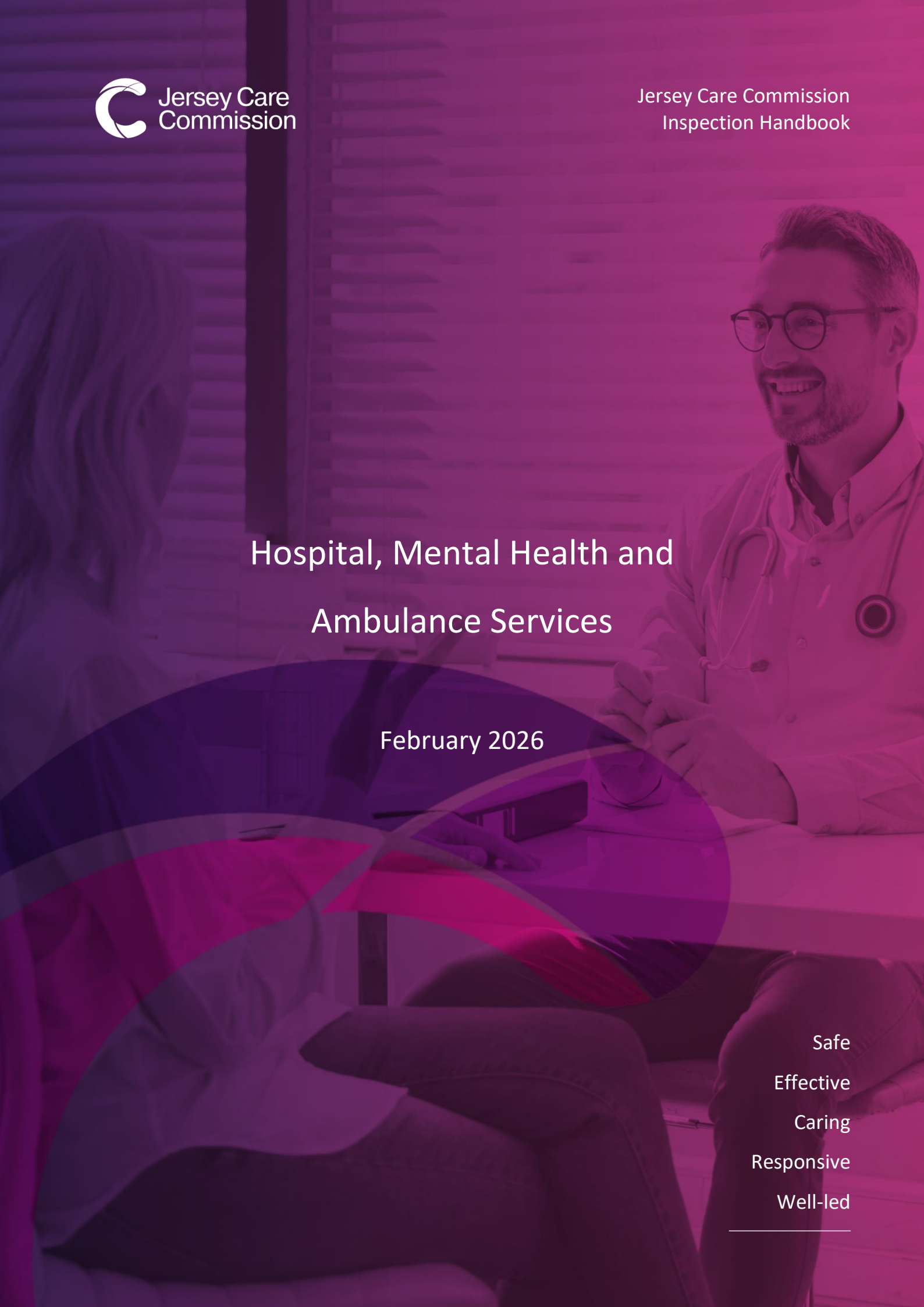
Jersey Care Commission

Jersey Care Commission
Inspection Handbook



Hospital, Mental Health and Ambulance Services

February 2026

Safe

Effective

Caring

Responsive

Well-led

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INTRODUCTION

The Jersey Care Commission (the Commission) was established under the provisions of the Regulation of Care (Jersey) Law 2014 (the Law). The Commission is independent of Government, Ministers, and elected representatives although accountable to the Government of Jersey. The functions of the Commission are described in the Law and the associated Regulations.

The Commission's purpose is to:

- Provide the people of Jersey with independent assurance about the quality, safety and effectiveness of their health and social care services
- Promote and support best practice in the delivery of health and social care by setting high Standards and challenging poor performance
- Work with service users and their families and carers to improve their experience of health and social care and achieve better outcomes.

Our work is based on these core values:

- A person-centred approach – putting the needs and the voices of people using health and social care services at the heart of everything we do.
- Integrity – being objective and impartial in our dealings with people and organisations
- Openness and accountability – acting fairly and transparently and being responsible for our actions
- Efficiency and excellence – striving to continually improve and providing the best possible quality and value from our work
- Engagement – work together with, and seeking the views of, those using, providing, funding, and planning health and social care services in developing all aspects of our work.

INTRODUCTION TO THE INSPECTION HANDBOOK

The Jersey Care Commission (the Commission) was tasked with preparing for an expansion of its statutory remit to include the regulation and inspection of Hospital, Ambulance and Mental Health Services.

This Handbook sets out:

- The purpose and underlying principles of inspection and its statutory basis
- The inspection approach and frequency
- The evidence that will be used
- The activity that will take place before, during and after the inspection, including what providers need to do to prepare and be ready for inspections.

The Commission has published a Single Assessment Framework (SAF). This is a fundamental set of standards, which sets out how Hospital, Ambulance and Mental Health Services should ensure that they provide care, which is Safe, Effective, Caring, Responsive and Well-led. These standards and the detailed universal and service specific requirements which support their delivery are set out on the website www.carecommission.je. These Standards, read in conjunction with the Regulation of Care (Jersey) Law 2014 and Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 provide a clear set of expectations about the safety and quality of care people in Jersey should expect to receive.

The Commission's focus, as already demonstrated in inspections of other sectors, is to highlight and support best practice, to challenge poor performance, and to identify what might be improved. Where our inspections identify aspects of care which do not comply with the relevant Standards, reports will set out clear 'areas for improvement', with timeframes for completion. Equally, reports will incorporate any areas of innovation and good practice recognised by inspectors.

Where performance does not meet the relevant Standards, the Commission will work with registered providers and, where required, expert external bodies, to ensure the necessary improvements are made so that people receive the safe care and good quality outcomes they need. Progress will be monitored and assessed in several ways, including via focused follow up inspections and by seeking regular updates from services between inspections.

The Commission has carefully considered the use of a graded judgement framework—applying labels such as ‘inadequate,’ ‘requires improvement,’ or ‘outstanding’ and has decided not to adopt this approach. While such frameworks can provide clarity and comparison where there is a broad range of providers and meaningful choice for users, this context does not apply in Jersey.
In such a context, applying simplified ratings risks creating stigma or misinterpretation, without offering meaningful benefits to the public or service users. Furthermore, the complexity of many services, particularly in health and social care, does not always lend itself to being distilled into a single word or rating. Doing so could obscure important nuances and overlook areas of good practice or specific challenges that need targeted improvement.

Instead, the Commission is committed to providing detailed, balanced reports that highlight both strengths and areas for development, supporting improvement without reducing complex services to a headline label. This approach promotes a deeper understanding of quality and performance.

The Handbook builds on the Commission's experience of inspections of other sectors. As a framework, it could be applied to inspections of a wider range of care providers. As a learning organisation, the Commission will commit to ensuring regular reviews of this Handbook, its helpfulness, impact and balance. We will proactively seek feedback from registered providers, and from people who use services and their relatives and carers, to form the backdrop for our review of the information contained within this Handbook is correct as of 1 February 2026.

LEGISLATIVE FRAMEWORK AND SCOPE OF HANDBOOK

The Commission has a statutory responsibility to register, inspect and report on the quality and impact of care services in Jersey. The Government of Jersey consulted on amendments to the Regulation of Care (Jersey) Law 2014 in April 2024. The States Assembly approved amendments in November 2025. Regulation of hospital, mental health and ambulance services is a continuation of a long-term policy to regulate all health and social care providers in Jersey. This will bring Jersey into line with most other jurisdictions in the British Isles, where independent regulation and inspection has been part of the care sectors for many years.

Regulation of Care (Jersey) Law 2014 will apply as follows:

Jersey General Hospital and satellite sites: inpatient and outpatient services, public and private (this includes services provided to people who visit the hospital for the purposes of attending appointments, daycare or obtaining medicines):

- Medical care
- Surgical care
- Urgent and emergency care
- Critical care
- Maternity and midwifery services
- Neonatal services
- Services for children and young people
- Rehabilitation services
- Outpatient services
- Daycare services
- Diagnostic and imaging services
- Assisted reproductive services
- Laboratory and management of blood, tissue and organs
- Pharmacy
- End of life care
- Acute mental health care at the hospital.

Services run from the Hospital delivered outside the premises, including hospital discharge and follow-up in the community, for example.

- Patient transport services (Example: Jersey Emergency Transfer Services)
- Rehabilitation services.

Mental Health Services - all Government of Jersey mental health services provided to inpatients and outpatients, with the sole exception of the Government of Jersey's outpatient Child and Adolescent Mental Health Service (CAMHS), including:

- Acute wards for adults
- Recovery or rehabilitation Mental Health units
- Community based Mental Health services for adults
- Community based Mental Health services for older adults.

Ambulance Service - services delivered by the Government of Jersey's Ambulance Service and private/charitable ambulance services:

- Emergency operations centre
- Emergency and urgent care services
- Patient transport.

Learning Disabilities and Autism Services are outside the scope of this inspection programme and are covered by the Commission's remit for adult social care.

CONSULTATION AND IMPLEMENTATION

Service providers new to regulation will be invited to register with the Commission with the registration process to be completed before the end of six months.

The first inspections will take place during the 12 months following registration.

To meet the requirement to inspect all services that are within scope within five and three years, the Commission will take a phased approach, inspecting blocks of services at one time. This will build coverage of all Hospital, Ambulance and Mental Health services and ensure that public assurance is maintained at the same time as efficient use of both Commission and provider resources.

As the inspection framework is rolled out on a test and learn basis, the Commission will seek the opinions of people using services and their families, as well as professionals and public organisations. This will ensure that the Standards and inspection framework are fit for purpose, allow for effective monitoring and scrutiny of care and are making a positive impact. Regular reviews and monitoring will take place to improve the inspection Framework.

HANDBOOK: SINGLE ASSESSMENT FRAMEWORK

The Single Assessment Framework (SAF) is a fundamental set of standards, designed to set out how care services should be provided across various sectors. Everybody has the right to expect clear standards, which set out how care providers make sure that their services are safe, effective, caring, responsive and well-led.

In developing the SAF a number of frameworks were reviewed, but the approach to defining a set of standards based on those used by the Care Quality Commission was considered the best fit for services, adapting its principles to suit the specific needs and context of Jersey.

The SAF has been written to:

- promote the safety and well-being of people's care
- help people understand that they should have high expectations of the service supporting them and of the outcomes they can achieve
- set out what the care provider must do to meet the high expectations of people who use their services
- set out the structure to be used to regulate and inspect the care provided.

It aligns with the set of guiding principles used by the Commission in developing its inspection approach in other sectors, reflecting people's rights which are central to any care or support given as well as ensuring that clinical outcomes are safe and effective.

The SAF comprises 34 Standards which set out what is needed to ensure high quality care. Compliance with the standards is central to striving for excellence.

Every Standard commences with a 'We' statement that outlines what providers must do to meet legal requirements and to fulfil the expectations of individuals using care services. Subsequently, an 'I' statement follows, describing the entitlements that individuals can rightfully expect from the service.

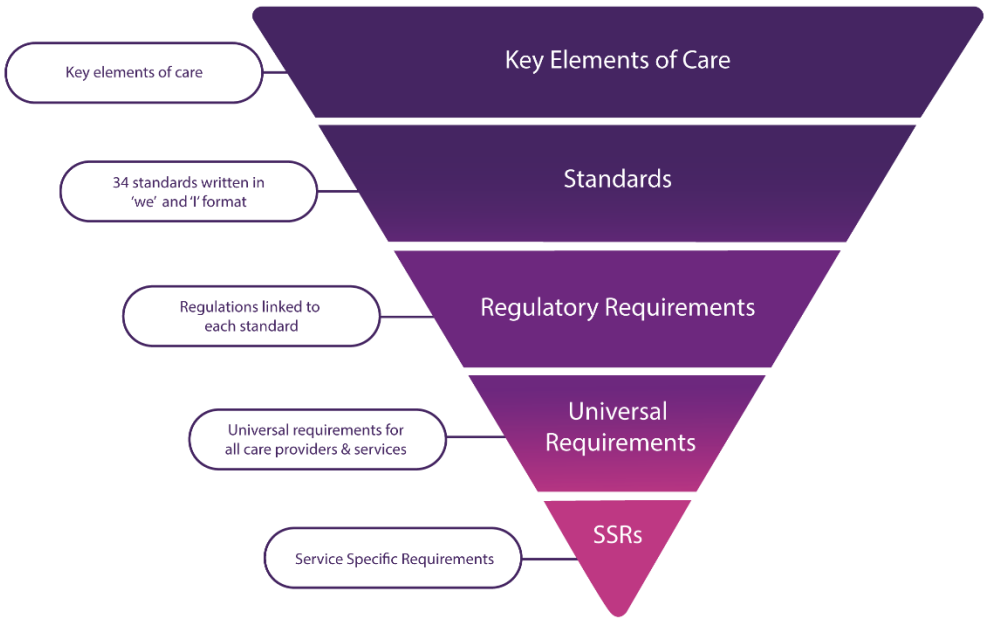

Diagram (1) Setting out SAF structure

For hospital and ambulance services a set of Universal Requirements applicable to all services have been defined, these set out the detail of what compliance with the standards looks like and every care provider should comply with these requirements. The depth of regulation and inspection is further expanded in Service Specific Requirements. This tier recognises the unique clinical challenges and requirements in various specialist settings.

For Mental Health Services the Commission has drawn upon the standards developed by the Royal College of Psychiatrists. The framework of standards and universal requirements set out in the SAF will be used for inspecting mental health services. However, the Core Standards for mental health services from the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) will be applied as service-specific requirements. This means inspections may involve specialist input from the College.

Each Standard is mapped to regulatory requirements as set out in the legislation. This ensures providers gain a clear understanding of the regulatory context for each standard. The SAF should be read in conjunction with the Regulation of Care (Jersey) 2014 Law, regulations and other relevant legislation.

The legislation requires the Jersey Care Commission to inspect all the regulated activities provided by the Hospital and Mental Health Services which are in scope, at least every five years and Ambulance Services at least every three years. The Commission will conduct annual inspections but not every service will be looked at every year.

The Single Assessment Framework of care standards applies to all inspections of care provided by Hospital, Ambulance and Mental Health Services registered with the Commission. All levels of the framework have been engaged on and published and the Commission's expectations about what high quality care looks like made clear.

STRUCTURE OF APPROACH

Although a wide range of services are included within scope, all hospital, ambulance and mental health services are part of a single provider organisation (Health and Care Jersey) with a shared senior leadership structure. To support an efficient approach to inspection, which reflects that the experience of patients is often not confined to a single ward, clinic, team or clinical specialty, the Commission has grouped services together, initially by core services.

These core services are the level at which the specific requirements which relate to specific services are applied;

Hospital Care:

- Surgical Care
- Critical Care
- Medical Care
- Urgent Care
- Maternity Services
- Neonatal
- Children and Young People
- Outpatients

Government of Jersey provided Mental Health Care:

- Inpatients
- Community Services

Ambulance Service:

- Frontline care
- Patient Transport
- Control Room

In addition, End of Life Care and Children and Young People have been identified as core services relevant in multiple areas and will be included in inspections as appropriate.

There is a further set of core services which the Commission will not routinely inspect directly, but will seek assurance from third party accreditation, for example, relevant Royal Colleges. These are Sterile Services, Radiology and Pathology (including Mortuary services).

HIGH LEVEL SCHEDULE

For the purposes of planning the overall inspection over a five-year period (for Hospital and Mental Health Services) and a three-year period (for Ambulance Services).

These six core services have been brought together into broader groupings under the headings of:

- Surgical (also covers Critical Care)
- Medical (also covers Urgent and Emergency Care)
- Women, Children and Families (Maternity, Neonatal, CYP)
- Outpatients
- Mental Health
- Ambulances
- 'Other' – services for which third party assurance will be used

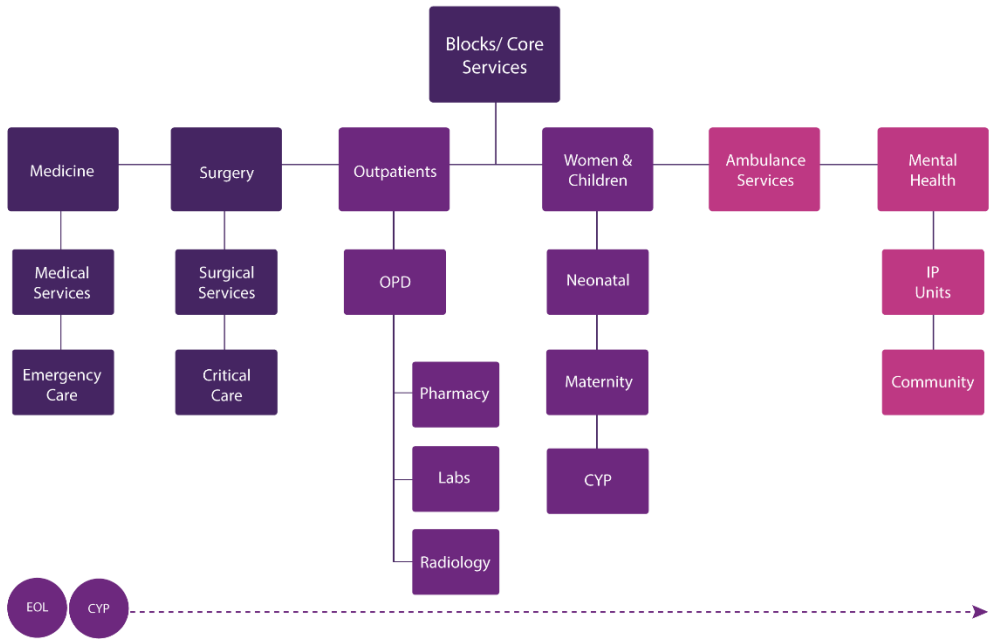

Diagram (2) Grouping of services for inspection purposes

The decision to group services together, rather than schedule each core service inspection separately, means that a high-level plan along the following lines can be put in place to form a basis for activity over a five-year period (note this is for illustrative purposes only and is not a formal plan).

Year	Inspection (Example)
Year 1	1 Inspection (Ambulance)
Year 2	1 Inspection (Hospital Block 1)
Year 3	2 Inspections (Hospital Block 2 and Mental Health
Year 4	1 Inspection (Ambulance)
Year 5	2 Inspections (Hospital Block 3 and Hospital Block 4)

COVERAGE OF THE ASSESSMENT FRAMEWORK

The Commission has published a framework which makes clear what providers need to do to consistently deliver care which meets required standards in all areas. The Commission has the powers to inspect against those standards at any time.

For reasons of proportionality and resource, even working to a schedule where not all services are covered every year, completely comprehensive inspections i.e., where all standards, universal and service specific requirements are covered within the inspected service, are not feasible. The Commission will therefore sample requirements within the framework. This will enable it to build a comprehensive view over time and provide a sufficient level of assurance on an annual basis.

This means that for each inspection at service block level, the Commission will aim to assess the 34 standards and plan to inspect at least two universal requirements under each of the standards and will inspect against a number of service specific requirements for that core service. During the inspection, the Commission will use the Service Specific Requirements to evidence good practice for that area of speciality.

This is on grounds of deliverability and level of assurance it provides. It means that each year the service blocks selected for inspection will be required to submit evidence in advance for only those universal requirements included in the notified scope of the inspection. The Inspection Team will then use the time on site to triangulate the evidence submitted prior to inspection and assess how care is meeting the relevant service specific requirements.

The Commission has the discretion to open the inspection out to cover other universal requirements should a concern arise. The output will be a report addressing all areas covered by the inspection of that service.

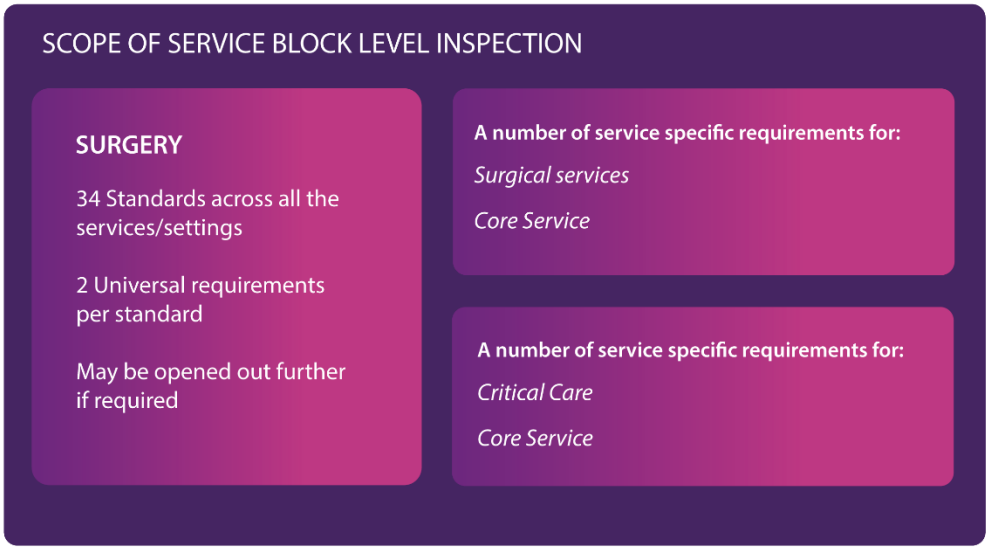

Diagram (3) Scope and coverage of inspections – Surgery example

SERVICES FOR WHICH THE COMMISSION WILL TAKE ASSURANCE FROM ACCREDITATION SCHEMES

For hospital services, core services have been identified with existing third-party accreditation schemes. The Commission can rely on these schemes for assurance instead of conducting full inspections.

These services are:

- Radiology - UKAS Imaging Services Accreditation
- Pathology (including Mortuary services) - UKAS Medical Laboratory Accreditation – ISO15199.

The approach the Commission will take is to:

- Map the content of the schemes to the SAF
- Use information from the schemes to provide assurance that quality standards are being met
- Gather additional information and evidence where gaps exist – e.g., information from people using services and other feedback
- Generate a report with findings across the services at some point during the inspection programme.

Taking this approach means that the Commission is taking the necessary steps to ensure that these services meet all statutory requirements.

PRIORITISATION OF INSPECTIONS

The Commission will make decisions about the order in which to inspect each service block rather than agree this at the start of the five-year programme, providing some flexibility to accommodate unforeseen risks and priorities.

The following information which may indicate potential areas of risk will be considered when determining the order in which inspections will take place.

- Information from the annual organisation level PIR, which may indicate differential levels of risk between services
- Concerns shared by other agencies
- Concerns shared by the leadership team or staff groups
- Intelligence from the public
- Notifications and other information
- Outcomes from recent reviews
- Areas of strategic priorities
- Risks inherent in certain types of service.

The Commission will also need to determine which universal standards should be sampled for each service level inspection. This will take place prior to the announcement of each inspection and will be based on the same set of criteria.

ASSESSMENT OF LEADERSHIP AT ALL LEVELS OF A PROVIDER AND ANNUAL CONVERSATION

The role of the Commission is to hold all levels of a provider organisation to account and to reflect this in the inspection and reporting on how well-led the organisation is.

Given the proposed structure of the inspection programme which will take place at least every five years for Hospital and Mental Health, and at least every three years, for Ambulance Services. Inspection against standards in the well-led key element of care for each service block will apply to all levels of leadership with reports and findings reflecting this.

This approach is being taken on the basis that it will ensure better assurance that all levels of the organisation are being held to account for inspection findings, and areas for improvement can be followed up at the most appropriate level and in a timely way. It is also a more cost-effective approach as an additional inspection focused on the senior leadership team will not be required.

The findings of the report of each inspection will then be followed up as part of an 'annual conversation' (appendix 1) with the senior leadership team, led by the lead inspector, where improvements can be tracked. This approach will apply across all HCJ inspections, including mental health.

For Ambulance Services, where there will be one full inspection every three years, the annual conversation will be a formal keeping in touch meeting which will provide assurance outside the formal inspection schedule that identified improvements are being made.

The outputs from the conversation will not be published, but a record will be made by the lead inspector.

Financial sustainability will be out of scope, as this would require additional financial specialist expertise/auditors and fits better with the responsibilities of the Comptroller and Auditor General.

NOTICE PERIOD

The five-year schedule will not be published in advance, but the Registered Provider will be provided with a 12-week period of notice of inspection of each service. At the same time, an information request will be issued which will include detail of the universal requirements for which the Commission requires evidence to be submitted in advance.

PRE – INSPECTION : PROVIDER INFORMATION REQUEST (PIR)

To support all stages of the inspection process, the Commission will formally request information from the provider as follows:

Provider level request (level 1 PIR) – this includes all relevant contextual and performance information for the Provider across all Standards. It includes some elements of self-evaluation in the Well-led section. It takes place annually with a completion period of 4 weeks and is timed to support decisions about prioritisation and focus of inspection.

Service block level request (level 2 PIR) – this requests information of relevance to the universal requirements being sampled for each standard. It includes some elements of self-evaluation against the sampled requirements. It is shared by the Commission at the point of notice of inspection for return within 6 weeks.

Service specific level (level 3 PIR) – some information may be requested in advance at the level of a core service within the block being inspected – although it is anticipated that much of what will be required at this level will be observational/interview evidence to be gathered on-site.

This information will be combined with evidence from other sources.

PRIVATE/NOT FOR PROFIT AMBULANCES SERVICES

A small number of Ambulance Services run by charitable and other non-governmental organisations are in scope of the inspection programme. The same methodology will be used, applied in a proportionate way to reflect the scale of the services involved – for example, whilst all the Standards may apply, not all service specific requirements will be looked at. The frequency for these inspections will be at least once every three years.

TYPES OF INSPECTION

In line with the detail set out above, during the initial five-year cycle of inspection each service block will receive a full inspection as defined below. During this period, the Commission may also undertake focused inspections as required and the scope and rationale for these are defined below.

The Commission will use the experience from the first round of inspections and feedback from providers and the public to determine whether the five-year cycle rolls forward or whether a different approach may be taken once all services have been inspected.

The types of inspection the Commission may carry out are defined as follows:

Full inspection – normally explores all areas of provision (within a service block) and will consider all 34 Standards, the universal requirements which have been selected, appropriate service specific requirements for the core services in each block and compliance with the regulations. The impact of care delivery on the outcomes and experience of people using the service and how services are working to improve care delivery and outcomes. It will normally be announced.

Inspections will centre on the core service allocated for review at the time of the visit. However, if concerns are identified in that inspection that fall within the remit of another department, the relevant aspects of that department may also be inspected, where appropriate, outside of their anticipated inspection schedule.

Focused inspection – will consider either:

- specific areas of a service (e.g., care in a particular ward).
- a theme such as access or staffing.

It will normally follow a full inspection and may cover more than one service block. The Commission will use a range of methods to determine the scope. It will normally be announced.

Exceptionally, the Commission may undertake an unannounced focused inspection in response to serious concerns raised and/or where it believes that people using a service are at serious risk of harm.

The Commission will also follow up on progress on areas for improvement identified or required in inspection reports. This may be done either on or off site depending on the circumstances.

Ongoing monitoring may lead to further inspections.

To support internal decision making about follow up and potential unannounced activity, the Commission will establish an internal process where concerns and information are reviewed on a regular basis in line with the prioritisation criteria, and decisions on what action to take recorded.

COLLECTING AND USING EVIDENCE AND INFORMATION

The Commission relies on several types of evidence during its regulatory process to assess the quality, safety, and effectiveness of health care services.

This helps the Commission's Inspection Teams form a holistic view of the service and can be categorised as follows:

- The views of people who are using or who have recently used the services (depending on the specific circumstances)
- The views of staff, including leader, managers, health and care staff and support staff; internal and external to the services
- Feedback from partner organisations
- Observation
- Reviewing of processes and systems
- Reviewing and analysing data.

Within these categories, the types of evidence commonly considered will include:

Evidence Category	Method of Collection
The views of people who are using or who have recently used the services	○ Face to face, online etc. with care receivers and their representatives. (This may be undertaken with groups already established by the service to gain feedback or through focus groups delivered by the Commission. Also, through discussions with individuals or households). ○ Surveys ○ Reviewing complaints, the services have received and responses to them.
The views of staff, including the leader, managers, health and care staff and support staff; internal and external to the services	○ Annual conversation ○ Staff surveys conducted by the Commission or the provider ○ Face to face, online etc. with staff. This may be as part of team meeting undertaken with groups already established by the service to gain feedback or through focus groups delivered by the Commission.

Feedback from Partner organisations	○ Formal requests for feedback by the Commission ○ Comments/feedback made between inspections.
Observation	○ Observing care and support being delivered and staff meetings including Multidisciplinary (MDT) and Senior Leadership Team (SLT) meetings.
Reviewing of processes and systems	○ Protocols, guidelines, staff rotas, escalation of issues, complaints ○ Minutes of meetings, reports, care records and staff files.
Reviewing and analysing data outcomes	○ Notifications – volume and trends ○ Clinical outcomes data ○ Clinical Audit Data

The application is flexible and tailored to the specific context of each inspection and evidence is gathered at different stages of the process—whether before, during, or after an inspection—ensuring a thorough evaluation of how well a service meets standards, universal requirements and service-specific requirements.

The relevance and weight of these evidence types can vary depending on the service being inspected. A standard applied to the hospital, for example, may be assessed using different evidence categories than when it is applied to ambulance services, reflecting the different environments and operational dynamics of each service type.

Inspection Teams will exercise professional judgement in applying these categories of evidence, adapting their approach based on what is most suitable for the specific service. This flexibility ensures that while the same core standards are being assessed, the evidence used may differ according to the context. The goal is to ensure that the evaluation of the service is both fair and comprehensive, taking into account the diversity of care settings and the fact that not all evidence types will be equally applicable in every case. This adaptive process allows the Commission to maintain consistency in upholding regulatory standards while acknowledging the unique circumstances of each service.

EVIDENCE SOURCES: COMPLAINTS, COMMENTS AND CONCERNS

The Commission always encourages anyone with a concern or complaint to contact the service provider in the first instance. All regulated services are required to have effective procedures for managing and responding appropriately to complaints and comments.

Information shared with the Commission may be considered in future inspections. Any information shared will be treated in the strictest confidence. If the Commission identifies trends in complaints or concerns about a service provider, it may then choose to investigate or take action, including through a regulatory inspection.

NOTIFICATIONS

In instances where there is a critical event such as loss of life or serious incident, it is the duty of the care provider to notify the Commission via a formal notifications process. The Commission then determines what action has been taken (police investigation, referral to Viscount, referral to Safeguarding etc) and what further action, if any, is required – including an immediate response if appropriate. Information from notifications may also be used as part of the inspection process, either to identify the priorities and focus for inspections, or as evidence as part of the inspection and reporting process.

The notifications list which providers within the scope of this handbook need to submit, will be available via *Resources for Service Managers | Jersey Care Commission*

FEEDBACK FROM STAFF

The Commission may commission a survey of the views and experiences of all staff working in hospital, mental health and ambulance services at an early stage in the inspection programme. This will be shared with providers, and the Commission will look for evidence that action is being taken based on the survey findings. It will also be used during the inspection process where findings may be explored on site as part of focused discussions with individuals and groups of staff. Staff feedback will always be anonymised, and care taken to ensure that information used in reports is not identifiable.

During the inspection process, the Commission may also follow up concerns raised by staff. Where staff have concerns about a provider, they are encouraged to first check their employer's whistleblowing policy. If they are worried about raising a concern with their employer or have raised a concern through their employer's Whistleblowing Policy but still have concerns, they can raise these directly with the Commission via published routes for raising a concern about a regulated service.

FEEDBACK FROM PEOPLE USING SERVICES, THEIR FAMILY MEMBERS AND CARERS

Feedback from people using services, their family members and carers will be an important source of evidence for the Commission.

Providers will be expected to carry out regular feedback surveys and to make these available to the Commission to inform the inspection process and for use as evidence.

The Commission may conduct interviews with individuals and focus groups – including speaking to existing groups of service users and advocacy services for those who may need support in communicating their views.

Feedback gathered onsite during the inspection will also be important – either through interviews with people currently using the service, or via feedback forms which the provider will be asked to make available.

Feedback will always be anonymised and care taken to ensure that information used in reports is not identifiable.

INSPECTION TEAMS

Inspection Teams will be a blend of the Commission's Regulation Officers, all of whom have relevant professional and service experience, alongside independent experts who have relevant clinical expertise.

There will be lead inspector for each service with the role of co-ordinating activity, bringing findings together into the report and feeding back. This lead inspector will have experience of inspecting complex clinical settings and will be external to the Commission for the first round of inspections, working alongside the Commission's Regulation Officers to transfer skills and knowledge.

The makeup of the Inspection Team will be dependent on the scale of the service being inspected and will be proportionate to the size and complexity of that service, for example:

Medicine*:* 1 external inspector, 4 Regulation Officers, 1 Pharmacist Inspector, 3 specialists,1 expert patient, 1 Business Support Officer.

Ambulance: 2 external inspectors, 2 Regulation Officers, 1 Pharmacist Inspector, 1 Business Support Officer.

Each regulated service inspected will be asked to provide details of their Executive Lead officer, or manager, with overall responsibility for the service, and to nominate an inspection Link Officer, who can be contacted with day-to-day enquiries, including information requests, clarification of evidence and queries about records.

The responsibilities of the Commissions Lead Inspector are:

- Key point of contact between the Executive Lead or manager, the Inspection Link Officer within the regulated service and the wider Inspection Team
- Management and successful conduct of the inspection
- Comprehensive collection and gathering of evidence during the inspection
- Meeting with the Inspection Team throughout the inspection process to support, challenge and analyse information, including all relevant lines of enquiry
- Facilitate meetings with the Inspection Team and consider evidence to reach robust conclusions on all aspects of the inspection
- Provide feedback on the daily findings of the Inspection Team to the Senior Leadership Team in the Service.

During the Inspection visit, the Inspection Team will be on-site at the provider's premises. It is anticipated that the Inspection Team will be welcomed by the provider, given a dedicated room to operate from, and be accommodated on- site as other members of staff would be. For example, made aware of fire drills, know the first aider, understand where the kitchen and toilets are. The Inspection Team members will each need the use of computers to access the record system. This access should be agreed before the on-site visit, with logins and other relevant information provided in advance.

INSPECTION METHODOLOGY

The inspection process and timeline can be summarised as follows:

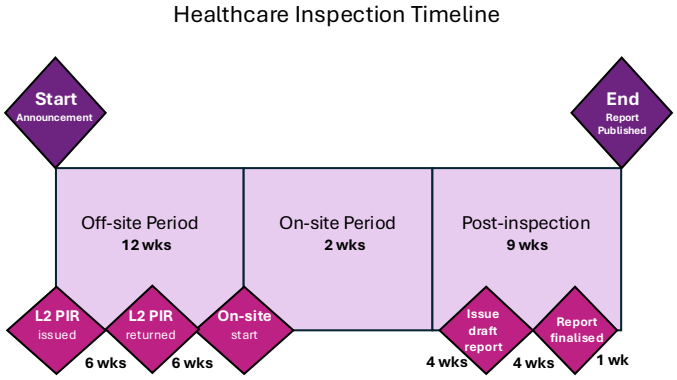

Diagram (4) Healthcare Inspection Timeline

PRE-INSPECTION PREPARATION

The Commission will issue a provider level information (Level 1 PIR) request to the provider for completion within a 4-week period. *The type of information included in this request may include:*

- Organisational structures, including lines of reporting and key personnel, including a list of all managers for all services
- Data about activity such as waiting times, length of stay and readmissions, including ward level data
- Documentation relating to monitoring of clinical quality and outcomes – including reports to relevant management teams and Boards
- Staffing related data including turnover and sickness absence at departmental level and training completion records
- Reports of any external, specialist enquiries conducted in the past 12 months
- Details and outcomes of complaints received
- Information about staff whistleblowing
- Strategic and transformation plans
- Workforce development plans.

This information will be used as part of the process for determining which services to prioritise for inspection and which universal requirements should be identified for further information collection and inspection. Once this process has been completed, notice of inspection at service block level will be issued, together with the service block specific (Level 2 PIR).

THE OFF-SITE PERIOD

Twelve weeks prior to on-site inspection taking place, the Lead Inspector or Regulation Officer will contact the Executive Lead of the provider advising that an inspection has been scheduled. The level 2 PIR will be issued via a secure portal for completion within a six-week period. For Mental Health this may be returned directly to the Royal College of Psychiatrists.

The Regulation Officer or Lead Inspector will provide the details of membership of the Inspection Team. A meeting will be set up at this stage to work through information, required for the inspection, and to answer any queries that may arise, so that the inspection runs smoothly.

After the relevant information has been returned from the provider, the Inspection Team will consider the information submitted alongside the other evidence gathered and if necessary, request any further information at core service level they may consider it helpful to see in advance.

During this period, the provider will arrange for training to take place for Inspectors on how to access relevant IT and record systems. The provider will give the Inspection Team access to their IT system for them to collectively prepare for any case tracking they may wish to conduct.

THE ONSITE PERIOD - DURING THE INSPECTION

It is anticipated that this phase of the inspection may take place over a period of up to ten days, although the duration may vary. During their time on-site, the Inspection Team will share information, meet daily to consider, challenge, scrutinise and validate findings. These meetings will be led by the Lead Inspector, and findings will be captured.

It is anticipated that the Inspection Team will be welcomed on-site by the provider and given a private room to use during their visit, as well as relevant IT equipment and facilities to enable them to work. It is anticipated that the relationship between the Inspection Team and provider staff will be one of mutual respect and professionalism.

The Lead Inspector will have a daily 'Keep in Touch' (KIT) meeting with the provider's Leadership Team – either at the beginning or end of each day. This will allow for feedback and ongoing dialogue.

During the on-site period, the Inspection Team may meet with executive leaders, and elected representatives such as the Minister for Health and Care, as well as any other key professionals who may be helpful to support the inspection evidence gathering.

The team may also ask to meet with existing, organised participation forums, such as a service user experience forums – particularly if such groups are already meeting during the on-site week. When the team meet and speak with service users, it will be in a sensitive manner to understand their lived experience, the impact of their involvement with the provider and what has been achieved through the support they've received. Communication needs will be made, anonymity will be assured, and no service user or family member will be identified in any inspection Report.

Where themes become apparent, the Lead Inspector may request additional information to consider as part of evidence. All requests for information will be contained in one list so the provider and the Inspection Team are clear about what information has been sought, and what the response was to each query.

On the final day, the Lead Inspector and the Inspection Team will meet with the Executive Lead and nominated senior staff within the organisation to provide feedback. The Lead Inspector will summarise the work completed, the strengths identified and will identify any areas for improvement. This feedback will form the basis of the Inspection Report. The meeting should usually not last longer than an hour. A written report will not be provided or presented during this meeting.

As daily ‘keep in touch’ meetings will have taken place and followed a similar format; the final feedback meeting and outcomes should not come as a surprise to the providers senior leadership team.

The meeting will allow the provider to:

- understand the evidence when evaluated against the standards
- understand strengths and areas for improvement
- discuss and consider further developments to maintain or build on good practice and next steps within the process as part of the cycle of activity
- consider key messages for dissemination, including information gathered, the analysis and themed summaries.

POST INSPECTION

A final draft report will be prepared and shared with the provider's Executive Lead within 28 days of the last day of the on-site inspection visit. This will report on the inspection findings, identify areas of good practice and areas for improvement assessed against the published Standards. The report will provide a summary of service strengths and areas for improvement.

Following inspection, the provider will have the opportunity to raise any comments within 28 days of receiving the draft report. Prior to publication, the Provider will have the opportunity to include a statement on what actions they will take in relation to each area of improvement. After a further 7 days, the final report will be sent to the provider and published on the Commission's website.

Inspection Reports may be combined where they cover shared areas.

ASSURANCE, CONFIDENTIALITY AND DATA PROTECTION

The Lead Inspector will be responsible for the conduct of the inspection and the quality assurance and robustness of evidence considered within the inspection. The Lead Inspector will be the liaison person between the provider and the Inspection Team.

The Lead Inspector will ensure that daily Inspection Team meetings (Keeping in touch meetings) take place to record and discuss evidence gathered.

Inspectors will, as part of discussions and meetings, summarise their inspection activity, the evidence they have reviewed and their evaluation of this against the Standards.

In situations where a member of the Inspection Team suspects a safeguarding concern or risk of other type of harm, or if it is unclear from a file review or discussion that an individual is safe, these concerns will be summarised immediately in writing and shared with the Lead Inspector, who will liaise with the relevant manager that day.

On the final day of inspection, the Lead Inspector will meet with the Inspection Team to consider the evidence collated, consider further analysis, and agree findings.

Where inspectors are reviewing medical records, or attending meetings, they will not use the names of individuals or families as part of their evidence summaries. Only ‘person1’ or a reference number within the Provider’s recording system will be used.

Where inspectors are meeting with staff, team managers or partners, notes of these meetings and any subsequent Inspection Team discussions will refer to initials and job titles, not full names.

Following an Inspection, the Commission welcomes all feedback, be it comments and suggestions, compliments, concerns, or complaints.

OUTCOME AND PUBLICATION

The inspection will evidence any good practice that is identified, where it is having a positive impact on patients and their families, and where innovation and creative practice are improving care.

The Inspection Report will outline:

a. A summary of the service
b. Summary of Inspection findings
c. Inspection Process
d. Detailed Inspection findings – detail of how improvement plans have been addressed (if any)
e. A space for the Registered Provider to provide a response.

Service block level reports will include findings and commentary on all Standards at service block level and all service specific requirements for the core services within them.

Service block level reports should include findings about leadership and culture within that service and more widely at Provider Senior Leadership Team level.

Where the Commission assesses that services are not meeting the required Standards, the Report will include one or more 'Areas for Improvement'. The Provider is required to address the concerns and identify steps intended to improve practice, performance, and impact. Ultimately, the Commission can implement its 'Escalation and Enforcement policy.'

Following an Inspection, a Provider might be on one of three pathways.

These are outlined in the table below:

Pathway	Status	Action
Pathway 1	No areas for improvement identified in Inspection Report	Inspected again after initial 3-5 year programme completed, unless areas of concern which may require a focused inspection are identified
Pathway 2	Some areas for improvement identified but overall, the Commission has confidence in the Provider's plan of action	The provider may be asked for additional meetings or updates on progress, dependent on the risk posed by the nature of the improvement area and type of service provided
Pathway 3	Areas for improvement identified have not been addressed and have not improved: Escalation and Enforcement	Proportionate monitoring visits based on risk assessment

An identified 'Area for Improvement' is a stated method to draw attention to a weakness in the provision. The Commission may ask that these areas are addressed and reported on for example, within immediate effect, three, six or nine month timeframe. These areas will automatically be the focus of the Annual Conversation and provide key lines of enquiry in following inspections.

An Improvement Notice is a formal notice issued and is published online. An Improvement Notice issued by the Commission requires the Provider to undertake actions to remove or reduce the identified risk or risks. The area or areas to which the Notice applies will be formally monitored as stipulated in the Notice and progress will be regularly reviewed. Depending on the circumstances giving rise to an Improvement Notice, the Commission reserves the right to schedule an additional focused inspection to assess progress. When relevant improvements are secured, the Commission rescinds the Improvement Notice.

The Commission will adhere to the following timescales regarding writing and sharing the draft report to the point of publication on its website.

Activity	Timeframe
Jersey Care Commission sends draft Report for comment to the Provider	Within 28 days of end of on-site Inspection
Provider returns comments about the draft Report	Within 28 days of receipt
Consideration of Provider's comments and finalisation of Report. Publication of the Report on Jersey Care Commission website	Within 7 days of receipt

APPENDIX 1: ANNUAL CONVERSATION AGENDA

Attendees: Chief Inspector, Lead Inspector, Chief Officer and other members of staff as required

Agenda:

- Introductions (5 mins)
- Key Themes (30 mins)
- This will draw on findings from recent inspections, information from self- evaluation, staff and patient surveys and other relevant information
- Issues impacting service delivery over previous year (30 mins)
- May be resulting in issues beyond the services control, e.g., political, recruitment, financial etc.
- Service priorities for the forthcoming year (30 mins)
- Given the strengths and areas for improvement identified, what are priority plans for the next year? Ideally top 3-5 to keep conversation focused.
- AOB (10 mins)