Health, Social Security and Housing Scrutiny Panel

MONDAY, 14th APRIL 2014

Panel:

Deputy J.A. Hilton of St. Helier (Vice-Chairman)

Deputy J.G. Reed of St. Ouen

Senator S.C. Ferguson

Witnesses:

Chair, Primary Care Body

General Practitioner, Primary Care Body

[14:02]

Deputy J.A. Hilton of St. Helier (Vice-Chairman):

Good afternoon and welcome to the Health, Social Security and Housing Panel public meeting hearing with Dr. Nigel Minihane and Dr. Philippa Venn. We will start by introducing ourselves and then maybe you would like to introduce yourselves. I am Deputy Jackie Hilton, Vice-Chair of this panel.

Deputy J.A. Hilton:

Thank you. I would like to draw the public's attention to the notice on the chair, if they would like to just note those comments. Also I would like to offer the apologies of our Chair, the Deputy of St. Peter, who is unwell at the present time. Thank you very much for coming this afternoon. I would like to start by asking you if you could briefly describe your involvement in the process - this is the Health White Paper process - and whether there have been any significant milestones.

Chair, Primary Care Body:

I will begin, if I may. We have been involved to a degree since the White Paper was brought over by KPMG, effectively. We had concerns from the beginning, firstly about its value for money on the basis that a lot of it was based on work from the King's fund and there were difficulties in 2 main areas. One was workforce planning. There were a lot of assumptions around how people might suddenly be placed in jobs, so where nurses, for example, would come from. Then also the transition from where we are now to where we intend to get to. There was very little by way of transition planning in the early part. I am pleased to say that there has been a lot of work on that, which I will come back to, and other models around the world we hope are being looked at, so it is not just a U.K. (United Kingdom) model that everything will be predicated on. Initially the consultations were pretty unwieldy as well. Lots of people were invited, Uncle Tom Cobley and all, and maybe people had their views and it was right that they should be there but the key players really had a diluted voice in there and many of the people who came along were not aware of what the current situation was, never mind where we are trying to get to. Again, there has been more of a focus on the key players becoming the main part of the discussions going forward. We have noticed there has been a high workload for us in primary care, for example, trying to get here on time, as you see today, and we hope that we have put forward that if we are going to look at primary care being at the heart of what will be effectively mainly community care in the future, despite the new hospital, that there should be some time set aside for us, but protected time, so that we can participate appropriately in the steps, not just as they are planned strategically, but as they are rolled out in the future. We would like to look a little bit more at assessment of the estates and what our capabilities are. We will touch on this possibly again later, but we feel there have been a lot of assumptions made but very little by way of metrics in terms of what is possible out in the community at the moment, certainly from the general practice point of view. There were other aspects of the process which were concerning, particularly commissioning. I think I voiced this before. But commissioning is a U.K. model. It might work in the U.K. perspective in terms of the fact that there are many groups that could potentially be involved in providing care in the U.K. but it has been highly criticised and continues to be criticised even this week. The bureaucracy and the extra costs involved do not appear to justify the original aims. The extra money that has been produced over here has already had some perverse incentives. We have seen, and it is evident to look on the public websites, and in the directories, that there are a large number of nursing homes

that have sprung up and the Regulation Law that was planned, I think, for 2016 has already had to be expedited on the basis that there are concerns about whether the people being employed by such agencies are necessarily fit for purpose. So, in terms of how we move things forward in a commissioning model, there are further doubts around that. As I said, the change now has been to collaborative working rather than commissioning however, with key players. And we have this introduction of regulation of care standards. Sustainability is another issue that is part of this and it is something that concerns us. We feel as general practitioners the work should have been done first, and I think that is accepted all round. But it is now being addressed. Jersey Consumer Council are actively involved and we are participating with them. They are planning to do a qualitative study very soon, I think it starts in May, where they are looking at particular groups of individuals from different elements of society to put forward their views. The nice thing about this is that it is not just the people who would normally write to the *Evening Post*, they are people who are going to be selected because of where they are in society, and they will be given all the information around what are the pros and cons, even if they have vested interest or particular beliefs at the beginning of the project. We are concerned about the number of individuals who are now what we would describe on the cusp of affordability. Many of the general practitioners now are charging nigh on £40 or just under and I think that is a significant perverse ... not perverse incentive but disincentive to people coming in and we have seen certainly, as now a grey-haired G.P., the problems have become more complex. We have our own agendas because we have to meet quality standards, and very rightly so, but equally the patients want value for money so they are coming in and bringing in a long list of problems, which is difficult for us to get through in an appropriate time. That is indeed if they do come in. So if they are avoiding us the concern from our perspective, from the medical point of view, is that either problems will not be seen early or if they are seen later there will be a complex problem, which will be more costly either to the secondary care sector or the tertiary care sector. So we want to work towards equitable access particularly for vulnerable groups.

The Deputy of St. Ouen:

That seems to be quite a large agenda ...

Chair, Primary Care Body:

A nice summary, I hope.

The Deputy of St. Ouen:

... for yourselves as obviously spokesman for the Primary Care Body. Could you just confirm whether you received any remuneration undertaking these tasks that you have been given?

Chair, Primary Care Body:

We do not at present. Our remuneration is from our members so our members contribute an amount and we are given 2 amounts, a smaller amount if we manage to find time, our own time, to do the work, and if we have to cancel patients then a larger amount, but that is at the moment not just the political work. We feel that if we are working on behalf of our members like, for example, if we were doing work akin to a union then our members should be paying for that. If we are working strategically, however, to contribute to the White Paper and the ramifications of that and the roll out of the programme then perhaps the organisation as a whole should recognise our work.

The Deputy of St. Ouen:

Has anyone suggested to you how that recognition may be given?

Chair, Primary Care Body:

Following the mediation process, which I believe we will come back to, there was recognition that it was not appropriate for us to be exchanging emails at 11.00 p.m. at night and rushing between patients to do this sort of work. So I believe there is work behind the scenes looking to set an appropriate rate in order for us to step outside of our day-to-day commitments. The problem for us is that because of the way Jersey G.P.'s are paid we have to see patients in order for money to come into our practice, so there is a consideration every time we see a patient there is a large amount of that fee that comes in going to the infrastructure. In the U.K. that is slightly different. The infrastructure is paid for separately. There are global sums based on the amounts of patients that you have in the practice, for example, and other terms, which means that it is only the salary that you are replacing if you step out of working as a doctor. So it is proving a little complex in terms of calculating what it is that should be put forward, and again I believe no overall amounts have been agreed.

General Practitioner, Primary Care Body:

No, not yet. I think that is one of the limitations with the White Paper work, is that often the ... I think initially it was quite difficult to get our voice heard and there has now been - and that is one of the positives I think - a recognition that we need to use the clinical voice to help start to guide services and that is not necessarily just G.P.s. That is about secondary care conditions, community nursing staff, etcetera, and that one of the things that has been quite frustrating is that because we cannot take the time out to try and support development of their services, often the people who have got the time are the people who are sitting in an office, not necessarily client facing, and are getting on and beavering away, and suddenly come up with these plans that we get sent 24 hours before a meeting to comment on, and again I think there is recognition this is a little bit better now that particularly within the White Paper process: "Could we get a comment from our members within 3 or 4 days?" and that is absolutely impossible for us to do, and it has been

very difficult for us to have a genuine collaborative view with our peers because it has been very difficult to engage them and bring them along with us. I think from their point of view they have seen very little impact on the day-to-day operation of their businesses and the day-to-day impact on their patients in general practice. So we have taken them to the brink several times and said: "Come on, listen to this, follow us, it is really important" and nothing has happened. So when we go back to them at the eleventh hour and say: "Could you comment on this service specification?" then in actual fact there is very little that comes back. Again, I think that is something that is understood. I think from the point of view of significant events during the White Paper process, eventually we have got to a point where I think the people who are heading it up are starting to listen to us, are starting to understand the wider impact of the services that they have and the fact that one cannot just roll out these services in silos and that the impact may be sometimes unintended consequences on different parts of the service needs to be thought about. I think that the profile of information technology within delivering a health service across the Island has been raised and it has become more prominent as an agenda. I still think we have got a danger that there are people championing their different particular systems so that somebody maybe needs to be brave enough to say we are going to go with this particular system and this particular arena because people all the time in the background are commissioning their own little solution for things and in actual fact it is about making sure that is a really joined up solution.

[14:15]

I think the encouraging thing for us is that now it would appear that the acute hospital, the sustainable primary care and the new hospital work all seem to be ... those groups of individuals are all talking to each other and recognising where the impacts might be and I think that is encouraging because again we are doing one piece of work, there are other pieces of work going on elsewhere. I think the other thing that is quite important is that we have had ... it has been very difficult and very frustrating for us when essentially our paymasters through the Social Security fund have not been at the same table as Health, so Health would commission services and they would say: "Well, we are dependent on Social Security to make that happen" and Social Security would say ... so we were sitting there in the middle of this saying that this feels like the right thing to do and Health have said: "Gosh, we cannot do that because ..." I hope there is a recognition now at a political level and certainly at a senior civil servant level that delivery of healthcare is dependent on how much of the Health, Social Security and Treasury being part of the enabling team that are going to make it happen, because I think there is a real danger that one does one or leaves it to the other to deliver a plan and says: "We need to know that everyone is thinking on the same page before we can really push forward."

Deputy J.A. Hilton:

I do understand that there are difficulties last year but those seem to have been overcome to a certain degree and that the group has been set up and now has a project to lead, and this is to do with the sustainable funding. I believe the group met either last week ...

General Practitioner, Primary Care Body:

Last week, yes.

Deputy J.A. Hilton:

Were you present at that meeting?

General Practitioner, Primary Care Body:

We are both on that, yes.

Deputy J.A. Hilton:

Were you satisfied with the general direction of where things were going from that first meeting? Has it given you a bit of confidence that you feel that you are going to make progress?

Chair, Primary Care Body:

The history was, and one of the reasons we came to mediation, that we felt that we had been done to rather than worked with and one of the situations that arose at the beginning, as I said, was the KPMG work value for money given that it was undoubtedly a catalyst change but actually when you look at the underlying assumptions of how it could be brought into Jersey, there was a lot of money for that in particular, and it has taken a long time to move things forward? So I think from our angle we wanted to see something that was a collaborative approach, sure, but were working from a system from within, so testing it out and moving it on. So rather than say: "This is what you will have, how can we modify it?" "What have we got? How can we change it and move it from there?" That is a well-recognised system. Senator Ferguson very kindly provided us with a book called *The Toyota System and Systems Thinking* which I read through quite assiduously and liked the idea and that is what we brought to the table. We think that is a more cost effective model from all points of view, based on the precedent we feel that organisations to date have not carried out what was set out from the beginning, and we feel that if we can get involved from the beginning we will be able to make a difference.

Deputy J.A. Hilton:

You obviously are happier now than you were 6 months ago but there is a huge way to go.

General Practitioner, Primary Care Body:

Absolutely. I think the right people are at the table. The emphasis is now on locally owned, locally grown and the governance over the process feels more comfortable and we feel more equal partners in the process. I think we have hopefully agreed through mediation process some codes of communication up to the Ministerial Oversight Group that feel more comfortable for us. Rather than our voice going indirectly it is hoped that the solutions are derived behind doors, then go to Ministerial Oversight.

The Deputy of St. Ouen:

Why was it necessary to move towards mediation?

General Practitioner, Primary Care Body:

I guess I probably speak for Nigel and I, but all the people who are on the Primary Care Board are very ... we are really passionate about what we believe health should not necessarily look like because we would not pretend to have to know all the answers but we are passionate about it being right and the healthcare being right in the Island. We felt that it was quite difficult to get some of our opinions heard and, as I say, it was not a question of saying: "Do it our way or the highway" it was a question of saying: "We are not certain that we have got the best mix here to move forward." So with the support, we talked initially to Scrutiny, to yourselves, I think on several occasions, for a variety of reasons we felt that we needed to make people aware that however much we voiced our opinions, and there was a lot of box-ticking we have engaged with the G.P.s but in actual fact we did not necessarily feel that it had been proper genuine engagement where we were listened to and heard. That was how we got to a point where we did not feel that the relationships were productive for anybody. It had become a bit siege mentality really.

The Deputy of St. Ouen:

We are talking about the relationship between the G.P, the Primary Care Body and the Health Department?

Chair, Primary Care Body:

Not just. We have already mentioned we felt we were not being listened to but that applied to some of our hospital colleagues that we felt the clinical voice was becoming diluted. There was also the concern about silo mentality. Unfortunately Jersey has a silo mentality and every organisation tends to work separately from other organisations. We would say we wanted to blur the boundaries. We wanted to make sure we are part of it, that the patient is cared for, where it is appropriate for him or her to be cared for, it did not really matter where that was, and what we were seeing was an expansion of H.S.S. (Health and Social Security) rather than H.S.S. supporting the development of primary care. There was always this problem about, which we still

have to look at in terms of the sustainability issue of private versus public, and that comes to, I suppose, an acute stage when one is sick out of hours. Personally as a patient if I had a big wait in A. and E. (Accident and Emergency) I would probably go to Out-of-Hours. If A. and E. was not busy I would probably go there because I would not have to pay anything and both would provide good quality care. So we need to look at how we incentivise people to do the right thing and get the right care in the right place. So we are looking overall at a unified health policy and there are aspects of what is going on in terms of budgetary transfers, which are again a part of different silos that create a problem in terms of Jersey PLC, so for example where do we buy our drugs. At the moment lots of drugs are going out into the community but there are pharmacy colleagues in the community to buy those drugs, they probably have to pay something like 3 times as much for some of them than if we bought them as an Island as a whole. So if we start looking at a unified policy we start to save money and we can make a difference. We wanted to look at it from that angle. There were concerns, as we have mentioned about command and control, and also allegations of bullying from within the organisation. Although we are aware there is a whistle blower policy it was difficult for us to assess how effective this was. So that is really what led in combination to the mediation process.

The Deputy of St. Ouen:

What is being discussed through mediation?

General Practitioner, Primary Care Body:

We are not allowed to tell you. **[Laughter]** I mean to be fair it was bound by confidentiality and we all signed up to that, and I think there has been an output to John Richardson, we agreed what terms of reference ... what would go to John Richardson. But I think the really interesting thing has been hearing everybody's point of view, understanding the frustrations on both sides, understanding from our point of view in the private sector, understanding more some of the political processes that constrain government organisations that do not constrain the private sector. I think an ability for us to voice our opinions that it was not just one department who need to think about health care it is a collaborative. I think we have agreed some terms of working that we are all trying to abide by and thus far have been ... everyone has been doing what we undertook to do. I think the other thing that came out of it is that we as a primary care body cannot continue to support health just on a practical level. At the moment it is very much on the back of a fag packet at 11.00 p.m. We are not as effective as the Island needs us to be when it comes to supporting health policy and development and we need to be able to do that. Again that piece of work is happening.

The Deputy of St. Ouen:

What would be a successful outcome of the mediation?

General Practitioner, Primary Care Body:

A really good piece of work on sustainable primary care, which we are all very comfortable with and all feel part of and delivers what we need it to deliver to the Island. That to me is the ultimate objective of having put everyone in the same room for 2 or 3 days to talk it through, because that to me, we can all agree to behave properly and treat each other with respect and to communicate properly but the real test is getting a robust project out of the whole thing at the end because that is what we need. We need the 3 groups of individuals to work together.

Senator S.C. Ferguson:

Presumably one of the real sort of points that nobody can possibly or perhaps cannot reach agreement on is the funding.

General Practitioner, Primary Care Body:

I think what we all recognise is that the funding is a real constraint for all of us. It is a real frustration for all of us and we also agreed that it was not up to us to find the solution for that. The solution for funding, we can suggest funding levers and mechanisms and the way the money might flow around the system but at the end of the day over to you, I am afraid. It is a political decision about how the public pay for their health care and whether or not that is an insurance system, continuation of the co-payment, free at the point of delivery, however that is not really within our remit, and to me the biggest challenge for Jersey is about how you incentivise the public to pay for their health care because at the end of the day some public are paying for their health care because they use primary care services appropriately, some people are not. They are circumventing it and maybe through need are making choices not to use primary care appropriately. As I say, a lot of that is need rather than choice.

Chair, Primary Care Body:

I would just say the other aspect running alongside that is effectively what has been coined a primary care hub, so in other words where we can step out. Not just that we be part of the strategy. It helps with communication because we meet people and work with people on a regular basis. It also allows us to start looking at some of the things that are not working and analyse how things could work better so we could look at discharges, referral patterns, things like that, that are only being looked at from one direction at the moment, whereas in general practice because we have a different viewpoint we can look at them from a different perspective. I was going to say there are about 5 models of primary care in terms of funding: general taxation, social health insurance, voluntary and private health insurance, out-of-pocket payments and donations to and from charities. Interestingly the O.E.C.D. (Organisation for Economic Co-operation and Development) have done a study on that and they say that most countries understandably feature

a mix of all 5 models and all are compatible with an efficient health system. So what we do is not clear.

General Practitioner, Primary Care Body:

So that is where it may be that building on some of what we have got is the most pragmatic, sensible thing to do because people understand it but it needs tweaking to make it effective.

Deputy J.A. Hilton:

How difficult is it for you to get this sort of information out to your members. It must be quite ...

General Practitioner, Primary Care Body:

Our poor members do have information overload because our agenda is ... so unfortunately we have sort of been consultant and strategy and change overloaded and it is like any group of people, when you are doing your day job you just want to know how it is going to impact on you next week, not in 3 or 4 years' time, and I think that is human nature. I guess it is about when we have got something very significant to tell them.

Deputy J.A. Hilton:

Have you had much concern expressed to you by your members at the lack of progress that has been made over the past year with regard to the sustainable fund and a way forward?

General Practitioner, Primary Care Body:

People are frustrated by the fact that on a day-to-day basis it is becoming harder for people to access us and that certainly I have noticed in 15, 16 years of practice over here, it is often a negotiation with your patient about how much they are prepared to pay and whether or not they will come in to access medical care. That makes it quite difficult to deliver really proper robust, clinical practice because we know what we want to do in their best interest but they are exercising and discussing with us whether or not they will pay for that, and that is becoming more and more of a feature, I think.

The Deputy of St. Ouen:

It is rather disappointing for me to hear that we still have not necessarily come to grips with access to G.P.s and funding and development of the sustainable fund, especially as commitments were given by politicians that we would have a new mechanism by September this year, which obviously clearly is not going to happen. Could you just confirm whether you have raised these matters with the powers that be about access to G.P.s during the initial periods of consultation?

[14:30]

Chair, Primary Care Body:

We have with the sustainable fund. I have been involved personally just last week but that came from the mediation process where it was raised, and I have been raising the issue in conjunction with the J.C.C. (Jersey Consumer Council), as I said. So the J.C.C. are moving this forward and they have sought our help and Rachel Williams has been on behalf of Health, so they are well aware. I think that information will be very useful because I think it can give you, as politicians, a good sounding as to how the public feel as to what sort of direction they want to take. Whether they want to have hypothecated tax ...

The Deputy of St. Ouen:

Was it not only an issue that was identified in the White Paper?

Chair, Primary Care Body:

Was that identified in the White Paper?

The Deputy of St. Ouen:

Yes.

Chair, Primary Care Body:

No, I do not think it was. I think the sustainable work should have been done prior to the White Paper but unfortunately choice was to go the direction that was taken.

The Deputy of St. Ouen:

Where are we at? We have gone through a period of about 2 years and we are now at a period of mediation. So are we simply starting to look at how to move forward or have we gone further than that?

Chair, Primary Care Body:

I think we have learnt how to work together better. I think we have established that there are changes that will be better so if I give you an example, one of the prior questions coming today was the specifics of the full business cases. Bits of them have gone well and bits of them have not.

Deputy J.A. Hilton:

Can I just stop you there? Which bits do you think have gone well and which have not?

Chair, Primary Care Body:

I was going to give you just a little overview. **[Laughter]** If you look at what is now called Jersey Talking Therapies that began its life as I.A.P.T. (Improving Access to Psychological Therapies) and we said I.A.P.T. was a very specific thing. It did not really fit with the Jersey context where we were able to look after our patients to a degree but we had problems with psychology, and it centred around a disease process or disease therapy called C.B.T. (Cognitive Behavioural Therapy) and we said that is fine for certain parts of psychological problems but people are more complex than that, they come in with lots of different things and they need lots of different finalities of treatment. That has been taken on board and it has become a more multimodal model. Although it has a C.B.T. Centre, because it has the biggest evidence base, there are other areas of therapy that are being tagged on, which has been very nice to see.. With intermediate care the initial move is to put social workers and occupational therapists rather than G.P.s and nurses at the heart of intermediate care. The latter 2 groups however have been the traditional gatekeepers and case managers with previous extensive knowledge of the patient while occupational therapists and social workers have to get to know the patient as they are referred to them. You might argue because we have a vested interest but I would say evidence would support us that we tend to be more efficient at that and it is why, going back to my original point about this is where we are vs this where we want to be, there was no transition model. It was just this is how it is going to be. That, I think, was a difficulty and I suspect was not value for money again. We have also stressed the link between intermediate care, i.e. care in the community for people who are becoming vulnerable from a clinical perspective, and end-of-life care because unfortunately one often runs into the other. How do we link those 2? Again, that has come on board. We stressed at the beginning that the original model around end-of-life care was very expensive. I remember sitting in there and we were told: "It does not matter. Just put down what you want." I said: "What budget are we working to?" "No, do not worry. Just put down what you want." Then they said: "Funnily enough, we cannot afford that." **[Laughter]** Right, so we all sat in that room for hours only to be told that. We then toned that down and the major thing we were proposing at the beginning that was completely ridiculous was we had an end-of-life group in terms of the hospice looking after cancer patients, and everybody who was not dying of cancer had nothing, effectively. If you were "lucky" enough to have cancer, in inverted commas, you had the full might of the hospice behind you but otherwise you did not, so there was a lot of emphasis on getting them involved. They have npw become involved and end-of-life care is now about end-of-life care, not just cancer care. There was a push towards, and again this is where we overlap with sustainability, the under-5s. That was a project in the early stage. Why were they demarcated in preference to other vulnerable groups because if I was a pensioner or a person with diabetes out of work why are under-5s getting money? Why am I not getting it? The sustainability work had to be part of this and yet it was not and it was not recognised. Now it is and I would hope that has come from pushing from the G.P.s to some extent. Then the bit that has not gone quite so well is mental

health. I believe that was signed off last week and I had a phone call this morning to tell me it had been signed off and would we like to make our contribution. I said "Yes, absolutely. When could we come and meet with you?"

Deputy J.A. Hilton:
Is this the new psychologist?

Chair, Primary Care Body:
No, this is dementia policies.

General Practitioner, Primary Care Body:
This is the dementia. That one I have to say has been lost in a vortex that we have not been able to influence at all. But we have voiced that to the person who is overseeing it from the Commissioner point of view.

Chair, Primary Care Body:
We were invited to a meeting today.

General Practitioner, Primary Care Body:
Interestingly, yes, because there was a complete collaborative workshop for 2 days to discuss how it was going to go forward and we were not invited until the eleventh hour, only because I have just put my head above the parapet.

Senator S.C. Ferguson:
But you are the people who recognise it first.

Chair, Primary Care Body:
I was about to say the original work said there should be free access for everybody who thought they might have a memory problem going direct for assessment at memory clinic, and we said: "You will be overwhelmed and surely the gatekeeper role of general practice in every format applies to this." So, if I see someone as a G.P. who has a memory problem the first thing I want to know is; is it genuine? Is it short-lived confusion? Is it something to do with depression, because often that is a manifestation of depression? Then I as a clinician would want to do all the appropriate tests as they are laid down in evidence-based practice to rule out something that is treatable and at the same time I would probably refer to the memory centre appropriately having assessed their memory. Why did that need to change?

Senator S.C. Ferguson:

Are you finding - I do not know, there is no way to say this tactfully - that with being heard more there is less inclination to pull everything to the centre and for Health to run everything? Is there more pushing it out to the G.P.s because the G.P.s are the co-ordinators of the health set-up?

General Practitioner, Primary Care Body:

I still think that is a step to take and part of that is constrained by funding because nobody ... and Nigel and I have been in this game since New Directions in 2003.

Senator S.C. Ferguson:

Absolutely.

General Practitioner, Primary Care Body:

Anyway I can remember standing at the first meeting and saying: "How are we going to address the public/private interface?" and we still have not addressed the public/private interface. If you look at what has happened with midwifery care, the service has been moved into the community but the patients are paying that, and they were not.

Deputy J.A. Hilton:

I know. I can distinctly remember asking a question about that in the States a couple of years ago.

General Practitioner, Primary Care Body:

I do not have a problem with that because that is just redressing where we were 10 or 15 years ago and the patients were paying for their antenatal care and a really small group of very specialist, complicated, high-risk patients then used to go to the hospital and people used to get a maternity grant to cover their ... not the maternity benefit, the maternity grant was there to cover your antenatal care. That was eroded as the free service was developed in the hospital and so all the ... so this is to me is just redressing where we should be, to be honest with you, but probably with more midwifery input, which again is what women want and what all evidence suggests gives you good outcomes.

Chair, Primary Care Body:

By keeping the G.P.s involved.

General Practitioner, Primary Care Body:

By keeping the G.P.s involved.

Chair, Primary Care Body:

One of the things we try to preserve is the traditional model. We touched upon G.P.s being gatekeepers but we are more than that. My view, and the reason I became a G.P. was the cradle to the grave. I want to be able to see my mums ... Philippa, you told a story about your mum who missed you for 2 years.

General Practitioner, Primary Care Body:

Yes. I had a lady who was sucked into the public system and appeared to have quite a serious alcohol problem so when she had her baby there was a child at risk and none of the triangulation of the information had happened. It was okay, the baby was okay but it was about making sure the knowledge is in the right place. In answer to your question, there is this constraint and that is why this sustainable primary care work is so important. It is about making sure the money can follow the patients. Which patients are going to get their care supported? Which long-term conditions, illnesses, groups of patients are going to be funded by the States? How much of that care is going to be funded? Then how is the patient going to be incentivised to pay for the rest of whatever they have to pay for out of their pocket if that is what is decided? It is quite difficult to remodel your services all the time with this artificial ... fundamentally we collect money when people come and see us and nowhere else in the system does that happen.

Senator S.C. Ferguson:

It was talking about the Medicare sort of stuff and there was a comment made, not with these series of hearings, some time ago, that: "Yes, the patient will have this little machine which will report back into the hospital." It seemed to me that it did not seem to be going the right way because I have this theory - presumably this is the model most people have - that the co-ordination is done by the G.P.

Chair, Primary Care Body:

Can I refer you back to my presentation to the States Members last Thursday?

The Deputy of St. Ouen:

Can I ask what new funding, if any, have G.P.s received from the overall resources that were allocated in the Medium-Term Financial Plan to deliver the first stage of the White Paper?

General Practitioner, Primary Care Body:

None.

The Deputy of St. Ouen:

None? That is all?

General Practitioner, Primary Care Body:

We will probably get some rental for the psychologists eventually. That is Health and Social Services employed, trained and governed staff, which does have its advantages particularly with the point of view of governance over psychologists sitting in our premises.

Deputy J.A. Hilton:

I was going to ask you that because I know that they are currently recruiting their Talking Therapies. Are the G.P.s going to be used to base those services in the G.P.s?

General Practitioner, Primary Care Body:

Yes.

Deputy J.A. Hilton:

That is a given, is it?

General Practitioner, Primary Care Body:

Yes.

Deputy J.A. Hilton:

I suppose the same applied with midwifery services as well because that was something else I wanted to ask you. That has been rolled out in the community now and we have midwifery services being delivered out of some G.P.s surgeries, so is it just a question that the Health Department is covering the rental of the space they are occupying?

General Practitioner, Primary Care Body:

No. They do not for that, not for midwifery. We derive an income because we can take a signature ... we can take some money out of the Health Insurance Fund but the patient is paying. The Health Insurance Fund is paying and we get the expertise of the midwife from the Health Department. But there is no ... we tried to factor that in in the overall cost.

Deputy J.A. Hilton:

To date, then, the G.P.s have not benefited at all.

General Practitioner, Primary Care Body:

Nothing at all.

Chair, Primary Care Body:

No.

General Practitioner, Primary Care Body:

More importantly, neither have the patients. Nothing has flowed into our businesses to allow us to support our patients in any way. Just intermediate care, if we do a home visit on a patient we can claim from a fund to do that. So, if the patient goes into 6 weeks of intermediate care we can bill the intermediate care pathway rather than the patient.

Deputy J.A. Hilton:

Intermediate care is where a patient has been in hospital, is released back into the community with support?

General Practitioner, Primary Care Body:

Yes.

Deputy J.A. Hilton:

You are saying in the 6 weeks after that that is not going to cost the patient any money because you can claim from the Social Security Fund for that.

General Practitioner, Primary Care Body:

Yes. It may not be the Social Security Fund. I think it is the Health budget it comes from.

Chair, Primary Care Body:

Or we prevented admission, so sometimes it is because you do not necessarily need the investigations. You know the problem but with extra support at home the patient ...

Deputy J.A. Hilton:

The G.P. is the person who makes that decision about the patient not going into hospital, then?

Chair, Primary Care Body:

Initially, yes.

The Deputy of St. Ouen:

Given that we are supposed to be improving community health services and the G.P.s are key in that delivery, why is it that funding has not been directed initially to help G.P.s improve the services to their patients?

General Practitioner, Primary Care Body:

I think community health services is not just general practice and that is quite an important thing. There has certainly been, for example, pulmonary rehab has been very successful. Lots of

evidence base behind that, that programme is up and it is running and it is really starting to deliver now. We had a 9 month wait and we can now get people in within 2 or 3 weeks, which has lots of evidence behind that reducing admission.

Deputy J.A. Hilton:
Can you just explain exactly how that programme works?

General Practitioner, Primary Care Body:
Essentially there is lots of evidence that when somebody has been in hospital with exacerbation of chronic pulmonary disease if you get them into an exercise programme you can ... it is quite a holistic programme but the emphasis is on exercise, on nutrition, on compliance with medications, on looking at the psychological well-being. That is delivered usually by physiotherapists and I think it has been delivered at Springfield.

Chair, Primary Care Body:
There is a group out of hours, Breathing Space, that meets as well to supplement that.

General Practitioner, Primary Care Body:
Yes, that supports them. That is then going to have a transition into prescription for health up at the Fort. It is about enabling people. That is really good. That is money that has gone into the community and delivering a service in the community for the patients.

[14:45]

The Deputy of St. Ouen:
The money is being directed to the Health Department that is providing an extended service.

General Practitioner, Primary Care Body:
Yes. That probably is the right thing, to be honest with you, because fundamentally, and again I think this is something where essentially we do not have the engine power. We do not have the ability to put together a proper bid in a competitive tendering. We do not have the expertise, we do not have the finance, we do not have the H.R. (Human Resources); we do not have any of that to put together a bid. There is a school of thought in the U.K. which says if you really want very robust community services what you need to do is have clusters of 20,000 to 30,000 patients, which might be 2 or 3 practices served by an integrated care team that has social work input, community nursing input, O.T. (occupational therapy), physiotherapy and dietician. In fact that is all coordinated in one true ... a couple of practices configuring together and that is an efficient way of doing it. That would - and this is the thing that Nigel has emphasised - the transition from where

you have general practice currently bolted on the edge of your healthcare system to integrating that and making it central to co-ordinating all of your community services is a big step. So, enabling general practice to ... and I think that is one thing that has changed is that I think there is a recognition we cannot just sit on the outside if you want to have cost-effective, sustainable, safe health care for Jersey. There is worldwide precedent on that, that robust primary care delivers you your best outcomes. We have to be brought in somehow. It is very, very difficult for all of us, to be fair, to make that happen.

The Deputy of St. Ouen:

Given what you just said has the primary care body ever considered deploying, for want of a better description, expert advisers or an adviser to help represent the G.P.s in the development of this sustainable fund and with community services generally?

Chair, Primary Care Body:

It is interesting you should say that because that is exactly what my take is on this at the moment. One of the things I would like to do when we were talking about building it up locally for everything. What did you say: locally grown, locally owned?

General Practitioner, Primary Care Body:

Locally owned, locally grown.

Chair, Primary Care Body:

One of the things we would like to do is put together an idea of how it is we might finance things because we do need politicians' buy-in very early on. In a low-tax jurisdiction is capitation, state payment appropriate, or is co-payment the way forward? My feeling is that, based on talking to several different health economists, we are probably looking at a mixed model of some kind but it is how that mix is put together. What we would like to do is to get an idea of what is acceptable and then get in a health economist, someone from the U.K. basically because they speak English and the U.K. is where we all come from in terms of training, but also someone who has knowledge of other areas around the world, because not everything in the U.K. works, as we are well aware. We can use other models, we can use that expertise and start bringing that in so we can put something together that we can bring to you and say: "This is the sort of rough direction of travel we think is acceptable. These are the economic parameters. What do you want to do? How do you want to support us?"

General Practitioner, Primary Care Body:

To answer your question, James, we do not have the resource to employ that sort of expertise and that is where we are hoping this collaborative model will allow us to influence, along with our

pharmacy colleagues, opticians, dentists, the right sort of support organisations or individuals to help inform this debate.

The Deputy of St. Ouen:

Because developing a sustainable funding mechanism for primary care is so important I am amazed that an offer has not been made by the States, the Health Department, to help fund some support for the primary care body, because we all know that the States are quite keen to go out and seek consultants for all sorts of things that some might believe are far less important than this. Have you ever been offered financial support to help you find a representative, an independent person, expert to help in the delivery of a sustainable funding mechanism?

General Practitioner, Primary Care Body:

No. We did have a team put together of fairly high calibre individuals but could not resource it.

Chair, Primary Care Body:

Part of that, to be fair to colleagues in the Civil Service, is that they were constrained by the States procurement processes so there was only so much that they could do in that respect. We hope that by using small pieces of information and small bits of commissioning in terms of expertise we do not necessarily have to go through the whole procurement process. We can use bits as we go along and develop the model rather than the big bang of £300,000 to £600,000 that I think was put aside for whichever big company from the U.K. was prepared to do that last year.

Senator S.C. Ferguson:

Have they offered any alternatives to this because obviously the stumbling block is the fact that you are all independent businesses. Did they offer any alternatives?

General Practitioner, Primary Care Body:

Not that I am aware of.

Senator S.C. Ferguson:

Do they have any other ideas as to how to cope with this problem?

General Practitioner, Primary Care Body:

Not that I am aware of, no. I think again we also have to understand that pharmacists particularly and general practitioners are the key people who are the private practitioners on the outside. The opticians and the dentists are less dependent on input from the Social Security Fund, et cetera. But no, we have not been offered, but as I say, I think we are hopeful that with the current group of

people who sat down last week. It is not a voting board. It is a collaborative decision-making body that will be able to come up with the right people to support the whole process.

Senator S.C. Ferguson:

They did not think of bringing you into the Civil Service or anything like they are in the U.K.?

General Practitioner, Primary Care Body:

I am not certain that is the right thing for Jersey. I think the strength for our patients is our externality to the ... there are pros and cons to doing that. I am not saying that would not be a way to do it because that would clearly be a way to do it, but I think the strength for the Island is that fact that we can challenge on behalf of our patients, really act as advocates.

The Deputy of St. Ouen:

Has agreement been reached with the Health Department as to what services should be provided by G.P.s in the future?

General Practitioner, Primary Care Body:

No. That is part of the sustainable model.

The Deputy of St. Ouen:

It disturbs me a little bit that a comment - I know you have not misheard it - Nigel spoke about focusing on funding. But I would have thought you are better off to determine what services you require from your G.P.s first before you then consider how you are going to fund it.

Chair, Primary Care Body:

I think the model will change. That is the problem. At the moment we are moving ... we had a very reactive model and we are moving to a preventive model. That has moved gently. We are now looking at an integrated model and that is being okayed around the world. There are different forms of integrated model, so it is difficult to say exactly what services will sit where. I think the important thing that I did say earlier on was it is blurring boundaries and how you blur those boundaries exactly. We are in fact in discussions with Bernard and others who are sitting in the room here. It is interesting, though, that our agendas matched independently when we sat down to discuss this only recently.

General Practitioner, Primary Care Body:

If you ask a G.P. in Scandinavia, if you ask a G.P. in Canada, if you ask a G.P. anywhere else in the world what their job is it will be significantly different to ours. A generic G.P. is different depending on which health system they are operating in. I think you are absolutely right. We

need to know are we designing a health system that is a Rolls-Royce, a BMW, a Mini or a push bike. **[Laughter]** We need to know what spectrum we are designing. We also need to know how much of that health budget the Government are going to be responsible for and how much one expects the patient to be responsible for. To a certain extent we need a funding envelope. We had this discussion last week at the board. It is a chicken and egg situation. Do we go and say: "How much have we got?" or do we come up and say: "This is the model; can you make the funding fit?"

The Deputy of St. Ouen:
In part the community services and the services you will be required to provide as well as others need to be developed and funded to ensure that we do not need a larger hospital.

General Practitioner, Primary Care Body:
Totally, yes.

Chair, Primary Care Body:
Even with the larger hospital, marginally larger, but even with that with the projected demographics ...

The Deputy of St. Ouen:
The idea that you can somehow put off sorting out the services that need to be provided by G.P.s and others and the funding that goes with it and yet start making decisions around a hospital is a bit odd.

Chair, Primary Care Body:
Yes.

The Deputy of St. Ouen:
Isolated to say the least. Disjointed, should I say, not isolated.

General Practitioner, Primary Care Body:
It acknowledges you have to identify a site or sites. You have to identify a funding mechanism and these things take a long while to develop. The question is what you put in it and how it works and where the wall is between the inside of the hospital and the outside of the hospital is something that needs to be defined, in actual fact. It should not be ... there will be a physical wall but to a certain extent some of the hospital care can be delivered in the community, some of the community care can be delivered in the hospital. It should be fairly fluid. Those are the sorts of discussions that are going on at the moment.

The Deputy of St. Ouen:

How far advanced are those discussions because it seems clear from people we have discussed it with that this dual site option is the one that has been selected and obviously there are consequences and issues around that.

Chair, Primary Care Body:

It is outside our remit but one would assume there are problems around having a dual site. But equally I am assuming there are cogent reasons why that has been chosen, and not least the expense. It probably would have not been the ideal but it seems to be what Jersey can afford.

Deputy J.A. Hilton:

Just why we touch on then hospital, have you got a view on the issue of single-bedded rooms?

Chair, Primary Care Body:

We understand from work done in the U.K., and it is only what we have read, that it is not the answer for all. Not everyone wants that. I think, as one might put it, it is a matter of choice. It is providing choice for people.

General Practitioner, Primary Care Body:

Yes, choice is important. There is quite a lot of evidence that if you have a short stay a single bedded room is desirable. If you have a longer stay then there are lots of reasons why it might be safer for you to be in a room with more than one person.

The Deputy of St. Ouen:

This morning we had a discussion with Dr. Graham Prince, who is the clinical lead on I.T. and who first of all highlighted the fact that the G.P. central server is just about complete and ready for action. But equally the community health system that was proposed in the original health plans was excluded due to lack of funding. That is a very important tool that is required not only to improve the services to the public with regard to health but equally to support any development around the 2-site hospital. Are you having an input into encouraging the powers that be to deliver their part of the bargain?

Chair, Primary Care Body:

I.T. is something that I am passionate about, as you know. I am sorry but it was last Tuesday and not last Thursday I presented to the States Members. It has come about largely because it facilitates change and that is the major issue around what you are saying. What we had in the U.K. is that the I.T. systems were developed in primary care some 20 years before secondary care, so they are much more advanced and centred around clinical care so they are around the

point of contact with the patient. From the point of view of what you need on a day-to-day basis they are way ahead of most other systems. I said at the meeting last week that I have begun to recognise over the years I have been involved that there is a certain core data set that is available and should be available for patients on a day-to-day basis. So, wherever they are seen, again blurring the boundaries, whether it is in a secondary care diabetic clinic or in primary care in front of one of our doctors here, then that information is available. But every organisation, general practice, the hospital, various aspects of the community, whether they are working in the community or in the hospital, will want their own bits around outcome data, et cetera, et cetera. I think we have to make sure that the emphasis is on making that core data available as we move things ahead. I think with EMIS Web what we have done as G.P.s is what we could do at the time and we have taken a long time to persuade people how effective this will be. But we have put all that community data and most of the population data there, so all that clinical data that we have collected for years will be available.

[15:00]

We want to make sure that links in with the hospital. The difficulty is, again going back to silo working, the hospital system has developed in a silo compared with the community system and it is not only the local factors that have determined that, unfortunately. That is what has happened in the U.K. as well. We hope to be able to work as integrated models are rolled out in the U.K. and elsewhere, in conjunction with the I.T. developers in the U.K., to move things towards this model whereby the important data is there for patients when it is needed.

Senator S.C. Ferguson:
How much of a risk is the fact that they have a different identifying field in the hospital? Do the identifying fields they are going to be having with the G.P.?

Chair, Primary Care Body:
They have not exactly. As the proverbial John the Baptist here I have been talking about keeping the unique identifier mapped since 2003 and even as far back then, as it was called hospital number in those days, I suggested that there was a link to the JY number that was likely to be the population identifier and effectively that was what I.S.D. chose. The hospital, again to be fair to it, has its own - again going back to what I was saying a few moments ago - needs. So, if we are looking at a patient who resides in Jersey, a JY number is entirely appropriate and if you are following them through a long illness that is right. But you might come over here as a holidaymaker and therefore you only need to have a hospital number for the time you are here, not a JY number. You might come over here and begin seasonal work and decide to stay so you

move and you would have a JY number. We have to be prepared for the different variations that would occur, but the JY number for those who are resident in the population is the important one.

Senator S.C. Ferguson:

Or said why you were born elsewhere.

Deputy J.A. Hilton:

Thank you very much indeed for coming this afternoon. It is 3.00 p.m. so we will close the meeting. Thank you. That was very useful.

[15.02]