



Health and Social Security Scrutiny Panel

Redesign of the Health and Social Care Governance Model



Presented to the States on 10th November 2017

S.R.9/2017


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1. CHAIRMAN'S FOREWORD

Some might glance at the proposals for the redesign of health and social care governance and wonder why we need another level of bureaucracy. But the principle of involving the public and all health and social care providers in planning the future direction of services, is sound. We are asking GPs to play a greater part in our healthcare and services are increasingly being provided by voluntary and third sector agencies. It is right that they should have a voice in setting the strategy.

So, in broad terms, my Panel has come to support the proposal. However, we do have concerns relating to the establishment, size and composition of the proposed System Partnership Board and its sub-groups. As explained in our report, there is still much for the Minister to do to ensure that the Board is fit for purpose. We make an overarching recommendation that, should the Minister's proposition be approved, he update the Assembly at least twice before the new system becomes operational.



Deputy Richard Renouf
Chairman, Health and Social Security Scrutiny Panel

2. EXECUTIVE SUMMARY

P.60/2017 '*Health and Social Care System: A New Governance Model*' asks States Members to decide whether to introduce a System Partnership Board (the Board) for a trial period of three years that would be responsible for advising the Minister for Health and Social Services. It proposes the introduction of a Public and Patient Advisory Group, a Voluntary and Community Sector Forum and a Clinical and Professional Forum to sit on THE Board with the Corporate Directors of Health and Social Services. This would be overseen by an independent Chair and two Non-Executive Directors.

The Panel has reviewed the proposition with the assistance of its expert advisor, Dr. Amy Hughes, MBE, and has concluded that the proposed model is a welcome change to the governance of health and social care in the Island. However, concerns regarding the implementation of the model need addressing. In the advisor's report, several key questions were put forward, which the Health and Social Services Department answered prior to a public hearing. Further to these answers and the public hearing with the Minister, the Panel has identified seven key areas that require attention from the Minister.

The Panel has found that there needs to be more certainty as to how the voice of children will be represented on the Board. In light of the recommendations in the Independent Jersey Care Inquiry and the role the Board will play in advising the Minister, it is essential that mechanisms are put in place within the Board to allow a broad voice for children to be put forward.

Further details are required as to how the Patient and Public Advisory Group and the Voluntary and Community Sector Forum will be created. The Panel has found that the Department is reluctant to influence the creation of these groups, as it feels that members of the sector and general public should be responsible for the formation of any Terms of Reference. The Panel finds this argument circular and in light of the evidence received believes that in order for the proposed group and forum to be effective, the Minister should ensure that adequate direction and support is given by the Department. It is the view of the Panel that the Board should not begin its operation until the forum and group are satisfactorily established, with representatives appointed to the Board.

Within the Advisor's report there was a strong theme put forward by stakeholders that the proposed model required further details as to how it would be implemented in practice. The Panel's Advisor noted that worked examples of how the Board would reach decisions would provide details to key stakeholders addressing these concerns. The Panel received examples from the Health and Social Services Department in response to this question, although it is of the opinion that greater detail is required in order to provide clarity.

One of the key areas examined by the Panel was the size and composition of the proposed model. It is noted that the proposed Board would consist of 21 members that would be drawn from across the Health and Social Services Department, the two forums and the Public and Patient Advisory Group. The prevailing view from the evidence received is that a strong Chair is necessary in order ensure the effectiveness of the Board. The Panel questioned why it was necessary for the nine Corporate Directors from Health and Social Services (including the Chief Executive) to sit on the Board. An argument has been put forward by the Minister as to why this was necessary, however it is not agreed by the Panel. There is an expectation that the three representatives from the Voluntary and Community Sector Forum would need to represent the views of the entire sector which, in turn, has led the Panel to question why this

cannot be replicated with the representation from Health and Social Services. It is the view of the Panel that the Minister should revisit the number of members on the Board with a view to reducing it to create a more manageable Board.

The Panel understands that £150,000 has been budgeted for the first year of the three-year pilot and this amount will be evaluated as the Board progresses. Further details as to how the Voluntary and Community Sector Forum and Public and Patient Advisory Group are funded are necessary and the Minister should ensure that appropriate remuneration is made available to representatives from those areas.

The future direction of this Board is uncertain and as the trial period develops there will need to be a focus on what role the Board will play. One such option could be that the Board takes on more responsibility in terms of the delivery of health and social care, meaning a change in role of the Minister for Health and Social Services. Although this is not the purpose of this proposition, the Panel is of the opinion that a future States Assembly could be presented with a decision as to the direction of health and social care in the future. The Minister should maintain open and transparent conversations regarding the future of the model and report back to Assembly on the progress made by the Board.

From the documentation reviewed and evidence gathered during the course of its review, the Panel acknowledges there is wide support in principle for improving the present governance arrangements for health and social care in the Island. As a result, the Panel also supports the principle of establishing a new governance model in the form of a System Partnership Board. However, the Panel has concerns relating to various aspects of the operation and implementation of the proposed model as laid out above and therefore has brought an amendment to the proposition. This amendment proposes that the Board should not be formally established before April 2018 in order to give the Minister an opportunity to report on progress to the Panel and the Assembly, to allow Members to ask questions of the Minister, and to allow time for any further debate if considered necessary.

3. KEY FINDINGS AND RECOMMENDATIONS

KEY FINDINGS

KEY FINDING 1:

The System Partnership Board will consist of Health and Social Services Department representatives, a Voluntary and Community Sector Forum, a Public and Patient Advisory Group, a Clinical and Professional Forum and an independent Chair and two Non-Executive Directors.

KEY FINDING 2:

There is widespread support among stakeholders for a change to the current governance of health and social care.

KEY FINDING 3:

The consultation exercise undertaken to establish a new governance model generated widespread in principle agreement that the System Partnership Board should be established.

KEY FINDING 4:

Concerns have been raised that further preliminary work needs to be undertaken before the System Partnership Board is established and to give assurance to stakeholders that the proposed governance model is workable and appropriate for Jersey.

KEY FINDING 5:

Evidence given at a public hearing suggests that the Minister for Health and Social Services considered children would be given a voice by the presence on the board of the Chief Executive Officer and Corporate Directors of Health and Social Services.

KEY FINDING 6:

There is no certainty that any other representative on the System Partnership Board would directly represent the voice of children and young people.

KEY FINDING 7:

There is currently no official forum or group that exists to represent the public and patient voice on the System Partnership Board.

KEY FINDING 8:

The Health and Social Services Department has asked Citizens Advice Jersey to lead in establishing a Public and Patient Advisory Group, though it is not yet clear what processes will be used.

KEY FINDING 9:

The Minister for Health and Social Services and his department have been reluctant to involve themselves in arrangements to establish the group, notwithstanding that the proposition suggested the System Partnership Board could be fully functional by the end of 2017. The Panel considers this approach unhelpful and contrary to the public interest.

KEY FINDING 10:

There is uncertainty over the composition of the Public and Patient Advisory Group, its Terms of Reference, how it would represent the wider sector from which it is drawn, how it would operate and be accountable to that sector.

KEY FINDING 11:

There is uncertainty over how the Patient and Public Advisory Group would elect its members onto the System Partnership Board. The Minister for Health and Social Services has suggested that selection onto the System Partnership Board be based both on nomination and an assessment of an individual's capacity, capability and approach. It is not clear to the Panel how a nomination process would also ensure representation based on merit.

KEY FINDING 12:

The Minister for Health and Social Services has suggested that at the point the Public and Patient Advisory Group puts its representatives forward, they would meet a specification the System Partnership Board has agreed. The Panel finds this a circular argument. The Board cannot agree a specification if board members have not yet been elected. The Panel believes the Health and Social Services Department is relying upon the independent Chair and Non-Executive directors to oversee the establishment of the Public and Patient Advisory Group and ensure its good governance.

KEY FINDING 13:

Upon approval of the proposed governance model, resources will be allocated to form the Voluntary and Community Sector Forum.

KEY FINDING 14:

No current forum exists with a clear role and remit to represent the diverse voluntary and community sector. The need to find a means of establishing a representative body is a challenge to the sector which lacks the resources available to the Health and Social Services Department.

KEY FINDING 15:

There is uncertainty over the composition of the Voluntary and Community Sector Forum, its Terms of Reference, how it would represent the wider sector from which it is drawn, how it would operate and be accountable to that sector, and how it would elect representatives to sit on the System Partnership Board.

KEY FINDING 16:

Stakeholders frequently raised the view that there was little clarity as to how the proposed model would be implemented.

KEY FINDING 17:

Although the Health and Social Services Department provided a worked example to the Panel, there was insufficient detail to understand how the System Partnership Board would operate.

KEY FINDING 18:

The System Partnership Board in the proposed model will consist of 21 members.

KEY FINDING 19:

The Minister for Health and Social Services has agreed that the size of the System Partnership Board could be problematic.

KEY FINDING 20:

The Health and Social Services Department will be represented by nine Corporate Directors including the Chief Executive Officer.

KEY FINDING 21:

It is the view of the Minister for Health and Social Services that no Corporate Directors should be left off the System Partnership Board.

KEY FINDING 22:

There is a prevailing view from both the Minister for Health and Social Services and key stakeholders that a strong Chair is crucial to the success of this model.

KEY FINDING 23:

The Health and Social Services Department will fund the administrative cost of the System Partnership Board and will also provide research facilities to the Board.

KEY FINDING 24:

There are currently no proposals as to how the System Partnership Board would develop once the three-year trial period has concluded.

RECOMMENDATIONS

Please note: Each recommendation is accompanied by a reference to that part of the report where further explanation and justification may be found.

RECOMMENDATION 1:

The System Partnership Board should align its Terms of Reference with any work being undertaken by the incoming Children's Commissioner, and any other persons appointed pursuant to proposals following recommendations made in the Independent Jersey Care Inquiry. **[Section 7.1]**

RECOMMENDATION 2:

The Minister for Health and Social Services should ensure that one or more of the appointees among the Chair and Non-Executive Directors has significant and relevant training and experience in community and social services, to better ensure the voice of children is represented. **[Section 7.1]**

RECOMMENDATION 3:

There are risks in the fluid approach adopted by the Minister for Health and Social Services. It is important that the Public and Patient Advisory Group should be able to represent the diverse interests of the public and patients and that it should be supported by its own system of governance. Given the part the Public and Patient Advisory Group will play in setting future strategy, the Panel considers it is in the public interest for the Minister to ensure that appropriate departmental resources are allocated to lead in establishing this group. **[Section 7.2]**

RECOMMENDATION 4:

The System Partnership Board should not begin its operational role until the Public and Patient Group is satisfactorily established and their representatives are elected onto the System Partnership Board. **[Section 7.2]**

RECOMMENDATION 5:

The Minister for Health and Social Services should ensure that a detailed worked example of how the Voluntary and Community Sector Forum will operate is made available to assist the sector to understand its role in the new model. **[Section 7.3]**

RECOMMENDATION 6:

The System Partnership Board should not begin its operational role until the Voluntary and Community Sector Forum is satisfactorily established and their representatives are elected onto the Board. **[Section 7.3]**

RECOMMENDATION 7:

The System Partnership Board should not begin its operational role until detailed worked examples are provided to the key stakeholders to their satisfaction. These examples should make reference to the communication pathways, training pathways, evaluation criteria and development of a set of guidelines to deal with challenges during implementation and operation. **[Section 7.4]**

RECOMMENDATION 8:

The roles and responsibilities of each System Partnership Board Member should be clarified. **[Section 7.4]**

RECOMMENDATION 9:

The Minister for Health and Social Services should give consideration to the composition and size of the System Partnership Board with a view to reducing the number of Health and Social Services Department representatives. **[Section 7.5]**

RECOMMENDATION 10:

System Partnership Board members who would not be remunerated for attendance by virtue of their employment should receive an honorarium to reflect the work and commitment involved as a board member. It is not sufficient to offer the reimbursement of a day's pay if this is lost because some board members might be retired persons or would participate in the board in their own time. **[Section 7.6]**

RECOMMENDATION 11:

The Minister for Health and Social Services should ensure that the Public and Patient Advisory Group and Voluntary and Community Sector Forum are adequately resourced to allow them to participate on an equal basis with other System Partnership Board Members. **[Section 7.6]**

RECOMMENDATION 12:

The Minister for Health and Social Services should ensure that the costs of establishing and operating the System Partnership Board are published on an annual basis. **[Section 7.6]**

RECOMMENDATION 13:

The Minister for Health and Social Services should ensure that open and transparent discussions take place as to the future direction of the System Partnership Board. Any changes that may be proposed should be subject to full consultation and be brought to the States Assembly with adequate time for scrutiny and debate. **[Section 7.7]**

As a result of the evidence received, the Panel has identified the following overarching recommendation for the Minister for Health and Social Services:

OVERARCHING RECOMMENDATION

The Minister for Health and Social Services should report to the States Assembly at the last sitting of 2017, and the first sitting of March 2018, with an update on the progress made in implementing the System Partnership Board and its associated forums and groups.

4. INTRODUCTION

Context and Background

In 2012, the States of Jersey approved P.82/2012 *'Health and Social Services: A new way forward'*.¹ Since the proposition was approved the Department has undergone a significant amount of change with many voluntary, third sector and primary care organisations delivering significant and increasing elements of service.

The changing roles and relationships, plus the development of a system-wide and integrated approach to planning and delivery of services, has created concern amongst some stakeholders about their involvement (or lack thereof) in the governance of this emerging system.²

In 2016, the Council of Ministers tasked the Minister for Health and Social Services to review the current governance arrangements for health and social care to ensure that Jersey has the most effective health and social care system for the future.³ In order to achieve this, KPMG was commissioned by the Health and Social Services Department to review current arrangements and identify potential changes. The consultation process was undertaken across the space of seven months and involved collaborative working with a wide range of stakeholders delivering health and social care in the island⁴. Governance models from other health systems were examined during this process in order to identify aspects that could be utilised within a unique Jersey model.⁵ Subsequently, a preferred model emerged that has been accepted in principle by the various stakeholders involved in the consultation.

The Proposition (P.60/2017: *"Health and Social Care System: A New Governance Model"*) was lodged by the Council of Ministers on 23rd June 2017 and asks Members to approve the proposed model for a trial period of three years. The debate is due to take place on 14th November 2017.

The Review

For the purposes of this review, the Health and Social Security Scrutiny Panel appointed Dr. Amy Hughes, MBE, of OMNI Medical Training and Consultancy as its expert advisor to undertake a review of the proposed governance model. Dr. Hughes' report is appended to this report at [appendix one](#). In order to undertake this review Dr. Hughes was provided with several documents relating to the proposed model and held interviews with key stakeholders involved in the formation of the model during September 2017.

The Panel undertook its own work and requested written submissions detailing views on the proposed model from various health and social care providers and organisations.

Dr. Hughes' report put forward key questions on the proposed model, the answers to which were provided by the Health and Social Services Department prior to a public hearing with the Minister for Health and Social Services (the full answers can be found at [appendix two](#)).

¹ P.82/2012 - <http://www.statesassembly.gov.je/assemblypropositions/2012/p.082-2012.pdf>

² P.60/2017 - p.4 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

³ P.60/2017 - p.4 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁴ P.60/2017 - p.11 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁵ P.60/2017 - p.12 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

5. THE PROPOSED MODEL

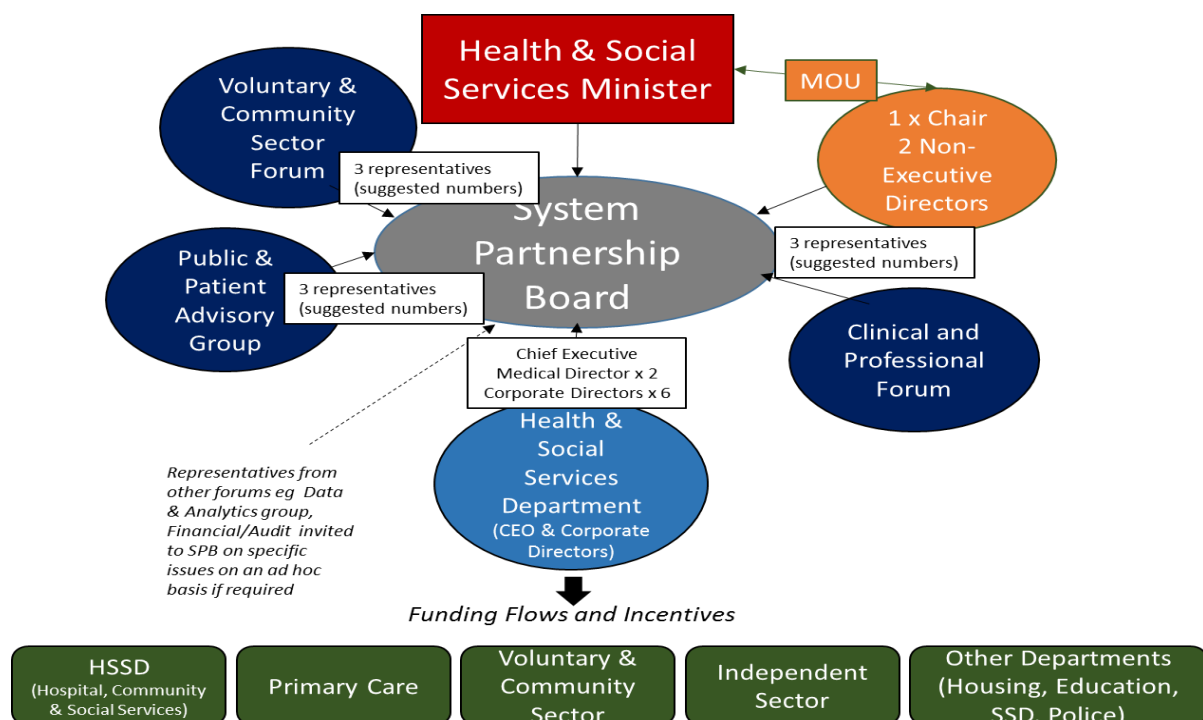
5.1 Overview of the Model

P.60/2017 asks States Members to approve the formation of a System Partnership Board (SPB) which would draw together representatives from across the spectrum of health and social care in Jersey. This would be piloted for an initial three years. The SPB would contain representatives from the Health and Social Services Department, voluntary and community sector organisations, a clinical and professional forum (including primary care) and a public and patient advisory group. The Board would also include an independent Chair and two Non-Executive Directors.⁶ The SPB would act in an advisory capacity with any Board decisions or recommendations being presented via the Chair to the Minister for Health and Social Services. The ministerial role and the functions of the Health and Social Services Department would remain unchanged.

Overall accountability will remain with the Minister for Health and Social Services and an agreed Memorandum of Understanding (MOU) would exist between the Chair of the SPB and the Minister in respect of roles and responsibilities of the Board.⁷

P.60/2017 outlines several key benefits that the proposed model would deliver, namely:

- health and social care governance becomes inclusive of the stakeholders across the system;
- Independent Chair and Non-Executive Directors;
- Change in culture;
- Gaps in access and inequality reduced; and
- A LEAN based approach to reducing waste by improving decision making.⁸



⁶ P.60/2017 - p.15 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁷ P.60/2017 - p.14 & 15 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁸ P.60/2017 - p.13 & 14 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

5.2 Structure of the Board

Chair and Non-Executive Directors

It is proposed that the Board would be overseen by an independent Chair and two Non-Executive Directors. A MOU would be agreed between the Chair and the Minister for Health and Social Services which would lay out key objectives and indicators for the Board. The Chair would oversee the meetings of the SPB in an impartial manner and would relay Board recommendations to the Minister. The Chair and Non-Executive Directors would be appointed through the Appointments Commission.⁹

Health and Social Services Representation

It is proposed that the Health and Social Services Department would be represented by the following nine members on the Board.

- Chief Executive Officer;
- Finance Director;
- Managing Director of the General Hospital;
- Managing Director of Community and Social Services;
- Director of System Redesign and Delivery;
- Chief Nurse;
- Human Resources Director; and
- Two Medical Directors.

Clinical and Professional Forum Representation

Three members from this forum would be put forward to sit on the Board. It is proposed that the Clinical and Professional Forum would be made up of various groups of people. Primary Care will be represented through this forum (general practitioners, pharmacists, dentists, and optometrists) as well as other professionals working in the field of health and social care (i.e. social workers, nurses and care workers). It is envisaged that the Forum would form its own Terms of Reference outlining its purpose and ensuring that a representative view is put forward to the SPB.¹⁰

Patient and Public Advisory Group Representation

Three members from this forum would be elected to sit on the Board. It is proposed that a Patient and Public Advisory Group would be created to bring the views of the service users and the general public to the SPB. It is envisaged that the forum will form its own Terms of Reference outlining its purpose and ensuring that a representative view is put forward to the SPB.¹¹ It is noted that Citizens Advice Jersey will lead the work to create this forum.¹²

Voluntary and Community Sector Forum Representation

Three members from this forum would be elected to sit on the Board. It is proposed that a strengthened Voluntary and Community Sector Forum would bring forward the voice of the broader system partners, and would be representative of the third sector organisations currently commissioned by Health and Social Services to undertake aspects of health and social care in the community (i.e. Family Nursing and Home Care, Silkworth Lodge etc.). It is

⁹ Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.44

¹⁰ Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.10

¹¹ Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.10

¹² Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.7&8

envisaged that the forum will form its own Terms of Reference outlining its purpose and ensuring that a representative view is put forward to the System Partnership Board.¹³

It is noted in the proposition, that the SPB would have formal links to other States Departments such as Education, Housing and the Strategic Public Health Unit.¹⁴ It is also noted that once the Board is established, a 'compact' will be produced between service providers regarding values, behaviours, service delivery, performance, partnership working and accountability.¹⁵¹⁶

KEY FINDING 1: The System Partnership Board will consist of Health and Social Services Department representatives, a Voluntary and Community Sector Forum, a Public and Patient Advisory Group, a Clinical and Professional Forum and an independent Chair and two Non-Executive Directors.

¹³ Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.10

¹⁴ P.60/2017 – p.16 - <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

¹⁵ P.60/2017 – p.16 - <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

¹⁶ [Appendix 2 – Questions on P.60/2017 – p.5](#)

5.3 Stakeholder views on the Model

Throughout the review, the Panel has been assured by the Health and Social Services Department that the partner agencies involved in this proposed model are very keen for it to be implemented expediently:

The Deputy of St. Owen:

Has any one group within the community agitated for this change?

The Minister for Health and Social Services:

I think we have whet their appetite to such a level that they want it, you would have to ask them, but I do believe that the people who have been working with us in developing this will be very disappointed if we fail to deliver it.¹⁷

The Panel's advisor, Dr Amy Hughes, MBE, reviewed the proposed structure, held interviews with key stakeholders and examined written submissions. Evidence received from stakeholders has shown that there is a great deal of willingness for the new model to be implemented. Examples include:

- *'Will help provide better, safe and seamless care...less disjointed'*
- *'The new model will improve decision making and help minimize the hierarchy which currently exists regarding decision making'*
- *'There is currently no foundation for joint decision making – new model helps address this'*
- *'More public involvement in processes and decisions around service provision'*
- *'Shared responsibility of decision-making'*
- *'Improved synergy'*
- *'Strengthened robustness of decision making, and transparency'*
- *'New structure helps 'minimise' the 'loud' voices currently influencing decisions'*
- *'Improved visibility of process and decision making to patients and users'*
- *'Clearer pathways of patient care may evolve'*
- *'New structure helps build confidence'*
- *'The systems partnership board helps provide a platform for decision making based on user needs'*
- *'Better scrutiny of decisions'*
- *'Helps rebuild relationships and public trust'*
- *'Advantages in richness of evolving a system which has input from those with lived experiences, as well as professionals'*

¹⁷ Public Hearing with the Minister for Health and Social Services – 19th October 2017 – p.3&4

- *'There is commonly a 'Silo' mentality across many organisations and this approach needs to be addressed in order to successfully implement P82/2012 recommendations¹⁸*

Whilst the advantages of the proposed model have been noted, concerns have also been raised by key stakeholders. Examples include:

- *My only major concern is that this model, based on a hybrid of others, will be specific to Jersey and therefore remains untested. In particular, I'm not sure who/what will have ultimate responsibility for policy change, the introduction of new services or change of service provision. I made this point during the consultation process but have yet to see a worked example. Consequently, I would appreciate some configurability/fluidity in how the model is eventually formulated.¹⁹*
- *My concerns and observations about the success factors are that there should be a strong, independent Chair with strong independent board members. The significance of this is that one of the risks to successful implementation is changes to the current culture and behaviours of the current HSS directorate²⁰*
- *There needs to be an emphasis on operational delivery and more thought needs to be given to how exactly this will work in practice.²¹*
- *There are concerns regarding waiting times for them [clients/patients] to be seen and wonder what the impact will be, with limited resources both personnel and financial, if the service demand is increased by these new proposals.²²*
- *If it is to be some sort of hybrid arrangement, in that the power remains with the Minister and HSSD, which also remains the main provider of health and social care services, it may be harder to sustain engagement amongst the membership of the whole board, (in particular representatives from the patient forum and the voluntary sector). This may impact the model of partnership working.²³*
- *It is important to note that the System Partnership Model is a model devised by the participants, following their review of models in other jurisdictions. As such it is not a proven model.²⁴*
- *While the Voluntary and Community sector is committed to improving services for the communities they serve and, therefore, contributing to work such as this, it is a reality that those organisations are often restricted with resource and funds.²⁵*

¹⁸ [Appendix One - Advisor's Report – p.12&13](#)

¹⁹ Written Submission – Dr N. Minihane – Primary Care Body

²⁰ Written Submission – Dr P. Venn – Primary Care Body

²¹ Written Submission – Dr P. Venn – Primary Care Body

²² Written Submission – Relate Jersey

²³ Written Submission – Jersey Hospice Care

²⁴ Written Submission – Jersey Hospice Care

²⁵ Written Submission – Jersey Recovery College

KEY FINDING 2: There is widespread support among stakeholders for a change to the current governance of health and social care.

KEY FINDING 3: The consultation exercise undertaken to establish a new governance model generated widespread in principle agreement that the System Partnership Board should be established

KEY FINDING 4: Concerns have been raised that further preliminary work needs to be undertaken before the System Partnership Board is established and to give assurance to stakeholders that the proposed governance model is workable and appropriate for Jersey.

6. THE PANEL ADVISOR'S REPORT

The Panel appointed Dr. Amy Hughes, MBE as its expert advisor on the proposed governance model.

Dr. Hughes, undertook a desk-top study of the proposed model and held interviews with key stakeholders during September 2017²⁶. Her final report identified key questions in relation to 12 areas of the proposed model and can be found in [appendix one](#). The twelve areas were identified as follows:

1. Structure: Evolution of the Model (Section 6.1.1)
2. Structure: Operationalising the 'Model' (Section 6.1.2)
3. Structure: HSSD Representation (Section 6.1.3)
4. Structure: Sector (Volunteer, Community, Public/Patient and Clinical/Professional) representation (Section 6.1.4)
5. Structure: System Partnership Board (Section 6.1.5)
6. Structure: Funding (Section 6.1.6)
7. Leadership: Chair and Non-Executive Directors (Section 6.2)
8. Staff Roles and Responsibilities (Section 6.3)
9. Human Resources and Administration (Section 6.4)
10. Education and Training (Section 6.5)
11. Performance Measures and Evaluation (Section 6.6)
12. Culture and Behaviour (Section 6.7)

The key questions raised in the report were sent to the Health and Social Services Department and answers were provided in advance of a public hearing with the Minister for Health and Social Services, which allowed the Panel to undertake further questioning on the responses given by the Department. The answers can be found in [appendix two](#).

Based on the evidence received throughout the review, Dr. Hughes summarises the proposed model within the following section of the Executive Summary:

*The proposed governance model re-design has been very much welcomed and supported by those engaged in the review. The proposed changes are likely to support improvements in services across Health and Social Care and strengthen patient interaction and partnerships. However, for the model to be successful and effective, further details of how the model will be operationalised is welcomed.*²⁷

In the conclusion of the report, Dr. Hughes reported that the proposed new governance model is well received and recognised as a much needed change to health and social care in Jersey. The governance model – in its operational capacity – should be patient-centric, dynamic and reflective, and provide an approachable and productive platform for governance activities. If its implementation is one that encourages regular review and evaluation, the model will likely be strengthened as it becomes operational.

Dr. Hughes further commented that joint working is essential to success of the model and to achieve this strong leadership, clear vision, shared goals, and adequate resources and infrastructure are required. Joint working examples internationally, in particular those implemented to support large scale change, have been most successful when they have been;

²⁶ [Appendix Four – 12.7 – Interviews held by Dr. Hughes](#)

²⁷ [Appendix One - Advisor's Report – p.4](#)

- patient focused;
- collaborative;
- when emphasis is on learning and knowledge;
- when data and information is fed back to providers; and
- when strong administration and management systems are developed.

However, the greatest influence to success is likely to be the extent to which culture and behavioural change can be encouraged and supported in Jersey's Health and Social Care System.

Following on from this, Dr. Hughes put forward the following recommendations in her report:

1. Ensure the System Partnership Board is patient-centred and outcome focused.
2. Provide worked examples to demonstrate in detail how the governance system will be operationalised: from decision-making through to operational delivery.
3. Provide clarity of the roles and responsibilities for those engaged in the governance model:
 - a) Forum and Advisory group representatives,
 - b) Board members
 - c) Chair
 - d) Non-Executive Directors
4. Provide clarity of the accountability and legislative responsibility each representative and board member has;
5. Illustrate the communication pathways and feedback mechanisms available within the governance model.
6. Provide further detail on the expected training pathways board members expected to engage with
7. Provide a more detailed overview of the performance measures and evaluation criteria planned for the Systems Partnership Board.
8. Develop a set of guidelines to support 'actions on' challenges which may present during implementation and roll-out of the proposed governance model

7. ISSUES FOR FURTHER CONSIDERATION

The Panel received answers to the questions put forward by the Advisor's report prior to a public hearing with the Minister for Health and Social Services. This allowed the Panel to question the Minister further on key issues and to help understand the plans for certain aspects of this proposed model. Further to the public hearing and the evidence received, the Panel accepts that the concept put forward is clearly one that is approved by key stakeholders and does create a more inclusive forum for health and social care governance. However, the Panel still has concerns in relation to the following areas of the proposed model.

- 7.1 Voice of Children
- 7.2 Public Engagement
- 7.3 Voluntary and Community Sector Representation
- 7.4 Testing the Model
- 7.5 The Composition and Size of the Board
- 7.6 Funding the Model
- 7.7 Future Development of the Board

7.1 Voice of Children

Recommendation two of the Independent Jersey Care Inquiry (IJCI) asks the States of Jersey to give children and young people a voice at a strategic level. The Panel notes that although P.60/2017 was lodged prior to the publication of the IJCI, there is not one reference made within the proposition to children and young people.

A submission made by the NSPCC highlighted the need to focus on children and young people's needs:

*I have read the new governance model document and welcome the changes to continuously improve partnership and service user voices in the delivery of services. I would hope there will be a specific focus on children and young peoples' needs.*²⁸

Further questioning at the public hearing with the Minister for Health and Social Services elicited the following answers:

Deputy J.A. Hilton:

Can you tell me how children are represented on the partnership board?

Chief Executive Officer:

*Children are represented like every other type of person who lives on the Island, through all the members of the board ... If you are asking for some reassurance, which I think you probably are and I would expect you to given your interest, that children are not somehow going to be lost in all of this, the department is responsible for the delivery of Children's Services and we have our own internal ways of working together through the Community and Social Services Department. We have the Children's Improvement Board at the moment. There are all sorts of places that are going to be keeping an eagle eye on safeguarding the interests of children and making sure that those resources are available and those improvements are being made. The partnership board can add to that by making sure that when it is considering bids for P.82 monies that Children's Services bids are coming through that route and getting their place and getting supported. Obviously in terms of the membership the most direct support for that will clearly come from the managing director for community and social services, who of course is by default the Island's chief social worker, and she is going to make very sure of it. If she is sitting in a board meeting and she is not hearing children's issues...*²⁹

The Deputy of St. Ouen:

How can children be given a voice in the proposed governance procedure? We are told children must be listened to.

Managing Director, Community and Social Services:

Yes. There is a lot of work taking place, particularly led by the Youth Service, who are really the professional experts in terms of young people's participation. There is a lot of work happening within the broader children's landscape around that. There is work going on with that. I think we do need to have children's voices in here. We are

²⁸ Written Submission - NSPCC

²⁹ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.35

purchasing an app that can be used on mobile devices and it is called M.O.M.O., Mind of My Own. I think we mentioned it on Monday [at the Safeguarding Partnership Board Conference] As I was sitting here thinking about how you include people's voices who probably do not want to come along to a meeting and listen to the likes of us talking about things might want to feed in in a different way. I think some of that is about saying: "How do you use technology for young people? How do you use the Youth Service? How might you use the Children's Commissioner or children's rights? I think it is about how you bring the pieces of the jigsaw together to truly bring it in. I do think as we develop strategies and policies, as the Chief Executive mentioned a moment ago, there does need to be a challenge about: "How does this impact on children? What is the impact assessment? What is the benefit to children's life of this policy or this strategy?" I think the board has a role there. I do think for children and young people, you have to look at how they might want to buy into contributing.³⁰

The Panel had initial concerns that membership of the Board was weighted heavily in favour of clinical and acute services, with little emphasis being placed on community and social services. In response, the Health and Social Services Department gave the following answer:

Answer to Question 27 – Appendix Two

The Health and Social Services Chief Executive will be a Board Member and holds accountability for the entirety of health and social services strategy and delivery, reporting to the Minister. The Managing Director of Community & Social Services will also be a Board member, and it is worth noting that, as an integrated Health and Social Services Department, all HSSD representatives have both health and a social services responsibilities as part of their role.³¹

KEY FINDING 5: Evidence given at public hearings suggests that the Minister for Health and Social Services considered children would be given a voice by the presence on the board of the Chief Executive Officer and Corporate Directors of Health and Social Services.

KEY FINDING 6: There is no certainty that any other representative on the System Partnership Board would directly represent the voice of children and young people.

RECOMMENDATION 1: The System Partnership Board should align its Terms of Reference with any work being undertaken by the incoming Children's Commissioner, and any other persons appointed pursuant to proposals following recommendations made in the Independent Jersey Care Inquiry.

RECOMMENDATION 2: The Minister for Health and Social Services ensure that one or more of the appointees among the Chair and Non-Executive Director's has significant and relevant training and experience in community and social services to better ensure the voice of children is represented.

³⁰ Public Hearing with the Minister for Health and Social Services – 19th October 2017 – p.41

³¹ [Appendix Two – Questions on P.60/2017 – p.9](#)

7.2 Public Engagement

The Panel understands that the Public and Patient Advisory Group will be created in order to bring forward issues to the System Partnership Board. The proposition (P.60/2017) states that the SPB would be supported by 3 key advisory groups, of which one is the Public and Patient Advisory Group, comprising individuals with an agreed set of skills and expertise who can be effective in influencing the work of the Board.³²

One of the key questions put forward by Dr. Hughes' in her report was how representatives of this Public and Patient Advisory Group would be representative of the wider sector from which they were drawn.³³ The Department's response was as follows:

"The System Partnership Board representatives will be selected by the respective group, based on nomination and an assessment of the individual's capacity, capability and approach (e.g. their ability to be broadly representative, work positively and professionally in partnership, consider alternatives and work collaboratively towards shared solutions, and operate at a strategic level).

The Terms of Reference, constitution, operation and objectives of the Clinical and Professional and Voluntary and Community Sector groups will be a matter for those groups, but will include:

- *Being accountable to their constituents, communicating the outcomes of the System Partnership Board*
- *Representing the breadth of views from their constituents*
- *Identifying key issues from their constituents*
- *Building cross-system relationships*
- *Resolving issues within their control or influence*

Furthermore, it is expected that each of the overarching Advisory Groups will have appropriate links to other professional, public and voluntary sector groups and part of the representative role is to actively involve and inform these other groups and act as a conduit for issues to be brought to the attention of the Board.³⁴

Upon further questioning, the reasoning behind this answer was given by the Chief Executive of Health and Social Services in a public hearing:

Chief Executive, Health and Social Services

...one of the important things here is it is not me or the Director of System Redesign or any officer that is designing and thinking through how might a patient in a public forum work. It is people who are representative of, so for example, Citizens Advice Bureau, Consumer Council, who are used to having relationships with the public, and we are working with them and asking them to help us to formulate what will work better for people in Jersey.³⁵

³² P.60/2017 – p.16 <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

³³ [Appendix One - Advisor's Report – p.19](#)

³⁴ [Appendix Two – Questions on P.60/2017 – p.4](#)

³⁵ Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.7

The Panel notes that the Department for Health and Social Services do not want to influence the manner in which this particular group is formed. It is therefore worth noting that no current forum exists to represent the public and patient voice. It was confirmed that the work being undertaken to form this Patient and Public Advisory Group would be led by the Chief Executive Citizens Advice Jersey;

Director, System Redesign and Delivery

The chief executive of the Citizens Advice Jersey is leading on the public and patient element for us because he has great experience of doing exactly that. We can also learn from experience like with the mental health strategy when we have a citizens' panel, there were various mechanisms that we used then to elicit the views of those groups that are less heard.³⁶

The Panel questioned whether this Forum could lead to specific 'lobbying' groups taking up a disproportionate representation, effectively rendering the group as a mouthpiece for a specific topic (e.g. medicinal use of cannabis). This challenge was acknowledged by Health and Social Services, however it is anticipated that controls will be in place in order to alleviate these concerns:

The Deputy of St. Ouen:

Is it enough to say that these groups will need to find a way because they are each going to put 3 persons on to a board, which is going to have a very great influence on the direction of health and social care in the Island? Do we just say it is up to them to find the way through?

Chief Executive Officer:

They must find a way that they are comfortable with and we will support and give them information that will help them do that. But at the point they put their representatives forward they will be meeting a specification which the board has agreed. In the early days that is the chairman and the non-executives and we work with the people who are already a part of our partnership relationship who can give us guidance until they have got to the point where they have gone through a process, which is open to scrutiny, and which gives them confidence that they are putting forward the right sorts of representative.³⁷

The Deputy of St. Ouen:

But then I come back to the question: how do you ensure that there is diversity and the people who joined that group are truly representative?

Chief Executive Officer:

Because the partnership board would work out together its modus operandi: its rules of engagement, its expectations in relation of its behaviours, what they would value, how they would hold each other to account. So they would be making it very, very clear the types of representatives that they would see being brought forward from

³⁶ Public Hearing – Minister for Health and Social Services, 19th October 2017 – p.7&8

³⁷ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.10

*these individual groups. The individual groups themselves will negotiate and agree their terms of reference and how they want to work together and it will be very clear that allowing single interest organisations to dominate proceedings and get places on a board would not be tolerated by the independent chair because it would be not in accordance with the terms of reference and the rules of engagement that they themselves have agreed.*³⁸

It appears that the Board will set out a specification for individuals representing the group at the Board level, with the intention of dealing with this potential issue. The Panel notes the suggestion that this specification will be created by the Board (initially the Chair and Non-Executive Directors) prior to any elections that would take place within the Public and Patient Advisory Group. This would be supported by Health and Social Services.

As it is necessary for the States Assembly to give approval prior to implementation, it is noted that there is a degree of uncertainty as to the finer details of the proposed model. Should the States Assembly approve this new governance model, then further work would then be undertaken to create the group:

Director of System Redesign and Delivery

*So we have got that broad framework. Subject to the outcome of the States debate on 14th November then we will start to put in place, with the partners that will be leading the element of this, the exact details of how it is going to work, but we will do that together. It is not a case of saying: "We want you to run the public forum, off you go. Do whatever you want" because the individual that is currently working on what does the public forum look like was part of all of those workshops, was part of all of those interviews. It set this desired direction together with us. Once the States debate has happened then is the time for us to then go out and start talking with the public about: "This is what it looks like, this is how it might operate, this is what it is aiming to do, and this is how you could be involved."*³⁹

The Panel received a submission from Jersey Recovery College which included the following recommendation:

*Jersey Recovery College is a service that has benefitted from the power of co-production and the richness that comes from developing a service between those with lived experience, carers and professionals as equal partners. We would recommend that this model of working is the most effective in empowering the patient / public voice and feel it is important to create joint working between the proposed Forums and Public and Patient Advisory Group. In order to facilitate co-production it is important that all parties have equal access to the discussion and that support, if required, is offered to anyone with lived experience to contribute fully.*⁴⁰

³⁸ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.8&9

³⁹ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.11

⁴⁰ Written Submission – Jersey Recovery College

KEY FINDING 7: There is currently no official forum or group that exists to represent the public and patient voice on the System Partnership Board.

KEY FINDING 8: The Health and Social Services Department has asked Citizens Advice Jersey to lead in establishing a Public and Patient Advisory Group, though it is not yet clear what processes will be used.

KEY FINDING 9: The Minister for Health and Social Services and his department have been reluctant to involve themselves in arrangements to establish the group, notwithstanding that the proposition suggested the System Partnership Board could be fully functional by the end of 2017. The Panel considers this approach unhelpful and contrary to the public interest.

KEY FINDING 10: There is uncertainty over the composition of the Public and Patient Advisory Group, its Terms of Reference, how it would represent the wider sector from which it is drawn, how it would operate and be accountable to that sector.

KEY FINDING 11: There is uncertainty over how the Group would elect certain of its members onto the System Partnership Board. The Minister has suggested that selection onto the Board be based both on nomination and an assessment of an individual's capacity, capability and approach. It is not clear to the Panel how a nomination process would also ensure representation based on merit.

KEY FINDING 12: The Minister for Health and Social Services has suggested that at the point the Public and Patient Advisory Group puts its representatives forward, they would meet a specification the System Partnership Board has agreed. The Panel finds this a circular argument. The Board cannot agree a specification if board members have not yet been elected. The Panel believes the Health and Social Services Department is relying upon the independent Chair and Non-Executive directors to oversee the establishment of the Public and Patient Advisory Group and ensure its good governance.

RECOMMENDATION 3: There are risks in the fluid approach adopted by the Minister for Health and Social Services. It is important that the Public and Patient Advisory Group should be able to represent the diverse interests of the public and patients and that it should be supported by its own system of governance. Given the part the Public and Patient Advisory Group will play in setting future strategy, the Panel considers it is in the public interest for the Minister to ensure that appropriate departmental resources are allocated to lead in establishing this group.

RECOMMENDATION 4: The System Partnership Board should not begin its operational role until the Public and Patient Group is satisfactorily established and their representatives are elected onto the Board.

7.3 Voluntary and Community Sector Representation on the Board

Concern was raised by representatives of the Voluntary and Community sector that a lack of existing infrastructure within the third sector could undermine the proposed model. The Jersey Voluntary and Community Sector Ltd had been incorporated in 2014 through funding from the Chief Minister's Department to officially represent the third sector and act as a critical friend to States of Jersey.⁴¹

However, funding was withdrawn from the company in 2016 and although temporary money was allocated, it ran out in early 2017 and the company has now been formally wound-up.⁴²

*This leaves the island without a formal representative body to talk for the sector although there is some talk about eventually creating a compact between the VCS and the States.*⁴³

The Panel understands that the Association of Jersey Charities (AJC) is limited by its constitution to charitable purposes and could not act as a representative of the third sector, or a critical friend to the States of Jersey.

One of the key questions put forward in the Advisor's report asked the Department to provide clarity on the presence of an existing voluntary and community sector forum and how this would be supported both administratively and financially.⁴⁴

In response, the Health and Social Services Department gave the following answer:

There are a number of fora where Voluntary and Community Sector organisations work closely together – both as individuals supporting one another and as a larger group of organisations with a common goal. The Disability Partnership is a good example of this. In addition, voluntary sector organisations from health and social care have met to identify the areas where they could work better together, for example by sharing training and other assets.

Since the workshops, key individuals from the Voluntary and Community Sector have met to start forming the beginning of the Voluntary Sector Forum. They are keen to raise awareness about the proposed strategic governance model and to offer the opportunity for more organisations to contribute. However, this cannot be progressed until after the States Debate.

In terms of resource support, the emerging Voluntary and Community Sector Forum is currently being supported by an HSSD Manager, at the request of the voluntary sector organisations. Subject to States approval in the debate, administrative support will be provided by HSSD to ensure the Forum is able to function effectively, for example, ensuring clear communications and that meetings are well planned, organised and executed. It is hoped that room hire for such meetings will be made available by the voluntary sector organisations, but if this is not possible, rooms will be available within HSSD for this purpose.

⁴¹ Written Submissions – Jersey Voluntary and Community Sector Ltd

⁴² Written Submissions – Jersey Voluntary and Community Sector Ltd

⁴³ Written Submissions – Jersey Voluntary and Community Sector Ltd

⁴⁴ [Appendix One – Advisors Report – p.19](#)

HSSD will fund the new governance model for the three years of its pilot; this includes the project management and secretarial support for the three Advisory Groups. Work is also underway to consider issues in relation to the potential funding of participants time, looking at how this is approached in other jurisdictions and how such funded participation can evidence value for money.⁴⁵

During the workshops that helped co-produce the proposed model it is clear that voluntary and third sector organisations were involved. The Panel understands that the Jersey Disability Partnership and Jersey Community Partnership are two groups that represent certain organisations within the voluntary and community sector, however there is no clear, identifiable group that exists to bring together all views and concerns from across the wide spectrum of the sector. This was highlighted in written submissions:

There is NO real VCS Forum as alluded to in the proposed Governance review to represent / appoint Board members at this time although the key participants including myself from the sector are trying to pull together something to achieve this aim.⁴⁶

This presents particular challenges for the Voluntary and Community Sector given the absence of an existing group where suitable representatives might be willing and able to effectively represent them. As the sector do not currently have a formalised forum with a clear role and remit, or the resources to engage in the current proposals, this needs further clarification.⁴⁷

Consideration needs to be given to how three voluntary/community organisations can represent the sector. The organisations selected and the communities they represent must be balanced and those involved must be able to positively represent their peers. In order to do this, the representatives involved must be able to communicate with the sector as a whole and reflect back all views to the Board.⁴⁸

It will be important to ensure therefore that the membership of the System Partnership Board is diverse in all senses, not only representing a spectrum of different organisations, but also ensuring that the representatives from those organisations are diverse and the views of disparate groups in our community are heard.⁴⁹

The Panel took forward this concern in the public hearing with the Minister for Health and Social Services on 19th October 2017. The Panel questioned how this particular forum would be created, bearing in mind the number of organisations within the sector:

The Deputy of St. Ouen:

The voluntary and community sector forum as well, it must face the same difficulties. So we have got any number of charities or voluntary sector groups in Jersey. They have somehow got to come together and elect 3 members to the partnership board,

⁴⁵ [Appendix Two – Questions on P.60/2017 – p.3](#)

⁴⁶ Written Submission – Jersey Voluntary and Community Sector Representative – Jim Hopley

⁴⁷ Written Submission – Brighter Futures

⁴⁸ Written Submission – Jersey Recovery College

⁴⁹ Written Submission – Jersey Hospice Care

but there is no constitution for this group to provide for that election. Is it expected that...

Chief Executive Officer:

Again the partners in the third sector are busy meeting and talking about these issues currently. Again, we are guiding and supporting them in terms of providing them with evidence from elsewhere about how that would work. They are very conscious of the sort of challenges that you are raising because obviously we know them as well, and they will need to find a way of getting their representatives that they, as a broad group, are comfortable with. They will have to work hard. There are large charities, there are small charities, and there are charities that deal with children, people who deal with older people.⁵⁰

The Panel understands that further work is intended to be done subsequent to States Approval, in response to one of the Advisor's key questions:

Can the roles and responsibilities of the forum and advisory groups be provided please?

A Terms of Reference (ToR) has been provided to the Scrutiny Panel as policy under development. The outline is also include in P60 and in the KPMG report.

This will be developed further, by the relevant groups themselves, should the States Debate approve the proposed strategic governance model.⁵¹

KEY FINDING 13: Upon approval of the proposed governance model, resources will be allocated to form the Voluntary and Community Sector Forum.

KEY FINDING 14: No current forum exists with a clear role and remit to represent the diverse voluntary and community sector. The need to find a means of establishing a representative body is a challenge to the sector which lacks the resources available to the Health and Social Services Department.

KEY FINDING 15: There is uncertainty over the composition of the Voluntary and Community Sector Forum, its Terms of Reference, how it would represent the wider sector from which it is drawn, how it would operate and be accountable to that sector, and how it would elect representatives to sit on the System Partnership Board.

RECOMMENDATION 5: The Minister for Health and Social Services should ensure that a detailed worked example of how the Voluntary and Community Sector Forum will operate is made available to assist the sector to understand its role in the new model.

RECOMMENDATION 6: The System Partnership Board should not begin its operational role until the Voluntary and Community Sector Forum is satisfactorily established and their representatives are elected onto the Board.

⁵⁰ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.9&10

⁵¹ [Appendix Two – Questions on P.60/2017 – p.6](#)

7.4 Testing the Model

During the Panel and Advisor's work, a particular theme was drawn out in regard to how the proposed model would be implemented. Some key feedback from written submissions included:

- *My only major concern is that this model, based on a hybrid of others, will be specific to Jersey and therefore remains untested. In particular, I'm not sure who/what will have ultimate responsibility for policy change, the introduction of new services or change of service provision. I made this point during the consultation process but have yet to see a worked example. Consequently, I would appreciate some configurability/fluidity in how the model is eventually formulated.*⁵²
- *A critical function of this will be measures devised to ensure accountability in performance and service delivery.*⁵³
- *There needs to be an emphasis on operational delivery and more thought needs to be given to how exactly this will work in practice.*⁵⁴

The Panel's advisor, Dr. Hughes, noted in her report that;

*A frequently raised concern addressed the lack of clarity provided on how the proposed governance model will be operationalised. In particular, some stakeholders felt there was a gap in the provision of worked examples for the governance model. Worked examples would be welcomed particularly in detailing processes of System Partnership Board decision-making; translating strategic decisions into operational delivery; and managing board disagreements and 'hung' votes.*⁵⁵

In response to this feedback, Dr. Hughes put forward a key questions requesting the Minister for Health and Social Services to provide 'worked examples' of the new governance model.⁵⁶

The Panel submitted this question to the Minister for Health and Social Services in advance of its public hearing and received the following answer:

These will be devised in detail following the outcome of the States Debate. Should the States approve the new strategic governance model, a couple of worked examples might be:

Example 1: Strategic Investment decisions. Members of the Public and Patient Forum identify that there is a gap in services for individuals with mild to moderate mental health needs, who are unaware of where to go for help and/or that easily accessible, low level help is not available outside of working hours.

The Public and Patient Forum would identify this gap, and present it (along with evidence that it exists and the impact on Islanders) to the System Partnership Board, through their representatives. The Board would discuss the issue and, if they agreed that there may be a need for strategic development, ask members of the Board to develop a business case which clearly sets out the need, the gap, the options for service development, the costs and the benefits / outcomes. The business case would

⁵² Written Submissions – Dr N. Minihane, Primary Care Body

⁵³ Written Submissions – Jersey Hospice Care

⁵⁴ Written Submissions – Dr P. Venn, Primary Care Body

⁵⁵ [Appendix One – Advisor's report – p.17](#)

⁵⁶ [Appendix One – Advisor's report – p.18](#)

be presented at the Board; Board members would use a clear prioritisation process which is clearly based on the strategic outcomes set by the Minister, to agree whether:

- i. The need is urgent and P82 (strategic) funding needs to be re-allocated in order to address the need quickly*
- ii. The need can be met by restructuring existing services, within the same budget*
- iii. The need is not urgent but investment is required in a longer time period, so should be incorporated into the following year's P82 investment plan, or into the next MTFP funding bid*
- iv. The need is not a priority, and other strategic investments would offer a greater impact and value for money*

The Board recommendation would be presented to the Minister for a decision.

Whilst the above example is generated from the Public and Patient Forum, it could also be generated from the Voluntary and Community Forum or the Clinical and Professional Forum – any of these groups can identify an unmet need and/or a request for strategic investment and service development.⁵⁷

KEY FINDING 16: Stakeholders frequently raised the view that there was little clarity as to how the proposed model would be implemented.

KEY FINDING 17: Although the Health and Social Services Department provided a worked example to the Panel, there was insufficient detail to understand how the System Partnership Board would operate.

RECOMMENDATION 7: The System Partnership Board should not begin its operational role until detailed worked examples are provided to the key stakeholders to their satisfaction. These examples should make reference to the communication pathways, training pathways, evaluation criteria and development of a set of guidelines to deal with challenges during implementation and operation.

RECOMMENDATION 8: The roles and responsibilities of each System Partnership Board Member should be clarified.

⁵⁷ [Appendix Two – Questions on P.60/2017 - p.1&2](#)

7.5 Composition and Size of the Board

The Panel questioned the size of the board (21 members) and further examined the reasoning behind the weighting given to representatives from Health and Social Services.

In response to questioning from the Panel, the Health and Social Services Department provided the following answer:

The Board is currently designed to comprise 21 individuals, of which 9 individuals are employed by HSSD. The majority (12) are from partner organisations. Of the HSSD representatives, only the Hospital Managing Director and Community & Social Services Managing Director have HSSD-only responsibilities. The other HSSD representatives have specific whole system responsibilities – for example, the Chief Nurse, the Deputy CEO who is the HSSD Chief Information officer and Director of Resources (who leads the whole system Informatics Strategy) and the Director of System Redesign and Delivery, whose role includes whole system redesign, Primary Care and Voluntary Sector partner support. The Chair will need to ensure that these whole-system perspectives are clearly considered – holding the meetings in public will help to achieve this.⁵⁸

The Panel does not agree with the assertion that the majority of the Board will be made up of partner agencies. There are nine representatives from across the three forums, with the Chair and Non-Executive Directors operating from an independent position.

During a public hearing with the Minister for Health and Social Services, further reasoning was given for the number of members of the Board:

The Deputy of St. Ouen:

Minister, I would like to ask you about the size of the board. It will have 21 members. Is that workable?

The Minister for Health and Social Services:

It needs a skilled chairman, as you are probably implying, it needs a skilled chairman to do that, but I like boards of 9 or 10, if I was to be honest, and then I started looking at who would you not have at the table? There is nobody there. If you are going to be truly inclusive and involve all the partners, there is nobody there that you would not have at the table. That is why I think it is important that we have that independent very skilled chairman to ensure that everybody gets a voice, a board of 21 is not the easiest thing to manage, and it would be very easy for those with the loudest voice, if I can put it that way, to drown those who are less used to working on boards, however may have very important contributions to make. That is why the selection of the chairman, not only in their past experience, but their skill in running a board of that size, is going to be crucial.⁵⁹

The Panel questioned the weighting given to the Health and Social Services representative and received the following answer:

⁵⁸ [Appendix Two – Questions on P.60/2017 - p.2](#)

⁵⁹ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.17

The Deputy of St. Ouen:

Can I ask the Minister? Is it essential to have all the 6 corporate directors there?

The Minister for Health and Social Services:

Yes, because I challenged on this and when you look at who would you not have there, other than you might say we will have less representatives from the community or from the voluntary sector or from the service providers, and then when you drill that down, so who are you going to have directed at primary care, you are going to have G.P.s or you are going to have dentists or you are going to have pharmacists. I think initially everybody has to be at the table. It may change.⁶⁰

The Panel notes that:

- Board Members elected by the forums and group would be representative of their respective sectors and therefore would bring forward comprehensive views from the organisations and people they represent.
- The diagram of the proposed model suggests that other forums would be invited to the Board on specific issues on an ad hoc basis if required.⁶¹
- During the Panel's public hearing with the Minister, the Chief Executive Officer referred to the possibility of sub-groups of the Board undertaking specific work on strategic issues⁶²

In the light of this information, the Panel questions why the Health and Social Services Department takes the view that it is not possible for a limited number of its Directors to represent other areas within the Department on the Board.

The composition and requirements of the Board were brought forward regularly in written submissions from key stakeholders. Key points raised were as follows:

- *The contribution of the independent Chair and independent board members will be important factors in my view in achieving these outcomes.⁶³*
- *Leadership will be critical to its success and it is important to appoint a Chair and Non-Executive Directors who can demonstrate integrity, transparency, accessibility and a lack of bias.⁶⁴*
- *It is important to understand that there should be strong leadership and that, at all times, the independent advocates on the system partnership board should ensure that HSS paid directors take a cross system view. This is particularly important when considering human resource decisions and financial resourcing.⁶⁵*

⁶⁰ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.19

⁶¹ P.60/2017 - <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁶² Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.40

⁶³ Written Submission – Jersey Hospice Care

⁶⁴ Written Submission – Jersey Recovery College

⁶⁵ Written Submission – Dr P. Venn – Primary Care Body

KEY FINDING 18: The System Partnership Board in the proposed model will consist of 21 members.

KEY FINDING 19: The Minister for Health and Social Services has agreed that the size of the System Partnership Board could be problematic.

KEY FINDING 20: The Health and Social Services Department will be represented by nine Corporate Directors including the Chief Executive Officer.

KEY FINDING 21: It is the view of the Minister for Health and Social Services that no Corporate Directors should be left off the System Partnership Board.

KEY FINDING 22: There is a prevailing view from both the Minister for Health and Social Services and key stakeholders that a strong Chair is crucial to the success of this model.

RECOMMENDATION 9: The Minister for Health and Social Services should give consideration to the composition and size of the System Partnership Board with a view to reducing the number of Health and Social Services Department representatives.

7.6 Funding the Model

The proposition (P.60/2017) states that funding for the proposed model, for the duration of the three year pilot, will be met from within the existing Health and Social Services Department budget. It is estimated that this will be £150,000 per year.⁶⁶ This will allow for the appointment of a Chair and Non-Executive Directors and intended to enable the three advisory groups to function effectively.⁶⁷

The initial view of the Panel from the proposition was that an estimate of £150,000 may not be enough to allow for the effective functioning of the Board, specifically the administrative function of the Board. This was questioned further at the public hearing with the Minister:

The Deputy of St. Ouen:

But you need administrative assistants to the board and administrative assistants to the forum.

The Minister for Health and Social Services:

That exists already.

Chief Executive Officer:

Yes. That is part of what we contribute as a department to the successful launch of this board. We have people who will produce papers, make sure they are circulated to everybody and take notes of meetings and do those sorts of pieces of work. If the board generates a request to find some information about a service area then we have people who can go and research and bring that information back. The resources of the department will be made available to support this board.⁶⁸

The Panel found that in written submissions the issue of financial compensation for members of the Board who came from the voluntary and community sector should be considered. Examples included:

- *It is my view that the same considerations should be given to each representative group, so to the extent financial resources are afforded to one group for participating in the board, they should be made available to all others on the same terms. If therefore representatives from HSSD would be paid for attending the board, because it is a requirement of their employment, the representatives from the patient and voluntary sector groups should receive some equivalent benefit.⁶⁹*
- *It is also suggested that the representative on the Public/Patient group are remunerated for their times as those in the other forums will likely be contributing as part of their paid employment.⁷⁰*

The Panel questioned the Minister as to whether this had been considered and were given the following answer:

⁶⁶ P.60/2017 – p.17 - <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁶⁷ P.60/2017 – p.17 - <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁶⁸ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.24

⁶⁹ Written Submission – Jersey Hospice Care

⁷⁰ Written Submission – Jersey Recovery College

Deputy J.A. Hilton:

I was just wondering what plans were in place or whether you had any discussions around whether there would be any resources made available to those people taking part in that. It is all time and presumably some of them...

The Minister for Health and Social Services:

We have talked about whether it would be a salary or not. I think we are coming down to nobody should be disadvantaged by attending and so I think the route that we will probably take is that if someone has lost a day's pay because they have attended the meeting on our behalf then that would be reimbursed. Along those lines but it will not be a salary as such.⁷¹

In terms of the salary and expenses of the Chair and Non-Executive Directors, it is noted that at this stage as part of the three year trial, estimates have been made based on information provided by the Finance Director or Health and Social Services:

Chief Executive Officer:

There will be salary-based for the non-executives. There will be out-of-pocket expenses. With the Director of Finance's guidance, we have taken a view on how much we think that will cost. Part of testing this as a pilot is to say: "Can we do it within that sort of sum?" If the sum has to increase then obviously we are evaluating this pilot because the question that we may have to bring back to the Minister is: "There are all these benefits that you can see from having this board working in this way, and there is a cost. Is there a sense that this is giving the system and the Island value for money?"⁷²

KEY FINDING 23: The Health and Social Services Department will fund the administrative cost of the System Partnership Board and will also provide research facilities to the Board.

RECOMMENDATION 10: System Partnership Board members who would not be remunerated for attendance by virtue of their employment should receive an honorarium to reflect the work and commitment involved as a board member. It is not sufficient to offer the reimbursement of a day's pay if this is lost because some board members might be retired persons or would participate in the board in their own time.

RECOMMENDATION 11: The Minister for Health and Social Services should ensure that the Public and Patient Advisory Group and Voluntary and Community Sector Forum are adequately resourced to allow them to participate on an equal basis with other System Partnership Board Members.

RECOMMENDATION 12: The Minister for Health and Social Services should ensure that the costs of establishing and operating the System Partnership Board are published on an annual basis.

⁷¹ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.24

⁷² Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.25

7.7 Future Development of the Board

The proposition asks States Members to approve the proposed governance model for a three year trial period.⁷³ The Panel asked the Minister for Health and Social Services what was likely to happen at the conclusion of the three-year trial period:

The Deputy of St. Ouen:

What are the possibilities? You have looked at other jurisdictions and how have other jurisdictions moved forward?

The Minister for Health and Social Services:

Some jurisdictions have a board that runs the whole service. That is not the plan at the moment but that could be an outcome very much in the future. You would have to evaluate, or it has to be evaluated, whoever is in post in 3 years' time ... it has to be evaluated against the criteria we set. Was it successful? Was it not? What worked well? What did not work well? What could work better? Do we need to tweak it? Then you would look: "Going forward, how would this look?" I honestly cannot answer that at the moment.⁷⁴

A written submission from Jersey Hospice Care questioned how successful the Board would be if power remained with the Minister and Health and Social Services Department:

If it is to be some sort of hybrid arrangement, in that the power remains with the Minister and HSSD, which also remains the main provider of health and social care services, it may be harder to sustain engagement amongst the membership of the whole board, (in particular representatives from the patient forum and the voluntary sector). This may impact the model of partnership working.⁷⁵

During the public hearing with the Minister for Health and Social Services, the Panel questioned whether or not this could lead to an arms-length organisation (such as Andium Homes) being created that would have overall responsibility for the delivery of health and social care in the island. Although the Minister responded that this would not be a politically suitable option,⁷⁶ and that it was not being suggested, the notion that the Board could evolve to this point was a potential option should the Board be successful:

Deputy J.A. Hilton:

Do you mean that there is the potential to have the board as sort of an arm's-length organisation, like Andium?

The Minister for Health and Social Services:

No.

Chief Executive Officer:

You could. That is an option.

The Minister for Health and Social Services:

Well, you could.

⁷³ P.60/2017 - p.2 - <http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>

⁷⁴ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.31

⁷⁵ Written Submission – Jersey Hospice Care

⁷⁶ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.31

Chief Executive Officer:

It is not what we are suggesting.

The Minister for Health and Social Services:

Politically, I would say no.

Deputy J.A. Hilton:

OK, but there is the potential for it to go that way.

The Minister for Health and Social Services:

I do not believe there is but I suppose anything is possible.

Deputy J.A. Hilton:

You obviously have a different view on this.

Chief Executive Officer:

If I was to reflect the views of all the stakeholders when we did this piece of work, there was a whole spectrum from pretty much where we are now, which is what I think the stakeholders would call a small step, and it is a safe step. I think it is because we have recognised - we have debated this at length across the whole stakeholder group - that I think this board and the work it can do, the benefit it can have, has to be proven. I think that if this board, in the way it works together and the things it can do, proves itself to be valuable, then you will build up trust and confidence. As that builds it may well be that at some point in the future, and it could be 5 years, 10 years, it could be never, there could be a decision taken, a political decision by the Assembly, to say it would make sense for them to do more. That could go all the way down the spectrum to saying: "Let us set up the delivery of health and social services as a completely standalone organisation."⁷⁷

Within the KPMG report that was commissioned in the consultative process, reference is made to the longer term changes that may come about if the proposed model is accepted. These include:

- Single budgets for health and social care based on whole pathway approaches to integrate health and social care.
- New organisational structures and forms for service providers.
- An Operational Executive with collective responsibility for service delivery, performance and achieving outcomes.
- New funding flows, mechanisms and incentives.

There is also mention that a potential longer term outcome of this model would be the sharing of operational responsibility across the system and a change in the role of the Health and Social Services Department.

The Panel is of the opinion that this proposed model, if successful, could create the opportunity for a fundamental change in the way health and social care is delivered in the Island. Whilst

⁷⁷ Public Hearing – Minister for Health and Social Services – 19th October 2017 – p.31&32

this is not the intention of the proposed model, the Panel would like to draw attention to the possibility that a future States Assembly may be presented with this decision.

KEY FINDING 24: There are currently no proposals as to how the System Partnership Board would develop once the three-year trial period has concluded.

RECOMMENDATION 13: The Minister for Health and Social Services should ensure that open and transparent discussions take place as to the future direction of the System Partnership Board. Any changes that may be proposed should be subject to full consultation and be brought to the States Assembly with adequate time for scrutiny and debate.

8. CONCLUSION

The Panel has concluded that this proposed redesign of the governance system for health and social care is to be welcomed, however concerns still exist as to how this proposed model will be implemented.

It has received evidence from key stakeholders which supports the introduction of a new model that will allow further involvement from the community and organisations that are delivering increased elements of service, as a result of P.82/2012. However, there has been concern from stakeholders as to how the proposed model would be implemented, with the Panel taking forward further concerns for consideration by the Minister for Health and Social Services.

The Panel has found that the voice for children has not been given full consideration in this proposed model and in light of the recommendations in the Independent Jersey Care Inquiry, the Panel believes that further consideration should be given by the Minister as to how this will be captured within the Board.

Likewise, the Panel is not convinced that there is enough detail as to how the proposed Public and Patient Advisory Group and Voluntary and Community Sector Forum will operate. It is vitally important that these two groups are given adequate resources in order to function effectively. There is evidence to suggest that the Health and Social Services Department do not wish to influence the formation of these two groups, however the Panel find that this argument is circular and without appropriate direction from the Department, there is a possibility that the proposed group and forum would not be able to function as they are intended. The Panel is also concerned that there is a conflicting view between the Department and the sector as to the existence of an all-encompassing forum that can adequately represent the voluntary and community sector.

A key theme that was drawn out in the Panel Advisor's report was the absence of any worked examples of the proposed model. These examples would provide the prospective Board members with a clear understanding of the processes that would be in place in order to deal with a variety of situations. The Department did provide the Panel with examples in response to the advisor's key questions, however the Panel is not convinced that the level of detail provided is sufficient to demonstrate the complexities that could exist within the Board.

The proposed System Partnership Board would contain 21 members, of which nine representatives would be from the Health and Social Services Department. Although an argument has been put forward to justify the inclusion of the Health and Social Services representatives, it is not agreed by the Panel. The Panel understands that a group of three individuals from the Voluntary and Community Sector Forum would have to represent the differing views and opinions of the entire sector, therefore it questions why the Minister cannot apply the same thinking to how the Department is represented. The size of Board has potential to be unwieldy, and without strong leadership there is possibility that the effectiveness of the Board could be compromised. A strong Chair has been identified by both the Minister and stakeholders as being key to the success of this model, a view which is echoed by the Panel.

The manner in which the model will be funded is due to be evaluated as the three-year trial progresses. The Department will fund aspects of the Board, including the administrative costs, and will also provide a research function to the Board. However, further clarity needs to be given as to how the Voluntary and Community Sector Forum and the Public and Patient Advisory Group will be funded, and the Minister should ensure that appropriate departmental resources are provided to ensure the effectiveness of the forums. It is noted that the representatives from some sectors will be paid in order to undertake work on the Board, however further consideration should be given to the manner in which Board members who may be retired or contributing in their own time are remunerated. The Panel also recommends that the Minister publishes the annual costs of the Board during the three-year trial period in order to help evaluate its effectiveness.

Finally, the Panel understands that this proposed model would evolve during the trial period but there is no indication as to the future direction the model would take if successful. One possible direction could be the formation of an arm's length organisation (similar to Andium) with the responsibility for delivery of health and social care services in the Island. Although this is not the intention of the proposed model, the Panel feels it is necessary to draw States Members attention to the possibility that a future Assembly could be asked to make this decision.

In light of the evidence received and the concerns that have yet to be fully addressed, the Panel has brought an amendment to the proposition, whereby the System Partnership Board cannot be formally introduced until April 2018. The Panel believe that on the weight of the evidence received, the Minister for Health and Social Services must ensure that the concerns raised in this report are dealt with prior to the model becoming operational. The Panel understands that the appointment of the Chair and Non-Executive Director's would not be completed until February/March 2018 and therefore believes that this amendment would not present significant difficulty for the Minister.

The Panel has identified the lack of clarity as to how certain aspects of this model are to be implemented as an overarching theme from its review and therefore puts forward the following recommendation for the Minister for Health and Social Services:

OVERARCHING RECOMMENDATION: The Minister for Health and Social Services should report to the States Assembly at the last sitting of 2017, and the first sitting of March 2018, with an update on the progress made in implementing the System Partnership Board and its associated forums and groups.

Health and Social Security Scrutiny Panel Review: Redesign of Health and Social Services Governance Structure

Dr Amy Hughes

OCTOBER 2017

Submitted 6th October to Health and Social Security Scrutiny Panel, States Assembly, Jersey.

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1.0 Executive Summary

This independent review was conducted at the request of the Jersey States Assembly Health and Social Security Scrutiny Panel. The review reflects the opinions of individuals, organisations and members of the public who contributed towards the consultative process. Information was gathered from background documents, correspondence between the Scrutiny Panel and Minister for Health and Social Services, written submissions from Stakeholders and interviews with a range of relevant individuals and organisations. The time period allocated for the review, and the 20 days over which it was conducted during the summer months, impacted slightly on its scope and range.

Health and Social Care in Jersey State has undergone extensive review since 2011, with an evolving new approach to health and social care emerging¹. Increasing visibility of service provision, strengthening collaboration, and supporting inclusive partnership working are examples of the recommended changes. In addition, enhancing engagement with patients in strategic decision-making was a key recognised need for improvement. With resultant changing relationships and roles across sectors and organisations, Stakeholders were keen to clarify their role in the governance of this emerging new system. Consequently, a new Health and Social Care governance model has evolved to capture the need for integrated care and partnership working, and to support the delivery of a safe, sustainable and affordable services.²

The governance model re-design process was conducted over a six month period, engaging Stakeholders from across sectors in a consultative process. Workshops and interviews were hosted to provide a forum for sector representatives to voice their thoughts, concerns and recommendations regarding the governance model re-design. Global examples of governance models were discussed, and components within each model considered most applicable to the Jersey Health and Social Care System were extrapolated and assessed against a framework for inclusion within the proposed new model. This re-design process was considered inclusive and reflective of user's views and recommendations.

Examining the proposed governance model and assimilating information gathered from desk-based review, consultative interviews and written submissions, the governance model is considered to represent appropriate and much needed changes to cross-partnership working and decision-making identified from P82/2012.¹ The model illustrates a more integrated, collaborative and inclusive approach to decision making and, in particular, identifies the importance of contribution to strategic decisions from all sectors, especially Patient, Public and Third Sector.

The proposed governance model re-design has been very much welcomed and supported by those engaged in the review. The proposed changes are likely to support improvements in services across Health and Social Care and strengthen patient interaction and partnerships. However, for the model to be successful and effective, further details of how the model will be operationalised is welcomed.

During the consultative process, a number of concerns regarding the operationalisation of the model were raised by Stakeholders. These concerns have been organised into themes for the purpose of this review and have helped mould some key questions for use by the Health and Social Security Scrutiny Panel.

The proposed new governance model is well received and recognised as a much needed change to Health and Social Care in Jersey. The governance model – in its operational capacity – should be patient-centric, dynamic and reflective, and provide an approachable and productive platform for governance activities. If its implementation is one that encourages regular review and evaluation, the model will likely be strengthened as it becomes operational. Joint working is essential to its success and to achieve this strong leadership, clear vision, shared goals, adequate resources and infrastructure are required.

2.0 Scope of review

A consultative review of the proposed 'Health and Social Care Governance Model Re-Design' was conducted over a 20 day period between July 2017 – September 2017.

Objectives of review:

1. To examine the proposed governance model and assess the appropriateness of the changes in relation to Third Sector and Voluntary Organisations, Primary Care Organisations, members of the public and States Assembly;
2. To determine if the proposed changes will improve services in Health and Social care;
3. To determine if the proposed changes will improve patient interaction with services providing Health and Social Care
4. To determine if the proposed changes will enhance integrated partnership working in Health and Social Care
5. *To examine the financial and manpower implications of the proposed changes;*
6. To examine and compare the proposed governance model to those in similar jurisdictions to Jersey.

The review was primarily focused on capturing the views of those engaged with the consultative process regarding objectives 1 -4.

3.0 Consultative Process

The consultative process was conducted in a manner to ensure sufficient and relevant information could be gathered from as many sources as possible within the timescale of the review.

Background Information

Background information on Jersey's Health and Social Care system was made available via a secure online portal prior to consultation visits.

Transcripts of relevant correspondence between the Social Security Scrutiny Panel and the Minister for Health and Social Services were also made available via the online portal.

Stakeholder, Community and Patient Contribution

Stakeholders, community members and patients across multiple sectors were invited by written correspondence from the Scrutiny Officer to contribute organisational and individual thoughts towards the 'Governance Redesign Model'. Comments were particularly encouraged on two key questions:

1. Whether the proposed model will improve integrated partnership working with other service providers;
2. Whether the proposed model will give patients a greater say in their health care.

Written submissions and face to face discussions were invited. All correspondence was co-ordinated via the Scrutiny Officer. Contributors were advised that information gathered from submissions and consultations would be incorporated anonymously into a final report for the Health and Social Security Scrutiny Panel addressing the objectives of the review.

Written submissions were collated and reviewed as part of a desk based activity. Consultations with representatives from a variety of Stakeholders were conducted face to face in Jersey in the presence of the Scrutiny Officer. One consultation was conducted via conference call.

4.0 Limitations of Review

- Individuals contributing to the review process may not have represented views of all their colleagues, community or sector.
- The report captures the thoughts and opinions of individuals and organisations who engaged in the review process, in combination with information gathered from background documentation. The term 'Stakeholder' is used throughout the review and used to reflect **only** the opinions of those individuals and organisations who contributed to the review. To provide a more comprehensive review, a longer consultation period would be required with inclusion of all Stakeholders involved in delivery of care.
- The review focused on addressing only the objectives detailed in the Terms of Reference primarily from a Stakeholder perspective.
- The content of this report has been provided by the author for information purposes only. While every care has been taken to ensure that the content is balanced and accurate, the author gives no guarantees, undertakings or warranties in this regard and does not accept any legal liability or responsibility for the content or the accuracy of the information provided. Any errors or omissions brought to the attention of the author will be corrected as soon as possible
- This report is presented by the author in their capacity as an independent consultant, on behalf of Omni Medical Training and Consultancy Ltd.

5.0 Overview and Definitions

Following an extensive review into the Health and Social Care structure in Jersey, the States of Jersey approved P82/2012: 'Health and Social Services: A new way forward'.¹ A number of key recommendations emerged from the review:

- Greater partnership working
- Integrated cross-sector decision making
- Shared communication
- Joint working with a system wide approach to strategic development, planning and delivery of services
- Strengthened patient and public input into strategic decision making
- A change in the culture and behavior across a number of organisations

The resultant changing roles and relationships of Stakeholders in the emerging new system has created concern amongst Stakeholders about their involvement (or lack thereof) in the governance of this new system.² As a result, and in order to support the strategic aims of P82/2012 and deliver on the States Strategic Plan, the Health and Social Service Department conducted a review of the existing governance model in 2016/17 and proposed a re-design. The proposed new governance model aims to address the recommendations put forth by P82/2012 – in particular enhance cross-sector working, communications, inclusivity and shared decision making, and support quality, safe and sustainable services.

A key focus of the proposed new governance model is to provide a platform and opportunity to significantly enhance the voice of the patient and their contribution to the development of services.

5.1 Governance: Definitions

The complexity of governance is difficult to capture in a simple definition. Governance literature proposes a number of different definitions, each suggesting the foundation for governance rests on three dimensions: authority, decision-making and accountability.³

Definitions of Governance	
How societies make and implement decisions'	European Observatory on health Systems and Policies series: Strengthening health System Governance: Better Policies; stronger performance. ⁴
Governance determines who has power, who makes decisions, how other players make their voice heard and how account is rendered	Institute on Governance ³
A framework through which organisations and their staff are accountable for continuously improving the quality of patient care	UK Department for International Development ⁵
'The process for making and implementing decisions'	Good Governance Guide ⁶

In relation to health, focus primarily should be on strengthening a people-centered health system - one which is safe and effective.⁷ Governance helps provide the platform for societies and health systems to manage conflict, make collective decisions and exert authority. Transparency, accountability, participation, integrity and policy capacity provide the building blocks for an effective and safe governance system.⁴

5.2 Governance: Why is it important?

Governance is a systematic way in which decisions are made and implemented, a process which helps mould the capacity of a health system to cope with challenges as well as new policies and problems. The quality of governance affects the ability of the health system to be sustainable, universal and of high quality, and is integral to the effectiveness of any health system.⁴

To effectively implement clinical and care governance for integrated health and social care, in addition to quality leadership, co-operation with partners and cross-sector joint working is essential.⁷ Kickbusch and Gleicher indicate this can be achieved through broad horizontal relationships across sectors, providing the foundation for achieving sustainable and productive relationships.⁸

Service users are an essential and integral part of the health systems quality monitoring and improvement and hold a central role in not only evolving and moulding services but, importantly, in identifying where improvements may be required.⁷ Thus an effective governance system is one which integrates service users experiences, thoughts and concerns into decision-making, planning and service delivery.

5.3 Governance: Comparable models?

Eleven international governance models were critiqued as part of the governance redesign process.² The case studies selected represented jurisdictions similar to that of Jersey and have helped inform the development of the proposed Health and Social Care governance model. The applicability and effectiveness of a governance model is only part due to its proposed structure however. The predominant factors in its success are its leadership and organisational infrastructure and, in particular, the cultural and behavioural attitude in supporting cross-sector working, shared vision, collaborative partnerships and decision-making.^{7,8,9}

Comparisons can be made however to the ‘building blocks’ used to create the foundation of a governance model. Successful models in similar jurisdictions to Jersey have predominantly focused on:

- Strengthening the patient and public voice in strategic decision making;
- Emphasised the need for organisational development as part of governance evolution;
- Provided clarity on definitions of roles and responsibilities, especially important for joint working;
- Focused on cultural and behavioural change across organisations
- Smoothed the transition between strategic decisions and policy making to operational delivery
- Incorporated the use of information technology systems to support evidence based decisions, best practice and help deliver performance measures.
- Streamlined funding
- Focused on ‘Health Pathways’ rather than individual elements of care when decision making

Governance in the form of a Primary Care Governance Team exists within Jersey. Established in 2012, the main role is to provide governance to General Practitioners, supporting their revalidation and complaints procedures.¹⁰ Consideration should be given to shared learning from the experiences of

the Primary Care Governance Team and the implementation of the proposed Health and Social Care governance model.

5.4 Joint Working

Whole health economy or cross-sector working is often promoted to support large-scale transformational change and is integral to the delivery of successful outputs.⁹ In Health and Social Care, joint working also provides a strong foundation for supporting and strengthening the patient care pathway.

Benefits to joint working include:

- Improved information sharing between organisations
- Co-ordinating provision of care
- Improved planning and communication of care
- Strengthened monitoring, review and regulation
- Streamlining of assessments and outputs
- Improving efficiency of whole care system

There are a number of facilitators and barriers however to effective joint working. A review by the Health Foundation suggested facilitators and barriers can be categorised broadly in terms of leadership and vision, culture and attitudes, staff roles and training, infrastructure and processes.⁹ Those deemed most applicable to the success or failure of the proposed governance model have been captured in the table below with consideration given to each throughout the review.

	Facilitators	Barriers
Leadership and Vision	Clear vision and shared goals	Undertake change to solely to reduce costs
	Focus on outcomes	Poor co-ordination
	Strong leadership	Top down approaches
	Good change management	
	Clear decision making process	
	Engagement of stakeholders	
Culture and Attitudes	Positive organisational culture	Lack of buy-in from multiple stakeholders
	Developing good relationships and communication	Jurisdiction battles
	Allowing time to build relationships and trust	Unwillingness to change and adapt
Staff roles and training	Clear roles and responsibilities	Power relations
	Competence and capacity building	Role confusion
	Joint training about issues, partners and benefits	Lack of incentives or alignment with issues of importance
		Lack of focus on staff needs
Infrastructure	Adequate resources	Lack of joint incentives
	Shared processes to guide coordinated strategy, management and service delivery	Lack of resources
	IT infrastructure	Lack of time
	Alignment of financial and other incentives	Issues of sharing information
Processes	Joint processes	Ethical and confidentiality concerns
	Single point of entry into system and clear communication pathways	Audit and monitoring demands
		Short term targets
Table adapted from:	<i>'Cross-Sector Working to Support large-scale change'; The Health Foundation; 2012. ⁹</i>	

5.5 The Proposed new Governance Model: Why was a Redesign needed?

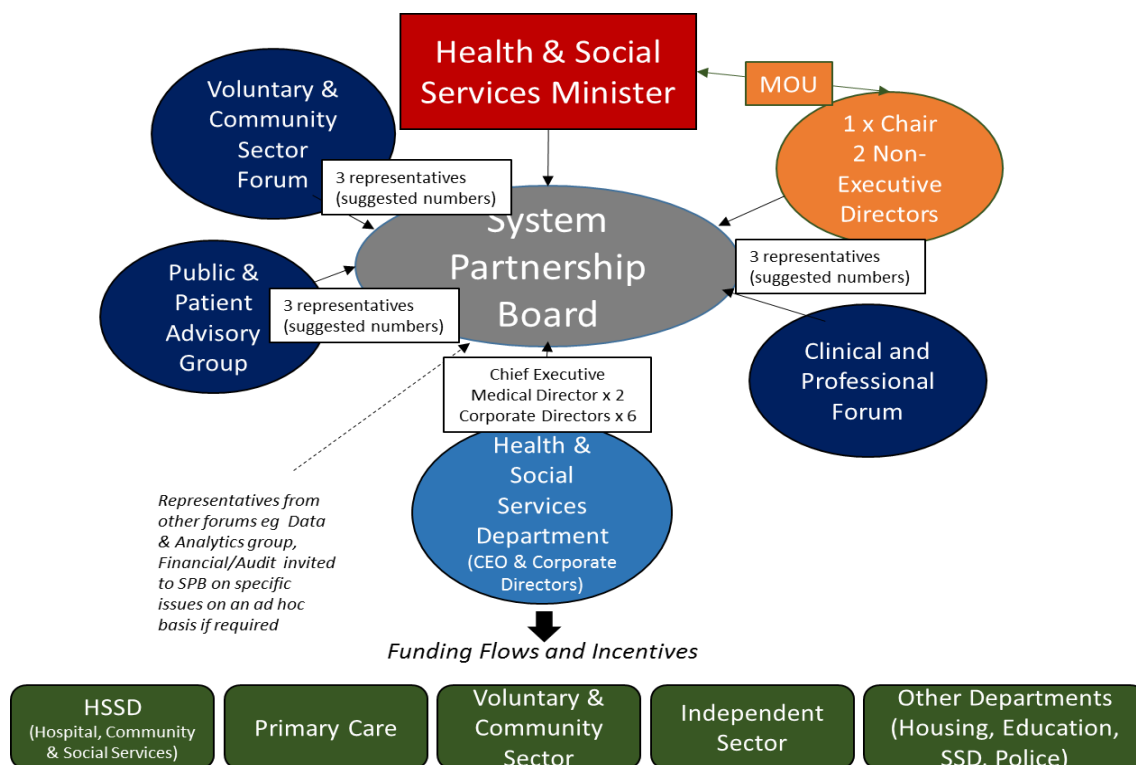


Image extracted from 'Health and Social Care System: A New Governance Model, 2017 (P60-/2017)' ²

During the initial phase of the review, a desk-based exercise examining the existing literature was conducted. Information sourced from these documents, in addition to that gathered during the consultations and written submissions, have helped capture 'service user' thoughts on why the re-design was needed. Detailed below are some key statements and comments made by individuals involved in the review regarding the proposed new model:

- 'Will help provide better, safe and seamless care...less disjointed'
- 'The new model will improve decision making and help minimize the hierarchy which currently exists regarding decision making'
- 'There is currently no foundation for joint decision making – new model helps address this'
- 'More public involvement in processes and decisions around service provision'
- 'Shared responsibility of decision-making'
- 'Improved synergy'
- 'Strengthened robustness of decision making, and transparency'
- 'New structure helps 'minimise' the 'loud' voices currently influencing decisions'

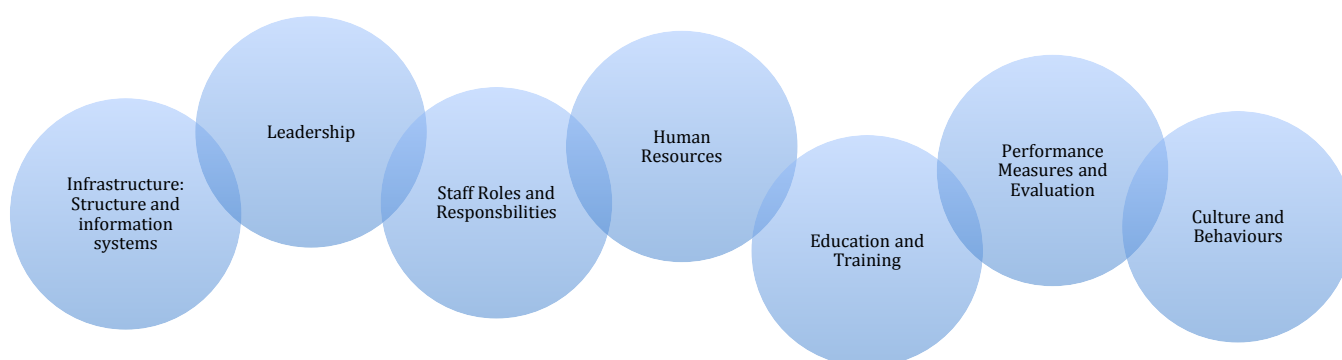
- *'Improved visibility of process and decision making to patients and users'*
- *'Clearer pathways of patient care may evolve'*
- *'New structure helps build confidence'*
- *'The systems partnership board helps provide a platform for decision making based on user needs'*
- *'Better scrutiny of decisions'*
- *'Helps rebuild relationships and public trust'*
- *'Advantages in richness of evolving a system which has input from those with lived experiences, as well as professionals'*
- *'There is commonly a 'Silo' mentality across many organisations and this approach needs to be addressed in order to successfully implement P82/2012 recommendations'*

The 'Sustainable Primary Care Strategy for Jersey' (2015-2020) outlined the direction of travel for developing primary care in Jersey as part of the transformation of the whole health and social care system.¹⁰ Partnership collaboration, improved integration of services and joint working was seen to be pivotal in achieving improved health outcomes. In synergy with comments raised by individuals during the consultative review, the Primary Care Strategy review recognised the need to break down systemic barriers to integrated care in order to achieve improvements in health and social care. In addressing the question on the impact of the proposed new governance model on the Primary Care Strategy, consultations and documentary evidence suggest there is synchronicity in what both the Primary Care Strategy and the proposed new governance model are hoping to achieve in regard to creating a more integrated, transparent and patient-centered health and social care system

6.0 Emergence of Themes

The proposed health and social care governance model is generally very well received and considered a very positive step towards change. A need for stronger collaborative working, more inclusivity of sectors, better joint decision-making and strengthened partner integration were clearly recognised as key areas for improvement by those contributing to the review. The proposed model is perceived to reflect these needs, and provides a platform for cohesiveness and collaboration.

However, a number of questions and concerns arose from Stakeholders during the review. Common themes were identified from these concerns and are presented in the schematic below. The themes have been used to inform the content and structure of this review. A question which arose frequently was how the proposed model would be operationalised and delivered in practice.



Common themes to address: extrapolated during consultative process

6.1.1 Structure: Evolution of model

The proposed model illustrates cross-sector collaborative working achieved through Forum and Advisory Groups and a System Partnership Board. Feedback from consultations suggest the evolution of the model was well implemented, inclusive and considered, and the end result reflected service user's views and concerns.

A list of those involved in the workshops is provided in the annex of the P60/2017 report.² Workshop numbers, as a proportion of Jersey's population and 'service users', were very small. However, a range of Stakeholders from across different sectors were engaged in the groups and attendance across all working groups over the period was reported to be good. Contribution included those from Third Sector, Volunteer and Community Groups, Primary Care and Health and Social Care. Assessment criteria for evaluating international governance model examples and extrapolating strengths and weaknesses from each seemed relevant and applicable. The process of capturing opinions and concerns from Stakeholders engaged within the workshops was detailed and implied robustness and inclusivity.

Key Question

Patient contribution to strategic decision-making has been identified as a key component of the proposed governance model. How were patient views captured during the consultative process for Governance Redesign?

6.1.2 Structure: Operationalising the 'model'

A frequently raised concern addressed the lack of clarity provided on how the proposed governance model will be operationalised. In particular, some Stakeholders felt there was a gap in the provision of worked examples for the governance model. Worked examples would be welcomed particularly in detailing processes of System Partnership Board decision-making; translating strategic decisions into operational delivery; and managing board disagreements and 'hung' votes. Worked examples can assist in identifying strengths and weaknesses in the planned delivery and implementation of a 'conceptual' model and prompt changes from resultant reflective learning. Examples can be paper-based and theoretical, delivered via table-top exercises or via large group work and role play. Although such worked examples may be executed at a later stage of development and piloting of the governance model, early recognition of potential challenges and limitations to operationalisation are advantageous. Guidelines or 'Standard Operating Procedures' (SoPs) based on these worked examples can further help with governance system implementation.

Key Question

Can the Minister provide some worked examples demonstrating processes and operations of the proposed model?

6.1.3 Structure: HSSD representation

The proposed model illustrates 3 Forum/Advisory Groups contributing 3 representatives each towards the System Partnership Board. In conjunction, the Health and Social Services Department (HSSD) contribute 9 representatives towards the board. The HSSD representatives include the Chief Executive, 2 Medical Directors and 6 Corporate Directors.



The 'weighting' of HSSD representatives to other Stakeholder representatives raised concerns. Specifically, how the presence of 9 representatives from HSSD on the board may impact on supporting the board as a neutral, non-hierarchical and approachable platform for discussion and decision-making.

Key Question

Can rationale be provided for the 'weighting' (number) of HSSD representatives on the board, and how a neutral, non-hierarchical and approachable board be supported by this presence?

Reference is made frequently throughout the 'P.60/2017' about the need for a culture and behavioural change. How does the structure and composition of the board help achieve this?

6.1.4 Structure: Sector (Volunteer, Community; Public/Patient and Clinical/Professional) representation

Board members from the Third Sector, Public and Patient Group and Clinical and Professional Forum are very much welcomed and seen as an extremely positive development. Observations during the

consultative process indicated that the presence of Public/Patient contribution to the board was particularly supported and important.

The model proposes three Forum/ Advisory Groups:

1. Voluntary and Community Sector Forum
2. Public and Patient Advisory Group
3. Clinical and Professional Forum

Each 'body' is shown on the model to contribute 3 representatives to the System Partnership Board. There is some confusion from Stakeholders regarding the mechanisms in place to 'select' representatives for both the Forum and Advisory groups, and those chosen to represent the board. Questions were raised in regard to the reported presence of an existing Voluntary/Community Forum. Additional concerns were raised about how individuals would be 'representative' of their sector and how diversity amongst those representing each sector is ensured.

Key Question

Comment is made (pg 16 P60/2017 Report²) that the Voluntary and Community Sector forum would be strengthened rather than created. Can the Minister provide clarity on the presence of an existing Volunteer and Community Forum, and provide additional details if required of how creation of a forum would be supported financially and administratively.

Key Question

Please advise how board members from these advisory groups/forum will be representative (and support diversity) of the wider sector from which they are drawn. Comment on the process of 'transparent' selection of individuals to the board and duration of representation. In particular please advise of the processes in place to ensure the appropriate clinical speciality is represented on the SPB when required (for example Social worker versus occupational therapist).

What mechanisms are in place to support and manage an individual who no longer chooses to be a board member (particular reference please to those from the Public/Patient Forum)

6.1.5 Structure: System Partnership Board

The System Partnership Board is shown to be composed of a 21 individuals, inclusive of the Chair and two Non-Chief Executives. The dynamic and behaviours across the board are integral to its productivity and effectiveness.

Key Question

What considerations have been given to the functioning and output delivery of the board in terms of its size and composition?

In order to improve alignment of provider performance, the p60/2017 document² has made reference to a 'Compact' Agreement being developed to help govern behaviours between service partners and a 'Charter' developed to formalize shared values and provide clarity to Islanders.

Key Question

Is the Minister able to provide further detail on the planned 'Compact' and 'Charter' and the timeline for development. An example of a Charter and Compact is noted to be provided in the P60/2017 document² – is this representative?

6.1.6 Structure: Funding

Details regarding provision of funding have been supplied on request by HSSD and made available to the Health and Social Security Scrutiny Panel. Questions raised by Stakeholders regarding funding focused on what financial resources would be provided to support Forum and Advisory Group representatives and those on the board. Specifically, what financial provision and incentives are offered to the organisations from which individuals are drawn from to attend Forum and Advisory Groups and board commitments. Please refer to section 6.8.

6.2 Leadership: Chair and Non –Executive Directors

An independent Chair and 2 Non-Executive Directors form an essential and critical part of a governance model. The Chair is responsible for leadership of the board and should promote integrity, forward thinking, cohesiveness and inclusiveness in decision-making. The Chair and Non-Executive Directors should encourage the highest standards of governance and, through their leadership and diplomacy, enable board members to feel comfortable and able to voice thoughts, concerns and questions openly and transparently. Failure of a Chair to deliver on their role can lead to ineffectiveness and 'failure' of the board and the resultant governance system.

Key Question

Can further details be provided about the personal attributes, experience and professional expertise required for the role of the Chair **(A Job Description can be provided to the Scrutiny Panel to address this question)**. What mechanisms will be implemented to ensure independence of the appointed Chair?

Key Question

Quality leadership of the System Partnership Board is integral to its effectiveness and cohesiveness. Can the Minister outline the processes in place to support strong and appropriate leadership by the Chair, and any mechanisms in place to encourage regular review and reflection of the Chair's role?

Key Question

Can further details be provided about the appointment of the Non-Executive Directors?

Key Question

Can confirmation be provided that the Minister for Health and Social Services remains accountable for board decisions in the initial pilot phase? How will the Minister formally hold the 'system' to account?

How does 'accountability' and 'ownership' of decision-making – particularly in reference to System Partnership Board member responsibilities – evolve after the pilot phase of implementation?

The governance model illustrates a Memorandum of Understanding (MoU) between the Chair and the Minister.

Key Question

Can details of the proposed MoU between the Chair and the Minister be shared with the Panel and Stakeholders?

6.3 Staff Roles and Responsibilities

A number of questions were raised during the review process about the roles and responsibilities of individuals within the forum / advisory group and in their potential role as members of the board. Although descriptors for roles and responsibilities are likely to mature as the initial phase of implementation occurs, a framework or Terms of Reference outlining expected key deliverables and responsibilities for the advisory group / forum and each board member is an important precursor to model roll-out. Terms of Reference help provide individuals with information to make a fully informed

choice about engagement as a representative and board member, and provide an essential component to the volunteer/selection process to the Forum and Advisory groups.

Key Question

Can the roles and responsibilities of the forum and advisory groups be provided please?

A Terms of Reference (ToR) can be provided to the Scrutiny Panel to communicate some of this information.

Key Question

Can the roles and responsibilities of the Board Members, Chair and Non-Executive Directors be provided please?

A Terms of Reference (ToR) can be provided to the Scrutiny Panel to communicate some of this information.

Accountability of the System Partnership Board is referenced a number of times throughout documentation. Reference is also made to the accountability of the Minister for Health and Social Services for the board's decisions. It is unclear what processes are in place or planned to 'hold' individuals or the board to account.

Further clarity on the accountability of the following would be welcomed:

- Advisory group / Forum members;
- Board members;
- Chair;
- Non-Executive Directors and
- Minister for Health and Social Care

Key Question

The accountability of the board is referenced throughout the P60/2017 document². Can clarity be provided on SPB, Chair and Minister accountability for board strategic decisions and operational delivery?

A Terms of Reference (ToR) can be provided to the Scrutiny Panel to communicate some of this information.

6.4 Human Resources and Administration

P60/2017 reports that the System Partnership Board will meet regularly². Incentives for attendance include re-numeration for board members. During the consultative review, particular concerns were raised regarding the financial support available to organisations and individuals for their engagement in both the forum/advisory groups and board activities. Specific questions were raised regarding the provision of financial support both for direct contribution to board meetings and advisory/forum groups, and indirect engagement (for example preparation for board meetings; attendance at training and board development courses). Further clarity on the provisions for financial support for organisations from which representatives are drawn is also welcomed.

It was noted that for representatives from HSSD attendance at board meetings and relevant trainings would be part of a job role, as would financial support for the participation. Information was viewed to be less clear regarding the support as part of a job plan for representatives from Volunteer/Community Sector, Public/Patient Group and Clinical/Professional Forum.

Key Questions

Can further details be provided about the re-numeration package, and administrative support, available to individuals engaged in the advisory groups /forum (particularly Voluntary/Community Sector and Public/Patient Sector) and those representing the SPB? Can the following points be addressed:

- **What administrative support will be provided to the advisory group/forum representatives, especially those from the Public/Patient group to support them in attending and representing the advisory group and board?**
- **What financial support will be provided to organisations from which individuals may be drawn to attend forum/group meetings and board meetings? (E.g. in terms of absence of staff member to attend board meeting/training; financial support as required for 'bank/locum' staff; related transport costs).**
- **Can some guidance be provided please regarding the likely time commitments required by forum/advisory group individuals for attendance at board meetings / training over a 12 month period and how much notice regarding required attendances is likely to be provided?**

6.5 Education and Training

Comment is made in P60/2017 about the need for organisational development². Specifically, that the implementation of the model should be supported by training and leadership development. However, there is little further reference to how this training would be implemented, the time-frame for delivery, ongoing training and leadership development needs, and the key themes relevant for training. Training and education is particularly pertinent for joint working, individual personal and professional development and board development. In regions where health and social care are jointly commissioned, facilitators of cross sector working include training as an essential component to effective delivery of governance. Training is focused on building relationships; multi-agency working; communication strategies and exploring the capacity for individuals and organisations to work together.⁹ Joint learning experiences can help individuals and organisations to look at patient care from an overarching perspective rather than from their own professional or organizational perspective.

The essential need for training, particularly for board members, was raised frequently by those engaged with the review process.

Three 'domains' of training were considered important:

- a) Joint-working training
- b) Training for forum/advisory group representatives;
- c) Board development and leadership training.

The scope of this review does not extend to evaluation training needs and recommendations. However, the following training and education themes for knowledge acquisition and skill development have been used for strengthening many governance systems:

1. Joint-Working (cross-sector)

- a. Relationship Building
- b. Human factors and Team Dynamics
- c. Organisational infrastructure and decision making strategies
- d. Roles and responsibilities

2. Forum/Advisory group representatives:

- a.** Roles and responsibilities as part of board membership;

- b.* Strategic and operational decision making;
- c.* Accountability and Liabilities
- d.* Declaring and managing Conflict of Interests, disclosure and transparency
- e.* Critical Incident Reporting

3. System Partnership Board development and training

- a.* The effective board: Structure, function and operations of a governance board
- b.* Leadership
- c.* Joint decision making and accountability
- d.* Board practices and procedures: impact and implementation
- e.* Board dynamics, diplomacy and human factors
- f.* The governance of risk
- g.* Reporting

Key Question

How will training and board development opportunities be integrated into the implementation phase of the proposed governance system? Please provide details on:

- a) Type of training to be offered,**
- b) Duration over training,**
- c) Financial support for training attendance and delivery, and**
- d) Outputs expected.**

6.6 Performance Measures and Evaluation

External and independent quality assurance provides an important oversight, especially to an evolving governance model. External quality assurance should not be burdensome but create a culture of aspiring to achieve best performance and engage in reflective critique.

Key Question

What independent quality assurance processes have been considered for the proposed governance model?

Performance measurement, and the use of Key Performance Indicators (KPIs) is integral to any governance model.^{4,8} Such measures assist in providing feedback to inform and improve public service

delivery and in promoting accountability by demonstrating to stakeholders the results that are being achieved.¹¹

Performance indicators for governance systems can include:

- Attendance target at forum/advisory group and board meetings
- Board composition achieved
- Annual training needs achieved
- Production and delivery of reports
- Annual review of Mission, Strategic objectives and plan
- Performance of Chairperson / Board

Performance indicators can also be used as a tool for an 'Early Warning Score' to indicate a 'stalling' governance system and board. For example, if a Performance Indicator such as 'board attendance target' is routinely noted to fall below target requirements, an alert can be triggered with corresponding action plan to investigate the root cause of poor attendance. Continued poor attendance will impact on the effectiveness, cohesiveness and dynamic of the board and its decision-making capability.

Provision of data to help inform decision making and to reflect effectiveness and impact of deliverables is integral to providing measures and evaluation of a system. A move towards an integrated patient record system to support confidential sharing of data across relevant sectors and measure impact of change would be advantageous.

Key Question

What performance measures and evaluation will be used to help determine the effectiveness and outputs of the System Partnership Board? Has an 'early warning toolkit' been considered?

A governance system should provide a clearly defined, accessible, transparent and single point of entry channel for feedback and concerns to be raised without fear of reprisal. The proposed model does not clearly illustrate the feedback cycle or communication channels for this. The platform provided for feedback should be approachable, confidential and should aim to deliver a well-considered response. A culture of supporting individuals who raise concerns in relation to practice that endangers safety to service users and other wrong doing should be encouraged.

Key Question

Can further details be provided on the expected mechanisms to be created within the Governance Model for feedback and reporting concerns? What systems of support will be available for those reporting concerns?

6.7 Culture and Behaviour

Shared common goals and the presence of strong leadership are essential for cross-sector working.⁴ However evidence identified by The Health Foundation demonstrated that organisational culture, staff engagement and behaviours are crucial components.⁴ ‘Organisational Culture’ in this context can be defined as ‘*the way we do things*’ and is routinely a barrier to change. A change to organisational culture requires a change in thinking, adaptations to roles, and a strong organisational infrastructure. Multiple factors can impact on the likelihood of achieving behavioural and culture change including politics, power relations, individual status and resources within organisations. Culture change is something that happens over time but impacts significantly on the effectiveness and success of an infrastructure.

Throughout the review, concerns around culture and behavior was a theme most frequently raised. Many of those consulted expressed reservations about whether ‘culture and behaviour’ within health and social care in Jersey could change enough to facilitate successful implementation of a new governance model – and in particular support the creation of an operationally effective System Partnership Board.

Key Question

Comment has been made of the need for a cultural and behavioural change, along with relevant structural changes, in P60/2017² (*Change in culture, Pg 13*). How will culture and behaviour be encouraged to change to support successful implementation the proposed governance model?

7.0 Summary and Recommendations

The proposed new governance model is well received and recognised as a much needed change to health and social care in Jersey. The governance model – in its operational capacity – should be patient-centric, dynamic and reflective, and provide an approachable and productive platform for governance activities. If its implementation is one that encourages regular review and evaluation, the model will likely be strengthened as it becomes operational. Joint working is essential to its success and to achieve this strong leadership, clear vision, shared goals, and adequate resources and infrastructure are required. Joint working examples internationally, in particular those implemented to support large scale change, have been most successful when they have been patient focused; collaborative; when emphasis is on learning and knowledge, when data and information is fed back to providers; and when strong administration and management systems are developed. However, the greatest influence to success is likely to be the extent to which culture and behavioural change can be encouraged and supported in Jersey's Health and Social Care System.

7.1 Key Recommendations:

- a) Ensure the System Partnership Board is patient-centred and outcome focused.
- b) Provide worked examples to demonstrate in detail how the governance system will be operationalised: from decision-making through to operational delivery.
- c) Provide clarity of the roles and responsibilities for those engaged in the governance model:
 - a. Forum and Advisory group representatives,
 - b. Board members
 - c. Chair
 - d. Non-Executive Directors
- d) Provide clarity of the accountability and legislative responsibility each representative and board member has;
- e) Illustrate the communication pathways and feedback mechanisms available within the governance model.
- f) Provide further detail on the expected training pathways board members expected to engage with.

- g) Provide a more detailed overview of the performance measures and evaluation criteria planned for the Systems Partnership Board.
- h) Develop a set of guidelines to support 'actions on' challenges which may present during implementation and roll-out of the proposed governance model

8.0 References

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8.0 Appendix

8.1 Contributors to review

Ms J. Garbutt; Chief Executive Officer, Health and Social Services Department

Ms R. Williams, Director of System Redesign and Delivery, Health and Social Services Department

Dr N. Minihane, Primary Care Body

Ms S. Devlin, Managing Director, Community and Social Services

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Mr P. Romeril; Pharmacy Contractors Group

Mr A. Heaven, Former Mental Health Lead, currently Director, Children's Policy

Mr J. Hopley, Voluntary and Community Sector Ltd

Ms L. Arthur, Royal Pharmaceutical Society

Mr B. Place, Future Hospital Director

Ms A. Trudgeon, Office of the Comptroller and Auditor General

Mr M. Ferey, Chief Executive, Citizens Advice Jersey Ltd

Ms J. Moon, NSPCC

Dr P. Venn, Primary Care Body

Ms A. Eidukas, Relate Jersey

Ms E. Robbins, Chief Executive Officer, Jersey Hospice Care

Ms. B. Moore, Recovery College Manager, Jersey Recovery College.

Ms. R. Brunton, Chief Executive Officer, Brighter Futures

I would like to thank all those that contributed to the review.

8.2 Accountable Care Systems

Accountable Care Systems (ACS) can be seen as an evolved version of a sustainable and transformation partnership (the process through which local areas are expected to save money by transforming their health and care system).¹²

Accountable Care Systems (also known as Accountable Care Organisations) comprise of three core elements:

1. A provider or alliance of providers that collaborate to meet the needs of a defined population
2. Providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population. Examples of providers can be GPs, and examples of commissioners can be local authorities
3. Work under contract that specifies the outcomes and other objectives they are required to achieve within the given budget.

Local context is appropriate in shaping the approach taken to ACO development. For example, in some areas integration of hospital, community, mental health and adult social care services will make sense whereas in other jurisdictions more broadly based partnerships may be better.^{12,13}

As well as improving care for patients, a common aim is to reduce unnecessary hospital use and associated costs by anticipating the needs of patients before they experience a crises. A good example of an ACO is Canterbury Health Board in New Zealand. The Health Board has invested in services in the community to avoid the rapid growth in hospital use. GPs and consultants also come together to agree health pathways for the diagnoses and treatment of patients.¹²

Challenges around ACO's include budgetary, provision of incentives to enable to providers to deliver the expected outcomes and the need to develop trust between organisations and leaders.¹²

Recently in the UK, 8 accountable care systems have been announced. The aim is to bring together local NHS organisations in partnership with social care services and the voluntary sector.¹³

The rationale for moving to an ACS/ACO in Jersey would be to continue on the path of integrated health care and further enhance and refine this. The recommendations from P82/2012 have already triggered in Jersey a significant change in approach to healthcare. The current trajectory for Health and Social Care is one of improved integration of services, cross-sector working, shared vision and

collaborative decision-making. Progressing to an ACO would be progressing along similar lines likely but more streamlined. In contrast to the NHS, Jersey already has a health and social care system which is integrated to some degree. ACO/ACS's are a more 'radical' change to services within the NHS as these tend to be less integrated and decisions regarding strategy, policy and delivery is spread across a number of organisations. One area that the Minister in his response is suggesting will be strengthened is the engagement and inclusiveness of the public / patient sector which supports a patient-centred approach to health care and governance. The NHS already has a fairly extensive and robust system of patient and public feedback into health systems and delivery and implements changes as a result. This is an evolving faction of the Jersey Health and Social Care system currently – and one the proposed new governance model emphasises strongly.

10. APPENDIX TWO - Response from Health and Social Services to Key Questions

Health and Social Security Scrutiny Panel

Questions on P.60/2017

- 1. Patient contribution to strategic decision-making has been identified as a key component of the proposed governance model. How were patient views captured during the consultative process for Governance Redesign?**

The proposals for the new strategic governance model were co-produced during 2016. This involved interviews with a wide range of stakeholders and 4 workshops. Representatives from the voluntary and community sector were involved throughout – these organisations represent certain groups of Islanders. In addition, the Chair of the Disability Forum and Chief Executive of Citizen's Advice participated fully in the workshops, specifically to provide a clear patient and public perspective.

Following the States Debate, public awareness sessions will be held, led by the Chief Executive of Citizen's Advice; these are being planned now, and will explain the proposed new model and the opportunities for involvement (subject to the States Debate agreeing to the proposed strategic governance model).

It is worth noting that the exact detail of how the public and patient element of the proposed model will operate will be developed by the Public and Patient Forum following the States Debate; this has deliberately not been devised in detail in order to provide the public with ample opportunity to shape and develop how they wish to be involved and engaged.

At the public awareness sessions, Islanders will be given the opportunity to express an interest in being part of the development group and / or part of the Public and Patient Forum. The Public and Patient Forum will then select the three representatives who will be full members of the System Partnership Board (subject to the States Debate agreeing to the proposed strategic governance model).

- 2. Can the Minister provide some worked examples demonstrating processes and operations of the proposed model?**

These will be devised in detail following the outcome of the States Debate. Should the States approve the new strategic governance model, a couple of worked examples might be:

Example 1: Strategic Investment decisions. Members of the Public and Patient Forum identify that there is a gap in services for individuals with mild to moderate mental health needs, who are unaware of where to go for help and/or that easily accessible, low level help is not available outside of working hours.

The Public and Patient Forum would identify this gap, and present it (along with evidence that it exists and the impact on Islanders) to the System Partnership Board, through their representatives. The Board would discuss the issue and, if they agreed that there may be a need for strategic development, ask members of the Board to develop a business case which clearly sets out the need, the gap, the options for service development, the costs and the benefits / outcomes. The business case would be presented at the Board; Board members would use a clear prioritisation process which is clearly based on the strategic outcomes set by the Minister, to agree whether:

- i) The need is urgent and P82 (strategic) funding needs to be re-allocated in order to address the need quickly
- ii) The need can be met by restructuring existing services, within the same budget
- iii) The need is not urgent but investment is required in a longer time period, so should be incorporated into the following year's P82 investment plan, or into the next MTFP funding bid
- iv) The need is not a priority, and other strategic investments would offer a greater impact and value for money

The Board recommendation would be presented to the Minister for a decision.

Whilst the above example is generated from the Public and Patient Forum, it could also be generated from the Voluntary and Community Forum or the Clinical and Professional Forum – any of these groups can identify an unmet need and/or a request for strategic investment and service development.

Example 2: Progress on P82 investment. The Director of System Redesign and delivery will present a report detailing the progress against agreed action plans for each strategic investment. This will be accompanied by a risk and issue log.

The Director of Informatics will present a report detailing the outcomes achieved for each strategic investment.

The Board will discuss these and agree any mitigating actions and communications. The reports, along with Board recommendation, will be presented to the Minister for approval.

3. Can rationale be provided for the 'weighting' (number) of HSSD representatives on the board, and how a neutral, non-hierarchical and approachable board be supported by this presence?

The Board is currently designed to comprise 21 individuals, of which 9 individuals are employed by HSSD. The majority (12) are from partner organisations. Of the HSSD representatives, only the Hospital Managing Director and Community & Social Services Managing Director have HSSD-only responsibilities. The other HSSD representatives have specific whole system responsibilities – for example, the Chief Nurse, the Deputy CEO who is the HSSD Chief Information officer and Director of Resources (who leads the whole system Informatics Strategy) and the Director of System Redesign and Delivery, whose role includes whole system redesign, Primary Care and Voluntary Sector partner support. The Chair will need to ensure that these whole-system perspectives are clearly considered – holding the meetings in public will help to achieve this.

The role of the Chair and Non-Executive Directors is critical; this is why the whole system of partners strongly believe that a Board is needed, and why the Proposition has been lodged for States debate.

The Chair will ensure all voices are heard and all partners have equal opportunity to contribute. The Chair will set the tone and culture of the Board, and must hold to account any individual who does not comply with the agreed values (which will be co-produced and set out in a Compact).

It should also be noted that Board members may experience conflicts of interest, for example where a strategic investment is proposed which may benefit their organisation or the individual Board member financially. This will be clearly identified and addressed through the Conflicts of Interest Policy.

4. Reference is made frequently throughout the 'P.60/2017' about the need for a culture and behavioural change. How does the structure and composition of the board help achieve this?

The cultural and behavioural principles will be co-produced by the Board, led by the Chair, once the key personnel have been selected. This will happen as soon as possible after the States Debate.

The stakeholders involved in producing the proposed strategic governance model are extremely committed, and wholeheartedly agree with the need to ensure the values, cultures and behaviours are co-produced, clearly expressed and applied consistently. Any Board member who deviates from the agreed values and behaviours must be held to account by the Chair – as previously noted, this is one of the key reasons why the stakeholders strongly agreed that a Chair and non-executives are required; the 'right kind of Chair' will need to be carefully selected and this will be achieved with the Appointments Commission. It is expected that values and behaviours will be aligned with those already in place for the States of Jersey

Holding the meetings in public will also help to hold individual Board members to account for their behaviour.

5. Comment is made (pg 16 P60/2017 Report²) that the Voluntary and Community Sector forum would be strengthened rather than created. Can the Minister provide clarity on the presence of an existing Volunteer and Community Forum, and provide additional details if required of how creation of a forum would be supported financially and administratively.

There are a number of fora where Voluntary and Community Sector organisations work closely together – both as individuals supporting one another and as a larger group of organisations with a common goal. The Disability Partnership is a good example of this. In addition, voluntary sector organisations from health and social care have met to identify the areas where they could work better together, for example by sharing training and other assets.

Since the workshops, key individuals from the Voluntary and Community Sector have met to start forming the beginning of the Voluntary Sector Forum. They are keen to raise awareness about the proposed strategic governance model and to offer the opportunity for more organisations to contribute. However, this cannot be progressed until after the States Debate.

In terms of resource support, the emerging Voluntary and Community Sector Forum is currently being supported by an HSSD Manager, at the request of the voluntary sector organisations. Subject to States approval in the Debate, administrative support will be provided by HSSD to ensure the Forum is able to function effectively, for example, ensuring clear communications and that meetings are well planned, organised and executed. It is hoped that room hire for such meetings will be made available by the voluntary sector organisations, but if this is not possible, rooms will be available within HSSD for this purpose.

HSSD will fund the new governance model for the three years of its pilot; this includes the project management and secretarial support for the three Advisory Groups. Work is also underway to consider issues in relation to the potential funding of participants time, looking at how this is approached in other jurisdictions and how such funded participation can evidence value for money.

- 6. Please advise how board members from these advisory groups/forum will be representative (and support diversity) of the wider sector from which they are drawn. Comment on the process of 'transparent' selection of individuals to the board and duration of representation. In particular please advise of the processes in place to ensure the appropriate clinical speciality is represented on the SPB when required (for example Social worker versus occupational therapist).**

As noted on page 26 of the KPMG report, "The System Partnership Board representatives will be selected by the respective group, based on nomination and an assessment of the individual's capacity, capability and approach (e.g. their ability to be broadly representative, work positively and professionally in partnership, consider alternatives and work collaboratively towards shared solutions, and operate at a strategic level).

The Terms of Reference, constitution, operation and objectives of the Clinical and Professional and Voluntary and Community Sector groups will be a matter for those groups, but will include:

- being accountable to their constituents, communicating the outcomes of the System Partnership Board
- representing the breadth of views from their constituents
- identifying key issues from the perspective of their constituents
- building cross-system relationships
- resolving issues within their control or influence"

Furthermore, it is expected that each of the overarching Advisory Groups will have appropriate links to other professional, public and voluntary sector groups and part of the representative role is to actively involve and inform these other groups and act as a conduit for issues to be brought to the attention of the Board.

- 7. What mechanisms are in place to support and manage an individual who no longer chooses to be a board member (particular reference please to those from the Public/Patient Forum)**

System Partnership Board members can resign their position at any time. It is hoped that sufficient notice will be provided, to enable a replacement to be selected by the relevant Advisory Group. In the case of the Public and Patient group, the individual would discuss their intention to step down with the Public and Patient Advisory Group Chair, who would then support that individual through their decision and their exit. If the Chair decides to resign their position, they would discuss this with the Chair of the System Partnership Board, and with the Public and Patient Advisory Forum. A replacement would be selected by the Forum using the same approach as the initial selection decision.

- 8. What considerations have been given to the functioning and output delivery of the board in terms of its size and composition?**

The Board is necessarily large in order to ensure broad representation.

The Chair will need to be experienced in leading Boards, including listening to a range of views whilst ensuring the meeting achieves its intended outcomes and runs to time.

The Non-Executive Directors will oversee the assurance function; this will include robust processes, which will be developed once the Board has been constituted; this is subject to the States Debate.

It will also be important for HSSD, in its support role, to ensure that papers are circulated with enough time to be read and, if necessary, discussed with constituent organisations. In practice, as the function of the Board is to drive the continuing delivery of the service transformation envisioned in P82.2012, there is a well development infrastructure of multi-disciplinary, multi-organisational groups already in place which will be developing proposals for consideration by the Board and these can similarly be commissioned by the Board to take forward pieces of work on its behalf. Likewise, the Board could request or empower one of the Advisory Groups to undertake a piece of work for consideration by the Board.

9. Is the Minister able to provide further detail on the planned ‘Compact’ and ‘Charter’ and the timeline for development. An example of a Charter and Compact is noted to be provided in the P60/2017 document² – is this representative?

The Compact and Charter will be developed by the System Partnership Board once the Board has been constituted; this is subject to the States Debate.

10. Can further details be provided about the personal attributes, experience and professional expertise required for the role of the Chair

A Job Description has been provided to the Scrutiny Panel

11. What mechanisms will be implemented to ensure independence of the appointed Chair?

The personal attributes, experience and professional expertise required for the role of the Chair are provided in the draft Job Description. The Appointments Commission will lead and provide oversight and assurance to the selection process.

Any applicant will need to both demonstrate their skills and experience, and also clearly state any pre-existing relationships or conflicts of interest. The Chair is intended to be independent; any individual who has conflicts of interest will not be shortlisted for the role.

12. Quality leadership of the System Partnership Board is integral to its effectiveness and cohesiveness. Can the Minister outline the processes in place to support strong and appropriate leadership by the Chair, and any mechanisms in place to encourage regular review and reflection of the Chair’s role?

The Chair’s approach to strong and appropriate leadership will be tested as part of the selection process. The Chair must be a credible, experienced leader with extensive experience of governance of health and social care and must demonstrate these essential qualities.

The Memorandum of Understanding between the Chair and the Minister sets out the mechanisms for reporting and for support of the Chair. Review and reflection will be part of the regular meetings between the Chair and the Minister. It will also form part of meetings between the Chair and the HSSD Chief Executive Officer, plus other individuals with whom the Chair meets.

13. Can further details be provided about the appointment of the Non-Executive Directors?

Subject to the States debate, the Non-Executive Directors will be selected through the usual processes of the Appointments Commission. The Job Description has been provided to the Panel.

14. Can confirmation be provided that the Minister for Health and Social Services remains accountable for board decisions in the initial pilot phase? How will the Minister formally hold the 'system' to account?

The Minister will remain accountable for decisions relating to the Health and Social Care System; the Minister will remain Corporate Sole and will continue to be accountable to the Council of Ministers and the States Assembly.

As noted on page 18 of the KPMG report "the role of the Health and Social Services Minister would remain largely the same as the current role. The Minister will:

- agree the system-wide objectives, with advice from the System Partnership Board (see Section 3.2.2)
- formally hold the system to account
- set policy, high level strategic direction and outcomes
- be politically accountable, and accountable to the public for the Department and the system
- secure States funding, receive and present Business Cases for additional funding
- along with the Council of Ministers, devise and deliver on the States' Strategic Plan
- adhere to States' mandated, formal Ministerial processes e.g. Ministerial Decisions, Propositions, Scrutiny Panel etc".

Page 22 of the KPMG report goes on to say, "The Chair of the System Partnership Board will agree objectives with the Minister at the beginning of each year, and will agree a Memorandum of Understanding (MOU) with the Minister on agreed objectives, responsibilities and accountabilities. The Chair and System Partnership Board will be held to account for achieving the objectives through regular, quarterly reporting by the Chair to the Minister. The formal quarterly reporting will be complemented by monthly trilateral meetings between the Chair, HSSD Chief Executive, and Minister to discuss the key decisions made at the previous System Partnership Board meeting and forthcoming priorities and decisions. These trilateral meetings will provide the Minister with greater visibility over the key decisions made as well as a proactive insight into significant issues for discussion."

15. How does 'accountability' and 'ownership' of decision-making – particularly in reference to System Partnership Board member responsibilities – evolve after the pilot phase of implementation?

This will be determined as part of the pilot evaluation, in discussion with the Minister. At present, there are no plans to change the accountability for decision making, which is with the Minister.

16. Can details of the proposed MoU between the Chair and the Minister be shared with the Panel and Stakeholders?

This has been provided to the Panel as policy under development.

17. Can the roles and responsibilities of the forum and advisory groups be provided please?

A Terms of Reference (ToR) has been provided to the Scrutiny Panel as policy under development. The outline is also include in P60 and in the KPMG report.

This will be developed further, by the relevant groups themselves, should the States Debate approve the proposed strategic governance model.

18. Can the roles and responsibilities of the Board Members, Chair and Non-Executive Directors be provided please?

Job descriptions for the Chair and Non-Executive Directors have been provided. Terms of Reference (ToR) for the Board have also been provided. P60 and the KPMG report also outline the functions, core values / expectations and key responsibilities.

19. The accountability of the board is referenced throughout the P60/2017 report². Can clarity be provided on SPB, Chair and Minister accountability for board strategic decisions and operational delivery?

The System Partnership Board would be responsible for considering strategic investments designed to deliver the vision set out in P82/2012 and overseeing their implementation and outcomes. It is not responsible for operational delivery.

The System Partnership Board would make recommendations to the Minister regarding health and social care strategy, to meet the strategic objectives and vision identified by the Minister, within the context of the overall approach approved by the States Assembly [(P82/2012)]. The Minister remains accountable for decision making.

The Terms of Reference (ToR) and Memorandum of Understanding, which have been provided to the Scrutiny Panel, is clear about this.

20. Can further details be provided about the re-muneration package, and administrative support, available to individuals engaged in the advisory groups /forum (particularly Voluntary/Community Sector and Public/Patient Sector) and those representing the SPB? Can the following points be addressed:

a) What administrative support will be provided to the advisory group/forum representatives, especially those from the Public/Patient group to support them in attending and representing the advisory group and board?]

Please see response to question 5.

b) What financial support will be provided to organisations from which individuals may be drawn to attend forum/group meetings and board meetings? (E.g. in terms of absence of staff member to attend board meeting/training; financial support as required for 'bank/locum' staff; related transport costs).

Please see response to question 5.

c) Can some guidance be provided please regarding the likely time commitments required by forum/advisory group individuals for attendance at board meetings / training over a 12 month period and how much notice regarding required attendances is likely to be provided?

The System Partnership Board is currently anticipated to meet every 2 months.

The Forum / Advisory Groups will meet at a frequency which they determine for themselves.

At least 6 weeks' notice will be provided for meetings; the System Partnership Board meetings will be scheduled for the year, by 31 October of the preceding year, other than in the first year for which dates will be released if the Assembly gives approval for P60/2017 in November 2017.

21. How will training and board development opportunities be integrated into the implementation phase of the proposed governance system? Please provide details on:

- a) Type of training to be offered,**
- b) Duration over training,**
- c) Financial support for training attendance and delivery, and**
- d) Outputs expected.**

The detail of the training and development activities for the Board will be developed once the States Debate has concluded. The Chair and Non-Executive Directors appointment process is likely to take 3 months, and cannot commence until after the States Debate. The training and development programme will be developed during this 3-month period; it will be developed with advice and guidance from the HSSD HR Director and his Training and OD colleagues and with the views of the emerging representatives from the Advisory Groups taken into account.

22. What independent quality assurance processes have been considered for the proposed governance model?

The Chair and Non-Executive Directors will provide independent assurance for the Board. The implementation of the governance model and the operation of the Board will be informed by good practice from other jurisdictions that utilise similar approaches. It is also likely that the Chairman and Minister would wish to see a regular review of governance and the operation of the Board by Internal Audit.

23. What performance measures and evaluation will be used to help determine the effectiveness and outputs of the System Partnership Board? Has an 'early warning toolkit' been considered?

The performance measures and evaluation will be based on the Board's purpose, which is outlined in the Terms of Reference. The detail will be developed after the States debate, in the three months of the Chair and Non-Executive Director appointment process, with advice and guidance from relevant States Officers, again drawing on good practice from other jurisdictions. The draft will be discussed with the Chair when the individual takes up post and then agreed with the Minister.

24. Can further details be provided on the expected mechanisms to be created within the Governance Model for feedback and reporting concerns? What systems of support will be available for those reporting concerns?

The proposed strategic governance model pertains to strategic matters only. Any concerns regarding operational matters, including patient comments and complaints, will remain unchanged and will be directed through the relevant organisation's complaints processes.

Raising concerns about the strategic governance model will be incorporated into the Compact, and in the values and behaviours of the System Partnership Board and Advisory Groups.

Concerns from Advisory Group members regarding the Advisory Group should be raised in the first instance with the relevant Chair. Concerns about the System Partnership Board should be raised, in the first instance, with the Board Chair. Individuals can ultimately raise concerns directly with the Minister, should they believe their concerns have not been adequately addressed.

25. Comment has been made of the need for a cultural and behavioural change, along with relevant structural changes, in P60/2017² (*Change in culture, Pg 13*). How will culture

and behaviour be encouraged to change to support successful implementation the proposed governance model?

See response to question 4

26. Can the department provide a list of all the organisations who were invited to take part in the initial workshops developing the model?

This is provided in Appendix A of the KPMG report, which was provided to the Scrutiny Panel in June 2017.

27. Is there a risk that Social Services can be under-represented on the board given the importance of its role, especially in light of the recommendations in the Care Inquiry

The Health and Social Services Chief Executive will be a Board Member and holds accountability for the entirety of health and social services strategy and delivery, reporting to the Minister. The Managing Director of Community & Social Services will also be a Board member, and it is worth noting that, as an integrated Health and Social Services Department, all HSSD representatives have both health and a social services responsibilities as part of their role.

It is also important to note that the operational responsibilities relation to health and social services remain within the governance processes of the Health and Social Services Department and are not delegated or devolved to the System Partnership Board. It is also important to note the existence of specific political and officer led panels and group dedicated to taking forward the recommendations of the Care Enquiry.

This having been said, it would be a requirement that all members of the System Partnership Board were aware of the Report, its recommendations and delivery plans and ensured that any proposals being developed by the Board were fully congruent with these plans.

Subject to the selection process, one or more Board members from the Clinical and Professional Forum, Public and Patient Forum and Voluntary and Community Sector Forum may have a Social Services and/or Children's Services background.

28. How will the Mental Health strategy be represented on the board?

The HSSD Chief Executive will be a Board member and holds accountability for the entirety of health and social care strategy, reporting to the Minister. The Director of System Redesign and Delivery will be a Board member and is the Director lead for the Mental Health Strategy chairing the Mental Health Implementation Group. The Managing Director of Community & Social Services will be a Board member and provides a wide range of specialist community and inpatient mental health services.

Subject to the selection process, one or more Board members from the Clinical and Professional Forum, Public and Patient Forum and Voluntary and Community Sector Forum may have a background in Mental Health services.

STATES OF JERSEY



HEALTH AND SOCIAL CARE SYSTEM: A NEW GOVERNANCE MODEL (P.60/2017) – AMENDMENT

Lodged au Greffe on 31st October 2017
by the Health and Social Security Scrutiny Panel

STATES GREFFE

HEALTH AND SOCIAL CARE SYSTEM: A NEW GOVERNANCE MODEL
(P.60/2017) – AMENDMENT

PAGE 2 –

After the words “for a 3-year trial period” insert the words, “commencing no earlier than April 2018”.

HEALTH AND SOCIAL SECURITY SCRUTINY PANEL

REPORT

The Health and Social Security Scrutiny Panel has carried out a review of [P.60/2017](#) 'Health and Social Care System: a new governance model' and will be presenting its report to the Assembly prior to the debate on Tuesday 14th November 2017. The Panel's key findings and recommendations will be put forward in this report.

From the documentation reviewed and evidence gathered during the course of its review, the Panel acknowledges there is wide support in principle for improving the present governance arrangements for health and social care in the Island. As a result, the Panel also supports the principle of establishing a new governance model in the form of a system partnership board. However, the Panel has concerns relating to various aspects of the operation/implementation of the proposed model, which are also reflected in some of the submissions made to the Panel and in the report of the Panel's adviser.

The Panel considers that the Minister should provide greater assurance to the Assembly in the coming months during which he and departmental officers propose to develop the planned model. This amendment therefore proposes that the Board should not be formally established before April 2018, in order to give opportunities to the Minister to report on progress to the Panel and the Assembly, to allow Members to ask questions of the Minister, and to allow time for any further debate if considered necessary.

The following aspects of the proposed model have concerned the Panel –

1. How the voice of children would be heard in the proposed model;
2. How the Public/Patient Group, the Voluntary and Community Sector Forum and the Clinical and Professional Forum are to be established;
3. How representatives from each of the forums and the group are to be selected to sit on the proposed Board;
4. Whether 21 members would make the proposed Board unwieldy and less effective;
5. Whether it is necessary for the Health and Social Services Department to have 9 representatives on the proposed Board;
6. How members of the Voluntary and Community Sector Forum and the Public/Patient Group would be trained and resourced to participate effectively at Board level and in their respective forum or group.

The Panel does not believe its amendment would create any significant difficulty for the Minister, as he has already indicated he would be spending the early part of next year working with stakeholders to establish the proposed model. The following extract is taken from the Public Hearing with the Minister for Health and Social Services on Thursday 19th October 2017, and indicates a proposed timescale for the development of the model –

Chief Executive Officer

The Appointments Commissioner is aware that this proposition is being lodged and that there may be a requirement for them to engage with this process, and obviously they have companies that they work with to source people. I would expect that in the first couple of months of next year, assuming that this gets signed off in November, December/January time we would go through that

process. I would hope by February/March time we would have the chair and the non-executives available to us. Clearly in that same 3-month period we can start to up the profile around working with the individual forums so they can start to think seriously about how they will find their representatives, so that by the time we get into late spring we can start bringing people together.

Financial and manpower implications

There are no additional financial or manpower implications for the States arising from this proposed amendment.

12. APPENDIX 4

12.1 Terms of Reference

The Panel's Terms of Reference for the review were as follows;

1. To examine the proposed governance model and assess the appropriateness of the changes in relation to third sector and voluntary organisations, Primary Care Organisations, members of the public and the States Assembly.
2. To determine if the proposed changes will improve services in health and social care.
3. To determine if the proposed changes will improve patient interaction with services providing health and social care.
4. To determine if the proposed changes will enhance integrated partnership working in health and social care.
5. To examine the consultation process that was undertaken in order to inform the proposed model.
6. To examine the financial and manpower implications of the proposed changes.
7. To examine and compare the proposed governance model to those in similar jurisdictions to Jersey.

12.2 Panel Membership

The Health and Social Security Scrutiny Panel comprised the following Members:

Deputy Richard Renouf, Chairman

Deputy Terry McDonald

Deputy Jacqueline Hilton

Senator Sarah Ferguson

*Deputy Geoffrey Southern, Vice-Chairman, did not participate in the Panel's review.

12.3 Expert Advisor – Dr. Amy Hughes, MBE, BMBS, BMedSci, DTM&H, EMDM, MRCEM

Dr Amy Hughes is an Emergency Medicine clinician and Clinical Academic Lecturer in Emergency Humanitarian Response and Global Health. In addition to a long career in the NHS, Dr. Hughes has worked within a variety of roles in complex humanitarian environments which have included: post-conflict northern Sri Lanka (Medecins Sans Frontier); Typhoon Haiyan, Philippines; and the recent West Africa Ebola outbreak in Sierra Leone. She has been engaged in the World Health Organization Emergency Medical Team (EMT) initiative and development of the UK EMT since 2013, with a particular focus on supporting and mentoring EMTs in achieving the required minimal standards for humanitarian response, co-leading the EMT working group on minimum training standards, and supporting improved accountability and governance amongst EMTs. During the West Africa Ebola outbreak, Dr. Hughes was

Team Leader for the UK-Med quality assurance team, providing technical, clinical and operational quality assurance guidance and support to deploying NHS clinical teams and DFID supported Ebola Treatment Centres. Previous clinical work has also included Pre Hospital and Retrieval Medicine with London and County HEMs teams and The Royal Flying Doctors Australia, and expeditionary work to austere environments. Dr Hughes has completed the Diploma Tropical Medicine and Hygiene (Liv) and European Masters in Disaster Medicine. She was awarded an MBE in the 2016 for services towards Emergency and Humanitarian Medicine

12.4 Evidence Considered

1. P.82/2012, Health and Social Services: A New Way Forward
<http://www.statesassembly.gov.je/assemblypropositions/2012/p.082-2012.pdf>
2. P.60.2017, Health and Social Care System: A New Way Forward
<http://www.statesassembly.gov.je/assemblypropositions/2017/p.60-2017.pdf>
3. KPMG report: Redesign of the Jersey Health and Social Care Governance Model
4. KPMG Report: Appendix C – Case studies used to inform development
5. KPMG Report: Appendix E – Case study desktop assessment
6. A Sustainable Primary Care Strategy for Jersey 2015 – 2020
7. A Mental Health Strategy for Jersey (2016 – 2020), Planning together for our Future

12.5 Briefings

The Panel received a briefing on the proposed governance model on 1st June 2017.

12.6 Public Hearings

Witness	Date
Senator A.K.F. Green, M.B.E, Minister for Health and Social Services	Thursday 19th October 2017
Mr M. Richardson, Assistant Director Policy and Ministerial Support, Health and Social Services	
Mrs J. Garbutt, Chief Executive, Health and Social Services	
Ms R. Williams, Director of System and Redesign and Delivery, Health and Social Services	
Ms S. Devlin, Managing Director, Community and Social Services, Health and Social Services	

12.7 Interviews held by the Panel's Advisor

Stakeholder	Date
Ms J. Garbutt, Chief Executive, Health and Social Services Ms R. Williams, Director, System Redesign and Delivery, Health and Social Services	Friday 4th August 2017
Dr N. Minihane, Representative, Primary Care Body (via conference call)	Thursday 24th August 2017
Ms S. Devlin, Managing Director, Community and Social Services	Thursday 7th September 2017
Ms H. O'Shea, Managing Director, General Hospital	Thursday 7th September 2017
Mr P. Romeril, Representative, Pharmacy Contractors Group	Thursday 7th September 2017
Mr A. Heaven, Director, Children's Policy, Former Lead Officer for the Mental Health Strategy	Thursday 7th September 2017
Mr J. Hopley, Representative, Voluntary and Community Sector Ltd.	Friday 8th September 2017
Mrs L. Arthur, Representative, Royal Pharmaceutical Society, Jersey Branch	Friday 8th September 2017
Mr B. Place, Future Hospital Director	Friday 8th September 2017
Ms A. Trudgeon, Associate, Jersey Audit Office (<i>this meeting was held in relation to a forthcoming audit that will be carried out by the Comptroller and Auditor General, in relation to the governance of Health and Social Services and did not contribute towards the evidence in the review</i>)	Friday 8th September 2017

12.8 Written Submissions

The Panel received written submissions from the following individuals and organisations:

- Citizens Advice Jersey
- Dr. Nigel Minihane, Primary Care Body
- NSPCC
- Dr. Philippa Venn, Primary Care Body
- Relate Jersey
- Jersey Hospice Care
- Jersey Recovery College
- Brighter Futures
- Jim Hopley, Jersey Voluntary and Community Sector Ltd.