



Office of the Comptroller and Auditor General

Governance Arrangements for Health and Social Care

13 September 2018



JERSEY AUDIT OFFICE

R.120/2018

Governance Arrangements for Health and Social Care

Background

- 1.1 Good governance is essential for good public services. Good governance involves clarity, openness and taking into account the views of the public including service users.
- 1.2 Good governance is of particular importance for Jersey's health and social care because of:
 - the scale of States expenditure in this area, excluding expenditure from the Long-Term Care Fund, amounting to nearly £270 million in 2017;
 - the substantial changes being implemented within health and social care;
 - the incidence of high profile failings in health and social care where governance arrangements were unsatisfactory: Jersey has seen failings in its system for caring for children, Guernsey in its midwifery services and the UK a series of failures, most recently relating to the care of the elderly in Gosport War Memorial Hospital; and
 - the particular need for public confidence in the health and social care system.
- 1.3 In October 2012 the States Assembly adopted P.82/2012 'Health and Social Services: A New Way Forward'. In doing so it endorsed the Health and Social Services Department's (HSSD's) plans to design and implement a programme of service developments to respond to the challenges presented by increasing demand for healthcare, including through demographic changes.
- 1.4 The States' Strategic Plan 2015-18 states that the objective of the Council of Ministers is to 'promote health and social wellbeing for the whole Community, providing prompt services for all and protecting the interests of the frail and the vulnerable'. A Transition Plan Steering Group oversees the review, prioritisation and implementation of P.82/2012 in three phases over the period 2013 to 2021.
- 1.5 The first phase of change, from 2013 to 2015, emphasised the importance of non-HSSD providers of health and social care, including the voluntary and independent sectors. The changes had a significant impact on how parts of the system related to each other. HSSD recognised that new partnership arrangements were required to support a 'whole system' approach to service and patient pathway improvement.
- 1.6 A move to an integrated approach to strategic planning, design, delivery and evaluation of health and social care services for Jersey has significant implications for governance arrangements.
- 1.7 In 2016, the Council of Ministers asked the Minister for Health and Social Services to review the strategic governance arrangements to ensure that Jersey has the most effective health and social care system for the future. Following support from consultants, a proposal for a powerful System Partnership Board with public and patient representatives was developed but subsequently withdrawn.

Objectives and scope

1.8 The focus of the review is on:

- the adequacy of arrangements for the governance of health and social care; and
- the adequacy of arrangements for development of proposals for changing the governance of health and social care.

1.9 The review extends to:

- governance arrangements put in place within the States that relate to provision of health and social care that is not within the direct control of the States, including services provided by independent contractors, the private sector and the voluntary and community sector; and
- the relationship between the government departments involved in health and social care – HSSD, the Social Security Department (SSD) and Community and Constitutional Affairs (CCA).

1.10 The review does not extend to the operation of or expenditure from the Long-Term Care Fund.

1.11 The review reflects the governance structures in place as at May 2018. It does not reflect the governance structures being introduced as a result of the implementation of the new Target Operating Model. However, initial findings from this review have been discussed with the Chief Executive.

1.12 The approach I have adopted is based on *The Good Governance Standard for Public Services* (see Exhibit 1).

Exhibit 1: Overall Structure for the report



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

Overall arrangements

2.1 In this section I consider aspects of the arrangements as at May 2018 and proposals for the establishment of a System Partnership Board that have not been implemented. I consider many of the arrangements in more detail in subsequent sections of this report.

Arrangements as at May 2018

2.2 Responsibility for health and social care within the States of Jersey was unnecessarily complex for a jurisdiction the size of Jersey. Responsibility was split between three departments with different ministerial accountabilities without strong system wide oversight to identify future needs, provide assurance on current delivery, maintain effective relationships with the voluntary and private sectors and drive change (see Exhibit 2).

Exhibit 2: Responsibilities for health and social care within the States of Jersey as at May 2018

Health and Social Services	Social Security	Community and Constitutional Affairs
<ul style="list-style-type: none">• Expenditure: £233.7m pa• Staff: 2,141.0 WTE• Secondary care• Community care• Social services• Ambulance services• System Transformation, including services commissioned from NHS, independent and voluntary organisations• Primary care quality (jointly with SSD)	<ul style="list-style-type: none">• Expenditure: £32.2m pa• Staff: 1.2 WTE• Managing Health Insurance Fund payments for Medical and Pharmaceutical Benefits• Primary care quality (jointly with HSSD)	<ul style="list-style-type: none">• Expenditure: £1.0m pa• Staff: 12.0 WTE• Strategic public health including the Medical Officer of Health• Professional and care regulation

2.3 The allocation of responsibilities reflected:

- the historical development of funding of health and social care rather than the needs of service users. The funding of certain elements of primary care is from the Health Insurance Fund: as this was the responsibility of the Minister for Social Security, responsibility for aspects of primary care fell to the Social Security Department (SSD);

- a conscious decision to move the statutory Medical Officer of Health and strategic public health function from the Health and Social Services Department (HSSD) to Community and Constitutional Affairs (CCA) from 2017. The Medical Officer of Health, whilst accountable on a day to day basis to the Chief Officer of CCA, reported directly to the Chief Executive as Chairman of the Emergency Planning Board and to the Chief Minister as Chairman of the Emergencies Council. The Medical Officer of Health also advised Ministers and senior officers on public health matters. The move was designed to ensure that public health issues are routinely considered in strategic planning and is in line with the recommendations of the World Health Organisation; and
 - the establishment of a regulatory function for health and care professionals under the Regulation of Care (Jersey) Law 2014. Subject to the bringing into force of the remaining provisions of the 2014 Law and the adoption of relevant Regulations, the Health and Social Care Commission will assume responsibilities for oversight and inspection of some elements of health and care services, whether provided by the States or third parties, with expansion to other elements of health and care on a phased basis. Officers envisage that this will entail an expansion of the small existing regulation team in CCA.
- 2.4 Although responsibilities were split between departments, the rationale for the model is not clear. It did not reflect:
- a commissioner/provider model;
 - a strategy/delivery model; or
 - any other model drawn from best practice and adapted to the circumstances of Jersey.
- 2.5 In my view management should not have allowed this situation to persist and should have proposed and driven changes in arrangements.
- 2.6 Within individual departments there were conventional management structures, including management teams comprising responsible officers and those reporting directly to them. However, there were also a number of additional groups with specific responsibilities (see Exhibit 3).
- 2.7 I am concerned that there was no document setting out the network of groups, their responsibilities and accountabilities, including the relationship between those with responsibilities for change and those with responsibilities for business as usual. Indeed no one person could explain how these groups linked together to support those charged with leading and managing the service. This means that a common understanding of governance and accountabilities was not secured, increasing the risk that governance arrangements failed.

Exhibit 3: Key groups outside departmental management structures involved in governance of health and social care as at May 2018

Group	Role	Reported to
Integrated Governance Committee, HSSD	Assurance over design and operation of controls and minimisation of HSSD's exposure to risk	Management Executive, HSSD (the management team for HSSD)
Care Quality Group, General Hospital, HSSD	Review of General Hospital risk management Obtaining assurance around impact, implications and application of internal and external reviews and accreditations	Integrated Governance Committee
Care Quality Group, Community and Social Services, HSSD	Ensuring appropriate arrangements for Community and Social Services Department (CSSD) to meet statutory, clinical, professional and financial responsibilities Ensuring professional practice in CSSD covers risk management; clinical and social care audit; education, training and continuous professional development; evidence-based care and effectiveness; staffing and staff management	Integrated Governance Committee
Joint HSSD/SSD Steering Group	Oversight of the clinical and corporate governance of primary care Examination of key strategic issues relevant to delivery by HSSD and SSD Oversight of joint HSSD/SSD projects	Chief Officer HSSD and Chief Officer SSD
Primary Care Governance Team	Oversight of governance of primary care practitioners	Joint HSSD/SSD Steering Group

Group	Role	Reported to
Transition Plan Steering Group	Support and challenge to the cross-system strategic direction of the P.82/2012 transformation programme	Management Executive, HSSD (management team for HSSD)
Transition Plan Workstream Steering Groups	Oversight of individual P.82/2012 workstreams	Transition Plan Steering Group
Clinical Directors Group, HSSD	Supporting the General Hospital leadership to deliver a clinically led, patient focussed, financially sustainable organisation	Hospital Board (management team for the General Hospital)

2.8 In my view the group structure was not fit for purpose:

- the network of groups and their relationship with line management structures has evolved over time without a coherent overarching rationale; for example, although many reported to HSSD's Management Executive, there were no documented arrangements for delegation by or reporting to the Management Executive;
- the effectiveness and continued need for the different groups had not been subject to systematic challenge and review. For example, the joint HSSD/SSD Steering Group has not reviewed its Terms of Reference since it started in April 2013, despite a requirement to do so annually. In other cases Terms of Reference were clearly out of date. I note, for example, that the Terms of Reference for the Clinical Directors Group date from 2011 and predate P.82/2012;
- in some cases reporting lines were not clearly set out and are ambiguous;
- the rationale for two separate Care Quality Groups with different Terms of Reference was unclear. I struggle to understand why two groups were needed, especially given the priority of breaking down the sharp distinction between hospital and community care; and
- the structure did not adequately reflect the Future Hospital project that, although pivotal in plans for the delivery of healthcare, was managed separately and insufficiently integrated with the delivery of other elements of health and social care.

2.9 Independent regulation and inspection, including of health and social care directly delivered by government, is an essential component of effective governance. Although I welcome the plans to extend the regulation and inspection of health and social care to the full range of provision, I am

concerned that there is no clear timetable for all services to be covered. This would mean that some services, including crucially those provided in the General Hospital, would for some time not be covered by independent regulation and inspection. In my view such a situation cannot be allowed to persist.

Proposals for change

- 2.10 In 2017, HSSD developed proposals for a fundamental change in the governance of health and social care through the establishment of a System Partnership Board (SPB) with a wide membership to focus on the delivery of the P.82/2012 transformation programme. The SPB was to have included HSSD management, voluntary and community sector representatives, patient and public representatives, clinicians and professionals and three non-executive members, including the Chairman. It would have incorporated the responsibilities of the Transition Plan Steering Group.
- 2.11 In June 2017 a proposition to the States Assembly outlined plans for a three year pilot of the SPB. It envisaged working towards delegation of individual decisions to HSSD management to allow significant operational decisions to be made without lengthy approval or lengthy governance processes.
- 2.12 In November 2017 the proposition was withdrawn following concerns expressed by Members of the States Assembly that Ministers had failed to consult the Health and Social Services Scrutiny Panel, the Public Accounts Committee and the Privileges and Procedures Committee before establishing a remunerated board. In January 2018 plans for the SPB were paused in light of wider changes proposed for the management of the States and potential changes arising from the 2018 General Election.
- 2.13 In a previous report, *Use of Consultants* (October 2016), I explained how consultants can add value, particularly in a time of change. But I also identified that the steps necessary for the effective use of consultants - from identification of the need for a consultant to evaluation of the impact of their work - were often not in place.
- 2.14 In June 2016, following a procurement process, HSSD appointed independent consultants to work on the proposal for the SPB. Their work cost approximately £50,000. The consultants were responsible for:
- developing criteria for evaluation of alternative models for the organisational reform of health and social care;
 - developing and documenting a recommendation; and
 - implementation planning.
- 2.15 Following a series of stakeholder workshops which considered other models of health and social care governance, the consultants identified key weaknesses with current arrangements:
- responsibility for system leadership was unclear and decision making was slow;

- mechanisms for securing different perspectives and insight in decision making were underdeveloped;
- there was no alignment in performance management at a system level;
- there was no consistent and co-ordinated approach to capturing the public's input to inform strategy;
- funding is based on provision of services rather than achievement of outcomes; and
- stakeholders were concerned that structural change alone without behavioural and cultural change would be ineffective.

2.16 The identification of key weaknesses is helpful and largely consistent with the findings of this review. However, I am of the view that the consultants were not used effectively:

- there was no documented assessment of the adequacy of the existing governance arrangements;
- there was no report from the consultants to the States assessing alternatives against agreed criteria;
- there was a lack of clarity as to the respective roles of the consultants and management. The consultants prepared a report supporting the proposed solution and that formed the basis of the proposition to the States. However, that report did not bear the name of the consultancy firm;
- there was insufficient transparency in the decision making process: it is not possible from the available documentation to see how management, with the support of the advice of consultants, evaluated alternatives against any objective criteria and developed a proposed solution; and
- it is not clear how HSSD management proposed to address the underlying findings of the consultants.

Recommendations

- R1** Ensure that effective over-arching structures are in place to manage health and social care provision.
- R2** Review the effectiveness of and rationalise the current groups supporting the governance of health and social care, ensuring that they are fit for purpose and have up-to-date Terms of Reference and clear accountabilities.
- R3** Publish a timetable for the extension of independent regulation and inspection to all elements of health and social care, including services directly provided by the States.
- R4** Ensure that consultancy reviews leading to proposals for change include documented evaluations of alternatives against agreed criteria.
- R5** Thoroughly review the findings of the consultants that led to the proposal for the Strategic Partnership Board, determine actions in response and monitor their implementation.

Focussing on service objectives and on outcomes for citizens and users

- 3.1 Focussing on the purpose of a service from the perspective of those who use and fund it is at the heart of good governance of public services. In undertaking my review I have focussed on four different dimensions (see Exhibit 4).

Exhibit 4: Focussing on service objectives and on outcomes for citizens and users: focus



Being clear about health and social care's purpose and its intended outcomes for citizens and service users

- 3.2 A starting point for good governance is a clear statement of the objectives for a service that is in turn reflected by the departments responsible for aspects of health and social care.

Across health and social care

- 3.3 The strategic objective for health and social care and associated ambition were set out in the States' Strategic Plan 2015-18:

'...Promote health and social wellbeing for the whole community, providing prompt services for all and protecting the interests of the frail and the vulnerable.'

'...Islanders live healthier lives, with access to high quality, sustainable health and social care.'

- 3.4 More tangible goals were set out in 'Future Jersey' published in March 2018:
- improve healthy life expectancy;
 - improve mental wellbeing;
 - reduce obesity;
 - reduce alcohol consumption; and
 - reduce smoking.

Health and Social Services Department

- 3.5 The strategic objectives for health and social care were reflected in the Health and Social Services Department's (HSSD's) business planning. HSSD's 2017 Business Plan highlighted four key priorities:

- improving safety and quality;
- providing clinical capacity;
- providing sustainable health and social care; and
- improving value for money.

- 3.6 The Plan, which was published on the States' website, included departmental objectives that linked to Medium Term Financial Plan (MTFP) success criteria and to which activities in the Business Plan could be mapped:

- **Objective 1:** *Redesign of the health and social care system to deliver safe, sustainable and affordable health and social services.*
- **Objective 2:** *Improved health outcomes by reducing the incidence of mortality, disease and injury in the population.*
- **Objective 3:** *Improved consumer experience of Health and Social Services.*
- **Objective 4:** *Promotion of an open culture based on good clinical and corporate governance with a clear emphasis on safety.*
- **Objective 5:** *Manage the Health and Social Services budget to deliver services in accordance with the Medium Term Financial Plan.*

- 3.7 In 2015 HSSD published a Sustainable Primary Care Strategy setting out five ambitions:

- **Patients** - *develop an understanding of the population health needs of Islanders to enable design of services which most closely meet that need.*
- **Payment** - *explore payment models which incentivise outcomes but maintain the strengths of the current system.*
- **Partnerships** - *develop more integrated working across the whole system to enable improved efficiency and safety.*

- **People** - assess and develop the Primary Care workforce and provide career opportunities for people to develop the skills required to meet future challenges.
- **Processes** - develop governance and IT processes to support quality, safe, and efficient delivery of care.

Social Security Department

- 3.8 The Social Security Department (SSD) demonstrated business planning rooted in its statutory responsibilities. Its annual Business Plan makes specific reference to its responsibilities for the management of the Health Insurance Fund that supports the costs of a range of primary care services, including GP visits and community prescription drugs.

Community and Constitutional Affairs

- 3.9 Public health plays a vital role in protecting people from threats to their health, promoting good health and ensuring that health services are efficient, effective and accessible.
- 3.10 A 2015 document, 'Protecting and improving the wellbeing of all Islanders 2015-2020' set out ambitions for Public Health in Jersey:
- *working to improve health outcomes, reducing the incidence of disease, injury and death;*
 - *encouraging and promoting good health in Jersey and working towards making healthy lifestyle choices earlier; and*
 - *developing an understanding of health inequalities and ways to reduce them.*
- 3.11 The 2015 document reflected the Medical Officer of Health's intention to begin developing a new, overarching Health and Wellbeing Framework for the Island, focussing on preventative measures and working in partnership across Jersey's public and private sector. However:
- such a Framework has not yet been adopted;
 - there is no publicly available workplan for delivering a Framework; and
 - the 2015 document has not been updated to reflect the new structural arrangements for Public Health.

Planning services based on an understanding of need

- 3.12 Effective service planning requires good quality information on the needs of service users. Such information embraces both 'hard' and 'soft' information from a number of sources.
- 3.13 Service planning has been reliant in particular on:
- the Strategic Public Health Unit's 2016 Health Profile, which compared the health status of adults and children in Jersey with Guernsey, the UK and EU data; and

- the Public Health Statistics Unit's Disease Projections 2016-2036. These considered each disease and condition, evaluating the current pattern of prevalence in the population and the projected incidence over the next 10 and 20 years. For example, the Unit estimated that there will be an additional 900 patients on the stroke and transient ischaemic attack (TIA) register by 2036, an increase of 64% from 1,400 people in 2016 to 2,300 in 2036.

3.14 Softer information was also obtained:

- the 'My Jersey' survey includes questions about the health and social care needs and the ambitions of Islanders. This survey informed the longer term health and social care goals set out in 'Future Jersey' published in March 2018; and
- relevant questions were included in the Jersey Lifestyle and Opinions Survey and the Schools Health Survey.

3.15 Consultation has been used to inform specific policy plans. For example:

- consultation in 2013 on 'smokefree children' resulted in nearly 3,000 responses and drove the prioritisation of legislation to restrict smoking in motor vehicles; and
- the Strategic Public Health Unit is working with the Youth Service and Youth Ambassadors to secure views on restricting the take-up of smoking by young people.

3.16 HSSD had mechanisms in place for capturing feedback and receiving complaints. However, I have concerns over the effectiveness of these arrangements that I discuss later in this report.

3.17 Prescribing patterns are a valuable source of information on health needs. SSD secures and analyses such information for General Practitioners. Work is in hand to secure electronic capture of prescribing by hospital doctors to patients being discharged from the General Hospital. Plans are in place to extend the analysis of prescriptions to dentists where the absence of prescriber codes and the use of handwritten prescriptions make analysis more difficult.

Making sure that users receive a high quality service

3.18 Well governed services focus on the delivery of high quality services to users by:

- establishing appropriate targets for service delivery;
- monitoring performance against those targets using validated information; and
- benchmarking themselves against services in other locations.

Health and Social Services Department

3.19 HSSD developed a monthly Integrated Performance Report that monitors performance against a wide range of indicators, many focussing on quality of service (see Exhibit 5).

Exhibit 5: HSSD Integrated Performance Report: Examples of indicators

Infection control
Incidents
Complaints
Safety for Older People and Mental Health Services
Waiting times
Re-admission rates
Delayed transfers of care

3.20 However:

- management accepts that there were weaknesses in arrangements for securing data quality;
- there was slow progress in developing benchmarking arrangements to understand how the quality and outcomes of services in Jersey compare with other jurisdictions;
- in some areas, such as 'Did Not Attend', targets were set by reference solely to the change in performance and not against an absolute standard to which HSSD aspired; and
- there was a focus on reporting of activity rather than on the quality of or the outcomes from the health and social care services provided and there is significant scope for development in this area (see Exhibit 6).

Exhibit 6: Performance reporting: Examples of areas for improvement

Area	HSSD 'activity' indicators (Note 1)	Potential 'quality' and 'outcome' indicators
Maternity services	Number of women using services	Number and percentage reduction in pre-term births (Note 2)
Overseas acute referrals	Number of referrals	Number and percentage of patients receiving high quality services from overseas providers

Area	HSSD 'activity' indicators (Note 1)	Potential 'quality' and 'outcome' indicators
Inpatient services	Length of stay (LOS) for acute and community beds by service provided	Number and percentage of patients discharged or transferred in line with the LOS targets Number and percentage where primary care facilitated discharge or transfer (Note 3)
Delayed transfer of care	Number of patients waiting 0-3 days, 4-7 days and 8+ days	Number and percentage of patients at the right stage of the system-wide care pathway Number and percentage of patients expected to return home who achieve that (Note 4)
Outpatients	Number and percentage of outpatients who 'Did Not Attend' (DNA), including those under 18 coded as 'Was Not Brought' (WNB)	Number and percentage of patients under 18 whose non-attendance was followed-up, in line with safeguarding practice (a system-wide response including primary care referrers) (Note 5)

Notes: (1) HSSD's Integrated Performance Report (2) Better Births: Improving outcomes of maternity services in England - A Five Year Forward View for maternity care (NHS England, 2006) (3) Moving healthcare closer to home: Enabling early discharge (Monitor, 2005) (4) Delayed transfers of care: a quick guide (Blog, The King's Fund, 2018) (5) Torjesen, I, Children who miss appointments may be at risk from lack of follow-up (The BMJ, 2017)

- 3.21 The Group Managing Director for Health and Community Services is undertaking work to develop benchmarking, targets, improved indicators and improved reporting of performance.
- 3.22 The Jersey Nursing Assessment and Accreditation System (JNAAS) was developed in 2015 working with the Salford Royal NHS Foundation Trust to help understand how the quality of nursing care delivered by individuals and teams compares with good practice. JNAAS comprises 14 standards that are aligned and referenced to the UK's Care Quality Commission benchmarks and other recognised accreditation standards. Rollout was proposed across all HSSD inpatient areas and other publicly funded health and care providers can access the methodology. However:

- due to issues with senior nursing resources at the General Hospital and in CSSD, rollout of this assurance framework was delayed; and
- there was no requirement for other publicly funded health and care providers to adopt the methodology.

Social Security Department

3.23 In 2015, SSD introduced the Jersey Quality Improvement Framework (JQIF). The JQIF is a reward and incentive programme based on the NHS's Quality Outcome Framework. It involves the collection and analysis of data on GP Practice activity against agreed standards, driving payments to GPs of £1.6 million in 2017. Examples of the 34 organisational and clinical measures used are provided in Exhibit 7.

Exhibit 7: Jersey Quality Improvement Framework: Examples of organisational and clinical measures

Organisational measures:
Practice has safeguarding lead(s) and implements a safeguarding policy
Practice has a process for notes summarisation that includes coding of all relevant diagnoses, medical history and current problems
Practice has a process for monitoring safe use of prescribed medication
Clinical measures relating to:
Coronary Heart Disease
Hypertension
Diabetes mellitus
Dementia

Making sure that taxpayers receive value for money

3.24 Good governance requires continued focus on securing value for money.

Health and Social Services Department

3.25 HSSD managed efficiency savings and effectiveness improvements via its Safely Removing Costs programme launched in 2015 with a focus on using Lean methodologies. For 2018 the Safely Removing Costs efficiency savings target was £6.2 million of which virtually none had been identified and reflected in budgets at the start of the financial year. At that stage the response to the Safely Removing Costs slippage was very generic: workstream leads were asked to focus on areas where savings were still unidentified.

- 3.26 HSSD was better at planning for growth than for securing savings. It had an established framework for assessing its funding priorities. Two in-year reviews – the Spring and the Autumn reviews – enabled cost pressures to be understood and cases to be made for additional funding. Service Directors submitted Resource Request Forms, which enabled comparison against set criteria concerning risk and opportunity, to produce a score driving a priority rating. An example of the use of the process is provided in Case Study 1.

Case Study 1: Spring and Autumn Review process: an example

An application was presented to the Autumn Review 2017 to enable the invitation of 2,810 unscreened women to breast screening because:

- the number of women in the Island who were not being invited to breast screening was not known until recent work by the Informatics Team, cross-checking names and addresses from the population register with Patient Administration System data; and
- an invitation to breast screening delivers about a 20% reduction in breast cancer mortality, with one breast cancer death averted for every 235 women invited to screening for 20 years, and one death averted for every 180 women who attend. Extrapolating to the 2,810 women, 12 potential deaths and 194 breast cancer diagnoses could be averted by extending screening.

The Autumn review process recommended that Corporate Directors approve the allocation of £30,000 from the 2% investment in service standards recurrently to fund the breast screening catch-up programme. In December 2017 Corporate Directors agreed that the option of 'doing nothing' did not fit with:

- HSSD's Business Plan objective of reducing morbidity and mortality in the population; or
- the context of the evidence presented at the political debate which led to the adoption of the Register of Names and Addresses (Access for Medical Purposes) (Jersey) Regulations 2015.

- 3.27 HSSD also drove forward a Person Level Information and Costing System (PLICS) to improve its ability to report on value in health and social care but did not have concrete plans for wider rollout (see Case Study 2).

Case Study 2: Person Level Information and Costing System (PLICS)

HSSD's development of a Person Level Information and Costing System (PLICS) enabled comparison of the value of different types of treatment and intervention. Similar systems are used throughout the NHS to understand the interaction between finance and activity and so provide the cost of each of the 'building blocks' that make up a pathway of care. PLICS went beyond the UK models as it extended to social care.

The first year implementation project was formally closed in February 2018.

Information from the system has already been used to review alternative pathways of care and assess the value in terms of the cost compared with the outcome for the service user. In addition, HSSD used PLICS output to inform the Private Patient tariff for 2018 and to model services over the 20 year horizon for the Chief Economic Advisor.

HSSD's goal was to embed PLICS in business processes and existing governance structures. It planned the next stage as engagement with the wider health and social care community on the benefits of the system so that care pathways that involve voluntary and independent providers could be included but did not have concrete plans or timescales for implementation.

HSSD intended to use PLICS to focus attention on areas where value for money could be improved. Benchmarks with the NHS and other public bodies had been built in allowing further investigation of cost differences.

HSSD intended that PLICS would be used in the annual financial planning processes, for example for informing or challenging business cases, for modelling for strategic planning, supporting service redesign and focussing the Safely Removing Costs process.

- 3.28 In primary care, HSSD commissioned consultants to review funding structures and incentives with the review part-funded by SSD and overseen by a Joint SSD/HSSD working group.

Social Security Department

- 3.29 SSD did not have structured arrangements for driving value for money in health care. However, there is evidence of action to drive value for money:
- in 2015 contractual arrangements were agreed with GPs to facilitate payments for telephone consultations and consultations by practice nurses, incentivising more modern mechanisms of delivery;
 - historically, reimbursement for influenza vaccinations could only be made for vaccinations administered by GPs. From 2017 a new contract was set up to enable reimbursement of provision of seasonal influenza vaccinations on a contract basis. This allowed the vaccinations to be delivered by a wider range of primary care health professionals (such as practice nurses and community pharmacists) in addition to GPs; and
 - a Prescribing Scheme had been agreed but not yet fully implemented to support GPs to meet best practice prescribing indicators.

Recommendations

- R6** Review and update documents setting out objectives for departments involved in health and social care in light of the new structures established under the Target Operating Model.

- R7** Adopt a clear timetable for the development of a Health and Wellbeing Framework for Jersey, supported by a work programme to deliver the Framework.
- R8** Develop a comprehensive, integrated approach to capturing and using patient views across all provision of health and social care.
- R9** Develop a comprehensive programme for improving performance reporting across health and social care, including securing data quality and adoption of meaningful targets.
- R10** Prioritise the development of benchmarking of the quality and outcomes of health and social care in Jersey against other jurisdictions.
- R11** Develop a plan for the rollout of Jersey Nursing Assessment and Accreditation System across all elements of health and care, including other publicly funded health and care providers, and monitor implementation.
- R12** Operate a structured approach to identifying and implementing efficiency savings across health and social care, ensuring that savings are identified before the commencement of the financial year.

Performing effectively in clearly defined functions and roles

- 4.1 Good governance involves clarity of functions and responsibilities at a senior level and ensuring that those responsibilities are carried out. I have considered the arrangements across health and social care and those within individual departments.

Across health and social care

- 4.2 The departments involved in the delivery of health and social care operated within the established accountability frameworks operating within the States. These included the allocation of specific responsibilities to Ministers and Accounting Officers and a duty on officers to comply with Financial Directions, Human Resources Codes of Practice and Schemes of Delegation.
- 4.3 A key group responsible for co-ordination across health and social care was the Transition Plan Steering Group which was established in 2015 to:
- ‘...provide support and challenge to the cross-system strategic direction of the transformation programme (as outlined in P.82/2012 ‘A New Way Forward for Health and Social Care’.)’*
- 4.4 Its Terms of Reference set out the Group’s key responsibility to:
- ‘...create and maintain an integrated multi-organisational collaborative environment in which the strategy is able to progress and succeed;...’*
- 4.5 However, the Terms of Reference:
- did not establish the roles and responsibilities of different members of the Group; and
 - did not set out the decision making powers of the Group or how decisions were to be made.
- 4.6 Following work commissioned in 2017 by the Director for Service Redesign and Delivery, the Group’s Terms of Reference were refined to reflect the responsibilities of the Group. In doing so, explicit consideration was given to my reviews of:
- *Community and Social Services* (December 2015);
 - *Risk Management* (September 2017); and
 - *Decision Making: Selecting a Site for the Future Hospital* (November 2017).
- 4.7 However, the revised Terms of Reference still did not cover the Group’s decision making powers or process.

Health and Social Services Department

- 4.8 Until January 2018, the Health and Social Services Department (HSSD) operated two overarching strategic governance groups:
- a smaller Corporate Directors; and
 - a larger Corporate Management Executive where the members of the Corporate Directors were joined by the Medical Directors.

- 4.9 However, there was an absence of up-to-date documentation of the responsibilities and membership of the groups:
- the Corporate Directors operated without any Terms of Reference; and
 - the Terms of Reference for the Corporate Management Executive dated from 2010 and failed to reflect two subsequent key appointments – the Medical Director for Primary Care and the Director for System Redesign and Delivery.
- 4.10 A paper to the Corporate Directors in 2017 recognised the need for a review and streamlining of governance arrangements within HSSD. As a result, in January 2018 HSSD agreed that the direction and assurance for HSSD should be vested in one group to be called the Management Executive. The Management Executive had Terms of Reference and templates for structured agendas and reports.
- 4.11 HSSD subsequently agreed a draft ‘target’ delegation and assurance model, structured into three tiers:
- directing and assuring – a role to be performed by the Management Executive;
 - managing, such as Hospital and Ambulance Management and Integrated Governance; and
 - delivering, such as Risk Management and Serious Incidents.
- 4.12 HSSD adopted a ‘blank page’ approach, recognising that work needed to be done to:
- understand fully how current governance structures need to be changed to meet the streamlined model, and to map the required relationships and communications; and
 - test the new model by taking practical examples, such as a drug error, and identifying how the connections between different parts of the system would work in managing, assuring, learning and changing practices.
- 4.13 HSSD recognised the need to:
- take into account the changes being put in place by the new Chief Executive; and
 - standardise governance documentation so functions, responsibilities, accountabilities and delegations can be clearly understood.
- 4.14 A key group within HSSD’s structures has been the Integrated Governance Committee (IGC) with responsibility for seeking assurance that controls are in place and operating effectively to deliver the department’s objectives and to minimise risk. Terms of Reference were developed in 2015. However:
- the first responsibility was to develop an Integrated Governance Strategy and Plans. No such Strategy or Plans have been developed. Without them, the IGC was unable to discharge its other responsibilities, such as provision of assurance on governance matters;

- the Terms of Reference provided for an annual review of the IGC's work. No such review has been undertaken since the establishment of the IGC;
- the Terms of Reference have not been updated to reflect structural changes. The Medical Officer of Health was listed as a member of the IGC in the Terms of Reference but, following the move of Strategic Public Health out of HSSD to Community and Constitutional Affairs, was no longer a HSSD Corporate Director and accordingly ceased attendance at HSSD management meetings, including the IGC. There was no evaluation of the impact or appropriateness of such a change in IGC membership; and
- there is evidence that the IGC did not effectively discharge its responsibilities to provide assurance about arrangements for and the effectiveness of clinical and care governance (see Case Study 3).

Case Study 3: Failure to provide assurance about clinical and care governance

Two groups focussed on the quality of care, one each for the General Hospital and for the Community and Social Services Department (CSSD), working at operational level and escalating issues to the IGC.

In June 2017, the Clinical and Care Audit and Effectiveness Department delivered its 2016 annual report to these two groups highlighting concerns that:

- *Specific actions resulting from audit recommendations are not formally monitored.*
- *Clinical audit reports submitted to the department rarely have well developed action plans, making accountability for results and time frames for change difficult to interpret.*
- *Abandoned projects:*
 - *within CSSD are mostly attributable the lack of clarity across the directorate about what activity to register and how to register it;*
 - *in the Emergency Department were due to lack of communication with the Clinical and Care Audit and Effectiveness Department about the progress of audit activity and projects that were identified as priority but failed to start; and*
 - *within the division of Medicine were due to problems with project administration and failure to acknowledge status update requests.*
- *Low levels of audit project completion were seen in CSSD and Theatres. Only 50% of CSSD clinical audits resulted in a report.*

The report made relevant recommendations, for example:

- *Develop an overarching organisational audit programme agreed by IGC with mandatory service / division yearly audit plans which meet the key organisational priorities.*
- *Quarterly reporting to Care Quality Groups and IGC to oversee and direct defined organisational governance and audit priorities.*

- *All audit activity must be registered using the clinical audit registration form.*

The annual report was subsequently presented to the Management Executive some six months after the date of the review. But there was no accompanying action plan or update on achievement to provide the Management Executive with assurance.

An action plan received from the Head of Clinical Governance and Risk Management in March 2018 showed some progress against the recommendations but that development of an overarching audit programme that meets organisational priorities remained outstanding.

4.15 There are evident weaknesses in key underpinnings necessary for the effective operation of the IGC:

- clinical audit was not fully effective. It was only as a result of an external review of blood donor services that significant gaps in assurance, standard operating procedures and documentation were identified. These gaps led to a decision in January 2018 to close the blood donor service for an initial period of six months to take corrective action; and
- monitoring of implementation of agreed recommendations from internal and external reviews is not effective. HSSD had taken action to improve tracking of implementation: the status of recommendations was highlighted in the Integrated Performance Report and a senior officer assigned to compile this part of the report, taking a more robust approach and challenging previous conclusions that implementation is complete when supporting evidence has not been provided. However, responsibility for action was not allocated to individual departments and groups.

Social Security Department

4.16 The Minister for Social Security has statutory responsibility for the Health Insurance Fund out of which certain primary care expenditure is met although professional expertise in many aspects of primary care rested in HSSD. This led to complex arrangements:

- a Memorandum of Understanding (MoU) between the Accounting Officers of the Social Security Department (SSD) and HSSD so that the cost of the Primary Care Governance Team, operated by HSSD, is borne by the Health Insurance Fund;
- appointment of a Medical Director for Primary Care, integrated into HSSD's governance arrangements;
- operation of a Primary Care Governance Team within HSSD but funded by SSD led by the Medical Director for Primary Care and responsible for the development and implementation of governance processes for primary care; and
- establishment of a Joint HSSD/SSD Steering Group to promote alignment between the respective strategies and plans of HSSD and SSD. However:

- the Terms of Reference were last updated in 2013 although a long overdue review is scheduled; and
 - a review of minutes from August 2017 to January 2018 highlighted that many senior members of the Group neither attended nor sent apologies and other members routinely sent more junior staff in their place.
- 4.17 The representative arrangements for primary care providers differ. GPs liaise with the States via a Primary Care Body, a Committee established by GPs which operates informed by UK standards. Two separate groups represent community pharmacists. Dentists and optometrists have established local groups that are less active in formal negotiations with the States.

Community and Constitutional Affairs Department

- 4.18 Following the transfer of the Strategic Public Health Unit to the Community and Constitutional Affairs Department (CCA) in 2017, a Memorandum of Understanding was put in place between the relevant accounting officers, allowing the Medical Officer of Health to continue to fulfil statutory responsibilities, and for the HSSD to continue to have access to necessary public health specialist expertise. The Medical Officer of Health continues to attend the Transition Plan Steering Group and the Sustainable Primary Care Board (which I understand became an implementation group in 2018), as an invited external member of these multi-agency meetings.
- 4.19 However, as noted above, since leaving the HSSD Corporate Director role, the Medical Officer of Health no longer attends HSSD internal management meetings, including the IGC. Following this organisational change there has been no change to the IGC Terms of Reference.

Recommendation

- R13** Develop and implement a plan for robust oversight of governance of health and social care including:
- determining the appropriate groups, their membership, terms of reference and accountabilities;
 - developing underlying strategies and plans;
 - strengthening clinical and care audit and its oversight;
 - monitoring attendance at key governance groups;
 - ensuring engagement across health and social care; and
 - developing strengthened arrangements for engagement with community pharmacists, dentists and optometrists.

Promoting values of good governance and demonstrating these through behaviour

5.1 Good governance depends not only on effective structures and accountabilities but also on a common understanding of and commitment to the values of good governance driven from the top. In health and social care good governance is crucially dependent on a culture where speaking up and challenge by colleagues is promoted, respected and welcomed. I have focussed on how values are established and promoted.

Across health and social care

5.2 All States of Jersey good governance is promoted via:

- the States' Code of Conduct issued in 2002 and intended to help protect the integrity of the States and its employees by providing clear guidance on standards of behaviour; and
- the 'public facing' values adopted in 2015 and widely publicised as part of email signatures and in policy documents. These comprise:
 - customer focus;
 - constantly improving;
 - better together;
 - always respectful; and
 - we deliver.

5.3 Although the States have a whistleblowing policy in place, the States Employment Board has recognised that the existing policy is inadequate and has commissioned work to establish revised arrangements. Important challenges in the application of a whistleblowing policy are:

- the inter-relationship with the statutory regulatory framework of health and care professionals; and
- the recognition of the obligations of health and care professionals to professional bodies governed by their own rules and codes of conduct.

Health and Social Services Department

5.4 In 2017 HSSD built on the States of Jersey's public facing values through its 'OUR Values OUR Actions' initiative that set out the behaviours expected from staff under each of the public facing values. For example, for 'Customer focus' it set out expected behaviours that each staff member:

- puts the customer at the centre of everything they do;
- produces and shares information that meets the needs of all individuals and their circumstances;
- is helpful;
- is accessible, approachable and professional;

- responds to needs in a timely and sensitive manner or directs to those who can help;
- does everything we can to protect those who use our services from avoidable harm.

The initiative was driven by HSSD's recognition that the majority of complaints from patients and members of the public related to staff attitudes.

- 5.5 The 'OUR Values OUR Actions' initiative also reflected the provision of constructive feedback to colleagues and for action to be taken on that feedback. The expected behaviours include:
- seeks and acts on feedback from service users, carers and staff about their experiences;
 - encourages people to share their ideas and respect the contribution everyone can bring; and
 - communicates well by being open, listening, sharing and giving feedback.
- 5.6 The initiative is at an early stage. Champions have been identified and trained but constant reinforcement of values is necessary for them to become embedded, especially in difficult areas, such as challenging more senior colleagues. Some mechanisms for doing so, including through monitoring their impact, for example through staff appraisals, have yet to be established.
- 5.7 A learning culture facilitates good governance. However, my previous reviews of health and social care indicated that such a culture was not consistently in place. For example:
- my review of *Community and Social Services* (December 2015) highlighted the absence of effective arrangements across HSSD for monitoring the implementation of agreed actions arising from reviews, accreditation and complaints and assessing the effectiveness of the action taken;
 - my follow-up review of *Private Patient Income: Health and Social Services Department* (February 2017) identified a need to focus not only on the implementation of individual recommendations but also on the effectiveness of the action taken; and
 - my review *Decision Making: Selecting a Site for the Future Hospital* (November 2017) identified inadequate arrangements for engagement with and listening to the views of clinicians as service providers in the process for selecting a site for the Future Hospital.
- 5.8 One mechanism for reinforcing values is through an effective complaints policy. HSSD's Complaints Policy was refreshed in 2018. It sets out clearly the purpose of the policy and roles and responsibilities. It also promotes early resolution.
- 5.9 But complaints are not used effectively to promote common values:
- although internal reports on themes and trends in complaints are prepared, these are not publicly available; and

- performance on handling complaints has been poor. The target for responding to a complaint is 25 days but in July 2017 compliance with this target was only 39% for complaints relating to the General Hospital and 25% for complaints relating to CSSD. External training on handling complaints has subsequently been provided to 25 key staff and HSSD has adopted a structured action plan to improve complaints handling.

Social Security Department

- 5.10 For primary care, in 2018 the JQIF includes an indicator that GP Practices should report the number of complaints received as well as the percentage attributed to different categories (including attitudinal). GP Practices were required to report on how learning outcomes have been identified and cascaded.
- 5.11 However, there was no similar approach in place to understand how patients and the public could use their experience to influence community dentistry and optometry services. I do, however, recognise that these services are not publicly funded.

Recommendations

- R14** In developing new States-wide whistleblowing arrangements, reflect the statutory regulatory framework under the Regulation of Care (Jersey) Law 2014 and the obligations of health and care professionals to professional bodies.
- R15** Develop and implement mechanisms for measuring the impact of the 'OUR Values OUR Actions' initiative on culture and behaviours.
- R16** Develop public reporting on complaints, including their incidence, nature, handling (including speed of handling), resolution and learning.
- R17** Extend the requirement for reporting on complaints to all primary care providers.

Taking informed, transparent decisions

6.1 Good governance entails making decisions transparently on the basis of good information. I have reported previously on the quality of decision making in my 2017 report *Decision Making: Selecting a Site for the Future Hospital*.

In this review I have focussed on three different dimensions (see Exhibit 8).

Exhibit 8: Taking informed, transparent decisions: focus

Health and social care contributes to a clear annual account of how it makes sure that its priorities are put into practice

Decisions are based on up-to-date and complete information and good advice

The Service prepares a clear annual statement on the effectiveness of its risk management system

Health and social care contributes to a clear annual account of how it makes sure that its priorities are put into practice

6.2 I have considered the information available to the public at both a States-wide and departmental level.

States-wide

6.3 At a States-wide level, arrangements were in place for reporting of corporate governance and performance as part of the Annual Report and Accounts of the States. Prior to 2017 performance reporting was very limited and restricted to an Annex. I welcome the publication of a fuller Annual Report for 2017 including more performance reporting, including quantitative information. However:

- most indicators were activity measures, such as number of referrals or scans, rather than measures of quality or outcomes. Although there were some such measures, for example take up rates for vaccinations, overall the public reporting reflects the same weakness as the internal reporting in the Health and Social Services Department's (HSSD's) Integrated Performance Report to which I refer above;

- although indicators were presented alongside comparative information for the previous year, only for ambulance services and mental health was there any reporting of performance against targets to which the States has committed itself; and
- there were inadequate arrangements to validate non-financial information included in the Annual Report leading to material errors in reported performance. For example, the Annual Report stated that 1,222 patients were waiting for an outpatient appointment for more than 90 days as at December 2017 whereas HSSD's Integrated Performance Report indicated a figure of 3,368. The errors were only identified as part of my work for this report and management subsequently changed them.

Health and Social Services Department

- 6.4 Compared with health services in the UK, HSSD made very little information specifically available to the wider public about:
- the process of decision making; or
 - the performance of Jersey's health and social care services against targets.
- 6.5 HSSD's website set out 'What we do' and 'Our responsibilities' but did not:
- set out ambitions for how patients and the public will experience services; or
 - include performance information.
- 6.6 HSSD's Business Plan included a narrative on what had been achieved by different parts of the Department but did not clearly set this out in the context of HSSD's priorities.
- 6.7 In practice, much information reached the public domain piecemeal in response to Freedom of Information requests. These responses covered performance measures that would routinely be reported publicly in the UK, such as:
- waiting times for inpatient, day case and outpatient appointments;
 - waiting times in the Emergency Department;
 - safety information, for example hospital acquired pressure ulcers and infection rates; and
 - patient experience indicators, in particular the number and nature of complaints.
- 6.8 There have, however, been welcome individual initiatives to improve transparency. In some cases implementation has been inadequate (see Case Study 4) or taken too long (Case Study 5). In others, the drive for transparency has been from HSSD staff (see Case Study 6).

Case Study 4: Mental Health Strategy

Jersey's Mental Health Strategy which launched in 2015 committed to producing a set of measures describing the quality and performance of local services. HSSD developed a Mental Health Quarterly Report and performance dashboards including indicators for service access, care co-ordination, continuity of care and staff satisfaction with the service they are able to provide. HSSD committed to further work to develop the indicators and improve their quality and to engage with stakeholders on factors that might impact on reported performance.

Performance dashboards were published for quarters 1, 2 and 3 of 2017 but not subsequently. Management did not record an explicit decision to cease publication or an explanation for the delay in publication.

Case Study 5: Annual Report for the Ambulance Service

The Chief Ambulance Officer and his team decided to produce a public annual report for 2016, covering performance in the year and priorities for the future, similar to the annual report for the States of Jersey Police.

However, lack of resources meant that the Annual Report was not ready for review until the middle of 2017. At that stage it was subject to review by the Hospital Managing Director, HSSD's Corporate Management Executive, Minister for Health and Social Services and Corporate Management Board. Due to the delays in finalisation the report was distributed internally but not made available to the public.

For 2017 an Annual Report was prepared and published.

Case Study 6: Transparency boards

Nurses at the General Hospital and in community inpatient facilities have helped develop a 'transparency' board, which is displayed at the entrance to wards, for patients and the public to see. The board sets out important information on the quality of care, such as:

- 'safe staffing' levels: expected and actual;
- the number and nature of complaints, and what has been done in response; and
- safety information, including infection rates, falls, hand hygiene compliance and ward cleanliness.

However, there is no public information on how the performance of individual wards compares with others, with comparable organisations or with performance in previous periods.

6.9 HSSD had an aspiration to publish its Integrated Performance Report but had no concrete timetable or plan for doing so.

Social Security Department

- 6.10 The Primary Care Governance Team produced an Annual Report that included JQIF measures and anonymised outcomes. However, due to agreement with GPs, no information at practice level was publicly available.

Community and Constitutional Affairs Department

- 6.11 In 'Future Jersey' published in March 2018, five priorities were identified for health and social care:

- improve healthy life expectancy;
- improve mental wellbeing;
- reduce obesity;
- reduce alcohol consumption; and
- reduce smoking.

- 6.12 A dedicated website has been set up to enable Islanders to see how policies and action plans across departments align to deliver these and to see progress against the priorities. The content though is in the early stages of development.

Decisions are based on up-to-date and complete information and good advice

- 6.13 I have considered arrangements in individual departments.

Health and Social Services Department

- 6.14 HSSD worked to develop an integrated approach to information management. From a low base, the Informatics Strategy sets out ambition to improve the quality, availability and use of hard data as a basis for decision making.

- 6.15 The strategies for Mental Health, Sustainable Primary Care and Acute Services all set out the need for improved information. The Mental Health Strategy recognised some of the priorities for high quality information, including the need to ensure high quality clinical coding and to secure integration across systems.

- 6.16 Establishing clear information sharing protocols between primary care, secondary care and external agencies is central to promoting effective decision making. The Digital Health Strategy for Jersey, launched in 2016, drove such information sharing and focussed on longer-term objectives of developing:

- the Jersey Care Record, a secure universal online record of health designed to improve access to records and interactions between health and care organisations, facilitating better decision making;
- the Jersey Health Database, designed to allow the sector to improve how care is planned, delivered and managed through population data analysis; and

- a local Digital Health supplier hub to promote local capability and eventually export Jersey's Digital Health innovation.

Social Security Department

- 6.17 Information from primary care had important roles in the strategies for Mental Health, Sustainable Primary Care and Acute Services and this is reflected in the JQIF. For example, one indicator of mental health activity in primary care was the extent of prescribing for certain mental health conditions.

The Service prepares a clear annual statement on the effectiveness of its risk management system

- 6.18 Effective risk management is an essential component of good governance. I have reported previously on the weaknesses in the States-wide arrangements and made recommendations for improvement in my report on *Risk Management* published in September 2017.
- 6.19 In this report I focus on specific aspects of arrangements with HSSD and the Social Security Department (SSD).

Health and Social Services Department

- 6.20 The Integrated Governance Committee (IGC) was designed to perform a key role in providing assurance on arrangements for risk management. However, for the reasons discussed in Section 4 above, I am not satisfied that the work of the IGC provided the required assurance, including the assurance required for the Accounting Officer to sign the Annual Governance Statement.
- 6.21 I have identified a particular gap in arrangements within the Community and Social Services Department (CSSD) (see Case Study 7).

Case Study 7: Risk management in CSSD

In my December 2015 report on *Community and Social Services*, I identified a number of issues with risk management in the division. I recommended that CSSD establish and monitor implementation of effective arrangements for reporting, evaluating, escalating and responding to risks.

CSSD accepted the recommendation and established a mechanism to measure and report on progress against recommendations from the report. It determined that each service area would be subject to a twice-yearly challenge of its risk register by senior management.

Challenge meetings were held in December 2015 and June 2016, but not subsequently. CSSD has set out plans to re-establish challenge meetings by mid 2018.

Social Security Department

- 6.22 I have found arrangements for risk management relating to primary care were inadequate:
- the Terms of Reference of the Joint HSSD/SSD Steering Group made it responsible for reviewing and agreeing plans for mitigating risks relating to primary care governance and joint HSSD/SSD projects. However, in March 2017 the Group agreed to refocus its work away from operational to strategic issues but its Terms of Reference were not changed;
 - following the March 2017 decision, the Group's risk register was rewritten with a number of risks closed and others recorded as 'on hold'. There is no evidence that management of these risks was assigned to another body or individual. The risks placed 'on hold' included a series of risks relating to dentistry. Subsequently, between August 2017 and January 2018, the Group discussed concerns about the governance of dental services but the risks remained 'on hold' in the risk register; and
 - inexplicably, the Group's risk register fell into disuse. The risk register provided to me for review in April 2018 had not been updated for thirteen months and included three red risks where the target date for mitigation had passed without the register being updated. At its April 2018 meeting the Group agreed to revive the risk register and review it at least quarterly.

Community and Constitutional Affairs Department

- 6.23 The approach to risk management within the Strategic Public Health Unit was embryonic. Whilst there was a risk register:
- the risks were very generic and all attributed to lack of capacity, knowledge and skills;
 - in at least one instance, the mitigation appeared unrelated to the stated risk;
 - the risk register was not routinely considered at the Unit's team meetings;
 - there were no targets or tolerances against which to monitor any of the mitigating actions identified; and
 - none of the risks in the Unit's risk register were reflected in the Community and Constitutional Affairs Department's risk register.

Recommendations

- R18** Extend the availability and scope of public performance reporting to increase the focus on the quality and outcome of health and care services, including performance against targets.
- R19** Establish robust mechanisms to validate performance information before publication in the Annual Report.

- R20** Extend the scope and nature of routine public reporting of the performance of all elements of health and social care, including through the States' website, taking into account performance reporting in other jurisdictions.
- R21** Establish structured arrangements for monitoring, validating and reporting of action taken in response to agreed recommendations arising from internal and external reviews.
- R22** Establish robust arrangements for the preparation, maintenance, review and challenge of risk registers relating to health and social care, including arrangements for escalation.

Developing the capacity and capability of those involved in governance

- 7.1 Good governance is dependent on the people responsible for governance. In this review I have focussed on how the involvement of people from across a wide cross-section of society was encouraged.
- 7.2 HSSD focussed on the opportunities for greater stakeholder engagement in its work to transform services. Steering groups for the major P.82/2012 workstreams included clinical professionals and representatives from the voluntary and independent sectors.
- 7.3 The proposed System Partnership Board would have involved a wider range of people in decision making. I am pleased that following the decision to withdraw the proposition to establish the Board, HSSD has looked at an alternative approach aimed at delivering the key benefits of wider involvement and engagement in decision making.
- 7.4 In March 2018 the Transition Plan Steering Group agreed the establishment of a Patient and Public Advisory Group. Work is being led by the Chief Executive of Citizen's Advice Jersey with the aim of new arrangements being in place by September 2018.

Conclusion

- 8.1 The governance arrangements for health and social care in place at May 2018 were inadequate. At an overall level they were overly complex for a relatively small health and social care system but at the same time poorly defined and communicated. In my view, the operation of groups without up-to-date Terms of Reference and without clarity to whom they report detracts from good governance.
- 8.2 In many respects the Integrated Governance Committee, that had key responsibilities for securing clinical governance, was not fit for purpose. It failed to develop a strategy and plans, failed to review its own Terms of Reference, did not oversee an effective clinical and care audit programme and did not take an effective role in monitoring the implementation of recommendations.
- 8.3 The fragmentation of responsibilities reflected silo working. Even if the three individual departments involved had managed their risks and resources well, without effective working across services, delivery of health and social care would not have been optimal.
- 8.4 Although the structural changes arising from the implementation of the Target Operating Model should simplify structures, there is much work to do to rationalise, clarify, communicate and implement the underlying governance structures going forward.
- 8.5 But good structures alone are not sufficient. Effective governance is dependent on a strong culture, driven by management, that promotes worthwhile change, encourages challenge and embraces learning. In health and social care it is essential that staff have the confidence to speak out knowing that colleagues will respect and welcome challenge. A consistent focus on making a learning, responsive culture a reality must be a top priority for management.
- 8.6 I am also concerned that:
- there has been insufficient impetus to implement independent regulation and inspection of all health and social care provision, including that provided by the States, as an essential means of securing quality and providing assurance;
 - proposals for structural change were developed without a clear, documented evaluation of current arrangements and without a clear trail from the analysis undertaken by the consultants to the proposal developed;
 - there has been insufficient focus on the development and operation of comprehensive systems to monitor the quality and outcomes of health and social care services;
 - there has been insufficient focus on the effective use of complaints and whistleblowing as tools of governance;
 - the availability and scope of public reporting of performance has been inadequate and on occasions reporting has been inaccurate;

- there has been insufficient focus on monitoring the implementation of agreed recommendations from internal and external reviews; and
- arrangements for the preparation, maintenance, review and challenge of risk registers relating to health and social care, a key tool of effective governance, have been inadequate.

8.7 I have made a number of recommendations, many of them fundamental in nature. Robust action is necessary to secure their implementation.

Appendix 1: Summary of Recommendations

Overall arrangements

- R1** Ensure that effective over-arching structures are in place to manage health and social care provision.
- R2** Review the effectiveness of and rationalise the current groups supporting the governance of health and social care, ensuring that they are fit for purpose and have up-to-date Terms of Reference and clear accountabilities.
- R3** Publish a timetable for the extension of independent regulation and inspection to all elements of health and social care, including services directly provided by the States.
- R4** Ensure that consultancy reviews leading to proposals for change include documented evaluations of alternatives against agreed criteria.
- R5** Thoroughly review the findings of the consultants that led to the proposal for the Strategic Partnership Board, determine actions in response and monitor their implementation.

Focussing on service objectives and on outcomes for citizens and users

- R6** Review and update documents setting out objectives for departments involved in health and social care in light of the new structures established under the Target Operating Model.
- R7** Adopt a clear timetable for the development of a Health and Wellbeing Framework for Jersey, supported by a work programme to deliver the Framework.
- R8** Develop a comprehensive, integrated approach to capturing and using patient views across all provision of health and social care.
- R9** Develop a comprehensive programme for improving performance reporting across health and social care, including securing data quality and adoption of meaningful targets.
- R10** Prioritise the development of benchmarking of the quality and outcomes of health and social care in Jersey against other jurisdictions.
- R11** Develop a plan for the rollout of Jersey Nursing Assessment and Accreditation System across all elements of health and care, including other publicly funded health and care providers, and monitor implementation.
- R12** Operate a structured approach to identifying and implementing efficiency savings across health and social care, ensuring that savings are identified before the commencement of the financial year.

Performing effectively in clearly defined functions and roles

- R13** Develop and implement a plan for robust oversight of governance of health and social care including:
- determining the appropriate groups, their membership, terms of reference and accountabilities;
 - developing underlying strategies and plans;
 - strengthening clinical and care audit and its oversight;
 - monitoring attendance at key governance groups;
 - ensuring engagement across health and social care; and
 - developing strengthened arrangements for engagement with community pharmacists, dentists and optometrists.

Promoting values of good governance and demonstrating these through behaviour

- R14** In developing new States-wide whistleblowing arrangements, reflect the statutory regulatory framework under the Regulation of Care (Jersey) Law 2014 and the obligations of health and care professionals to professional bodies.
- R15** Develop and implement mechanisms for measuring the impact of the 'OUR Values OUR Actions' initiative on culture and behaviours.
- R16** Develop public reporting on complaints, including their incidence, nature, handling (including speed of handling), resolution and learning.
- R17** Extend the requirement for reporting on complaints to all primary care providers.

Taking informed, transparent decisions

- R18** Extend the availability and scope of public performance reporting to increase the focus on the quality and outcome of health and care services, including performance against targets.
- R19** Establish robust mechanisms to validate performance information before publication in the Annual Report.
- R20** Extend the scope and nature of routine public reporting of the performance of all elements of health and social care, including through the States' website, taking into account performance reporting in other jurisdictions.
- R21** Establish structured arrangements for monitoring, validating and reporting of action taken in response to agreed recommendations arising from internal and external reviews.
- R22** Establish robust arrangements for the preparation, maintenance, review and challenge of risk registers relating to health and social care, including arrangements for escalation.



JERSEY AUDIT OFFICE

KAREN McCONNELL
COMPTROLLER and AUDITOR GENERAL

JERSEY AUDIT OFFICE, DE CARTERET HOUSE, 7 CASTLE STREET, ST HELIER, JERSEY JE2 3BT
T: 00 44 1534 716800 E: enquiries@jerseyauditoffice.je W: www.jerseyauditoffice.je