P.2019/3

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

HEALTH AND CARE REGULATION IN THE BAILIWICK

The States are asked to decide:

Whether, after consideration of the Policy Letter entitled 'Health and Care Regulation in the Bailiwick', dated 7th January 2019, they are of the opinion:

1. To agree that there should be a phased establishment of a structured, independent and proportionate statutory regulatory regime of health and care for the Bailiwick of Guernsey, which includes the following elements:

   a) a regulatory regime overseen by an independent Commission;
   b) provisions of the existing Regulation of Health Professions (Enabling Provisions) (Guernsey) Law, 2012 (which would be repealed and replaced); and appropriate provisions to save the effect of Ordinances and subordinate legislation made under or referred to in that Law or otherwise relating to the medical and health professions;
   c) Ordinances and other subordinate legislation to regulate persons, premises and systems involved in providing health and care services within the Bailiwick; and
   d) consultation with the relevant committees of the States of Alderney and the Chief Pleas of Sark, as appropriate;

2. To agree that the regulatory regime of health and care for the Bailiwick of Guernsey shall be implemented by and under a Bailiwick-wide enabling Law;

3. To direct the Committee *for* Health & Social Care to begin work on a prioritised programme to develop regulatory standards and/or identify designated accreditation schemes for health and care services as appropriate, in consultation with providers, service users and other relevant stakeholders;

4. To agree that the Committee is to report back to the States in due course with proposals to direct the preparation of Ordinances made under a general

enabling Law to give effect to regulatory standards and designated accreditation schemes in respect of particular services, and to otherwise regulate these services (persons, premises and systems as appropriate);

5. To agree that all reasonable opportunities should be pursued to achieve a joint Commission with Jersey;

6. To agree that the Commission should be established by the Committee *for* Health & Social Care on a 'shadow' basis until it is fully constituted in law, and to direct the Policy & Resources Committee to take account of the costs of operating the Commission when recommending Cash Limits for the Committee *for* Health & Social Care for 2020 and subsequent years;

7. To rescind the resolutions from Article XI of Billet d'État XX 2007 in respect of Residential and Nursing Homes and to direct the Committee *for* Health & Social Care to establish suitable and effective regulatory standards for care homes and care agencies under the Law described in Proposition 1 pursuant to its prioritised programme of work; and

8. To direct the preparation of such legislation as may be necessary to give effect to the above Propositions.

The above Propositions have been submitted to Her Majesty's Procureur for advice on any legal or constitutional implications in accordance with Rule 4(1) of the Rules of Procedure of the States of Deliberation and their Committees.

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

HEALTH AND CARE REGULATION IN THE BAILIWICK

The Presiding Officer
States of Guernsey
Royal Court House
St Peter Port

7th January, 2019

Dear Sir

1. Executive Summary

1.1 People who use health and care services[1] within the Bailiwick of Guernsey – at home or in a care home, in a hospital or at their GP surgery, at the opticians or the dentist, or anywhere else they may receive treatment or care – should reasonably expect to be kept safe and free from avoidable harm. Through sensible and proportionate regulation of health and care providers[2] it is possible to support all islanders in receiving treatment and care of the best quality that the Bailiwick can offer.

[1] "Health and care services" is a term given in this document which includes "Health Care" and "Social Care". Health Care includes all forms of health care (including nursing care) provided to individuals whether relating to physical or mental health, and also includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition". Social Care includes all forms of personal care and other practical assistance, and all forms of personal support, provided for individuals who by reason of their age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or by any other reason, are in need of such care, assistance or support. Nursing Care means services that, by reason of their nature or circumstances, including the need for clinical judgement, should be provided by a nurse, including – (a) providing care; (b) assessing, planning and evaluating care needs or the provision of care; and (c) supervising or delegating the provision of care. Personal care means assistance in daily living that does not need to be provided by a nurse, being – (a) practical assistance with daily tasks such as eating, washing or dressing; or (b) prompting a person to perform daily tasks. Personal support includes supervision, guidance, counselling (other than counselling that is health care) and other support in daily living that is provided to an individual as part of a programme of such support.

[2] "Provider" means the person or organisation that operates a health or care service (effectively the business owner).

1.2 The single most important thing for Islanders is receiving the service that they need. Regulation must not stifle service provision by tying it up in bureaucracy nor make practitioners so wary of punishment that they are afraid to try anything new or engage positively with those who may be responsible for investigating incidents or practices that may be a cause for concern.

1.3 People who use services need to know what they can expect, and providers of services know what is expected of them. It is vital that regulation works to promote quality and minimise harm within the health and care system, that regulators can take action to prevent things from going wrong, and step in to address concerns or make changes where needed, and that it strengthens patient and public trust in health and care services.

1.4 The Committee *for* Health & Social Care ("the Committee") in its Partnership of Purpose Policy Letter (Billet d'État XXIV of 2017), committed to *"improving health outcomes through effective commissioning and independent regulation"* and is determined to develop a system of health and care regulation for the Bailiwick that is proportionate and fair. The development of comprehensive regulation for health and care is part of the 'H&SC Regulatory & Support Policy' priority of the Policy & Resource Plan. To support this, the Committee commissioned Professor Dickon Weir-Hughes to work with its staff to review options for health and care regulation based on different systems around the world.

1.5 The approach recommended by Professor Weir-Hughes would, in his opinion, allow the Bailiwick to become a world leader in terms of regulating health and care. The Committee endorsed his report (which can be found in Appendix 1) and its officers have worked these proposals into a more detailed set of recommendations, as set out in this Policy Letter.

1.6 Professor Weir-Hughes's report recognised that Guernsey need not reinvent the wheel when it comes to setting standards for health and care services. There are a whole range of internationally-accepted schemes for evaluating and accrediting best practice among various services, such as the CHKS scheme already used among Primary care practices; the Royal College of Psychiatrists' Accreditation Scheme used for mental health services; or the Magnet® recognition scheme for acute and community nursing.

1.7 The Committee will identify best practice evaluation and accreditation schemes for each service and profession to be regulated in Guernsey. The schemes which it thinks are a good fit for Guernsey and will deliver the quality care expected, will be established as 'designated accreditation schemes' through Ordinances or subordinate[3] legislation. Providers will be required to sign up to the scheme and keep their accreditation up-to-date. This closely reflects the process already in place for nurses, doctors and other allied health professionals, who are required to be registered with their professional body in the UK in order to be registered to practice in Guernsey.

1.8 The Committee will choose proven and effective recognition schemes from around the world – schemes which set high quality standards for providers and schemes which are backed by evidence demonstrating that they really do improve performance among those who use them.

1.9 In some instances, however, there may not be a ready-made scheme that is a good fit for Guernsey, or the schemes that exist may require some adaptation. Where this is the case, the Committee will be able to set its own regulatory standards.

1.10 There will be an independent Commission which is responsible for the regulation of health and care across the Bailiwick. The Commission's role and powers will be defined under an Enabling Law. Putting the Commission on a statutory footing helps to ensure that it is able to do its job without inappropriate political interference and, where necessary, equally holding public sector and private sector health and care providers to account.

1.11 The model is sufficiently similar to that in Jersey that the two Bailiwicks should be able to share resources and support each other – perhaps ultimately moving to a single Channel Islands regulator. There is renewed enthusiasm for this approach following the 2018 General Election in Jersey, and other senior officers in both islands are exploring how this could be done.

1.12 The Commission's role will principally involve monitoring providers' compliance with standards and schemes, rather than active inspections of providers. However, the Commission will have the power to step in and investigate, or take regulatory action, if it has reason to believe that a provider is not

[3] For the avoidance of doubt, subordinate legislation includes Regulations made by the Committee *for* Health & Social Care

complying with required standards or schemes. This would happen, for example, if an accreditation process highlighted concerns about their practice, or if the Commission became aware of concerns from other sources.

1.13 The health and care services to be regulated by the Commission are very diverse, and staffing the Commission with experts from every area would result in a very large team. However, this would be disproportionate to the size of the Bailiwick and its health and care services, and would result in the team being severely under-utilised for most of the year. Instead, it is proposed that the Commission should have only a small core, permanent staff, with the ability to draw on agreed external expertise to support investigations into different areas, where needed.

1.14 As in Jersey, it is proposed that the new regulatory regime will be introduced gradually. Through this Policy Letter, the Committee is seeking the States' approval to draft a new Enabling Law (similar in scope to the Regulation of Care (Jersey) Law 2014[4]) which will establish the general scope of health and care services regulation and allow the Commission to be formed. In order to regulate health and care services holistically, this Enabling Law should incorporate the provisions of the Regulation of Health Professions (Enabling Provisions) (Guernsey) Law, 2012, which should be consequentially repealed.

1.15 Enforcement powers of the Commission, such as improvement notices, enforcement notices and fines, will also be introduced on a gradual basis, following consultation. Standards, schemes and sanctions alike will be introduced through Ordinances and subordinate legislation.

1.16 The Committee will introduce designated accreditation schemes or regulatory standards on a priority basis – beginning with the areas of highest risk (which are not currently regulated) – after consultation with the new Commission and those affected. Based on its analysis of risks, the Committee considers that the first area for which regulation should be developed include the unregistered workforce (that is, healthcare assistants and carers who look after people within their own home) and acute hospital services. Other areas of concern are health care premises, including hospitals and dental surgeries; psychotherapists, counsellors and alternative therapists; and those providing clinical cosmetic procedures. In each case a key consideration for the

[4] https://www.jerseylaw.je/laws/revised/Pages/20.820.aspx

Committee is the level of risk posed to vulnerable people if these services are not regulated.

1.17 These priorities should be seen in the context that some of the highest risk services and professions such as doctors, nurses, pharmacists, care home providers and others – are already regulated by their respective professional bodies (e.g. the General Medical Council, Nursing and Midwifery Council and the General Pharmaceutical Council) and/or within extant local legislation. It should be noted that where effective statutory professional regulation already exists, this system will not add another layer of bureaucracy, as the existing statutory regulation will where possible simply be brought under the auspices of the new Enabling Law.

1.18 In some cases, although there is statutory regulation already in place, the existing regime is inadequate and needs to be strengthened. This is especially true of the regulation around residential and nursing care homes, where the current regime lacks any statutory powers of enforcement. In developing this new comprehensive regulation system, the Committee recommends replacing those areas of local law with provisions made under the new Enabling Law.

1.19 The Committee hopes that the drafting of the new Enabling Law and proposals for Ordinances under it will commence in 2019. This will include working up a detailed operational plan and consulting with health and care providers in respect of fees and charges: as with most regulators, it is anticipated that the Commission will raise a proportion of its income from a States' grant and the remainder from regulated services. This will enable the Committee to include a full funding request in respect of the Commission in its 2020 Budget submission, with a view to establishing the Commission from, or as soon as possible after, 1 January 2020.[5]

1.20 The Committee is mindful that the cost of regulation, like its scope, must also be proportionate to a small Island community, and has included anticipated figures in this Policy Letter based on the most up-to-date information available to it. These figures will be finalised in the course of 2019.

[5] The Commission may initially be established in 'shadow' form, until the relevant parts of the new Enabling Law and subordinate legislation come into force. This is discussed further in the body of the Policy Letter.

1.21 The Committee believes that the overall cost of the Commission will be £368,000 per annum. This will not all be new expenditure: for example, HSC already employs an Inspections Officer and a Registrations Officer to oversee nursing and residential care homes – roles which could be incorporated into the Commission in due course. After factoring in these existing costs the additional cost of Regulation of Health and Care is estimated to be £272,000 per annum. Some of this cost will be offset by fees from regulated providers, such as the £78,000 per annum already collected from care homes. It is proposed that the current fees and charges will be revised and will include other providers of health and care services, after prior consultation with the relevant stakeholders.

1.22 The approach to regulation set out in this Policy Letter is consistent with the core principles of the Partnership of Purpose for health and care – **user centred care**, where people are valued and listened to; **proportionate governance** with clear boundaries between provision and regulation; a **focus on quality**, understanding the impact of services on health outcomes, patient safety and patient experience; and a **partnership approach** which recognises the value of public, private and third sector organisations in meeting the Bailiwick's health and care needs.

2. Regulation in the Bailiwick – What do we have now?

2.1 Regulation in Guernsey, as in many other places, has developed gradually over many years – a combination of reflecting developments in the United Kingdom and responding to local circumstances with proactive initiatives, including both statutory and voluntary regulation.

2.2 Over recent years, the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) have called on the Bailiwick to build on these foundations and introduce a full independent and robust regulatory regime. The implementation of a new Target Operating Model for health and care in the Islands, through the Partnership of Purpose, provides an opportunity for the Committee to do so, with a regime which is proportionate to the size, resources and requirements of the Bailiwick.

2.3 The UK, especially England, has one of the most complex health and care regulatory frameworks in the world. There is even a regulator of regulators, the Professional Standards Authority for Health and Social Care. Replicating this

web of regulation in a small island community would not be possible, desirable or proportionate. For this reason, this Policy Letter explores regulatory solutions that look far beyond the shores of the UK, aiming to put the Bailiwick in a position where Islanders benefit from a complete, proportionate and world-class system of protection from harm.

Types of Regulation

2.4 Statutory regulation of health and care in other jurisdictions normally takes two distinct forms: systems regulation and professional regulation. Health Inspectorate Wales is a systems regulator, which protects the public by regulating all healthcare facilities and services in the Welsh health system. The NMC is a professional regulator, which protects the public by regulating all members of the nursing and midwifery professions in the UK and the Crown dependencies.

2.5 A small number of statutory regulators have legislation that enables them to protect the public by regulating both systems and professionals. An example of this type of integrated regulator would be the General Pharmaceutical Council, which regulates pharmacists, pharmacy technicians, pharmacy premises and pharmacy training facilities in Great Britain. There is an emerging view amongst regulators worldwide that the public could benefit from more integrated regulation of this type and this is a recommendation of the (UK) Professional Standards Authority for Health and Social Care.

Systems regulation in Guernsey

2.6 In Guernsey, some statutory systems of regulation currently exist for community pharmacies, private nursing and residential homes and pharmaceutical manufacturing and wholesaling. There is also a regulatory regime in respect of children's nurseries and early years services, although that is outside the scope of this Policy Letter.

2.7 Community pharmacies, for example, are regulated by the Chief Pharmacist, whose role is defined in the Medicines (Human and Veterinary) (Bailiwick of Guernsey) Law, 2008, and who has extensive inspection and enforcement powers in respect of the safety of drugs and medicines. In terms of the misuse of drugs, this is a matter for criminal law. The Regulator would only become involved in terms of situations where a health and care professional's fitness to

practise was called into question as a result of the misuse of drugs. This investigation would be separate to any criminal proceedings.

2.8 The Nursing Homes and Residential Homes (Guernsey) Law, 1976, establishes a regime of registration and inspection for local care homes. However, the regime lacks meaningful regulatory powers to improve services or enforce sanctions where needed. The weakness of this regime has been of concern to successive States, with resolutions in 2007 directing the (then) Health and Social Services Department to bring this more in line with modern regulatory standards. This Policy Letter aims to discharge those resolutions.

2.9 There are also a range of regulatory powers attached to the Medical Officer of Health role, mostly related to hygiene and infectious diseases. This is a role which the States agreed to disband in December 2017, and the Committee is carrying out a review of relevant legislation to ensure that any important powers are transferred to other officers. The majority of those powers are likely to go to the Director of Public Health, Medical Director or Office of Environmental Health & Pollution Regulation – however, if the review identifies powers which fit best within a comprehensive approach to the regulation of health and care, those may be translated into regulatory standards and powers under this new regime.

2.10 In addition to the existing statutory regimes, there have also been some positive steps in respect of voluntary accreditation locally, such as the adoption of CHKS by local primary care (GP) practices. However, there are a number of forms of health and social care provision which are not covered by any form of regulation in Guernsey, including (but not exclusively):

- Advertisements for services[6];
- Agencies;
- Chiropody & Podiatry practices;
- Dental practices;
- Psychotherapy and Counselling Practices;
- Physiotherapy Practices; and
- A number of States of Guernsey provided services.

[6] With the exception of medicines and pharmacies, which are regulated under the Medicines Law 2008 in respect of advertisement, and use of titles or false representations as various medical or health professionals.

Professional regulation in Guernsey

2.11 In terms of professional regulation, the following regulatory bodies are among those that regulate individual care practitioners in Guernsey:

- General Chiropractic Council (GCC);
- General Dental Council (GDC);
- General Medical Council (GMC);
- General Optical Council (GOC);
- General Osteopathic Council (GOsC);
- General Pharmaceutical Council;
- Health and Care Professions Council (HCPC)[7];
- Nursing and Midwifery Council (NMC).

2.12 Current Bailiwick legislation generally does not set out separate regulatory regimes for health professionals, but instead requires them to be registered with their professional body in the UK before they are allowed to practice in the Bailiwick. Judgments made by these UK bodies (such as whether a professional should be suspended from practice or struck off the register altogether) also have effect in Guernsey or in Alderney or Sark as the case may be.

2.13 The process for registration of doctors has recently been strengthened by the introduction of "revalidation" – a scheme created by the GMC to assess doctors' ongoing fitness to practise. To support this approach, the role of the Responsible Officer was created under the Regulation of Health Professions (Medical Practitioners) (Guernsey and Alderney) Ordinance, 2015. This role is held by a senior doctor and is responsible for overseeing and making recommendations about local doctors' fitness to practise. There is a further layer of oversight by the Registration Panel, which has a responsibility to review decisions made by the Responsible Officer where necessary. The Nursing and Midwifery Council also carries out revalidation on registered nurses and midwives.

[7] Health and Care Professions Council (HCPC) regulates: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England (due to change to Social Work England in 2018/19) and speech and language therapists.

2.14 The following practitioners are not regulated in Guernsey:

- Aesthetics (although some are regulated by GDC, GMC or NMC, this is not statutory);
- Carers working for care agencies and domiciliary/residential support workers;
- Complementary Therapists (e.g. Sports Injury and Rehabilitation, Acupuncture, Hypnotherapy, Herbal, Homeopathy, Bowen therapists or 'Bonesetters');
- New 'professions'[8];
- Psychotherapists and counsellors; and
- Visiting services (by various private providers).

2.15 While health and care professionals within the Bailiwick are well-regulated by their UK regulatory bodies where these exist, there are acknowledged gaps and inconsistencies there, too. In the UK, for example, dental assistants (who rarely work unsupervised by a dentist) are regulated, whereas care support workers (many of whom work alone in the community with vulnerable people) are unregulated. This mismatch of regulation and risk is replicated in Guernsey at present.

A fragmented and deficient system

2.16 While some services and professions are well-regulated, the overall approach to regulation locally is fragmented and complex. There are significant gaps where services may operate without any monitoring of their safety, standards or quality of care. These are also instances where regulation does exist, for example in respect of residential and nursing homes, but the framework has become out of date, and does not reflect modern regulatory good practice or the renewed emphasis on proactive encouragement of incremental improvement.

2.17 Some concerning deficiencies in the current system include:-

[8] New professions are new roles and professions which develop as the health and care sector evolves its scientific knowledge, understanding and practice. New professions can also evolve through reorganisation of health and care economies.

- **The absence of regulation for the domiciliary care agency system (home care sector)**

  There is no legal requirement for agencies which provide care in people's own homes to ensure that their workers are trained or even police checked. This means that care may be provided without any oversight in place to ensure that staff are safe, competent and suitable to provide care.

  People receiving care at home are especially vulnerable: not just for reasons connected directly to their health or care needs but also because they can be tremendously isolated behind their front door. This makes it all the more urgent to establish a regulatory framework for health care support workers and nursing assistants with suitable quality standards which will also reduce opportunities for individuals without the necessary skillset to move between employers undetected.

- **The absence of regulation for the majority of States of Guernsey services**

  Most States-operated services are not regulated, although many of the professionals working within them are. While the Committee strives to deliver high quality services and ensure appropriate clinical governance arrangements are in place, the lack of independent standards and oversight is a risk. This lack is felt especially keenly when things go wrong, as they inevitably do from time to time.

  In addition, the Committee wishes to establish a genuine partnership approach across the health and care system and it is an act of good faith to demonstrate that its own services will be subject to the same level of independent scrutiny as those provided by others. The States has already resolved in debate on the Committee's Partnership of Purpose Policy Letter that health and care services and facilities provided directly by the States (such as Hospital Services, Community Services and Children's Services) should be subject to clear Service Standards and inclusion in the regulatory regime would support this.

- **Lack of flexibility to respond to evolutions in health care provision**

  Health and care services evolve gradually. From time to time, new roles are defined and new activities become routine. Current regulatory standards

have developed slowly and do not have the flexibility to adapt as services change. A modern regulatory framework would allow the States to introduce clear definitions for regulated activities as these emerge and to put in place tailored care standards reflecting Island life as the need arises.

- **Insufficient emphasis on safeguarding**

  All care providers have a role to play in ensuring that their servicer users are safe and protected from abuse or exploitation. However, there is little statutory requirement to safeguard adults from harm or abuse at present. Although there are multi-agency safeguarding arrangements already in place, a modern regulatory regime would help to ensure that all providers have robust procedures in place to support those arrangements.

- **Lack of regulatory independence**

  The various regulatory functions created under existing Guernsey legislation are currently discharged through the Office *of the* Committee *for* Health & Social Care, which also has a role as provider and commissioner of services. This lack of separation has caused concern locally for some time and the Partnership of Purpose Policy Letter reinforced the importance of clear boundaries between the provision of services and their regulation.

2.18 The absence of a consistent and trusted regulatory regime means that it is difficult both to demonstrate areas of existing excellence in health and care services and to rebuild confidence when things go wrong. Most importantly, the absence of robust standards of care and governance arrangements in certain areas of the health and care system leaves people who require care critically vulnerable in certain areas.

2.19 The risks associated with a lack of effective regulation have been demonstrated in other jurisdictions, sometimes with tragic consequences. These proposals are, therefore, a proactive step to ensure that people who use health and care services in the Bailiwick are kept safe and that those services continue to be delivered to the high standards that islanders rightly expect.

3. New Commission – Structure and Powers

3.1 In line with the strategic vision and direction of the Partnership of Purpose Policy Letter, the Committee is recommending that an independent statutory Commission should be set up as the body responsible for regulation of health and care services in the Bailiwick. This would include the regulation of persons, premises and systems.

3.2 As in Jersey, the Commission will be created through the proposed Enabling Law. The Committee would normally request and obtain advice from the Commission on the standards and schemes that are considered appropriate to regulate particular sectors of health and care services. The Committee would in turn recommend the most appropriate standards and schemes and a regulatory regime for the particular sector, for approval by the States. Ordinances would then be drafted to give the Commission powers to regulate health and care providers (including public sector services) in accordance with those standards and schemes. This statutory role will give the Commission a degree of independence from the States which will allow it to hold both public- and private-sector providers to account impartially.

Regulatory Standards

3.3 The first step is to draft and enact an Enabling Law that establishes the Commission as an independent statutory body and gives the States the power by Ordinance to prescribe or authorise the adoption (e.g. by subordinate legislation) of designated accreditation schemes or local standards and other appropriate regulatory measures. Subject to approval of this Policy Letter, the Committee will progress this during 2019.

3.4 The next step is then to determine suitable standards for each service, activity or profession which is to be regulated. This will be done gradually, starting with the areas of highest risk that are not presently regulated. Standards will be set through enactment of Ordinances or making of regulations by the Committee under the new Enabling Law. Once a standard is introduced for a particular type of service, the Commission will be responsible for regulating those services in accordance with it. The Committee will be responsible for bringing these standards forward, in accordance with its policy-making function, but will do this with the advice of (where appropriate) and in consultation with the

Commission, and in consultation with stakeholders in the sector to be regulated.

3.5 In some cases, the Committee may need to develop specific local standards which reflect the constraints of providing care in a small island environment. But, wherever possible, standards will be drawn from best practice in other jurisdictions – that is, standards which are transparent and proportionate, which ensure good quality while holding providers to clear and straightforward requirements.

Designated accreditation schemes

3.6 The Committee's general approach will be to identify existing voluntary systems of accreditation (such as CHKS for primary care, or Magnet® for hospital nursing) which set good standards for health and care services. It will be a regulatory requirement for local services to participate in their designated accreditation scheme, and the Commission will provide oversight – ensuring compliance with the process, stepping in to investigate where concerns are highlighted and sharing best practice among providers.

3.7 There will also be a backstop of statutory regulation which clearly identifies the circumstances in which the Commission can intervene to require improvement or take enforcement action. This should only be needed in the most serious breaches of acceptable practice as participation in designated accreditation schemes should generally provide an effective and proportionate way to promote standards and demonstrate best practice.

3.8 An example of a well-established, international accreditation scheme for high quality care is Magnet® Recognition, which is specific to nursing. Originally developed in the 1980's from research into the characteristics of leading hospitals, recognition is achieved by demonstrating adherence to a series of evidence-based, outcome focused standards. The standards are updated every four years and made more challenging and contemporary, recognizing the rapidly changing nature of health care. Research indicates that hospitals who have achieved Magnet® Recognition and even those working towards it can demonstrate improved patient outcomes, mortality and morbidity rates[9] plus

[9] McHugh, M. D., Kelly, L. A., Smith, H. L., Wu, E. S., Vanak, J. M., & Aiken, L. H. (2013). Lower Mortality in Magnet Hospitals. *Medical Care*, *51*(5), 382–388. http://doi.org/10.1097/MLR.0b013e3182726cc5

higher patient and staff satisfaction[10]. A number of studies have noted that Magnet® organisations lead the way in developing high quality nursing care and are characterised by excellent leadership, nurses with advanced education, a track record of innovation and improved recruitment and retention[11]. Whilst the scheme is likely to require certain adaptations for local context and other options will also be considered, this is one way in which Guernsey could set clear standards for excellent nursing and provide significant reassurance to islanders that the care they could expect to receive is externally scrutinised and recognised as world class.

Inspection Arrangements

3.9 The Commission's primary assurance in relation to safe practice will come from overseeing health and care providers' compliance with designated accreditation schemes. However, in order to have any credibility, the new Enabling Law, and any Ordinances or subordinate legislation made under it, must also provide for the Commission to have inspection and enforcement powers where these are needed.

3.10 The Commission cannot afford to staff up to have an inspector who is expert in every area of health and care provision – Guernsey's health and care system is as diverse as that of any large nation but its scale is very much smaller. Expert inspectors would be seriously under-utilised, except in case of emergencies: a situation which would not only be wasteful of resources, but would carry the risk of the regulatory regime ballooning to fill the time available.

3.11 Instead, the Committee proposes that the Commission should have a small core staff, complemented by arrangements with larger oversight and inspection bodies (which might include statutory regulators or approval bodies for designated accreditation schemes) to provide some routine or *ad hoc* support to the Commission in respect of the specific service area, activity or profession in which they have expertise.

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[10] Kelly, L. A., McHugh, M. D., & Aiken, L. H. (2011). Nurse Outcomes in Magnet® and Non-Magnet Hospitals. *The Journal of Nursing Administration*, *41*(10), 428–433. http://doi.org/10.1097/NNA.0b013e31822eddbc

[11] Stimpfel, A. W., Rosen, J. E., & McHugh, M. D. (2014). Understanding the Role of the Professional Practice Environment on Quality of Care in Magnet® and Non-Magnet Hospitals. *The Journal of Nursing Administration*, *44*(1), 10–16. http://doi.org/10.1097/NNA.0000000000000015

3.12 In its inspection role, the Commission will not simply be expected to detect poor quality through its oversight of regulatory standards and designated accreditation schemes but actively to work with health and care providers to support quality improvement. This is critical in ensuring that the Bailiwick maintains and develops the services it needs to meet Islanders' growing health and care needs. However, despite a focus on improvement, the Commission may from time to time need to take enforcement action against providers. This is discussed further in Section 6 below.

Services to be regulated

3.13 Regulatory standards and designated accreditation schemes will be introduced gradually over a period of years. The Committee will prioritise these on a risk basis and will respond as necessary to evolving circumstances. In the long term, it is anticipated that the Commission will regulate the vast majority of local health and care services and activities for adults and children; from hospitals and care homes to community hubs and dental practices; from cosmetic procedures to care at home; and the provision of social work.

3.14 The regime will cover services provided on-island by established providers, but also by visiting professionals. Visiting health and care professionals fall into a spectrum of arrangements. There is already robust governance in place for the visiting medical practitioners who work under defined arrangements with HSC. However, there is a serious concern in respect of health care services (for example dental and health screening consultations) which are currently being offered by private providers in hotel rooms and other unregulated environments. This is an area in which the public require much more effective protection from potential harm than currently exists.

Registration of Providers

3.15 The new Enabling Law will authorise Ordinances or subordinate legislation to be made to set out general conditions relating to the registration of services, activities or professions with the Commission. Details of any specific registration requirements for different kinds of service provision will be introduced through Ordinances or subordinate legislation at the same time as designated accreditation schemes or other regulatory standards are introduced for those services.

3.16 It is expected that registration criteria will include requirements as to the qualifications and suitability of those managing care services, as well as obligations on providers to ensure that these services are well conducted, demonstrating high standards of care and a safe and appropriate environment within proper facilities. There will be requirements as to record keeping and the employment of sufficient appropriately qualified and competent staff.

3.17 It is also expected that the new Enabling Law will authorise Ordinances or subordinate legislation to be made to allow the Commission to put conditions on registrations, or even for registrations to be refused or cancelled by the Commission on certain grounds. These are discussed further in Section 6 on Enforcement.

Commission Structure

3.18 The Committee is recommending the creation of a Commission made up of a team of people who may have a breadth of regulatory knowledge between them, rather than an individual Regulator operating as a single statutory official, whose technical competence is likely to be limited to a specific area of expertise. The operational organisation structure of the Commission is discussed further in Section 10 and at Appendix 2.

3.19 Although the Commission will have statutory independence from the Committee, it will remain accountable to the States, with a requirement to produce annual reports and accounts, and to demonstrate its compliance with the principles of good governance and its effectiveness and value for money.

3.20 Ultimately, it is hoped that a joint Commission would be set up for the Channel Islands to support the common aims of both Guernsey and Jersey, prove cost effective and be reflective of the mutual political will for collaborative working. The Committee is keen to avoid artificial barriers to achieving this and it, therefore, proposes that any legislation which is drafted to implement the proposals set out in this Policy Letter is as similar as possible to Jersey's to provide a common operating framework for the regulation of care in both islands.

3.21 Although there are distinct differences of approach between the two Islands (Jersey has made a much bigger commitment to inspection, and each Island has different priorities for the development of standards), the Committee believes

that the different needs of the two Bailiwicks could be managed pragmatically within a pan-Island Commission. This option continues to be explored at officer level and through the ongoing work of the Channel Islands Joint Working Group for Health and Care.

3.22 A joint approach would require a common process for appointing Commissioners and agreement on their terms of office and remuneration. It would also be likely to require a reorganisation of staff and functions. At this stage, the two Islands have agreed, where possible, to try and appoint regulatory staff to split roles, part in Guernsey and part in Jersey, so that common working practices are established from the beginning.

3.23 It is possible that the Committee will be able to make definitive plans for working together with Jersey from the beginning of the new regulatory regime, and every opportunity to make this happen will be explored alongside the drafting of the new Enabling Law and any Ordinances and other subordinate legislation made under the Law.

4. New Enabling Law, Ordinances and Regulations

Enabling Law

4.1 The proposed new Law will be a Bailiwick-wide Enabling Law. It will establish the Commission itself, as well as the concept of regulated activities. It will contain Ordinance and Regulation making powers which may be used in a phased manner to introduce regulatory standards and designated accreditation schemes as discussed above. The Enabling Law, Ordinances and subordinate legislation will as far as possible be aligned to the Regulation of Care (Jersey) Law, 2014[12].

4.2 There will be four key areas to the new legislation. It will:

1) Establish an independent commission for the purpose of regulating health and care provision in the Bailiwick;
2) Describe how the commission will be appointed;
3) Enable Ordinances and subordinate legislation to be enacted under the Law to regulate health and care services;
4) Provide for registration, accreditation, inspection and enforcement powers, and appeals, under the regulatory regimes.

[12] https://www.jerseylaw.je/laws/revised/Pages/20.820.aspx

4.3 This approach will provide sufficient flexibility to tailor regulatory requirements to each different part of the health and care system. The regulatory standards and designated accreditation schemes that will be put in place through Ordinances and subordinate legislation are discussed further in Section 5.

Incorporation of Regulation of Health Professions (Enabling Provisions) (Guernsey) Law, 2012, within new Law

4.4 Under the proposals The Regulation of Health Professions (Enabling Provisions) (Guernsey) Law, 2012, would be incorporated into the new Enabling Law and/or, Ordinances or subordinate legislation made under the Law.

Management and Sharing of Information and Data Protection

4.5 At set out above, regulation seeks to promote quality and minimise harm within the health and care system. This relies not simply on the care being directly provided to service users but just as importantly to the underlying processes in place to inform and guide service provision. Central to this, as set out in the Partnership of Purpose, is the appropriate sharing of health and care information (including where appropriate, personal data) in order to optimise the care delivered and provide a seamless, integrated service. Effective data management and data sharing will be a fundamental requirement for all regulated bodies, making clear their duty to share information with the regulator in support of the regulatory regime itself and their duty to share with other regulated bodies in accordance with the policies of their professional bodies to support the best interests of patients and service users. Acknowledging the importance of a data sharing model which complies with relevant legislation and which provides flexibility to respond both the transformation of health and care in the Bailiwick and the increasing adoption of technology, it is recommended that the primary legislation provide for specific provisions to be made regarding the management of health and care information.

4.6 In addition, the Enabling Law should also authorise Ordinances or subordinate legislation to provide for information sharing (where appropriate) between the Commission and other bodies, such as accrediting organisations, government departments, law enforcement agencies, and other regulatory bodies.

5. Setting Standards – How will we choose them? How will it work?

5.1 The first step towards regulating health and care services in the Bailiwick is to carry out a risk analysis and identify the areas where Islanders are most at risk due to a lack of regulation (or its ineffectiveness). An initial risk analysis has been conducted and is included in Professor Weir-Hughes' report at Appendix 1. This identified four high priority areas for the development of regulation: i) the unregistered health and care workforce; ii) health care premises; iii) psychotherapists, counsellors and alternative therapists; and iv) those who provide clinical cosmetic procedures.

5.2 Once the need for regulation has been identified, the Committee will establish desired outcomes appropriate for the services being provided, for example: What quality do we expect of these services? What harms should regulation prevent? It will work with the Commission and with service providers in the area to be regulated to identify whether there are any existing voluntary schemes which help to secure these outcomes. If so, it may recommend that one of these schemes becomes the 'designated accreditation scheme' under the new Enabling Law, Ordinances or subordinate legislation, for this service area. Services will then be required to sign up to and demonstrate compliance with this scheme.

5.3 Whilst the Committee believes there are many effective voluntary schemes which will prove adaptable to the Bailiwick, if this is not the case for a particular sector, the Committee will work with the Commission and regulated providers to design a Guernsey-specific set of regulatory standards which are proportionate to the Island's needs and draw on best practice wherever possible., the Committee intends this to be its approach of last resort as locally-designed standards are likely to require a much higher overhead in terms of compliance monitoring and inspection than designated accreditation schemes.

5.4 On an ongoing basis, the Commission will monitor the effectiveness of regulatory standards in securing quality health and care services and assess whether they remain appropriate and proportionate to the needs of the Bailiwick. It will work with the Committee to support a risk-based approach to developing new areas of regulation and improving existing regimes where these are demonstrably inadequate.

5.5 Designated accreditation schemes or regulatory standards will be introduced through Ordinances and subordinate legislation made under the Enabling Law. This gives the States oversight of the whole process, with the opportunity to withhold approval for Ordinances or annul regulations if need be should it feel that they were not appropriate to the size, scale and nature of the Bailiwick's health and care economy.

5.6 Standards will be designed to complement existing regulatory arrangements, where these exist, and to provide a publicly accessible framework of acceptable care levels.

6. Functions and Powers – what can the Commission do?

Functions

6.1 The Commission shall discharge the functions conferred on it by or under the Enabling Law and any other enactment.

6.2 Effective enforcement powers are essential for the credibility of the regulatory regime and proportionate powers are necessary for it to have a constructive impact locally. The Enabling Law should authorise Ordinances or subordinate legislation to be made conferring adequate and appropriate enforcement powers.

Power to inspect premises and obtain information

6.3 It is envisaged that the Commission will be able to inspect premises and obtain information in respect of health and care providers and professionals within the Bailiwick.

Granting and refusal of applications to register

6.4 It is envisaged that the Commission will have the power to refuse an application for a provider to register with it, where that provider falls short of the basic criteria for registration, as discussed in Section 3 above.

Improvement notices, enforcement notices, fines, and revocation of registration

6.5 It is envisaged that where the Commission finds that a provider is falling short of the relevant regulatory standards or designated accreditation scheme, it should have powers to require improvement within a given timeframe (e.g. through improvement notices) and ultimately, if no improvement is made, to sanction the provider by issuing an enforcement notice or a fine. The Commission may also be able to place specific conditions on a provider's registration.

6.6 As a last resort, if a health or care service poses a real risk of harm to the public and no improvement can be made, the possibility of revoking a provider's registration or closing it down directly must exist. However, there are many sole providers of services in Guernsey (there is, for example, only one acute hospital and only one mental health centre), and there are issues around capacity and impact on patients and service users even in instances where there are multiple providers, for example, a person who has lived in a nursing home for several years, and for whom it is really "home", would be profoundly affected if it were to close. The needs of Islanders in respect of access to services and continuity of care must, therefore, be balanced carefully against the risks posed by that service.

6.7 It is envisaged that the Commission should have the power to recommend to an appropriate authority (which may be a democratically elected body, such as the Committee, or a judicial body, such as the Royal Court) that a service should be deregistered or closed down. This would apply to all providers of health and care. The authority will be responsible for weighing where the balance of public interest sits between the management of risks associated with the ongoing operation of the service and the need to ensure islanders have continuing access to health and care services.

6.8 It is envisaged that there will also be a process in place for providers to appeal against deregistration, or against conditions being placed on their registration.

Fitness to Practise

6.9 It is envisaged that the Commission will also have a limited power to act in respect of health and care professionals whose fitness to practise has been questioned, where their continued practice would place at immediate and

serious risk the health and wellbeing of patients or service users. This includes situations where:

- A health and care professional has been impaired due to alcohol or drugs during practise;
- There are allegations of serious misconduct or incompetence by a professional which had led to user harm;
- There are allegations of serious misconduct or incompetence which may put patients at immediate risk and for which regulatory action by a regulatory body is likely to be taken; or
- A health and care professional experiences health problems which makes their practice potentially unsafe.

6.10 In those instances, it is envisaged that the Commission would have the power to suspend registered health and care professionals from the Guernsey register (effectively removing them from practice) for a limited period while a formal referral is made to their UK regulatory body (e.g. the General Medical Council or the Nursing and Midwifery Council). The Committee also envisages conferring powers on either the Commission or a panel of some kind to set further conditions on or effect the suspension of a registered health and care professional. This is already in place for doctors.

6.11 A flowchart in Appendix 3 sets out the proposed process for Fitness to Practise concerns.

7. Priority areas for regulation and future areas of work

7.1 The Committee proposes to develop new regulation for the unregulated health and care workforce (healthcare assistants and carers who look after people in their own homes), and providers of home-based care, in the first instance. This will be followed by regulation of acute hospital services.

7.2 Based on the risk analysis included in Professor Weir-Hughes' report (Appendix 1), the Committee considers that subsequent priorities for new regulation should include healthcare premises, such as hospitals and dental surgeries, psychotherapists, counsellors and alternative therapists and those providing clinical cosmetic procedures.

7.3 Additionally, the existing regulation regime for nursing and residential care homes is in urgent need of updating and will take a high priority for the Committee. The Medicines Law will also need to be reviewed in light of changes to the regulatory framework, both in Guernsey and in the UK.

Unregistered Health and Care Workforce

7.4 The unregistered health and care workforce includes domiciliary carers (that is, carers who visit people with significant care needs at home, in order to provide care) and health care assistants (who work in a variety of environments, including the community, residential and nursing care homes and hospital).

7.5 One of the biggest concerns is domiciliary (home) care, where carers are generally working by themselves, in an environment where they cannot be observed and with people who often have significant needs who may struggle to communicate if things are going wrong.

7.6 Healthcare assistants working in residential homes present a similar level of concern because their work is generally not overseen by a Registered Nurse. In nursing care homes and in hospital, the risks are mitigated by the presence of qualified senior staff and clinical assessment of the people being cared for.

7.7 It is nevertheless a concern that domiciliary carers and healthcare assistants do not have a regulatory body (such as the GMC or the NMC); are not required to demonstrate their competence through qualifications or any other means and are not required to have an enhanced police check to carry out the job, unless that is a condition of their particular employer. Although the kind of care they provide should not require extensive medical training, the fact that they are caring for very unwell or disabled people should require them to meet a basic professional standard of conduct and competence.

7.8 At a minimum, regulation should require that people working in this sector have an enhanced police check, are registered with the Commission and undertake mandatory training. In addition, standards should set out expectations around information sharing, record keeping, training and supervision and processes for the development and review of care and support plans. Specific standards governing domiciliary care agencies and other similar provider organisations will also be developed.

7.9 Regulation in this area will only apply to people who are carers on a professional basis. It will not include people who are caring voluntarily for a family member or friend although the Committee acknowledges that, even in those circumstances, people receiving care can sometimes be badly mistreated, and it has adult safeguarding procedures in place to offer some protection.

Acute Hospital Services

7.10 The fact that services in the Princess Elizabeth Hospital (also known as the acute hospital) are delivered in an unregulated physical environment (i.e. premises and systems) has been a concern, from time to time, of the Nursing and Midwifery Council and the General Medical Council.

7.11 This has its roots in the fact that there is no separate regulatory body locally: the Committee is responsible for providing hospital services (or commissioning them from organisations such as the Medical Specialist Group and the Guernsey Therapy Group) and for setting standards and governance.

7.12 This is counterbalanced in part by the fact that acute hospital services are highly professionalised delivered by qualified doctors, nurses and allied health professionals, who are registered with and regulated by their professional bodies on an individual basis. This is essential in ensuring that patients in Guernsey receive the quality of care they rightly expect.

7.13 However, the kinds of services provided in the acute hospital are generally significant, specialised medical procedures which could have a major impact on the wellbeing or even the survival of patients if they go wrong. For this reason, the Committee considers it a high priority to develop effective regulation around acute hospital services premises and systems. It should be noted that this includes the provision of mental health services.

Premises – Alternative Therapists – Cosmetic Procedures

7.14 Professor Weir-Hughes's report identified specific concerns in relation to a lack of premises regulation on Guernsey (meaning that, for example, private clinics or dental surgeries can be established anywhere and that there are no official guidelines for the storage of medicines and use of X-rays in dental practices); the number of unregulated psychotherapists and alternative therapists practising in Guernsey (who, in some cases, work one-to-one with extremely

vulnerable people); and the risks associated with beauticians carrying out clinical cosmetic procedures which should only be undertaken by registered health professionals.

7.15 In respect of psychotherapists, alternative therapists and of beauticians, there are UK-based registration schemes which could be adopted as designated accreditation schemes in Guernsey. In respect of premises, there are models of voluntary regulation already in use locally (such as the approach used by Specsavers for its opticians' branches), as well as statutory regulation of piercing and tattoo studios. Further work could be done with the Office of Environmental Health & Pollution Regulation to draw up suitable regulatory standards for a wider range of health and care-related premises.

7.16 These are all areas which the Committee will pursue, in consultation with the services to be regulated, once it has made progress on developing and implementing standards and schemes for the unregulated health and care workforce and for acute hospital services.

Residential and Nursing Care Homes

7.17 There has been an outstanding States Resolution, since 2007 (Art XI, Billet d'État XX), to improve the quality of the regulatory regime governing nursing and residential care homes. The current regulatory regime is set out in the Nursing Homes and Residential Homes (Guernsey) Law, 1976. Although it provides for homes to be registered with the States and inspected from time to time, the Inspector has virtually no powers to act if they identify a need for improvement.

7.18 The States have already given direction that the new regulatory regime should include:

- An expanded definition of "care home" to include both independent and States' operated services and clarifying the meaning of both "personal care" and "nursing care" and the creation of care standards;
- A regulatory regime for domiciliary care and nurses' agencies;
- The inclusion of the voluntary sector where personal and/or nursing care is provided;

- Clarification of the enforcement process, including the authority of the Inspector and allowing the Committee to take emergency action subject to an appropriate appeal process;
- Further aspects to be developed through Ordinance, for example, regarding premises, fitness to manage or work in a care establishment or agency; and
- Various notification requirements.

7.19 These directions fit well with the proposed shape of the new and the proposed powers of the Commission. Revised regulatory standards for nursing and residential care homes will, therefore, be developed in the same manner as the standards discussed above and the 1976 Law will be repealed in due course.

7.20 Due to the fact that most people who live in residential or nursing care homes need high levels of care, that there is likely to be growing demand for these homes in light of the ageing population and that the need to improve regulation in this area has been known for well over a decade, this will be treated as a high priority by the Committee.

Medicines Law

7.21 The Medicines (Human and Veterinary) (Bailiwick of Guernsey) Law, 2008 developed a long-standing system of pharmacy regulation which includes not only community pharmacy and the staff working within that system but also the industry around supply and marketing of medicines.

7.22 The Law includes regulatory and other provisions relating to medicinal products, their manufacture and licensing; Guernsey's relationship with the Medicines and Healthcare products Regulatory Agency (MHRA); licensing procedures and the claims which may be lawfully made; the operation of pharmacies and rules around the packaging, identification and promotion of medicinal products.

7.23 The Law is already in need of review following changes made in the UK through the Human Medicines Regulations 2012, which implemented a series of EU directives into domestic law and consolidated existing UK provisions. As well as ensuring alignment with the UK, the Committee also wishes to review the enforcement powers in the current Law and the roles of the Chief Pharmacist and Inspector.

7.24 The introduction of a new approach to the Regulation of Health and Care provides an ideal opportunity to do this. There is some uncertainty in this area at present, both due to the effect of the UK's withdrawal from the EU on the cross-border medicines market and due to emerging proposals for the revalidation of pharmacy professionals. Nevertheless, the Committee hopes to progress a review of the Medicines Law during this term.

8. Health and Care Governance – The Commission in Context

8.1 The proposed Commission and new Enabling Law, Ordinances and subordinate legislation will be important in setting standards for, and helping to improve the quality of, health and care in the Bailiwick. But there are also some functions that sit outside of its scope for example, the management and resolution of individual complaints will continue to be handled by service providers, perhaps backed up in future by some form of Ombudsman; while adult safeguarding and child protection cover a range of concerns which cannot easily be regulated for but for which providers should have effective processes and policies in place.

Complaints handling and Ombudsman

8.2 If a person is unhappy with the treatment they have received at the hands of a health or care provider, their first step is usually to complain directly to that organisation using its internal complaints process. There may then be various levels of appeal to more senior or more independent bodies.

8.3 There is some overlap between regulation and complaints handling in that a complaint may reveal a concern about fitness to practise or about the quality of services provided by the organisation which may need to be referred to the Commission. The existence of a good complaints handling process and general data on complaints and compliments are also likely to be requirements of most regulatory standards.

8.4 However, the regulator would not normally be involved directly in the resolution of individual complaints. If there is to be an independent body involved in hearing complaints and helping the parties to them to find resolution, this is more normally the role of an Ombudsman. (The

complementary roles of the Guernsey Financial Services Commission and the Channel Islands Financial Ombudsman are an example of this).

8.5 The Committee's Partnership of Purpose Policy Letter suggested that a health Ombudsman might be useful for the Bailiwick. The Committee is aware that work is being done across the States to consider the possible need for a general public sector ombudsman and is supportive of this approach. Pending the outcome of that work, the Committee is not bringing forward any recommendations for the creation of an ombudsman for health and care services only, but may return to this in due course.

Safeguarding of Adults and Children

8.6 All providers have a duty to ensure that children and adults (especially adults who are vulnerable because of ill health or disability) are kept free from harm. Child protection responsibilities are set out in the Children (Guernsey and Alderney) Law, 2008. It is expected that responsibilities towards adults who may lack mental capacity will be set out in Capacity Law which the Committee intends to bring to the States during 2019.

8.7 Child protection and adult safeguarding responsibilities are wide-ranging – health and care providers have a responsibility to keep people safe through the services they provide but also to report concerns if they believe a child or a vulnerable person is being harmed by people close to them (such as friends or family). This may initially be dealt with through 'multi-agency' groups which draw together the various different providers and professionals involved in a person's care, to put in place a plan for their protection but may ultimately be a matter for law enforcement and the criminal law.

8.8 It is envisaged that the proposed new Enabling Law, Ordinances and subordinate legislation will reinforce providers' responsibility in respect of child protection and safeguarding of vulnerable adults by requiring, in relevant regulatory standards and designated accreditation schemes, that providers:

- have in place an appropriate safeguarding policy supporting local guidelines;
- take steps to identify risks and preventing abuse occurring;
- respond to allegations of abuse;
- ensure care workers have safeguarding training;

- participate in investigations;
- prevent care workers who pose a risk of harm from contact with those receiving care;
- avoid employing anyone who is on a barred list or who has been cautioned or convicted for an offence against someone receiving care.

8.9 The obligation to share information with other providers, regulatory bodies, law enforcement agencies or other bodies and agencies where this would assist in safeguarding people who are receiving care, will also be reinforced. Data sharing is critical to ensure that people receive effective support from health and care services. The Committee and the Commission will work within the framework of the Data Protection Law to ensure that a patient-centred approach to data sharing is established, and providers can work together confidently to tackle important safeguarding issues.

9. Strategic fit

9.1 The States of Guernsey has already established Health and Care Regulatory and Support Policy as one of the key priorities of the Policy & Resource Plan. This will require the development of appropriate, proportionate and robust standards across health and care through an effective regulatory regime.

9.2 As well as being prioritised through the Policy & Resource Plan, the development of effective regulation is a core part of the Committee's work on the Partnership of Purpose for Health and Care, recognising the close links between work to improve health and wellbeing and the regulation of services and professionals.

9.3 Under the Partnership of Purpose, the model of care provided across the Bailiwick will evolve with more integrated and user-centred care and an ever increasing emphasis on enabling people to receive care closer to home. While this is responsive to the preferences of individual islanders and will have significant benefits in terms of outcomes, the inevitable increase in domiciliary care and the invaluable, but unregistered, role of healthcare assistants and care workers in delivering it makes the need for effective regulation in these areas all the more urgent.

9.4 Steps need to be taken alongside the transformation of health and care to ensure that all islanders whether being cared for in their own home, within

Health & Social Care premises or within the private sector are adequately protected.

10. Organisation Structure, Cost and Funding

10.1 The proposed organisation structure for the new Commission's secretariat is enclosed at Appendix 2. As discussed above, the Commission is expected to have a small core staff with access to external expertise where this is required. In order to facilitate joint working with Jersey, it is hoped that some of the Commission's permanent staff can be appointed to a split role, half in Jersey and half to serve the Bailiwick.

10.2 The Committee recognises that it would be helpful to have the Commission (or at least some of its membership) in place early on in the development of the Enabling Law, Ordinances or subordinate legislation, particularly in order to advise on the creation of standards and to begin engaging with health and care providers. The Committee is therefore proposing to establish the Commission in 'shadow' (or non-statutory) form initially, until the Enabling Law, Ordinances or subordinate legislation comes into force.

10.3 The Committee proposes to lay the groundwork for the Commission during 2019 recognising that, due to States' budgeting processes, it will not be possible to fully establish the Commission until 2020 at the earliest. It intends to work with the Policy & Resources Committee to include a funding request for the Commission in the 2020 Budget.

10.4 However, the Committee has worked out, as far as possible, the likely running costs of the Commission and anticipates that the total cost will be £368,000 per annum once the Commission is fully operational. There are a small number of regulatory posts within the Committee which may be transferred to the Commission in due course and some income associated with the regulation of residential and nursing care homes, which would also contribute towards the Commission's operating costs.

10.5 The Commission will be supported by regulatory fees, including fees to cover the initial application, continued registration or variation of licensing conditions and administrative fees where necessary, for example, for replacement registration certificates. These will be developed in line with the States' Fees and Charges Policy to reflect the size and complexity of the regulated activity. It

should be noted that, in some cases, providers will have to pay to participate in their designated accreditation scheme and the Committee is keen to ensure that the additional cost of registering with the Commission is not overly burdensome.

10.6 It is therefore unlikely that fees will cover the full running costs of the Commission – certainly not initially - when only a small number of services will be regulated, and, based on the experience of other jurisdictions, probably not in the long term either. The balance of the cost will need to be funded by a States' grant.

10.7 This is common practice in other jurisdictions. For example, the States of Jersey agreed to fund approximately 45% of the cost of its Care Commission, with fee income accounting for the remaining 55%. In the UK, the Care Quality Commission receives 34% of its funding through governmental grant and the Scottish Care Inspectorate some 65%. A particularly high level of public subsidy in Northern Ireland means that the fees charged by their Regulation and Quality Improvement Authority are significantly lower than elsewhere in the United Kingdom.

10.8 In the first year of operation, the running costs of the Commission are expected to be £368,000 (including the two existing staff posts). The net additional cost to the States would, therefore, be £272,000 after these posts are factored into the calculation. This would be further offset by £78,000 in fee and charges income (based on 2018 figures). The total additional cost in the first year to the States would, therefore, be £194,000. Over a period of five years, the balance will adjust as new regulation and fees and charges are introduced and the Commission is fully established.

10.9 The anticipated costs for a Guernsey Regulatory regime are outlined below. Establishing the exact costs this early is difficult as these are dependent on further negotiation with Jersey. However, projected costings have been obtained from Jersey in relation to the cost to the island of the new regulatory regime and have been used to inform local calculations.

10.10 Based on these calculations, if the States wished to establish a balance of 50% grant funding for the Commission and 50% funding through fees and charges, the Commission would need to raise £106,000 more per year in fees than the Committee currently collects from registered providers. This may be feasible in

the long term, once the Commission is regulating a sufficiently broad range of services, but will not be achieved immediately. The level of fees and charges will be the subject of further consultation with providers in order to ensure that the fees charged are reasonable and proportionate, and will be as prescribed by subordinate legislation.

10.11 The Committee would seek to make reasonable steps to accommodate the costs within its existing Cash Limit, and will submit a bid as part of the 2020 Budget.

Table 1: Anticipated Costs – Projected Expenditure (comparison with Jersey)

Expenditure	Jersey Proposed Per Annum	Guernsey Anticipated Costs (Estimates) Per annum
Regulation of Care functions	£600,000- 620,000	£368,000
Breakdown of expenditure • Commissioner (Fees, Travel, Training)	£37,000	£16,000[13]
• Staff costs (salaries/training)	£530,000	£274,000[14]
• Legal costs	£10,000	£10,000
• Rent, IT equipment, etc.	£14,000	£12,000[15]
• Stationery, PR, etc.	£6,000	£6,000
• External Consultancy (i.e. continued development of Regulation and external inspectorate expertise.	N/A	£50,000

[13] £16,000 is based on 3 Commissioners on joint Commission with Jersey at pro rata of Jersey cost, with allowance for up to 50% share of Chair of Commission in addition. Please note that this may, subject to negotiation, be adjusted to reflect the size of the respective Bailiwick populations.
[14] £274,000 staff costs. This also includes provision based on 0.5 Full Time Equivalent (FTE) share joint Head of Regulation with Jersey.
[15] No rent if based in current HSC premises and access to meeting rooms. Calculation factors in £10k one-off cost for IT equipment and £2k for furniture.

Table 2: Projected Income (comparison with Jersey)

Income	Jersey Proposed Per Annum	Guernsey Anticipated Costs (Estimates) Per annum
Income projections • Care homes	£220,000[16]	£78,000[17]
• Home care new registration	£25,000	Subject to future consultation
• Home care annual	£36,000	Subject to future consultation
• Adult day new registrations care	£10,000	Subject to future consultation
• Adult day care annual	£9,000	Subject to future consultation
• Laser clinics	£1,500	Subject to future consultation
• Dentistry/Yellow Fever, Piercing and Tattooing	£14,000	Subject to future consultation
• Medical practitioners and health care registration	£16,000	Not applicable – currently charged and offsets Responsible Officer roles.
Total Fee target (Income)[18]	£300,000	£184,000
States Grant	£300-320,000	£184,000

11. How will we assess outcomes?

11.1 This Policy Letter sets out the Committee's intent to establish an independent, robust and proportionate regulatory regime for the Bailiwick's health and care

[16] Of which £180k is annual fees as opposed to provider registrations.
[17] Based on 2018 income (Rounded down). Annual fee per home (19 x £362), annual fee per place in home (587 x £110). Note that fees for the medical practitioners (doctors) and in pharmacy offset the Responsible officer roles and so cannot be factored into these calculations. It also factors in a projected £6,710 in additional income as bed numbers increased subject to planning application.
[18] Represents 45-50% of total forecast cost of Commission (Jersey), 50% in Guernsey.

economy. As ever, the test will be how this translates into a culture of safe, person-centred care with a commitment towards continuous improvement and learning for the benefit of Islanders' health and wellbeing.

11.2 The introduction of regulation is expected to shape providers' behaviours in terms of providing health and care services; support consistent, high quality care; and lead to improved health and wellbeing outcomes. Regulation which is effective in avoiding episodes of poor care and the trail of negative consequences that follow may even at times help to reduce the costs of health care provision.

11.3 Thus, assessing the success of a regulatory regime is not about box-ticking or simply measuring providers' compliance with its standards. Regulation which is really focused on the needs and context of the Bailiwick can serve as a true enabler: working with providers to foster a learning culture where ideas and insights on how practice may be improved are encouraged and shared. It can sustain an ethos of promoting quality, safety and improved patient experience at all times which is of benefit both to providers and to the public.

11.4 The Commission may also prove a valuable link in the development of future health and care policy. Through engaging with providers and the public, the Commission is bound to gather invaluable information and evidence about the expectations and experiences of people who use health and care services and those who provide them which can be used to inform strategic goals. The Commission's work may reveal areas where there is variation in the care delivered, highlight areas in which interventions through revised standards could improve care and monitor the impact of these changes.

11.5 Although some aspects of the Commission's work will be fairly intangible (at least in the short term), the Committee will also draw up a number of Key Performance Indicators for the regulation of care which will be publicly available to ensure transparency. Nowhere is the saying "measure what you value, don't value what you measure" more apt than in a health and care setting and this will be central to the information collected. This will be as much about demonstrating what is going well in the health and care system, to encourage public confidence where it is deserved as it will be about evidencing the case for change where things are not working well.

11.6 These Key Performance Indicators will relate to health and wellbeing outcomes in the Bailiwick but also to patient experiences and perceptions of health and care services. In drawing up KPIs for the Commission, the Committee will draw on the governance arrangements it has put in place for its own services since the NMC Review of Nursing and Midwifery. These include a performance management framework based around a balanced scorecard of Safety; Service Quality, Staff and Spend as well as various initiatives (the Care Values Framework and Safer Everyday initiatives) which are based around the Institute for Healthcare Improvement[19] model and framework for healthcare quality improvement.

12. Views of stakeholders

12.1 In developing the proposals set out within the Policy Letter, the Committee has engaged widely. A full list of consultees is enclosed at Appendix 4. As HSC further develops the regulatory framework, continued engagement and consultation will include:

- People who use health and social care services
- Carers and relatives of people who use such services
- Providers of care services
- Voluntary and community organisations
- Existing health and social care regulatory and professional bodies

12.2 Providers of health and care locally have anticipated the introduction of increased regulation for some time and most have been supportive of the Committee's plans.

12.3 The proposals were presented to CareWatch which was positive about the proposals. Feedback included concerns around the priority given to Mental Health Services in terms of the development of regulatory standards. CareWatch Members were reassured that regulation of Mental Health would be given a high priority and included under the work around Acute services.

12.4 In response to questions around the timescales for the drafting and implementation of the necessary enabling legislation, CareWatch was assured

[19] www.ihi.org

that the Committee would be setting it as a high priority in terms of its legislative programme and that aspects such as the shadow Commission could be formed whilst the necessary legislative drafting was underway.

12.5 There was particular emphasis around the importance of user-centred consultation as part of the ongoing consultation and engagement with service users, their families and carers as the work stream continued to evolve and develop. This would include consultation over the setting of regulatory standards and provider fees and charges. Accreditation Schemes such as Magnet and Planetree designation also had a strong emphasis on patient/person centred care based on evidence and standards and ensuring excellent patient outcomes.

12.6 The Committee has formally consulted with the Policy & Resources Committee and the Committee *for* Employment & Social Security in respect of the full breadth of the Policy Letter. The Policy & Resources Committee asked that the Committee took reasonable steps to accommodate the costs associated with the proposals within its existing Cash Limit and submit a bid as part of the 2020 Budget. The Committee has included a commitment to this within section 10.11 of this Policy Letter and altered proposition 6 to direct the Policy & Resources Committee to take account of the costs of operating the Commission when recommending Cash Limits for the Committee for 2020 and subsequent years.

12.7 In addition, the Policy & Resources Committee also commented that "*it has welcomed the policy approach taken by the Committee for Health & Social Care and notes:*

- *the proportionate approach to regulation and the Committee for Health & Social Care's intent for pan-island working which is supported by the Committee for Employment & Social Security; and*
- *the Committee for Health & Social Care's commitment in the policy letter (paragraph 10.11) to make reasonable steps to accommodate the full costs within its existing Cash Limit, and submit a bid for any shortfall as part of its 2020 Budget submission. The additional costs of the new regulation model will be £194,000 in the first year; reducing to £88,000 as the balance between States' grant and fee income adjusts as the Commission is fully established and new fees and charges are introduced."*

12.8 The Committee *for* Employment & Social Security has confirmed its broad support for the proposals contained within this Policy Letter, in a letter dated 22nd November, 2018. The letter states that:

"The Committee discussed the benefits of the regulatory framework in that it increases protection for vulnerable individuals, safeguards against incompetent service providers and assists customers with a path to redress their claims. An independent scrutiny and oversight body is a beneficial method to ensure compliance. However the Committee would like to highlight the need for the framework to be proportionate to Guernsey's needs, and for the regulatory Commission's enforcement powers to be limited to only what is necessary. The Committee supports the regulatory framework to strengthen the existing regime, rather than add another layer of bureaucracy.

The Committee agreed a cost to care providers to implement the regulation was warranted and providing it was immaterial they would have no objection to it. However, the Committee would like to stress their reluctance to widen the regulatory framework to include alternative or even holistic therapies. While the regulatory framework is compatible for care service providers in the home, the Committee is unable to recognise how regulating holistic providers would succeed in practice.

The Committee would like to take this opportunity to remind HSC that partial coverage of regulatory powers exists in care homes through Health and Safety regulation. The Committee agreed that joint working with Jersey, as far as possible, and sharing resources was a good and reasonable plan."

12.9 The Committee is pleased to note the broad support for these proposals. A proportionate approach is one of the key themes of this Policy Letter and the Commission's functions and enforcement powers will be limited to only what is necessary. This Policy Letter also commits to ensuring that any proposals in terms of fees and charges are consulted on widely with providers and people using those services prior to the setting of any tariffs.

12.10 Complementary and Alternative Medicine is a term used to describe a diverse range of health care practices that fall outside of mainstream medicine. There has been a rapid growth of this sector during the 21st century. The Committee notes the concerns of the Committee *for* Employment & Social Security in respect of the proposed regulation of this sector.

12.11 Mindful that the primary purpose of the regulation of health and care is to ensure public safety, the growth in this sector of the health and care economy signals a pressing need to ensure that those using these therapies are sufficiently protected from unscrupulous and incompetent practitioners who can prey on a patient's desire for hope and control over often serious health conditions. Indeed, complementary and alternative therapies was one of the areas assigned priority as a result of the risk-based analysis in Professor Dickon-Weir Hughes's report (see also paragraphs 1.16, 5.1, 7.2, 7.14 and 7.15 of this Policy Letter).

12.12 There are the risks associated with complementary therapies and medicines (as with any form of healthcare), especially if they are delivered inappropriately.

12.13 During the consultation exercise three complementary and alternative therapies emerged as being of particular concern to health and social care practitioners and leaders in the Bailiwick. None of these examples are regulated in the Bailiwick, either in terms of the practitioner involved or the premises in which the activity might take place. These were:

i. **Bowen therapy,** which is an alternative type of physical manipulation named after Australian, Thomas Ambrose Bowen (1916–1982). Despite there being no clear evidence that the technique is a useful intervention it is advertised in Guernsey to treat a wide range of conditions including muscle and skeletal injuries, breast 'problems', infant colic, fertility issues and irritable bowel syndrome. The risks of Bowen therapy are largely undocumented in the literature. However, it could be argued that such treatments give false hope to vulnerable people with hard to manage chronic conditions.

ii. Whilst **Aesthetic Medicine** is well defined as a medical speciality, aesthetics more generally is less well defined. Collectively, this area covers a wide range of therapies and treatments from major cosmetic surgery to a simple procedure like eye lash tinting. There are a number of clinics in Guernsey who operate to UK and internationally accepted high standards and employ registered medical doctors, registered dentists and registered nurses. However, in all cases the premises are unregulated and with some it is difficult to tell from the advertising whether it will be a registered health care professional or an unregulated beautician who is providing the treatment. They offer a

wide range of treatments from Botulinum toxin injections to highly invasive vaginal rejuvenation to teeth whitening. The General Dental Council are clear that teeth whitening is practising dentistry (not medicine or nursing) and state that dentists cannot delegate this procedure.

iii. **Counselling and psychotherapy** can overlap. A therapist can provide counselling with certain situations and a counsellor can use psychotherapy in their approach. Whilst a psychotherapist is qualified to provide counselling services, a counsellor may or may not have the training and skills to provide psychotherapy. Education for counsellors and psychotherapists comes from a wide range of providers including short weekend courses and distance learning programmes to 'gold standard' highly supervised Master's degree and Doctoral degree programmes at leading universities. The titles and training are not regulated and nor are the premises and yet these practitioners deal with some of the most vulnerable people in society. However, the plethora of qualifications are highly confusing to the consumer and practitioners in the Bailiwick with a very wide range of qualifications offer to consult with people with everything from relatively straightforward natural human responses, such as bereavement, to highly complex mental health problems such as Asperger's Syndrome.

12.14 Other risks include how complementary therapies are advertised and marketed and how patients can be easily misled.

12.15 There are also issues relating to informed consent[20] which is an essential prerequisite when offering tests, treatment or therapies.

12.16 The Committee is also mindful that there is evidence that many of these therapies can be used alongside conventional or mainstream medicine to the holistic benefit of the patient. The Committee believes that where someone is treating a person for a medical condition and making a claim that their therapy will improve health outcomes for that person, then this has to be evidence-based. In this sense, the Committee is of the view that as with other health care providers, there is a role for the regulator to oversee these activities and ensure that they meet appropriate standards. As with any other health care sector, the

[20] Informed consent from a healthcare provider's viewpoint means that the provider must make every effort to be sure that the patient understands, the purpose, benefits, risks and options of the test or treatment. The provider then must get the patient's consent before commencing any test, treatment or therapy.

Committee would consult with Complementary and Alternative Medicine and Therapies providers as part of its development of regulatory standards and accreditation for this sector.

12.17 Finally, the Committee notes that some regulatory power exists in Health and Safety legislation and regulation, and would not propose to duplicate this. Instead standards might require providers to ensure compliance with the relevant health and safety legislation and regulatory standards, approved codes of practice, etc.

12.18 The Committee has further consulted with the Committee *for* Education, Sport & Culture. In a letter dated 23rd October 2018 the President of the Committee *for* Education, Sport & Culture said that the Committee had no issues with the matters covered, and comments or advice to put forward at that time.

12.19 The Committee has further liaised with both Alderney and Sark in respect of the application of the Enabling Law, Ordinances or subordinate legislation. While the Committee is keen for the Commission to have statutory standing across the Bailiwick, it is clearly recognised that the needs of the respective Islands are likely to differ significantly based on the services available. Quite simply, the range of services available in Guernsey could not be replicated across the other Islands and where such services do exist, they are being delivered in a way which reflects the distinctiveness of very small insular communities. This uniqueness of care provision is, in many ways, to be celebrated for capturing the true essence of patient-centred care and therefore it is vital that the regulatory regime retains the flexibility to respond directly to this, while maintaining at its very core the ability to ensure high quality services.

12.20 To this end, the Committee recommends that the designated accreditation schemes or proposed local standards to be established under the Scheme should be capable of applying either to the Bailiwick as a whole or to specific Islands within. This approach would allow the development of proportionate and transparent standards which best support the needs of Islanders.

12.21 The Committee undertakes that before introducing any standards, or schemes by way of Ordinances or subordinate legislation under the proposed primary legislation, it would consult with the relevant committees of the States of Alderney, and the Chief Pleas of Sark, where those standards or schemes are to have effect in Alderney or Sark respectively.

13. Conclusion and next steps

13.1 The Committee is proposing a robust, independent and proportionate regulatory system for health and care in accordance with the aims of the Partnership of Purpose Policy Letter and the goals of the Policy & Resource Plan.

13.2 Regulation has a key role in promoting good governance arrangements in health and care providers and improving health and wellbeing outcomes for islanders. This Policy Letter proposes that this is done through the use of globally recognised accreditation schemes and the implementation of regulatory standards. This will allow Guernsey to put in place a regulatory system which draws on best practice from around the world, while remaining proportionate to the needs of a small island community.

13.3 Subject to the agreement of the States Assembly and in accordance with the Implementation Plan set out in Appendix 5 (subject to the States-wide prioritisation of legislation process currently in place), the Committee now intends to pursue the following key work streams relating to Regulation of Health and Care:

- To assist the Law Officers in preparing and drafting the necessary Enabling Law to give effect to the proposals in this Policy Letter;
- To commence work on setting up the Commission (in 'shadow' or non-statutory form) during 2019, with a view to launching it fully from the beginning of 2020;
- To continue exploring opportunities to work more closely with Jersey on the regulation of health and care;
- To continue its engagement with providers of health and care services on the operation of the regulatory regime; and
- To commence work on the establishment of regulatory standards and schemes, starting with the unregistered workforce and the domiciliary or home-care sector, in order to bring proposals before the States to direct the preparation of Ordinances to implement these standards and schemes.

13.4 The Committee will report back to the Assembly through the annual updates to the Policy & Resource Plan in respect of the Commission's implementation and development.

14. Compliance with Rule 4 of the Rules of Procedure

14.1 In accordance with Rule 4(4) of the Rules of Procedure of the States of Deliberation and their Committees, it is confirmed that the Propositions have the unanimous support of the Committee.

14.2 In accordance with Rule 4(5), the Propositions relate to the primary duty of the Committee to protect, promote and improve the health and well-being of individuals and the community.

14.3 Also in accordance with Rule 4(5), in developing these proposals, the Committee has consulted with the Policy & Resources Committee, the Committee *for* Employment & Social Security and the Committee *for* Education, Sport & Culture.

Yours faithfully

H J R Soulsby
President

R H Tooley
Vice President

R G Prow
D A Tindall
E A Yerby

R H Allsopp, OBE
Non-States Member

The Office *of the*
Committee *for*
Health & Social Care

The Regulation of Health & Social Care in Guernsey

Progress report and case for change

Professor Dickon Weir-Hughes
Healthcare Regulation Consultant
October 2017

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Introduction

The regulation of Health and Social Care within the Bailiwick of Guernsey (islands of Alderney, Guernsey, Herm, and Sark) (referred to as the Bailiwick throughout the remainder of this paper) is a fundamental element of the new Target Operating Model (TOM) and essential to the prevention of harm to users and for the promotion of high quality care.

One of the outcomes of the recent NMC Review into Nursing and Midwifery was the development of a robust and independent regulatory framework across the Bailiwick of Guernsey.

Indeed, a key part of any piece of work focused on improving health and wellbeing is how services and professionals are regulated. No element of health or social care is completely risk free but the ultimate purpose of regulation is to protect the public from harm and this principle objective should be borne in mind whilst considering the content of this paper and the recommendations.

As in some other jurisdictions, Health and Social Care regulation in the Bailiwick has developed iteratively over many years with some developments following in the footsteps of the United Kingdom (UK) and others being implemented reactively to local circumstances. However, there are also several great examples of proactivity amongst health care leaders in the Bailiwick, for example: the implementation of a system of voluntary regulation, known as CHKS, in Primary Care; the use of The Royal College of Psychiatrists (UK) accreditation scheme in mental health; and the huge enthusiasm for external voluntary scrutiny by Specsavers franchisees in the Bailiwick.

One of the prompts for this piece of work was concerns raised by the Nursing & Midwifery Council about the regulatory landscape in the Bailiwick, specifically in relation to Revalidation and midwifery. Whilst those concerns have been ameliorated and indeed the Bailiwick is now held up as a beacon of best practice in Revalidation it was agreed that a more comprehensive piece of work should be undertaken. One of the key issues is the volume of regulatory gaps within the Bailiwick. For example, the premises of the Princess Elizabeth Hospital and associated services are not regulated. The Bailiwick lacks an independent system of regulating health and social care. This is a serious gap in the protection of the public in the Bailiwick.

More recent work on the Target Operating Model (TOM) also indicates the need to embark upon this project as it is one of the pillars of the health and social care system.

The subject of regulation, in any sector, often gives rise to concerns about cost and proportionality, especially amongst tax payers. However, one of the key benefits of providing health and social care in a relatively contained island community that is not

burdened by the bureaucracy of larger jurisdictions is the opportunity to develop regulatory approaches that are both world leading and proportionate.

The Bailiwick has an exciting opportunity to lead the way in health and social care regulation by designing a regulatory framework that not only provides robust public protection but is also innovative, cost effective, sustainable and leads to measureable improvements in service user outcome.

The purpose of this paper is to provide a progress report on the fact finding first stage of the work and to set out a case for change including structures, processes, priorities and next steps. Ultimately, the aim is to ensure that Islanders are protected from harm and receive exceptional care in line with the 2020 Vision to promote, improve and protect health and wellbeing. The Review of the regulation of health and social care in the Bailiwick is also strategically aligned to HSC's transformation vision of providing "High quality services jointly designed by our communities and staff, enabling access to healthy lifestyles and social wellbeing for all of the Bailiwick".

It is important to emphasise that the principle of proportionality has been foremost throughout this phase of the work and it is hoped that this is evident from the report and the proposed approach.

I would like to acknowledge the support of numerous health and social care professionals, third sector leaders, the financial regulators, colleagues from the States of Jersey and of course Professor Juliet Beal, Mr. Martin Gavet.

Professor Dickon Weir-Hughes
Healthcare Regulation Consultant

October 2017

Executive summary

The regulation of health and social care is a complex topic in any jurisdiction but the challenge of achieving the optimal balance between proportionality and protecting the public is magnified in a smaller community.

A key driver in initiating this work was the Nursing & Midwifery Council's focus on midwifery and revalidation the Bailiwick in 2015 and whilst those issues are resolved a wider concern was the overall regulatory framework for health and social care in the Bailiwick.

Like the States of Jersey, this report recommends an independent Commissioner Model with underpinning legislation that focuses on the key issues in the Bailiwick, which differ somewhat from the priorities in other jurisdictions. Whilst legislation is required that enables the Commissioner to take robust regulatory action to the protect the public if necessary, the model recommends that the Commissioner will normally receive assurance that services are safe by requiring organisations to demonstrate best practice by using a range of internationally accepted sources of best practice evaluation and recognition. This avoids the need to set up an expensive and unwieldy inspection mechanisms in all but the most extreme of circumstances. This approach has been supported by stakeholders and validated by a senior regulator with many years of experience in the Channel Islands.

Regulatory priorities for the Bailiwick include developing a regulatory framework for the unregistered health care workforce, the regulation of health care premises including dental practices and a framework of assurance to better protect the public who use the services of psychotherapists, counsellors and alternative therapists. These priorities are set against the backdrop of an independent regulatory function.

There are number of co-dependencies related to this project that are out with the scope of the work but which do require resolution. An example is the legislative framework and resourcing in Early Years services.

Stakeholder engagement has been a major part of developing this report and will continue to be a key facet of the work as it moves into the developmental phase.

The principles, background and benefits of health and social care regulation

Principles

This paper has been written in accordance with the following guiding principles which it is suggested should be the cornerstone of health and social care regulation in the Bailiwick. Health and social care regulation must:

- Protect citizens, residents and visitors.
- Be proportionate and cost effective.
- Be open, transparent and understandable to all.
- Be world class.
- Be focused on the needs of small Island communities.
- Aim to be evidence-based.
- Promote equality.

Statutory health and social care regulation is normally divided into two distinct areas or work streams, namely systems regulation and professional regulation.

- An example of a statutory systems regulator would be Health Inspectorate Wales, which protects the public by regulating all heath care facilities and services in the principality.
- An example of a statutory professional regulator would be the Nursing & Midwifery Council, which protects the public by regulating nurses and midwives in the UK and the Crown dependencies.
- A small number of statutory regulators have legislation that enables them to protect the public by regulating both systems and professionals. An example of this type of integrated regulator would be the General Pharmaceutical Council, which regulates pharmacists, pharmacy technicians, pharmacy premises and pharmacy training facilities in Great Britain (i.e. the UK minus Northern Ireland). There is an emerging view amongst regulators worldwide that the public could benefit from more integrated regulation of this type and this is a recommendation of the (UK) Professional Standards Agency (2016).

These examples provide an insight into the complexity of regulation. Replicating this web of regulation in a small island community would not be possible, desirable, proportionate or cost effective and this paper proposes alternative solutions. The UK, especially England, has one of the most complex health and social care regulatory frameworks in the world. There is even a regulator of regulators, the Professional Standards Agency. For this reason, the recommendations contained within this paper seek to explore regulatory solutions that look far beyond the shores of the UK and aim to put the Bailiwick into a position where Islanders benefit from a truly world class, proportionate system of protection from harm.

Background

Health professional regulation

Health care professional regulation is quite a complex maze of mechanisms that is difficult for the public to navigate, especially if they wish to raise a concern. In almost all jurisdictions worldwide regulation has developed iteratively and hence may appear to be unwieldy. The systems may not always appear to be logical or proportionate either. Taking the UK as one example, scanning the scope of professions and occupations that are regulated and those that are not is an interesting activity and indicates that the principles of proportionality and public protection have not always been applied. For example, a dental practice team consists of various people, including dental assistants, who rarely work unsupervised by a dentist, are regulated. However, care support workers, especially those who work in the community, almost always work alone and with some of the most vulnerable people in our society. Care Support Workers are unregulated. This is clearly undesirable and presents significant levels of risk to the most vulnerable islanders in receipt of care.

Social care regulation

Social Workers only became registered professionals in 2001 with the title 'Social Worker' only becoming protected as recently as 2005. Social work regulation in England has been in a state of flux ever since the UK Government opened the first regulator, the General Social Care Council, in 2001 only to close it in 2012 and devolving regulation to each country of the UK and in England moving regulation into the Health and Care Professions Council (HCPC). Since 2016 the UK Government has been looking at reforms around Children and Social Work Regulation as part of its Children and Social Work Bill. Any work around the future regulation of health and social care in Guernsey and Alderney will therefore need to take developments in this area into account.

Systems regulation

Health care systems regulation is also a recent development. For example, in England, the Commission for Health Improvement (now the Care Quality Commission or CQC) was the first ever organisation to assess the clinical performance of NHS hospitals less than 20 years ago in 1999. However, other jurisdictions have been more forward-thinking and as long ago as 1951 The Joint Commission in the USA started to write and promote standards of care in hospitals and conduct inspections of health care facilities. Founded by the American College of Surgeons, the Joint Commission is now a not-for-profit regulator with multiple registration options including acute care, long-term care, laboratories and specific patient pathways. In theory, it is a voluntary regulation scheme but such is the strength of its quality mark that many funders of health care (such as the Federal health insurance systems Medicare and Medicaid in the USA) will only authorise care to be funded in a Joint Commission approved setting. Outside of the USA, Joint Commission International now operates in over 100 countries and seeks to improve patient safety and quality through accreditation which provides assurance to statutory regulators, the public and professionals.

The European Partnership of Supervisory Organisations (EPSO)[1] has different approaches to regulation across the membership. Some countries such as The Netherlands have very well developed regulatory systems and processes whilst others have what one would call a regulation light approach that rely on a combination of self-evaluation and independent scrutiny.

The concept of organisations striving for excellence and being able to assure funders, regulators and the public through systems of ostensibly voluntary regulation demonstrates a level of professionalism and responsibility that should be applauded and removes the need for a 'big brother' approach in all but the most extreme cases. This is, as previously stated, is the model from which Islanders in the Bailiwick benefit in primary care and mental health, for example. However, the CQC in England is now in a difficult position. Many people assert that its inspection regime is overly burdensome and disproportionate and yet inspectors continue to unearth failings in a wide range of care settings. The inspection regime is indeed a huge operation with, in some cases, 70-80 inspectors descending on an organisation. Even with this number there will be gaps in speciality coverage. However, whilst organisational failures continue it is difficult to imagine a change of policy. It could be argued that in a smaller jurisdiction, a more positive and less burdensome regulatory regime based on speciality expertise maybe more appropriate.

There are several pieces of interrelated systems legislation in the Bailiwick that the Committee will also need to consider (or is already due to do so) alongside the regulation of health and social care. For example, The Children (Child Minders and Day Care Providers) (Guernsey and Alderney) Ordinance, 2015, the Medicines Law (2008) and associated ordinances and the Health Benefits Law which needs to be updated to enable non-medical prescribers to better care for patients.

Guernsey's current regulatory environment

The following professional bodies regulate health and social care professionals in Guernsey:

- General Chiropractic Council (GCG).
- General Dental Council (GDG).
- General Medical Council (GMC).
- General Optical Council (GOC).
- General Osteopathic Council (GOsC).
- General Pharmaceutical Council.
- Health and Care Professions Council (HCPC) - Arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, social workers in England and speech and language therapists.
- Nursing and Midwifery Council (NMC).

[1] www.epsonet.eu - seeks to improve the quality of health care and social care in Europe, to connect between supervisory organisations and their individual members to improve exchange of ideas, outcome of research, information and good practice; to promote co-operation on topics such as education and dissemination of knowledge.

Care practitioners not covered by regulation in Guernsey include:

- Aesthetics (some covered by GDC and GMC, et al).
- Care Agencies.
- Carers & Domiciliary/Residential Support Workers.
- Complimentary Therapists (e.g. Sports Injury & Rehab, Acupuncture, Hypnotherapy, Herbal, Homeopathy, etc.)
- New professions.
- Psychotherapists and counsellors.
- Visiting services (variety of different providers).

Care practices/premises which are regulated/accredited in Guernsey include:

- Community Pharmacies.
- Nurseries.
- Nursing and Residential Homes.
- Primary Care Practices (CHKS).
- Pharmaceutical manufacturing & wholesaling.

Care practices, and other aspects of health and social care provision not covered by regulation in Guernsey include:

- Advertisements for services.
- Agencies.
- Chiropody & Podiatry practices.
- Dental practices.
- Psychotherapy and Counselling Practices.
- Physiotherapy Practices.
- States of Guernsey provided services.

The States of Jersey regulatory developments

Since 2006, colleagues in the States of Jersey have developed a new regulatory regime which follows an Independent Commissioner model, underpinned by a traditional inspection team. It is not yet clear how a small team of inspectors will have all the specialist expertise required to inspect such a wide range of services.

The Regulation of Care (Jersey) Law 2014 is the primary legislation which enables a new framework for the regulation of health and social care in Jersey.

The law seeks to ensure:

- All providers meet the required standards (both public and private sector).
- Protection of vulnerable individuals.
- Establishment of an independent Health and Social Care Commission to implement the ethos of the law and support and encourage service improvements.
- Transparency of inspection reports.
- A skilled and knowledgeable inspectorate.

There are **6 key areas** to the 2014 Law:

1. Transfer of responsibility for regulating health and social care from the Minister for Health and Social Services to an independent commission.
2. Sets out how the Health and Social Care Commission will be appointed.
3. Requires providers of care services to be registered by the commission.
4. Enables regulations and standards to be enacted under law about the quality of care services.
5. Describes the commission's powers of inspection.
6. Explains the enforcement procedures and appeals process.

Diagrams 1 and 2 below illustrate how the Jersey law works and its governance.

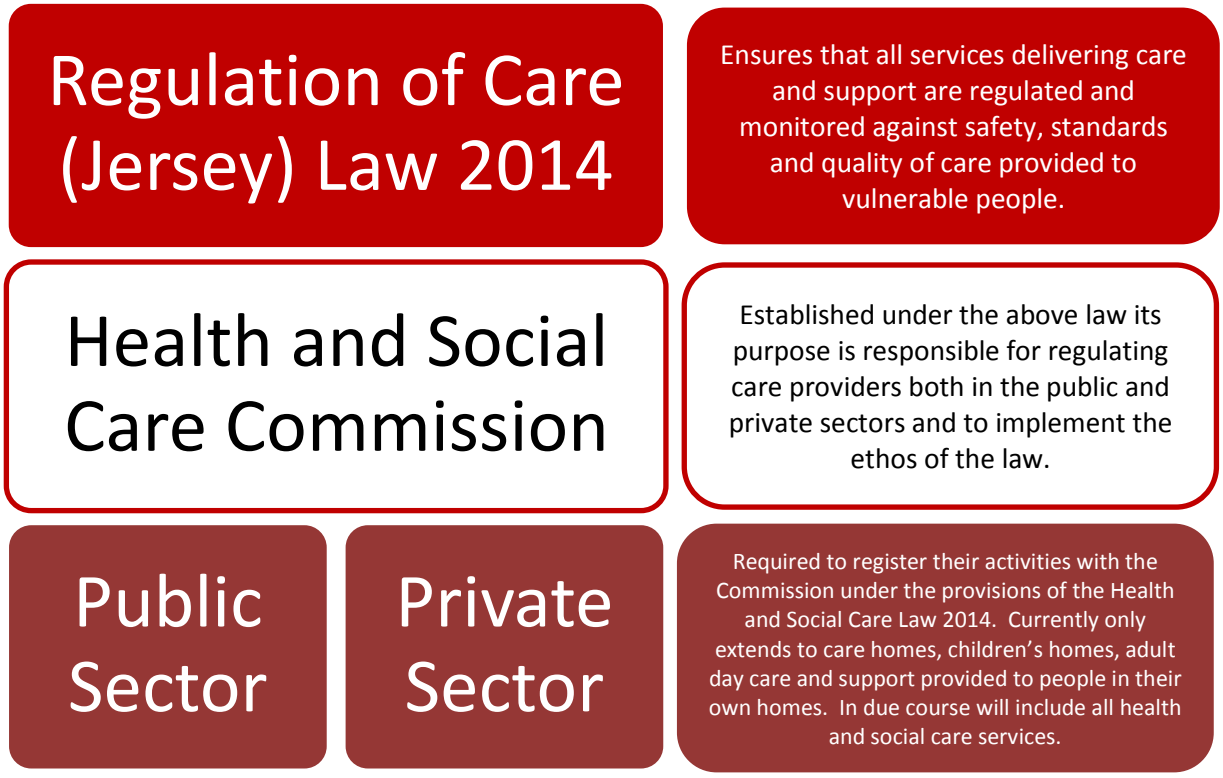

Diagram 1: The Regulation of Care (Jersey) Law 2014

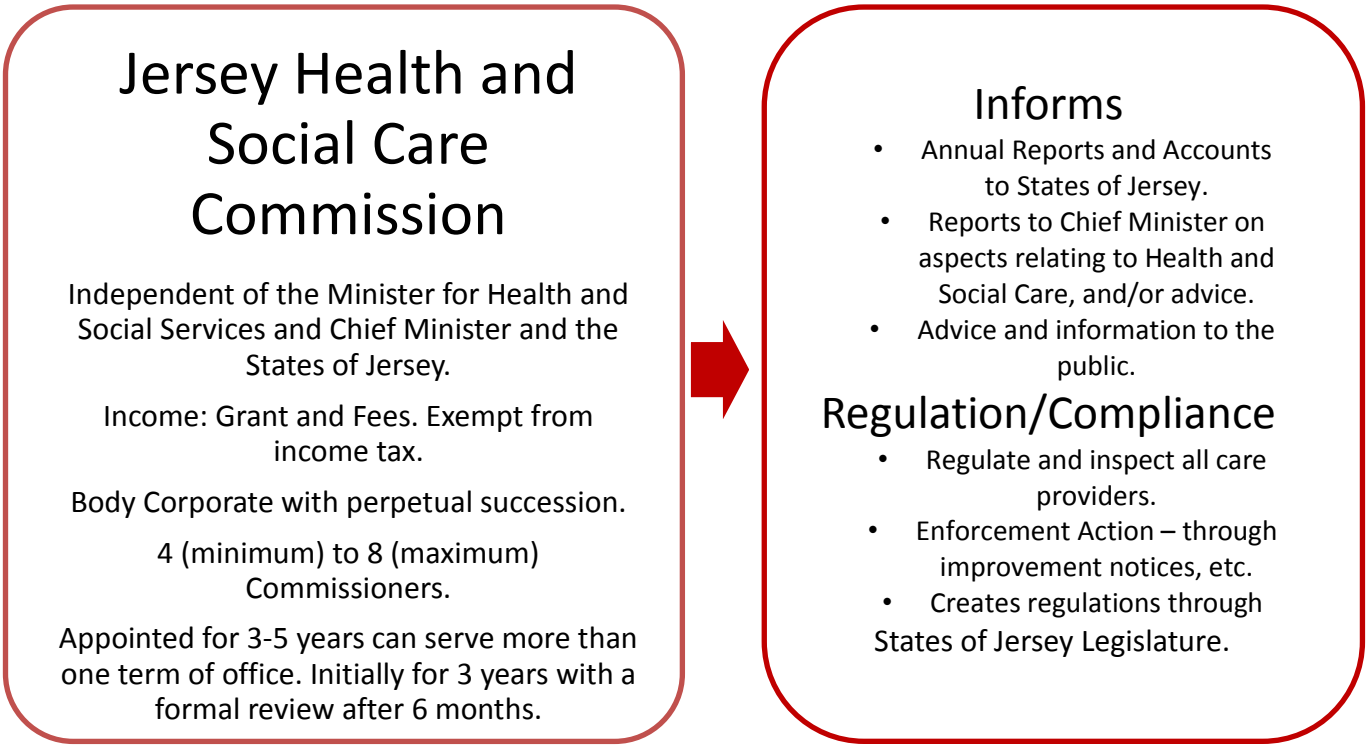

Diagram 2: The constitution of the Jersey Health and Social Care Commission and role.

There are some differences in the priorities identified in the Bailiwick's stakeholder work when compared to Jersey. As in the Bailiwick, colleagues in Jersey identified care homes, domiciliary care and dentistry as priorities. However, Jersey colleagues have also identified cosmetic procedures, tattooing and body piercing as a priority. In the Bailiwick, these procedures are separately regulated under Environmental Health Law.
In the Bailiwick of Guernsey, the highest levels of risk to public safety centre around domiciliary care and the unregistered workforce (Care Support Workers). Other areas included psychotherapy and certain alternative therapies, such as Bowen therapy due to the vulnerable nature of the users. Jersey colleagues have made it clear that they do not wish to regulate alternative therapies, psychotherapy or homeopathy.

Whilst the States of Jersey face different immediate operational challenges to the Bailiwick with the opening of a new health care facility and the Independent Jersey Care Inquiry 2017[2], which will inevitably be time consuming, it will be important to continue to work in collaboration with the Commissioner and his team as the work progresses in the Bailiwick, even though our priorities are different. Moving forward, it would be possible to collaborate with colleagues in Jersey to develop joint standards for certain areas. For example, the Commissioner in Jersey is focusing on community care and it might be possible for these standards to be shared across the Channel Islands. Similarly, work done in the Bailiwick could be shared.

[2] http://www.jerseycareinquiry.org/

Benefits of health and social care regulation

Statutory regulation

The benefits of statutory health and social care regulation are frequently assumed and whilst there is much written about regulation there is a paucity of good quality research evidence to support specific approaches. Cox and Foster (1990) studied the Costs and Benefits of Occupational Regulation on behalf of the Bureau of Economics of the US Federal Trade Commission. Whilst this study is somewhat historical, their work is interesting because in the USA occupational regulation is within the gift of State legislature and it is for this reason at that it is so variable. For example, California has 132 regulated occupations and Iowa has just 52. They studied all occupations and not just health care occupations but, in part, from the perspective of cost benefit and with the view that costs of occupational regulation may be passed onto the consumer. They explored some interesting issues in relation to the fact that some professionals seek to gain financially from being regulated especially when they have a dual role of diagnostician and provider of treatment and the associated potential for conflict of interest. This has been an issue in private medical and dental practice in the UK.

They also explored the desire of many consumers for increased regulation to prevent various sorts of market failure. Overall, they concluded that regulation was especially beneficial in health care where consumers do not have the technical expertise to evaluate a provider's skills or abilities. However, they called for a system that protects the consumer from conflicts of interest.

Proportionality of statutory regulation

Proportionality has been outlined as a key principle of this piece of work but what is proportionality in the context of health and social care regulation and how do regulators achieve proportionality. It should be noted that regulations are often put into place because of the negative actions of a few and then become a burden for many. These are sometimes politically motivated actions aimed to reassure the public that action has been taken but these initiatives have far reaching consequences and often add to the burden of regulation on the tax payer and individuals with little evidence that the initiative is proportionate. There are numerous examples of such actions in the UK.

In considering proportionality, it is important to weigh up the level and impact of certain risks and whether a proposed system will effectively mitigate those risks. An example of a risk stratification table can be found in Appendix 3.

New Zealand has a reputation for proportionality in health and social care regulation where the standards that the public can expect are explicit and transparent, particularly in relation to the licensing of hospitals and care homes.
http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services

As this work continues in the Bailiwick it will be important for the Commissioner to horizon scan internationally and to continually reflect on proportionality and whether each initiative proposed is indeed proportionate and adheres to the principles agreed by the Committee.

Voluntary regulation shows more promise

In contrast, there is good evidence to suggest that certain forms of voluntary regulation do make a statistically significant difference. Possibly one of the most researched is the international recognition scheme for high quality nursing known as Magnet® Recognition. Magnet® was started in the late 1980's with a large-scale piece of research looking at the characteristics of leading hospitals in relation to nursing. It is now a recognition scheme that requires hospitals to work towards and then adhere to a set of standards that is made more challenging every 4 years. There are only about 550 Magnet® recognized hospitals worldwide, with many others on the journey but research indicates that even those who are on the journey has improved patient outcomes. One of the many studies was conducted by the Centre for Health Outcomes at the University of Pennsylvania and included examining 508 non-Magnet hospitals and 56 Magnet® hospitals. The study included over 600, 000 surgical patients and found that patients in Magnet® hospitals were significantly less likely to die and suffer a life-threatening complication with 'failure to rescue'. The study noted that the Magnet® hospitals had developed high quality nursing care and were characterised by excellent leadership, nurses with advanced education and a track record of innovation. It is important to point out that even when researchers used several controls to eliminate the variations in mortality one might expect to see in complex versus minor surgery and issues such as academic medical centre versus a district general hospital they still found that it was the differences in the quality of nursing that explained the significant Magnet® advantage (McHugh, D et al, 2013).

The McHugh et al study links to a one that was conducted closer to home in 9 European countries and involving over 400, 000 patients and 26, 000 Registered Nurses and found a direct link between levels of nurse education and mortality and morbidity and found that hospitals with higher numbers of Bachelors or Master's prepared nurses (as opposed to diploma) educated nurses had significantly lower mortality and morbidity. They also discovered that hospitals with higher numbers of health care assistants had significantly higher mortality and morbidity and worse re-admission rates (Aiken, L et al, 2015)

There is also evidence to suggest that doing the morally right thing to improve care by engaging with systems of voluntary regulation like Magnet® can also save money. Work at Oxford University Hospitals has suggested that bringing nurse-sensitive indicators (like falls with harm, pressure injuries and nurse turnover) into line with typical Magnet® hospitals will save in the region of £3.7 million per annum (Weir-Hughes, 2017).

In summary, it appears that an innovative mixture of statutory and voluntary systems of regulation could be a proportionate and cost effective way forward for the Bailiwick. There will always be a requirement for a robust scheme of statutory regulation, including enforcement action, with a tight legal framework but this should only be needed in extreme circumstances.

Stakeholder engagement, findings and recommendations

Methodology

The methodology for this piece of work included literature review and a series of semi-structured interviews. Participants were initially drawn from a list of stakeholders agreed with the Chief Nurse / Director of Governance but by using a 'snowball' technique the list grew as themes emerged. Participants were enthusiastic to help and to be involved and consensus or data saturation on many of the main issues was achieved rapidly, meaning that there appears to be a shared understanding of the issues and possible solutions.

Participants included health and social care professionals, third sector leaders, financial regulators and colleagues in the States of Jersey. With very few exceptions there was genuine appetite for the Bailiwick to be a world leader in innovative approaches to health and social care regulation.

High level findings

There were several high-level findings and risks identified with the existing systems including:

- Participants were positive about a Commissioner led model, distanced from The States of Guernsey Health & Social Care Department geographically and structurally, underpinned with enabling legislation plus a series of Ordinances to be developed from a prioritised list from 2018-2021. This would include reorganising relevant, existing staff into the new, more independent function;
- Participants felt that the system by which the Commissioners receive assurance of safe practice should be by using specialist accreditation or recognition schemes as this was felt to be more proportionate and contemporary than developing an inspection regime although it was acknowledged that the legislation must support an inspection regime using specialist inspectors from other jurisdictions with enforcement actions should the need arise;
- The Bailiwick has a partly unregulated acute and community care system, including the hospital in terms of premises and unregistered staff (e.g. Care Support Workers). However, all professional staff are regulated by UK based health care professional regulators (such as the General Medical Council) and this does provide the public with protection;
- The Bailiwick has a partially regulated nursing and residential care home sector. This is because whilst there is a robust inspection regime, legislation does not enable the inspector to issue enforcement action. There is also a regulatory issue in relation to the designation of certain homes and there is no clinical overview in residential homes;
- There is a long-standing system of pharmacy regulation but one that is dependent on one individual who is potentially conflicted given that he is the chief pharmacist, the

inspector and the enforcer of the legislation. This exposes a degree of vulnerability in the system in terms of reliance on one individual and the risks that poses, particularly in respect of succession planning and continuity;

- An unregulated domiciliary care agency system, meaning that there are no legal requirements for agencies to require their workers to be trained or police checked. There was great enthusiasm from all stakeholders to resolve this matter;
- A lack of a regulatory framework for health care support workers / nursing assistants, which means that there is a lack of consistency in training and that individuals who are incompetent in one environment can easily move to different employers within the Bailiwick undetected. There was great enthusiasm from all stakeholders to resolve this matter;
- A lack of premises regulation means that dental surgeries and various private clinics can be developed anywhere. There was consensus that premises regulation should be explored and that premises regulation should include arrangements for the proper storage of medicines;
- A lack of premises regulation coupled with a weak system of managing certain visiting health care professionals from outside the Bailiwick, means that health care services are being offered in hotel rooms and other unregulated environments (for example, dental and health screening consultations). There was great enthusiasm from stakeholders to resolve this matter;
- The Responsible Officer role has been well embedded into medicine but doesn't exist in dentistry or any other profession. This is a major issue for Social Workers who are Approved Mental Health Practitioners (AMP);
- A very complex system of for managing concerns about children and young people out with the control of the Children's Convenor results in duplication and perhaps a lack of clarity about referrals. This area has already been the subject of an external report[3] but stakeholders felt that further work was required and in particular to explore Local Safeguarding Board requirements;
- There was widespread concern about the number of unregulated psychotherapists and alternative therapists practising in the Bailiwick;
- The issue of beauty parlour employees providing medical treatments which should only be carried out by a registered doctor, dentist or nurse has also been widely discussed;
- There are significant issues in terms of the extant legislation, resourcing and governance arrangements related to regulation of Early Years provision and most notably The Children (Child Minders and Day Care Providers) (Guernsey and Alderney) Ordinance, 2015 which need to be resolved;

A range of social and equality issues emerged from the work including access to health care for migrant workers and their families; and there were significant issues in relation to drug

[3] Guernsey Children Law Review – Kathleen Marshall (November 2015)

and alcohol consumption, including prescription opiates. The linkages between substance misuse and domestic violence/poor mental health and wellbeing were also of note. It was noted that there are separate Domestic Violence and Drug and Alcohol strategies in this respect. Whilst it is strictly outside of the scope of this piece of work, this feedback has been included as they are both key public safety issues. Regulation does have a role to play in ensuring that there is efficient and effective governance structures between health and social care providers and other agencies and timely intervention which helps to prevent instances of abuse and/or promote best outcomes for victims.

High level findings and recommendations

Findings	Stakeholder / s	Recommendations
1. Stakeholders felt that the Commissioner model was appropriate for the Bailiwick	All	The Commissioner model should be developed as part of a business case once the Committee have given approval in principle. It should be independent from The States of Guernsey Committee for Health & Social Care both geographically and structurally. The Commission could be set up under **primary enabling legislation (similar to Jersey) followed with a series of secondary legislation (regulation standards introduced through Ordinances) to be developed from a prioritised list from 2018-2021, based on risk-level.** This would include reorganising relevant, existing staff into the new, more independent function. Whilst Jersey's priorities are currently different, embedding the Commissioner Model would be relatively easy. The two Bailiwicks could bring the two Commissions together into a single Channel Island regulator in years to come (subject to appropriate legislation and political consensus). The cost of the Commissioners to Jersey is estimated circa £30k per annum (not including existing inspection staff). Unlike Jersey, the Bailiwick has no Head of Regulation to run the service so consideration will need to be given as to how this is managed and a fully costed appraisal will need to be developed as part of a business case. **This and indeed all the recommendations in this report are consistent with the Target Operating Model (TOM).**
2. The Commissioner should seek assurance that services are safe by using specialist recognition schemes, this would include the underpinning evidence to support licensing the hospital	All	In parallel with developing the Commissioner model and business case a study should be undertaken of all the relevant specialist recognition schemes. The cost of participating would be met by the relevant provider with the scheme being approved by the Commissioners. However, some infrastructure costs will need to be met by the States.
3. A range of concerns about healthcare provision and regulation in Alderney were raised	Multiple stakeholders	The Committee is asked to consider an approach to ensuring that islanders in Alderney receive high quality, safe care in consultation with stakeholders from Alderney

High level findings and recommendations (continued)

Findings	Stakeholder / s	Recommendations
4. An inspection regime should be developed with a directory of suitable specialists for use in the unlikely event of a significant event OR if a specialist recognition scheme cannot be identified for a service	All	In parallel with developing the Commissioner model and business case this work should be undertaken. Job descriptions, terms of engagement and a small budget for fees will also need to be identified
5. Nursing and residential homes will be required to assure the Commissioner that they are safe and effective but the current legislation needs to be updated to enable the Inspector to use enforcement action when required. In addition, provision should be reviewed.	Nursing and residential home leaders, users, carers and the Inspector	In parallel with developing the Commissioner model a suitable recognition scheme will be identified and piloted. Amendments to the current legislation should be drafted. The inspector should move from HSC to the office of the Commissioner.
6. The relevant legislation will need to be reviewed and updated to disaggregate the management and leadership of pharmacy with inspection and enforcement.	Chief Medical Officer, Chief Nurse / Director of Governance, Chief Pharmacist, Community Pharmacists	In parallel with developing the Commissioner model, amendments to the current legislation should be drafted and operational disaggregation arrangements put in place in order that the pharmacy inspection and enforcement function moves to the office of the Commissioner.
7. The domiciliary care agency system is unregulated, meaning that there are no legal requirements for agencies to require their workers to be trained or police checked.	Office of the Commissioner and industry partners	Further consultation is required in parallel with developing the Commissioner model but the enthusiasm for resolving this risk by almost everyone consulted should be noted. As detailed in recommended in 2 it is proposed that this group of workers is subject to some form of regulation.

High level findings and recommendations (continued)

Findings	Stakeholder / s	Recommendations
8. A lack of a regulatory framework for health care support workers / nursing assistants, which means that there is a lack of consistency in training and that individuals who are incompetent in one environment can easily move to different employers within the Bailiwick undetected.	Office of the Commissioner, the Chief Nurse / Director of Governance, industry and third sector partners	Further consultation is required in parallel with developing the Commissioner model but the enthusiasm for resolving this risk by almost everyone consulted should be noted. An options paper should be developed for the Committee on models of regulation for a) Domiciliary care workers and b) health care assistants in the acute, community and long-term care sectors.
9. A lack of premises regulation means that dental surgeries and various private clinics can be developed anywhere. There was consensus that premises regulation should be explored and that premises regulation should include arrangements for the proper storage of medicines and the use of X-Ray in dental practices	Office of the Commissioner, the Chief Nurse / Director of Governance, industry and dentistry partners, Environmental Health, the Chief Pharmacist and Radiation Protection Advice	Further consultation is required in parallel with developing the Commissioner model but the enthusiasm for resolving this risk by almost everyone consulted should be noted. A model of premises inspection already exists in high street optics, Specsavers specifically and this could be built upon with the support of Environmental Health.
10. There is an inconsistent system of managing visiting health care professionals from outside the Bailiwick	Office of the Commissioner, Chief Medical Officer, Chief Nurse / Director of Governance	Whilst many visiting health care professionals (such as those accompanying sports teams) are well managed, existing legislation needs to be strengthened to better protect Islanders from unmanaged practitioners offering clinical services from hotel rooms and other unregulated premises.
11. The Responsible Officer (RO) role needs to be extended to other health care professionals outside of Medicine	Office of the Commissioner, Chief Nurse / Director of Governance, Dentist and Social Work representatives	In the UK, the RO role is statutory for GMC registrants but not for other health care professionals. However, the extension of the RO role to others is a 2016 recommendation of the Professional Standards Agency (England) so this is an initiative in which the Bailiwick could lead the way. Consultation and subsequent Ordinance drafting would be required to make it mandatory in the Bailiwick.

High level findings and recommendations (continued)

Findings	Stakeholder / s	Recommendations
12. The Westminster Government proposed the opening of a new Agency for Social Workers registration. This has now been overturned meaning that registration in England is in a state of flux	Chief Nurse / Director of Governance and Social Worker representatives	It is recommended that the Committee review the situation with Social Worker regulation in England as it unfolds. A paper will need be prepared for the Committee suggesting a way forward. The decision may need to be included in a relevant Ordinance.
13. The complex system for managing concerns about children and young people out with the control of the Children's Convenor results in duplication and a lack of clarity.	Children's Convenor, Chief Nurse / Director of Governance initially	This area has also been the subject of an external review by Professor Kathy Marshall but it is suggested that a further review and / or a robust action plan is required. This work is outside of the immediate scope of this report and accountabilities will need to be agreed by the Committee. The original report can be found at: https://www.gov.gg/CHttpHandler.ashx?id=103201&p=0
14. There was widespread concern about the number of unregulated psychotherapists and alternative therapists practising	Office of the Commissioner	In parallel with developing the role of the Commissioner, the Professional Standards Agency (England) registration scheme should be evaluated in more detail and professionals consulted with subsequent recommendations to the Committee to adopt the scheme (which would be at no cost). An Ordinance would be required.
15. There is an issue related to beauty parlour employees providing treatments which should only be carried out by a registered doctor, dentist or nurse.	Office of the Commissioner	In parallel with developing the role of the Commissioner, the Professional Standards Agency (England) registration scheme for Cosmetics should be evaluated in more detail and professionals consulted with subsequent recommendations to the Committee to adopt the scheme (which would be at no cost). An Ordinance would be required.
16. There are issues in terms of the extant legislation related to regulation of Early Years provision and most notably The Children (Child Minders and Day Care Providers) (Guernsey and Alderney) Ordinance, 2015 which need to be resolved	To be confirmed	It is recommended that further work, including legal advice is sought in terms of the existing issues in this respect, inter-departmental governance arrangements and possible legislative change, before any firm recommendations are brought to Committee about the future regulation of Early Years providers.

Conclusion

This report marks the beginning of a complex series of tasks and activities which aim to better protect the Islanders of the Bailiwick by creating a proportionate yet world leading system of health and social care regulation. The individuals who participated in this consultation sessions that helped to build this report all had useful contributions to make but towards the end of the process we consulted another experienced regulator with significant experience of Financial Services regulation in the Bailiwick, in Jersey and in UK. He strongly supported the approach detailed in this paper. This was an important step in validating the recommendations.

This is a legacy piece of work which will have far reaching implications beyond the life of the existing committee and many of the employees who will be involved in the next few years and it is with this in mind that the Committee are respectfully asked to consider:

- The principles of health and social care regulation for the Bailiwick detailed in this paper.
- The Commissioner Model and the advent of independent health and social care regulation in the Bailiwick.
- The concept of the use of specialist recognition schemes to provide assurance to the Commissioner.
- The need for robust legislation including mandatory inspection and enforcement options that can be used in situations where there is no other more proportionate option to protect the public.
- The other recommendations contained within this paper.
- The approval of a budget of £50k for the financial year 2018/19 to pursue these recommendations.

Next steps

Subject to Committee's approval of this paper, the next steps include:

- Writing a detailed project plan, commencing initial discussions with legal experts and commencing some of the initial planning work to set up the Office of the Commissioner and scoping several of the more straightforward recommendations, such as options for adopting specialist recognition schemes and the Professional Standards Agency (England) licensing arrangements for certain health workers. This can be delivered within existing financial resources during 2017 / 2018. The project plan will be presented to the Committee on a date to be agreed.
- The business case will include a funding model but the costs of professional regulation in the Bailiwick are already met by individual health and social care professionals through paying their own fees. In the main, these fees are not passed onto the consumer because most health care and social care professional in the Bailiwick do not work on a fee for service basis. This would include nurses, midwives, social workers and most allied health professionals, such as paramedics. The costs of participating in specialist recognition schemes will need to be assessed but it is suggested that these would be met by providers. There will be some additional costs to running the Office of the Commissioner and this needs to be quantified for the Committee once the overall direction is agreed but some of this can be off-set against premises and other sorts of license fees, many of which already exist, such as nursing and residential home fees and pharmacy licence fees. Overall the model of funding which will be proposed will be a blended approach underpinned with the key principle of proportionality and assessment of risk.
- A Green paper will be prepared to deliver the other recommendations, including a public consultation, which will be presented to the Committee.
- An Equality Impact Assessment also needs to be undertaken, subject to the Committees approval of these recommendations.

References

Aiken, Linda H; Sloane, D; Bruyneel, L et al (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *The Lancet,* Volume 383, Issue 9931, 1824 - 1830

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Weir-Hughes, D (2017) The business case for Magnet® Recognition at Oxford University Hospitals

http://www.ouh.nhs.uk/about/trust-board/2017/march/documents/TB2017.36-magnet-recognition-programme.pdf

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Appendix 1: Stakeholder Engagement – Phase 1 List of Consultees

Internal to HSC

- Alastair Richards, Head of Radiology and Clinical Services Director (Interim)
- Carolyn Barrett, Manager, Prison Healthcare
- Chris Guy, Head Biomedical Scientist
- Dom Bishop and Jenny Cook, Community Adult Mental Health Service
- Ed Freestone, Chief Pharmacist, Assistant Director and Registrations Officer (Health Professionals)
- Elaine Burgess, Deputy Chief Nurse
- Elaine Torrance, Head of Midwifery
- Jan Coleman, Director of Hospital Services
- Julie Barnes (Fostering and Adoption)
- Juliet Beal, Chief Nurse / Director of Governance
- Kristina Willis, Programme Manager, Target Operating Model
- Leon Le Cras, Head of EBME
- Madeleine Dunn, Multi Agency Support Hub (MASH)
- Mark de Garis, Chief Secretary
- Mary Carré, Theatres Manager
- Matt Jones, Senior Operating Manger
- Myfanwy Datta, Dietetics
- Nick Phipps, Supported Living (Grand Courtil)
- Nicky Gallienne, Assistant Director, Children and Family Community Services
- Oberlands Nursing Staff on Tautenay Ward
- Peter Rabey, Medical Director
- Rachel Stevenson (Duty and Brief Intervention)
- Ruby Parry, Locum Consultant Social Care
- Sarah Lyle, Head of Service, Children's Dental Services
- Theresa Prince, Community Nursing
- Vanessa Penney, Registration & Inspection – Nursing and Residential (HSC)

External to HSC

- Bob Gallagher/Paul Williams and Ed Partridge, Primary Care Practices
- Commissioner of Health and Social Care, Jersey
- Dr John Curran, Aesthetic Skin Clinic, Former president and Fellow of BCAM, British College of Aesthetic Medicine
- Emily Litten, Guernsey MIND
- Felicity Quevatre, Catalyst
- Hayley Jordan, Senior Aesthetic Nurse Practitioner & Director of Medical Governance, Aesthetic Skin Clinic
- Jo Boyd, Director, Les Bourgs Hospice

- Jon Beausire, Chief Officer, St John Ambulance and Rescue Service
- Karen Brady, Children's Convenor
- Karen Le Page, Guernsey Cheshire Home
- Keith Otty, Guernsey Dental Association
- Linda Edwards, Early Years Team Manager
- Nick Hynes, Director of Learning, Performance & Intervention, Education Services
- Nick Trott, CI Healthcare (Domiciliary Care and Residential/Nursing Homes)
- Paula Burbridge, Connie's Carers
- Peter Neville, former Chief Executive Guernsey Financial Services Commission and current Board member, Channel Islands Competition Regulatory Authority (CICRA)
- Philippi Trust
- Rob Platt MBE, Guernsey Disability Alliance
- Rodney Gregg, Physiotherapist
- Roy Lee, Law Officers of the Crown
- Dan Ormesher and Sarah Burchett, Specsavers Opticians
- States of Jersey Health and Social Services Department (Regulation)
- Sue Fleming, Matron, St. John's Residential and Nursing Home

Appendix 2: Examples of voluntary regulation schemes

The following schemes are examples of the 'best practice' specialist recognition schemes that could be used to provide assurance to the Commissioner. It should be noted that if the Committee approved this model as a way forward that further work will be required to evaluate each scheme, consult with stakeholders and to make recommendations to the Commissioner.

Scheme	Area	Notes and website link
Magnet® recognition	Acute and community nursing	See notes on pages 11 and 12 http://www.nursecredentialing.org/Magnet
Joint Commission International	Hospital services	See notes on page 7 https://www.jointcommissioninternational.org
Planetree	Nursing and residential homes	The focus of Planetree is person-centred care. Whilst some acute hospitals have pursued recognition it is particularly suited to longer-term care environments, especially when coupled with robust health and safety and premises regulation http://planetree.org/reputation/
Imaging Services Accreditation Scheme (operated by the Royal College of Radiologists and the College of Radiographers)	Radiology	This well-established scheme is designed to promote best practice in radiology and provide assurance of a safe and effective diagnostic radiology service. https://www.rcr.ac.uk/clinical-radiology/service-delivery/imaging-services-accreditation-scheme-isas
CHKS	Primary care	CHKS is the scheme of voluntary regulation already used within Primary Care http://www.chks.co.uk
Royal College of Psychiatrists Accreditation Scheme	Mental health in-patient wards	Mental health inpatient wards are high risk environments. This scheme has already been used in the Bailiwick to provide assurance of safe care. http://www.rcpsych.ac.uk/workinpsychiatry/
Royal College of Nursing Advanced Practice Credentialing	Advanced Nurse Practitioners, Nurse Specialists and Nurse Consultants	This robust scheme offers independent assessment of nurses in advanced roles and provides assurance to their public and employers that those with the credential are indeed competent to practice safely at an advanced level. https://www.rcn.org.uk/professional-development/professional-services/credentialing/credentialing-model
Professional Standards Authority Accredited Registers	Occupations not statutorily regulated	The PSA accredited registers scheme offers the public protection by providing a platform for accredited registers for occupations that are not regulated by statute such as alternative therapists and counsellors. http://www.professionalstandards.org.uk/what-we-do/accredited-registers

Appendix 3: Example of an occupational risk stratification decision-making tool to guide decision making about the proportionality of regulation

Occupational group	Intervention risk (1)	Context of care risk (2)	Typical level vulnerability of users (3)	Notes
Domiciliary care workers	Low	High	High	Domiciliary care workers work alone with vulnerable people who are not clinically assessed in their own homes unsupervised
Health Care Assistants (HCA's) (Nursing Homes)	Low	Medium	High	Nursing Homes based HCA's are supervised by a Registered Nurse who is accountable for their work and this reduces the level of risk
Health Care Assistants (Residential Homes)	Low	High	High	Residential Home HCA's do not have access to a Registered Nurse and residents are not clinically assessed. This increases risk.
Health Care Assistants (Hospital)	Medium	Medium	High	Hospital based HCA's are supervised by a Registered Nurse or Midwife who is accountable for their work and this reduces the level of risk
Health Care Assistants (Community)	Medium	High	High	Community HCA's work alone with vulnerable people but do have immediate access to a Registered Nurse who is accountable for their work, which reduces the contextual risk
Psychotherapists and Counsellors	High	High	High	These individuals work with highly vulnerable individuals in unregulated premises usually one-to-one without a chaperone
Emergency Medical Technicians (EMT's)	High	High	High	EMT's aren't regulated but there is a proposal that they should be able to administer a range of drugs without prescription, hence the high-risk score for intervention
Dental Team members (other than Registered Dentists)	Low	Medium	Low	Dental team members are already registered by the General Dental even though they do not present a risk, although this isn't mandatory in the Bailiwick. The context of care risk is medium because dental practices are not regulated

Appendix 4: Brief notes on the history of regulation and underpinning research

Health care professionals were amongst the first professionals to be regulated. The earliest reference to medical regulation dates from 1421 when physicians petitioned parliament to ask that nobody without appropriate qualifications be allowed to practice. Little happened until 1511 when statute placed medical regulation in the hands of Bishops. However, modern health care professional regulation started in 1858 with the passing of the Medical Act and the formation of the General Medical Council. Midwifery followed in 1902 with the passing of the Midwives Act and Nurses in 1919 with the passing of the Nurses Registration Act. In those days, many of the professions we now have didn't exist and, for example, the activities of Social Workers (then known as Almoners), Dieticians and Physiotherapists were part of nursing. In more recent years, multiple professional regulators have been formed to protect the public from the numerous emerging and distinct professions now in existence.

In social care regulation focused more on containment rather than care originally, it could be argued that the systems regulation of social care in England and Wales started with the passing of the Elizabethan Poor Law in 1601. It is only in recent years that Social Workers have been registered and regulated.

Since regulation started, there has been a problem with developing an evidence base for it. Both statutory professional regulation and systems regulation are complex and multi-faceted areas in which to conduct research. It would be a brave or perhaps even cavalier research ethics committee who approved a study that required, for example, the reduction of regulation to assess the impact of various systems on levels of harm amongst members of the public. The only way in which this could be done would be to assess outcomes across different jurisdictions with very similar populations and health systems and yet with different regulatory frameworks but even then, the approach would be plagued by methodological difficulties.

Appendix 5: Benefits Analysis

Outputs	Benefits	Corporate Goals
Inspection against standards and regulations set by law	Better joined-up inspection regime Improved Service User Safety Improvements to Quality of Service (Safe, Timely, Efficient, Effective, Equal, Person-centred) Better Enforcement	Policy and Resource Plan 2020 Vision SLAWS
Enforcement	Ability to serve improvement notices and ensure compliance with standards under law.	Policy and Resource Plan SLAWS
Information	Better Information	Policy and Resource Plan 2020 Vision SLAWS
Advice	1-stop shop for complaints/feedback Independent ombudsman (re: raising concerns) – see Francis Report Feb 2015	Policy and Resource Plan 2020 Vision Raising Concerns SLAWS
Engagement	User involvement – setting of regulations, standards and outcomes.	Policy and Resource Plan

		2020 Vision/CareWatch
Trust and Confidence	Assurance to stakeholders that services provided are safe.	Policy and Resource Plan 2020 Vision, SLAWS

Appendix 6: Equality Impact Assessment Toolkit

Committee *for* Health & Social Care

Equality Analysis

Section 1 - Summary

1	Title	
2	What are the intended outcomes of this work?	
3	Who will be affected by this work? List your key stakeholders here.	

Section 2 - Evidence

4	What evidence have you considered?	

5	**Age** Consider and detail here age related evidence. This can include safeguarding, consent and welfare issues.	
6	**Disability** Consider and detail here disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities	
7	**Gender Identity** (including transgender) Consider and detail here evidence on transgender people. This can include issues such as privacy of data and harassment.	
8	**Marriage and other partnerships** Consider and detail evidence on marriage or partnerships. This can include working arrangements, part-time working, caring responsibilities.	
9	**Pregnancy and maternity** Consider and detail evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities.	
10	**Race** Consider and detail race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers.	

11	**Religion or belief** Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.	
12	**Sex** Consider and detail evidence on men and women. This could include access to services and employment.	
13	**Sexual orientation** Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.	
14	**Carers** Consider and detail evidence on part-time working, shift-patterns, general caring responsibilities.	
15	**Other identified groups** Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status, etc.	

Section 4 – Engagement, inclusion and valuing people

16	**How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?**	
17	**How have you engaged stakeholders in testing the policy or programme proposals?**	
18	**For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs.**	

Section 5 – Summary of Analysis

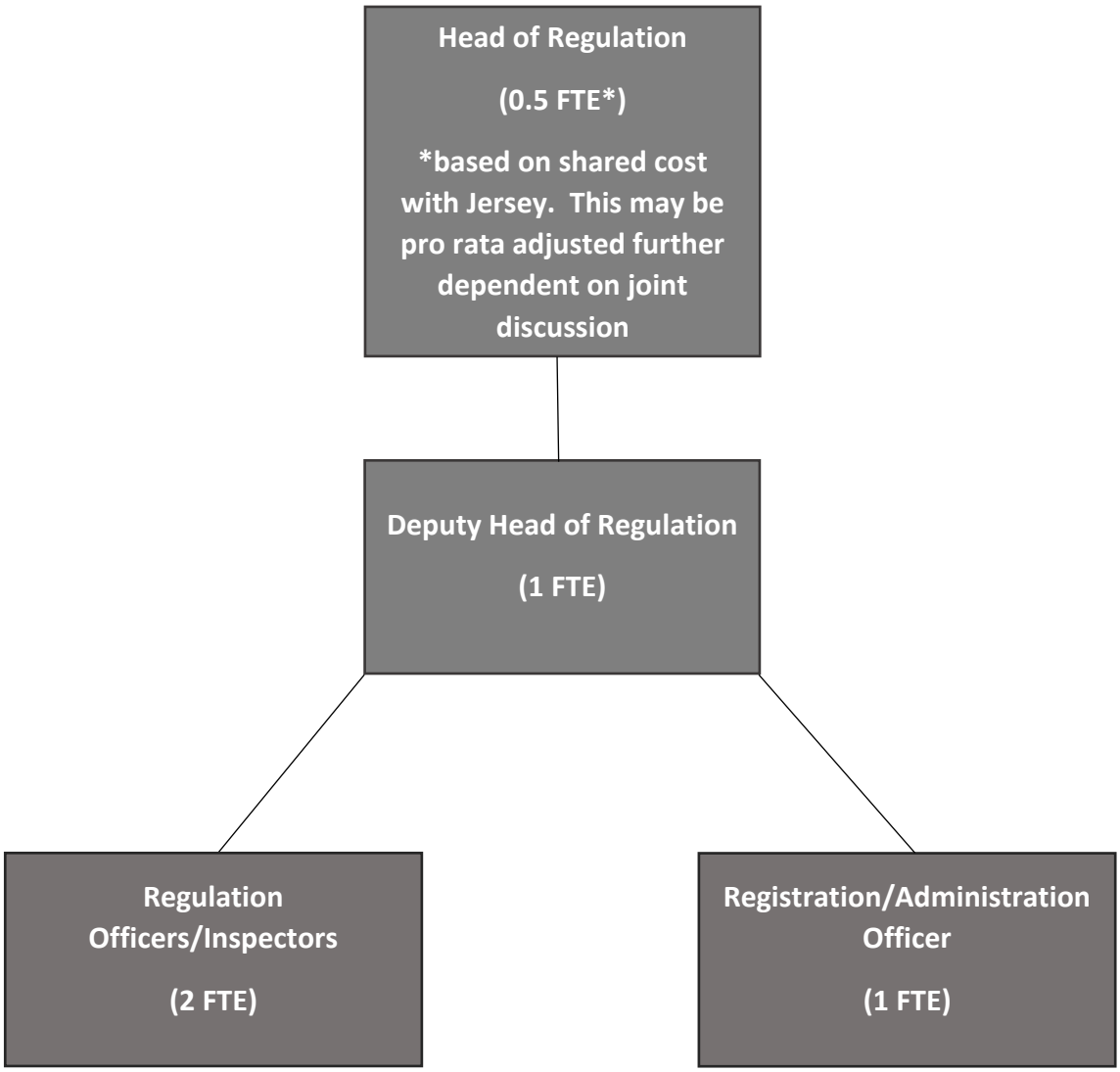
19	**Summary of Analysis** Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life? Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.	
20	**Eliminate discrimination, harassment and victimisation** Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).	
21	**Advance equality of opportunity** Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).	
22	**Promote good relations between groups** Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation).	

Section 6 – Evidence-based decision making

23	**Conclusion** Please give an outline of what you are going to do based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to eliminate discrimination issues, partnership working with stakeholders and data gaps that need to be addressed through further consultation or research.	

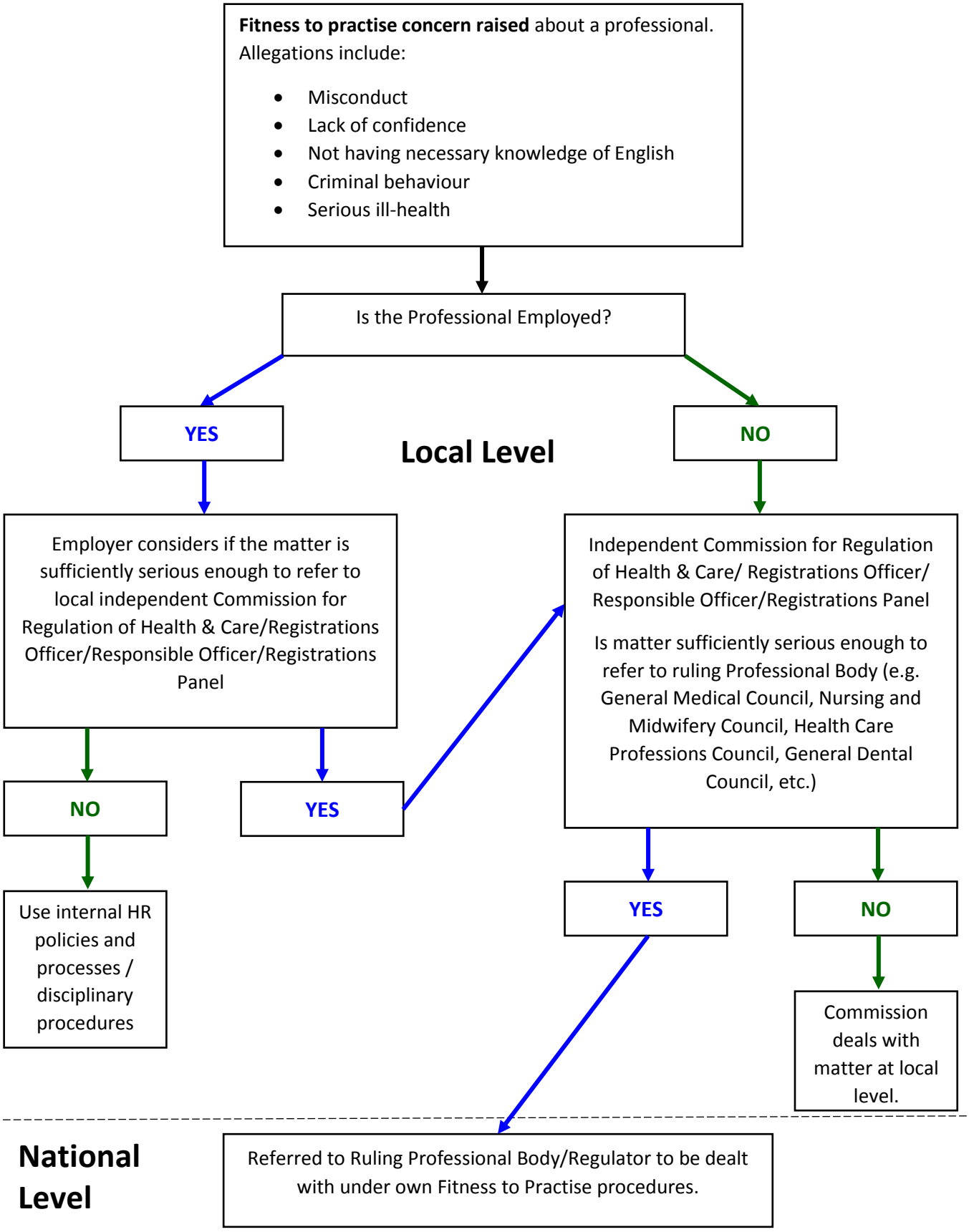
APPENDIX 2

Proposed Organisation Chart - Office of the Commission



APPENDIX 3

Regulation - Fitness to Practise Process Flowchart



APPENDIX 4

Consultation

Internal to Health & Social Care

- Head of Radiology and Clinical Services Director (Interim)
- Manager, Prison Healthcare
- Head Biomedical Scientist
- Community Adult Mental Health Service
- Chief Pharmacist, Assistant Director and Registrations Officer (Health Professionals)
- Deputy Chief Nurse
- Head of Midwifery
- Head of Hospital Services
- Fostering and Adoption Service
- Chief Nurse / Director of Governance
- Programme Manager, Target Operating Model
- Head of EBME
- Multi Agency Support Hub (MASH)
- Chief Secretary
- Theatres Manager
- Senior Operating Officer
- Dietetics
- Supported Living (La Grand Courtil)
- Head of Children and Family Community Services
- Oberlands Nursing Staff on Tautenay Ward
- Medical Director (in capacity as Medical Director and Responsible Officer)
- Duty and Brief Intervention
- Locum Consultant Social Care
- Head of Service, Children's Dental Services
- Community Nursing
- Registration & Inspection Officer – Nursing and Residential (HSC)
- HSC CareWatch
- HSC Clinical Reference Group
- HSC Quality Governance Committee

External to Health & Social Care

- Policy & Resources Committee
- Committee *for* Employment & Social Security
- Committee *for* Education, Sport & Culture
- Committee *for* Home Affairs
- States of Alderney
- Sark

- Aesthetic Skin Clinic, Former president and Fellow of the British College of Aesthetic Medicine
- Albecq Foot Clinic
- Avenue Clinic (Physiotherapy, Osteopathy, Podiatry, Acupuncture)
- Catalyst
- Chief Officer, St John Ambulance and Rescue Service
- Children's Convenor
- CI Healthcare (Domiciliary Care and Residential/Nursing Homes)
- CMC
- Commissioner of Health and Social Care, Jersey
- Connie's Carers
- Director of Learning, Performance & Intervention, Education Services
- Director, Les Bourgs Hospice
- Early Years Team Manager
- Falla & Le Page Chiropodists
- First Contact Health
- Former Chief Executive Guernsey Financial Services Commission and current Board member, Channel Islands Competition and Regulatory Authority (CICRA)
- Guernsey Cheshire Home
- Guernsey Chiropractic Clinic
- Guernsey Dental Association
- Guernsey Disability Alliance
- Guernsey MIND
- Guernsey Therapy Group
- Island Ultrasound
- Law Officers of the Crown
- Matron, St. John's Residential and Nursing Home
- Medical Specialist Group
- Neat Feet
- Philippi Trust
- Physio & Rehabilitation Clinic
- Physiotherapists
- Primary Care Practices (Healthcare Group, Island Health & Queen's Road Medical Practice)
- Senior Aesthetic Nurse Practitioner & Director of Medical Governance, Aesthetic Skin Clinic
- Specsavers Opticians
- St Martin's Foot Clinic
- States of Jersey Health and Social Services Department (Regulation)
- The Studio
- Thrive Physiotherapy

APPENDIX 5

Implementation Plan

	2019	2020	2021	2022
Regulation Model Policy Letter				
Prepare draft Primary Legislation				
Projet de Loi to States Assembly				
Projet de Loi to Privy Council				
Shadow Commission formed				
Preparation of Draft Ordinances				

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

HEALTH AND CARE REGULATION IN THE BAILIWICK

The President
Policy & Resources Committee
Sir Charles Frossard House
La Charroterie
St Peter Port

8th January, 2019

Dear Sir,

Preferred date for consideration by the States of Deliberation

In accordance with Rule 4(2) of the Rules of Procedure of the States of Deliberation and their Committees, the Committee *for* Health & Social Care requests that the propositions contained in its policy letter entitled 'Health and Care Regulation in the Bailiwick' dated 7th January 2019, be considered at the States' meeting to be held on 27th February, 2019.

This request is made on the basis that agreement of the States on the regulatory framework for health and care will enable the Committee to have sufficient time to carry out further consultation and engagement on its proposals and to liaise further with Jersey about the structure of the Commission Office. A timely debate by the States is essential to ensure that the budgetary requirements of the Committee for the year 2020 are fully informed by this additional work.

Yours faithfully,

H J R Soulsby
President

R H Tooley
Vice President

R G Prow
D A Tindall
E A Yerby

R Allsopp