MICHAELMAS MEETING of the CHIEF PLEAS
to be held on 2nd OCTOBER 2024 at 5pm in the ASSEMBLY ROOM

AGENDA

1. MATTERS ARISING from the Midsummer Meeting held on 3rd July 2024.
2. QUESTIONS Not Related to the Business of the Day.
3. To CONSIDER a Report with Proposition from the POLICY and FINANCE COMMITTEE entitled "**Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024**" and to APPROVE the Projet de Loi entitled **"The Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024"**.
4. To CONSIDER a Report with Proposition from the MEDICAL and EMERGENCY SERVICES COMMITTEE entitled "**Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024**". and to APPROVE the Projet de Loi entitled **"Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024"**.
5. To CONSIDER an Information Report from the TAXATION REVIEW (SPECIAL) COMMITTEE entitled **"Taxation Consultation with the Residents of Sark".**
6. To CONSIDER a Report with Proposition from the EDUCATION COMMITTEE entitled **"Change to Mandate".**
7. To CONSIDER a Report with Proposition from the POLICY and FINANCE COMMITTEE entitled **"Amendment to the Constitution and Operation of Chief Pleas Committees"**.
8. To CONSIDER a Report with Proposition from the DOUZAINE entitled **"Commercial Rubbish Charges".**
9. To CONSIDER a Report with Proposition from the DOUZAINE entitled **"Rubbish Incineration".**
10. To CONSIDER an Information Report from the DOUZAINE entitled **"Sewage Plant".**
11. To CONSIDER an Information Report from the DOUZAINE entitled **"Relocation of the Incinerator".**
12. To CONSIDER a Report with Proposition from the POLICY and FINANCE COMMITTEE entitled **"Appointment of a Managing Director of the Isle of Sark Shipping Company Limited".**
13. To CONSIDER an Information Report from the POLICY and FINANCE COMMITTEE entitled **"A Study of Water Supply in Sark".**

14. To CONSIDER an Information Report from the DOUZAINE entitled **"Handling of Complaints against the Constable – Progress Report".**

15. VERBAL REPORT from the DOUZAINE entitled **"Election / Reappointment of Constables".**

16. VERBAL REPORT from the DOUZAINE entitled **"Election / Reappointment of Assistant Constables".**

17. VERBAL REPORT from the DOUZAINE entitled **"Appointment of Procureur des Pauvres".**

18. VERBAL REPORT from the DOUZAINE entitled **"Appointment of Deputy Procureur des Pauvres".**

19. COMMITTEE ELECTIONS: To Elect Conseillers to Committees, as required.

20. COMMITTEE and PANEL ELECTIONS: To Elect Non-Chief Pleas Members and Panel Members to Committees and Panels, as required.

P M Armorgie
Speaker of Chief Pleas

11 September 2024

NOTES:

Anyone wishing to see any of the Reports and Supporting Papers may do so at the Committee Offices, Monday to Friday, 9am to 2pm; copies may be obtained from the Committee Office. The Agenda, Reports and Supporting Papers may also be seen on the Sark Government Website at: www.sarkgov.co.uk

ITEM 03

POLICY & FINANCE COMMITTEE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

THE SEXUAL ASSAULT REFERRAL CENTRE (PROCEDURE) (BAILIWICK OF GUERNSEY) LAW, 2024

The Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024 is intended to regulate the manner in which the SARC retains and discloses evidence and information emanating from clients, including from forensic medical examination.

The Committee brings this legislation to Chief Pleas for approval.

Proposition –

That Chief Pleas approves the attached draft Projet de Loi, entitled 'The Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024'.

Conseiller John Guille
Chairman, Policy & Finance Committee

PROJET DE LOI

ENTITLED

The Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024

ARRANGEMENT OF SECTIONS

PART IV

SHARING OF INFORMATION AND TRANSFER OF EVIDENCE

PART V

MISCELLANEOUS PROVISIONS

PROJET DE LOI

ENTITLED

The Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024

THE STATES, in pursuance of their Resolution of the 17th October 2023[a], have approved the following provisions which, subject to the Sanction of His Most Excellent Majesty in Council, shall have force of law in the Bailiwick of Guernsey.

PART I

INTRODUCTION

Meaning of the Sexual Assault Referral Centre.

1. Throughout this Law, any reference to "**the SARC**" is a reference to the Sexual Assault Referral Centre established by the Committee for providing -

(a) the examination service (see section 3), and

(b) the retention service (see section 7).

Availability of service.

2. (1) The SARC's examination service is to be available to any person falling within section 3(2), regardless of the person's place of residence.

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[a] Article VI of Billet d'État No. XVII of 2023.

(2) The SARC's retention service is to be available in relation to any person to whom the SARC provides the examination service.

PART II

THE EXAMINATION SERVICE

The examination service.

3. (1) The examination service consists of providing forensic medical examinations to persons falling within subsection (2), but subject to the limitations set out in section 4.

(2) A person falls within this subsection if -

(a) the person is referred by a police officer to the SARC for a forensic medical examination in connection with an incident in which -

(i) a sexual offence is alleged to have been committed against the person, or

(ii) the person is alleged to have been the subject of harmful sexual behaviour by a child under the age of criminal responsibility, or

(b) the person -

(i) is aged 16 or over,

(ii) is not referred by a police officer to the SARC, and

(iii) requests a forensic medical examination in connection with an incident reported to the SARC by the person as being of the type mentioned in paragraph (a).

(3) Throughout this Law, a "**forensic medical examination**" is a physical medical examination carried out for purposes including the collection of evidence for use in connection with -

(a) any investigation of the incident which gave rise to the need for the examination, or

(b) any proceedings in relation to the incident.

(4) The Committee may by regulations substitute a different age for the age for the time being specified in subsection (2)(b)(i).

(5) The age substituted for the age for the time being specified in subsection (2)(b)(i) in regulations made under subsection (4) must be -

(a) no lower than 13, and

(b) no higher than 18.

(6) Regulations under subsection (4) may make any incidental, supplementary, consequential, transitional, transitory or saving provision.

(7) In subsection (2) -

"**sexual offence**" -

(a) means an offence which involves -

(i) an element of physical, sexual contact, or

(ii) the ejaculation of semen, or the emission of urine or saliva sexually, onto a person, and

(b) includes an act done outside the Bailiwick which, if done in the Bailiwick, would constitute such an offence,

"**harmful sexual behaviour**" means behaviour (in the Bailiwick or elsewhere) which -

(a) causes or risks causing harm (whether physical or not) to another person, and

(b) involves -

(i) an element of physical, sexual contact, or

(ii) the ejaculation of semen, or the emission of urine or saliva sexually, onto a person.

Limitation on provision of forensic medical examinations.

4. Nothing in this Law requires -

(a) a forensic medical examination to be carried out where a professional judgement is made that the examination should not be carried out, or

(b) a particular action to be carried out as part of a forensic medical examination where a professional judgement is made that the action should not be carried out.

Information to be provided before examination.

5. (1) This section applies where a person is referred for or requests a forensic medical examination as mentioned in section 3(2).

(2) Before any evidence is collected -

(a) the person who has been referred for or, as the case may be, who requested the examination must, so far as reasonably practicable, be provided with the information mentioned in subsection (3), and

(b) the information must, so far as reasonably practicable, be explained to the person.

(3) The information is -

(a) information about -

(i) the circumstances in which any evidence collected during the examination may be transferred to a police officer, and

(ii) the purposes for which such evidence may then be used, and

(b) where the forensic medical examination is requested under section 3(2)(b), information about -

(i) the person's rights to request the return of certain items under section 8 and to request the destruction of evidence under section 9(1)(a),

(ii) the destruction of evidence under section 9(1)(b), and

(iii) the circumstances in which information relating to the incident can be shared with a police officer under Part IV.

(4) Failure to comply with subsection (2) does not by itself render any evidence collected during the examination inadmissible in any proceedings in relation to the incident.

(5) In this section "**incident**" means the incident that gave rise to the need for a forensic medical examination.

Health care needs.

6. (1) The SARC must take such steps as are reasonably practicable to ensure that, where a person is referred for or requests a forensic medical examination as mentioned in section 3(2), any health care needs of the person arising from the incident that gave rise to the need for the examination are identified and addressed.

(2) Subsection (1) applies even where the person does not proceed to undergo a forensic medical examination.

(3) In discharging its obligation under subsection (1), the SARC -

(a) is to have regard to the importance of providing health care in a way that seeks to avoid re-traumatisation and is otherwise trauma-informed, and

(b) may refer the person to other service providers.

PART III
THE RETENTION SERVICE

The retention service.

7. (1) The retention service consists of storing, for the purpose mentioned in subsection (2), evidence which -

(a) was collected during a forensic medical examination carried out by virtue of section 3, and

(b) has not been transferred to a police officer under section 17.

(2) The purpose is the preservation of the evidence for use in connection with -

(a) any investigation of the incident that gave rise to the need for the examination, or

(b) any proceedings in relation to that incident.

Return of certain items of evidence.

8. (1) This section applies where evidence collected during a forensic medical examination carried out by virtue of section 3(2)(b) and stored by the SARC under section 7 includes an item that was worn or otherwise present during the incident that gave rise to the need for the examination.

(2) The person who underwent the examination may request in writing that the item be returned to the person.

(3) Subsection (4) applies where -

(a) the SARC is not satisfied that the requested item belongs to the person who made the request,

(b) the SARC considers that the requested item should not be returned to the person on safety grounds,

(c) the person who made the request is under the age of 18 years, or

(d) a request under section 17(2) for the transfer of the requested item to a police officer -

(i) was made before the making of the request under subsection (2), or

(ii) is made after the making of the request under subsection (2) but before the requested item is returned to the person.

(4) Where this subsection applies, the SARC must -

(a) refuse the request, and

(b) except in a case mentioned in subsection (3)(d), explain the reason for the refusal to the person who made the request as soon as reasonably practicable.

(5) If subsection (4) does not apply, the SARC must comply with the request as soon as reasonably practicable.

Destruction of evidence.

9. (1) Subject to the remainder of this section, the SARC must ensure that any evidence collected during a forensic medical examination carried out by virtue of section 3(2)(b) and stored by the SARC under section 7 is destroyed as soon as reasonably practicable after whichever of the following occurs first -

(a) the expiry of the period of 30 days beginning with the day of the making, by the person who underwent the examination, of a valid request that the evidence be destroyed, or

(b) the expiry of 24 months from the relevant date or, if the SARC has agreed in writing with the person who underwent the examination to store the evidence for more than 24 months from the relevant date, the expiry of such a longer period agreed.

(2) For the purpose of subsection (1)(a) a "**valid request**" is a request in writing from a person who has attained the age of 18 years.

(3) For the purpose of subsection (1)(b) the "**relevant date**" is –

(a) if the person who underwent the examination had attained the age of 18 years on the date of that examination, the date that the evidence was collected,

(b) if the person who underwent the examination was under the age of 18 years on the date of that examination, the date that the person attains that age.

(4) The SARC must ensure that evidence is not destroyed under subsection (1)—

(a) on the basis of a valid request made under paragraph (a) of that subsection if the request is withdrawn by the person who made it before the expiry of the period mentioned in that paragraph, or

(b) if subsection (5) or (6) applies.

(5) This subsection applies where—

(a) a request was made under section 17(2) before the expiry of the period mentioned in subsection (1)(a) or, as the case may be, (b) for evidence to be transferred to a police officer, and

(b) at the time the period expires, the request has not been complied with.

(6) Subject to subsection (7), this subsection applies where a request is made under section 17(2) for evidence to be transferred to a police officer -

(a) after the expiry of the period mentioned in subsection (1)(a) or, as the case may be, (b), and

(b) before the evidence is destroyed.

(7) Subsection (6) does not apply where the request is made at a time when it is not reasonably practicable to stop the destruction of the evidence.

(8) The Committee may by regulations amend the periods specified in subsections (1)(a) and (1)(b) and such regulations may make -

(a) different provision for different purposes,

(b) any incidental, supplementary, consequential, transitional, transitory or saving provision.

Retention and destruction after examination of self-referring, under-age person.

10. (1) Subsection (2) applies where -

(a) a forensic medical examination has been carried out by virtue of section 3(2)(b), and

(b) the SARC subsequently establishes that the person was, at the time of the examination, under the age mentioned in that section at that time.

(2) The fact that the person was under that age at that time does not on its own –

(a) affect the validity of -

(i) the carrying out of the examination,

(ii) anything done by the SARC prior to the person's true age being established in relation to any evidence collected during the examination,

(iii) the continuing storage of any such evidence under section 7,

(b) render evidence collected during the forensic medical examination inadmissible in any proceedings in relation to the incident that gave rise to the need for a forensic medical examination, or

(c) render such proceedings an abuse of process.

Transitional arrangements for the retention and destruction of evidence.

11. (1) This section applies where, on the commencement of this Law, the SARC already has in its possession evidence obtained from a forensic medical examination of a person who, if this Law had been in force at the time of that examination, would have fallen within section 3(2)(b).

(2) The provisions of this Part and sections 17 to 19 apply (with any necessary modifications) to the retention, destruction and transfer of that evidence as though that evidence -

(a) was collected on the day that this Law commenced,

(b) was collected during a forensic medical examination carried out by virtue of section 3(2)(b), and

(c) is being stored under section 7.

PART IV

SHARING OF INFORMATION AND TRANSFER OF EVIDENCE

Non-disclosure where self-referring client wishes to report to police.

12. (1) This section applies where a self-referring client indicates that they wish to directly report the incident to a police officer.

(2) Where this section applies then, subject to sections 16, 17 and 19, the SARC does not have any obligation to disclose to a police officer incident information.

Disclosure without anonymisation with agreement of self-referring client.

13. (1) This section applies where a self-referring client -

(a) does not wish to directly report the incident to a police officer, but

(b) agrees to the SARC providing incident information to a police officer without that information being anonymised.

(2) Where this section applies then, subject to the remainder of this section, the SARC must disclose incident information to a police officer without anonymising that information.

(3) Before any disclosure under subsection (2), the SARC must explain to the self-referring client that -

(a) the consequences of the self-referring client's agreement described in subsection (1)(b) are that a police officer may -

(i) commence a criminal investigation,

(ii) request evidence from the SARC under section 17, and

(iii) contact the self-referring client with a view to securing a statement from the self-referring client, and

(b) if a criminal investigation results in criminal proceedings against an alleged perpetrator of the incident, it is possible, although not inevitable, that the self-referring client's attendance at trial will be compelled through powers under other enactments, or under the customary law.

(4) Until disclosure under subsection (2), a self-referring client may withdraw their agreement under subsection (1)(b), in which case -

(a) the incident information must not be disclosed under subsection (2), and

(b) the self-referring client may instead agree to proceed in accordance with section 12, 14 or 15.

Anonymised disclosure with agreement of self-referring client.

14. (1) This section applies where a self-referring client -

(a) does not wish to directly report the incident to a police officer, but

(b) agrees to the SARC providing incident information to a police officer provided that the information is anonymised.

(2) Where this section applies then, subject to the remainder of this section and sections 16, 17 and 19, the SARC must disclose incident information to a police officer in a manner that ensures that the information is anonymised.

(3) Before disclosure under subsection (2), it must be explained to the self-referring client that the consequences of anonymisation are that a police officer -

(a) will not be able to request evidence from the SARC under section 17, and

(b) may not have sufficient information or evidence to commence a criminal investigation.

(4) Until disclosure under subsection (2), a self-referring client may withdraw their agreement under subsection (1)(b), in which case -

(a) the incident information must not be disclosed under subsection (2), and

(b) the self-referring client may instead agree to proceed in accordance with section 12, 13 or 15.

(5) After a disclosure under subsection (2), a self-referring client may agree to the SARC providing incident information to a police officer without that information being anonymised, in which case section 13 applies.

Non-disclosure where self-referring client does not agree to disclosure.

15. (1) This section applies when a self-referring client -

(a) does not wish to directly report the incident to a police officer, and

(b) will not agree to the SARC providing incident information to a police officer irrespective of whether or not that information is anonymised.

(2) Where this section applies then, subject to sections 16, 17 and 19, the SARC must not disclose incident information to a police officer.

Disclosure without agreement.

16. (1) Nothing in this Part affects any obligation under any other enactment or the customary law to disclose information (whether to a police officer or otherwise) in order to safeguard -

(a) any person who is under the age of 18 years,

(b) any person who is vulnerable, or

(c) a self-referring client who lacks capacity, within the meaning of section 4 of the Capacity (Bailiwick of Guernsey) Law, 2020[b], to make a decision on the sharing of information under this Part,

and accordingly a disclosure in such circumstances does not contravene any provision of this Part, irrespective of the absence of the self-referring client's agreement to such a disclosure.

(2) Notwithstanding the provisions of this Part, the SARC must disclose incident information without anonymisation to a police officer when -

(a) a forensic medical examination has been carried out by virtue of section 3(2)(b), and

(b) the SARC subsequently establishes that the person was, at the time of the examination, under the age mentioned in that section at that time,

and accordingly a disclosure in such circumstances does not contravene any provision of this Part, irrespective of the absence of the self-referring client's agreement to such a disclosure.

(3) Where the serious harm test is met, and notwithstanding the provisions of this Part, the SARC must disclose as much incident information to a

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b Order in Council No. II of 2021; this enactment has been amended.

police officer as, in the SARC's assessment, is sufficient to mitigate the risk of serious physical or psychological harm.

(4) Subsection (3) applies irrespective of whether such a disclosure would be contrary to a self-referring client's wish for -

(a) no disclosure, or

(b) only anonymised disclosure.

(5) In subsection (3) "**the serious harm test**" means that, if the disclosure is not made, or if it is made only after being anonymised, as the case may be, the self-referring client, the public or any particular person or class of person would be at a material risk of serious physical or psychological harm.

(6) If, in accordance with any provision of this section, a decision is made to disclose incident information without the self-referring client's agreement to that disclosure, the self-referring client must be informed of that decision unless the SARC assesses that -

(a) it is impracticable to do so,

(b) it would expose the self-referring client to a material risk of physical or psychological harm, or

(c) there would be a substantial risk of prejudice to the administration of justice if the client was so informed.

Transfer of evidence to police.

17. (1) This section applies in any of the following circumstances namely -

(a) where a forensic medical examination has been carried out following a person being referred for such an examination as mentioned in section 3(2)(a),

(b) where -

(i) a forensic medical examination has been carried out following a person requesting such an examination as mentioned in section 3(2)(b), and

(ii) either -

(A) the person has subsequently reported the incident in connection with which the examination took place to a police officer, or

(B) the SARC has under section 13 disclosed incident information without anonymisation, and with the agreement of the person, to a police officer,

(c) where -

(i) a forensic medical examination has been carried out following a person requesting such an examination as mentioned in section 3(2)(b),

(ii) the SARC has subsequently established that the person was, at the time of the examination, under the age mentioned in that section at that time, and

(iii) accordingly incident information without anonymisation has been disclosed to a police officer under section 16(2).

(2) Where this section applies, a police officer may request the transfer to the police officer of any evidence collected during the examination and stored or otherwise held by the SARC that is required for the purposes of -

(a) investigation of the incident that gave rise to the need for the examination, or

(b) proceedings in relation to the incident.

(3) The SARC must comply with the request as soon as reasonably practicable.

Non-compliance with this Part.

18. (1) Failure to comply with any of sections 12 to 17 does not by itself -

(a) render evidence inadmissible in any proceedings in relation to the incident, or

(b) render such proceedings an abuse of process.

(2) A court may, if it considers it to be in the interests of justice to do so, consider any failure to comply with the provisions of this Part when deciding whether or not to issue a witness summons obliging a self-referring client's attendance at court proceedings.

Court order for disclosure or production of SARC material.

19. (1) Nothing in this Part alters the obligation of the SARC to comply with a court order made under any other enactment or under the customary law for the disclosure of, or production of, material held by the SARC.

(2) Subsection (3) applies when -

(a) a person makes an application for a court order described in subsection (1), and

(b) section 17 does not apply.

(3) Where this subsection applies, the court must have regard to the importance of the SARC being able to provide the examination service and the retention service in a confidential manner and must refuse the application unless -

(a) the granting of the application is necessary to avoid a material risk of a miscarriage of justice, or

(b) there are other exceptional reasons why it is in the interests of justice to grant the application.

(4) This section is without prejudice to any other criteria required for the making of the order, within the enactment or the customary law (as the case may be) under which the application is made.

(5) Where a court receives an application for an order described in subsection (1) it may, prior to determining the application, direct the SARC to retain the material specified in the direction until further direction.

(6) The SARC must comply with a direction under subsection (5) and the direction suspends any obligation of the SARC under this Law to destroy or return the material specified in the direction.

(7) Where a court makes a direction under subsection (5) it must, if it refuses the application, revoke the direction under subsection (5) and notify the SARC that it has done so.

Interpretation of this Part.

20. In this Part –

"**anonymised**" means disclosed in such a manner, such as through the use of redactions, that the self-referring client's identity is not revealed to the police officer receiving the information, and "**anonymisation**" shall also be construed accordingly,

"**incident**" means the incident reported to the SARC by the self-referring client as being of the type mentioned in section 3(2)(a),

"**incident information**" means any fact relating to the incident, including the identity of any person involved in that incident, and

"**self-referring client**" means a person to whom section 3(2)(b) applies.

PART V

MISCELLANEOUS PROVISIONS

Exclusion of liability.

21. (1) The SARC, and anyone employed by the SARC, shall not be –

(a) liable in damages, or

(b) personally liable in any civil proceedings,

in respect of anything done or omitted to be done after the commencement of this Law in the discharge or purported discharge of functions under Part III or Part IV, unless the thing was done or omitted to be done in bad faith.

(2) Subsection (1) does not apply so as to prevent an award of damages in respect of the act or omission on the ground that it was unlawful as a result of section 6(1) of the Human Rights (Bailiwick of Guernsey) Law, 2000.[c]

Power to make Ordinances.

22. (1) The States may by Ordinance amend -

(a) Part II of this Law in respect of -

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[c] Order in Council No. XIV of 2000; this enactment has been amended.

(i) the type of incident in connection with which the examination service may be provided, or

(ii) the circumstances in which the examination service may be provided to a person without that person having been referred to the SARC by a police officer,

(b) Part III of this Law in respect of the circumstances in which -

(i) a person's request for items to be returned to that person under section 8 may or must be accepted or refused, or

(ii) the SARC may or must destroy or retain evidence,

(c) Part IV of this Law in respect of -

(i) the circumstances in which information may, must or must not be shared with, disclosed to, transferred to or produced to a police officer (including the circumstances in which such information may, must or must not be anonymised),

(ii) the matters that may or must be considered by a court when deciding whether to grant an application for the disclosure or production of

material held by the SARC, and the criteria to be applied when determining such an application, or

(iii) the power of the court to prohibit the destruction of material held by the SARC pending the court's determination of an application for the disclosure or production of that material,

(d) sections 24 and 25 and any defined term (including the definition of that term) elsewhere in this Law, or

(e) any provision of this Law -

(i) in respect of the information that may or must be given to any person using (or deciding whether to use) the examination service or the retention service, or

(ii) that the Committee has power to amend by regulation.

(2) The States may by Ordinance make any provision they think fit -

(a) in respect of the processes and procedures of the SARC, or

(b) for the purposes of, in connection with, or for giving full effect to, this Law,

and may, for this purpose and by such an Ordinance, modify this enactment, any other enactment or the customary law.

Further provision regarding regulations.

23. Regulations made by the Committee pursuant to sections 3(4) or 9(8) shall be laid before a meeting of the States as soon as possible after being made; and if at that or the next meeting the States resolve that the regulations be annulled, the regulations shall cease to have effect but without prejudice to anything done under them or to the making of new regulations.

Interpretation.

24. (1) In this Law, unless the context requires otherwise -

"**age of criminal responsibility**" means the minimum age at which a child can be guilty of a criminal offence in accordance with section 3 of the Criminal Justice (Children and Juvenile Court Reform) (Bailiwick of Guernsey) Law, 2008[d],

"**anonymised**" has the meaning given in section 20,

"**the Committee**" means the Committee for Home Affairs,

"**evidence**" has the meaning given in section 25,

"**the examination service**" has the meaning given in section 3(1),

"**forensic medical examination**" has the meaning given in section 3(3),

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d Order in Council No.VI of 2009; this enactment has been amended.

"**harmful sexual behaviour**" has the meaning given in section 3(7),

"**investigation**" means -

(a) a criminal investigation, or

(b) a police investigation of behaviour by a child under the age of criminal responsibility,

"**police officer**" means -

(a) in relation to Guernsey, Herm and Jethou, a member of the salaried police force of the Island of Guernsey and, within the limits of the member's jurisdiction, a member of the special constabulary of the Island of Guernsey,

(b) in relation to Alderney, a member of the salaried police force of the Island of Guernsey, a member of any police force which may be established by the States of Alderney and, within the limits of the special constable's jurisdiction, a special constable appointed pursuant to section 47 of the Government of Alderney Law, 2004[e],

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[e] Order in Council No. III of 2005; this enactment has been amended.

(c) in relation to Sark, the Constable, the Vingtenier and a member of the salaried police force of the Island of Guernsey,

"**proceedings**" means criminal proceedings,

"**relevant date**" has the meaning given in section 9(3),

"**the retention service**" has the meaning given in section 7(1),

"**the SARC**" has the meaning given in section 1,

"**self-referring client**" has the meaning given in section 20,

"**sexual offence**" has the meaning given in section 3(7), and

"**valid request**" has the meaning given in section 9(2).

(2) References in this Law to the need for a forensic medical examination include, where the person referred for or, as the case may be, requesting the examination does not proceed to undergo such an examination, reference to the need for the referral or, as the case may be, request for such an examination.

(3) Subsection (4) applies where, by virtue of section 25(3), something is to be regarded as having been collected or created during or in connection with a forensic medical examination despite the person who was referred for or requested the examination not proceeding to undergo such an examination.

(4) Where this subsection applies, Parts III and IV are to be read as if a forensic medical examination has been carried out, and references to the person undergoing the examination are to be construed accordingly.

Meaning of references to "evidence".

25. (1) References in this Law (however expressed) to evidence collected during a forensic medical examination include reference to -

(a) images created,

(b) samples (for example, samples of blood, semen, urine, or hair and samples taken by swabbing a person's genitals or bodily orifices) collected,

(c) any notes or other records (including notes or records about matters other than the physical condition of the person undergoing the examination) created,

(d) items worn or otherwise present during the incident that gave rise to the need for such an examination and collected,

during or in connection with the examination.

(2) Such references do not include reference to anything collected or created during or in connection with the examination if the thing was collected or created for use other than use as is mentioned in section 3(3) (for example, for use in identifying, recording and addressing the health care needs of the person undergoing the examination).

(3) Anything collected or created in anticipation of a forensic medical examination being carried out under this Law is to be regarded as having been collected or created during or in connection with such an examination even

where the person who was referred for or, as the case may be, requested the examination does not proceed to undergo such an examination.

(4) References in this section to images, notes and other records include reference to those things in all forms that the things exist (for example, digital or physical form).

Extent.

26. This Law shall have effect in the Bailiwick of Guernsey.

Citation.

27. This Law may be cited as The Sexual Assault Referral Centre (Procedure) (Bailiwick of Guernsey) Law, 2024.

Commencement.

28. This Law shall come into force on the date of its registration on the records of the Island of Guernsey.

ITEM 04

MEDICAL & EMERGENCY SERVICES COMMITTEE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

REGULATION OF CARE (ENABLING PROVISIONS) (BAILIWICK OF GUERNSEY) LAW, 2024

The Regulation of Care legislation is intended to provide a legal framework to implement a system of fair, proportionate regulation across the Bailiwick.

The enabling law will give powers to make Ordinances that will set out standards for care professions and providers. Officers in Guernsey will liaise with the Medical & Emergency Services Committee and Officials, in particular the Island Safeguarding Officer, to receive guidance as to what is proportionate for Sark.

The Committee therefore requests Chief Pleas to consider and approve the **Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024**.

Proposition –

That Chief Pleas approves the 'Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024'.

Conseiller Helen Plummer
Chairman, Medical & Emergency Services Committee

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

Contents

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
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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.

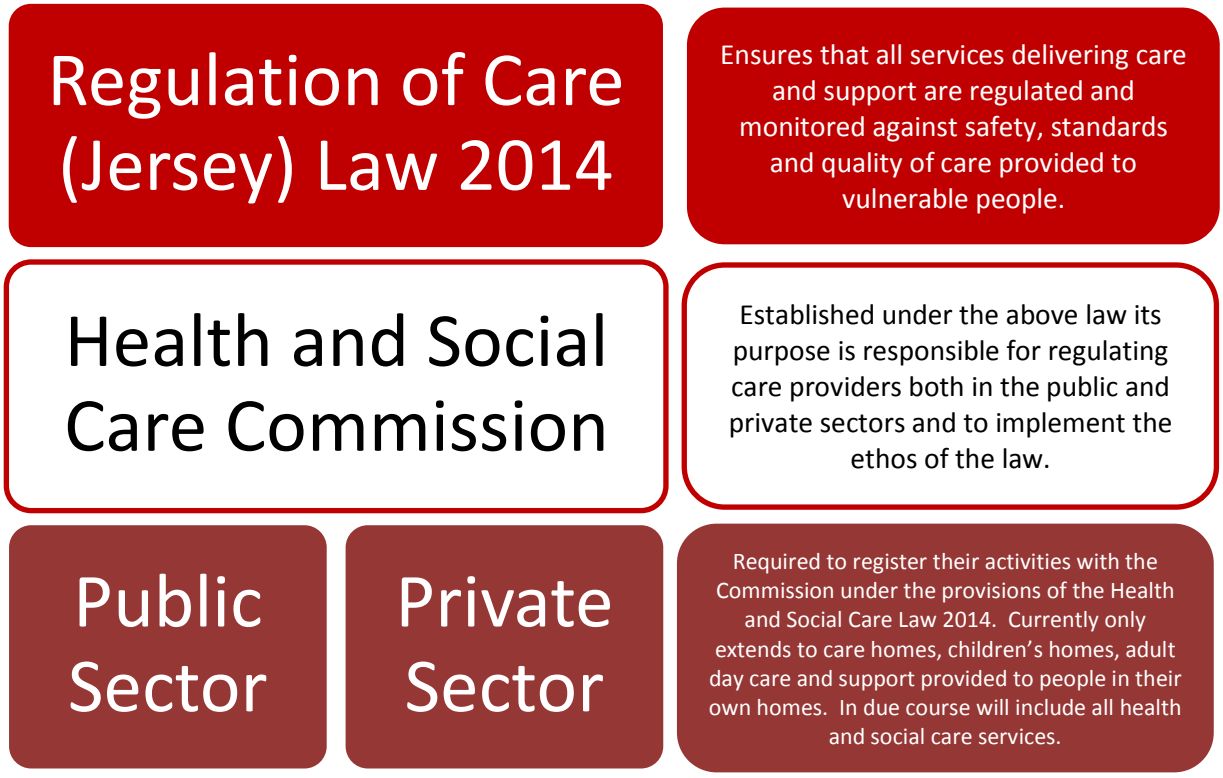

Diagram 1: The Regulation of Care (Jersey) Law 2014

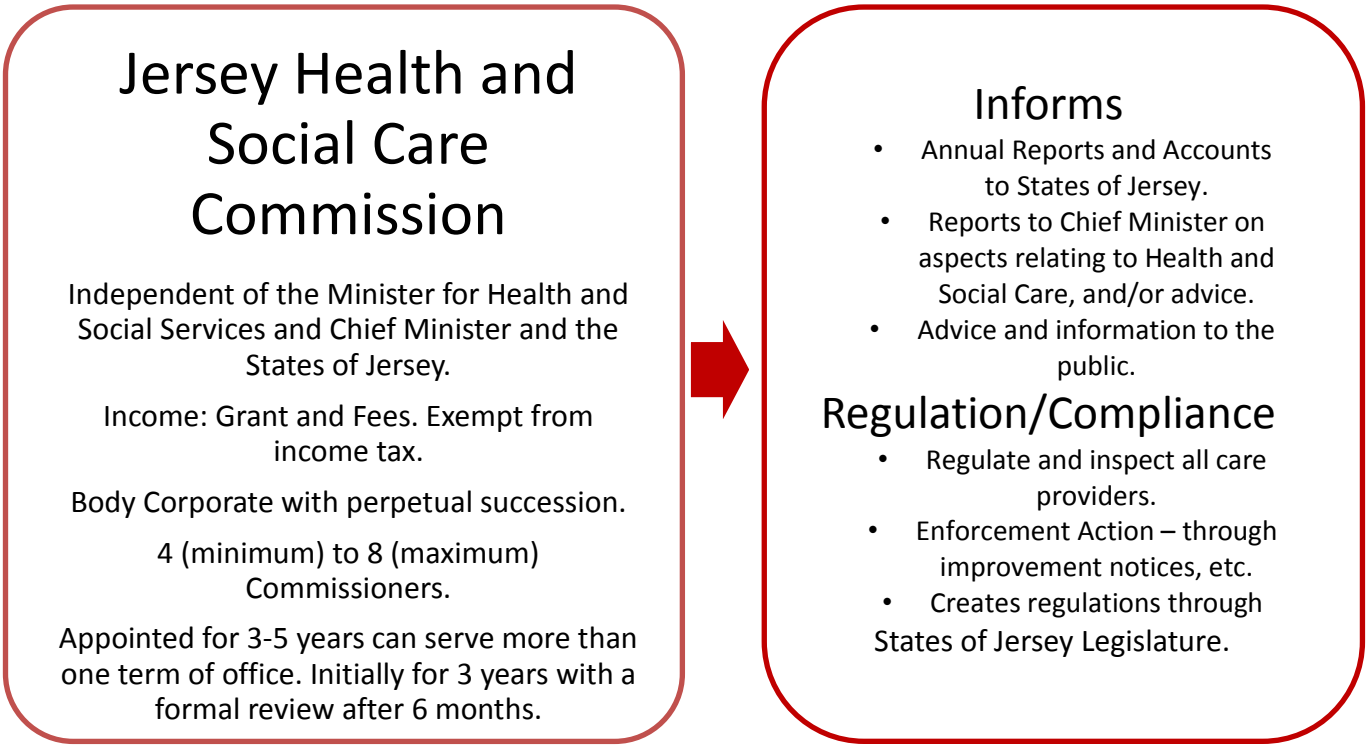

Diagram 2: The constitution of the Jersey Health and Social Care Commission and role.

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

McHugh, M. D., Kelly, L. A., Smith, H. L., Wu, E. S., Vanak, J. M., & Aiken, L. H. (2013). Lower Mortality in Magnet Hospitals. *The Journal of Nursing Administration*, *43*(10 0), S4–10. http://doi.org/10.1097/01.NNA.0000435145.39337.d5

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

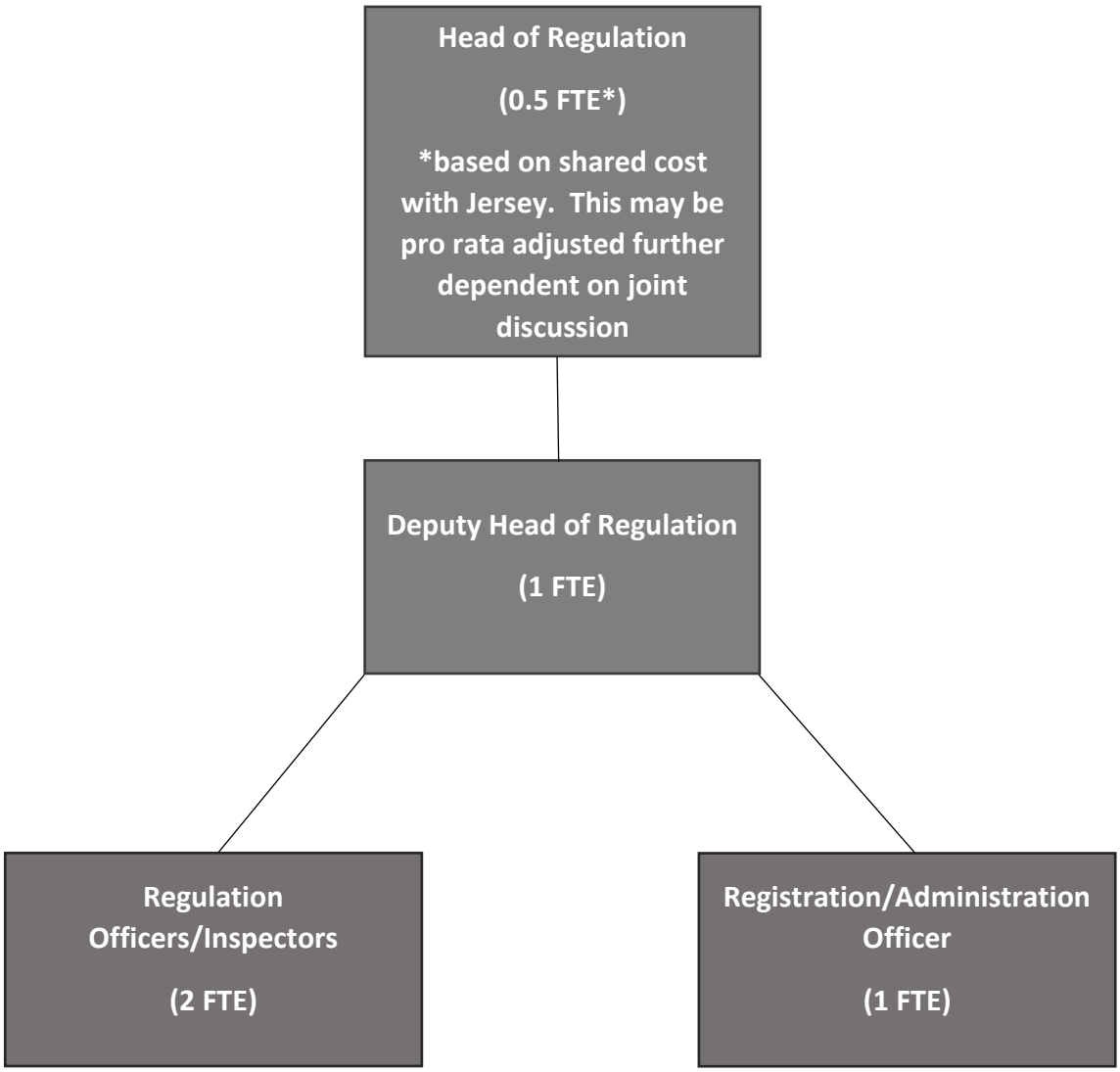
19	**Summary of Analysis** Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will 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.	

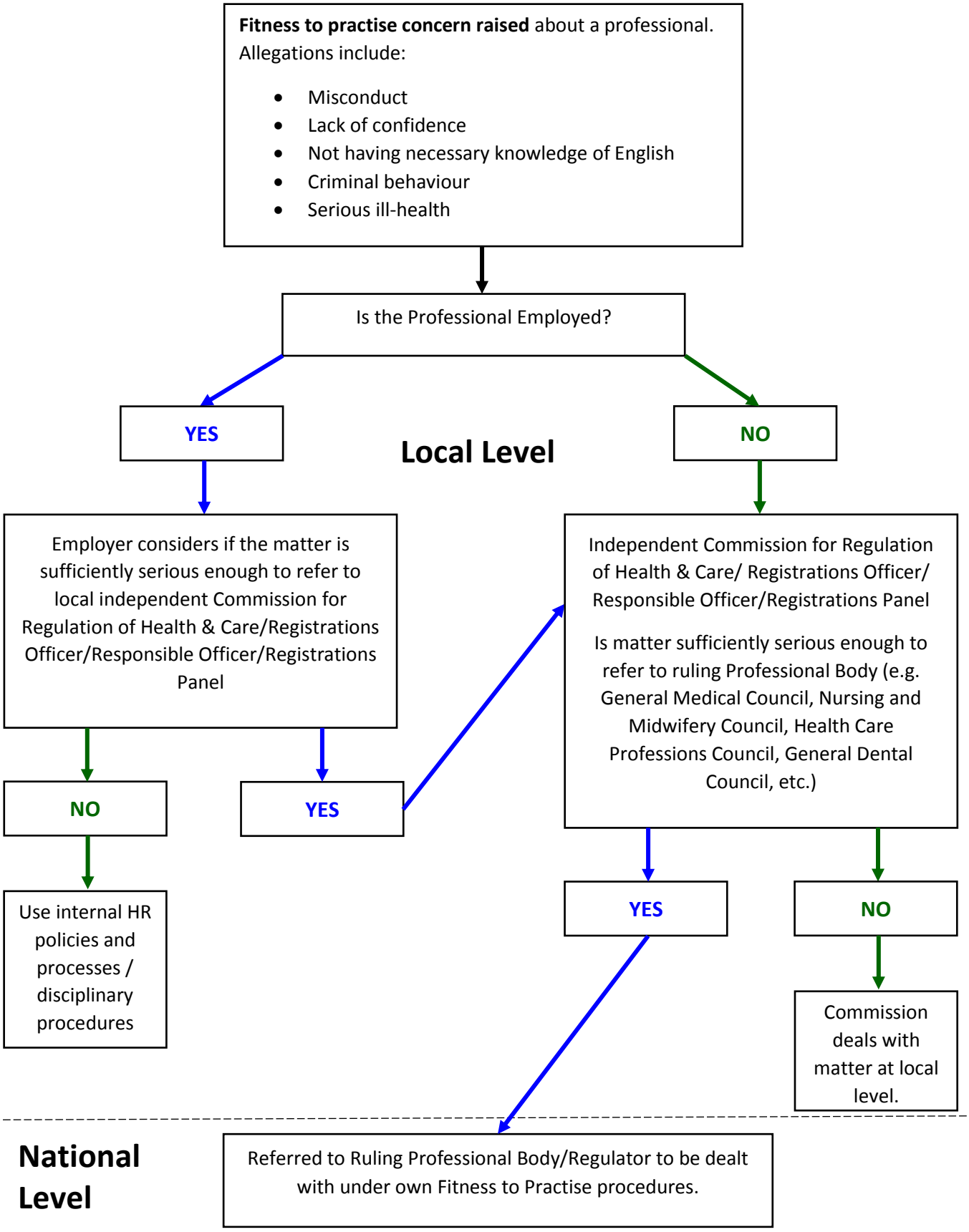
APPENDIX 2

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

PROJET DE LOI

ENTITLED

The Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024

ARRANGEMENT OF SECTIONS

PROJET DE LOI

ENTITLED

The Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024

THE STATES, in pursuance of their Resolution of the 28th February, 2019[a], have approved the following provisions which, subject to the Sanction of His Most Excellent Majesty in Council, shall have force of law in the Bailiwick of Guernsey.

Object of this Law.

1. The object of this Law is to -

(a) protect public safety and the safety of individuals who receive care,

(b) promote, and where practicable ensure, safety and quality in relation to care, and

(c) ensure the appropriate regulation of care.

General power to make Ordinances relating to care.

2. (1) The States may by Ordinance make any provision they think fit relating to the following -

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[a] Article V of Billet d'État No. III of 2019.

(a) health care,

(b) social care.

(2) Schedule 1 has effect.

(3) In this Law, "**health care**" and "**social care**" have the respective meanings given by Schedule 1.

Specific matters and purposes for which Ordinances may make provision.

3. (1) Without limiting the generality of section 2, an Ordinance may make provision in relation to the following -

(a) the provision of care,

(b) the practise of a care profession,

(c) any matter set out in Schedule 2,

(d) any purpose set out in Schedule 3.

(2) In this Law, "**care profession**", "**practise**" and "**provision of care**" have the respective meanings given by Schedule 1.

Ordinances may amend or repeal section 7 and Schedules 1, 2, 3 and 4.

4. The States of Deliberation may at any time by Ordinance amend or repeal all or any part of the following -

(a) section 7,

(b) Schedule 1,

(c) Schedule 2,

(d) Schedule 3,

(e) Schedule 4.

Ordinances having effect in Alderney or Sark.

5. (1) Before recommending that the States of Deliberation enact an Ordinance under this Law having effect in Alderney or Sark, the Committee must consult on the terms of the proposed Ordinance with -

(a) in the case of an Ordinance having effect in Alderney, the Policy & Finance Committee of the States of Alderney, and

(b) in the case of an Ordinance having effect in Sark, the Policy and Finance Committee of the Chief Pleas of Sark.

(2) However, failure to comply with subsection (1) does not invalidate an Ordinance.

(3) An Ordinance ceases to have effect -

(a) in Alderney if, within the period of four months immediately following the approval date, the States of Alderney resolve to disapprove its application to Alderney, and

(b) in Sark if, at the first or second meeting of the Chief Pleas of Sark following the approval date, the Chief Pleas resolve to disapprove its application to Sark.

(4) If the States of Alderney or the Chief Pleas of Sark resolve to disapprove the application of an Ordinance in accordance with subsection (3), the Ordinance ceases to have effect in Alderney or (as the case may be) Sark, but without prejudice to -

(a) anything done under the Ordinance in Alderney or (as the case may be) Sark, or

(b) the making of a new Ordinance having effect in Alderney or (as the case may be) Sark.

(5) In this section, "**approval date**", in relation to an Ordinance, means the date of its approval by the States of Deliberation.

General provisions as to Ordinances.

6. (1) Subject to subsection (2), an Ordinance under this Law may do any or all of the following -

(a) repeal, replace, amend, extend, adapt, modify or disapply any rule of custom or law,

(b) make provision under the powers conferred by this Law despite the provisions of any enactment for the time being in force,

(c) without limiting the generality of paragraph (a) or (b), make any such provision to such extent as might be made by Projet de Loi.

(2) An Ordinance under this Law must not -

(a) provide for an offence to be triable only on indictment,

(b) provide that a person is to be guilty of an offence as a result of any retrospective effect of the Ordinance, or

(c) authorise the imposition, on conviction of an offence, of imprisonment for a term exceeding two years.

(3) An Ordinance under this Law may amend or repeal a Law specified in Schedule 5.

(4) Nothing in this section limits the effect of section 20 of the Interpretation and Standard Provisions (Bailiwick of Guernsey) Law, 2016[b].

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[b] Order in Council No. V of 2018; this enactment has been amended.

Interpretation.

7. (1) In this Law, unless the context requires otherwise -

"**approval date**": see section 5(5),

"**care**" means health care or social care,

"**care profession**": see Schedule 1,

"**the Commission**" means a Commission established and constituted under this Law,

"**the Committee**" means the States of Guernsey Committee for Health and Social Care,

"**cosmetic intervention**": see Schedule 1,

"**health**" means physical or mental health,

"**health care**": see Schedule 1,

"**this Law**" includes –

(a) an Ordinance made under this Law, and

(b) any subordinate legislation made under any such Ordinance,

"**medical**", for the avoidance of doubt, includes dental,

"**the Medical Device Regulation**" means Regulation (EU) 2017/745 of the European Parliament and of the Council of 5 April 2017 on medical devices, amending Directive 2001/83/EC, Regulation (EC) No 178/2002 and Regulation (EC) No 1223/2009 and repealing Council Directives 90/385/EEC and 93/42/EEC,

"**nurse**" includes a person registered as a nurse or midwife in the register of health professionals maintained under section 3 of the Registered Health Professionals Ordinance, 2006[c] or section 3 of the Regulation of Health Professions (Non-medical) (Sark) Ordinance, 2018[d],

"**nursing care**" means a service that should be provided by a nurse because of its nature and circumstances, including the need for clinical judgment,

"**personal care**" -

(a) means assistance in daily living, including -

(i) practical assistance with daily tasks, such as eating, washing and dressing, and

(ii) prompting a person to carry out daily tasks, but

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c Ordinance No. III of 2006; this enactment has been amended.

d Sark Ordinance No. IV of 2018.

(b) excludes health care,

"**personal data**" has the meaning given by section 111(1) of the Data Protection (Bailiwick of Guernsey) Law, 2017[e],

"**personal support**" -

(a) includes supervision, guidance, counselling or other support in daily living provided for an individual as part of a programme of such supervision, guidance, counselling or other support, but

(b) excludes health care,

"**practise**": see Schedule 1,

"**prescribed**" means prescribed by or under an Ordinance,

"**provision of care**": see Schedule 1,

"**social care**": see Schedule 1,

"**specified matter or purpose**" means any matter or purpose mentioned in -

(a) section 2(1), or

---

e Order in Council No. VI of 2018; this enactment has been amended.

(b) section 3(1), and

"**specified thing**": see Schedu1e 1.

(2) In this Law, a reference to a Community directive or regulation, or any provision of a Community directive or regulation, is a reference to it as from time to time amended or re-issued (with or without modification).

(3) In subsection (2), "**Community directive or regulation**" means a directive or regulation, within the meaning of Article 249 of the Treaty establishing the European Community.

Repeals and revocation.

8. (1) The following enactments are repealed -

(a) the Regulation of Health Professions (Enabling Provisions) (Guernsey) Law, 2012[f], and

(b) the Regulation of Health Professions (Enabling Provisions) (Sark) Law, 2012[g].

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[f] Order in Council No. IX of 2013; this enactment has been amended.

[g] Order in Council No. XIV of 2013; this enactment has been amended.

(2) The Regulation of Health Professions (Medical Practitioners) (Guernsey and Alderney) Regulations, 2015[h] are revoked.

Transitional and savings.

9. (1) Despite section 8(1), the enactments in subsection (2) of this section -

(a) continue to have effect as if they were duly made under this Law, and

(b) may be amended, repealed or, as the case may be, revoked, accordingly.

(2) Subsection (1) refers to the following -

(a) the Regulation of Health Professions (Medical Practitioners) (Guernsey and Alderney) Ordinance, 2015[i],

(b) the Regulation of Health Professions (Medical Practitioners) (Guernsey and Alderney) (Amendment) Ordinance, 2015[j],

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h G.S.I. No. 105 of 2015.

i Ordinance No. XXII of 2015; this enactment has been amended.

j Ordinance No. L of 2015.

(c) the Regulation of Health Professions (Medical Practitioners) (Sark) Ordinance, 2017[k],

(d) the Regulation of Health Professions (Non-medical) (Sark) Ordinance, 2018[l],

(e) the Regulation of Health Professions (Medical Practitioners) (Guernsey and Alderney) Regulations, 2016[m],

(f) the Regulation of Health Professions (Medical Practitioners) (Sark) Regulations, 2017[n].

Extent.

10. This Ordinance has effect in the Bailiwick of Guernsey, including its territorial waters.

Citation.

11. This Law may be cited as the Regulation of Care (Enabling Provisions) (Bailiwick of Guernsey) Law, 2024.

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k Sark Ordinance No. VI of 2017.

l Sark Ordinance No. IV of 2018.

m G.S.I. No. 53 of 2016.

n G.S.I. No. 74 of 2017. Approved by the Committee for Health & Social Care and signed by Deputy Rhian H. Tooley on 26th May, 2017.

Commencement.

12. This Law shall come into force on the day appointed by Ordinance of the States; and different dates may be appointed for different provisions and for different purposes.

SCHEDULE 1

Section 2(2) and (3); section 3(2)

MEANING OF KEY EXPRESSIONS

In this Law -

"**care profession**" -

(a) means any kind or description of profession or occupation in, directly or indirectly connected with, or represented to be connected with, health care, social care or the provision of care, and

(b) without limiting the generality of item (a), includes a profession or occupation specified in Schedule 4,

"**cosmetic intervention**" -

(a) means any intervention, procedure or treatment carried out with the objective of changing an aspect of a person's physical appearance (whether or not it is also carried out for any other objective),

(b) includes non-surgical procedures, and

(c) for the avoidance of doubt, includes the use of a laser, or light source or device, to improve skin tone, texture or colour, or to remove tattoos or hair,

"**health care**" -

(a) includes the following -

(i) any form of medical or surgical care,

(ii) any other form of care (including nursing care) provided for the health of an individual,

(iii) any procedure similar to a form of medical or surgical care even if the procedure is not provided in connection with a medical or health condition, and

(b) is deemed to include the following (to the extent that these do not fall within item (a)) -

(i) any intervention, procedure or treatment involving, or carried out for the purpose of -

(A) the ingestion, inhalation, injection or implantation of any product or substance into any part of the human body, or

(B) the application of any product or substance in or onto any part of the human body,

(ii) any information, advice or service relating to any health or medical matter, including, for the avoidance of doubt, human nutrition,

(iii) any cosmetic intervention,

"**practise**", in relation to a care profession, includes -

(a) undergoing practical training to practise a care profession,

(b) using a name, title or description associated with, or purportedly associated with, a care profession,

(c) using or providing any premises, facility or equipment in connection with, or purportedly in connection with, a care profession,

(d) carrying out any activity or providing any service in connection with, or purportedly in connection with, the care profession,

(e) purporting to do anything mentioned in item (c) or (d), and

(f) purporting to be qualified to do anything mentioned in item (c) or (d),

"**provision of care**" -

(a) means provision of health care or social care, and

(b) includes the following -

(i) using, or providing or permitting the use or provision of any premises, facility or equipment, for health care or social care,

(ii) carrying out any activity in connection with the provision of health care or social care,

(iii) giving or providing any information, advice or service to any member of the public (whether or not for payment or reward) relating to any specified thing,

(iv) purporting to do any of the things specified in sub-item (i), (ii) or (iii),

(v) any other prescribed activity or service,

"**social care**" -

(a) includes any form of personal care, practical assistance or personal support provided for an individual in need of the care, assistance or support because of the individual's age, illness, disability, pregnancy,

childbirth, dependence on alcohol or other substances or for any other reason, but

(b) excludes health care, and

"**specified thing**" means the following -

(a) any health or medical matter, including, for the avoidance of doubt, human nutrition,

(b) any apparatus, instrument, appliance or combination of these -

(i) presented as having properties for treating or preventing disease in human beings, or

(ii) which may be used in or administered to human beings either with a view to restoring, correcting or modifying physiological functions by exerting a pharmacological, immunological or metabolic action, or to making a medical diagnosis,

(c) any other medical device, or accessory for a medical device, within the meaning of the Medical Device Regulation,

(d) any other prescribed matter.

SCHEDULE 2

Section 3(1)(c)

SPECIFIC MATTERS FOR WHICH AN ORDINANCE MAY BE MADE

1. Any form of regulation of, or restriction on, the provision of care or the practise of a care profession, including prohibiting it, unless the person providing the care or practising the profession satisfies prescribed requirements or conditions, for example -

(a) being employed by or having a prescribed connection with a prescribed person,

(b) being registered, licensed, certified or accredited in a prescribed manner,

(c) holding a prescribed qualification or being qualified in a prescribed manner,

(d) providing the care or practising the profession only in prescribed premises or premises that meet prescribed requirements or conditions, or

(e) using or providing prescribed premises, prescribed facilities or prescribed equipment, or carrying out a prescribed activity, in connection with the provision of the care or the practise of the profession.

2. The grant to, or conferral on, any person of the exclusive right to provide

prescribed care or practise a prescribed care profession.

3. Standards or requirements relating to –

   (a) the fitness to provide, or continued fitness to provide, care, or

   (b) the fitness to practise, or continued fitness to practise, a care profession.

4. Standards or requirements relating to conduct (including codes of conduct), ethics or performance in relation to the provision of care or practise of a care profession.

5. Use of names, titles or descriptions in any way associated with the provision of care or practise of a care profession.

SCHEDULE 3

Section 3(1)(d)

SPECIFIC PURPOSES FOR WHICH AN ORDINANCE MAY BE MADE

1. Establishing and constituting a Commission for the purposes of this Law, including giving the Commission powers, duties and other functions.

2. Establishing, constituting, appointing or recognising any other body or authority or other person for the purposes of this Law, including giving the person powers, duties and other functions.

3. Providing for the Commission or any other body, authority or other person established, constituted, appointed or recognised under paragraph 1 or 2 to provide services or carry out activities outside Guernsey or the Bailiwick, which may include services or activities -

   (a) relating to the regulation of care, and

   (b) in return for payment.

4. Imposing duties and obligations, or conferring rights and privileges, on any person in relation to the provision of care or practise of a care profession.

5. Requiring or authorising any person to provide or verify any information, or make any information returns at prescribed intervals, which may include personal data.

6. Imposing a fee, charge or levy payable by any person in connection with any

specified matter or purpose.

7. The creation, trial (summarily or on indictment) and punishment of offences.

8. Excluding liability for any person in respect of anything done or omitted to be done in the discharge or purported discharge of any of the person's functions under this Law unless the thing is done or omitted to be done in bad faith.

9. Giving to any person any powers considered necessary or expedient for the enforcement or due administration of this Law, including (without limitation) powers of entry, inspection, questioning, search, seizure, forfeiture and disposal, or arrest and detention.

10. Providing for appeals in relation to any decision made under this Law.

11. Dealing with any matters necessary or expedient to be dealt with in making provision in relation to anything set out in section 3(1) of this Law.

12. Providing for any other matters necessary or expedient for giving full effect to this Law and for its due administration.

Note: In this Schedule, any reference to a person includes a person that has a prescribed connection with any person providing care or practising a care profession.

SCHEDULE 4

Schedule 1

EXAMPLES OF CARE PROFESSIONS

1. Medical practitioner, dentist or pharmacist (including pharmaceutical chemist, chemist or druggist).

2. Nurse, midwife or health visitor.

3. Arts therapist.

4. Biomedical scientist.

5. Chiropodist or podiatrist.

6. Chiropractor.

7. Clinical dental technician.

8. Clinical scientist.

9. Dental nurse.

10. Dental technician.

11. Dental therapist.

12. Dietitian.

13. Occupational therapist.

14. Operating department practitioner.

15. Orthodontic therapist.

16. Orthoptist.

17. Osteopath.

18. Paramedic.

19. Physiotherapist.

20. Practitioner psychologist.

21. Prosthetist or orthotist.

22. Radiographer.

23. Social worker.

24. Speech and language therapist.

25. Any other profession or occupation registered, licensed or otherwise regulated by any of the following bodies in any part of the United Kingdom -

(a) the General Medical Council,

(b) the Nursing & Midwifery Council,

(c) the General Dental Council,

(d) the General Pharmaceutical Council,

(e) the Pharmaceutical Society of Northern Ireland,

(f) the General Optical Council,

(g) the General Osteopathic Council,

(h) the General Chiropractic Council,

(i) the Health & Care Professions Council,

(j) Social Work England.

26. Provider of cosmetic interventions.

27. Nutritionist.

SCHEDULE 5

Section 6(3)

SPECIFIC LAWS THAT MAY BE AMENDED OR REPEALED BY ORDINANCE

1. Loi relative à la Santé Publique, 1934[o].

2. Nursing Homes and Residential Homes (Guernsey) Law, 1976[p].

3. Nursing and Residential Homes (Registration and Occupation) (Alderney) Law, 1987[q].

4. The Tattooing, Piercing, Acupuncture and Electrolysis (Guernsey and Alderney) Law, 2000[r].

5. The Medicines (Human and Veterinary) (Bailiwick of Guernsey) Law, 2008[s].

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o Ordres en Conseil Vol. IX, p. 386; this enactment has been amended.

p Ordres en Conseil Vol. XXVI, p. 71; this enactment has been amended.

q Ordres en Conseil Vol. XXX, p. 371; this enactment has been amended.

r Order in Council No. V of 2000; this enactment has been amended.

s Order in Council No. V of 2009; this enactment has been amended.

ITEM 05

TAXATION REVIEW (SPECIAL) COMMITTEE

Information Report to Michaelmas Chief Pleas, 2nd October 2024

TAXATION CONSULTATION WITH THE RESIDENTS OF SARK

It is the wish of the members of the Tax Review (Special) Committee to make themselves available to answer questions and expand on the various options offered within the consultation paper entitled TAXATION CONSULTATION WITH THE RESIDENTS OF SARK.

The paper, distributed Island wide during week commencing 23rd September, offers a selection of revenue raising options that the committee have been considering. The paper invites residents to express their approval or disapproval by rating each option on a scale of one to five. On page four of the paper residents are invited to inform the committee of any further thoughts they may have on taxation on Sark that they would wish to see the Taxation Review (Special) Committee take into consideration.

Conseiller Kevin Delaney
Chairman, Taxation Review (Special) Committee

ITEM 06

EDUCATION COMMITTEE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

CHANGE TO MANDATE

At the Christmas meeting of Chief Pleas in January 2024, the Education Committee changed the name of the Board of Education to the Board of Governors to reflect the change from the Board being responsible for all education on Sark to being responsible for the education taking place at Sark School only.

As such, the Education Committee has now taken over responsibility for Sark Government funded 13+ education off-island as well as for any children of mandatory school age (5 – 16) being educated anywhere on island other than at Sark School and needs to amend the mandate accordingly.

The Committee therefore asks Chief Pleas to approve the Education Committee's amended mandate as attached to this report.

Proposition –

That Chief Pleas approves the amended Education Committee mandate, as attached.

Conseiller Jolie Rose
Chairman, Education Committee

EDUCATION COMMITTEE
MANDATE

CONSTITUTION:

- Five members who shall be sitting members of Chief Pleas, two of whom shall be selected as Chairman and Deputy Chairman by their fellow Committee Members.
- Parents of school age children currently being educated in the Sark system shall not be members of the Committee.
- Up to 2 non-voting members who shall not be sitting members of Chief Pleas but who shall be elected by Chief Pleas.
- From time to time, as required, the Head of School, the Chair and/or other members of the Board of Governors and/or other teachers may be invited to attend meetings, as deemed relevant and necessary by the Committee.
- A quorum shall consist of three voting members.

MANDATE:

1. In conjunction with relevant stakeholders, set out a strategic vision for education on Sark and link this to the future prosperity of the Island.
2. Appoint a Board of Governors, representative of the community of Sark and constituted in accordance with the terms of reference.
3. Establish a high quality, statutory system of public education for the children of Sark, in accordance with the Education (Sark) Ordinance, 2003.
4. Consider all matters relating to Sark Government funded education, from preschool to Year 11.
5. Monitor the annual Home Education Plan (agreed between the parent(s)/carer(s) and Education Committee) and its implementation for any child of mandatory school age (5 – 16) who is educated anywhere on-island other than at Sark School.
6. i) Develop policy expectations regarding education for key groups of Sark learners including SEND and those vulnerable to underachievement.
   ii) In conjunction with the Medical & Emergency Services Committee, ensure safeguarding for all young people educated on-island up to 16 and Sark children being educated off-island as far as it is able to.
7. Fund education (on Sark and elsewhere) within the constraints of Island finances, including the provision of education for children with special needs.
8. Negotiate and manage a Service Level Agreement for Education Services with the States of Guernsey acting by and through the Committee for Education, Sports and Culture.
9. Receive information from representatives from the States of Guernsey connected with the Service Level Agreement and from the Board of Governors concerning Sark School in sufficient depth and with regularity so as to enable the Committee to fulfil their role.
10. Approve and champion the Education Policy for Sark and approve the School Development Plan for Education, as recommended by the Board of Governors, on an annual basis, commending the plan and expenditure to Chief Pleas.
11. Commission an independent inspection of Education for the children of Sark at suitable intervals (at least once in every three years); and ensure that actions are taken to implement recommendations in a timely fashion so as to rectify any deficits.
12. Provide the finances to the Board of Governors to enable them to maintain a school and its equipment, and the facilities for education, physical education and recreation.
13. Approve the appointment, definition of conditions of service and salary, appraisal and pay progression, disciplining and the dismissal of staff at Sark school and of other roles which fall under the remit of the Education Committee, following recommendations from the Board of

Governors.

14. Act in management for the purposes of teachers' accommodation.
15. Uphold the behaviour expectations and disciplinary measures when necessary, including decisions at appeal for the temporary and/or permanent exclusion of unruly children from school.
16. Monitor complaints regarding the Education, Welfare or Safety of a child and act as the final body of appeal in accordance with the published complaints procedure.
17. Report on education matters to Chief Pleas and communicate with the electorate as necessary.

LEGISLATION

Laws

- The Education (Sark) Law, 2001
- The Education (Amendment)(Sark) Law, 2003
- The Children (Sark) Law, 2016
- The Child Protection (Sark) Law, 2020

Ordinances

- The Education (Sark) Ordinance, 2003
- The Education (Repeals)(Sark) Ordinance 2004
- The Education (Sark)(Amendment) Ordinance, 2005
- The Education (Sark) (Amendment) Ordinance,2018
- The Education (Sark) (Amendment) Ordinance,2019
- The Education (Sark) (Amendment) Ordinance,2020
- The Child Protection (Sark) Ordinance, 2021
- The Education (Sark) Amendment Ordinance 2023

Service Level Agreements

- Sark Education Services agreed with the States of Guernsey acting by and through the Committee for Education, Sports and Culture
- Secondary Education Services for Sark Students agreed with the States of Guernsey acting by and through the Committee for Education, Sports and Culture
- Service Level Agreement agreed with the States of Guernsey acting by and through the Committee for Health and Social Care

October 2024

ITEM 07

POLICY & FINANCE COMMITTEE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

AMENDMENT TO THE CONSTITUTION & OPERATION OF CHIEF PLEAS COMMITTEES

The Constitution & Operations of Chief Pleas makes reference to the 'Chief Secretary' and the 'Assistant Chief Secretary'. These roles have now been replaced by the 'Senior Executive Officer' and the 'Senior Operations Officer'.

The Committee asks Chief Pleas to approve the amended Constitution & Operations of Chief Pleas Committees, as attached to this report, to reflect these changes.

Proposition –

That Chief Pleas approves the amended Constitution & Operation of Chief Pleas Committees, as attached.

Conseiller John Guille
Chairman, Policy & Finance Committee

THE CONSTITUTION AND OPERATION OF CHIEF PLEAS COMMITTEES

As amended consequential upon amendments made to the 2008 Reform Law by the Reform (Sark) (Amendment) (No. 2) Law, 2010. Approved by Michaelmas Chief Pleas on 2nd October 2013 and further approved, as presented to Chief Pleas on 1st October 2014, on 21st January 2015, 30th September 2015, 6th April 2016, 26th April 2017 and 17th January 2018 (coming into effect on the 11th January 2019, less for Rule 5 (1) & (2) that shall be effective from the 4th January 2019), October 5th 2022 and 3rd July 2024.

1. Constitution

Prescribed by Resolution of Chief Pleas with the following provisions, except where contrary provision is made -

(a) by any enactment;

(b) by any subsequent resolution of Chief Pleas.

2. Definitions

In these Rules the expression -

"Chief Pleas Committee" means any body constituted either by enactment or by Resolution of Chief Pleas, whether it be styled Committee, Board, Authority, or otherwise. This excludes the Policy Development Group.

"Standing Chief Pleas Committee" means any permanent Chief Pleas Committee.

"Special Chief Pleas Committee" means any temporary or *ad-hoc* Chief Pleas Committee charged with the execution or investigation of a particular matter.

"Sub-Committee" means a temporary or ad-hoc Committee of a Standing Committee charged with the execution or investigation of a particular Standing Committee matter.

"Ex-Officio Member" means any Committee member by virtue of their office (i.e. Medical Officer, Constable, Vingtenier or Harbourmaster etc.) Unless otherwise provided for, *ex-officio* members shall not have a committee vote.

The "Policy Development Group" is a group, consisting of all Conseillers, whose purpose is to prioritise the work streams of Chief Pleas.

3. Size

(1) Standing Chief Pleas Committees, less the Douzaine and Policy and Finance Committee, shall consist of four Conseillers, unless Chief Pleas specifically resolve to have a larger or smaller size committee; a minimum size shall not be less than three Conseillers.

(2) A sub-committee shall consist of three Conseillers.

(3) The Policy and Finance Committee shall consist of six Conseillers.

(4) The Douzaine: The Douzaine shall consist of seven Conseillers, unless under Section 43 of The Reform (Sark) Law, 2008 Chief Pleas resolve to have a larger or smaller size (such number to be at least 3 but no more than 12).

(5) A sub-committee of the Douzaine shall consist of not less than three Conseillers.

4. Non-Chief Pleas Committee Members

At the request of a Chief Pleas' Committee, Chief Pleas may elect up to three non-Chief Pleas members onto a Committee without voting rights. (Also applicable to special purposes committees and sub-committees.)

5. Chairman

(1) The Chairman of the Policy and Finance Committee shall be elected by Chief Pleas in a secret ballot, with the Greffier acting as Returning Officer, nominations are to be proposed and seconded and given to the Greffier a minimum of 5 working days before the meeting at which the election is to take place. The person so elected shall have a mandate to speak to the outside world on behalf of Chief Pleas.

(2) The Deputy Chairman of the Policy and Finance Committee shall be elected by Chief Pleas using the same election procedures as the Chairman.

(3) Other Chief Pleas Committee shall elect a Chairman and a Deputy Chairman from amongst those persons on that Committee who are Conseillers. The Speaker of Chief Pleas [the Speaker] must be informed within seven working days of the appointment/s or any changes thereto.

(4) The Chairman of a Chief Pleas Committee, or in the absence of the Chairman the member who presides at a meeting of such a Committee, shall have an original vote but not a casting vote.

6. Members

(1) To be eligible for election to membership of a Chief Pleas Committee as a non-Chief Pleas member a person should be, but does not have to be, a person normally resident on the Island.

(2) A person in the role of the Seigneur, the Speaker, the Seneschal, the Prévôt, the Greffier, the Tax Assessor or their Deputies may not serve on any governmental committee.

(3) There shall be no restriction on the number of Chief Pleas Committees on which a Conseiller may serve.

(4) Conseillers shall not be co-opted to membership of any Chief Pleas Committee.

7. Term of Office of Committee Members

Conseillers shall serve their Conseiller term of office on committees but may resign their membership at any time. A member shall be deemed to have resigned at a General Election and, if re-elected to Chief Pleas, shall be required to be elected to committees.

8. Term of Office of Non-Chief Pleas & Ex-Officio Committee Members

(1) The term of office for non-Chief Pleas Committee members shall be for the duration of the project or work to which they are contributing.

(2) Ex-officio members' term rests with the length of their original office.

9. Removal from Committee

Chief Pleas may, by Resolution, remove a person from any committee, including the Douzaine.

10. Resignations

Any Conseiller or non-Chief Pleas member of a Chief Pleas Committee wishing to resign before their term of office has expired, shall inform the Speaker and the Committee Chairman of their resignation from the specified Committee(s).

11. Motions of No Confidence

Motions of no confidence cannot be made against the Chairman or other member(s) of that Committee in Committee.

12. Nominations of Candidates for Election to a Committee by Chief Pleas

Conseillers shall be eligible for nomination from the floor of the Assembly on the day of election, less for the Chairman and Deputy Chairman of the Policy and Finance Committee, see 5 (1) and (2) above. Where a person is nominated as a non-Chief Pleas member of Chief Pleas, the Committee shall provide the Assembly with a verbal report containing background information of the candidate and the reasons for his name having been put forward. The committee must have had the prior consent of the proposed candidate for his name being put forward.

13. Quorum

(1) The quorum of any Chief Pleas Committee, less the Douzaine, shall be three Conseillers or such larger number of members as the Chief Pleas may, in respect of a specific committee, resolve.

(2) The quorum at a meeting of the Douzaine shall be half the number of Conseillers elected to the Douzaine rounded up to the next whole number, but never less than three.

14. Declaration of Interest

Where a decision relating to an agenda item has a direct pecuniary impact either positive or negative upon any member of that Committee, then that member shall remove himself from the debate and decision-making process for that agenda item.

15. Human Rights Compatibility

Every Chief Pleas Committee shall be cognisant of the need to review their existing legislation together with the associated policies, procedures and practices with human rights

compatibility.

16. Presence of Officers, etc. at Committee Meetings

(1) Any Committee meeting (where there are enough members to be quorate) shall be attended by a CSO and minuted fully.

(2) In addition to the CSO, the Senior Executive Officer or Senior Operations Officer shall attend all meetings pf the Policy & Finance, Douzaine, Education and Medical & Emergency Services Committees.

(3) The Senior Executive Officer or Senior Operations Officer shall attend the meetings of all Committees at least once annually also when requested by the Chairman.

17. Special Chief Pleas Committees

(1) Except for those parts which refer solely to standing Chief Pleas Committees, the principles set out above shall be followed in the constitution and operation of all Chief Pleas Committees including Special Chief Pleas Committees.

(2) Such Special Chief Pleas Committees (i.e., the members thereof) shall continue in office until –

(a) They have fulfilled their task, and

(b) any legislation designed to give effect to such recommendations of the Committee as Chief Pleas may have resolved to adopt has been presented to Chief Pleas, approved and registered.

18. Sub-Committees

(1) A sub-committee is formed by resolution of Chief Pleas at the request of a Standing Committee.

(2) Members are elected by Chief Pleas.

(3) A sub-committee reports directly to its Standing Committee.

(4) A sub-committee is disbanded by Resolution of Chief Pleas at the request of the Standing Committee.

19. Policy Development Group

(1) Except for those parts which refer to standing Chief Pleas Committees, the principles set out above shall be followed in the operation of the Policy Development Group.

(2) Conseillers who lose their position on a Special Chief Pleas Committee as a result of a General Election shall be automatically returned to that Special Chief Pleas Committee, unless they resign from that Committee.

20. Douzaine

Other rules for the Douzaine are contained in Section 43 of “The Reform (Sark) Law, 2008” as amended. Where any rule herein contained is at variance with Section 43 that Section takes precedence.

ITEM 08

DOUZAINE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

COMMERCIAL RUBBISH CHARGES

At the Christmas Meeting, 17th January 2024 (item 6) the Douzaine presented a Report with Propositions to increase, across the board, commercial charges to make up for the 6 years the charges had remained static.

The increases presented and approved at the Christmas Meeting were the first step in closing the gap between what it costs the Island to collect, process and dispose of commercial rubbish, and the charge it makes to businesses for the service. Whereas the charges made for domestic rubbish/recycling covers the cost, commercial rubbish is still costing the Island around £13,000 per year more than it collects in charges. While the Douzaine does understand that times are economically hard at present there is no mandate for the public purse to effectively subsidise commercial ventures on Sark.

The current schedule of charges is unfortunately inconsistent, at times its figures appearing arbitrary, which had led to a situation where similar business may well be charged different rates, while others may not have been charged at all.

The Douzaine has, assisted by the Public Works Department, reviewed the existing charges to produce a new schedule as set out in the table below. For clarity the various commercial operations on Sark have been grouped together, with each business in that group assigned a charge equal to a number of *effective adults*. This is not the number of people at that business, just a means to set the charge. The current charge per *effective adult* is £27.40, being the same as the domestic rubbish/recycling quarterly charge.

Bike shop	1 adult
Cafe	2 adults
Campsite - over 30 pitches	3 adults
Campsite - under 30 pitches	1 adult
Office	1 adult
Pub	4 adults
Restaurant	3 adults
Guesthouse	Based on number of people accommodated
Hotel	Based on number of people accommodated
Self-catering	Based on number of people accommodated

- Businesses that fall in several categories are charged for each that they fall into.
- Black Bin stickers would be required for all businesses (unless by separate arrangement).
- Live-in staff, to be charged as a ‘bed’.
- An ‘Extras’ will be charged separately.

For the purposes of Guesthouses/Hotel/Self-catering the number of people accommodated is taken from the ‘Accommodation Permit’ as issue by Tourism. The charge per person, is currently set at £5.87 per quarter.

While many businesses may be open for only part of the year, it is not practical for the Public Works Department to keep track of each business, and when they are open and for which part of the year. The charges therefore have been set to provide an average figure, over all the four quarters.

If approved these charges will come into effect for the billing quarter beginning 1st February 2025 and so will be applied to the bills sent out for the quarter ending 30th April 2025.

Letters will be sent to each of the businesses before bills are sent out, explaining how the changes will affect them.

Proposition –

That Chief Pleas approve the new commercial charges as outlined in the above Report.

Conseiller Chris Bateson
Chairman, Douzaine

ITEM 09

DOUZAINE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

RUBBISH INCINERATION

The Public Works currently collects domestic household waste in the form of Clear and Blue bag recycling, as well as (prepaid) burnable materials ('black bags').

The Island purchased a Matthews incinerator, during the year of 2006, and when the slaughterhouse was due to be opened, an Addfield incinerator was purchased in 2016 to handle the anticipated animal waste. While the Addfield never reached its full potential and ceased working some time ago, the Matthews has been pushed beyond its working capacity, needs a repair, and is coming to the end of its operational life.

The volume of burnable domestic rubbish generated by the Island, especially during the tourist season, has risen considerably since the first incinerator was purchased. While the recent introduction of domestic recycling has reduced the volume of material that has to be burned, it is still more than the operational limit of the current incinerators.

The Douzaine has been looking at a possible replacement system, but before committing any Island funds, wished to seek the opinion of Chief Pleas as to which direction it should take.

The two options the Douzaine see as being available to it are as follows:

a) To purchase a replacement incinerator, one that is able to cope with the volume of domestic burnable rubbish that the Island generates, or
b) To continue with open burning in some form or other.

While the Douzaine has been considering a possible relocation of the Harbour Quarry facilities, either in part or as a whole, this does not form any part of this Report, or the following Proposition.

Proposition –

That Chief Pleas directs the Douzaine to further investigate the acquisition of a new incinerator and to return to the Budget Meeting of Chief Pleas with details.

Conseiller Chris Bateson
Chairman, Douzaine

ITEM 10

DOUZAINE

Information Report to Michaelmas Chief Pleas, 2nd October 2024

SEWAGE PLANT

Due to a failure of one of the processing tanks the sewage handling facility at Les Lâches has not been functioning as expected, this has resulted in untreated effluent being discharged.

A report had been commissioned in 2023, to seek a solution to the problem, however the recommended bespoke installation came at an unrealistic cost.

An inspection of the existing facility indicated that if a repair was undertaken it would bring two of the tanks back into operation and so bring an end to, or at least reduce the discharge of untreated effluent. This phase of the work has been carried out within the existing budget for this year.

The Douzaine is considering the next stage of bringing the remaining sewage treatment back on-line. The progress of the next phase will be dependent upon funds being found.

Conseiller Chris Bateson
Chairman, Douzaine

ITEM 11

DOUZAINE

Information Report to Michaelmas Chief Pleas, 2nd October 2024

RELOCATION OF INCINERATOR

The Douzaine has long been aware that the location of its incineration and burning facility at the Harbour Quarry is not ideal. The idea of relocating this facility has often been considered, however the lack of an alternative, suitable, location has made this difficult.

A decision to move has not yet been made, however as one of the existing incinerators ceased working some time ago and is beyond repair, and the other is in need of attention while also reaching the end of its operational life, with a replacement being considered, the idea of a possible relocation of the facility has also been looked at.

At present, the only site the Island has access to, and that could support the incinerator facility, is Les Lâches.

While a decision as to a relocation has not been made, nor have any plans been drawn up prior to being brought before Chief Pleas, the Douzaine wished the subject should be mentioned, that any affected party had knowledge aforehand.

The Douzaine will welcome any submission on this subject.

Conseiller Chris Bateson
Chairman, Douzaine

ITEM 12

POLICY & FINANCE COMMITTEE

Report with Proposition to Michaelmas Chief Pleas, 2nd October 2024

APPOINTMENT OF MANAGING DIRECTOR OF THE ISLE OF SARK SHIPPING COMPANY LIMITED

After an exhaustive recruitment and interview process earlier this year, the directors of the Isle of Sark Shipping Company appointed Mr. Mark Roffey as General Manager of the Company. Mr. Roffey has more than twenty years' experience working in the marine industry in marine engineering, crew management and general management roles. The directors are of the opinion that he is well-suited to the role of Executive Managing Director to replace Mr. Yan Milner who is retiring.

The Policy & Finance Committee are happy to support the recommendation and therefore ask Chief Pleas to approve the appointment of Mr. Roffey as Executive Managing Director of the Isle of Sark Shipping Company Limited.

Proposition –

That Chief Pleas approves the appointment of Mr. Mark Roffey as Executive Managing Director of the Isle of Sark Shipping Company Limited.

Conseiller John Guille
Chairman, Policy & Finance Committee

ITEM 13

POLICY & FINANCE COMMITTEE

Information Report to Michaelmas Chief Pleas, 2nd October 2024

A STUDY OF WATER SUPPLY IN SARK

The Policy & Finance Committee commissioned a report in the spring of 2024 with the aim of making an assessment of the available water resources of Sark. Dr Derek Clarke BSc PHD was appointed to undertake the research. (See Appendix One attached to this report for Dr Clarke's CV).

Dr. Clarke spent 3 days on Sark in June, followed by 4 days analysing the data and writing the report (see Appendix 2). The purpose of the report is to set the scene for how much water is available on the island and whether the proposed new housing and increased resident population would exceed the available water. The issue of possible climatic change is also explored.

A series of key findings are presented, together with recommendations for action.

Conseiller John Guille
Chairman, Policy & Finance Committee

DEREK CLARKE BSc PhD

retired 2019

Formerly : School of Engineering, Southampton Boldrewood Innovation Campus, Burgess Road, Southampton, SO16 7QF, UK

Nationality: British
Personal web page:

Contact details:

Dr Clarke's research specialises in hydrology and water resource management including irrigation and groundwater hydrology. Focussing on the efficient and effective use of water, he has 40 years' experience in understanding soil-plant-water relationships and their importance for agriculture and coastal ecosystems.

He has worked globally on water resource issues and irrigated agriculture including projects in the UK, Europe, Kazakhstan, Saudi Arabia, Australia, Egypt, India, Bangladesh and Pakistan (plus others). He has acted as a consultant to Governments, NGO's and engineering companies.

He is particularly recognised for leading the development of the "CROPWAT for Windows", in collaboration with Food and Agricultural Organisation of the United Nations (FAO). This set a world-wide standard approach to the assessment of crop water requirements for irrigated agriculture.

Other research interests include simulation of tides and floods in estuaries and the impact of sea-level rise on flood risk. He has worked as part of inter- and multi-disciplinary teams investigating social and ecological impacts of environmental change in low lying coastal regions.

Current research projects include modelling adaptation strategies to irrigated agriculture in large delta systems and their impact on low income households, climate change impacts on slope stability and the evolution of flood risk in coastal regions.

He has taught undergraduate and postgraduate courses on a range of water related topics including hydrology, hydraulics, irrigation, groundwater, soil contamination and coastal flood defence. He has also delivered short courses on water resources management and irrigation in the UK, Netherlands, Egypt, Saudi Arabia and Kazakhstan

Qualifications

BSc. Geography,1975.
Ph.D. Groundwater Hydrology, 1980.

Funded Projects

2019-2021 UK NERC, "TaSE" Sustaiable Development Goals in West Bengal, India.
2015-2018 UK British Council, "INSPIRE" Salinity, agriculture and drinking water in Bangladesh
2012-2016 UK EPSRC, "iSMART" Climate and vegetation impacts on engineered slopes.
2012-2016 UK NERC,"ESPAdeltas" Integrative modelling of ecosystems services in delta of Ganges
2009-2011 EU Interreg IVB . Management for Europe's Coastal Resource – Groundwater Hydrology.
2009-2011 FAO. Consultant on irrigation water use and agro climatic research, Al-Hofuf. Saudi Arabia.
2007-2009 UK EPSRC, "BIONICS" Biological and Engineering Impacts of Climate Change on Slopes:

2005 INTAS-UNESCO & University of Cambridge. Modern and historical irrigation in Central Asia.
2005 CSIRO, Visiting Researcher Australia. Modelling irrigation systems in Murray-Darling basin.
2002-2004 UK EPSRC , “ROPA” monitoring and modelling vegetation impacts on stability of slopes.
1999-2001 EU INCO-COPERNICUS. “CROPSAL”- crop water use for typical crops in Kazakhstan
1999 EU TACIS. Contributions to regional water balances for Caspian Sea water level changes
1995-1998 FAO. ”CROPWAT FOR WINDOWS” : software for crop water requirements and irrigation.

Publications

https://scholar.google.com/citations?hl=en&user=sFCsCTwAAAAJ

Selected Recent Publications

Marcinko, C. L. J., Nicholls, R. J., Daw, T. M., Hazra, S., Hutton, C. W., Hill, C. T., **Clarke, D**., Harfoot, A., Basu, O., Das, I., Giri, S., Pal, S., & Mondal, P. P. (2021). The development of a framework for the integrated assessment of SDG trade-offs in the Sundarban biosphere reserve. *Water*, *13*(4), 528. [528]. https://doi.org/10.3390/w13040528

Shaw, P., Leung, K. C., & **Clarke, D**. (2021). The fractionation of phosphorus in UK chalk stream surface waters and its relevance to the regulation and management of water quality. *Journal of Environmental Management*, *289*, [112555]. https://doi.org/10.1016/j.jenvman.2021.112555

Asadul Haque, M., Jahiruddin, M., & **Clarke, D**. (2018). Effect of plastic mulch on crop yield and land degradation in south coastal saline soils of Bangladesh. International Soil and Water Conservation Research, 6 (4), 317-324. DOI: 10.1016/j.iswcr.2018.07.001

Payo Garcia, A., Lazar, A., **Clarke, D**., Nicholls, R., Bricheno, L., Salehin, M., & Haque, A. (2017). Modelling daily soil salinity dynamics in response to agricultural and environmental changes in coastal Bangladesh. Earth's Future, 1-32. DOI: 10.1002/2016EF000530

Abesser, C., **Clarke, D**., Hughes, A. G., & Robins, N. S. (2017). When is small not straightforward? The challenges of groundwater modelling in coastal dune systems. Journal of Coastal Conservation.

Jodder, R., Asadul Haque, M., Kumar, T., Jahiruddin, M., Zulfikar Rahman, M., & **Clarke, D**. (2016). Climate change effects and adaptation measures for crop production in south west coast of Bangladesh. Research in Argriculture, Livestock and Fisheries, 3(3), 369-378. DOI: 10.3329/ralf.v3i3.30727

Redhead, J. W., Stratford, C., Sharps, K., Jones, L., Ziv, G., **Clarke, D**., ... Bullock, J. M. (2016). Empirical validation of the InVEST water yield ecosystem service model at a national scale. Science of Total Environment, 1-23.

Clarke, D., Williams, S., Jahiruddin, M., Parks, K.E. and Salehin, M. (2015) Projections of on-farm salinity in coastal Bangladesh. Environmental Science Processes and Impacts, 1-11. DOI: doi:10.1039/C4EM00682H

Stevens, A.J., **Clarke, D**., Nicholls, R.J. and Wadey, M.P. (2015) Estimating the long-term historic evolution of exposure to flooding of coastal populations. Natural Hazards and Earth System Sciences Discussions, 3, (2), 1681-1715. DOI: 10.5194/nhessd-3-1681-2015

Stevens, Andrew, **Clarke, Derek** and Nicholls, Robert (2014). Trends in reported flooding in the UK:1884-2012. Hydrological Sciences Journal. Doi:10.1080/02626667.2014.950581.

Stratford, C.J, Robins, N.S., **Clarke, D**., Jones, L. and Weaver, G. (2013) An ecohydrological review of dune slacks on the west coast of England and Wales. Ecohydrology, 6, (1), 162-171. (doi:10.1002/eco.1355).

A water resources study for Sark

Dr D Clarke, Southampton
June 2024

Version 4.54

Introduction

This study was commissioned in the spring of 2024 with the aim of making a rapid assessment of the available water resources of Sark. The work was of short duration – a 3 day visit to Sark, followed by 4 days of data analysis, water balance calculations and report writing.

The purpose of the report is to set the scene for how much water is available on the island and whether the proposed new housing and increased resident population would exceed the available water. The issue of possible climatic change is also explored.

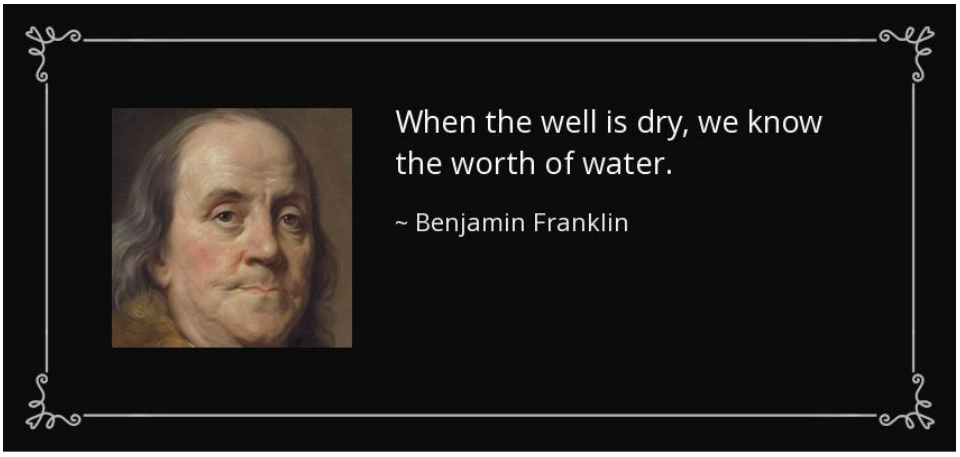
A series of Key Findings are presented, together with Recommendations for action.

Acknowledgements

We would like to thank the residents of Sark who were happy to assist in supplying information and background knowledge. Also, thanks to Peter Cole who helped to commission this report. Thanks must go to members of La Société Sercquaise who have collected climate data over many years and have provided mapping and population datasets.

A preliminary thought :-

As the vast majority of water resources on the island of Sark is from groundwater, we would like to remind readers of a well known quotation attributed to Benjamin Franklin :



https://www.azquotes.com/quote/358055

Executive Summary

We summarise the outcome of the water resources assessment for Sark as a set of Key Findings. Details of how the findings were obtained are in the report and Appendix A.

Key Finding 1 : Average annual rainfall is 825mm and it supplies 134mm/year to groundwater recharge at present.

Key Finding 2 : In densely populated parts of the island, groundwater extraction is estimated to be 64 mm/year.

Key Finding 3: Over the last 50 years, water extraction could be greater than groundwater recharge once every 5 years.

Key Finding 4: In the last 50 years, there have not yet been any "back to back" years of below average recharge (i.e. several years in a row of relative drought). As a result the groundwater has usually been replenished in the winter following a dry summer.

Key Finding 5: If the population rose to 700 people, the increased demands for water combined with the impacts of climate change may place impossible demands on the available groundwater. In the short term (10-15 years), drought frequency is likely to rise from 1 in 5 years to 1 in 3 years. By 2100 water extraction could exceed groundwater recharge every year.

This rapid assessment could not determine how quickly the groundwater recovers after a drought summer. There is an opportunity to gain a better understanding of the impact of dry years by re-instating the groundwater monitoring system and to gain additional "inside information" on how Sark coped with the severe drought of 1976.

Recommendation 1 : It is recommended that local knowledge is used to determine how the Island coped with specific severe drought years such as 1976.

Recommendation 2 : It is strongly recommended that the Island re-introduces a coordinated system to make regular measurements of ground water levels in observation wells and boreholes.

Recommendation 3 : An assessment should be made of the most productive boreholes, using local knowledge and drilling companies.

If new housing developments are to take place, they should incorporate water saving technologies and contribute a Water Development Fee to fund the groundwater monitoring programme

Recommendation 4 : Require that all new builds and major housing renovations incorporate water saving technologies to reduce water consumption.

Recommendation 5 : Introduce a "Water Development Fee" for all new builds and major housing renovations.

The groundwater of Sark is potentially at risk from a series of contamination sources. To reduce these risks, the general public and companies should be made aware of these risks.

Recommendation 6 : Make the greater population more aware of possible water contamination risks. It will hopefully help to identify contamination problems before they become an emergency.

Recommendation 7 : Create a coordinated storage system for all water quality test reports. This will provide information on the overall health of the water quality and help to identify any developing problems.

Background to water resources on Sark

Sark is an island of 5.45 sq km with most of its land surface being an undulating plateau about 90m above sea level. The soils on the plateau are thin, and the geology consists of dense volcanic rocks mainly gniess and igneous types. There is limited surface run off from small ephemeral streams. The bulk of available water used on the island is from groundwater. There are no major aquifers (i.e. porous rock systems such as sandstone) and water is held in cracks and fissures in the volcanic rocks.

Groundwater is recharged by rainfall only. There is no connection between the groundwater systems on Sark to any other island or the mainland of France.

The permanent resident population of Sark is 562 (2022 census). Water supply is via privately operated boreholes. These are typically less than 40m deep but there are a few examples of deeper wells (40-60m) and a small number are more than 90m deep, which places the base of the borehole close to sea level.

Additionally, some properties capture rainfall from roof surfaces and store this water in tanks on their property. A small number of shallow wells also exist.

However there are now concerns that

a) additional housing development may place an additional strain on the existing water supplies. The proposition by the Seigneur and Sven Lorenz is for the resident population of Sark to rise from 562 to between 800 and 1000 (an increase of 40% - 80%).

b) the onset of climate change may affect the amount of water getting into the groundwater system of Sark. Future climate scenarios by the UK Climate Projections / Met Office suggest higher temperatures which may cause more evapotranspiration loss, whilst projections of rainfall are less certain.

Assessing the available water resources of Sark

The usual approach to assessing available water resources is to carry out a water balance calculation. This is achieved using a spreadsheet model.

Once the water balance has been calculated, we have a measure of how much water gets into the groundwater system of Sark each year. The water balance calculation should be carried out over a relatively long time period so that it includes known problem years such as very wet or very dry years.

The average water balance can then be compared against how much water is extracted from wells and boreholes - currently and under different future scenarios. As there are no formal records of how much water is pumped, the volume of extracted water will have to be estimated based on typical water consumption patterns.

The water balance calculation involves making some assumptions but as long as these assumptions are clearly spelled out, it is possible to use gain an understanding of how much water may be available under differing scenarios (see Appendix A for detailed calculations). Ideally, the model could be compared with the measured changes in water levels in observation boreholes (wells or boreholes that are not being pumped) to see if any trends are evident and if problems are already developing.

Note that this assessment will not include an analysis of the quality of the groundwater extracted. Current water quality testing is carried out in the hospitality industry once-a-year, testing for bacteria. For domestic residents it appears that it is a matter of choice if they test their water or not. This report will discuss the issue of contamination of groundwater by sea water and other water pollution risks such as contamination of water by fuel oils, waste products and agro-industrial chemicals. It is known that there are possible contamination issues due to heavy metals in the geology, but this analysis is beyond the scope of this brief report. We include some brief recommendations on how water quality tests should be recorded centrally to help identify developing problems.

The Water Balance Model

This model is based in part on these earlier publications, but with significant updates. It is recommended that these should be used as background reading as they include useful descriptions.

1. Cheney, C (2006) “A preliminary hydrogeological study of the Island of Sark”. Groundwater Systems and Water Quality Programme Internal Report CR/04/237C British Geological Society. (PDF supplied by La Société Sercquaise)

2. Robins N S, Griffiths K J, Merrin P D and Darling W G (2000) “Reconnaissance Hydrogeological Survey of Guernsey” British Geological Survey Report WD/00/07 https://nora.nerc.ac.uk/id/eprint/12706/1/WD00007.pdf

3. Robins N S & Smedley P L (1998). “The Jersey groundwater study.” British Geological Survey Research Report RR/98/5. https://nora.nerc.ac.uk/id/eprint/3650/1/RR98005.pdf

4. Davis A.C. (1998) "Water Budget Analysis – Sark". Postgraduate Dissertation, Oxford Brookes University. (Scanned copy made available by La Société Sercquaise) *Note: the water balance calculation results in Davis contain a number of errors and although the overall approach is logical, the detailed methodology contains a number of flaws that make the numerical results questionable.*

Method Used

The water balance equation compares what water goes into the system and where it goes out, leaving a water balance, which is the water that can be pumped out for our use. This is much like a current bank account where you have incoming deposits and outgoing payments, leaving the bank balance, which is money available to be used.

Because water exists in various forms (rain, streamflow, groundwater flow, evaporation, soil moisture, water pumped), it is necessary to convert these volumes of water into the same units for consistent accounting. In this case the units of water will be in mm depth of water, the same units as rainfall.

The basic equation used, and the different components of the water system (numbered 1 to 9) are shown below :

WATER INPUTS	minus	WATER OUTPUTS	leaves	WATER BALANCE
1 rainfall 2 imported water		3 evaporation 4 plant transpiration 5 stream and surface flow to the sea 6 groundwater flow into the sea 7 water pumped from boreholes 8 water taken from wells		9 groundwater stored (seen as changes in levels in observation boreholes)

We have been able to construct a working water balance model between 1969 and 2023. We were missing some key climate data before 1969 which meant that accurate evapotranspiration calculations could not be done. Details of the calculations used and the assumptions made are shown in Appendix A.

From these calculations we have obtained the long term average values (1969-2023), for variables 1-8, which are shown in **red** text.

1 **Rainfall : 825mm/year**. We have good annual, monthly and daily measurements form the sites at Point Robert and Far Horizons.

2 **Imported Water** : **0 mm/year**. This is assumed to be zero as the cost of transporting water is high.

3 and 4 - Evaporation and transpiration, usually combined into "Evapotranspiration" and calculated using formula such as the Penman or Penman Monteith equation. **Actual Evapotranspiration : 429 mm/year**

5 **Stream and surface flow into the sea** : **255mm/year.** There are no direct measurements of flow so this was estimated.

6 **Groundwater flow out to sea : less than 50mm/year.** This was estimated using assumed values of the hydraulic conductivity of the rocks and estimates of flow from springs around the coastline.

7 and 8 - **Water from boreholes and wells : between 12 and 64 mm/year** (depending on well location). There are no direct measurements but human water demands can be estimated from typical consumption rates, population size and the density of borehole groupings on the island.

8 **Groundwater stored** - Changes in storage are demonstrated by the changes in water levels in the observation wells and boreholes which will be obtained by measuring water levels in key boreholes.

Placing these numbers into the water balance equation, we get

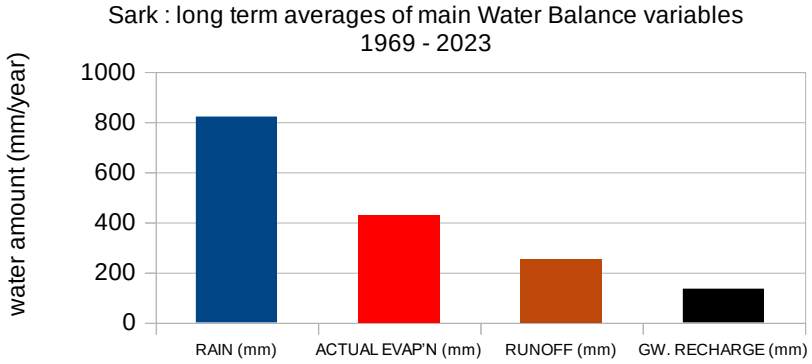
825 + 0 = 429 + 255 + 50 + 64 (years 1969-2023)

or 825mm/year inputs = 798 mm/year outputs

The balance is not perfect but the calculated outflows are within 3% of the rainfall inputs. Considering that several of the output variables had to be estimated, the agreement between inputs and outputs is very close. We can use this water balance to calculate how much rainfall gets into the groundwater system each year and then compare it against how much is pumped out and used by us.

In an average year between 1969 and 2023, of the 825mm/year of rainfall, we lose 429mm from actual evapotranspiration and 255mm from surface runoff. The remaining 141mm seeps in to the soil and groundwater system.

We estimate that deep groundwater flow through the rocks into the sea is very small (5-10mm/year, say 7mm), so we effectively receive 141-7 = 134mm/year recharge into the groundwater system that is available for use. If no water were pumped out, the water table would rise and increase horizontal flow through the surface rocks and soils towards the coast. This would in turn increase the spring flows around the coastline. A medium level of pumping would lower the water levels in the groundwater and reduce the spring flows. A high level of groundwater pumping would deplete the groundwater store, further reducing the spring and stream flows and dewatering the cracks and fissures that hold the groundwater until no more water can be easily extracted.



Groundwater Recharge – average year

Key Finding 1 : Average annual rainfall is 825mm and it supplies 134mm/year to groundwater recharge at present.

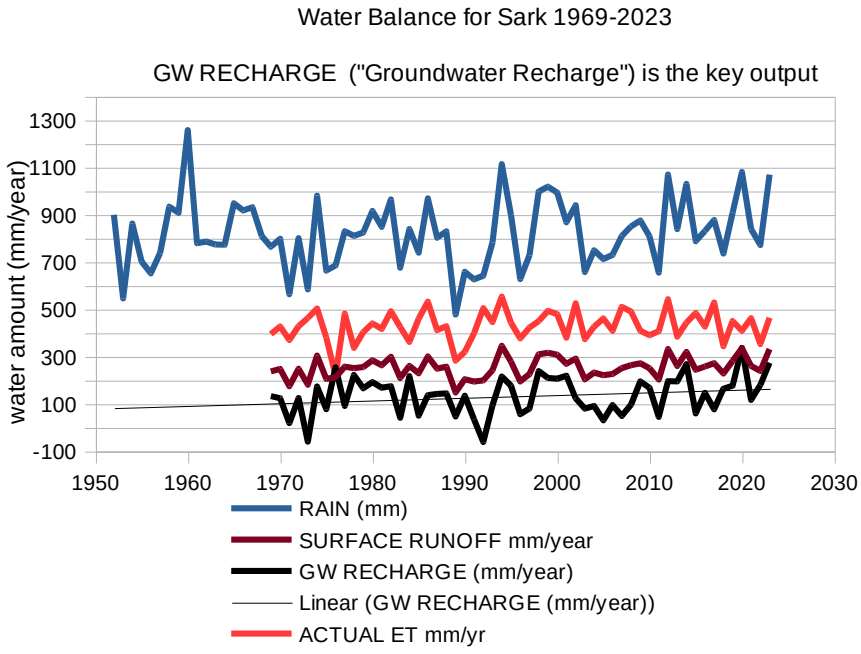
Of this 134mm/year, some of this water is pumped up from boreholes and wells (the amount varies in differing parts of the island). The rest drains laterally out of the rocks and into the sea.

In a similar study for the water resources of Guernsey by the British Geological Survey (Robins et. al., 2000), their estimate of ground water recharge was 128mm/year. This is very close to the value we obtained in this study.

Changes in the water balance over time

We repeated the water balance calculations for each year 1969-2023 to detect if there are any year to year variation or long term changes in groundwater recharge. The plot below shows that there is a slight trend towards increased groundwater recharge, probably due to the recent series of very wet winters.

However it must be noted that there are two years when groundwater recharge was below zero (in the 1970's and in the 1990's).



Estimates of water consumption

There are no formal records of how much water is extracted by individual households, hotels and businesses. Therefore water consumption must be estimated. In the UK the typical domestic consumption is around 150 litres per person per day. It is likely that water conscious residents on Sark consume less than this but there is no data to back this up.

In her 1998 thesis, Anita Davis assumed a consumption of 110-157 litres per person per day and she went to to make a detailed assessment of water consumption for hotels, guest houses, farm animals etc., together with likely water use by day trippers and campers. The overall consumption estimate was 64020933 litres per year.

When converted to the same units of rainfall (by spreading this volume over the land area of Sark), the water consumption is 12mm/year, which is much lower than the average annual ground water recharge of 134mm/year. However this does not take into account the varying density of housing (and their boreholes) and it refers to an average year.

If the boreholes used to extract water were evenly spread over the island (and the geology was uniform), then the extraction rate is 12mm/year (in units of rainfall). However, if the boreholes are grouped in the central 1 square kilometre of the island, the extraction rate is significantly higher (64mm/year) – see Appendix A. This would mean that extraction could exceed groundwater recharge in many more years, especially in areas where boreholes are close together.

Key Finding 2 : In densely populated parts of the island, groundwater extraction is estimated to be 64 mm/year.

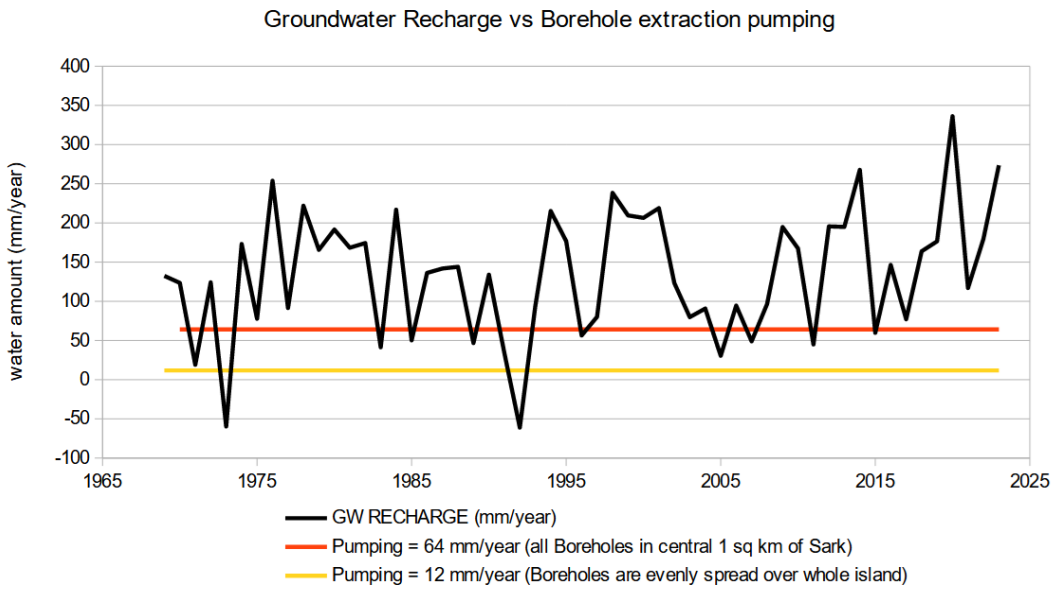
Dry years and pumping intensity

We know that there were notable drought events in 1974-6 and in the early 1990's. In 1976, the water levels in typical boreholes fell by around 5m as a result of consecutive years of below average recharge. It is entirely possible that these kinds of events could happen again, although recent years (2020-2024) have had relatively high rainfall.

From the plot below, in the 54 years of calculations, there were 11 years when the estimate of groundwater pumping (64mm/year) exceeded the groundwater recharge, so we can estimate the current state of the groundwater resource as :

Key Finding 3: Over the last 50 years, water extraction could be greater than groundwater recharge once every 5 years.

Key Finding 4: In the last 50 years, there have not yet been any "back to back" years of below average recharge (i.e. several years in a row of relative drought). As a result the groundwater has usually been replenished in the winter following a dry summer.

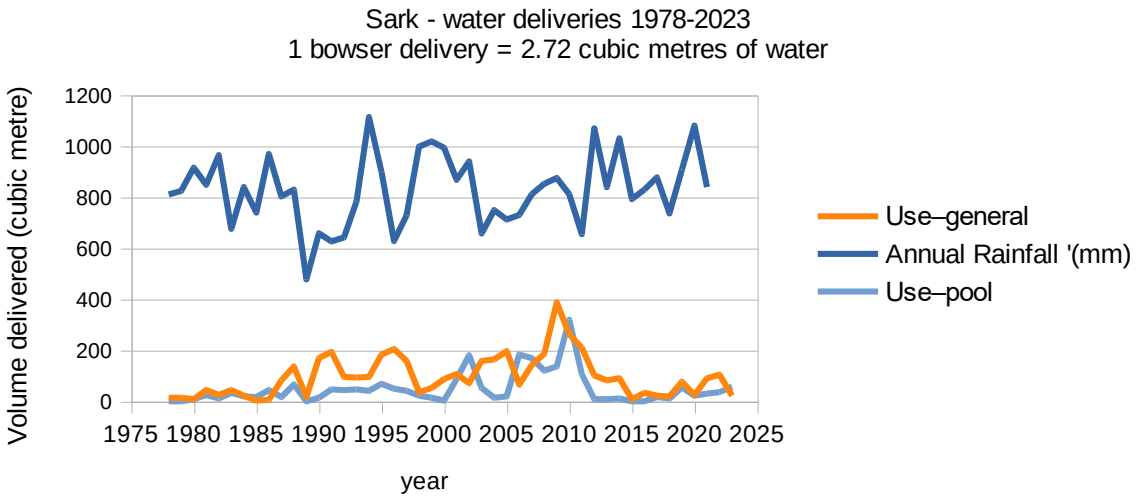


Responses to water shortages

Known drought years were recorded in 1976, 1989/91 and 1996. These prompted drilling additional boreholes. Dry years (with annual rainfall less than 670mm) have also been recorded in 2003 and 2011.

There is a system of delivering bowser loads of fresh water (2.7m^3/load) from a productive borehole in the centre of the island. This supplies water to properties when required for roof water collection tanks to be filled if they run dry, or for other purposes such as construction or filling a swimming pool (Kevin Adams, pers. comm. 2024).

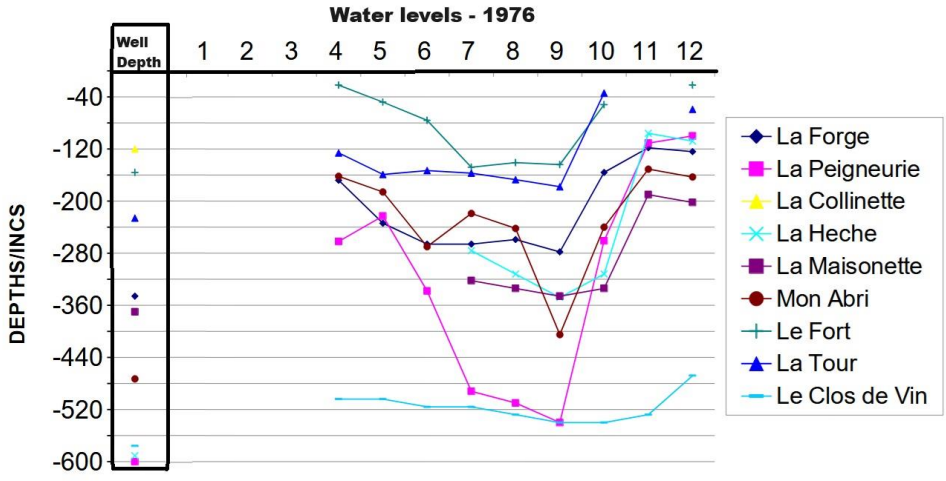
In discussions with staff delivering the bowsers of water, there have been no true water crisis years to their knowledge in the past 40 years. It is known that problems did develop on Little Sark in 1976, when water for cattle was delivered twice a day from La Moinerie Farm.



Records of deliveries between 1978 and 2023 suggest that the average annual water bowser delivery volume is 145m^3 and the highest year was 2011 with 580m^3 delivered. However there is no direct correlation with the pattern of annual rainfall evident. There is a possible increase in bowser deliveries 2005-2010 when rainfall was slightly below average, but this is not a confirmed cause and effect relationship.

Recommendation 1 : It is recommended that local knowledge is used to determine how the island coped with specific severe drought years such as 1976.

Because boreholes are owned and operated by individuals, there is no simple way of knowing how much water is abstracted from the groundwater. Nor is there a control on sinking new boreholes. Groundwater level measurements have been taken in a series of wells between 1994 and 2003 (Cheney). These suggest that there was no clear long term trend in groundwater levels but as this is a short record, longer term changes and severe drought periods may not have been detected. A check of the 1976 water levels showed that typical water levels fell by 200 inches (5m) and some boreholes were effectively dry.



Adapted from a spreadsheet supplied by La Société Sercquaise

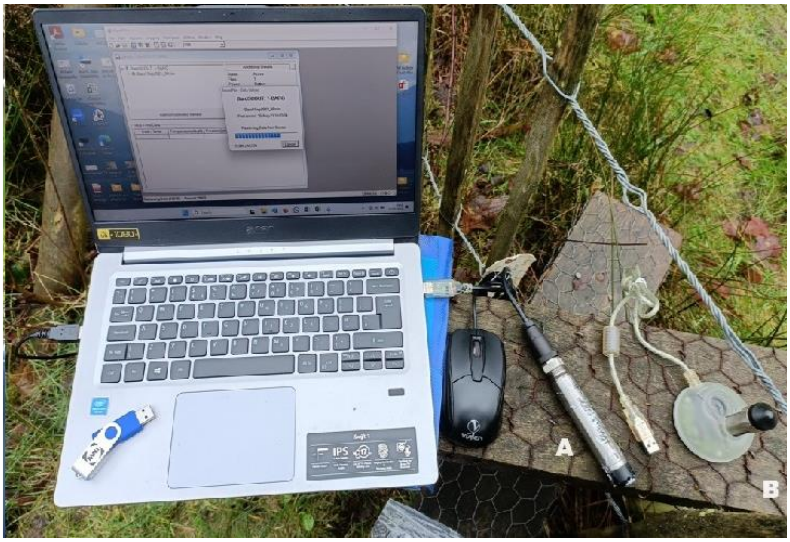
It is understood that that regular monitoring of groundwater levels ended sometime after 2003.

Recommendation 2. It is strongly recommended that the Island re-introduces a coordinated system to make regular measurements of ground water levels in observation wells and boreholes.

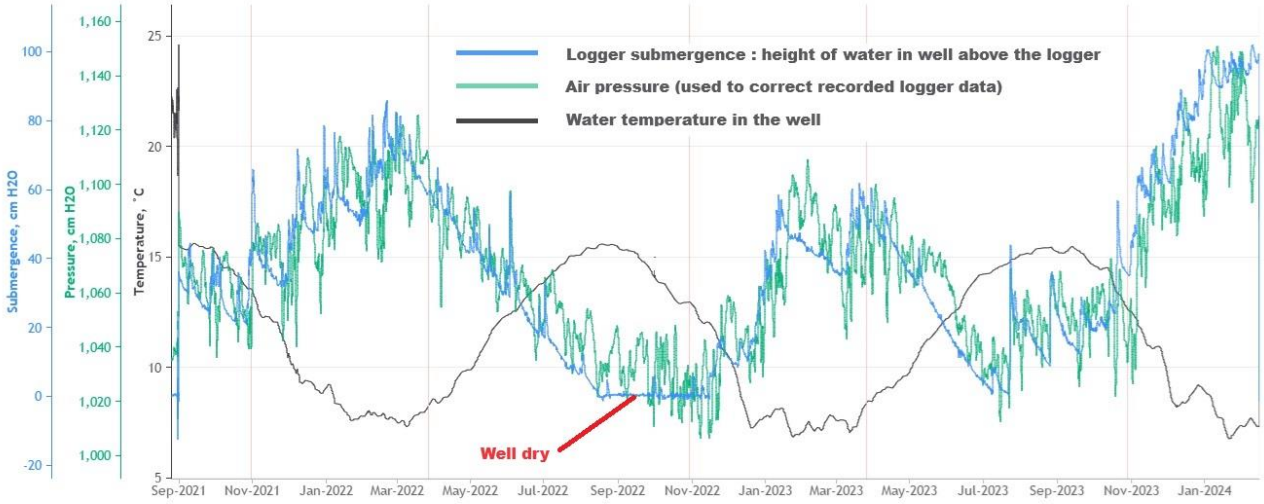
These observation sites should be in wells and boreholes that are never pumped for water supply. In the first instance, there should be a manual water level reading made on the first day of each month at 5-10 representative sites. This could be coordinated by La Société Sercquaise. By involving a network of interested individuals, this will create a "Citizen Science" project (possibly involving local school children/ teachers). The monthly measurements should be posted on a web page alongside monthly rainfall to inform the wider population of the current state of the available groundwater resource.

Ideally a system of 5 automatic water level recorders should be installed using data loggers (such as a "LevelScout" pressure recorder, together with a barometric compensation "BaroScout" https://www.vanwalt.com/water-level/ or Mini Divers https://www.vanessen.com/images/PDFs/Mini-Diver_Card_EN_Metric.pdf).

A MiniDIVER being lowered into an observation well



*Data collection from a LevelSCOUT (**A**) and a MiniDIVER (**B**)*



Typical data readout from a data logger. The pressure recorded by the sensor has to be corrected for changes in atmospheric pressure. Here we see that the well dried out between September and November 2022.

An estimated one off cost for these types of data loggers would be £600 per logger, plus about £30/year for routine logger maintenance and servicing (eg battery replacement every 3-4 years).

Key water sources

The use of the water bowsers to deliver water to properties that are short of water indicates that the central source is more productive than other wells and boreholes on the island. This is probably due to the pattern of fissures and fractures in the geology at the pumping site. A more detailed study of the capacity of this well/borehole should be made.

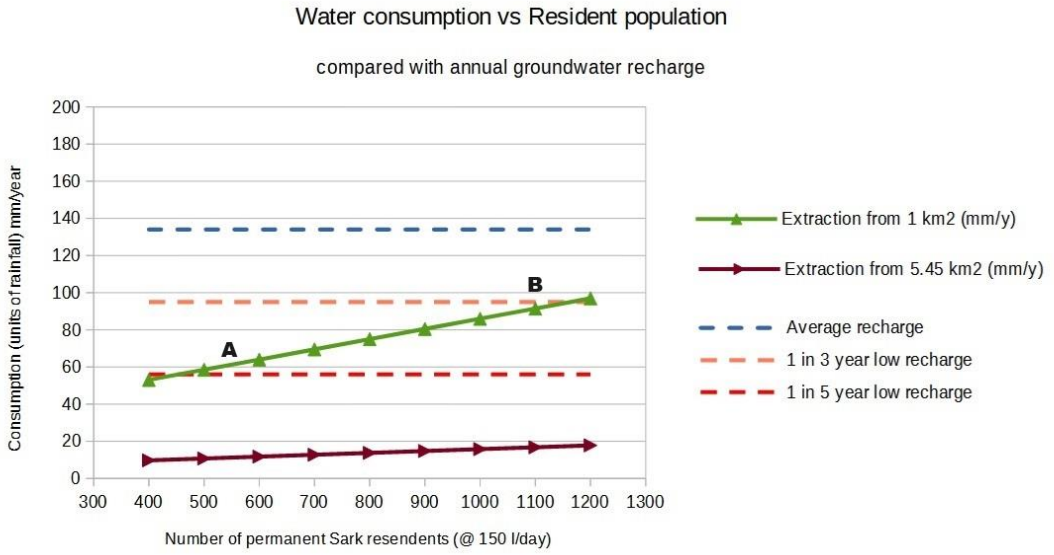
Recommendation 3 : An assessment should be made of the most productive boreholes, using local knowledge and drilling companies.

Future Changes 1: Increases in the resident population

If the permanent population of Sark were to increase, we need to estimate future demands for water. In the following scenarios, we assume that permanent residents consume 150 litres/person/day and all other water uses (tourists, animals, day trippers etc) remain the same as reported by Davis (1998).

SCENARIO 1 : In the graph below we are at point "**A**" with a resident population of about 562 (2022 census). As described above, the water consumption can be assumed to be extracted from either the whole island (brown line labelled "Extraction from 5.45km^2") or more realistically from a concentrated group of boreholes in the central 1 square kilometre of the island (green line labelled "Extraction from 1km^2").

Considering the 1 square kilometre case, the present day extraction of 64mm/year is about half of the average groundwater recharge of 134mm/year. However it is close to the 1 in 5 year low groundwater recharge (56mm/year). In other words, we can expect groundwater pumping to exceed groundwater recharge about once every 5 years or so (the exact timings are uncertain and they will not be evenly spaced apart). Note that this ignores climate change and population increases and that it assumes that all pumping is taken from the central part of the island - i.e. ignoring more distant properties and Little Sark.



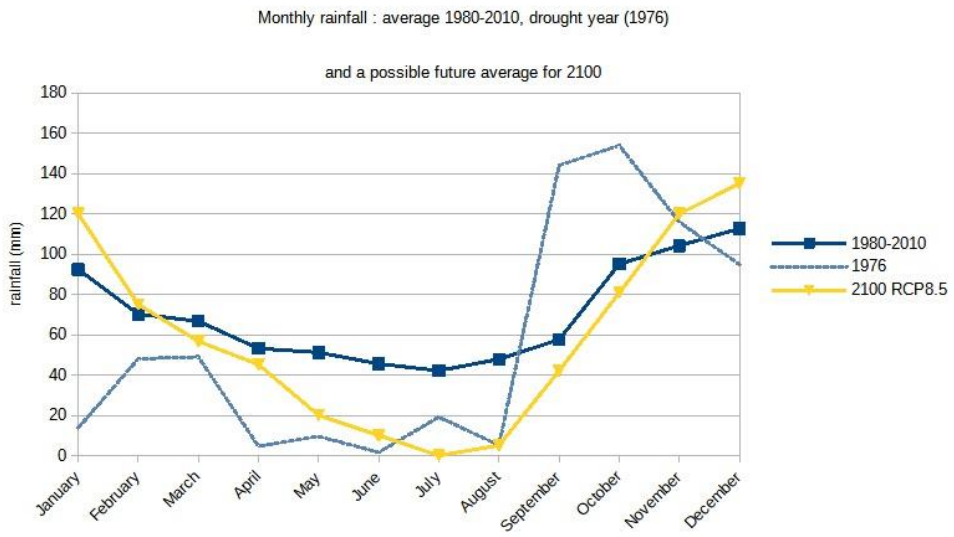
In a more extreme scenario, where the population of the island were to double to 1100 (and again most groundwater extraction is in the central 1 square kilometre), then demands would exceed groundwater recharge on average once every 3 years (point "**B**"). At this stage there is a much stronger possibility of sequences of "back to back" drought, meaning that there may not be enough groundwater recharge in winter for the groundwater levels in boreholes to recover.

Future Changes 2: Climate Change projections

Projections of climate change for the UK and north west Europe are for longer, hotter and drier summers, combined with wetter winters. It is not known if the increased winter rainfall will balance out the dry summers, but extended hot dry periods at times of high tourism is likely to put additional pressures on the available water resources when they are least available.

The UK Climate Impact Programme (https://www.ukcip.org.uk/) suggests that under a high carbon dioxide emissions scenario (RCP8.5) by the year 2100 the Channel Islands annual rainfall will remain much the same, but with an uncertainty of plus or minus 15%.

The graph below shows current average month rainfall and a low rainfall future climate scenario for 2100, together with the rain pattern that occurred in the great drought of 1976. In this admittedly pessimistic (but entirely possible) scenario, the *average* summer in 2100 could resemble the extreme drought year of 1976.



1980-2010 : https://www.metoffice.gov.uk/research/climate/maps-and-data/uk-climate-averages/gby1hzr7h
1976 : La Société Sercquaise
2100 : generated RCP8.5 scenario with low rainfall outcome (-15%).

Uncertainties in future climate projections

The projections of future rainfall are not certain. However there is a distinct possibility of wetter winters and drier summers, and under this scenario it is possible that groundwater demand will increase while the groundwater recharge may well decrease. This is because :

a) groundwater will be depleted by the additional water demands of a hotter, drier summer

b) the winter rainfall will be more intense and a higher proportion of the annual rainfall will flow off the island in the streams. This will reduce the opportunity for groundwater recharge to occur.

Whilst these projections contain a high degree of uncertainty, there is a definite *possibility* that Sark may experience extended hot dry summers which might place unmanageable stresses on the groundwater resource. A responsible approach to take is to be be prepared for this possible outcome.

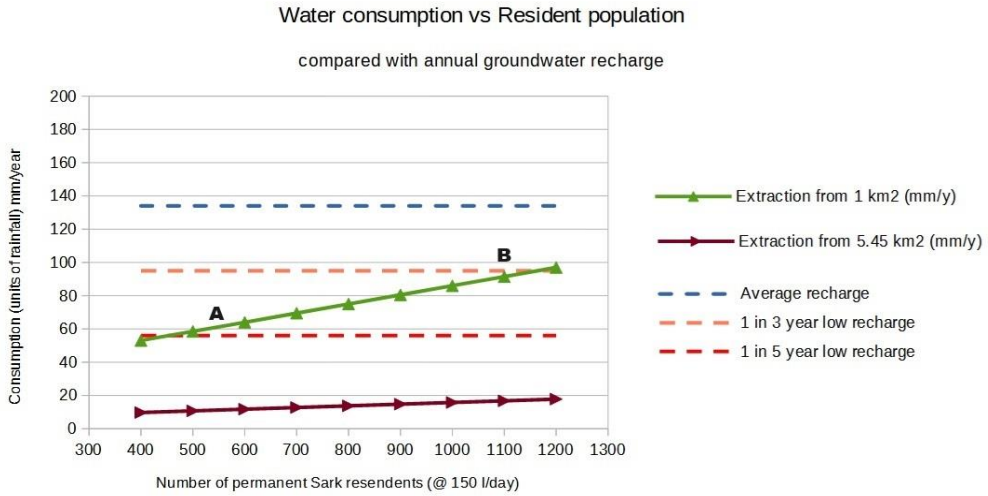
Possible future Scenarios

One way to do this is to look at cases where the climate has shifted and the groundwater recharge is reduced. Below are "Scenarios" where we compare the present day with future worlds in which annual groundwater recharge is reduced first by 25% then by 50%.

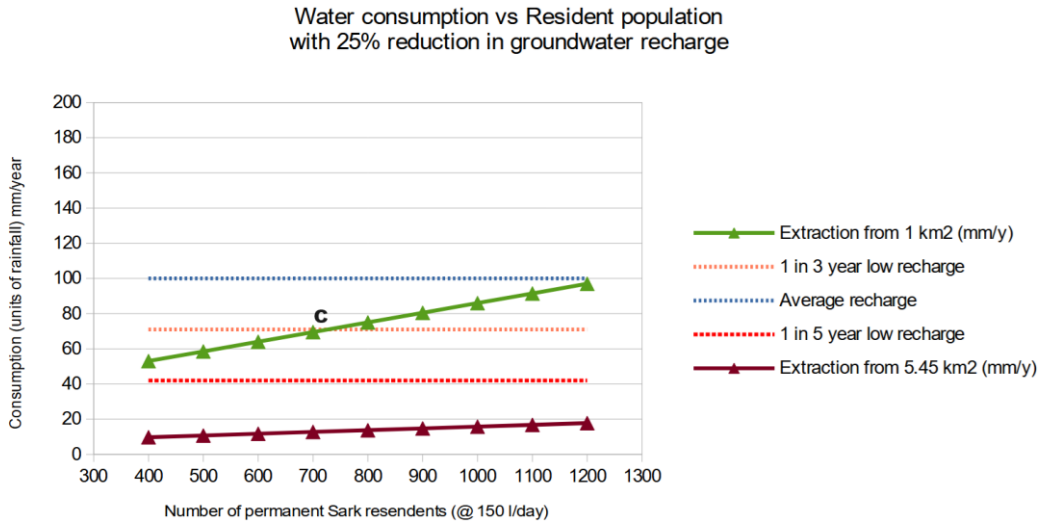
We begin with the current situation (SCENARIO 1) and present day climate.

Under current conditions, point "**A**" suggests that water recharge is close to the extraction on average once every 5 years. However if the climate remains the same and the population doubled to 1100 residents, then demands will be close to the present day 1 in 3 dry year (point "**B**").

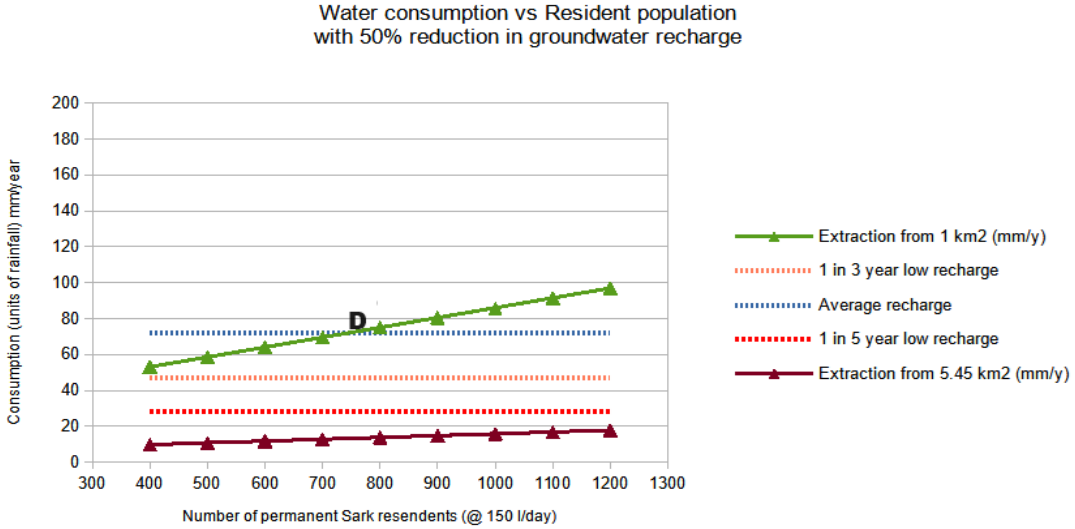
SCENARIO 1: Current groundwater recharge conditions.



SCENARIO 2: With a 25% reduction of recharge, and a population increase to 700 permanent residents, the extraction is approaching recharge once every 3 years (point "**C**") :



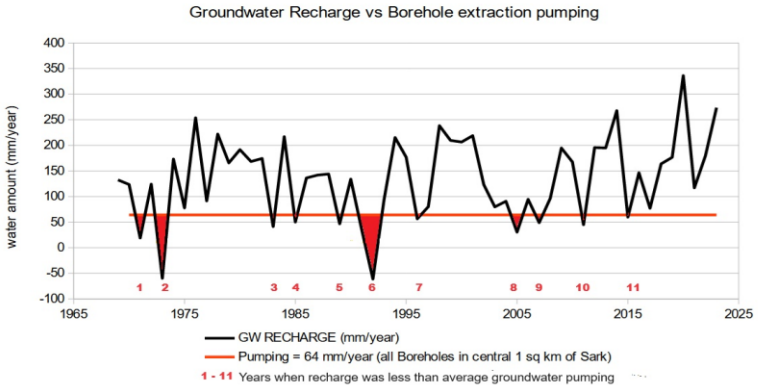
SCENARIO 3: With a 50% reduction in recharge and a slightly increased population. Groundwater extraction is close to the average annual recharge (point "**D**"). this means that in 50% of years, extraction will be greater than recharge.



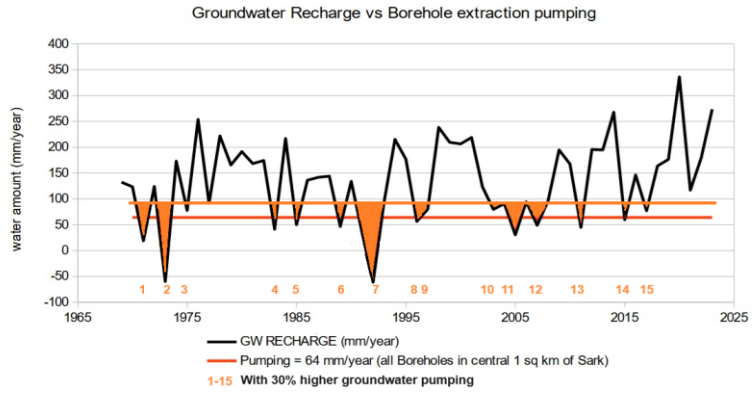
At point "**D**" any further water extraction will mean that the island is taking more water out than what is going in. This is known as "groundwater mining", and in this Scenario the water resources become unsustainable. It will result in continual lowering of groundwater levels until no more water can be extracted.

The three scenarios can also be shown as time series graphs – so how the number of drought years increases as demand increases and recharge decreases, and, more importantly how the occasional drought at the moment becomes almost the "norm".

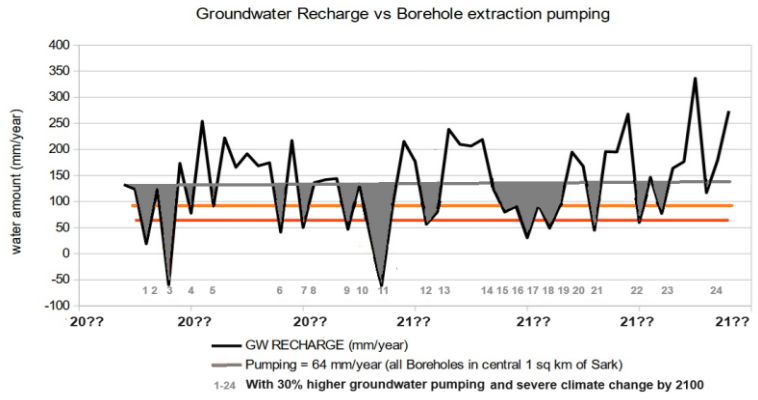
SCENARIO 1 (Present day, population 550). The red line is the estimated groundwater pumping rate. In 11 of the 54 years, pumping was greater than groundwater recharge, so we estimate that there is a nominal drought event on average once in every 5 years.



SCENARIO 2 (Present day, population increases to 700). If we increase the population on the island by (say) 50%, the groundwater pumping would probably increase by 30%. There will be more years when we extract more water than the groundwater recharge. Here the 15 drought events in 54 years means that there may be a water shortage 1 year in every 3 years. More seriously, there will be multiple years in a row when we pump more water than recharge. This means that the lowered groundwater levels may not recover ready for the



SCENARIO 3 (2100, population 700+). By 2100, with reduced groundwater recharge from rainfall combined with and longer hotter summers. There will be many more years when we extract more water than the groundwater recharge. Here the 24 drought events in 54 years means that there may be a water shortage 1 year in every 2 years. Very seriously, there will be many years in a row when we pump more water than is recharged in winter. This will cause groundwater levels to decline to an unsustainable situation.



Key Finding 5: If the population rose to 700 people, the increased demands for water combined with the impacts of climate change may place impossible demands on the available groundwater. In the short term (10-15 years), drought frequency is likely to rise from 1 in 5 years to 1 in 3 years. By 2100 water extraction could exceed groundwater recharge most years if the population goes above 700.

Once the groundwater recharge rate has been exceeded, constructing additional boreholes may not compensate for the lowered groundwater recharge. Indeed in many countries this has been the case – richer landowners drill deeper and deeper wells and install larger pumps, resulting in a "race to the bottom" of the groundwater resource. See for example https://eu.desertsun.com/story/news/environment/2015/12/10/how-unchecked-pumping-sucking-aquifers-dry-india/74634336/

Communicating this information : engaging with the local population

The only way to check on the impacts of climate change and increased pumping is to put in place a formal groundwater monitoring programme and have it running over several decades. (**Recommendation 5).** By engaging the local population in the monitoring this will encourage more responsible use of water.

It is not easy to communicate the exact impacts of future conditions to the general public, but we have found that asking questions such as these opens up useful thought processes :

- **What will our future weather and climate be like ?**
  (We don't know … but expectations are southern England in 2100 is likely to be more and more like the Bordeaux region of France today.)

- **How would we cope if every year was like 1976 ?**
  (Opening a dialogue with residents who experienced the drought in 1976 may give a better insight into the availability of water in dry years, noting that the winter in 1976-77 was exceptionally wet !)

- **What would we do if half of the wells and boreholes dried up?**
  (What water saving techniques and water saving technologies could be used?)

Reducing demands : adopting water saving technologies

The assessment of water demands carried out in this report assumed that the resident population consumes between 110 and 150 litres of water per person per day. These figures are based on typical UK consumption with an estimate of how a water conscious population (as on Sark) might lower their water use behaviour.

Existing properties

One way to reduce the impacts of future population and climate change on the demand for water is to encourage existing residents to modify their water use. A series of useful web links is listed below that could assist homeowners to reduce water use - either in a day to day behavioural change or by using new water saving technologies (when they may be renovating or upgrading their property).

A user can calculate their own water use and possible improvements https://watercalculator.uk/calculator/, together with a typical building specifications https://watercalculator.uk/example-specifications/

The UK Centre for Alternative Technology (CAT) provides a wide ranging advice service. It states "The average domestic use of water in the UK is 150 litres per person per day, but it is easy to reduce this to 70-80 litres per day". The CAT website provides information on improved domestic water management and sewage treatment. https://cat.org.uk/info-resources/free-information-service/. Grey water use (i.e. using rainwater and wastewater from taps and sinks) is a proven methodology to reduce overall water consumption. https://cat.org.uk/info-resources/free-information-service/water-and-sanitation/rain-and-grey-water/

There is a wealth of information on designing modern buildings with energy and water saving technology. Available at https://www.designingbuildings.co.uk/wiki/Greywater_recycling.
Also, see for example, https://www.tanks-direct.co.uk/water-tanks/rainwater-harvesting/c874

The European Union has created a "Unified Water Label" system, similar to the efficiency rating on electrical products https://uwla.eu/. It contains useful sections on domestic water saving devices https://uwla.eu/consumer/.

New builds and renovations

If the population of Sark were to increase by, say 50%, this might involve the construction of homes for 300 people. At an average occupancy rate of 2.2 persons/house (https://www.gov.uk/government/statistics/chapters-for-english-housing-survey-2022-to-2023-headline-report/chapter-1-profile-of-households-and-dwellings) this equates to about 130 homes.

We can expect there to be serious investment in renovating existing properties and the construction of new housing. This provides an opportunity for the Island of Sark to place some "soft touch regulations" on the owners and developers of these properties :

a) to ensure that all new homes are fitted with low water use devices (aerated taps, low flush toilets, water saving showers)
b) to connect grey water collection tanks for collecting water for toilet flushing or garden watering
c) to require the inclusion of rainfall harvesting systems eg https://www.tanks-direct.co.uk/water-tanks/rainwater-harvesting/c874

Recommendation 4 : Require that all new builds and major housing renovations incorporate water saving technologies to reduce water consumption.

Although regulations in Sark appear to be limited in many areas, there is also an opportunity to create a water management fund for the Island. This could be done by placing a (small) environmental levy on each new house/renovation by charging a one off "water development fee" of (say) £2500 per newly developed or renovated property. This sum is tiny in comparison with the overall costs of constructing a property.

If implemented, the Fees raised from the nominal 300 homes could create a fund of £0.75million. This fund could be used to pay for groundwater monitoring, water quality testing and to deal with any other water related emergencies.

Recommendation 5 : Suggest the introduction of a "Water Development Fee" for all new builds and major housing renovations.

Water Quality

This report was commissioned to assess the volume of water resources and the scope of the report will not cover water quality. However during the visit to the Island in June 2024, a number of issues relating to water quality monitoring and the risk of contamination were identified.

Water quality testing: this appears to be unregulated, except for businesses (hotels, bars, restaurants). It is up to the individual house occupier / owner to arrange testing of the quality of the water extracted from their own borehole. It is known that mineralisation and heavy metal contamination is a possibility due to the makeup of the geology of the island (Cheney 2006). Copies of typical water quality reports are included in Appendix B.

Advice on assessing water quality across the island could confirm the presence or absence of heavy metals, pharmaceuticals, pesticides, dog and cat flea treatments amongst others.

It would be very helpful if all water quality testing results from private dwellings and businesses were collated centrally by a Public Health Committee on Sark. Accurate water quality data would help recognise trends and areas with specific problems.

Saline intrusion risk : there have been no reports found that suggest that pumping groundwater from boreholes has caused ingress of sea water into the water supply of Sark. Most wells are no more than 60m deep and given that the land elevation is typically 90m, the base of these boreholes will be about 30m above sea level. However it must be noted that deeper boreholes, especially near to the coast, may connect with a fault or fissure that might permit the ingress of sea water.

Contamination risk of domestic boreholes : there appear to be no formal regulations in place to protect groundwater recharge zones – most householders own their own borehole and they may have a series of potential contamination risks in the vicinity of their borehole.

Such risks might include:

- A leaking septic tank releasing pathogens into the groundwater. This may be localised in nature due to the low permeability of the geology of Sark, but it reinforces the need for residents and businesses to carry out regular water quality tests (eg twice a year).

- Leaks from fuel oil storage – domestic fuel oil (a light Non Aqueous Phase Liquid or "LNAPL") is usually stored in tanks adjacent to the houses. An unnoticed slow leak, (or indeed a sudden catastrophic leak) would permeate through the soils into the groundwater and contaminate nearby boreholes. The same applies to fuel oils stored for agricultural use. LNAPL leaks are difficult to remediate once the contamination has occurred and it may result in one or several boreholes having to be abandoned as a source of water. (There is an example of this in the current 2024 news on the BBC website at https://www.bbc.co.uk/news/articles/czrrpw0702go - where the clean up from a petrol spill is disrupting domestic water supplies.)

- Commercial storage of herbicides, pesticides and other hazardous materials. We are not aware of any regulations relating to this.

- Waste disposal management - eg building waste (which may contain asbestos), paints, batteries, farm waste such as slurry and by products from processing meat and fish products.

- Human waste removed from septic tanks appears to be transported and stored for treatment at one coastal site. It is believed that in some circumstances, raw waste is discharged into the sea (unconfirmed). Although this is unlikely to have an impact on borehole water (which is extracted further inland), it raises the issue of who is responsible for dealing with a pollution incident should it occur.

Clearly, there are a number of potential risks to the existing groundwater which might compromise one or several water supply boreholes and thereby putting additional strain on other boreholes. Protecting the groundwater resource against contamination on Sark is difficult due to the apparent lack of formal regulations.

Recommendation 6 : Make the Island's population more aware of possible water contamination risks. This would be a first step in raising public awareness and hopefully will contribute to identifying a contamination problem before it becomes an emergency.

Recommendation 7 : Create a coordinated storage system for all water quality test reports. This will provide information on the overall health of the water quality and help to identify any developing problems.

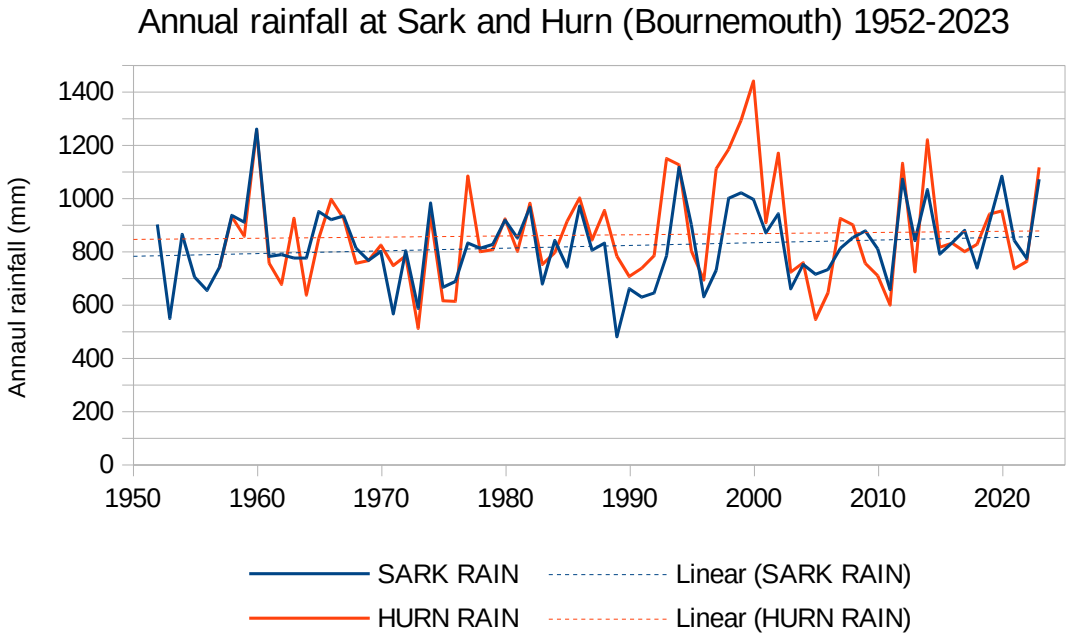
End of main report

APPENDIX A : DETAILED WATER BALANCE CALCULATIONS

Rainfall

All available fresh water on Sark comes from rainfall, but only a proportion of this gets into the rocks and becomes groundwater which can be extracted from wells and boreholes. The first action is to look at the trends of rainfall measured in Sark. Annual rainfall from 1952-2023 measured in Sark was provided by La Société Sercquaise.

The graph below shows the annual rain in Sark and for comparison rainfall at Hurn Airport, Bournemouth (a UK Met Office "Historic Climate" site - see https://www.metoffice.gov.uk/research/climate/maps-and-data/historic-station-data).



The Sark average rainfall is 825mm/year and at Hurn is 862mm/year. Comparable averages for Guernsey are 831mm/year and for Jersey are 877mm/year.

Overall the trend of annual totals is very slightly upwards. However the year to year variation is very large and Sark has experienced as little as 478mm (1989) and as high as 1247mm (1960).

Potential Evapotranspiration (PE) and Actual Evapotranspiration (AE)

Potential Evapotranspiration is the amount of water that would be evaporated from a field growing a short green crop (eg a playing field covered in grass) that was well watered. In this situation the evaporation is controlled by weather conditions only. However in summer the soil will dry out and reduce the evaporation rate to less than the "potential" rate. The Actual Evapotranspiration will therefore depend on both climatic conditions and the dryness of the soil.

We use a two step approach to calculating Actual Evapotranspiration :

i) For each month, calculate the Potential Evapotranspiration assuming the fields and soils are not short of water using the Penman Monteith equation,

ii) Calculate a running daily water budget for each year to determine when and for how long the soils dry out. Use this information to reduce PE to Actual Evapotranspiration.

The calculation of the PE using the Penman Monteith equation is complex, requiring monthly values of average temperature, humidity wind speed, sunshine hours and solar radiation intensity. (Much of these data is recorded on Sark but the short time scale of this report meant that there was insufficient time to process it.) As a starting point, we used the United nations FAO "CLIMWAT" climatic database together with the "CROPWAT8" programme to extract average climatic data for Guernsey and calculate monthly Potential Evapotranspiration using the international standard Penman Monteith equation :

Monthly ETo Penman-Monteith - C:\DEREK\CROPWAT8\CLIMWAT2\My_CLIMWAT_Files\Guer...

Country: Guernsey Met Office Station: 1980-2010 average

Altitude: 25 m. Latitude: 49.40 °N Longitude: °E

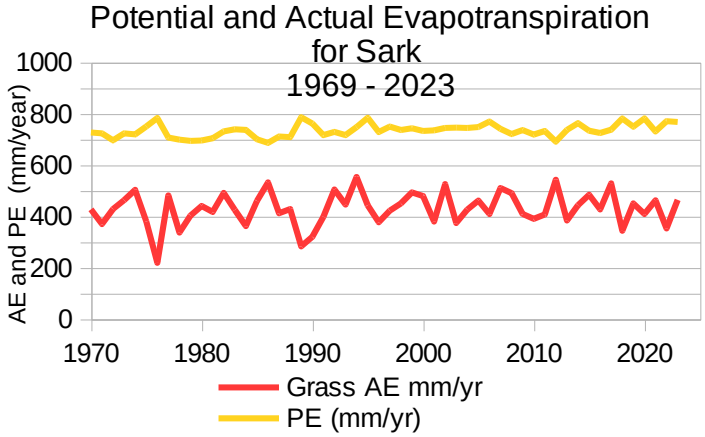
Month	Min Temp	Max Temp	Humidity	Wind	Sun	Rad	ETo
	°C	°C	%	km/day	hours	MJ/m²/day	mm/day
January	5.0	8.7	83	479	2.0	3.5	0.89
February	4.5	8.4	83	433	3.1	6.0	0.98
March	5.6	10.0	83	406	4.1	9.7	1.34
April	6.7	11.9	90	383	6.5	15.6	1.61
May	9.2	14.9	80	361	7.6	19.3	2.70
June	11.6	17.5	80	333	8.2	21.1	3.20
July	13.7	19.5	81	343	8.1	20.4	3.32
August	14.1	19.8	81	324	7.4	17.5	2.99
September	13.1	18.0	81	363	6.0	12.7	2.28
October	11.0	15.0	84	416	3.8	7.3	1.43
November	8.1	11.8	84	434	2.6	4.2	1.00
December	5.8	9.6	84	457	1.9	2.9	0.83
Average	9.0	13.8	83	394	5.1	11.7	1.88

https://www.fao.org/land-water/databases-and-software/cropwat/en/

PE is shown in the column labelled "**ETo**" (reference crop potential evapotranspiration). The annual average PE for Guernsey is 1.88mm/day or 686mm/year. By way of comparison, the BGS report in Jersey suggested 648-754 mm/year. Davis (1998) used the simpler Thornthwaite equation to estimate Potential Evapotranspiration and came up with a lower average of 613mm/year.

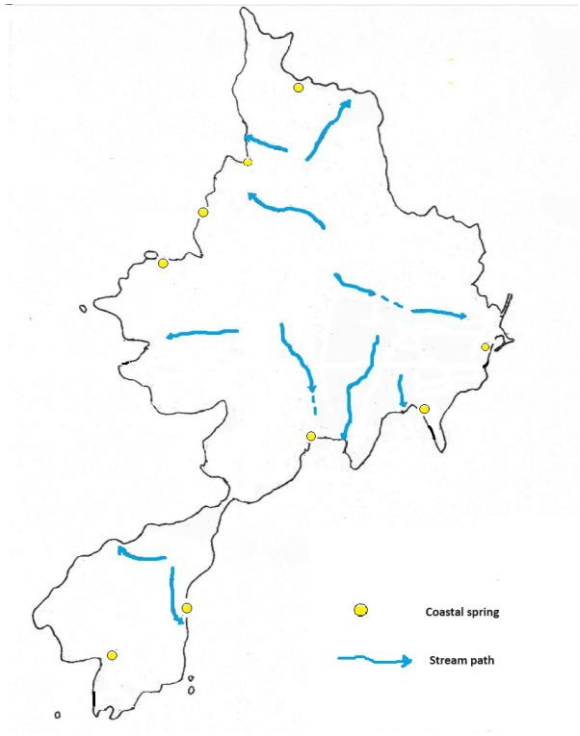
To create a time series of PE over several decades, we used data from the UK Met Office Historical climate station at Hurn Airport for the years 1969-2022. https://www.metoffice.gov.uk/research/climate/maps-and-data/historic-station-data . This was scaled for differences in wind speed and humidity between the two sites. The resulting average PE at Sark was 734mm/year which compares well with the BGS estimates for Jersey and is within 6% of the Guernsey ETo estimates.

Next, the effects of soil drying were simulated for each year using CROPWAT8. The provided the scaling factors that reduce Potential Evapotranspiration to Actual Evapotranspiration, primarily in the summer months. The average annual Actual Evapotranspiration (AE) for Sark was calculated as 429mm/year, approximately 58% of the potential rate. The graph below shows that PE and AE are increasing slightly over time, which is due to the gradual effects of climate change, particularly rising temperatures. The effects of soil drying on AE is visible in the drought summers of 1976 and 1989, when AE falls below 300mm/year.



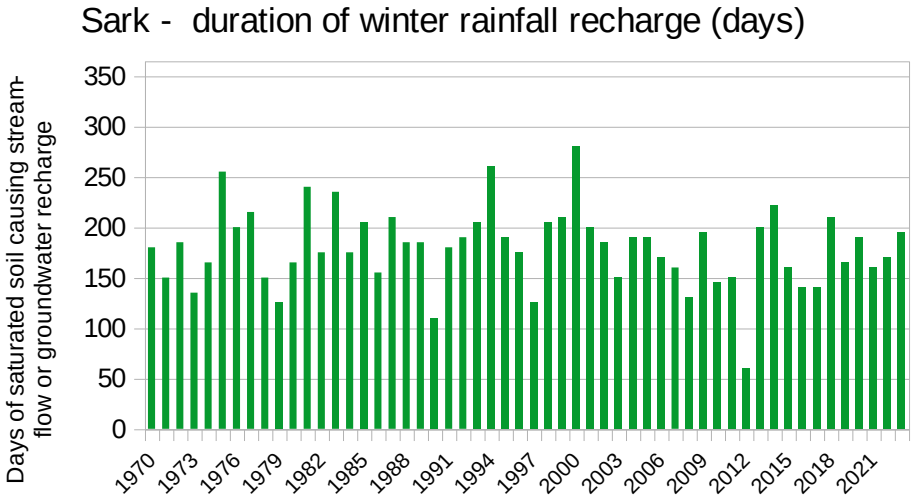
Stream Flow

Surface water is limited to a small number of minor streams (probably less than 10 – see map , which was adapted from Davis 1998). These flow mainly in winter, fed by excess rainfall and water draining from shallow saturated soils and groundwater (baseflow). No measurements of streamflow are available but it is estimated that each stream probably has an average flow of no more that 5 Litres/second when running.



Location of stream paths (based on Davis 1998) and coastal springs (La Société Sercquaise)

To estimate the volume of stream flow each year, we used the Actual Evapotranspiration soil drying calculation. The enabled us to determine when stream flow would stop in the summer months and restart later in the year. The average number of days a year that the soils ware saturated is 180 out of 365 (see graph).



By assuming that there are 10 streams flowing at an average rate of 5litres/second for 180 days of the year, the annual stream flow volume is 777,600m^3/year. To convert this to the units of depth of rain we divide by the area of Sark (5.45sq km) i.e. 777600/(5.45*1000*1000) = 0.142m or 142mm/year.

This stream flow represents approximately 17% of the annual rainfall on Sark. We still need to account for surface flow that seeps out of the soil in undefined small rivulets which is probably the same amount again. There is no simple way to measure this so in catchment hydrology we often use a "coefficient of runoff", or "percentage runoff" which is a fraction of the rainfall that drains off the soil surface. The percentage runoff calculated using the UK Flood Studies report methodology is 31% and by way of comparison Davis (1998) used a coefficient of runoff of 0.29.

Surface runoff was therefore estimated to be 31% of the annual rainfall (825*0.31=255mm) which is made up from 142mm/year stream flow and 114mm/year surface flow in undefined rivulets.

Groundwater flow into the sea

This is difficult to assess and there is no direct way to measure it. We know that the geology of the island is of dense volcanic and metamorphic materials. The rocks are very unlikely to be able to permit water flow though the deep compressed rocks tens of meters below ground level. With a hydraulic conductivity of 3 x 10^{-4} m/day (Davis, quoted in Cheney, 2006) a simple Darcy calculation suggests that the groundwater outflow from the island is likely to be less than the equivalent to 10mm of rainfall/year. However the geology does contain fissures and cracks and it is entirely possible that some groundwater will discharge through small springs at the cliff faces overlooking the sea (see stream flow and coast spring map above).

For this reason we will assume that groundwater flow out of the system is no more than 50mm/year. The value is chosen as it is much smaller than the observed streamflow. If it were any larger, it would become obvious that a significant spring is flowing.

Water extracted from boreholes and wells

There are numerous cracks and fissures in the local geology that fill with water and it is these that are used for the water supplies of the island of Sark. In the 1970's there were about 70 boreholes in operation. Cheney (2006) reported that there were approximately 250 deeper boreholes and 50 shallow wells being used for water extraction. It appears that there is no legislation that controls the construction of boreholes.

In general most properties have their own borehole but these are a few instances where several properties share a single borehole. Typical boreholes are less than 40m deep but there are a few examples of deeper wells (around 60m) and a small number are more than 90m deep (which places the base of the borehole close to sea level).

Additionally, some properties capture rainfall from roof surfaces and store this water in tanks on their property.

The majority of water extraction is for human use (homes, hotels etc). The resident population of Sark is relatively constant at around 550 people although this can double in the busy summer months with the arrival of tourists and day visitors.

There is no formal record keeping of water consumption on the island. A typical UK mainland person consumes 150 litres of water per day (drinking, bathing, washing). Davis (1998) suggested 155 litres of water per person per day, which is probably high for a water conscious island. She also added estimates of water consumption by tourists and in agriculture (animals). Her assumed water consumption rates were :

Residents	155 litres/person/day
Hotel visitors and guest houses	110 litres/person/day
Self catering guests	155 litres/person/day
Campers	60 litres/person/day
Day visitors	45 litres/person/day
Farm animals	50-150 litres/animal/day.

Other uses (eg industry, processing) are small. There is no formal use of water for irrigation of field crops on Sark (this can be an extremely large consumer of water). There may be some limited watering systems in a few domestic gardens.

For a typical year in the 1990's Davis estimated a water consumption of 64020 cubic meters per year. Spread pro rata over the 550 permanent resident population, this is approximately 319 litres per permanent resident per day. This figure may be useful in planning water resources use for future development and population projections.

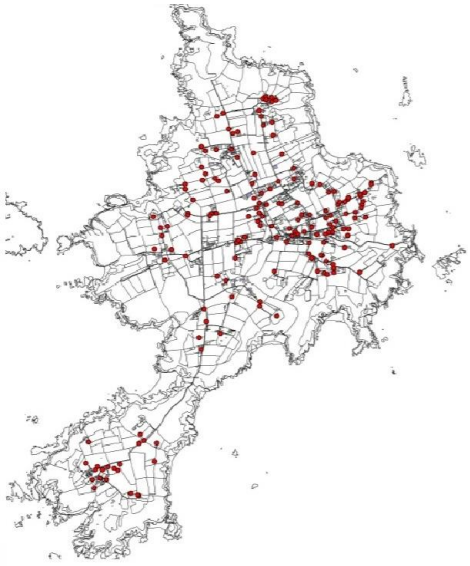
To place this water consumption into context and compare it with the annual rainfall of 825mm/year, we can convert the volume of 64020 cubic metres/year to an equivalent rainfall depth over the area of the whole island (5.45sq km) :

Volume of consumed water = 64020 m^3/year
Area of Island = 5.45 *1000*1000 m^2

Equivalent rainfall depth = Volume/Area
= 64020/ (5.45*1000*1000) m/year = 0.011747 m/year
= **11.7 mm/year** (units of rainfall used in the water balance equation)

Density of boreholes

We should note that the vast majority of water extracted is taken from the boreholes in central part of the island. Examining the distribution of boreholes provided on maps by La Société Sercquaise (image below), the concentration of water extraction boreholes is away from the coast. A rapid area assessment done using Google Earth suggests that the vast majority of these boreholes are within an area of 1 square kilometre :



Borehole locations

Central zone : 1 square km

Although this is an approximation (and ignores Little Sark), if we re-work the above water extraction calculation for the smaller area,

Equivalent rainfall depth = Volume/Area
= 64020/ (1.00*1000*1000) m/year = 0.06402 m/year
= **64.02**mm/year (units of rainfall used in the water balance equation)

We will use the extraction rate of 64mm/year as the best estimate of water extracted in the central populated area of Sark.

APPENDIX B : SAMPLE WATER QUALITY TEST DATA

Chemical Analysis of Groundwater in Sark

Laboratory number : S04-00584 **Date sampled : 23 June 2004**

Locality : Seigneurie Spring **Contact name : Mr M J Beaumont**

Grid Reference: 546243 5476524

Parameter	Data	Units
pH (lab)	7.03	
Conductivity	NR	µS/cm
Calcium (Ca)	18.8	mg/l
Magnesium (Mg)	10.7	mg/l
Sodium (Na)	74.4	mg/l
Potassium (K)	3.88	mg/l
Chloride (Cl)	103	mg/l
Sulphate (SO_4)	39.5	mg/l
Bicarbonate (HCO_3)	57	mg/l
Nitrate (NO_3)	7.2	mg N/l
Nitrite (NO_2)	0.0149	mg N/l
Ammonia (NH_4)	<0.03	mg N/l
Phosphorous (P)	0.21	mg/l

Parameter	Data	Units
Aluminium (Al)	<0.01	µg/l
Arsenic (As)	<0.05	µg/l
Barium (Ba)	0.0446	µg/l
Cadmium (Cd)	<0.001	µg/l
Chromium (Cr)	<0.002	µg/l
Copper (Cu)	<0.008	µg/l
Iron (Fe)	<0.005	µg/l
Manganese (Mn)	0.0047	µg/l
Nickel (Ni)	0.005	µg/l
Lead (Pb)	<0.01	µg/l
Zinc (Zn)	0.025	µg/l

Notes: **1.The "<" symbol refers to values which were less than the (stated) detection limit of the analytical technique used, and could not be resolved futher.**
2. In addition to the elements listed above, beryllium (Be), cadmium (Cd), cobalt (Co), lanthenum (La), molybdenum (Mo) vanadium (V), and yttrium (Y) were also analysed but in all cases values were below the detection limit of the analytical technique used.

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[redacted]

Test Report

Laboratory number(s)	242616
Number of pages	1 of 1
Date sampled	14/05/2024
Time sampled	10.00
Submitted by	K Rang
Date received	14/05/2024
Time received	12.50
Date analysis started	14/05/2024
Reporter(s)	TG
Sample matrix	Borehole water
Condition of sample(s)	Satisfactory

Sample site/ location	[redacted]

Method code	Test description	Result	Units	Limit
8	Colour *	<5	mg/l Pt/Co	<20
20	pH	5.64		6.5<pH<9.5
33	Turbidity	0.76	NTU	<4
9	Conductivity	333	µS/cm @ 20°C	<2500
3	Ammonium	<0.01	mg/l NH_4	<0.5
32	Total Oxidised Nitrogen	7.3	mg/l NO_3	<50
1	Alkalinity	25	mg/l HCO_3	
5	Calcium	6	mg/l Ca	
72	Iron*	64	µg/l Fe	<200
72	Copper*	31	µg/l Cu	<2000
#	Lead *	8.92	µg/l Pb	<10
72	Manganese	<10	µg/l Mn	<50
72	Zinc*	<10	µg/l Zn	
17	Nitrite	<0.03	mg/l NO_2	<0.5
47	Nitrate by calculation	7.3	mg/l NO_3	

Limits quoted on this report are those specified in The Private Water Supplies (England) Regulations 2016.

Comments:

ITEM 14

DOUZAINE

Information Report to Michaelmas Chief Pleas, 2nd October 2024

HANDLING OF COMPLAINTS AGAINST THE CONSTABLE – PROGRESS REPORT

At the Michaelmas Chief Pleas, 4th Oct 2023 (item 8) the Douzaine presented a Report entitled 'Handling of Complaints Against the Constables', unfortunately the two proposals in the Report were both lost. This has meant there has been no means of handling any complaints against the Constables, save those of a contractual nature.

Following the Michaelmas Meeting His Excellency the Lieutenant Governer and the Speaker of Chief Pleas arranged for a meeting between Mr Rauri Hardy, Head of Law Enforcement in Guernsey, and the Douzaine, with an aim of finding a solution to the problem. An initial meeting took place 25th March 2025, and the grounds were laid for a possible way forward.

Since the first meeting there has been an exchange of information which has led to the next step. Detective Inspector Jonathan Reeve is to review the Service Level Agreement between Guernsey and Sark, as well as the Terms of Reference of the Independant Policing Panel, and report back to the Douzaine, at a meeting in Sark to be arranged for later this year. Detective Inspector Reeve has considerable experience in Professional Standards and quality of service responsibilities.

The Douzaine will keep Chief Pleas informed of any progress.

Conseiller Chris Bateson
Chairman, Douzaine