementation

To ensure that the implementation process is not overwhelmed by the size and complexity of the task, it is intended to phase in the regulations for various activities over a realistic and manageable time frame[11].

There are some key drivers that will set the implementation timetable; primarily the introduction of the long-term care funding proposals which is contingent on the regulation of particular health and social care activities. Consequently it is proposed to bring into force the primary enabling Law and Regulations pertaining to the appointment of the independent regulatory body, long-term care homes, group homes, personal care workers, nursing and domiciliary care agencies, including those provided by Health and Social Services Department and other States departments during 2015.

The provisional timeframe for a phased regulation of other services, such as hospital and primary care and social services estimates implementation by 2020.

April 2013

[11] Appendix 3

APPENDIX 1

The Existing Legislation

At present, the principal pieces of legislation covering the provision of health and social care in Jersey are the Nursing and Residential Homes (Jersey) Law 1994 ("the 1994 Law"); and the Nursing Agencies (Jersey) Law 1978 ("the 1978 Law"). Political accountability for both lies with the Minister for Health and Social Services ("the Minister"). In very broad terms –

(a) the 1994 Law is concerned with regulating independent residential care homes, nursing homes, mental nursing homes and private hospitals; and

(b) the 1978 Law is concerned with the licensing of businesses that supply nurses, midwives and auxiliary nurses.

The 1994 Law

The 1994 Law covers –

- independent residential care homes
- nursing homes
- mental nursing homes
- private hospitals.

Care homes, which provide residential accommodation with both board and personal care (but not nursing or mental nursing care) are registered as **Residential Care Homes.**

Homes which provide nursing or mental nursing care are registered as **Nursing or Mental Nursing Homes.**

The definition of nursing home embraces a wide spectrum of provision from traditional long-term nursing care through to clinics, acute hospitals and psychiatric hospitals.

There are significant exemptions from the requirements of the 1994 Law.

These exemptions cover hospitals maintained or controlled by the States of Jersey, any other establishment or premises maintained or controlled by a Minister and any premises used wholly or mainly by a registered medical practitioner, registered dental practitioner or chiropodist for the purpose of consultations or treatment of his patients.

With regard to the regulation of premises to which the 1994 Law applies, the Law requires that the Minister maintain a register of each class of home and the persons who carry on these homes. He may, subject to a right to object and appeal, refuse an application for registration or cancel a registration where the persons running it or the accommodation is "not fit" for the purpose and in some other specific circumstances. It is an offence for any person to carry on such a home without it being registered and where a home falls into more than one class for the purposes of the 1994 Law the home must be registered in each of the appropriate registers.

The Minister must restrict the number of people who can have services provided to them by the home and may place some other specific types of conditions on a registration. Breach of these conditions on registration is an offence. Under Article 15 of the 1994 Law the Minister also has the power, by Order, to specify standards in respect of the accommodation and equipment kept in homes and the conduct of homes. A specific list of the matters relating to the conduct of homes that orders may provide for is included in the Article. Breach of such an Order is an offence punishable by a fine. A person authorised by the Minister may at any time enter and inspect a home or premises that may be being used as a home, interview residents or patients or require the production of their medical records. It is an offence, without cause, to obstruct such an inspection.

In exercise of the power in Article 15, 2 Orders have been made –

(a) the Nursing Homes and Mental Nursing Homes (General Provisions) (Jersey) Order 1995 ("the Nursing Homes Order"); and

(b) the Residential Homes (General Provisions) (Jersey) Order 1995 ("the Residential Homes Order").

Each of these requires homes to which they apply to compile a variety of different records.

They also set out a series of requirements that the person registered in respect of such a home shall comply with having regard to the number, age, sex and condition of the residents. Given the very wide variety of homes to which these orders apply, these requirements are not prescriptive, but rather provide a checklist of matters that those responsible for carrying on the home should have regard to.

Failure to comply with most of the provisions of either Order is an offence, but a person may not be prosecuted for failure to comply unless the Minister has served a notice explaining their opinion that the person has failed or is failing to comply with the Order, the action that the Minister proposes should be taken and giving a deadline for doing so.

The 1978 Law

The Nursing Agencies Law covers the licensing of businesses that supply nurses or midwives and auxiliary nurses.

There are significant exemptions from the requirement to hold a licence, covering the business carried on by any district nursing association or similar organisation and any agency carried on by any hospital controlled by the States or parochial authority. **Therefore personal and domiciliary care agencies are exempted from the effect of the Law, and are not licensed or regulated**.

With regard to the regulation of such agencies, a person who needs to obtain a licence must apply to the Minister annually and pay a fee. The Minister is entitled to place such conditions on the licence as he or she thinks fit for securing the proper conduct of the agency. The Minister may, subject to a right of appeal, refuse an application or revoke an existing licence, *inter alia*, on the grounds that the applicant is unsuitable or the agency is being improperly conducted or any licence condition has not been complied with. The 1978 Law limits the types of nurses who may be provided by an

agency and requires that selection for each role must be made under the supervision of a registered nurse or medical practitioner. The agency must keep such records as are prescribed by Order and may be inspected by the Minister's authorised officers. The Nursing Agencies (General Provisions) (Jersey) Order 1978 ("the Nursing Agencies Order") prescribes the records that must be kept by the agency with regard to the work undertaken by their nurses and midwives and requires that separate records be kept in relation to auxiliary nurses.

APPENDIX 2

OPTIONS AND RATIONALE FOR INDEPENDENT REGULATORY OVERSIGHT

Regulatory oversight has a key role in holding the executive and operational regulatory function to account. Various options for regulatory oversight were considered and evaluated on the basis of the key principles of independence, technical and regulatory competence, accountability, transparency, conflicts of interest, public and stakeholder confidence and cost efficiency. These options are set out below.

1. Maintain the status quo

The status quo, where the responsibility for regulation rests with the Minister for Health and Social Services does not meet any of the key principles other than cost efficiency. As the Minister is also responsible for the provision and commissioning of health and social care, there is no prospect of maintaining regulatory independence and the extent of this conflict of interest will become much greater if services provided by the States themselves became regulated.

The Minister may also be perceived to lack the proper degree of technical competence to regulate this sector, particularly when compared with the fully independent regulatory bodies created in other jurisdictions. Continuing to have the Minister regulate these services will result in poor public and stakeholder confidence in the regulation of health and social care services.

2. Regulatory function is put under the oversight of another Minister

An alternative to regulation by the Minister for Health and Social Services would be to put the regulatory function under the oversight of another Minister; however this would provide only a limited improvement in regulatory independence as there would still be a lack of political distance. Further, it might create a still greater perceived deficiency in the regulatory and technical competence of the regulator, further compromising public and stakeholder confidence.

3. A new statutory regulator operating as a Corporation Sole

The option of a new statutory regulator operating as a Corporation Sole was also considered. This would involve vesting responsibility for regulating health and social care in a new public office held by a particular individual.

This would provide independence as the regulator could have no conflicts relating to providing or commissioning services. He or she would however be responsible for both oversight and operational delivery of the regulatory function, thus decreasing accountability. However, whilst an individual regulator would be expected to have some regulatory competence, his or her technical competence is likely to be limited to a specific area of expertise and the health and social care sector is very diverse.

An individual regulator would also be more vulnerable to political pressures in cases where unpopular decisions may be required. There are therefore risks to public and stakeholder confidence in relying on the qualities, strength and expertise of one person

to deliver effective and robust regulation in what is a complex and technically varied field.

4. The appointment of a properly constituted Commission

The only model of regulatory oversight that meets all the key principles for effective regulation is the appointment of a properly constituted Commission.

That approach has been adopted by other jurisdictions, including England, Wales, Scotland and Northern Ireland, for equivalent legislation. These are –

- the Care Quality Commission in England
- the Care and Social Services Inspectorate Wales
- Social Care and Social Work Improvement Scotland (Care Inspectorate) and
- the Northern Ireland Social Care Council.

Whilst this is not the cheapest option, it **does** meet the criteria for independence and there is separation between oversight and the executive regulatory function which it can hold to account.

By carefully selecting the composition of such a Commission, it would be possible to ensure that there is sufficient technical and regulatory competence available among Commissioners and there would be strength in having a number of experienced individuals to resist political and other lobbying pressures whilst still being accountable to the States and the public. This model of regulation would in our view be much more likely to provide effective regulatory oversight that commands public confidence.

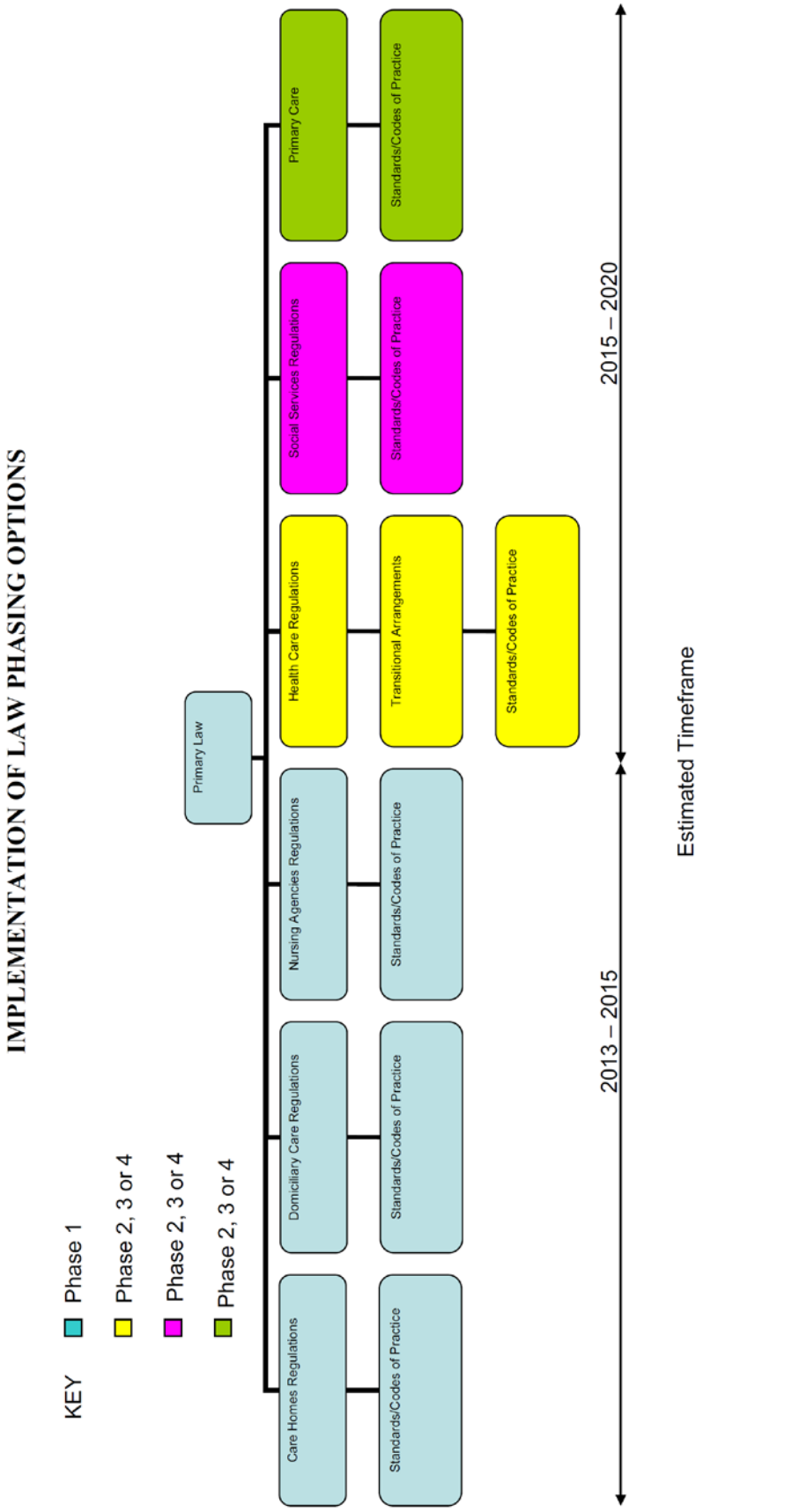
The legislation will therefore provide for the establishment of a non-departmental independent statutory body in the form of a Health and Social Care Commission to fulfil the functions of the regulatory authority under the Law. This provision may enable the detail of the Commissioner's terms of appointment and such provisions as may be necessary for its administration and operation of the Commission to be developed by the States in regulations.

Summary of Options for Regulatory Oversight

Option I	Independent joint CI/Crown Dependencies Commission	Key ○ = strong ◊ = limited x = weak
Option II	Independent Jersey Commission	
Option III	Individual Regulator – (Corporation Sole)	
Option IV	Other Ministerial Oversight	
Option V	H&SSD Minister Oversight	

Evaluation Criteria (Essential Key Elements for effective regulation)	**Option I**	**Option II**	**Option III**	**Option IV**	**Option V**
Regulatory independence	○	○	◊	◊	x
Technical competence	○	○	◊	x	x
Regulatory competence	○	○	○	x	x
Accountability	○	○	○	x	x
Transparency	○	○	○	◊	◊
Lack of conflicting interests	○	○	◊	x	x
Public confidence	○	○	◊	x	x
Cost efficiencies	◊	x	◊	○	○

APPENDIX 3


IMPLEMENTATION OF LAW PHASING OPTIONS
KEY
Phase 1
Phase 2, 3 or 4
Phase 2, 3 or 4
Phase 2, 3 or 4
Primary Law
Care Homes Regulations
Standards/Codes of Practice
Domiciliary Care Regulations
Standards/Codes of Practice
Nursing Agencies Regulations
Standards/Codes of Practice
Health Care Regulations
Transitional Arrangements
Standards/Codes of Practice
Social Services Regulations
Standards/Codes of Practice
Primary Care
Standards/Codes of Practice
2013 – 2015
2015 – 2020
Estimated Timeframe