States of Jersey
States Assembly

États de Jersey
Assemblée des États

Public Accounts Committee

Governance of Health and Social Care Review

Witness: Professor Hugo Mascie-Taylor

Monday, 10th July 2023

Panel:

Deputy L.V. Feltham of St. Helier Central (Chair)

Deputy M.B. Andrews of St. Helier North (Vice-Chair)

Deputy T.A. Coles of St. Helier South

Deputy M.R. Le Hegarat of St. Helier North

Mr. G. Phipps

Witnesses:

Professor Hugo Mascie-Taylor, Interim Chair, Health and Community Services Board

Chris Bown, Chief Officer, Health and Community Services

[11:30]

Deputy L.V. Feltham of St. Helier Central (Chair):

Thank you. Hello, everybody, and welcome to this public hearing of the Public Accounts Committee. Today is Monday, 10th July 2023 and we are holding a public hearing with the interim Chair of the Health and Community Services Board as part of our review into governance of health and social care. I would like to draw everyone's attention to the following: this hearing will be filmed and streamed live, the recording and transcript will be published afterwards on the States Assembly website. All electronic devices including mobile phones should be switched to silent. I would ask that any members of the public who have joined us in the room today to not interfere in the proceedings and as soon as the hearing is closed please leave quietly. For the purposes of the recording and transcript, I would be grateful if everyone who speaks could state your name and role and also speak clearly. We will begin with introductions. I am Deputy Lyndsay Feltham and I am Chair of the Public Accounts Committee.

Deputy M.R. Le Hegarat of St. Helier North:

Deputy Mary Le Hegarat, District North St. Helier, member of the Public Accounts Committee.

Deputy M.B. Andrews of St. Helier North (Vice-Chair):

Deputy Max Andrews, I am the Vice-Chair of the Public Accounts Committee.

Deputy T.A. Coles of St. Helier South:

Deputy Tom Coles of St. Helier South, a member of the Public Accounts Committee.

Mr. G. Phipps:

I am Graeme Phipps and I am a lay-member of the P.A.C. (Public Accounts Committee).

Affiliate, Jersey Audit Office:

Ann Trudgeon, Jersey Audit Office.

Deputy L.V. Feltham:

The officers that we have present are ...?

Interim Chair, Health and Community Services Board:

Hugo Mascie-Taylor, I am the Interim Chair of the shadow board.

Chief Officer, Health and Community Services:

Chris Bown, Chief Officer, Health and Community Services.

Deputy L.V. Feltham:

Thank you. We have about an hour today, so we will get on with questions and I will hand over to Deputy Le Hegarat.

Deputy M.R. Le Hegarat:

The Committee notes that your report on Health and Community Services clinical governance arrangements within secondary care was published in August 2022. Please can you provide an overview of how this report has impacted the work of Health and Community Services since its publication?

Interim Chair, Health and Community Services Board:

Yes, I think it has undoubtedly triggered in Jersey a discussion/debate about the quality of services that are on offer to the people of Jersey. My observation would be that people take quite different

views of the report and so the feedback that I have received personally, some people have described it as extremely accurate and have welcomed it, and some people have been less enthusiastic and have criticised either its methodology or its contents. So I think one can say, yes, it has triggered debate. That has recently, most publicly, been focused on the issue of the board. But within the organisation the discussions are rather different. So Chris and I are working very closely together, particularly since he has been appointed as Accountable Officer, on beginning to move the organisation, and particular the execs, to a point where the board, when formed, will be able to meet in public, a crucial point, in public, and to provide an effective form of communication between the organisation and the people of Jersey. The meeting in public itself of course is insufficient. It is what data goes to that board and what discussions take place there. So there is movement externally around the formation of the board and I would be happy to enter into that debate if that is what you wish me to do. Internally, we are moving in the direction and behaving, beginning to behave as if we had a board in place. It would be fair to say that the executives are beginning to feel both the pressure of having a board, but at the same time the potential advantages of having a board with some authority. I pointed out to them that the real authority of the board will derive from consistent and enthusiastic support from Government and the Council of Ministers. So the board will be as effective as it is allowed to be, to put it another way.

Deputy M.R. Le Hegarat:

Following your appointment as the Chair of the new Health and Community Services Advisory Board, how did you establish the board's priorities for oversight of the governance arrangements within Health and Community Services?

Interim Chair, Health and Community Services Board:

I am establishing that and it will not be established until the board is formed. At the moment I am the only, in effect, non-executive. So it is not a matter only for me. Having said that, the priorities are self-evident and I would put among them clinical safety, the money and the people. That is usually where one starts in most organisations, certainly in healthcare organisations. If you look at the emerging agenda that is coming to the shadow board, I think that you would see that it reflected that. Indeed, this afternoon we have the second meeting of the shadow board and I hope that the minutes of the first meeting will be signed off and therefore can enter the public domain.

Deputy L.V. Feltham:

Can I just ask a question, because we heard in the hearing just before as well that the shadow board is already meeting.

Interim Chair, Health and Community Services Board:

It has met on one occasion and today will be the second occasion, when the minutes of the first meeting will be signed off.

Deputy L.V. Feltham:

Given that we do not have the non-exec directors, who is attending those meetings?

Interim Chair, Health and Community Services Board:

The executive directors. The change team are in attendance. The only person with any formal non-executive function is me. That is clearly not satisfactory but it is all that we have. The quicker that we get competent non-executives into place, the better.

Deputy L.V. Feltham:

What is the reason that the meetings that have been organised so far have not been public? Because you said it was the intention to have public meetings.

Interim Chair, Health and Community Services Board:

Because I have taken the view, but I would be delighted to debate it, that while we have only one non-executive that is probably premature. When the board is formed, it will immediately be in public. Frankly, I am also using the shadow board to begin to get the group of people, the senior managers, the executives in the organisation, to bring forward appropriate papers and speak to them appropriately at a board meeting. Because I think it is in everyone's interests, when we get to a public meeting, it is handled in a competent way. For some of the executives, this is a new experience, so we are using it to some extent as a decision-making body but to some extent as a coaching and training body. If you do see the minutes of the last meeting, you will see that is what I said to them. So, if you like, we are in this runup to the first public meeting, which I will hold when we have non-executives in place above and beyond myself. Of course I am Interim Chair, my appointments ends in mid-November.

Deputy M.R. Le Hegarat:

To what extent was the Minister for Health and Social Services and the Chief Officer of Health involved in the goal-setting priorities?

Interim Chair, Health and Community Services Board:

I have very regular meetings, both with Chris and with the Minister. I would say fully it genuinely works as a team. As I say, the priorities for the board of any hospital or healthcare organisation are the ones I have set out. So this is not particularly contentious. What is much more difficult is, given the problems that exist in all of those 3 areas, which I would rate as very substantial, then how do we move the organisation over a period of time. I think Suzanne Wylie said that is going to be a 4

or 5-year process. How do we get the organisation, if you like, fit for purpose in all of those important domains? So I do not think there is any difference at all between the Minister, Chris, and myself on what the objectives are, the overall strategic direction. I think the challenges that presents are very considerable and indeed I think it would be fair to say become more apparent to us almost by the day.

Deputy M.R. Le Hegarat:

What differences do you see in the roles of the turnaround team and the new Health Board and how will turnaround team finding be incorporated into the new board's initiatives?

Interim Chair, Health and Community Services Board:

They are quite different. The board, as a board, is designed to be set up and to continue into the future. It will operate as boards must at a more strategic level and to gain assurance and then transmit to the Minister and the people of Jersey. So its role is quite different from the turnaround team, which does not mean they do not work together, but the role is different. The turnaround team is time-limited and it is in really to support the exec directors rather than to actively itself manage as an exec director would. I am not sure that has worked entirely as planned for a number of reasons. One is that Chris has become the Accountable Officer, so in a sense now has a dual role. The second is that, in the absence of the organisation having a Finance Director and an H.R. (human resources) Director, then the people occupying those roles have a much more hands-on executive type role. Of course a further problem is that the Chief Nurse role is filled by an interim, who has not had previous experience. She is very good and trying very hard but the nurse we have is very actively supporting her exec director role and developing policies. So to some extent the relative weakness of the executive team, both structurally and in terms of the personalities or the people, through no fault of their own, is being supplemented, in my view, by the change team, to a point that alarms me. Because the change team are going to go at the end of the year. At that point, frankly, I think that team will be significantly weaker than it needs to be. The organisation as a matter of some urgency needs HR and Finance at the executive table.

Deputy M.R. Le Hegarat:

So you have not been replaced on the turnaround team?

Chief Officer, Health and Community Services:

No, and I think that was a sensible decision, one that I supported, because to lead the turnaround, particularly of the cultural turnaround, you need to do that from the top rather than advising from the sidelines. So in some ways, it does not feel like it sometimes, but it has made my job easier that I can directly get involved in and direct activity. But what Hugo was saying is that the capacity that we have to deliver this enormous agenda on all fronts with the existing exec team is being bolstered

by the change team. We will see them go at the end of the year. Probably just to mention while I am on this that often said, and certainly since my arrival, about too many managers in health, from politicians and members of the public it is the normal sort of cry. So I did a review and the paper is going to the States Employment Board on management capacity in H.C.S. (Health and Community Services). That will go to the end-of-July meeting of S.E.B. (the States Employment Board). I was hoping I could find some savings by doing that but I have not. Just to give you a sort of insight into that, and it is in the public domain because I think the Minister or Chief Minister had to answer a public question in the Assembly, that if you look at the ratio of staff to managers, it is about 1.7 per cent of the staff are what you would call managers. That is low. We are certainly not over-managed. It is low, particularly considering the agenda that we have to deliver over the next 5 years.

Deputy M.R. Le Hegarat:
Is that ratio based on numbers or does that include the fact that we are 400-and-something staff adrift?

Chief Officer, Health and Community Services:
That is based on numbers against the total establishment for H.C.S. and it is also based on the fact that of course, when you look, and I mentioned in my hearing, that the leadership does not only run H.C.S. in its operational sense, but delivers the intermediate tier function you will see in a larger jurisdiction. It also has a commissioning role. So we commission various on-Island services. We obviously have more complexity because of the off-Island work as regards to commissioning and financing and governance, and we are also of course involved in a major health facilities programme as a client.

[11:45]

So there are multiple activities that 1.7 per cent of the total workforce, if you look at, and it is notoriously difficult to benchmark, notoriously difficult, because each jurisdiction, different functions, different abilities, but if you look at the figures around the percentage of management that you would expect to see in U.K. (United Kingdom) organisations, businesses, et cetera, just over 9 per cent would be a typical number. So my review shows it is certainly not over-managed by any stretch and I think what Huge is saying is that, particularly considering the agenda over the next 5 years, that we will lack that capacity to deliver what is required if we do not do something about that. That is something the Minister for Health and Social Services is aware of and we are discussing with her.

Mr. G. Phipps:
So just to be clear, you are saying that your front line staff, nurses, direct contact, and then the numbers of supervisors, managers, layers beyond front line, is only 1.7 per cent?

Chief Officer, Health and Community Services:

Yes, so it depends on your definition of manager. So if you take out what I would call the clinical manager, so if you are the specialty manager or the clinical lead for dermatology, so you are a full-time consultant but you also run the dermatology services.

Mr. G. Phipps:

So you would count that as a front line?

Chief Officer, Health and Community Services:

Yes, I would. So the head of O.T. (Occupational Therapy) or Physio is basically a practising O.T. so I do not include those. But what I would include is the executive team, general management, so those that support the delivery and operational management of clinical services that are not employed as doctors and nurses. They might be, but they are not employed. Then what I call specialist managers, so things like health and safety, catering, estates, those numbers of executives, general management, and specialist managers are 1.7 per cent.

Mr. G. Phipps:

Thanks for clarifying that.

Interim Chair, Health and Community Services Board:

By any standards that would be a low figure anyway you look at it in any bits of the world I know. So there are fewer managers and the organisation is unquestionably under-managed. Among the managers who are clinicians, and my insight into that is limited, probably only to the most senior of them, they are the ones I interview when I was doing my report, but I think it would be fair to say that group of 5, when I did the report of the 7 most senior managers, 5 were consultants. There was in effect a Chief Executive, Chris's role, Accountable Officer, Chief Officer, there was a C.O.O. (Chief Operating Officer) and there were 5 chairs. When I talked with those, I was not convinced they understood that they had a general management accountability for safety or money or H.R. issues. So that the management, you could look at the management of the organisation in terms of the numbers, and in my view the numbers are very small, or in terms of the managerial capacity or the management, and in that case it is clearly lacking. The evidence for that is clear. The H.R. process is poor. The finance is not well controlled. The clinical safety was as I put it in my report. So that I think anybody coming and looking at the organisation would have to conclude this is an organisation that is not well managed. The responsibility for that, to be clear, sits with a great many people in the organisation. It also sits, to be blunt, with people outside the organisation, including the previous boards. You have to remember, there has been a lot of fuss made, and I understand why, about the board that I proposed. I did not propose that there should be a board for the first time. There

has been a board in Jersey for some years. In fact, the largest board I have ever seen. There were 3 assurance committees. I have never seen as many assurance committees. All of those 4 committees were all chaired by senior politicians. I do not know whether you have had the opportunity to go back over the minutes of those meetings but, if you do, I do not think you will find any evidence they provided assurance of anything. That is the issue here. So my proposal was not that the board should be new, there had been a board, my proposal is that it should be different. It should have on it non-executives who understand the nature of the business. Because, with the greatest of respect, it is very difficult for someone to come from a completely different world and ask the right questions at a board. In the same way I would not be competent to be chair of a board in most organisations because it is not my world. If you go back over the minutes of the previous boards and assurance committees, what I think you will conclude is what I concluded that these did not provide you, this place, Jersey, with any assurance at all about the quality of services, sadly.

Deputy M.R. Le Hegarat:
Finally from me, what are the K.P.I. (key performance indicator) performance measures and targets for this board and how does this ensure value for money from this board?

Interim Chair, Health and Community Services Board:
I do not think we are at that point yet. We are developing a board assurance framework that works in progress and that will need to marry up with the performance measures within the organisation and with the views of the Minister. But frankly I do not think I am at that point.

Mr. G. Phipps:
Will you have that in place at some stage?

Interim Chair, Health and Community Services Board:
Indeed, yes.

Mr. G. Phipps:
You mentioned the other boards not doing anything.

Interim Chair, Health and Community Services Board:
I did not quite say that. It did a lot. They talked a great deal to be fair.

Mr. G. Phipps:
Maybe the word “appropriate” was not quite in there. But to clarify so I do not get out of line too much with the past, but I think the public will want to see and understand and track the performance

of this board. So you are saying at some stage you will have indicators, performance, and demonstrate that this is clearly value for money or you will close the board down I suspect.

Interim Chair, Health and Community Services Board:
Yes, well I think if the view is it is not value for money, then it should be closed down. But I think to make the board work, as I have said, there is going to have to be a consistent and active support of politicians supporting the board and the board holding the organisation to account. It is not that the board stands alone. The board accounts back to the Minister.

Mr. G. Phipps:
I understand that part. I was more interested in tracking and understanding the performance. In other words, by having the board there, it is pretty evident that things are different than if the board was not there.

Interim Chair, Health and Community Services Board:
Sure, absolutely, and not only should the board have that, but that should be by and large, with a few exceptions that I am sure we would agree, in the public domain.

Deputy T.A. Coles:
So you have mentioned that obviously you have had your first meeting of your shadow board. Can you explain your process that you have gone through inducting new members of this advisory board?

Interim Chair, Health and Community Services Board:
As yet we do not have them. So I have prepared for that as best I could by developing a potential code of practice for non-execs to adopt. We will be and have prepared some briefing papers for incoming non-execs. The only other way in which I have been able to prepare non-execs is by persuading a number of people, quite a large number of people, to apply to be non-execs. So, in those conversations as to why those individuals might want to be a non-executive, I have clearly described in some detail the situation here and the contribution that I think they could make. This has been an important part of the recruitment because, given the rate of pay, I think it is fair to say that none of the people that one is likely to recruit to the board will be doing it for financial reasons. They are doing it for far more altruistic reasons. At the end of that bit of the process, which probably ended in January or February, the last time I talked to the recruitment agency we had had over 100 applicants and that was the last time that I was aware of the nature of those applicants because, as you will know, I have been excluded from that process. So I am not part of the appointment process of the non-execs and I am not up-to-date on it. But certainly at that point, had someone said to me: “No further process is required, you go ahead and appoint a board,” I am not suggesting that should have happened, but had it happened I could have appointed 2 or 3 good boards out of our applicants.

Deputy T.A. Coles:
I was referring more towards the executives, the people who you said earlier have not previously sat on a board.

Interim Chair, Health and Community Services Board:
How are we preparing them?

Deputy T.A. Coles:
Yes.

Interim Chair, Health and Community Services Board:
Well, that is a really good question, and Chris and I are working on this and trying to coach. So I am trying to behave, as odd as it might sound, as a variety of non-executives. So, as we go through the shadow board I am Chair, but I am also trying to play somebody with a finance background and somebody with an H.R. background and going through the papers and, as they will see this afternoon, picking out the pertinent questions that I think non-executives would answer, critiquing their papers, putting into place the process, and then the change team, and this is one of the reasons why the change team are at it, because they all do have considerable executive director experience. They will then coach them after the meeting. So I am trying to get that group of execs to a point where they will perform adequately at least in a public meeting. Having said that, at risk of repeating myself, in 2 big areas we do not have exec directors.

Chief Officer, Health and Community Services:
Just to add, I think the change team are invaluable in getting the executive to look at best practice for reviewing a number of the papers, for example, on quality performance, dashboards, the medical director who is part of the change team is helping with that. But the change team have considerable experience, decades of working on health boards, in the same way as I have, so that has been really helpful and it is about getting papers together that are useful and informative for the public to understand.

Interim Chair, Health and Community Services Board:
Between last time and this time, there has been a noticeable improvement in the quality of the board papers. They are still frankly not at the point where I would like them to go to a public meeting. So this is a developmental process, it will take time.

Deputy T.A. Coles:
How have the priorities and responsibilities been delegated to members of the new advisory board?

Interim Chair, Health and Community Services Board:
As regards the execs of the non-execs?

Deputy T.A. Coles:
Broadly.

Interim Chair, Health and Community Services Board:
The non-execs, until they are appointed, that cannot happen. As I have indicated, I really do not know who is going to be appointed. I hope that the people making the selection are cognisant of the need to have a variety of skills. So I hope that we will have somebody who is competent to chair an audit committee. I hope we will have someone who is competent to chair a quality and safety committee. I hope we will have someone with substantial H.R. knowledge, particularly of public sector and ideally of the management of healthcare professionals. So when I have seen the people at our collective disposal, I will allocate those tasks. We have 3 assurance committees at the moment. I am going to chair all of them. That is not the future. The future is that each of those will be chaired by a different non-exec. So there is one in money, one in people, and one on safety and quality. So I am very much hoping that the people making the selection will be cognisant of that and make the appropriate selection. Does that address your question or not?

Deputy T.A. Coles:
That is fine, thank you. The Committee notes that your report made 61 recommendations relating to clinical governance arrangements within secondary care in H.C.S. Please can you provide an overview of how these recommendations are being implemented?

Interim Chair, Health and Community Services Board:
Yes. I can, although, as you might expect of someone occupying my role, that is to a limited extent. My role is to assure myself that they are being implemented. So the way that is happening is that coming to the shadow board this afternoon will be the list of 61 recommendations and where people think they are with each of those. I shall be asking some questions this afternoon, so those that have been completed my question will be: “Okay, I am pleased it is completed, but how are we going to be assured about compliance?” With those that have yet to be completed, I will be gently pointing out the completion dates and for those that have not been started I will ask why. That is my role in this, is to move from someone who wrote a report, obviously I did my best to provide appropriate recommendations, and the role I am now in is to assure myself those are being put into place. My overall judgment of that is progress is being made but some of them are going to be very demanding because they involve, as I suspect Chris has told you earlier, really very substantial cultural change

and introducing to the organisation an understanding of the nature of accountability and the importance of measurement, the importance of transparency, is a very major challenge.

[12:00]

These are notions that were repeatedly rejected as I did my report. So, in interviewing people, there was in some quarters a lack of enthusiasm for the sort of measures that you see across the world that drive quality and safety. A good example, a specific example, would be some people felt that the clinical guidelines, these are guidelines put together by experts, which up until this point I thought every practising clinician welcomed, but I discovered was not the case. It was put to me by a number of people that they were not required in Jersey. They might be required elsewhere in the world but not in Jersey. The Senior Leadership Team that Chris has put together have said that the guidelines will be followed and that is coming this afternoon to the board for endorsement. So that is a specific example of progress being made. So my next question will be: "I am delighted we are going to adhere to clinical guidelines like everybody else. I would like to know now about how we are ensuring compliance with those guidelines." I am not convinced as yet that we have done sufficient work around compliance.

Deputy T.A. Coles:

I was quite staggered to find out that N.I.C.E. (National Institute for Health and Care Excellence) guidelines were not being followed over here myself to be honest.

Interim Chair, Health and Community Services Board:

So was I. Not only that they were not being followed, which is alarming in itself, but there was a very firmly held view that they were not required. That is even more alarming. It indicates to us all the distance that has to be made up. We put clinical guidelines into effect when I was Medical Director in Leeds in the early 1990s. So this is 30 years.

Chief Officer, Health and Community Services:

Just to say, some clinicians do follow and very much welcome them, but some do not. But perhaps the 30 years is probably quite a good timescale to indicate the challenge that we have. Because many people that I have spoken to that are relatively new to the Island, whether they be a physio or O.T. or a nurse, that have worked in the National Health Service, for example, often refer to, particularly if they are of a certain age: "This feels like it was 30 years ago." So this is why I am saying that the cultural change and the programme of transformation is not a year to change that sort of position.

Interim Chair, Health and Community Services Board:

To make the point again, and it will be noisy. That is why it requires robust and consistent political support.

Mr. G. Phipps:

Just one last follow up on that line. So you have these recommendations, you are staying on top to make sure they are implemented, then the next step would be to make sure that they are achieving what is intended to be achieved in your measurement targets. I presume you are going to be ensuring that is also in place so we can track and monitor and know when it is achieving what it is supposed to achieve, that kind of thing?

Interim Chair, Health and Community Services Board:

What we have to do, will do, is to assure ourselves that the guidelines are being complied with. You then have to make a bit of a leap of faith to say that, if you comply with these guidelines, the outcomes will improve. To measure those outcomes in a meaningful statistical way in a small organisation just would not be possible. So there is something about it that says, what analogy can I use, it is likely to be safer if we all drive at less than 70 miles an hour than if we drive at 120. But you cannot prove for an individual that it is safer. This is an act of faith, is it not, because these guidelines are based on best practice, put together by experts. So frankly I am completely confident that, if you follow the guidelines, then your practice improves and the organisation is safer.

Mr. G. Phipps:

So the performance indicator will be following the practices. That is as far as you can go. I understand that.

Deputy T.A. Coles:

So the last question from me is, how does the work with the new healthcare facility programme fit in with the role of the new board and what would you like it to have achieved in the next 12 months?

Interim Chair, Health and Community Services Board:

So far I have had no involvement whatsoever with the new healthcare facility. I have little doubt that when the board is formed then it will want to ask some questions about that facility. It is clearly a key development. As someone coming to the Island, it is surprising that, after this very prolonged period of time and expenditure of really substantial sums of money, there is not a spade in the ground. Now, how robust the process is in the planning, frankly I do not know. I am familiar with the process of building new hospitals and have been personally involved in building a number of them. In general, the process that works best is that you have a clear clinical strategy. Or, to put it another way, this is form follows function. So you need to decide very clearly what the healthcare strategy for the Island is and what bricks and mortar is required to support that strategy. If you do it

the other way around, and the bricks and mortar define your strategy, it is not likely to be a happy ending. So I think the board will want to engage with that type of discussion as to what is the function. Then you load on to that all the other things. So this is the function clinically, but then there are all the other things that matter, the workforce, the cost of it, its location, and all of those things, all of which will come into a discussion. But frankly I do not know how far it has progressed and I do not think I am confident therefore to comment on it beyond that which I have. But the new board will have a view.

Chief Officer, Health and Community Services:

Yes, and just to say, Chair, in fact this afternoon we have got a presentation for the new hospital facilities. I have attended a number since I was made Accountable Officer, a number of the multiple meetings that exist around this, and so I am increasingly becoming familiar. I think that Hugo's point around we do not have a clinical strategy for Jersey. I think probably the closest we came to it was the Jersey Care Model, which reflected the sorts of strategies that you would expect to see globally across the world, i.e. a shift left out of hospital, but we do not have that now. So we do need a clinical strategy and that does then need to define the workforce strategy and the digital strategy, et cetera. But we are where we are. We have buildings and we will need to in some ways retrofit that to the buildings that we are going to see developed. So nothing we can do about that, that is where we are, but there is a great deal of work for the board and for H.C.S. to look at the services that are provided. I have said a number of times, and I will say it again, I have seen, as Hugo will have seen across the world, some of the most internationally renowned high-quality services provided from the most appalling Victorian buildings that are more or less falling down. But I have equally seen shocking and unsafe services provided from the most glossy and shiny expensive buildings. So the issue for me is buildings are important of course, but it is the services that go in. So from the point of view we talk about the 5-year timescale around turnaround, which is back to 5 years that we are talking about in regard to the new part of at least the acute hospital, that we now need to put time in and indeed resource, these things do not happen with someone doing it over the weekend, and I know the Minister is very clear about this, into developing a strategy of which the board will play a clear role in supporting. So it is exciting but there is plenty to do and I think goes back to my point around the capacity. We should do it once well.

Interim Chair, Health and Community Services Board:

I absolutely agree with that. If we are given a selection of buildings or those that follow us are given a selection of buildings, then you will have to work out how you can provide safe and cost-effective services in them. There are some givens, the more sites you have, the more problems there are with safety and the higher the cost. You might say that is worth doing. That may be a legitimate decision. But you will have to work out what you do and where. We can start doing that work without a new building. That is Chris's point. For example, we can talk much more actively about what is

done in primary care and what is done in secondary care. In terms of clinical safety, what is done in secondary care and what is not done here. So a really important point in driving clinical safety. As Chris said, you can monitor patients, sick patients well in old buildings and you can monitor them very badly in new buildings, it is not determined by the building.

Deputy M.R. Le Hegarat:

Just quickly, either one of you, so therefore really we should not be deciding any of where our buildings are going to be until we have a strategy.

Interim Chair, Health and Community Services Board:

I would prefer to do it that way. But there is a political reality here. There has been a debate here for years about this. Therefore that indicates to me a propensity for inaction rather than action. What I would like to happen with the board is that it steers a course between making the very best of the situation without saying: "Let us throw the whole thing away and start all over again." So there is some pragmatism in this because, as both Chris and I are saying, you will never get to a situation where everybody has the secondary care facilities they want, it is never like that, you finish up with a set of buildings, hopefully of good quality, hopefully built in a way that is adaptable, and as services evolve over time, as they surely will, you keep retrofitting. So I really do not want to get in the way of building a new hospital. Enough people have done that enough of the time here. But I do want to start the discussion about, if this is the building we are going to have, then how do we provide services in it safely and efficiently.

Deputy M.R. Le Hegarat:

I have one controversial thing. Should we then have disbanded the Jersey Care Model with nothing to replace it?

Chief Officer, Health and Community Services:

I was not here when it was reviewed and so it is difficult to say. The debate we are having here is sadly one that should have happened 10 years ago around establishing the strategy. We can do that now. We should move ahead. We should start building something. We have waited too long. We clearly do need to replace the hospital facilities and it will be for the Minister and the board and the exec team and others to design services that make the most of the buildings that we have available to us. But the workforce plan is going to be critical because there will be duplication. If you are on more than one site there is duplication, as Hugo said, so we need to understand that. We need to understand the costs associated with that. The big challenge for us is, even if we had all the money in the world, the issue is about recruiting. So if we are going to have a radiology department on 2 sites, which we will, then we need the staffing, radiographers to staff 2 sites, not one. It is not the money in that respect, it is finding the people. So what we want to avoid is having

buildings and equipment that we cannot use because we do not have the staff. So the workforce plan is absolutely critical.

Deputy L.V. Feltham:
I am just concuss of time. Just to clarify it, because I think you will probably be aware that the scrutiny panel that is looking at the healthcare facility is picking up all those questions. But, just to clarify, you are the client in all of this. There has been a functional brief been drafting. So have you had any input?

Chief Officer, Health and Community Services:
Yes, there has been input into the functional brief, yes.

Deputy L.V. Feltham:
All right. We will leave that there for this Committee and then move on.

Mr. G. Phipps:
That is a great lead in because what I am going to talk about is the deployment of staff resources in Health and Community Services and the establishment of the project board to oversee this activity. This is a separate board. Who is responsible for this board? Who does this board report to?

[12:15]

Chief Officer, Health and Community Services:
This is a board, if it does exist I am not involved with it, but I do not know whether this was a board that was established by central Government. It is not one that I am involved with.

Interim Chair, Health and Community Services Board:
I know nothing about it I am afraid. That is alarming.

Mr. G. Phipps:
It is the establishment of a project board and I do not know, I think some of the members will be able to enlighten us more, to oversee the development of Health and Community Services of our People Strategy and Workforce Strategy, which was to be in place at the end of June, this board. I was assuming that it would report to you but these are questions.

Chief Officer, Health and Community Services:
Whether this is something that is being developed by Mark Grimley's team, I do not know, but I am not involved.

Interim Chair, Health and Community Services Board:

I think the best we can do is to take it, it is embarrassing, I do not know, you do not know, we will take it away and try to find out what it is.

Mr. G. Phipps:

I think I can defer all my questions. We will send them to you in writing for your responses.

Deputy L.V. Feltham:

We have a few question areas around follow-ups to previous recommendations. So I will hand over to Deputy Andrews.

Deputy M.B. Andrews:

Thank you, Chair. Thank you both for again attending today. Hugo, I would just like to ask a question in relation to the purpose of this board, which many Islanders have maybe be confused about mixed messaging in the media.

Interim Chair, Health and Community Services Board:

For me, the purpose of a board in any organisation is to lead the organisation and to be a key part of the line of accountability. So in the private sector that might be accountability to shareholders, or would be accountability to shareholders usually. In the public sector, it is accountability, one way or another, to politicians directly. So the line of accountability is for me the people of Jersey and the politicians who represent them, here the Council of Ministers and the Minister for Health and Social Services and the Chair and then from that point into the organisation. So the line of accountability that exists between the people of Jersey and the organisation flows that way. So Chief Exec, in effect, Chair, Minister, Council of Ministers and the Assembly, and crucially the people of Jersey. That is the role. Those are the roles so I would expect the non-executives to bring experience, I would expect them to be able to offer advice and support to executives. I would expect them to have a profile in the organisation. So there are a great many things that one might hope they would do and if I am still around I would try to make sure they did. But the key role and the difference between the board I propose and the previous board and assurance committees is that, and this is not just my view, they did not do that. They clearly tried in good faith. It is not a criticism of individuals. But they were set up and peopled in such a way that they were not competent to do that. That is the key role, which is accountability and transparency to the people of Jersey. There are many other roles we could talk about but that is the key.

Deputy M.B. Andrews:

I know several of my colleagues have touched on about there being executive members who you are currently working alongside. However, what arrangements will be in place for the non-executive members and what will their role be?

Interim Chair, Health and Community Services Board:

They are going to be taken on the basis of working up to 30 days a year. I would expect them to attend most, if not all, board meetings and to come prepared for those board meetings. Some of them will chair assurance committees. I suspect other roles will develop around appointments committees and that type of thing. Currently the suggestion is they will report twice a year to the Council of Ministers, so a kind of board to board meeting with the Council of Ministers. They will account through the Chair to the Minister on a very regular basis. Does that ...?

Deputy M.B. Andrews:

Yes, that does indeed. Also, looking at the terms and references, the opportunity to create subpanels or subcommittees, in what areas will those subcommittees be constituted and arranged?

Interim Chair, Health and Community Services Board:

That is a discussion I would want to have with non-execs when they come in. But there will be, by definition, an audit committee, there will be a remuneration committee I suspect. I would quite like to see a quality and safety committee. There needs to be a discussion about a people-type committee. Then I would like to do away with quite a lot of the committees. Jersey does not seem to me to be short of committees. Jersey is, at the risk of offending you, Jersey in my view is very strong on processes. It is less strong on driving outcomes. Key to the success of the board will be, going back to our earlier conversation, not ticking the box there is a policy in place, but is there compliance. Not, do we have nice guidelines, and we have all agreed it would be a nice thing to use them, but are they using them? If not, how are they being held to account? So there is a change of almost vocabulary here between I am not engaging with you and asking if you would like to do it, but ultimately this is an organisation that works for the people of Jersey, we are the board, and this is what will have to happen. So there is I think a shift, and this is the cultural shift, part of the cultural shift that Chris is talking about. An understanding, by not just the Chair of the board about that line of accountability, but every employee understanding that they account through that to the people of Jersey. Both when I did the review, and more recently Chris, have seen quite obvious examples of where people are confused about that. There is a strong feeling among some that the line of accountability should be reversed. So there are going to have to be some quite tricky conversations about that.

Deputy M.B. Andrews:

Of course you have informed the panel that your period in office is coming up in November. So when will we see the appointment of the non-executive positions?

Interim Chair, Health and Community Services Board:
That to some extent is out of my hands. I hope that the non-executive appointment process is continuing and continuing successfully. As I said, we had 100 applicants, so we should get to a competent group of non-execs. The next step will be to have the appointment of a new Chair and that should, in my view, be a public appointment. That needs to take place hopefully, preferably, so that when I go somebody is there to pick up the role.

Deputy M.B. Andrews:
Thank you very much, Hugo. Thank you, Chair.

Deputy L.V. Feltham:
We are going to have just a few questions related to the Health and Community Services 2022 overspend. The Committee notes that H.C.S. reported an overspend in 2022. So what oversight does the new advisory board have over financial management or will it have over financial management of Health and Community Services?

Interim Chair, Health and Community Services Board:
Ultimately, the board will be accountable for the finances of the organisation and simply accountable for all other aspects of the organisation. So currently I am taking an interest in the recovery plan. That will be discussed this afternoon at the board. I will be asking people like Chris what degree of confidence do you have. We have KPMG in as you know and they are going to help the organisation work through what I think is a fairly standard list.

Chief Officer, Health and Community Services:
Yes, this is the basic assessment and drivers of the deficit that I mentioned at a previous hearing.

Interim Chair, Health and Community Services Board:
So let us say we have a board in place in the autumn and I would expect at that meeting a very clear presentation, I would love it to be from a finance director, but in the absence of a finance director, the board will know at its first meeting where the organisation stands financially.

Deputy L.V. Feltham:
You have mentioned several time in this hearing that there is a lack of a finance director and an H.R. director. But you do have finance and H.R. business partners in the centre of Government. So how do they relate to the board and how do they work with the board?

Interim Chair, Health and Community Services Board:

Again I think that is for discussion. But my view is that the organisation should have somebody at the executive table who is leading on H.R. and leading on finance. But whether you want to call them finance director or H.R. director seems to be politically sensitive and there is a debate in Jersey about what you hold centrally and what you hold in an organisation. I need to be clear about it, I would like to see H.C.S. have a finance director and H.R. director and then that would encourage the quality of applicants that we would want to see occupy those roles. Whether or not that is possible in Jersey, which is a small jurisdiction, I am not certain, because I understand that there are complexities almost introduced by the lack of size. But there are discussions going on about both H.R. and about finance. But at least it will produce, I am confident, a stronger finance and H.R. presence, whatever the label is. Is that fair?

Chief Officer, Health and Community Services:

It is and just to say that the business partners, we have a vacancy for the finance business partner, but the H.R. business partner sits in my Senior Leadership Team and Executive Team and there is a vacancy at the moment in finance. So we are integrating those 2 people into my team. But of course they are not accountable to me, they are accountable to their Chief Officers in other departments.

Interim Chair, Health and Community Services Board:

That creates some difficulties. At the moment both of those functions are far more robust than they have been for a long time because of the change team. So, as I said to you, the change team are not able to adopt a straightforward support or mentoring role. They are performing those functions to some extent.

Deputy L.V. Feltham:

We have lots of questions now, I am sure we will follow them up perhaps with another hearing. I am just thinking through what you have told us today in relation to the skillset that currently exists within the executive team and maybe some of the gap that is being filled with the change team and then the non-executive directors. Again, one of the questions that the public ask is why do we need a board? Why are the senior managers that are already there not filling the function? Would we ever get to a place in your view, or is there an aim to get to a place where we have fully-functioning executive directors who could fulfil the role of the board?

Interim Chair, Health and Community Services Board:

I would not choose to move in that direction because this is the only healthcare organisation that I know of, and I clearly know the U.K. system well, I know a fair amount about Australia and New

Zealand, and I do not know of another place that does not have a board with non-execs. I do not know of private sector businesses by and large, but there clearly are exceptions. So it seems to me that this notion of a board with independent and knowledgeable non-execs is one that has been around now for literally centuries. It applies to all organisations across the world. The N.H.S. (National Health Service) came to it fairly late, in the late-1980s and early-1990s, and I do not see why in Jersey one would not want to do what everybody else does. One of the things that I encounter here, and again I recognise the risk of appearing rude, I do not want to do that, but I have had so many conversations here, which follow a formula of, "Why do you not do this here, everybody else does it?" and the answer is, "Well this is Jersey." As if that were a sufficient reason. I suppose my challenge to it is always, "Just because it is Jersey does not mean you do not have to do it. You have to have a better reason for not doing something." Plagiarism is an honourable idea. If everyone else does it that way, because that is what drives safety and quality everywhere else in the world, then why do you not just do it? It does not need a new debate in my view.

Chief Officer, Health and Community Services:

I think I would support that. I have never, I have been a healthcare executive for longer than I wish to remember. I have never not been accountable to a board, ever. As a chief executive I was accountable to a chairman, be it statutory boards with complete authority.

[12:30]

But as an executive director, and this is going back early-1990s, and certainly anyone coming to take this role would expect to be accountable to a board. It is not about the relative weakness of executive teams. This is about a unitary board that is made up of executive and non-executive, so some of the most high-performing health organisations in the world will have highly experienced and strong executives, but you always have a non-executive that holds those executives to account, brings skills to the board, provides support to the executive team, to the organisation. So I think sometimes we are conflating the change team, executive team, and board. A board really, for me, the most effective board is a unitary board with executives and non-executives. So I would say that the board, you need that for ever, it is not about the relative quality or not of executives. It is the way you run effective healthcare.

Interim Chair, Health and Community Services Board:

Everyone should surely be accountable, so that is why when you said we are running out of time, I said I would genuinely be pleased to come back. I should be held to account. We should all be held to account. The executives should be held to account by the non-executives.

Mr. G. Phipps:

The board ultimately will demonstrate through its actions as an effective board that Jersey is better off by having that board in place. So there will be actions that will occur through the input from that board if it is effective that would not have happened if they were not in place, as in every other board we are on. As the P.A.C. we have to also be accountable ourselves. We should make a difference or we are wasting our time.

Interim Chair, Health and Community Services Board:

Just to make the point, actions have occurred as a result of processes that we have started. So the one that we have been quoting today is N.I.C.E. guidelines. But other actions have occurred. Other policies are being put into place before we even have a formed and functioning board. But that, as I keep saying, will require consistent support from politicians who understand the nature of this model. They account to the people. I and the non-execs account to the Minister. The execs account to the non-execs. Everyone in the organisation, and this is the cultural change, have to understand they are accountable. At the moment, frankly, there is not a great deal of evidence that they do.

Deputy L.V. Feltham:

Did you have one further question?

Deputy M.R. Le Hegarat:

Yes, I do. This goes back, I always have something in the back of my head. Therefore, having had this discussion this morning, do you believe that as an Island our healthcare facility, whatever that is, should be part of an outside inspection process?

Chief Officer, Health and Community Services:

So like a Jersey Care Commission? Yes, absolutely.

Interim Chair, Health and Community Services Board:

I think it is not just a single body. It should be benchmarked, another function of the board, so when figures start to emerge out of the board in the public domain, wherever possible they should be benchmarked against the performance of other organisations. One of the reasons why I said, and I hope I was clear about this, I do not think there is any assurance, is because there is a paucity of benchmarked data. I just do not know how the organisation performs. That is, for me, pretty worrying.

Deputy L.V. Feltham:

I am sure worrying for the public as well. On that note, we have come to the end of our time. We will see you again I am sure as part of this review. But thank you for your time today and thank you to the officers that have supported and I will bring this hearing to a close.

[12:34]