S.P. 2/22

St Helena Government

AUDIT ST HELENA

PERFORMANCE AUDIT REPORT
BENCHMARKING HEALTH, OCTOBER 2021

Laid on the Table 11th March 2022

AUDIT ST HELENA
External Auditors

Performance Audit:
Benchmarking Health

October 2021

Audit St Helena is the body that carries out financial and performance audits on behalf of the Chief Auditor.

The Chief Auditor is an independent statutory office with responsibilities set out in the Constitution and the Public Finance Ordinance. Section 29(2) of the Ordinance requires the conduct of performance audits on behalf of the Legislative Council to determine whether resources have been used with proper regard to economy, efficiency and effectiveness.

This report has been prepared in accordance with section 29(2) and published by the Acting Chief Auditor, Brendon Hunt. The audit team consisted of David Brown, Damian Burns and Tyanne Williams, with contributions from Mufaro Chikandwa and former Chief Auditor Phil Sharman.

Contents

Abbreviations

A&E	Accident and emergency
BMI	Body mass index
CT	Computed tomography
DFID	Department for International Development
FCDO	Foreign, Commonwealth and Development Office
FTE	Full-time equivalent
FY	Financial year
GMC	General Medical Council
GP	General practitioner
HCHS	Hospital and Community Health Service
MOU	Memorandum of understanding
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Cooperation and Development
SHG	St Helena Government
TC	Technical Cooperation
UK	United Kingdom
WHO	World Health Organisation

Key Facts

£8.8 million

spent by the Health Directorate in FY 19/20, or 22% of SHG's total operational spend for the year

17 of 28

performance targets met in FY 19/20

£3.0 million

spent on Technical Cooperation by the Directorate in FY 19/20, or 37% of SHG's total TC spend for the year. This included 7.5 FTE medical doctors, 7.3 FTE nurses and 17.2 FTE other staff

£1.1 million

spent on local staff in FY 19/20, a total of 96 positions

1.64

medical doctors employed per 1,000 people on the island, 0.31 fewer per 1,000 than the global average of 1.95

8.18

nurses and midwives employed per 1,000 people on the island, 3.66 more per 1,000 than the global average of 4.52

112

patients referred abroad for treatment during the year, including emergency medical evacuations, at a total cost of £2.2 million

Summary

1. This report examines the St Helena Government (SHG) Health Directorate's (the Directorate's) provision of healthcare, in particular its performance in the provision of primary, secondary and tertiary care. The report presents the results of our performance audit, which proceeded along three key lines of enquiry:

   a) What indicators does the Directorate use to measure performance in its provision of primary, secondary and tertiary care?
   b) What do these and other indicators tell us about how the Directorate is performing?
   c) How is the Directorate performing against international benchmarks?

2. This is the second in our series of benchmarking reports, following *Benchmarking Primary and Secondary Education* published in July 2020. As with that product, the scope of this report does not include an overall assessment as to whether SHG is achieving value for money in its provision of healthcare. Instead, decision makers and other readers may use our evaluative findings and recommendations to spur discussion and investigate how performance can improve.

3. We reviewed available financial and performance data through the end of financial year (FY) 19/20. Our key findings are outlined below, with additional details about our methodology presented in Appendix One.

KEY FINDINGS

THE DIRECTORATE'S CORE ACTIVITIES AND HOW THEY ARE DELIVERED

4. **The Directorate administers St Helena's healthcare system, including on-island primary and secondary care, arrangements for overseas tertiary care and health promotion campaigns in the community.** The Directorate's role within SHG is to deliver a high standard of healthcare that improves the health status and wellbeing of St Helena's population. Its remit includes traditional primary care, such as appointments with general practitioners (GPs) and dental exams; specialised secondary care, such as maternity services and arthroscopic surgery; and public health initiatives in the community, such as sugar reduction and smoking cessation programmes. The Directorate refers patients overseas for most tertiary care, but has the facilities to provide some complex treatments like chemotherapy and joint replacement on-island. The Directorate delivers its services at the Jamestown hospital campus, with on-site clinic, dental and mental health facilities, and at three community clinics across St Helena. Unlike most SHG entities, it is expected to serve the community at all hours, every day of the year. (paragraphs 1.1 to 1.3)

THE DIRECTORATE'S PERFORMANCE MEASUREMENT SYSTEM

5. **The Directorate derived its performance indicators from SHG's 10 Year Plan and its own strategic plan, which includes both indicators and targets.** The Directorate's performance measurement system relies on indicators that ultimately derive from the island's 10 Year Plan, which aims to "cover all aspects of health for Islanders and visitors" within the overarching goal known as "Altogether Healthier". This is expressed in the Directorate's 2019/22 Strategic Plan through a single overarching strategic objective and seven strategic priorities. Each strategic priority has associated targets, actions necessary to achieve those targets and the intended outcomes of those actions. Directorate leadership told us their performance indicators are developed in-house, and are based in part on the priorities of the Director of Health in place at a given time. In addition, they look to the United Kingdom (UK) for guidance. (paragraphs 1.4 to 1.8)

6. **The Directorate's performance indicators could be improved.** We assessed the Directorate's 28 performance indicators for FY 19/20 and found that while each was measurable and aligned with strategic priorities, they could be improved in several ways. For example, the Directorate's first strategic priority focusses on "access to a range of health services" but there were no indicators measuring access to emergency or semi-urgent care, general mental health services or general dental services. Overall, the indicators tended toward measuring the relative availability of services, and how quickly they were delivered, as opposed to the quality or effectiveness of the services themselves. Certain indicators published by England's National Health Service (NHS) may be appropriate for the Directorate to adopt as quality measures, such as patient-reported improvement in health status following common elective procedures, emergency readmissions within 30 days of discharge from the hospital and 1-year survival rate for all patients with cancer. Comparisons to the NHS, other overseas territories and international benchmarks show that (1) the Directorate's FY 19/20 performance indicators were consistent with the international focus on preventing and controlling non-communicable diseases, and (2) its targets were generally set at reasonable levels with the possible exception of diabetes care, where the Directorate aims to have less than 50 percent of known diabetics exhibiting 'poor control' of their disease (as measured by blood sugar levels). Performance indicators and their associated targets became both more specific and more complete between FY 18/19 and FY 19/20, which demonstrates a maturing performance measurement framework feeding lessons from recent experience back into the development of its annual indicators. (paragraphs 1.9 to 1.17)

7. **The Directorate's ability to monitor its performance is hampered by its electronic patient record systems.** According to leadership, the Directorate's two electronic patient record systems do not meet its needs. The original system has hundreds of codes to learn, leading to poor data quality, and is essentially GP-focused with other specialities "bolted on". The system's limited capacity to record tests means that patients must be re-tested repeatedly. Further, as the software evolved the Directorate's version was no longer supported, while the newer, web-based version will not function in St

Helena without extensive customisation that the vendor is not offering (though it is still providing technical assistance). The Directorate completed a procurement process to bring in a new vendor at a cost of £210,000 over 9.5 years, but that product and the vendor's support has not constituted a satisfactory replacement. Because the Directorate does not have a suitable system, it struggles to track basic metrics associated with patient experience. For example, neither system can (1) calculate average waiting time for outpatient appointments, accident and emergency (A&E) cases or out-of-hours visits, or (2) easily extract the total number of patients seen over a specific period. (paragraphs 1.18 and 1.19)

THE DIRECTORATE'S FINANCIAL PERFORMANCE IN FY 19/20

8. **The Directorate consumed the highest proportion of SHG's budget in FY 19/20.** The Directorate's operating budget for FY 19/20 was £5.7 million, or 14% of SHG's total operating budget of £41.6 million. (We use 'operating budget' to mean planned recurrent expenditure excluding pensions and benefits.) The Directorate ultimately spent £5.8 million in FY 19/20, or 14% of SHG's actual operating expenditure of £40.6 million. This planned and actual spending does not include staff allotments from SHG's Technical Cooperation (TC) budget, which is funded by the UK's Foreign, Commonwealth and Development Office (FCDO). TC personnel are specialists, such as medical doctors and senior nurses, who are recruited from overseas and funded centrally through SHG's Corporate Human Resources rather than from the individual budgets of departments where the TCs are posted. After allocating these TC positions to their respective departments, the Health Directorate's share of SHG's total operating budget grows to 21% (£8.7 million). (paragraphs 2.1 and 2.2, and Figure 1)

9. **The Directorate spent more on Technical Cooperation than any other SHG department in FY 19/20.** The Directorate spent £2.9 million on TC employees in FY 19/20, including recruitment, relocation, salary and allowances, and another £152,000 on short-term consultants that are also funded from the TC budget. The resulting £3.0 million expenditure accounted for 37% of SHG's £8.2 million total TC spend. Once TC costs are added to the Directorate's total, SHG's FY 19/20 spending on health increases from £5.8 to £8.8 million, or 22% of SHG's total operating spend for the year. Over time the Directorate's share of SHG's total spend increased from 19% to 24% from FY 15/16 to FY 16/17 and then declined slightly through FY 19/20. (paragraphs 2.3 to 2.5, and Figures 2, 3 and 4)

10. **While almost half of the Directorate's budget was spent on personnel, overseas medical care along with medication and other supplies also accounted for significant sums.** The Directorate's FY 19/20 spending was spread across its several functional areas, such as Medical, Hospital (Acute Care) and Management & Administration. As with many government departments in St Helena and around the world, the Directorate spends a substantial portion of its funding on personnel. TCs represented the Directorate's single largest expenditure, at £3.0 million, and combined with local staff (£1.1 million) accounted for 46% of its total spend. Overseas medical care

was another major cost driver, with overseas treatment (£2.0m) and emergency medical evacuation (£0.2m) together amounting to 59% of spending in the Medical area and 25% of the Directorate's total spend. This £2.2 million expenditure allowed the Directorate to refer 112 patients abroad for specialist and tertiary care. Both the number of patients referred and resulting expenditure in FY 19/20 increased sharply over FY 18/19 but are still below recent highs. However, as we reported in 2019, one of the primary goals of the £3 million hospital refurbishment completed in 2017 was to reduce overseas medical referrals and their associated costs. Another significant cost driver was supplies, including medication, which accounted for an additional £0.8 million in spending. (paragraphs 2.6 to 2.9, and Figures 5, 6 and 7)

THE DIRECTORATE'S STAFFING STRUCTURE, LEVELS AND CHALLENGES

11. **The Directorate spent about the same amount on TC medical doctors as on all local staff, which together accounted for more than half of its personnel costs.** Local staff fill medical, administrative and technical positions, from nursing, physiotherapy and laboratory work to accounting, appointment booking and community pest control. There were at least 96 full-time positions filled by local staff for all or part of FY 19/20 for a total cost of £1.1 million. Costs associated with medical doctors on TC employee contracts totalled £1.0 million for the financial year: together with local staff, they accounted for 52% of the Directorate's personnel costs. The remaining £2.0 million in TC spending was directed at nursing, mental health, dentistry and other specialties, along with recruiting. Nursing is a key role within the Directorate that relies upon both local and TC employees. At the end of FY 19/20 there were 28 nursing positions in the Directorate's Hospital section, as well as 16 more in the Community Health, Mental Health and Dental sections. Of the 28 positions in the Hospital, 21 were local and 7 were classified as TCs, with the latter tending to be more senior, such as the Head Nursing Officer, Theatre Sister and Senior Staff Nurses. To assess real staffing levels, we calculated full-time equivalents (FTEs) for medical doctors, nurses and other TCs, who arrive and depart throughout the year. The Directorate employed about the same level of TC medical doctors and TC nurses in FY 19/20 – 7.5 and 7.3 FTEs, respectively. (paragraphs 2.10 to 2.15, and Figure 8)

12. **Directorate leadership told us the number of medical doctors is appropriate but the skills mix should be re-calibrated, while various challenges hamper recruitment.** Directorate leadership told us that the total number of medical doctors in St Helena is appropriate for its population size and income level. As stated in paragraph 11, the Directorate employed 7.5 medical doctor FTEs in FY 19/20 supplemented by additional doctors on short-term consultant contracts. Notwithstanding their satisfaction with the number of doctors, leadership told us the skills mix may be wrong, primarily because there are fewer full-time GPs than needed. Rather than relying upon doctors with other specialties to spend some of their time as GPs, Directorate leadership would prefer to recruit GPs who have additional specialities. However, the Directorate has found the recruitment of suitably qualified and experienced medical doctors to be an ongoing challenge in part because versatile generalists have become harder to find.

While the Directorate is assisted by a search firm that identifies promising candidates, it has past experience with a more extensive relationship where an outside agency supplied and managed the island's doctors. (paragraphs 2.16 to 2.18)

13. **Regulations governing recruitment of medical doctors changed in 2019 but these may require further revision.** Recruitment of medical doctors is governed in part by St Helena's Medical Practitioners Ordinance. In 2019, an amendment to this ordinance was enacted that changed how new doctors could be approved to work in St Helena. Before this amendment, the Governor, as recommended by the Chief Medical Officer, periodically added specific countries to a schedule of acceptable places from which to hire new doctors, typically to allow a recruited candidate to begin work. As a result of the 2019 amendment, the Governor is now authorised to appoint individual doctors as recommended by the Directorate. In addition, according to the amended ordinance, the Governor now acts on the recommendation of the Director of Health instead of the Chief Medical Officer. This latter change appears regressive because the Directorate's Chief Medical Officer must be a medical professional with clinical experience, while the Director of Health is not required to have such a background. In the UK, the General Medical Council (GMC) is the independent regulator for medical doctors, deciding which doctors are qualified to work, overseeing medical education and training, and setting the standards that doctors need to follow throughout their careers. According to Directorate leadership, every doctor recruited to St Helena goes through extensive vetting to ensure their qualifications are "GMC equivalent". However, in the absence of an independent regulatory body to serve as the gatekeeper for acceptable qualifications in St Helena, that assessment of GMC equivalence is inherently subjective and the arbiter is not qualified to make such a judgement independently. Accordingly, the Medical Practitioners Ordinance should be revisited and strengthened, and the need for performance indicators that ensure clinical quality is heightened. (paragraphs 2.19 to 2.21)

THE DIRECTORATE'S OPERATIONAL PERFORMANCE IN FY 19/20

14. **The Directorate did not meet 11 of its 28 performance targets for FY 19/20, and its performance reporting was incomplete.** Appendix One presents the Directorate's results for each of its performance indicators for each quarter of FY 19/20, grouped by strategic priority. From this data we conclude that:

    - The Directorate maintained equitable and proportionate access to the range of local health services it tracks, except for elective surgery.
    - The Directorate failed to expand the preventative healthcare services as intended.
    - The Directorate did well in protecting the population from clinical, environmental and other health threats and emergencies.
    - The Directorate had some success addressing diabetes in St Helena's population, however it is not possible to assess its progress in tackling other long-term conditions such as hypertension and kidney disease.

- The Directorate provided specialist and tertiary care through overseas referrals to South Africa and the UK, however it is unclear whether this was sustainable or affordable.
- The Directorate did not provide data that would help determine whether St Helena's existing and emerging health workforce needs were adequately met for the year.
- While both of the tracked targets were met, it is not possible to tell whether community engagement and patient experience actually improved using the Directorate's indicators. (paragraphs 2.22 to 2.24)

ACCESS TO CARE AND OTHER BENCHMARKS

15. **The Directorate is unable to provide complete data on waiting times for patients in both primary and secondary care but some comparisons with the NHS are possible.** We attempted to benchmark various waiting times throughout the patient journey in order to compare the efficiency of the health service on St Helena with that of the NHS, including waiting times for (1) GP appointments, (2) referral to treatment and (3) A&E and walk-in services. According to the data we collected:

    - There is an indication that St Helena's waiting times for routine appointments are shorter than those of the NHS – 90% within 10 days on St Helena compared to 82% within 14 in England for FY 19/20 – but we cannot say how many appointments occurred within other time frames, for example on the same day.
    - St Helena's median waiting time for referral to treatment is not available for comparison to the NHS, nor is data on the proportion of cases that started treatment within 18 weeks – although 89% of surgeries happened within 12 weeks compared to 72% within 10 in England for FY 19/20.
    - The Directorate cannot currently measure waiting times for A&E or walk-in patients at the hospital. (paragraphs 3.3 to 3.9)

16. **Despite incomplete data on waiting times, the information we gathered indicates that St Helena residents generally enjoy expedited access to medical care relative to people living in England.** According to an independent charity, as of February 2021 it had been more than 4 years since the NHS's 18-week referral-to-treatment standard for planned care was last met, more than 5 years since the national 4-hour A&E standard was met and more than 6 years since the 62-day cancer treatment standard was met. Conversely, in St Helena GP appointments and A&E care are delivered with little to no wait, while referrals overseas for specialist procedures are scheduled for routine commercial flights or emergency evacuation, with treatment provided largely through private healthcare facilities soon after arrival. (paragraphs 3.10 and 3.11)

17. **Compared to the rest of the world, St Helena had a below-average number of doctors but an above-average number of nurses.** In FY 19/20 St Helena had in an average month 1.64 medical doctors per 1,000 people. This is 0.31 fewer doctors per 1,000 people than the global average (1.95), noting however that most tertiary and some secondary medical services are provided overseas. Even so, St Helena had more

doctors relative to the population than South Africa and most other developing countries. In the same year, in an average month St Helena had 8.18 nurses and midwives per 1,000 people. This is 3.66 more nurses per 1,000 people than the global average of 4.52. (paragraphs 3.12 and 3.13, and Figures 9 and 10)

18. **The mix of clinical and non-clinical staff in the Directorate was nearly identical to the NHS.** Fifty-three percent of hospital and community health staff in England were professionally qualified clinical staff as of March 2020, with the rest supporting clinical staff or working in administration. In the same month, 54% of St Helena Health Directorate staff were professionally qualified clinical staff using the NHS's definitions. In addition, the proportion of clinical, support and administrative staff in the Directorate was nearly identical to their corresponding staff groups in the NHS. (paragraphs 3.14 and 3.15, and Figure 11)

COMPARISON TO OTHER OVERSEAS TERRITORIES

19. **St Helena's status as a remote island with a small population limits the number of comparators available for healthcare benchmarking.** St Helena's remote geographical location and small population make it directly comparable to very few places in the world. Given its unique characteristics, we selected four other UK overseas territories to benchmark healthcare spending and hospital services. These territories are:

    - Ascension Island
    - Falkland Islands
    - Montserrat
    - Tristan da Cunha

    The selected territories are imperfect comparators – for example, Ascension Island has a predominantly working-age population due to its requirement that prospective residents have an employment contract or accompany someone who does. But in addition to being UK territories that are islands with small populations, places like Ascension and the Falklands are familiar to many St Helenians. (paragraphs 3.16 to 3.19)

20. **In FY 19/20 the Falkland Islands spent more per person on healthcare than St Helena, while St Helena spent more per person than Ascension Island, Tristan da Cunha and Montserrat.** The Falkland Islands has the strongest of the selected territories' economies, resulting in a relatively large annual healthcare spend of £3,100 per capita. St Helena spent about £1,900 per person on healthcare in FY 19/20, £500 more than Ascension Island and Tristan da Cunha which both spent roughly £1,400 per person on very different populations. Montserrat, the only one of these territories with a private healthcare system supplementing the public one, had a public budget of £900 per person in FY 19/20. St Helena's spending per capita was lower however than in many developed economies. (paragraphs 3.20 and 3.21, and Figure 12)

21. **Several of the overseas territories have recently upgraded their medical facilities or are now doing so, and facilities available on St Helena compare favourably to those in the other territories.** The UK government-funded Jamestown hospital refurbishment was completed in June 2017. In the same month, a new UK-funded healthcare centre opened in Tristan da Cunha. The UK government has also agreed to fund the construction of a new 24-bed hospital in Montserrat as part of a broader capital investment programme. In the Falkland Islands, hospital improvements were included in both the FY 19/20 and FY 20/21 budgets. From our sample of territories, St Helena's 24-bed Jamestown hospital seems fairly advanced:

    - Its facilities are on par with those in the Falkland Islands, which has a much larger budget.
    - While it has a relatively low number of beds for the size of St Helena's population, it is better equipped with more consultation rooms and a delivery suite.
    - It was the only hospital in our sample of territories with an operational CT scanner. (paragraphs 3.22 to 3.26, and Figure 13)

CONCLUDING REMARKS AND RECOMMENDATIONS

22. Delivering quality healthcare services in remote locations is a demanding endeavour even with St Helena's mix of public and private sector provision. Staffing is clearly one of the Health Directorate's major challenges, and one that has yet to be overcome. In FY 19/20 the Directorate spent more than any other SHG department on TC resource, but recruitment of medical doctors with the right skills continues to be an obstacle. Despite this, the Directorate manages to deliver a substantial number of services for the population across primary, secondary and tertiary care. Moreover, comparisons with other countries show that St Helena has a sufficient number of doctors and nurses when fully staffed, given its relative size and resource level, along with a reasonable range of medical facilities. St Helena residents generally receive care more promptly than their English counterparts, and overseas referrals, while costly, provide patients with vital specialist care not available on-island, often in private facilities. In essence, St Helena enjoys the benefits of a private healthcare model through direct taxpayer funding.

23. However, this high level of service comes at a high cost. Spending on healthcare in recent years has approached a quarter of SHG's operational spend, in part because of the reliance on TC resource, and overseas referral costs are hard to control. Given this level of public expenditure and the expectation that the cost of health services will continue to increase as a function of an aging population and more expensive healthcare interventions, the long-term financial sustainability of the current publicly funded private healthcare model is in question. As such, SHG should consider whether a national healthcare insurance scheme similar to those established in other UK overseas territories would be appropriate to help meet the escalating cost of health provision in St Helena.

24. Turning to performance measurement, our analysis points to a number of areas in which the management of the Directorate could improve. Firstly, while the Directorate has made progress in maturing its set of performance indicators, they do not adequately measure the population's access to basic healthcare services. Secondly, there is limited data available as to the quality or effectiveness of the services themselves – a critical deficiency given the absence of a UK-style regulator of medical providers. Thirdly, the Directorate's ability to collect, report and analyse even the most basic patient data – such as the number of patients seen over a set period, their reasons for seeking care and how long they wait to receive it – is many years behind what more advanced healthcare systems such as the NHS are able to do. Collecting this fundamental data depends upon the ongoing project to install a new electronic patient record system, which should be prioritised so that these issues can be resolved as soon as possible.

25. **We have identified the following recommendations for SHG:**

a) To ensure its performance measurement system establishes key benchmarks and adequately measures performance against its strategic objectives, the Directorate should:
   i. Introduce performance indicators that assess clinical quality as indicated by patient outcomes, such as those published by the NHS.
   ii. Introduce performance indicators that measure access to emergency care, semi-urgent care, general mental health services and general dental services.
   iii. Introduce performance indicators that measure the prevalence of kidney disease and the efficacy of interventions to reduce it.
   iv. Consider raising its target for the percentage of known diabetics exhibiting control of their disease as measured by blood sugar levels.

b) The Directorate should urgently prioritise the establishment of an electronic patient record system that can address the needs of all users and in particular can produce timely reports required by those users.

c) The Directorate should establish a process, possibly using the new electronic patient record system, to monitor and track waiting times for GP services, referral to treatment and A&E.

d) Given the ongoing challenges faced in the recruitment and retention of appropriate medical doctors, the Directorate should work with the Attorney General to strengthen the appointment regulations and review its methods for recruitment of health professionals, including the potential restoration of an agency relationship for the provision of qualified healthcare staff.

e) SHG should examine the advantages and disadvantages of creating a national healthcare insurance scheme that would establish an investment-backed fund designed to meet the long-term health needs of St Helena's population, including the cost of overseas medical referrals.

Part One

How the Health Directorate Measures Its Performance

THE DIRECTORATE'S CORE ACTIVITIES AND HOW THEY ARE DELIVERED

The Directorate administers St Helena's healthcare system, including on-island primary and secondary care, arrangements for overseas tertiary care and health promotion campaigns in the community.

1.1 The Directorate's role within SHG is to deliver a high standard of healthcare that improves the health status and wellbeing of St Helena's population. It aims to promote healthy lifestyles and reduce the incidence of non-communicable diseases while working collaboratively with both the public and private sectors. Its remit includes traditional primary care, such as appointments with general practitioners (GPs) and dental exams; specialised secondary care, such as maternity services and arthroscopic surgery; and public health initiatives in the community, such as sugar reduction and smoking cessation programmes. The Directorate refers patients overseas for most tertiary care, but has the facilities to provide some complex treatments like chemotherapy and joint replacement on-island.

1.2 Unlike most SHG entities, the Directorate is expected to serve the community at all hours every day of the year. It delivers its services across St Helena in a variety of ways:

- A 24-bed[1] hospital in Jamestown provides care to inpatients, operates an out-of-hours emergency service for outpatients and maintains diagnostic capacity via laboratory services, X-ray, ultrasound, mammography and computed tomography (CT) scans.
- Doctors and nurses provide outpatient services at community clinics on the Jamestown hospital campus and three other sites around the island.
- A Dental department offers preventative, therapeutic and emergency dental care, including annual screenings and denture manufacture.
- Mental health specialists offer services in outpatient clinics, private residences, social care homes and the Jamestown prison.
- A school nurse regularly visits the three primary schools and the high school to provide preventative care and educate youth on maintaining a healthy lifestyle.

[1] According to Directorate leadership, as of April 2021 the hospital had 23 patient beds with capacity for 1 more.

While native St Helenians and other residents are charged fees for some of these services, they are deeply discounted relative to what visitors and other non-residents pay.

1.3 Throughout FY 19/20 the Director of Health served as the Directorate's accounting officer, responsible for the day-to-day management and continuous improvement of health services consistent with the priorities and values of SHG and its strategic plans. However, in June 2021, as we were completing our audit work, SHG appointed a Portfolio Director of Health and Social Care to oversee both directorates as part of the government's ongoing reorganisation. A Chief Medical Officer is responsible for maintaining oversight of primary and secondary care as well as leading initiatives to enhance safety and quality in preventative and clinical services.

THE DIRECTORATE'S PERFORMANCE MEASUREMENT SYSTEM

The Directorate derived its performance indicators from SHG's 10 Year Plan and its own strategic plan, which includes both indicators and targets.

1.4 The Directorate's performance measurement system relies on indicators that ultimately derive from the island's 10 Year Plan, which aims to "cover all aspects of health for Islanders and visitors" within the overarching goal known as "Altogether Healthier". This is expressed in the Directorate's 2019/22 Strategic Plan through a single overarching strategic objective: "Improve the health of the community". The Directorate pursues this objective through seven strategic priorities:

- Maintain equitable and proportionate local access to a range of health services in partnership with the community for all and the most vulnerable.
- Expand preventative healthcare services and promote healthy lifestyles for everyone.
- Protect the population from clinical, environmental and other health threats and emergencies.
- Tackle the high prevalence and incidence of chronic long term conditions among the population (diabetes, hypertension and kidney disease in particular).
- Provide access to specialist and tertiary care in a sustainable and affordable manner.
- Ensure that our existing and emerging health workforce needs are adequately met.
- Improve community engagement and patient experience of the local health service.

1.5 Each strategic priority in the Directorate's plan has associated targets, actions necessary to achieve those targets and the intended outcomes of those actions. For example, for strategic priority 1 (access to a range of health services), one target is to establish a baseline percentage for those with a registered disability who access an annual health check. An action needed to achieve the target is to establish annual health check programmes for people with disabilities, with access to defined essential services an intended outcome.

1.6 In performance measurement terminology, the Directorate's 'targets' actually contain both the indicator (what they will measure) and the target (the goal they aim to achieve); we use target exclusively in the latter sense below. In many cases the Directorate's targets contain numerical values, typically percentages, which set a measurable bar for the Directorate to meet for a given indicator. For example, the Directorate intends to maintain waiting times for elective surgeries at "less than 12 weeks". The remaining indicators without numerical targets are nonetheless measurable in a binary (yes/no) sense: for example, a hypertension database will either be established as planned, or it will not.

1.7 Given that the FY 19/20 strategic plan was meant to reflect the Directorate's planning for three financial years – through FY 21/22 – its performance indicator targets were designed to progress over time. For example, in FY 19/20 the Directorate hoped to achieve a 25% quit rate at 4 weeks among clients of its smoking cessation service: that target would escalate to 30% in FY 20/21 and 35% in FY 21/22. Sometimes a target reflected the Directorate's intent to set up a programme or capability in the first year in order to begin measuring progress in subsequent years, such as the plan to develop a record of body mass index (BMI) in FY 19/20, then establish a baseline and achieve a 10% reduction in patients with high BMIs, respectively, over the next two financial years.

1.8 Directorate leadership told us their performance indicators are developed in-house, and are based in part on the priorities of the Director of Health in place at a given time. In addition, they look to the United Kingdom (UK) for guidance. For example, they share each year's draft strategic plan containing the Directorate's performance indicators with their assigned health advisor from the UK's Foreign, Commonwealth and Development Office (FCDO) for comment.

The Directorate's performance indicators could be improved.

1.9 In FY 19/20 the Directorate evaluated itself against 28 performance indicators, which are listed in Appendix Two. We assessed the Directorate's indicators and found that each was measurable in either a numerical or binary fashion. This is an important first test of whether the indicators are fit for purpose.

1.10 A second test is whether the indicators measure the right things. One way to judge this is to see how they align with the Directorate's strategic priorities. We assessed the 28 indicators against the 7 priorities listed in paragraph 1.4 and found that, for the majority of the Directorate's priorities, their associated suite of indicators seemed relevant and sufficiently comprehensive. For example, for the third strategic priority (protect the population from clinical, environmental and other health threats and emergencies), there are indicators measuring aspects of infections while in hospital, food and water-borne disease, port health screenings and pest control, as well as an audit plan to track clinical outcomes (including complications and medical errors). However, our

assessment did identify several places where the performance indicators could be improved:

- The first strategic priority focusses on "access to a range of health services". While the six associated indicators address various services, there are no indicators measuring access to emergency or semi-urgent care, general mental health services or general dental services.
- The fourth strategic priority focusses on reducing the high prevalence of chronic conditions, "diabetes, hypertension and kidney disease in particular". Although there are four indicators addressing diabetes and hypertension, there are none measuring care related to kidney disease, and the one related to hypertension is in its infancy ("Establish a hypertension database").
- The seventh strategic priority focusses on "community engagement and patient experience". Its two indicators measure the availability of patient feedback forms and the Directorate's response time after receiving a patient complaint. However, neither of these measure actual engagement or client experience as they would if, e.g., the indicators contained targets for (1) the proportion of all patients who complete and return feedback forms, and (2) hospital patients' ratings of the services they received.
- Overall, the indicators tended toward measuring the relative availability of services, and how quickly they were delivered, as opposed to the quality or effectiveness of the services themselves. This approach can provide useful insights about service provision, but as the indicators mature we would expect them to increasingly measure performance over access. For example, in tandem with how long patients had to wait to receive care, new indicators could assess what difference that care made with respect to patient outcomes. See paragraph 1.12 for examples of such quality and outcome indicators drawn from England's National Health Service (NHS).

1.11 A third test of whether the Directorate's indicators are fit for purpose is whether their targets are set at reasonable levels – neither over- nor under-ambitious. This is primarily a technical judgement, and thus the Directorate's leadership, clinicians and other experts should be given wide latitude to set target levels they deem appropriate to the Directorate's capacity, the health needs of the island and the special circumstances on St Helena, like the requirement to travel overseas for most tertiary care. In light of this, our assessment of whether targets are set at the right levels required a comparison against the NHS, its overseas territories and other international benchmarks, as discussed in the next section.

Comparison to other sources of performance indicators

1.12 We researched other sources that could be used for benchmarking or otherwise inform the Directorate's performance measurement framework. Firstly, the NHS annually publishes a suite of performance indicators to give comparative information to local clinical groups and health boards about the quality of services they commission. While

the indicators do not have associated numerical targets, some may be appropriate for the Directorate to adopt after deriving its own targets. For example: patient-reported improvement in health status following common elective procedures, emergency readmissions within 30 days of discharge from the hospital and 1-year survival rate for all patients with cancer.

1.13 Another source for comparison is the National Institute for Health and Care Excellence (NICE), a non-profit organisation whose role is to improve outcomes for people accessing the NHS and other public health and social care services. Since 2009, NICE has maintained a catalogue with hundreds of detailed health-related performance indicators for use by practitioners at the clinical and community level. These indicators span a broad spectrum of conditions and diseases, from asthma, diabetes and cancer to hypertension, pregnancy and heart failure. Several of these indicators are substantially similar to indicators in the Directorate's suite of 28. Further, there are four indicators specific to chronic kidney disease, whose reduction (as noted above) is a strategic priority without a corresponding indicator in the Directorate's list.

1.14 Overseas jurisdictions with characteristics comparable to St Helena represent other potential sources for the Directorate's performance indicators. According to Directorate leadership, several years ago a former Director of Health asked the World Health Organisation (WHO) for places comparable to St Helena in order to develop partnerships and learn from others' experience. The WHO recommended the Republic of Mauritius, an island nation off the southeast coast of Africa that has a similar diet and ancestry, and faces similar challenges with chronic non-communicable diseases like diabetes. Mauritius's Ministry of Health and Wellness maintains a roster of over 100 performance indicators covering 26 strategic objectives. We found that in the key focus area of non-communicable disease prevention, the Directorate's indicators are at least as robust as those in Mauritius's list.

1.15 Finally, the United Nations – an international body with which St Helena is affiliated through the UK – has adopted relevant resolutions that provide guidance for achieving healthier populations. The first is a 2014 resolution concerning sustainable development for Small Island Developing States, an international cohort that St Helena recently joined. It contains a section on health and non-communicable diseases committing to urgent steps to establish 10-year strategies and targets to reverse the spread and severity of such diseases. The second resolution, adopted the following year, lays out the 2030 Agenda for Sustainable Development. Among the goals is to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment. We found that the Directorate's performance indicators are consistent with this international focus on preventing and controlling non-communicable diseases.

1.16 More generally, our assessment of whether the Directorate's indicator targets are set at appropriate levels, as informed by comparison to available benchmarks, did not identify any targets that were unreasonably low, with the possible exception of

diabetes care; however, many of the targets did not have close analogues for comparison. With respect to diabetes, both NICE and the Organisation for Economic Cooperation and Development[2] support the Directorate's approach of measuring the percentage of known diabetics who have had HbA1c (blood sugar) and retinopathy (eye) screenings in the past year. But a target of less than 50% with 'poor control' – HbA1c levels that are too high – means that the Directorate would still meet its performance goal even if nearly half of the island's diabetics were not safely managing their disease.

How indicators and targets have changed in recent years

1.17 As a final step in assessing the fitness of the Directorate's FY 19/20 performance indicators, we examined how the indicators and their targets evolved over recent years. We did this in two ways: (1) by examining how Year 1 indicators and their targets changed across the three strategic plans from FY 18/19 to FY 20/21, and (2) by comparing the Year 2 targets for indicators in the FY 19/20 strategic plan (i.e., for FY 20/21) to the Year 1 targets for those same indicators in the FY 20/21 strategic plan.

- *FY 18/19 Year 1 to FY 20/21 Year 1.* Performance indicators and their associated targets changed for the better between FY 18/19 and FY 19/20, in that they became both more specific and more complete. As part of this overhaul, the number of indicators grew from 22 to 28, augmented by eight new ones after two from FY 18/19 were dropped. The indicators then changed very little from FY 19/20 to FY 20/21. Overall, this demonstrates a maturing performance measurement framework feeding lessons from recent experience back into the development of its annual indicators.

- *FY 19/20 Year 2 to FY 20/21 Year 1.* Targets set out for Year 2 in the FY 19/20 strategic plan were meant to apply to the following year, i.e., FY 20/21. However, a new strategic plan created for FY 20/21 superseded that suite of indicators and associated targets. We reviewed the changes between the two suites to see if the indicators changed and whether targets were made more or less ambitious, or stayed the same. Twenty-seven of the 28 indicators carried over from the prior year. For those 27 indicators, 3 targets became more ambitious, 9 targets became less ambitious and the remaining 15 remained essentially the same. Taken as a whole, the nine targets that became less ambitious appeared to be reasonable amendments that still measured something meaningful about the Directorate's performance.

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[2] The Organisation for Economic Cooperation and Development (OECD) is an intergovernmental consortium of 37 countries that promotes economic progress and world trade. In the health arena, the OECD regularly publishes comparable data and trends on key indicators of health outcomes and health systems across its member countries.

The Directorate's ability to monitor its performance is hampered by its electronic patient record systems.

1.18 According to leadership, the Directorate's two electronic patient record systems do not meet its needs. The original system has hundreds of codes to learn, which is challenging given staff turnover: the consequent miscoding of patient data means that data quality is poor. In addition, the system is essentially GP-focused with other specialities "bolted on", and its limited capacity to record tests means that patients must be retested repeatedly. Further, as the software evolved the Directorate's version was no longer supported, while the newer, web-based version will not function in St Helena without extensive customisation that the vendor is not offering (though it is still providing technical assistance). The Directorate completed a procurement process to bring in a new vendor, but that product and the vendor's support has not constituted a satisfactory replacement. The Directorate is currently using both systems while working with SHG's Information Technology Division, Public Health England and other UK overseas territories to identify a new system that will meet its needs. According to SHG's contract register, the original system had a 6-year contract for £79,000, ending in September 2020 but extended through December, and the subsequent system has a 9.5-year contract for £210,000.

1.19 Because the Directorate does not have a suitable patient record system, it struggles to track basic metrics associated with patient experience. For example, neither system can (1) calculate average waiting time for outpatient appointments, accident and emergency (A&E) cases or out-of-hours visits, or (2) easily extract the total number of patients seen over a specific period. As waiting time for routine outpatient appointments is one of the Directorate's performance indicators, staff must research and calculate it outside of the system. The Directorate intends for its replacement system to be able to generate this and other basic metrics electronically. Our 2019 report on the Jamestown hospital refurbishment[3], a capital project completed in 2017, noted the problems with the hospital's existing patient record system and cautioned that adequate training and resources would be needed to ensure its replacement could adequately monitor hospital performance and produce accurate and timely reporting.

[3] Audit St Helena, *Performance Audit: Jamestown Hospital Refurbishment Project* (September 2019).

Part Two

The Performance of the Health Directorate

THE DIRECTORATE'S FINANCIAL PERFORMANCE IN FY 19/20

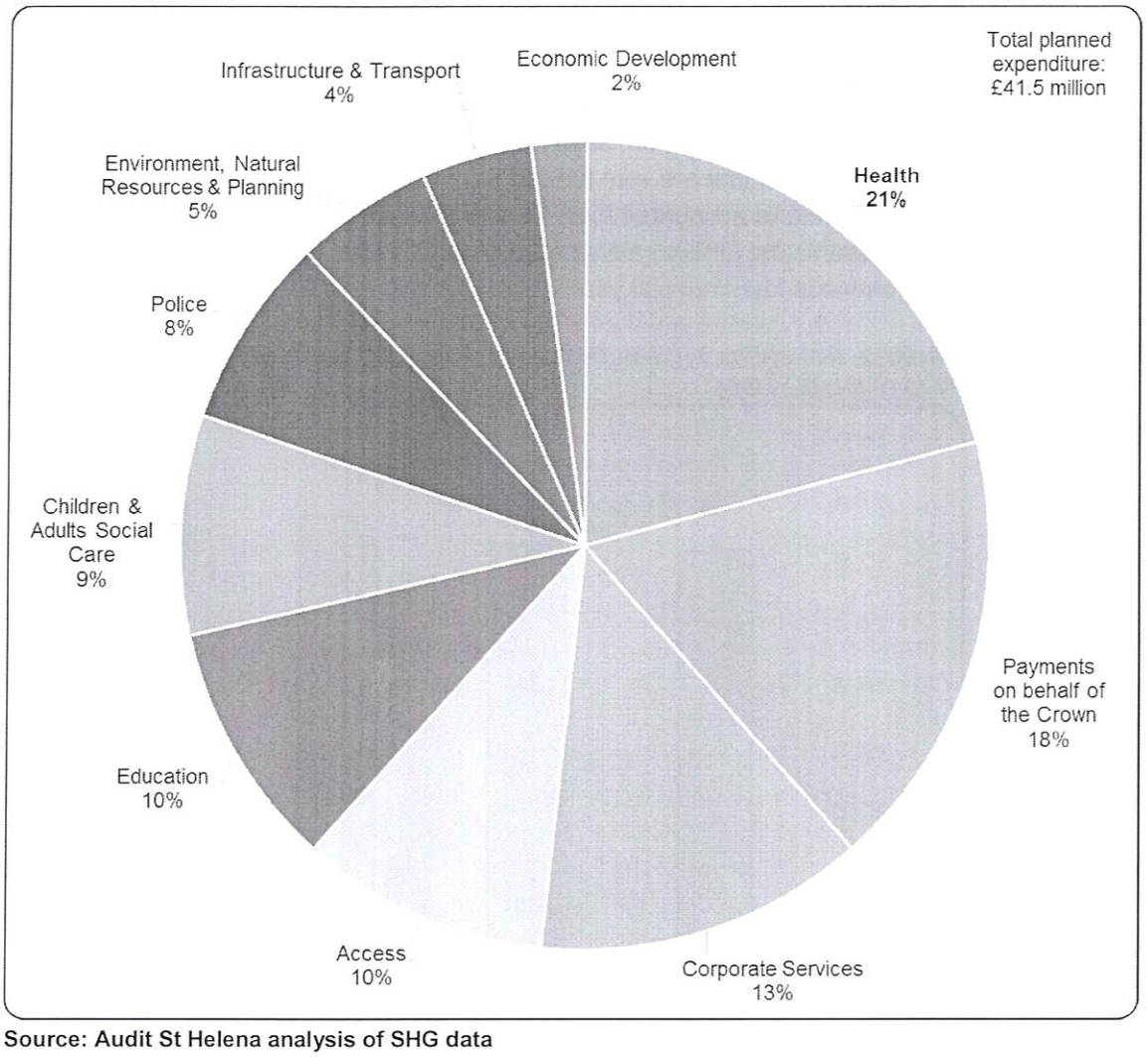
The Directorate consumed the highest proportion of SHG's budget in FY 19/20.

2.1 The Health Directorate historically has had one of the highest shares of SHG's budget among the various departments. For FY 19/20 the Directorate's operating budget[4] was £5.7 million, or 14% of SHG's total operating budget of £41.6 million. Turning from budgeted to actual expenditure, the Directorate spent £5.8 million in FY 19/20, or 14% of SHG's actual operating expenditure of £40.6 million. The department also collected revenues of £0.7 million for the year, mainly from charges for medical treatments and other fees.

2.2 The planned and actual spending cited above does not include staff allotments from SHG's Technical Cooperation (TC) budget, which is funded by FCDO. TC personnel are specialists, such as medical doctors and senior nurses, who are recruited from overseas. Funding for their relocation, salary and allowance costs is included in the overall budget for SHG's Corporate Human Resources office rather than in the individual budgets of departments where the TCs are posted. Figure 1 presents each directorate's share of SHG's budget for FY 19/20 after allocating these TC positions to their respective departments. The Health Directorate's 21% share of SHG's total operating budget, including TCs, amounted to £8.7 million in planned expenditure.

[4] We use the terms 'operating budget' and 'operating expenditure' to mean SHG's planned and actual recurrent expenditure across all departments excluding pensions and benefits (i.e., appropriated recurrent expenditure).

FIGURE 1: SHARE OF SHG OPERATING BUDGET BY DIRECTORATE FOR FY 19/20, INCLUDING TCs



Source: Audit St Helena analysis of SHG data

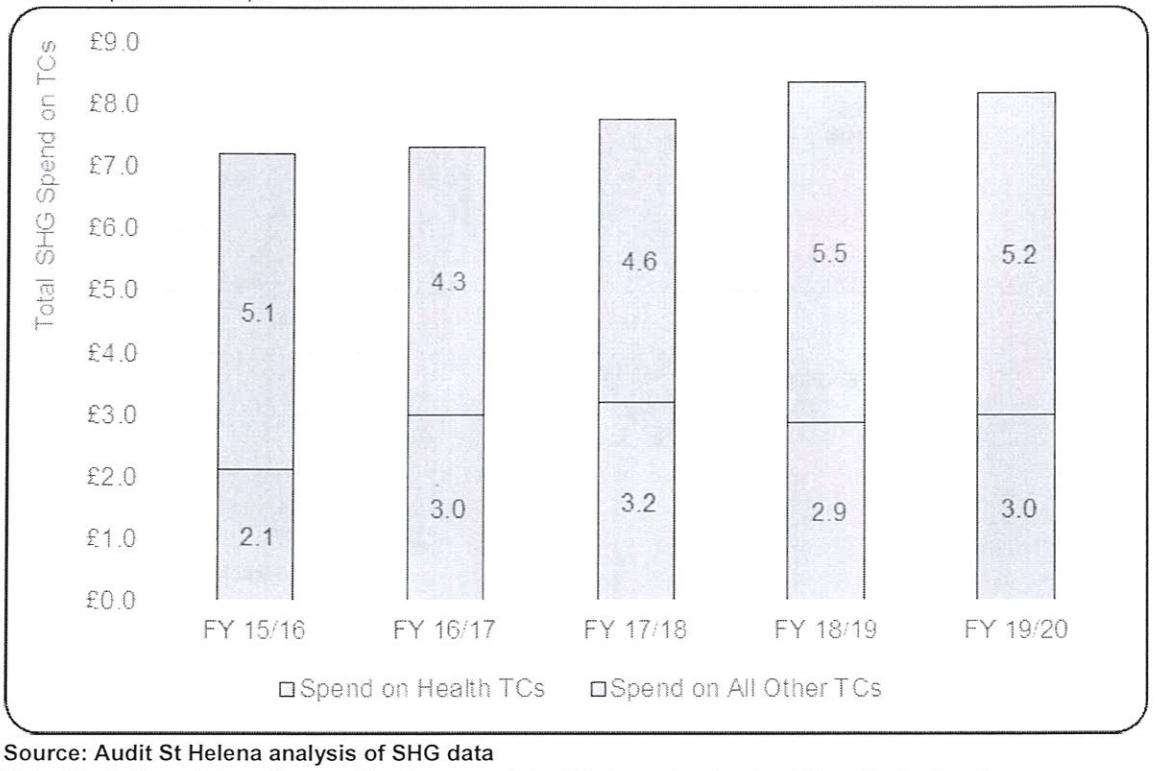
Notes:

1. **Does not include SHG's planned expenditure on pensions and benefits.**
2. **This analysis was based on SHG's original planned expenditure of £41.5 million. A supplementary appropriation later increased this operating budget slightly to the £41.6 million cited in paragraph 2.1, with most of this increase going to the Health Directorate.**
3. **Payments on behalf of the Crown is included in the Corporate Services budget for accounting purposes, and refers to payments that cannot be attributed to an operational directorate.**
4. **Access comprises Shipping, Airport Operations and the Airport Contract Management Unit.**

The Directorate spent more on Technical Cooperation than any other SHG department in FY 19/20.

2.3 The Health Directorate spent £2.9 million on TC employees in FY 19/20, including recruitment, relocation, salary and allowances, and another £152,000 on short-term consultants that are also funded from the TC budget. The resulting £3.0 million expenditure accounted for 37% of SHG's £8.2 million total TC spend. Figure 2 presents the Directorate's share of SHG's total spend on TCs in FY 19/20 and the previous four financial years.

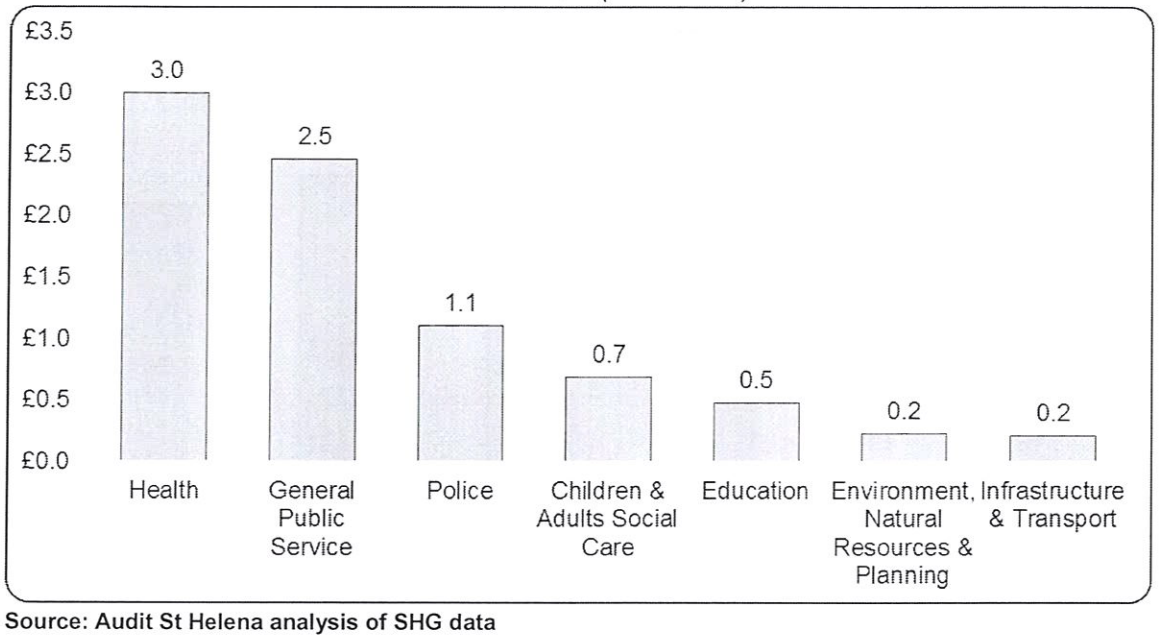
FIGURE 2: SHG SPEND ON HEALTH TCs COMPARED TO ALL OTHER TC SPEND, FY 15/16 THROUGH FY 19/20 (IN MILLIONS)



Source: Audit St Helena analysis of SHG data
Note: Each financial year's spending is presented at that year's price level (nominal values).

2.4 The Health Directorate's £3.0 million TC spend was £0.5 million more than the next highest spender, the General Public Service, which encompasses several SHG directorates and other offices – Corporate Finance, the Airport Directorate and the Attorney General's Chambers, among others. Figure 3 presents TC spending totals for the Health Directorate and other SHG entities.

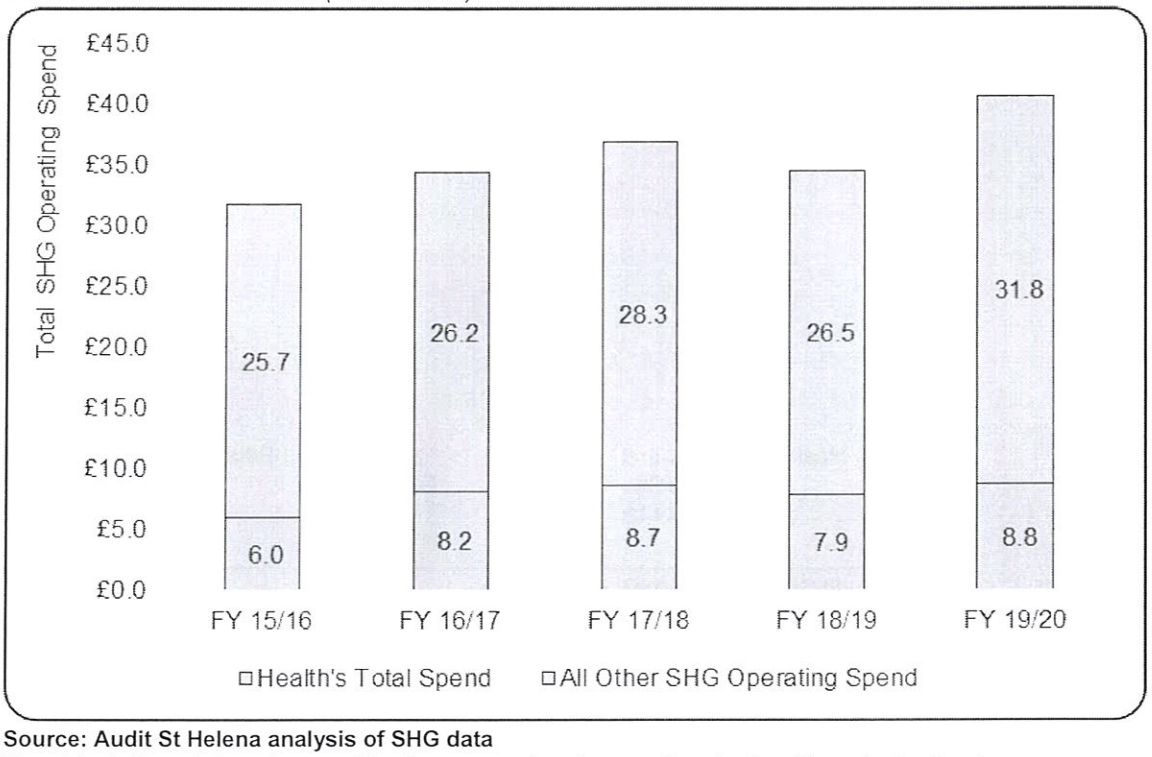
FIGURE 3: SHG'S TC SPEND BY ENTITY FOR FY 19/20 (IN MILLIONS)



Source: Audit St Helena analysis of SHG data

2.5 Once TC costs are taken into account, the Health Directorate's share of SHG's actual spend for FY 19/20 rises from 14% to 22% – £8.8 million of SHG's £40.6 million. Over time the Directorate's share increased from 19% to 24% from FY 15/16 to FY 16/17 and then declined slightly through FY 19/20. Figure 4 presents the Directorate's share of SHG's total operating spend across those five financial years.

FIGURE 4: SHG SPEND ON HEALTH DIRECTORATE COMPARED TO ALL OTHER OPERATING SPEND, FY 15/16 THROUGH FY 19/20 (IN MILLIONS)

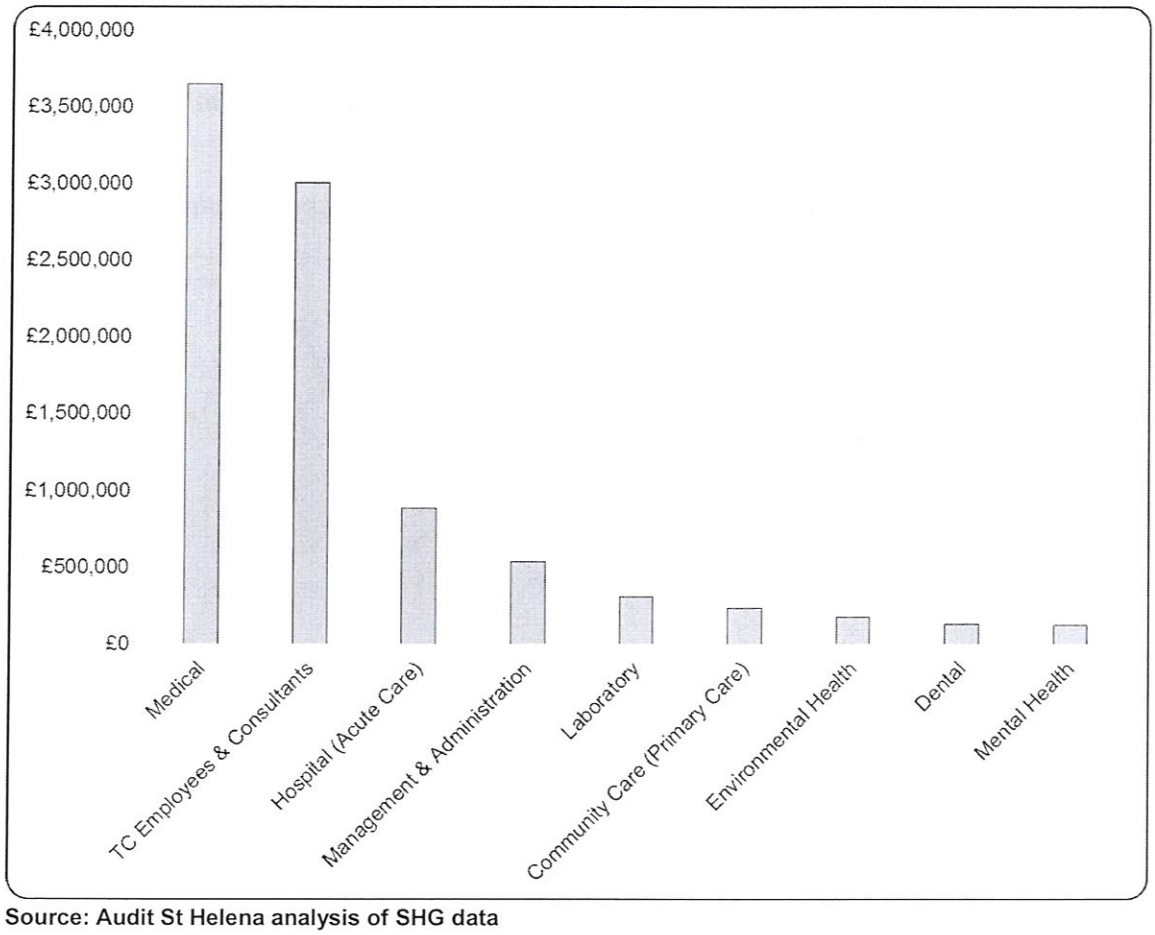


Source: Audit St Helena analysis of SHG data
Note: Each financial year's spending is presented at that year's price level (nominal values).

While almost half of the Directorate's budget was spent on personnel, overseas medical care along with medication and other supplies also accounted for significant sums.

2.6 The Directorate's FY 19/20 spending was spread across its several functional areas (known as 'cost centres') as shown in Figure 5. The Medical area was the primary cost driver followed by Hospital (Acute Care) and Management & Administration. However, TC spending is not included in these amounts because it is not tracked by the Directorate's cost centres in SHG's accounting system; it has been added to the figure for reference.

FIGURE 5: HEALTH DIRECTORATE'S TOTAL SPEND BY COST CENTRE FOR FY 19/20



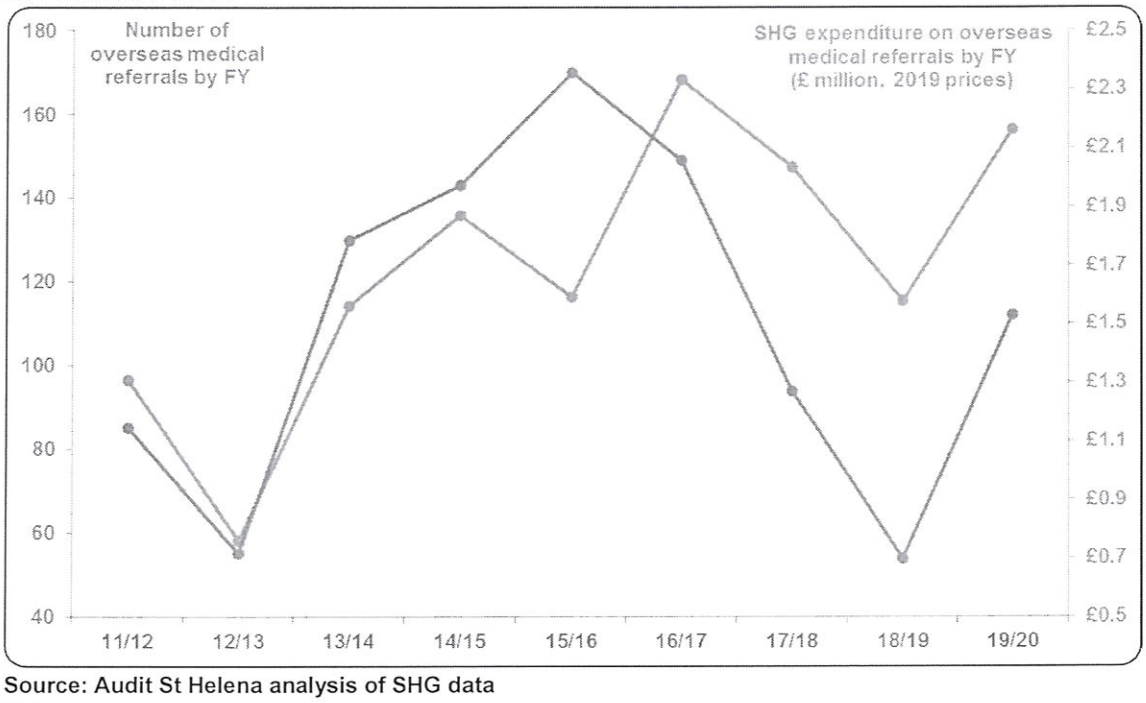
Source: Audit St Helena analysis of SHG data
Note: Excludes devaluation of non-current assets (capital reserve).

2.7 Instead of being tracked by cost centre, TC spending is reported separately as a standalone cost and represents the Directorate's single largest expenditure. We gain a better perspective on TC spending by considering it alongside other cost drivers across all of the Directorate's functional areas. As with many government departments in St Helena and around the world, the Directorate spends a substantial portion of its funding on personnel. In addition to the £3.0 million spent on TCs, the Directorate

spent another £1.1 million on local staff, which together represented 46% of its total spend.

2.8 Overseas medical care was another major cost driver, with overseas treatment (£2.0m) and emergency medical evacuation (£0.2m) together amounting to 59% of spending in the Medical area and 25% of the Directorate's total spend. This £2.2 million expenditure allowed the Directorate to refer 112 patients abroad for specialist and tertiary care. Both the number of patients referred and resulting expenditure in FY 19/20 increased sharply over FY 18/19 but are still below recent highs, as shown in Figure 6 comparing referrals (blue line) and expenditure (orange line) over the past nine financial years. However, as we reported in 2019, one of the primary goals of the £3 million[5] hospital refurbishment completed in 2017 was to reduce overseas medical referrals and their associated costs. According to Directorate leadership, some of the uptick can be explained by the Director of Health during FY 18/19 having a different prioritization scheme than other recent directors, such that the departure of some less urgent cases was effectively shifted forward to FY 19/20.

FIGURE 6: SHG SPEND ON OVERSEAS MEDICAL REFERRALS COMPARED TO NUMBER OF REFERRALS BY FINANCIAL YEAR



Source: Audit St Helena analysis of SHG data

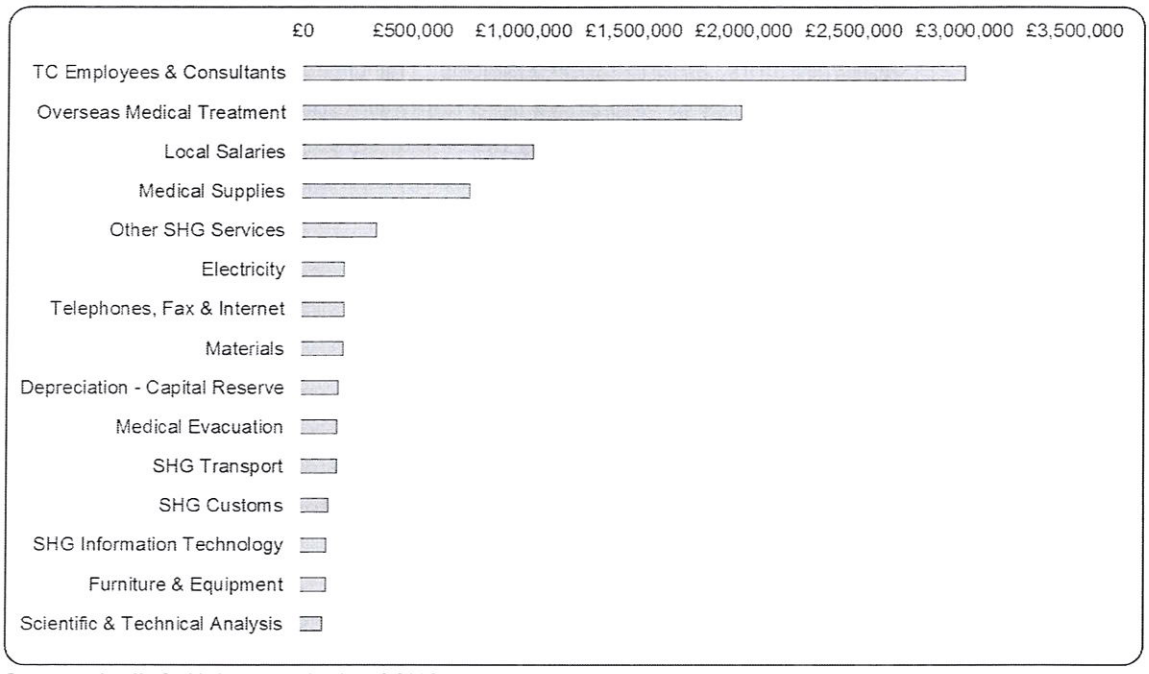
Notes:

1. **Expenditure on overseas medical referrals includes costs associated with (1) overseas medical treatment, such as commercial transport and hospital care, and (2) medical evacuation for urgent cases.**
2. **Each financial year's spending is presented at 2019 price levels (adjusted values).**

[5] We found that total actual spend on the refurbishment was hard to estimate owing to its long timescale, but our review of the project accounts and capital programme reports suggested it was between at least £3.28 million and £3.45 million excluding SHG management and staff time.

2.9 The Directorate spent another £0.8m on supplies, including medications. Figure 7 presents the top 15 types of expenditure for FY 19/20.

FIGURE 7: HEALTH DIRECTORATE'S TOTAL SPEND BY TYPE FOR FY 19/20



Source: Audit St Helena analysis of SHG data
Note: Excludes devaluation of non-current assets (capital reserve).

THE DIRECTORATE'S STAFFING STRUCTURE, LEVELS AND CHALLENGES

The Directorate spent about the same amount on TC medical doctors as on all local staff, which together accounted for more than half of its personnel costs.

2.10 Figure 8 on page 32 is an infographic presenting the Directorate's personnel costs in FY 19/20 arranged by the amount it spent on different types of staff. This includes locally-funded staff as well as those who are funded by the TC budget.

Local staff and TCs

2.11 As reported in paragraph 2.7, costs associated with local staff totalled £1.1 million for the financial year. These staff are the backbone of the Directorate. They fill medical, administrative and technical positions, from nursing, physiotherapy and laboratory work to accounting, appointment booking and community pest control. There were at least 96 full-time positions filled by local staff for all or part of FY 19/20. In addition to those positions, there were 16 local vacancies at the end of the year and 2 trainees being supported in England.[6]

[6] Two of the 96 positions filled for all or part of the financial year were among the 16 vacancies at the end of that year.

2.12 Costs associated with medical doctors on TC employee contracts totalled £1.0 million for the financial year. TCs typically are employed on fixed-term contracts ranging from several months to several years. They are medical doctors, including GPs and specialists in various aspects of physical and mental health; nurses; therapists; radiographers; biologists; dentists and hygienists; pharmacists; and senior administrators, among other positions. The Directorate's £3.0 million TC budget also funded consultants who arrive on a short-term contract to provide specialised medical care, like optometry, cardiology and facial surgery; perform maintenance on the hospital's complex equipment; and consult on aspects of the electronic patient record system, among other services.

2.13 Nursing is a key role within the Directorate that relies upon both local and TC employees. At the end of FY 19/20 there were 28 nursing positions in the Directorate's Hospital section, as well as 16 more in the Community Health, Mental Health and Dental sections. Of the 28 positions in the Hospital, 21 were local and 7 were classified as TCs.[7] The TC positions tended to be more senior, such as the Head Nursing Officer, Theatre Sister and Senior Staff Nurses. While there were Senior Staff Nurses, Practice Development Nurses and Nursing Sisters among the local positions, the majority of local positions were Staff Nurses.

FTEs as a measure of real staffing levels for TCs

2.14 Because TC employees and consultants are constantly arriving and departing, and even the longer-term employees may leave the island for scheduled holidays, a simple head count of TCs would be misleading when trying to assess the department's staffing levels. For example, even though there were 16 different medical doctors on staff at some point during FY 19/20, most months saw between 7 and 8 employed at any one time. To assess real staffing levels, we divided the number of months each TC employee was in post by 12 and then grouped them by type to arrive at an approximate measure of TC full-time equivalents, or FTEs. As shown in Figure 8, the FTEs and costs associated with each type of TC employee are as follows:

- *Medical doctors.* 7.5 FTEs at a cost of £1.0 million.[8]
- *Nursing staff.* 7.3 FTEs at a cost of £532,000.
- *Mental health staff.* 3.3 FTEs at a cost of £235,000.
- *Dental staff.* 3.0 FTEs at a cost of £216,000.
- *Other staff.* 10.9 FTEs at a cost of £800,000.

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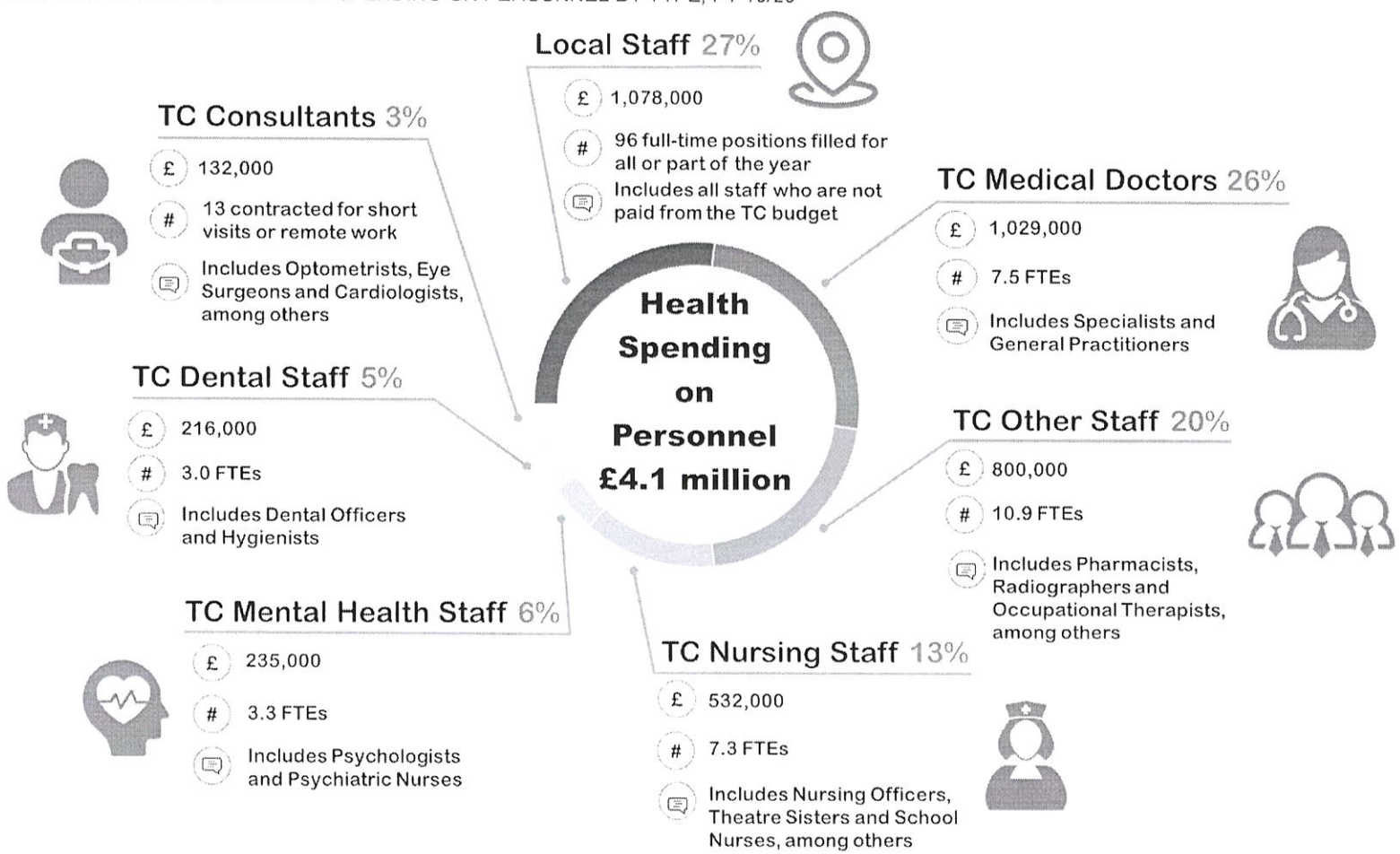
[7] As of March 2020, one of the local positions and two of the TC positions were vacant.
[8] These figures include one TC medical doctor who converted to a locally-funded position in March 2020.

2.15 In addition to TC employees, the Directorate's £132,000 TC consultancy spend allowed it to engage a variety of individuals for short-term visits and remote work throughout FY 19/20, including:

- Six visiting medical staff, including a cardiologist; an ear, nose and throat specialist; and an eye surgeon;
- Three locum specialists, consisting of two biomedical officers and a radiographer;
- Other miscellaneous service providers, including contractors supporting the electronic patient record system.

FIGURE 8. HEALTH DIRECTORATE SPENDING ON PERSONNEL BY TYPE, FY 19/20



Source: Audit St Helena analysis

Note: TC spending totals include relocation, salary and allowance costs but exclude recruitment costs, which are 2.0% of overall TC costs.

Directorate leadership told us the number of medical doctors is appropriate but the skills mix should be re-calibrated.

2.16 Directorate leadership told us that the total number of medical doctors in St Helena is appropriate for its population size and income level.[9] As reported in paragraph 2.14, the Directorate employed 7.5 medical doctor FTEs in FY 19/20, supplemented by additional doctors on short-term consultant contracts. See Part Three for comparisons of the number of doctors in St Helena to those in various other countries.

2.17 Notwithstanding their satisfaction with the number of doctors, leadership told us the skills mix may be wrong. Primarily this is because there are fewer full-time GPs than needed. Because of this, and the fact that locums are not typically brought to cover GPs' off-island leave, medical doctors with other specialties are often asked to spend some of their time servicing GP appointments. Rather than relying upon non-GPs to spend some of their time as GPs, Directorate leadership would prefer to recruit GPs who have additional specialties. Further, given St Helena's aging population and relatively high incidence of diabetes, there is a need for doctors with expertise in geriatrics and nephrologic (kidney-related) problems.

Various challenges hamper recruitment of medical doctors.

2.18 According to leadership, the Directorate has found the recruitment of suitably qualified and experienced medical doctors to St Helena to be an ongoing challenge in part because versatile generalists have become harder to find. Doctors increasingly tend to specialise in areas outside general practice, and often specialise again within that chosen specialty. For example, instead of an ophthalmologist who treats a range of eye conditions, he or she may instead treat only certain conditions or perform only certain kinds of surgeries. Doctors with such specialties are not likely to be as interested in staffing GP clinics dealing with general health issues as they would be asked to do in St Helena, an arrangement that could lead to more complaints or increased risk of litigation. In addition, spending multiple years caring for a small community can lead to loss of skills currency because doctors will treat fewer uncommon cases and, with limited professional development opportunities, may struggle to keep up with advances in their field. More generally, foreign doctors who work in St Helena (as well as nurses and specialist staff) will likely have to cross-train in multiple areas whereas in the UK or South Africa they may be able to concentrate on fewer techniques. While the Directorate is assisted by a search firm to identify promising candidates, it has past experience with a more extensive relationship where an outside agency supplied and managed the island's doctors.

[9] The conversations with leadership reported in this paragraph and the next occurred before the initial Portfolio Director of Health and Social Care was appointed in June 2021.

Regulations governing recruitment of medical doctors changed in 2019 but these may require further revision.

2.19 Recruitment of medical doctors is governed in part by St Helena's Medical Practitioners Ordinance, originally passed in 1910 and amended numerous times. For much of its existence the ordinance allowed people to practice medicine on the island only if (1) they were qualified to practice in the UK or (2) they met the requirements of a subsequent regulation that specified other acceptable qualifications. Before 2019, the latter generally took the form of legal notices naming individual countries to be added to the list of acceptable places from which doctors could be hired – for example, Guatemala, Italy and South Africa[10]. If a doctor was qualified to practice medicine in those countries, they would now be qualified to practice in St Helena. These regulations typically allowed a promising candidate that had already been identified from such a country to begin work, and were issued by the Governor as recommended by the Chief Medical Officer.

2.20 In 2019, an amendment to the Medical Practitioners Ordinance was enacted that changed how new medical doctors could be approved. Instead of requiring that the Governor add specific countries to the schedule of acceptable origins in order to recruit doctors from new places, the amended ordinance authorises the Governor to appoint individual doctors as recommended by the Directorate. In addition, according to the amended ordinance, this recommendation would now come from the Director of Health rather than the Chief Medical Officer. Notwithstanding the departmental management hierarchy, this latter change appears regressive because the Directorate's Chief Medical Officer must be a medical professional with clinical experience, while the Director of Health is not required to have such a background.[11]

2.21 The Directorate relies on its judgement, its search firm and Corporate Human Resources to assess potential candidates. This is different than in the UK, where the General Medical Council (GMC) is the independent regulator for medical doctors. In this role the GMC decides which doctors are qualified to work in the UK, oversees UK medical education and training, and sets the standards UK doctors need to follow throughout their careers. According to Directorate leadership, every doctor recruited to St Helena undergoes extensive vetting to ensure their qualifications are "GMC equivalent". However, in the absence of an independent regulatory body to serve as the gatekeeper for acceptable qualifications in St Helena, that assessment of GMC equivalence is inherently subjective and the arbiter is not qualified to make such a judgement independently. Accordingly, the ordinance regulating the appointment of medical practitioners should be revisited and strengthened. The need for performance indicators that ensure clinical quality is also heightened.

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[10] The full list through 2019: Guatemala, India, Ireland, Italy, Pakistan, Saudi Arabia, South Africa, Sweden and the United States of America.

[11] According to the recently appointed Portfolio Director of Health and Social Care, recommendations to the Governor on the hiring of medical doctors will now come from the Portfolio Director as advised by the Chief Medical Officer.

THE DIRECTORATE'S OPERATIONAL PERFORMANCE IN FY 19/20

The Directorate did not meet 11 of its 28 performance targets for FY 19/20.

2.22 In Part One we assessed the ability of the Directorate's performance indicators and targets to adequately measure its performance against the strategic priorities identified in its strategic plan. Notwithstanding the recommendations we made to improve those indicators and targets, in this section we use the Directorate's self-reported results as published by SHG's Corporate Services to assess whether or not it achieved its objectives for FY 19/20.

2.23 Appendix One presents the Directorate's results for each of its performance indicators for each quarter of FY 19/20, grouped by strategic priority. From this data we conclude that:

- **The Directorate maintained equitable and proportionate access to the range of local health services it tracks, except for elective surgery**. The Directorate exceeded its targets for country clinic opening times (100% open against published times), denture waiting lists (a 39% reduction in the number of patients on the list) and routine doctor-led appointments (patients seen in fewer than 10 working days 90% of the time). Further, it successfully developed a business case and secured funding for a psychiatric intensive care unit. While there was no target for the percentage of patients who have elective surgeries within 12 weeks, the Directorate's result was fairly high (89%) and its intended maximum waiting time is shorter than in the NHS, where the corresponding target is 18 weeks. Finally, it was unclear whether a baseline was established for the number of people with registered disabilities who receive an annual health check.

- **The Directorate failed to expand the preventative healthcare services as intended**. According to the data, only one member of the Health team received brief intervention training during the year, against a target of 90% of staff who have patient contact. Only 3% of smokers who "seriously wish to quit" attended community nurse smoking cessation services against a target of 50%, and in Quarter 4 only 11% of those who attended had quit after 4 weeks against a target of 25%. The Directorate did not develop an electronic patient record that captures body mass index (BMI), in part owing to its ongoing struggle with the implementation of its latest electronic patient record system (see paragraph 1.18). The only target the Directorate met in this group was for children's weight screening, where it managed to screen all consenting children against a target of 90%. Notwithstanding these individual results, in September 2020 the Directorate won a United Nations award for the prevention and control of non-communicable diseases recognising its promotion of healthier lifestyles through 2019, after nomination by Public Health England.

- **The Directorate did well in protecting the population from clinical, environmental and other health threats and emergencies.** It has exceeded its targets for five out of six indicators – there have been no incidents of Methicillin-resistant Staphylococcus aureus (MRSA) bacterial infections, all planned port health clearances have been conducted, 95% of pest control services were undertaken within 10 days and all food and water-borne disease outbreaks were investigated. Further, the laboratory maintained its ISO 17025 accreditation – the standard that demonstrates technical competence in laboratories. The only target the Directorate did not meet was in developing a clinical audit plan.

- **The Directorate had some success addressing diabetes in St Helena's population, however it is not possible to assess its progress in tackling other long term conditions such as hypertension and kidney disease.** The Directorate performed well against the targets set for the diabetes-related indicators in this group. By the end of Quarter 4, 67% of registered diabetics had received an annual HbA1c check[12] against a target of 60%. The percentage of registered diabetics with poor control fell from 46% to 42% between Quarter 1 and Quarter 4, with the Directorate aiming to remain under 50% for that indicator. Further, at least 79% of diabetics received annual retinopathy screening[13] against a target of 60%. However, for the two other diseases the Directorate says it wants to address – hypertension and kidney disease – no data was available from the Directorate to track progress. The indicator for hypertension is to establish a hypertension database, which the Directorate says is still in progress; we reported in Part One that no indicator exists for kidney disease care.

- **The Directorate provided specialist and tertiary care through overseas referrals to South Africa and the UK, however it is unclear whether this was sustainable or affordable.** Eighty percent of category 2 patients[14] departed for treatment within 3 months of approval, with 20% being unable to leave due to the South African airports lockdown that began in late March 2020; the target was 90%. The Directorate was unable to maintain the average cost of overseas treatment per patient due to a number of high cost cases (further analysis of overseas referral costs for the year is provided in paragraph 2.8). Its final target for the year for this group was to achieve a memorandum of understanding (MOU) with another country for a medical partnership. The Directorate reports that it explored opportunities with the government of Mauritius and has drafted such an MOU, however we were told this has not yet been signed due to the Covid-19 pandemic.

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[12] A test which measures a person's average blood sugar levels for the previous 2 to 3 months.
[13] A type of eye test which checks for eye problems caused by diabetes.
[14] Medical referrals are triaged into four categories based on how quickly patients need to depart: category 0, as soon as possible; category 1, within 1 month; category 2, within 3 months; and category 3, within 12 months.

- **The Directorate did not provide data that would help determine whether St Helena's existing and emerging health workforce needs were adequately met for the year.** The Directorate had two indicators for this group: (1) the percentage of defined core clinical conditions filled year round and (2) the percentage of incumbent TC posts with planned transition arrangements in place. Both have targets of 90%. The Directorate did not provide FY 19/20 data for publication in SHG's performance reports for either of these indicators.

- **While both of the tracked targets were met, it is not possible to tell whether community engagement and patient experience actually improved using the Directorate's indicators.** The Directorate consistently in each quarter had 80% of contact points stocked with feedback forms against a target of 75%, and responded in a timely fashion to 100% of complaints received in Quarters, 2, 3 and 4, missing its target of 90% only in Quarter 1, where it responded to 83% of complaints. However, as noted in Part One, neither of these indicators measure actual engagement or client experience.

The Directorate's performance reporting was incomplete for FY 19/20.

2.24 The Directorate did not fully report its performance results for FY 19/20. As described above, there were several instances where the Directorate failed to report results to SHG for its suite of performance indicators. In one instance the Directorate noted that a key staff member had been assigned to Covid-19 preparedness duties and as such was not available to assist with reporting. In addition, Directorate leadership told us that their time off island during Quarter 3 likely contributed to the Directorate's incomplete reporting for that period.

Part Three

Benchmarking against Other Places

3.1 In order to put into context the performance of the Health Directorate and the resources it used, this section attempts to provide some comparisons with other countries, territories and healthcare systems. While the Directorate provides a wide range of services as described in previous sections, we have focused our benchmarking on two key areas of healthcare provision:

- Access to primary care, including GP appointments, emergency services and out of hours access to services as well as the island's primary care resourcing; and
- Hospital care services, including urgent and emergency services, planned care and cancer services as well as the island's hospital resourcing, and overseas medical referrals.

3.2 We developed a set of audit questions for each area under investigation, summarised in Appendix One.

ACCESS TO CARE AND OTHER BENCHMARKS

The Directorate is unable to provide complete data on waiting times for patients in both primary and secondary care but some comparisons with the NHS are possible.

3.3 We attempted to benchmark various waiting times throughout the patient journey in order to compare the efficiency of the health service on St Helena with that of the NHS. The NHS collects vast amounts of data on waiting times from various points of entry – three of the most fundamental are discussed below.

Primary care – General practice

3.4 Most people in England are registered with a GP in their local area. GP appointments are usually the first point of call for people who are feeling unwell and need to see a qualified doctor for diagnosis and treatment – also known as routine appointments. GP bookings usually happen online or by telephone, and the NHS has started attempting to track the numbers of GP bookings across England on a month by month basis, as well as the length of time it takes to get an appointment with a GP. However, NHS Digital – the body responsible for collecting the data – note that the data contains only that information captured on the GP practice systems, which does not represent all work happening within a primary care setting or assess the complexity of activity. The data is also defined as "experimental statistics", meaning it is still in the testing phase and therefore subject to quality limitations.

3.5 According to the data, from April 2019 through March 2020 (St Helena's FY 19/20) there were a total of 299 million GP appointments recorded as booked in the NHS. Of these, 42% happened on the same day, 68% occurred within 7 days and 82% happened within 14 days of being booked. Over the same period in St Helena, the Health Directorate reported meeting its target for routine doctor-led appointments occurring within 10 days 90% of the time, however it is unable to provide the underlying evidence for this. Taking both sets of information at face value would indicate that St Helena's waiting times for routine appointments are shorter than those of the NHS, but we cannot say how many appointments occurred within other time frames, for example on the same day.

Secondary care – Referral to treatment

3.6 Under the NHS constitution, patients have a legal right to start treatment within 18 weeks of a GP referral unless they choose to wait longer or if there is a clinical reason for doing so. In England, around 72% of admitted patients met this target for FY 19/20, with a median waiting time of around 10 weeks.

3.7 The Directorate has a target of 12 weeks for waiting times for elective surgery, and in FY 19/20 89% of surgeries happened within this time frame. However the median waiting time is not available for comparison to the NHS, nor is data on the proportion of cases that started treatment within 18 weeks. Again, we did not have access to the underlying data for St Helena nor do we have data on waiting times for those patients referred overseas.

A&E and Walk-in

3.8 In England, patients who injure themselves or feel particularly unwell and cannot wait to see a GP can admit themselves to the Accident and Emergency area at a local hospital. The handbook to the NHS constitution pledges a maximum waiting time of 4 hours for A&E admissions. The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within 4 hours. For FY 19/20, 84% of A&E admissions met the 4-hour standard, dropping to 75% for Type 1 cases (defined as Major A&E).

3.9 On St Helena, the hospital operates a 24-hour walk-in service for A&E and weekend consultations. Upon arrival, patients are triaged by a nurse and allocated suitable care based on the severity of the ailment. The Directorate cannot currently measure waiting times for these patients, a condition it should aim to improve as it upgrades its electronic patient record system.

Despite incomplete data on waiting times, the information we gathered indicates that St Helena residents generally enjoy expedited access to medical care relative to people living in England.

3.10 Many high-profile NHS standards for waiting times have not been met in several years, and Covid-19 has exacerbated these shortcomings. According to The King's Fund[15], an independent English charity, as of February 2021 it had been more than 4 years since the 18-week referral-to-treatment standard for planned care was last met, more than 5 years since the national 4-hour A&E standard was met and more than 6 years since the 62-day cancer treatment standard was met. Conversely, in St Helena GP appointments and A&E care are delivered with little to no wait, while referrals overseas for specialist procedures are scheduled for regular commercial flights or emergency evacuation, with treatment provided soon after arrival in private healthcare facilities via the Medical Services Organisation management contract with SHG.

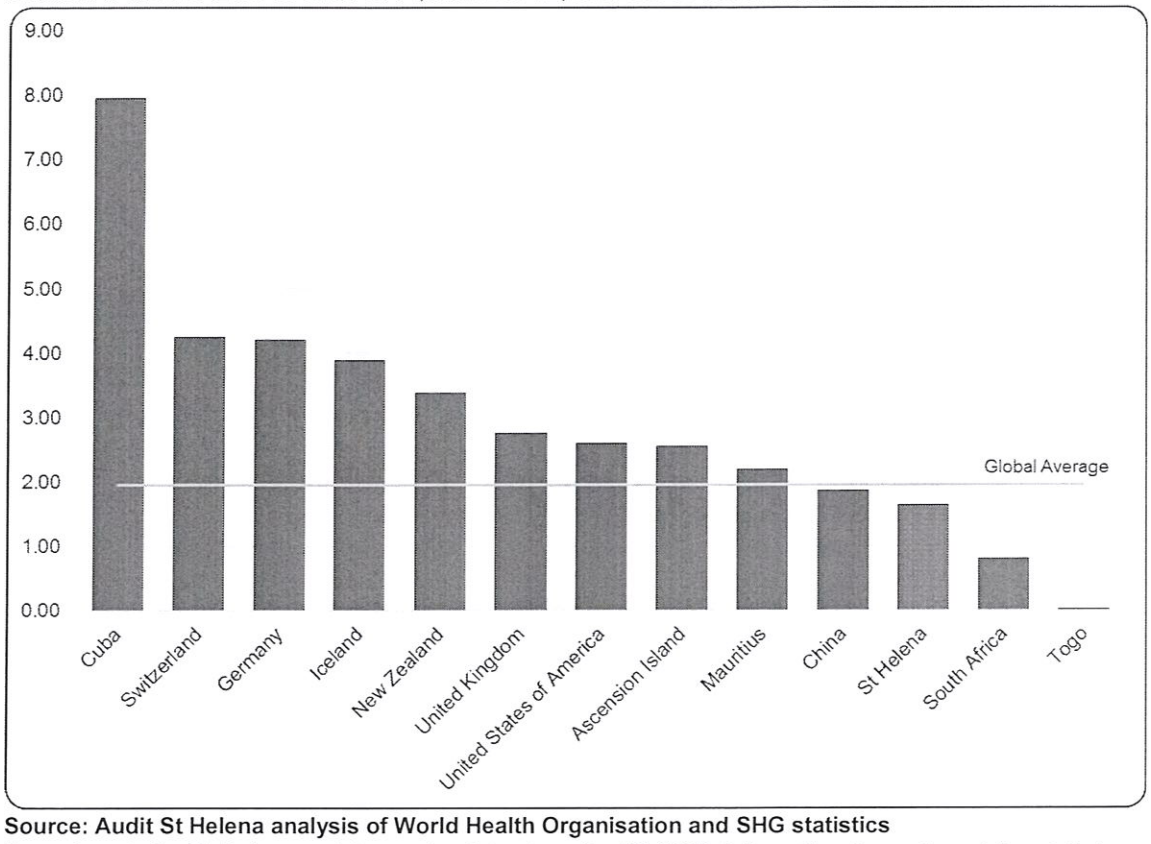
3.11 This speed of access to secondary and tertiary healthcare services by residents of St Helena as funded through the public purse would be experienced in England only by residents who purchase private health insurance or self-fund referrals into the private healthcare sector. All other patients accessing NHS services would experience significantly longer wait times from referral to treatment – an issue that has been further exacerbated by the Covid-19 pandemic with backlogged caseloads for elective surgery in particular.

[15] The King's Fund, *NHS Waiting Times: Our Position* (February 2021).

Compared to the rest of the world, St Helena had a below-average number of doctors but an above-average number of nurses.

3.12 In FY 19/20 St Helena had in an average month 1.64 medical doctors per 1,000 people. This is 0.31 fewer doctors per 1,000 people than the global average (1.95); 0.55 fewer doctors per 1,000 people than Mauritius (2.19), the country identified by the WHO as a health comparator for St Helena; and 1.12 fewer doctors per 1,000 people than the UK (2.76). St Helena having relatively fewer doctors may be partially explained by some secondary and most tertiary medical services being delivered overseas. Even so, St Helena had more doctors relative to the population than South Africa and most other developing countries. Figure 9 presents medical doctors per 1,000 people for selected countries and territories.

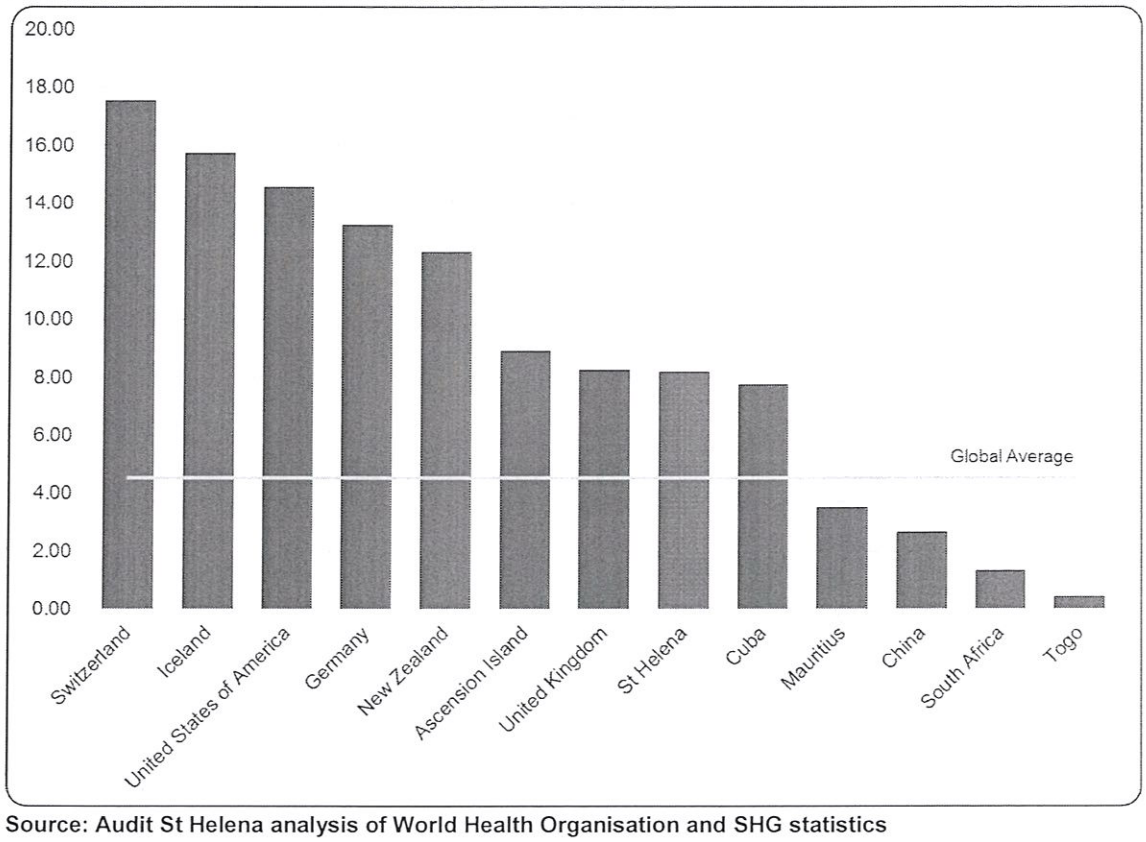
FIGURE 9: MEDICAL DOCTORS PER 1,000 PEOPLE, SELECTED COUNTRIES AND TERRITORIES



Source: Audit St Helena analysis of World Health Organisation and SHG statistics
Note: Counts for St Helena and Ascension Island are for FY 19/20. International counts and the global average are for 2016, the latest year available from the WHO.

3.13 During an average month in FY 19/20, St Helena had 8.18 nurses and midwives per 1,000 people. This is 3.66 more nurses per 1,000 people than the global average of 4.52, which could indicate that St Helena's hospital is fairly well staffed. Further, St Helena's number of nurses per 1,000 people is almost on par with the UK (8.22), as shown in Figure 10. It is worth noting, however, that as of December 2019 there was a shortfall in the NHS of around 35,000 nurses and midwives.

FIGURE 10: NURSES AND MIDWIVES PER 1,000 PEOPLE, SELECTED COUNTRIES AND TERRITORIES



Source: Audit St Helena analysis of World Health Organisation and SHG statistics
Note: Counts for St Helena and Ascension Island are for FY 19/20. International counts and the global average are for 2017, the latest year available from the WHO.

The mix of clinical and non-clinical staff in the Directorate was nearly identical to the NHS.

3.14 NHS Digital tracks the number of staff employed in the Hospital and Community Health Service (HCHS) in England month by month. At 31 March 2020 (i.e., the end of St Helena's FY 19/20), a total of 1.14 million people were working in HCHS. Of these, just over half (53%) were professionally qualified clinical staff, including doctors, nurses, health visitors, midwives and qualified scientific, therapeutic and technical staff.

3.15 At 31 March 2020, using the same definitions as NHS Digital, St Helena's Health Directorate had a total of 59 qualified or part-qualified clinical staff in post. This was 54% of the total staff included in our analysis (which excluded environmental services

and dentistry). Figure 11 shows that the proportion of clinical staff relative to all staff in the Directorate was nearly identical to that of the NHS's HCHS, and the same was true for the proportion of support and administrative staff, respectively.

FIGURE 11: CLINICAL AND SUPPORT STAFF IN ENGLAND AND ST HELENA

	Professionally qualified clinical staff	Support to clinical staff	Infrastructure and administrative support staff	Other staff
HCHS (NHS England)	604,265	350,036	183,064	2,058
As a proportion of all staff	53%	31%	16%	0%
St Helena Health Directorate	59	32	19	n/a
As a proportion of all staff	54%	29%	17%	n/a

Source: Audit St Helena analysis of NHS Digital and Health Directorate data

COMPARISON TO OTHER OVERSEAS TERRITORIES

St Helena's status as a remote island with a small population limits the number of comparators available for healthcare benchmarking.

3.16 St Helena is unique. Its remote geographical location and small population make it directly comparable to very few places in the world. While other sections of this chapter present benchmarking data on aggregate healthcare resources available across a selection of countries, this is harder to do for service provision for a number of reasons:

- Despite St Helena having a population of only about 4,500, the services required for those 4,500 are much higher than an average hamlet or village of a similar population. This is because in most other developed countries even the most rural areas will be densely populated enough for shared hospital provision across a number of towns and villages, with relatively short journey times between them (up to a few hours' drive). St Helena shares services for only the most complex cases, as the nearest alternative hospital facility requires medical evacuation by airplane.
- Similarly, rural areas in most developed countries will be a relatively short distance from the nearest specialist facilities. The specialist facility used by the Directorate for complex cases, located in Johannesburg, is approximately 2,300 miles away and in emergency cases requires evacuation by air.
- St Helena's small community and culture means that it has its own unique healthcare challenges which directly influence the policies that determine healthcare service provision on the island.

3.17 Given these unique characteristics, we selected places for benchmarking that match the following criteria:

- are British overseas territories, and are therefore subject to similar political and economic constraints and opportunities as St Helena;
- have populations less than 5,000, therefore subject to similar service needs for small places; and,
- are islands, meaning that medical evacuation by ship or by air is required for emergencies and specialist care not available in the territory.

3.18 This section attempts to provide some meaningful comparisons in terms of overall healthcare budget, services and facilities available at the hospital, nature of medical evacuations and healthcare challenges in the following territories:

- Ascension Island
- Falkland Islands
- Montserrat
- Tristan da Cunha

We acknowledge that these are imperfect comparators. For example, the Ascension Island and Falkland Islands economies benefit from a prominent military presence, and Ascension has a predominantly working-age population due to its requirement that prospective residents have an employment contract or accompany someone who does. Montserrat's society is still recovering from a disastrous volcanic eruption in 1995, while Tristan da Cunha is one of the most remote and least populous places in the world. Each of these characteristics affects public health and the resources available to devote to it. Still, in addition to the three bulleted criteria in paragraph 3.17, territories like these are good reference points because they are familiar to many St Helenians.

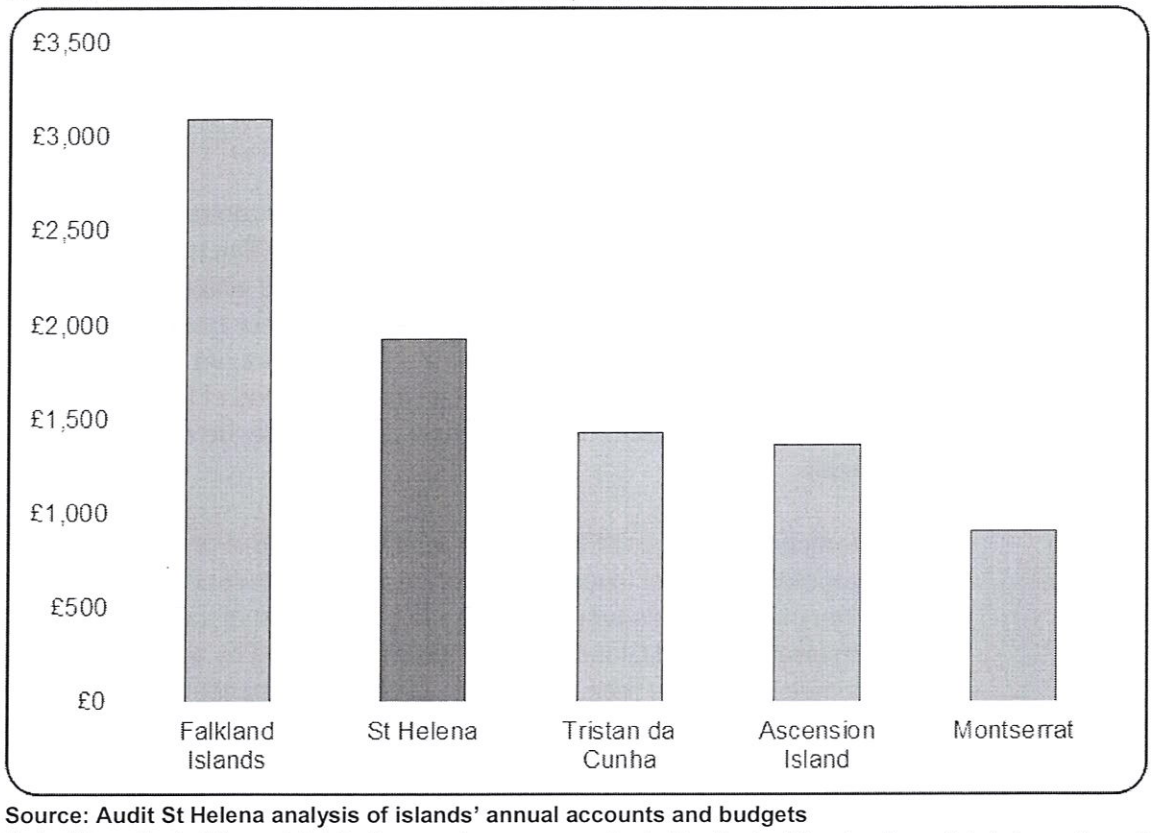
3.19 During the audit, we contacted the heads of government and healthcare departments in each territory with a data request. This yielded mixed results, so where data is missing we attempted to fill the gaps with online research into annual budgets and other sources to arrive at the below conclusions.

In FY 19/20 the Falkland Islands spent more per person on healthcare than St Helena, while St Helena spent more per person than Ascension Island, Tristan da Cunha and Montserrat.

3.20 The Falkland Islands has the strongest of the selected territories' economies, resulting in a relatively large annual healthcare spend of £3,100 per capita. St Helena spent about £1,900 per person on healthcare in FY 19/20, £500 more than Ascension Island and Tristan da Cunha which both spent roughly £1,400 per person on very different populations. Montserrat, the only one of these territories with a private healthcare system supplementing the public one, had a public budget of £900 per person in FY

19/20. Figure 12 summarises our findings on healthcare spending per person in the territories we selected.

FIGURE 12: HEALTHCARE SPENDING PER PERSON, SELECTED TERRITORIES



Source: Audit St Helena analysis of islands' annual accounts and budgets
Note: We collected financial data from various sources, including budget books, financial statements and correspondence with territorial officials. Data is annual from the 2018/19 and 2019/20 financial years.

3.21 St Helena's healthcare spending per capita was lower than in many developed economies. According to the Office for National Statistics, the UK in 2017 spent £2,900 per person on healthcare. The median expenditure for member states of the Organisation for Economic Cooperation and Development was also £2,900 per person, and the median for the EU15 countries was £3,700 per person.

Several of the overseas territories have recently upgraded their medical facilities or are now doing so, and facilities available on St Helena compare favourably to those in the other territories.

3.22 A number of territories have recently completed or are undertaking work to upgrade their hospital facilities in order to improve service provision. As noted in paragraph 2.8, the Jamestown hospital refurbishment was completed in June 2017 for a cost of £3 million, paid for by the then Department for International Development[16] (DFID) funded

[16] In September 2020 the UK's Department for International Development merged with its Foreign and Commonwealth Office to form the Foreign, Commonwealth and Development Office.

Capital Programme. The works involved improving health and safety, purchasing new equipment such as a CT scanner and upgrading the surgical suite to allow for a wider range of procedures to take place on-island. Our 2019 report on the project identified its three main goals as (1) reduce overseas medical referrals, (2) improve the quality of healthcare available on St Helena and (3) prepare for increasing healthcare demands. Our report concluded that the project was on track to deliver value for money, a conclusion strengthened when we consider the much higher capital expenditure per person on hospital upgrades in other territories.

3.23 In Tristan da Cunha, DFID funded a new healthcare centre, the Camogli Hospital, which opened in June 2017 at a cost of £8.3 million. The new facility replaced the old hospital built in 1971. The project provided the island with two doctor's consulting rooms, two patient wards, a dispensary, an emergency treatment room, an X-ray room, a small pathology laboratory, a large operating theatre, an instrument sterilisation suite, two dental surgery rooms and a dental laboratory. One of the aims of the project, like the Jamestown hospital refurbishment, was to reduce the number of overseas medical referrals.

3.24 In Montserrat, another DFID-funded hospital upgrade is underway as part of the government's Capital Investment Programme for Resilient Economic Growth. One of the key outputs of this programme is the construction of a new hospital. In 1995, Montserrat's 66-bed Glendon Hospital was destroyed by a volcanic eruption soon after its completion. Since then, emergency and secondary healthcare has been offered at a makeshift 30-bed hospital created by repurposing a former school. DFID and the Government of Montserrat agreed to the construction of a new 24-bed hospital with a modular design to accommodate daily peak demand of 31 on the current Glendon Hospital site. While how much of the capital programme's £30 million budget the hospital project will consume is still to be determined, the government's Head of Programme Management told us this project will receive the most significant portion of the funding.

3.25 The Falkland Islands budget for FY 19/20 allocated £24 million to "health and wellbeing services", including refurbishment of the hospital. This was followed by a £25.3 million outlay for health and wellbeing services including "hospital improvements" in FY 20/21. Although the proportion of these sums dedicated to capital improvements at the hospital is unclear, it appears to be a significant investment.

3.26 Figure 13 summarises some of the key facilities at the selected territories' medical centres. From our sample of territories, St Helena's hospital seems fairly advanced:

- Its facilities are on par with those in the Falkland Islands, which has a much larger budget.
- While it has a relatively low number of beds for the size of the population, it is better equipped with more consultation rooms and a delivery suite.
- It was the only hospital in our sample of territories with an operational CT scanner.

FIGURE 13: HOSPITAL FACILITIES IN SELECTED OVERSEAS TERRITORIES

	No. of beds in hospital	Population per bed	Radiology	Emergency room	Laboratory	Operating theatre
St Helena	24	190	X-ray, CT scanner, ultrasound and mammogram	Resuscitation room and 2 emergency consultation rooms	Newly refurbished laboratory	Newly refurbished operating theatre; delivery suite
Ascension Island	9	89	X-ray and ultrasound	No emergency room	No laboratory	Fully equipped operating theatre
Falkland Islands	29	121	X-ray	Emergency room	Laboratory	Single theatre with anaesthetist facilities
Montserrat	30	155	X-ray and ultrasound	24-hour emergency room	Laboratory for routine tests	Single theatre equipped for general surgery and anaesthesia
Tristan da Cunha	2 to 4	123	X-ray	Emergency treatment room	Small pathology laboratory	Large operating theatre

Source: Audit St Helena online research and data provided by territorial officials
Note: Information in the table generally reflects conditions as of early 2021.

Appendix One

Our Approach and Evidence Base

Our three key lines of enquiry:	**1. What indicators does the Health Directorate use to measure performance in its provision of primary, secondary and tertiary care?**	
	Divided into key sub-questions:	• What are the Directorate's strategic objectives? • What are the Directorate's core activities? • How does the Directorate deliver those activities? • What are the Directorate's key performance indicators? • What are the Directorate's targets for those indicators, and are they set at the right level? • Are the indicators and targets measuring the right things to ensure the Directorate is successfully delivering its core activities and meeting its objectives? • How can the Directorate's performance measurement and monitoring improve?
	2. What do these and other indicators tell us about how the Directorate is performing?	
	Divided into key sub-questions:	• What proportion of SHG's budget did the Directorate consume in FY 19/20, in terms of both planned and actual spend? • How was the Directorate staffed, including Technical Cooperation resources? • What were other sources of significant expenditure? • Did the Directorate meet its performance targets for the year with respect to access to care and other indicators?

	3. How is the Directorate performing against international benchmarks?	
	Divided into key sub-questions:	• How does St Helenians' access to care compare to that of their English counterparts? • How does the number of doctors and nurses in St Helena compare to the rest of the world? • How does healthcare in St Helena compare to care in other UK overseas territories?
Our evidence base:	To answer these questions, we researched, reviewed and analysed the following documents and data: **From SHG,** annual budgets, financial statements, Technical Cooperation expenditure summaries and other accounting records for the Health Directorate and SHG as a whole; the island's 10 Year Plan, annual strategic plans and other sources of performance indicators; and relevant laws, regulatory ordinances and the litigation claims register. **From the Health Directorate,** annual performance indicators, targets and published performance reports; departmental organograms and staff lists, comprising both local employees and TC officers; patient feedback forms and the Directorate's complaint log; terms of reference for leadership positions; and an end-of-term strategic review from a recent Director of Health. **From international sources,** healthcare performance indicators, targets, waiting times and workforce statistics from England's National Health Service and National Institute for Health and Care Excellence, the Organization for Economic Cooperation and Development, and the World Health Organisation; indicators and resource levels from Ascension Island, Falkland Islands, Mauritius, Montserrat, Pitcairn Island, Tristan da Cunha and Wales, among other nations and territories; the United Kingdom Foreign, Commonwealth and Development Office's annual assessments of SHG grant performance; and United Nations resolutions setting global heath targets. Throughout our work we interviewed and corresponded with officials in the Directorate, including leadership, administration and management, finance, medical records and clinical governance. Finally, while we reviewed relevant academic literature for certain key topics, such as diabetes care, our scope did not include consultation with health specialists beyond those at the Directorate and in the UK overseas territories. We conducted our audit work from July 2020 through June 2021, followed by a draft review and comment period with the Directorate prior to publication.	

Our conclusion:	Delivering quality healthcare services in remote locations is a demanding endeavour even with St Helena's mix of public and private sector provision. Staffing is clearly one of the Health Directorate's major challenges, and one that has yet to be overcome. In FY 19/20 the Directorate spent more than any other SHG department on TC resource, but recruitment of medical doctors with the right skills continues to be an obstacle. Despite this, the Directorate manages to deliver a substantial number of services for the population across primary, secondary and tertiary care. Moreover, comparisons with other countries show that St Helena has a sufficient number of doctors and nurses when fully staffed, given its relative size and resource level, along with a reasonable range of medical facilities. St Helena residents generally receive care more promptly than their English counterparts, and overseas referrals, while costly, provide patients with vital specialist care not available on-island, often in private facilities. In essence, St Helena enjoys the benefits of a private healthcare model through direct taxpayer funding. However, this high level of service comes at a high cost. Spending on healthcare in recent years has approached a quarter of SHG's operational spend, in part because of the reliance on TC resource, and overseas referral costs are hard to control. Given this level of public expenditure and the expectation that the cost of health services will continue to increase as a function of an aging population and more expensive healthcare interventions, the long-term financial sustainability of the current publicly funded private healthcare model is in question. As such, SHG should consider whether a national healthcare insurance scheme similar to those established in other UK overseas territories would be appropriate to help meet the escalating cost of health provision in St Helena. Turning to performance measurement, our analysis points to a number of areas in which the management of the Directorate could improve. Firstly, while the Directorate has made progress in maturing its set of performance indicators, they do not adequately measure the population's access to basic healthcare services. Secondly, there is limited data available as to the quality or effectiveness of the services themselves – a critical deficiency given the absence of a UK-style regulator of medical providers. Thirdly, the Directorate's ability to collect, report and analyse even the most basic patient data – such as the number of patients seen over a set period, their reasons for seeking care and how long they wait to receive it – is many years behind what more advanced healthcare systems such as the NHS are able to do. Collecting this fundamental data depends upon the ongoing project to install a new electronic patient record system, which should be prioritised so that these issues can be resolved as soon as possible.

Appendix Two

The Health Directorate's Performance Indicators and Results for FY 19/20

Strategic priority	*Performance indicator*	*Target*	*Reporting frequency*	*Q1*	*Q2*	*Q3*	*Q4*
1. Maintain equitable and proportionate local access to a range of health services in partnership with the community for all and the most vulnerable	Percentage of doctor-led country clinics open against published opening times	90%	Quarterly	99.9%	100%	No data	100%
	Percentage reduction in the number of patients on the dental clinic denture waiting list	25%	Quarterly	13%	18%	25%	39%
	Establish baseline percentage for those with registered disability who access annual health check	Establish baseline	Annually			All patients with a severe and enduring mental illness have had an annual physical check and this will continue each year	
	Waiting times for elective surgery maintained at less than 12 weeks for patients who are fit for surgery	Wait list less than 12 weeks	Quarterly and yearly	No data	No data	No data	89%

Strategic priority	*Performance indicator*	*Target*	*Reporting frequency*	*Q1*	*Q2*	*Q3*	*Q4*
	Waiting time for routine doctor-led outpatient appointments maintained at less than 10 working days 90% of the time	90%	Monthly				100%
	Establish funding and planning for a secure acute mental health facility to care for acute mental health clients	Business case and funding approval	Annually			This has been agreed by Health Directorate and Public Health Committee. The room has been designed and Planning Department has been consulted	Business case developed for a Psychiatric Intensive Care Unit. Project approved as a micro-project under the Economic Development Investment Programme for delivery in 2020/21
2. Expand preventative healthcare services and promote healthy lifestyles for everyone	Train 90% of staff who have patient contact in brief intervention	90% by end of the year	Quarterly	No data	No data	One member of team attended the Stirling University 'brief intervention' training and will be a mentor to other participants	No data

Strategic priority	*Performance indicator*	*Target*	*Reporting frequency*	*Q1*	*Q2*	*Q3*	*Q4*
	Percentage of the proportion of smokers who 'seriously wished to quit' attend community nurse smoking cessation service	50%	Annually				3%
	Achieve a 25% quit rate at 4 weeks among clients attending the smoking cessation service	25%	Monthly	19%	0%	No data	11%
	Develop an electronic patient record that ensures accurate capture of BMI	BMI electronically captured	Annually				Electronic patient record system in development
	90% of school children with consent have annual weight screening completed	90%	Annually	97%	97%	97%	100%
3. Protect the population from clinical, environmental and other health threats and emergencies	St Helena healthcare acquired MRSA bacteremia infections maintained at zero	No cases	Quarterly	0	0	0	0
	Establish an audit plan	Completed audit database	Annually				Development of an audit plan in progress
	Percentage of planned port health clearance conducted	100%	Annually				100%

Strategic priority	*Performance indicator*	*Target*	*Reporting frequency*	*Q1*	*Q2*	*Q3*	*Q4*
	Percentage of requested pest control services delivered within 10 working days	>70%	Quarterly	No data	97%	98%	95%
	Percentage of reported food and water-borne disease outbreaks investigated	100%	Annually				100%
	Maintain food and water laboratory service and accreditation	Pass	Annually		Assessment complete, awaiting results	ISO 10725 accreditation received	Both maintained
4. Tackle the high prevalence and incidence of chronic long term conditions among the population (diabetes, hypertension and kidney disease in particular)	Percentage of registered diabetics that receive annual HbA1c check	>60%	Monthly	35%	No data	No data	67%
	Percentage of registered diabetics that receive annual retinopathy screening	>60%	Quarterly	23%	36.8%	No data	19%
	Percentage of registered diabetics with poor control	<50%	Monthly	46%	No data	No data	42%
	Establish a hypertension database	Database established	Annually				Being developed as part of the electronic patient record system

Strategic priority	*Performance indicator*	*Target*	*Reporting frequency*	*Q1*	*Q2*	*Q3*	*Q4*
5. Provide access to specialist and tertiary care in a sustainable and affordable manner	Percentage of category 2 overseas referrals that departed for treatment within 3 months from approval	90%	Quarterly	No data	No data	No data	80% – the remaining 20% were unable to depart within the timeframe due to South Africa airport lockdown 26 March 2020
	Maintain average cost of overseas treatment per patient	Maintain within budget	Quarterly	No data	No data	No data	Unable to be maintained due to a number of high-cost cases during the period in question. Medical referrals budget line overspent as a result of this
	Explore opportunities for partnership	Achieve memorandum of understanding	Annually				Opportunities explored with the Government of Mauritius. MoU drafted
6. Ensure that our existing and emerging health workforce needs are adequately met	Percentage of defined core clinical positions filled all year round	90%	Annually				No data
	Percentage of incumbent TC posts with planned transition arrangements in place	90%	Annually				No data

Strategic priority	*Performance indicator*	*Target*	*Reporting frequency*	*Q1*	*Q2*	*Q3*	*Q4*
7. Improve community engagement and patient experience of the local health service	Percentage of contact points with feedback forms for service users	75%	Monthly	80%	80%	80%	80%
	Percentage of complaints received that are reviewed and responded to within the agreed timeline	90%	Quarterly	83%	100%	100%	100%

Source: SHG Corporate Services as supplemented by Health Directorate in response to Audit St Helena queries
Note: Some text has been edited for clarity.

Appendix Three

Recommendations Summary

Number	Recommendation
1	To ensure its performance measurement system establishes key benchmarks and adequately measures performance against its strategic objectives, the Directorate should: a) Introduce performance indicators that assess clinical quality as indicated by patient outcomes, such as those published by the NHS. b) Introduce performance indicators that measure access to emergency care, semi-urgent care, general mental health services and general dental services. c) Introduce performance indicators that measure the prevalence of kidney disease and the efficacy of interventions to reduce it. d) Consider raising its target for the percentage of known diabetics exhibiting control of their disease as measured by blood sugar levels.
2	The Directorate should urgently prioritise the establishment of an electronic patient record system that can address the needs of all users and in particular can produce timely reports required by those users.
3	The Directorate should establish a process, possibly using the new electronic patient record system, to monitor and track waiting times for GP services, referral to treatment and A&E.
4	Given the ongoing challenges faced in the recruitment and retention of appropriate medical doctors, the Directorate should work with the Attorney General to strengthen the appointment regulations and review its methods for recruitment of health professionals, including the potential restoration of an agency relationship for the provision of qualified healthcare staff.
5	SHG should examine the advantages and disadvantages of creating a national healthcare insurance scheme that would establish an investment-backed fund designed to meet the long-term health needs of St Helena's population, including the cost of overseas medical referrals.