Friends of Our New Hospital

Our objective is to create and sustain a public campaign to assist our Government in completing the construction and commissioning of a new hospital within four years from the date of the construction contract. To accomplish our objective, we will act as an independent and objective source of information, commentary and advice on Island Health Care in general and, in particular, on the Government's 'Our Hospital Project', mobilizing public opinion and lobbying as we progress.

The Jersey Care Model - Submission to the Health and Social Services Scrutiny Panel

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Delivering a Care Model for Jersey

Introduction

1. As the Friends of Our (new) Hospital, we have real concerns about the proposed Jersey Care Model (JCM), its practicality, likely cost, the use of resources and its suitability as a model of care in this small island community.

2. The States has spent an enormous amount of money since deciding in 2012 that Jersey needed a new hospital. To the declared total of £40.2 million was added a further £5 million in March 2019 to cover the shutdown cost of the J3 contract, the closure costs on the project team and £1.8 million to cover the cost of the hospital catering facility in the St Peter's Industrial Park, a facility that it still not in use. To this total has now been added the start-up costs of the Our Hospital project of £7 million, a hospital that, according to the Chief Minister[1] could be ready for use by "2028 to 2030", in 10 years' time and in sharp contrast to the construction of a 1,000 bed emergency hospital in 10 days in Wuhan.

3. To this overall cost of £45.2 million and the £7 million start-up costs we have the yet to be determine cost of the JCM[2]. The ambition is for it to be within the current HCS operating budget, but we do not believe that this is possible, as the WS Atkins Report[3] clearly states that if 'Care in the Community' is not introduced there would be an additional requirement of 9,000 m^2 in the size of the new hospital and an additional cost of £60 million.

4. This paper is in three parts:

   a. Part One: Our concerns about the proposed JCM
   b. Part Two: What we have now (and it is pretty good)
   c. Part Three: What we need to enhance it (See Page 9).

Part One – Concerns About the Jersey Care Model

Hospital Size, Staffing and Costs

5. Our major concern is that, despite having had consultants reports on the necessary size of the hospital,[4] the Government is proposing to build "a much smaller hospital 200-bed"[5] compared to the 300-bed, 64,000m^2 hospital recommended by KPMG, WS Atkins and Gleeds Management Services.

6. A further concern is that do not have the nurses, carers, occupational therapists, physiotherapists and social workers to implement what is being suggested. Care in one's own home may require a considerable number of carers to 'service' an individual. Where are these personnel to come from? Will we be able to retain them? (See Annex A)

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[1] Chief Minister's address to the Chamber of Commerce lunch on Wednesday 15th January 2020
[2] By PWC, to be delivered between April and June 2020
[3] KPMG - States of Jersey A Proposed New System for Health & Social Services - Jersey - 25 May 2011
The Pre-feasibility Spatial Assessment Project study and Strategic Outline Case
[4] The Pre-feasibility Spatial Assessment Project study and Strategic Outline Case
Gleeds Hospital Functional Area Estimate (The Design Brief) September 2016
[5] Deputy Hugh Raymond, Assistant Health Minister on numerous occasions

7. We are unconvinced that what is proposed will be the best way forward economically, as the JCM has not been costed. It is naïve and ill-informed to suggest that, 'Care in the Community', on which the JCM is based, can simply be expanded by using part of the existing Hospital's operational budget and the staff currently employed in the building. The Hospital is at full stretch now and is understaffed with some wards closed due to this.

8. Currently, all Hospital treatment, in particular referrals to consultants and follow-up appointments after treatment, is free to the patient. Any work 'farmed out' to GPs, will have to be paid for by the patient, unless there is a change in funding arrangements, as GPs run businesses and it is unrealistic to expect them to provide a free service in support of the JCM.

A General Hospital

9. Jersey only has one Hospital There is nowhere else to go. It should remain the cornerstone and be at the heart of care for Islanders. It should be a General Hospital, to cater for the needs of all the population. It cannot be just an 'acute hospital', as Islanders from tiny babies to the very elderly, need to receive care for chronic conditions e.g. renal failure, chronic eye conditions, cancer treatments, etc.

10. Islanders wish to be reassured that 'Our Hospital' will contain all the facilities and departments currently available, including catering, and possibly others, e.g. radiotherapy, if appropriate. They wish it to remain a teaching and learning hospital with an education centre, including a lecture theatre, and to have room for future expansion. Only if that is in place will Jersey be able, as now, to attract the very best medical Staff to work here.

Hospital Bed Numbers

11. The proposal that the number of beds in the new Hospital is to be 200, rather than the figure of 296 recommended in the WS Atkins report, (See Annex B) a figure based on a net inward migration of 700 people per year, as opposed to the current rate of 1200+ a year does not make sense, as we already are facing bed shortages on a daily basis, leading to the 'Amber Alert' of mid-January 2020. Islanders need to be reassured that they can be admitted to Hospital if they need to be.

12. We appreciate that surgical techniques have improved, and recovery from operations is quicker nowadays, but this occurred prior to the Atkins report and not since. Treatment for complex medical conditions has not become dramatically speedier. i.e. the Atkins report is still valid.

13. Currently there is a mantra within the Hospital of getting patients out as soon as possible, leading sometimes to the need for a repeat treatment. Consultants, the professionals, rather than managers, need to be allowed to determine who stays in hospital and who can go home.

14. Meanwhile, the number of Private beds has been halved from 24 to 12, one ward having been closed, despite having 50% of households with private medical cover[6]. This has led to a current shortage of private beds and reducing a healthy income stream for the Hospital.

15. We applaud the incorporation of mental health beds and specialist facilities in the plan for the Our Hospital project, but within that aim will be the need for at least an extra 35 mental health beds.

16. The 'default' position of the JCM on bed numbers and early discharge need to be seriously questioned. Beds do not determine the size of a hospital, clinical needs do. We cannot take risks with Islanders' lives. Sometimes patients need to be admitted to Hospital and to stay there until they are better.

Outpatient Appointments

17. Islanders wish to be able to be referred for a Consultant's opinion, when needed. Some GPs have undertaken additional training in a specialist field, but if a Consultant's opinion is needed, surely this should be allowed and in a timely fashion?

Decentralisation into the Community

18. We need the evidence of how much the proposed decentralization will cost, including the additional numbers of Staff required. Is it going to maintain the quality of our healthcare at a lower cost? What is the balance between the current method of delivery and the cost, both in time and equipment, of dispersing facilities and healthcare staff around the island?

19. It might work in the NHS, but Jersey is a small island, with a land area of 9 x 5 miles. Is it really sensible to propose spreading physiotherapy around Parish Halls and supplying duplicates of expensive equipment as a result?

20. The most precious resource is our highly qualified Staff. It is a waste of their valuable clinical time to expect them to leave the Hospital and travel some half an hour to see patients at a Clinic in the east or west of the Island. Leaving the Hospital site also means that they are not then available for their acutely ill patients or other patients.

21. It is far better for patients to travel to the Hospital where all their treatment can be carried in one location with immediate access to other consultants should that be necessary. It would be crazy to duplicate expensive equipment for peripatetic use, rather than full-time use in the specialist department.

22. Where is the evidence that many small hubs will provide better, more economic care compared to a centralized, fully equipped and staffed department, particularly in a small island community? What about patient confidentiality, patient safety, safeguarding and infection control?

Integrated I.T.

[6] KPMG - States of Jersey A Proposed New System for Health & Social Services - Jersey - 25 May 2011, page 31

23. We need a robust, integrated I.T. system across all Primary and Secondary Care deliverers. The JCM cannot not be implemented before this is established, but when will this be?

Dealing with Long Term Conditions

24. Referred to in the JCM as 'commissioning', the outsourcing of routine specialist appointments to GPs' is very inefficient, and contracts would have to be continually upgraded, including continuing professional development (CPD) and the updating of equipment to deliver it in their surgeries**.** The current model of payment is better. It is simple.

25. Suggesting that what is delivered free in hospital now will be delivered free within Primary care, with the savings made within the hospital budget following the patient will bring with it a huge bureaucracy and be less efficient.

The Health Insurance Fund (HIF)

26. The support for those on low incomes, irrespective of age, is a social and moral requirement. The HIF is primarily designed to provide financial assistance to Jersey residents who need access to GP services, partially offsetting the consultation charge and meeting, in most cases, the full cost of drugs prescribed by the GP. This means that sometimes patients can be seen for 'free' i.e. for just a signature and that GPs can receive some payment for seeing the patient. It also provides a safety net for some children and vulnerable adults. If the JCM is pushed through, we believe that the HIF should be maintained for its primary purpose. Currently the fund is in a relatively heathy position, but, at the current rate of expenditure,[7] will run out in 2035. Therefore, the HIF should be increased and used to support those on low incomes, if necessary, making it a means tested, but tax free, benefit.

The Emergency Treatment Centre (ETC)

27. The JCM proposes to have the ETC as a part of the Emergency Department (ED), aka A&E. This has the potential to destabilise GP practices. We seriously question the value of, or requirement for, such a centre. We already have the fully staffed ED. Patients suffering from either an accident or an emergency should be the only ones treated in the ED. Otherwise patients should see a GP/ Dentist/ Pharmacist. GPs could be co-located in the ED (as now) outside surgery hours i.e. after 6pm each day and 12noon Sat- 0800 Monday.

Hubs

28. There are three types proposed in the JCM:

[7] Jersey Government Actuary's Report on the Financial Condition of the Health Insurance Fund as at 31 December 2017, published on 25th March 2019.

a. **The Virtual Hub -** How will this work? It is already possible for GPs to pick up the phone and to talk to their colleagues in the hospital. Why are we proposing to create some form of bureaucratic filter?

b. **The Community Hub** - The purpose of the Community Hub is unclear. Parish Halls already host various activities and, in the past, have happily hosted FNHC. Are we re-inventing something?

c. **The Care Hub** - The Care Hub is another part of the JCM and is being recruited for now[8] despite the PWC report on the affordability of the JCM and its stress testing not having been completed. It is unclear what these hubs are, where they are to be located, what they will deliver, or how they are to be funded, both in capital and running costs terms.

29. On a small island, is this really the best use of resources? Where is the evidence that the JCM model has worked in a small island community? Is Jersey ready for and can it afford an experimental health model?

[8] https://www.gov.je/Working/JobCareerAdvice/pages/JobDetails.aspx?JobID=77682&JobTypeID=5

Part Two – We Have Care in the Community

Measures Already in Place:

The Basics

30. We have:

a. An excellent Primary Care system.
b. Excellent Care by Hospital Staff.
c. Preventative immunisation and screening;
d. Ensuring clean water supplies, sewage, clean air.

Health Campaigns

31. Covering:

a. Exercise;
b. Healthy eating; Stop obesity;
c. Stop Smoking campaign;
d. Reduce alcohol intake; screening programmes.

Jersey Doctors on Call

32. Doctors on call:

a. Providing advice 24 hours per day, 365 days a year.
b. Island wide visiting

The Jersey Ambulance Service

33. The Jersey Ambulance Service within the Department of Home Affairs:

a. Completely staffed by paramedics who triage and stabilize patients before moving them to hospital
b. However, to increase its functionality it should:

i. Re-integrated it into the HCS?
ii. Deployed through a single Emergency Services Control Centre

Family Nursing and Home Care

34. The primary deliverers of Care in the Community:

a. Were expanded to deliver that care, as a part of the Care in the Community strategy (P82/2012)
b. Sadly, had their funding cut by DHSS in 2016.
c. With funding from HCS and a Service Level Agreement (SLA) this well-established charity could deliver the essentials of the JCM.

Re-enablement Teams

35. As a part on P82/2012 and the consequent Care in the Community programme these small teams:

a. Provide temporary support after a hospital stay, or to help prevent hospitalisation.
b. Should be deployed through consultants and ED (the experts)

Midwives in the Community

36. These:

a. Provide ante natal care
b. Supervise home births
c. Deliver post-natal care in the home

On-Island Training

37. At Highlands:

a. Local training of Nurses to degree level (Many more are needed)
b. Health Assistant training at Highlands
c. Social Workers

38. In the Hospital:

a. GPs (all except their final year)
b. Continued Professional Development

Note: Having trainee doctors in the General Hospital is the principal reason why we can attract the very best consultants. Guernsey does not do this and suffers as a result.

Home Based Services:

39. Covering:

a. Physiotherapy delivered from the hospital
b. Occupational therapy in people's homes
c. Essential equipment e.g. ramps, grab rails, shower chairs, wheelchairs, walking aids, commodes, furniture raisers.
d. Home care

The Voluntary Sector

40. The list of charities at Annex C is not exhaustive, but all contribute towards the well -being of Islanders within the context of the JCM.

Part Three - What Next?

41. We have a good Healthcare system in place now. To improve it we need to:

a. Ensure that mental health is regarded as equally important as physical health.
b. Tackle loneliness amongst the housebound.
c. Encourage walking groups, volunteering, physical activity classes, and adult education classes with emphasis on personal and community care.
d. Look seriously at the current model and make minor changes over time, if it makes economic sense to do so.
e. Return to 24-hour Hospice care
f. Expand FNHC to deliver 24-hour District Nursing cover, together with homecare and overnight carers.
g. Introduce a step-down care for those needing it to free-up hospital beds, possibly at Overdale, or expand the current facilities at Sandybrook.
h. Be more careful about early discharge of patients from hospital. It is not all about bed vacancies, particularly if there are enough beds.
i. Technology is improving all the time, particularly remote monitoring and should be embraced early, given the universal availability of high-speed broadband.

The Bottom Line

42. The Health Service is not broken, but it does need a new Hospital. That must be the Island's top priority. Without it, not only will we reduce the quality of our health care across the Island, but we will also lose our status as a teaching hospital to the detriment of our ability to recruit top class consultants. Therefore, we need to:

a. Stress test and cost the JCM through the PWC Report.

b. Publish the findings of that PWC Report

c. Assess whether, or not, it is affordable and offers a real improvement on what we have now.

d. Carry out a cost benefit analysis on the proposal to introduce nuclear radiology (LINAC machines – nuclear accelerators) or stay using the NHS centre of excellence at Southampton General Hospital.

e. Complete the Design Brief for our new General Hospital, as quickly as possible to determine the size of the overall hospital campus and the buildings and facilities on it.

f. Build the new hospital (Our Hospital) with the required focus, energy and with active political assistance in a period of 48 months from the signing of the construction contract and as a condition of that contract.

g. Ensure that the 'Our Hospital' project is an election issue in May 2022 if the construction contract has not been let by then with a completion date, at the latest, of May 2026.

Annex A

Workforce Requirements

Kings Fund Jan 14th, 2019

Growing shortages in key parts of the workforce present a significant challenge to plans to expand community services.

The total number of nurses working in NHS community health services fell by 14 per cent between 2010 and 2018 whereas the number working in acute adult settings increased by 9 per cent over the same period. The number of qualified district nurses has fallen particularly sharply, dropping by 42 per cent between 2010 and 2018.2 These numbers do not include information from all non-NHS providers; some (but not all) of the fall may therefore reflect staff transferring to non-NHS providers

Annex B

A Summary of the WS Atkins Report of 2012

Introduction

"This Strategic Outline Case has been updated to take account of the revised population projections for Jersey, based on the 2011 Census. The activity and capacity modelling, on which the hospital key functional content has been based, utilises actual healthcare activity information for 2011/12. This actual activity has been projected forward using the latest updated population projections at September 2012. The updated capacity model reflects the revised population projections delivered by the States of Jersey Statistics Unit. The model is based on the revised inwards migration scenario titled '+350' (assuming a net inwards yearly migration to the island of 350 people); further sensitivities utilising other migration scenarios have also been run ('+700' migration and 'net nil' inwards migration) to test the effect of different migration scenarios on overall bed numbers".

Bed Numbers

The content regarding beds can be found on pages 18/19/20

2.2.7. Analysis 39. The analysis of current activity based on 2011/12 data clearly demonstrates that there is considerable pressure on beds to cope with current demand. In addition, the way the current bed stock is configured does not allow them to be used as flexibly as desired. Re-provision of beds in a more flexible manner (utilising single rooms) is an imperative to allow sufficient capacity to cope with future demand. Key issues here are the use of single rooms and a shift towards 7 day a week operation for all elective beds. The model can identify future bed content if these assumptions are not instigated, but any future development would need to incorporate additional bed numbers if the planning assumptions are not met

Excluding Day Case beds/trolleys at present, the hospital had a bed complement of c.245 beds in 2010. Scenario 1 identifies that significant demographic pressures would require that bed complement to rise to 409 beds (an increase of 164 beds) by 2040 if strategies were not put in place to treat and care for patients in an alternative manner.

This Hospital Pre-Feasibility Spatial Assessment Project Strategic Outline Case: v.07 Date: 14th October 2013 speaks to a scenario of a simple continuation of the current acute care profile, described as a continuation of business as usual but is unsustainable in the longer term.

42. A further scenario (Scenario 3) is identified of which two variants are shown; one is the effect of partial achievement of the community and other strategies as described within the H&SS White Paper, and one for significant achievement. The detailed modelling that has occurred to augment Scenario 3 within the White Paper is fully described in the Strategic section of this SOC. The key issue in terms of future sizing of the hospital is the trimming of long lengths of stay (for all patient groups). The two sub scenarios correspond to Scenario 3 as termed in the White Paper and have been used to

identify the future scale of the hospital based on the extent and timing of achieving strategic change to care delivery.

43. By 2040 an additional 83 beds (totalling 328 beds) would be required under Scenario 3 – partial achievement and an additional 51 beds (totalling 296 beds) under Scenario 3 - full achievement.

44. Additionally the model identifies separately to the calculation of new hospital bed requirements, the increase in bed numbers required in the short term to alleviate current bed crises within the hospital. Bed number pressures will continue to grow up to the development of a new hospital and by 2017 it is anticipated that up to 50 additional beds will be required in the short term to enable the acute hospital to continue to function without being in permanent bed crisis. The calculation of additional short-term beds takes into account future growth, current shortages and also allows for the inefficient configuration of current beds in the hospital.

Annex C

Charitable Organisations Allied to the Delivery of Community Care

Brook Centre	Women's Refuge
Youth Enquiry Service	Men's Refuge
Autism Jersey	Churches
Bereavement service	Citizen's advice
Headway	Help against Domestic Abuse
Cancer support services	JEND
Community Alarms	Family Nursing and Home Care
Hospice	Cerebral palsy
Les Amis	Eating disorders
Macmillan	Motor neurone disease
CLIC Sergeant	Parish Help Groups
MASH	Prince's Trust
Milli's Child Contact Centre	Samaritans
NSPCC	Senior Citizens