STATES OF JERSEY

HEALTH WHITE PAPER REVIEW: "A NEW HEALTH SERVICE FOR JERSEY: THE WAY FORWARD" (S.R.7/2012) – RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

Presented to the States on 13th February 2013
by the Minister for Health and Social Services

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HEALTH WHITE PAPER REVIEW: "A NEW HEALTH SERVICE FOR JERSEY: THE WAY FORWARD" (S.R.7/2012) – RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES

Ministerial Response to: S.R.7/2012

Ministerial Response required by: 26th November 2012

Review title: Health White Paper Review: "A New Health Service for Jersey: the way forward"

Scrutiny Panel: Health, Social Security and Housing

RESPONSE

The Minister for Health and Social Services welcomes the Panel's constructive review of the proposals contained in P.82/2012 and the White Paper. The Minister would like to extend her thanks to the Scrutiny Panel, and Scrutiny Officers, for all their work. It is recognised that their approach has been extremely thorough, thoughtful and wide-ranging, despite the very tight deadlines.

FINDINGS

	Findings	**Comments**
1	The proposals contained in the Report and Proposition: "*A new way forward for Health and Social Services*" require significant additional funding.	▪ The full implementation of this strategy will require a significant level of funding. ▪ The MTFP proposed funding for implementing the first 3 years of this strategy. This was agreed by the States in early November. ▪ Work is now progressing on translating the Outline Business Cases (OBCs) into Full Business Cases (FBCs) – detailed operational plans for the new services, including the detailed costs and benefits. ▪ Decisions on who will provide the new services will be made early in the new year. These decisions will be made on a balance of quality and value for money. ▪ We will continue to monitor spending and impact very closely. We will also continue to progress CSR, efficiency and productivity in order to secure best value for taxpayers' money. ▪ The Jersey Lean System has been introduced in my Department during 2012. This will continue to be rolled out in 2013 onwards, and will underpin our continued drive towards improvement in both quality and value for money. ▪ Proposition 82 required the Council of Ministers to bring back proposals for a sustainable funding mechanism in 2014 – HSSD are working with Treasury and Resources and with Social Security to progress this.

	Findings	Comments
2	Some third sector organisations had reservations about whether the proposals contained in the White Paper would come into fruition and whether all the extra monies required to implement the changes would be available.	HSSD notes the concerned expressed by some Third Sector organisations about the availability of monies. These concerns need to be viewed in the following context – ▪ The MTFP, which has been approved, proposed significant funding for implementing the first 3 years of this strategy: £4.5 million in 2013, an additional £4.4 million in 2014 and £2.1 million in 2015. This funding will be available from 2013. ▪ HSSD are working hard to ensure that the proposals come to fruition, through producing FBCs which are realistic and achievable. Third Sector organisations are heavily involved in this process. ▪ The Chartered Institute of Public Finance and Accountancy recent review, commissioned by Scrutiny, reported "a well-developed approach being taken which factored in a group of expected cost pressures which were fully considered and costed", and also noted that detailed costing approaches were being applied by the Department. ▪ Robust commissioning arrangements will be in place from 2013 in order to ensure the process for awarding service agreements and for monitoring delivery are transparent.
3	The scope of the proposed reforms is so significant that they will have major consequences for all. Islanders must be confident that these proposals are both appropriate and cost effective whilst meeting the changing demands of the community.	▪ This amount of change is unprecedented. HSSD and its partner organisations do not underestimate this. ▪ Detailed plans for the planned service changes (FBCs) are now being prepared. This is being achieved through a series of working groups and workshops for each service area, working with a range of stakeholders including clinical and professional staff, voluntary and community organisations and G.P.s. These individuals and organisations understand Islanders' health and social care need and what it takes to deliver services. Their input is critical to ensuring that the plans are achievable, and have broad ownership and buy-in. ▪ Things will change over time, hence HSSD will keep plans under review; will listen to professionals and to Islanders; will monitor services carefully to ensure delivery of efficient, cost-effective services. The FBCs will contain detailed service specifications setting out exactly what services are required; the metrics and measures used to monitor delivery and timescales for implementation.

	Findings	Comments
4	The existing data makes it difficult for comparisons over time, thus leaving it unclear whether funding has historically been able to meet changing needs or spent appropriately in relation to such needs. Therefore, it is essential that the States have more robust baseline data to monitor changes in the level of funding and its allocation to individual services over time.	HSSD have acknowledged that there is a lack of historical data, hence data and informatics are a key crossing cutting work-stream. HSSD will bring in – ▪ more robust routine monitoring, so that Islanders can be assured that services meet need and provide value for money; ▪ new service level agreements (SLAs), which will start to be introduced from 2013. All agreements will be clear about the data that needs to be provided. To date, HSSD has run this change programme using robust programme management and governance. This will continue.
5	Although KPMG recommended that Jersey should work towards scenario 3, it also identified various risks with adopting a new model of health and social care, including the risk that funding mechanisms might create financial disincentives to access primary care and other services.	The need to ensure that funding mechanisms promote effective health and social care is recognised in the White Paper (p. 27). This was identified as a work-stream impacting on several areas of the proposed changes. The Department will be working with Treasury and resources, Social Security and other departments (e.g. Housing) to ensure that any new or changed funding arrangement has the intended outcomes.
6	The survey questions contained in the Green Paper were not mutually exclusive and, therefore, did not require people to make a firm choice of one of the 3 scenarios.	▪ The questions in the Green Paper document were designed with the Statistics Unit, to test Islanders' viewpoints around certain important aspects of care – like who should pay and who should receive services. ▪ In addition, HSSD took advice from KPMG and from a professional PR company (Webber Shandwick) when we designed the Green Paper. ▪ It is always difficult to produce public consultation questionnaires. If too many options are included, there is a risk of confusion – and the options should be as mutually exclusive as possible, so there is a clear choice.
7	Some of the information provided in support of the various scenarios lacked detail and was open to challenge. Although most Islanders seemed to agree that scenario 3 was preferable, many had concerns over the	▪ The Green Paper outlined 3 scenarios at a high level, to help Islanders understand the choices that need to be made, and to get their views. ▪ Once we had a clear steer from Islanders, that was the time to work up the detail – and that's what is in the White Paper and the OBCs. ▪ However, there was a lot of detail available at Green Paper stage – the KPMG 'Technical Document' was almost 500 pages long.

	Findings	Comments
	implementation of the plan, the costs and associated risks. Therefore, they concluded that more information was required before they could conclusively endorse the option.	
8	The Panel questioned whether the overall population figures, demographic assumptions and projections used by KPMG and the Health Department could be accepted without comparison to the latest population data.	▪ HSSD figures are being cross-referenced with the latest population data. ▪ The analysis of future demand for hospital services is based on current number of service users, not on 2001 census figures. ▪ Therefore "extra" people living in Jersey, as identified in 2011 census, are already factored in because they are already service users. ▪ The Statistics Unit's 10 population scenarios confirm the very issues addressed through proposed new model for care, namely – o The total number of older people in Jersey is growing (this is the case for all 10 scenarios). o The growth in numbers of people aged 65+ will be significant. o The numbers of people aged 65+ by 2040 ranges from 27,700 to 31,000 across the 10 scenarios, with the average across all scenarios being 28,930 people aged 65+. This accords with the figure of 29,000 used when developing the proposed new model of care.
9	In the initial MTFP planning period, the White Paper predominantly focused on improvements to community services especially in the area of intermediate care, in order to relieve pressure on hospital capacity as well as improving care and containing costs.	▪ Both analysis and experience show that the hospital is becoming very full. If we have a surge of demand, for example over winter, we will run out of beds. ▪ 24 hour community services are not currently available in Jersey – one of the reasons the hospital is getting full. ▪ Creating extra beds in a hospital takes time. Community services can be increased more quickly, relieving pressure on the hospital. ▪ Islanders want more community services and home-based care. ▪ The development of intermediate care is a key component across a number of work-streams. It provides alternatives to hospital admission and improving hospital discharge. ▪ Early outcomes from the intermediate care pilot scheme are very encouraging, with positive outcomes and feedback from service users and Primary Care Professionals alike.

	Findings	Comments
10	Results of studies into the benefits of telehealth and telecare are still unproven and their utilisation has yet to be justified by evidence from randomised control trials.	▪ There is evidence that telehealth and telecare work – within an integrated care system, where professionals work well together – for certain types of patients. Like many things, it's not a case of 'one size fits all'. ▪ The latest UK trial showed a 20% reduction in hospital admissions. ▪ Like all service changes, it needs to be right for Jersey, so is being planned with a range of stakeholders. ▪ The introduction of new services, such as telehealth and telecare, will be carefully managed and monitored to ensure efficacy.
11	Although the White Paper suggests that the cost of scenario 3 is likely to be less than scenario 1 (business as usual), the Panel heard from some hospital clinicians that providing more services within the community will not necessarily eliminate the increasing pressures on hospital beds.	• Demand for health and social care will increase in the future, as older adults often have higher health and social care needs. • The pre-feasibility work undertaken by Atkins shows that, if we do not increase community services we will need 173 more hospital beds by 2040. This will cost an additional £60 million. • It also shows that, even with an increase in community services, we will still need 59 more beds.
12	The current hospital building is deteriorating, and does not comprehensively meet modern standards. If Jersey were to have a particularly bad winter with outbreaks of infection, the hospital could run out of beds. Essentially, the hospital is not fit for all current or future purposes which might reasonably be required of it.	The current hospital is deteriorating and does not meet modern standards. HSSD is addressing this in 3 ways – 1. The development of proposals relating to a new hospital (recognised that one is needed in the next 10 years). 2. The development of an Acute Services Strategy, with clinicians, to identify which services need to develop them pending a new hospital. 3. The relief of pressure on hospital beds and building in flexibility through projects such as intermediate care pilot (with non-recurrent money for 2012) and development of plans to increase 24 hour community services.
13	Within the White Paper, emphasis seemed to be on re-modelling services for children, services to encourage healthy lifestyles, services for adults with mental health issues and services for older adults. The future role of hospital provision with the re-configured services	• The White Paper focused mainly on the need to relieve the pressure on hospital beds and build in flexibility (both immediately and in the longer term). The White Paper – • clearly stated the need for a 'new' hospital in the next 10 years (work on this has already commenced including pre-feasibility study); and • specifically noted the need to develop renal and oncology services as a priority.

	Findings	Comments
	deserved greater attention than it was given in the White Paper, as the Report and Proposition recognises to some extent.	It is important to recognise that the White Paper outlined the 'big ticket' strategic investments needed, not the 'business as usual' changes that are already planned and will support improvements in acute services (e.g.: ICU and theatre upgrades). In addition, as already stated, HSSD is developing an Acute Services Strategy.
14	The Panel question whether there is sufficient G.P. capacity to deal with an extra 75% of A&E cases which has been suggested could have been dealt with in primary care.	HSSD is already working with G.P.s to discuss how they could/should work with the Emergency Department. The need to develop the right model for urgent care is widely recognised – it must include the right mix of Primary Care and the right use of the Emergency Department.
15	The Panel noted that some of the Green Paper respondents suggested that people should be charged to access A&E services.	▪ The proposals contained in the White Paper do not entail any additional charges for care. ▪ Any new charges proposed in the future will need to come before the States Assembly for approval.
16	A Workforce Planner has been appointed to facilitate the development of the FBCs. The Panel note that this example is one of several where work has begun in advance of the Report and Proposition being debated or approved by the States.	As set out in Key Finding 20 (below) there have been historical challenges associated with recruitment of an appropriately skilled workforce. It is therefore imperative that the plans set out in the White Paper had been subject to review but an experienced, specialist workforce planner. The White Paper needed the right staffing models to avoid the risk of introducing changes that would not work, were out of date or that did not support and develop our staff.
17	Enhanced community services will be required to interact with the services already being provided by States Departments. Therefore, the delivery of a new model of health and social care will be dependent on close collaboration between all relevant parties.	▪ Health and wellbeing impacts on many other areas of our lives – for example, housing and employment often impact on both physical and mental health – and vice versa. ▪ Health and social care is provided by many different individuals, professions and organisations – including other States Departments. ▪ Throughout the planning process, HSSD has worked closely with a wide range of professionals and organisations – for example, both Social Security and Housing have helped developed plans for Older Adults. ▪ The OBCs identified the key interactions, and the detailed FBCs will provide further detail – including care pathways, which will govern how care is delivered and how organisations work together with the needs of the individual at the centre.

	Findings	Comments
		▪ Close collaboration between all providers of care services is required to implement these proposals. Therefore significant effort has and will continue to be made to engage all community and voluntary sector agencies.
18	The Health and Social Services Department I.T. systems require further development and there is doubt as to whether it is able to provide the necessary information to deliver the proposed improvements in services.	▪ Information management and technology was identified in the White Paper as an area that needed to be developed to support the changes proposed. ▪ HSSD is preparing an Informatics Strategy and implementation plan to address the needs of the service over the next 6 years. ▪ Investigations are already underway in some areas, including the potential to link hospital and G.P. systems to facilitate the automatic delivery of test results.
19	Primary and secondary care on the Island have tended to be too isolated from each other.	▪ Throughout the planning process HSSD has worked closely with a wide range of professionals and organisations – G.P.s, hospital staff, community and Third Sector were on every working group. ▪ Integrated care is a key principle for the new services – organisations and professionals must work closely together, with the needs of the individual at the centre. ▪ The new care pathways will govern this, and will include things such as single assessment, single care planning, multi-disciplinary teams, better sharing of information, shared case notes.
20	Historical difficulties in recruiting trained nurses and other professionals have yet to be fully overcome. With this in mind, it is reasonable to question how far the Department will be able to meet the requirement for a large number of additional staff to deliver the improved services, particularly in the short-term.	▪ HSSD has had a relatively positive and successful year in recruiting and retaining nurses. This has been achieved through working closely with SEB, the Treasury, nursing unions and professional bodies. ▪ Further joint work is planned to build on this in 2013 and beyond. ▪ A similarly positive year with recruitment of senior doctors and further successful recruitment is anticipated in 2013. Many medical staff applicants have expressed a positive perception of the White paper which has informed P.82. ▪ Improvements have been achieved via a combination of local initiatives, and in partnership with other departments/providers, including – o Increasing places on-Island for nurse training (32 student nurses are training in Jersey). o 'Back to nursing' programme (14 nurses applied this year). o Placements for nurses training in U.K. interested in either returning to Jersey or working in Jersey (6–9 per year).

	Findings	Comments
		o Nurse Prescribing – this has made Jersey more attractive as a place to work, particularly to nurses who currently prescribe in other countries. o Annual on-Island programme – first group through in 2013 (14 local nurses will undertake the course). o Proactive recruitment of staff, Healthcare Assistants and Registered Nurses through the nurse bank (approximately 150 appointed per year). o Nurses attracted to work in areas with appropriate levels of staff – additional investment in nursing posts to increase staffing levels (circa 55 new posts over past 3 years). o Monitoring national/international workforce activity and targeting recruitment campaigns, and regular promotion of Jersey. o Relocation allowance. o Working with our partner organisations to support the development of the workforce across the Island.
21	The appointment of a Community Physician is not envisaged until June 2014. This appointment will lead the development of services across primary and secondary care.	▪ The OBC notes that a Community Physician should be appointed, temporarily, from mid-2013. ▪ This role is to "work with a Consultant Nurse or Allied Health Professional to focus on setting up and initiating the new model," *to "up-skill Primary Care via joint clinics between G.P.s and the Consultant Physician" and to "provide mentoring, education, specialist advice and support to G.P.s, and the specialist Nurses and Clinical Investigations Department will support G.P.s and Practice Nurses with ongoing education and advice*".
22	Some Service Level Agreements with the third sector are on an annual basis due to the way the budget system currently works. This provides uncertainty for some organisations and makes it difficult for them to expand and develop their services.	▪ HSSD recognise that annual planning does create uncertainly for Third Sector organisations. The new 3 year MTFP cycle will help HSSD and others States Departments to start agreeing longer-term contracts/ SLAs, where appropriate. ▪ In future, HSSD's SLAs will be monitored by a nominated lead officer and overseen by an appropriate Director. ▪ HSSD is working hard to develop relationships with third sector colleagues – and this is being recognised by many. ▪ HSSD is changing the formal of SLA documents, so that they reflect both sides of the relationship and are clear on what HSSD need to do, as well as what the third sector need to do.

	Findings	Comments
23	The newly established Third Sector Forum is a positive move to improve communication between the Health Department and third Sector.	▪ Officers from HSSD were instrumental in helping secure start-up funding for this Forum, and an HSSD Director is currently a non-voting member on the Forum. ▪ HSSD now holds quarterly briefing sessions with the Third Sector, of which many are (and will continue to be) heavily involved in the detailed planning of services.
24	Although a Third Sector Forum has been set up, it has been designed to represent all organisations. It could be argued that its remit is too wide to be effective in representing the main partners required to deliver improved community services relevant to health and social care.	▪ The Forum was set up with a remit across the whole sector and is undertaking work that is beneficial across the whole sector – not just health and social care organisations. ▪ That is a decision of the Sector and one which is supported by HSSD. ▪ Given the work taking place with HSSD however, the Third Sector Forum are focusing some of their efforts <u>first</u> on health and social care, with a view to then cascading the approach out to other sectors.
25	The potential remit of the Third Sector Forum Co-ordinator post is not fully clear. It is apparently intended that the post-holder will be asked to develop a governance framework for third sector organisations, set up policies and help to establish partnership models for government, private and third sector organisations. Our discussions with the Health Department left us unclear how this complex set of tasks would be fulfilled.	▪ The Forum is independent and these are issues to be addressed by the Forum, not be HSSD. ▪ HSSD meets regularly with the Third Sector Forum's Chief Executive Officer who presented and outlined his role at our quarterly briefing session that the Minister and senior Officers held with the Third Sector in October this year. ▪ We have had a number of meetings with the CEO, building relationships to understand what the Third Sector needs in order for HSSD to work better. ▪ We are looking forward to continuing to work with the CEO and the Third Sector Forum in the coming months and years, and to working closely with the Third Sector to develop and deliver excellent services for Islanders.
26	Some third sector organisations felt that the new services would duplicate those they are already providing.	▪ The services in the White Paper are a mixture of brand new services, expansion of current service models and changes to the way current services are delivered. It is therefore inevitable that some of the services in the White Paper are the same as some of the services that are already being delivered – because they are valued services and could be expanded to benefit more people. ▪ HSSD anticipate that Third Sector organisations will want to continue to deliver many of these services.

	Findings	Comments
27	The demise of the local welfare systems, based in each Parish, has left a number of Islanders without the personal contact which was previously available at Parish level.	▪ HSSD recognise this and therefore want to make more services available closer to where Islanders live, for example from Parish Halls, where appropriate. ▪ HSSD will work closely with the Parishes as new services are planned.
28	The long-term funding is difficult to identify and therefore funding of the proposed changes has not been identified after 2015.	▪ Funding for the first 3 years of this strategy was identified in the MTFP. ▪ In developing these proposals, consideration will be given to how the current system operates, including the impact of financial incentives and disincentives. ▪ Part (b)(iii) of the proposition requires the Council of Ministers to bring back proposals for a sustainable funding mechanism by the end of September 2014.
29	The different phases in the 10 year programme are interdependent with each other and with the re-design of health and social care services. At this time it is hard to determine whether the Report and Proposition proposals are affordable due to economic uncertainty.	▪ The Treasury's preparation of the Medium Term Financial Plan has included an assessment of all States income and expenditure over the 3 year period. ▪ The MTFP proposals were considered by the Assembly in early November, providing an opportunity to debate the economic and other assumptions underpinning the Plan.
30	The new long-term care benefit was originally to be implemented in 2013. The charge will now be introduced in 2014, but it is currently unclear how it will underpin the costs of existing or future health and social services.	▪ The Department is working with Social Security on the impact of introducing long-term care benefit and how it will interface with existing funding mechanisms and service provision. ▪ Part (b)(iii) of the proposition outlines the requirement to bring back proposals for a sustainable funding mechanism. In developing these proposals, consideration will be given to how the current system operates, including the long-term care benefit. ▪ The Department will be working with Treasury and Resources, Social Security and other departments (e.g. Housing) to ensure that any new or changed funding arrangement is comprehensive and considers all current issues.

	Findings	Comments
31	The flow of funding around the Health system needs to be addressed as a matter of priority. A new Primary Care model will need to incorporate appropriate long-term funding flows and incentivisation mechanisms.	▪ The White Paper recognises the need to ensure that there is effective and affordable Primary Care. Both Primary Care and funding are specific work-streams. ▪ The Department will be working with Treasury, Social Security and Primary Care providers to ensure that any new or changed primary care funding arrangements have the intended outcomes. ▪ This is covered in part (b)(ii) of the proposition (Primary Care) and part (b)(iii) of the proposition (sustainable funding).
32	There appears to be scope for greater communication between the Minister for Social Security, the Minister for Health and Social Services and Treasury and Resources about some of the Outline Business Cases being funded by the Health Insurance Fund. The Panel welcomes the recognition in the Report and Proposition that work to develop the proposals for a funding mechanism will involve Social Security.	▪ The development and implementation of the White Paper and associated work-streams have been overseen by a Ministerial Oversight Group, including the Minister for Social Security, the Minister for Health and Social Services and the Minister for Treasury and Resources. ▪ This oversight group has been supported by an Officer Steering Group, including senior officers and clinicians from Health and Social Services as well as Chief Officers from Health and Social Services, Social Security and Treasury and Resources. ▪ The development of proposals for funding outlined in the Report and Proposition will continue to be overseen politically and by Chief Officers of relevant Departments.
33	It appears that patients will face various additional costs if they are cared for in their own homes instead of in hospital where items such as nursing care and dressings are free.	▪ Work is currently underway on the FBCs. As part of this process, the financial implications and consequences of proposed changes on individuals, the Department and others will be considered in full. ▪ Certain services, such as dressings, are currently charged for; it is not intended that this will change. ▪ Therefore, patients who are cared for in their own homes will need to pay for these services, as they do now if they are treated in their own homes.

RECOMMENDATIONS

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
1	The initiation of the 10 year strategy should be accompanied by the provision of routine data on a consistent and comparable basis to facilitate monitoring over the full period of implementing the new strategy.		Accept	• HSSD has run this work programme to date using robust programme management and governance. This will continue, in order to monitor new services as they are introduced. HSSD is introducing robust routine monitoring. • New service level agreements (SLAs) will start to be introduced from 2013. Where appropriate, these will be longer-term agreements. • All SLAs will clearly set out what data that needs to be provided in order to better monitor value and ensure Islanders have the right services, as the population's needs change.	Note: the target for most actions is pending confirmation as part of the FBC process.
2	The Panel welcomes the intention under part (b)(iii) of the proposition to bring forward a sustainable funding mechanism, and recommends that such proposals clearly demonstrate how the potential financial disincentives in existing funding arrangements will be addressed. It is hoped that the Minister will accept the Panel's amendment to bring this forward by the end of September 2014.		Accept	▪ Funding for the first 3 years of this strategy is identified in the MTFP. ▪ In developing these proposals, consideration will be given to how the current system operates, including the impact of financial incentives and disincentives. ▪ Part (b)(iii) of the proposition requires the Council of Ministers to bring back proposals for a sustainable funding mechanism by the end of September 2014.	September 2014

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
3	The Panel recognises that the White Paper was drawn up on the basis of data available at the time, but recommends that further analysis is undertaken to establish the implications, if any, of the 2011 Census and projections based on scenario 3, their funding and the pressures driving service development. It will also be necessary to review the Health and Social Care Strategy in the light of any decisions that are made in 2013 regarding future population policies.		Accept	SEE KEY FINDING 8	
4	If telehealth and telecare are introduced in Jersey, their initiation should be carried out as a pilot trial and accompanied by rigorous cost benefit analysis and review.		Accept	SEE KEY FINDING 10: FBCs will be very clear about: the expected benefits and costs of services; when and how they will be introduced; how quickly they will be brought in; the management and monitoring processes associated with new services.	
5	The Full Business Case (FBC) for intermediate care and associated services should quantify the expected impact of this investment on demand for hospital services together with its predicted impact on patient and carer acceptability and satisfaction. Relevant baseline data on costs and outcomes should be collected and the results of introducing intermediate care services should be monitored against the		Noted	▪ Initial results from the current pilot study are being collated and are encouraging. ▪ FBCs will be very clear about: the expected benefits and costs of services; when and how they will be introduced; how quickly they will be brought in; the management and monitoring processes associated with new services.	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
	baseline and predicted impacts. While recognising that the initial results of the current pilot may be less substantial than those of the fully developed new service and facilities, the Panel recommends that data from the pilot should be as widely shared as possible as they become available to inform the development and acceptability of the new service.				
6	Before considering the implementation of a charge for accessing A&E services, further examination of where the burden is likely to fall and how affordable it will be for individual patient groups is required.		Accept	▪ The proposals contained in the White Paper do not entail any additional charges for care. ▪ Any new charges proposed in the future will need to come before the States Assembly for approval.	
7	The Panel is unconvinced that the introduction of Community Services will lead to a convenient balance of supply and demand between hospital care and care in the community. Rather it recommends that the Health Department should model the impact of investment in primary care and community services on the demand and supply of hospital services.		Accept	• Hospital and Community Services work in tandem to prioritise and allocate resources as appropriate. • Detailed modelling has been undertaken by W.S. Atkins as part of the pre-feasibility spatial assessment work. This included the impact of changing the service model as a result of investment in non-hospital services.	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
8	The Panel recommend that G.P.s and other primary care practitioners are actively engaged in the ongoing development of primary care services based on a holistic approach to care and multi-disciplinary working.		Accept	▪ This will be done as part of part (b)(ii) of the proposition – the proposed new model for Primary Care. ▪ This will be completed in September 2014 as time is required to fully engage with Primary Care practitioners (G.P.s, dentists, optometrists and pharmacists). ▪ Recognise need to make sure that the funding mechanisms for Primary Care link with the sustainable funding streams for the whole of health and social care (i.e. parts (b)(ii) and (iii) of the proposition link together).	September 2014
9	New and improved I.T. systems should be developed and funded as a matter of urgency. This should be coupled with ensuring highest standards of patient data protection prior to multidisciplinary teams handling patient information. An integrated I.T. system would help to improve the relationship between primary and secondary care.		Noted	SEE KEY FINDING I8	
10	It may be necessary to phase in new services over a longer timescale due to current difficulties with recruiting and retaining staff.		Accept	• There should be no requirement to phase in new service plans over a longer timescale solely because of recruitment challenges if HSS joint work with SEB, Treasury and nurse representatives continues the progress and momentum in recruitment and retention	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
				seen in 2012 (SEE KEY FINDING 20). • The detailed plans which are being produced as part of the FBCs will be tested by an experienced Workforce Planner and there will be challenges to ensure they are deliverable, given the challenges we face in recruitment and retention. (SEE KEY FINDING 16). • The plans will remain under review, and re-phasing will be undertaken should this prove necessary.	
11	Evidence suggests that there is an urgent need to develop the relationship between primary and secondary care. Therefore the appointment of a Community Physician should be made without delay.		Noted	▪ The OBC notes that a Community Physician should be appointed, temporarily, from mid-2013 (SEE KEY FINDING 21). ▪ This role is to "work with a Consultant Nurse or Allied Health Professional to focus on setting up and initiating the new model," to "up-skill Primary Care via joint clinics between G.P.s and the Consultant Physician" and to "provide mentoring, education, specialist advice and support to G.P.s, and the specialist Nurses and Clinical Investigations Department will support G.P.s and Practice Nurses with ongoing education and advice" [words taken directly from the OBC].	mid-2013

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
12	In order to assist in the development of services within the third sector, the Health Department should make every effort to enter into longer-term agreements with all providers. The intended move towards a 3 year funding envelope with the Medium Term Financial Plan will assist with this.		Noted	SEE KEY FINDINGS 22, 23, 24 AND 25	
13	Following the breakdown of communication between Silkworth Lodge and the Health Department, the Panel recommends that all Service Level Agreements cover a minimum period of 3 years and are monitored by a nominated lead officer. This would ensure the delivery and development of a sound working relationship that assists adaptation to changing needs.		Noted	SEE 12 ABOVE	
14	A sub-group of the Third Sector Forum that includes all key partners who currently deliver health and community services should be established by the end of 2012. This would improve working relationships between the third sector and the Health Department, and ensure better communication.		Noted	SEE KEY FINDINGS 22, 23, 24 AND 25 HSSD is committed to working with individual Third Sector organisations and with the Third Sector Development Forum. An HSSD Director is a non-voting member of the Third Sector Forum. It is a matter for the Forum whether it has a specific sub-committee for health and social care, although the Department would be very happy to work with such a sub-committee if it were established.	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
15	Before new programmes are rolled out, the Health Department should, in partnership with the third sector and other organisations, agree how specific services are to be managed to deliver efficiency improvements.		Noted	SEE KEY FINDINGS 22, 23, 24 AND 25	
16	The introduction of systems for monitoring service costs and outcomes should be dovetailed with the roll out of each new service. Therefore, baseline data should be established in order for this system to be developed.		Accept	SEE KEY FINDING 4 AND RECOMMENDATION 1	
17	The value and cost of services must be assessed objectively by robust monitoring. Where services are not sufficiently cost-effective or gaining acceptance from the public, their continuation should be publicly reviewed.		Noted	SEE KEY FINDING 4 AND RECOMMENDATION 1	
18	The Panel strongly support the intention behind part (b)(iii) of the proposition that there should be a sustainable funding mechanism for health and social care by the end of 2014, and the Panel recommend there should be no further slippage on the timescale. The Panel hopes the Minister will accept its amendment to bring this forward by the end of September 2014.		Accept	▪ Funding for the first 3 years of this strategy is identified in the MTFP. ▪ In developing these proposals, consideration will be given to how the current system operates, including the impact of financial incentives and disincentives. ▪ Part (b)(iii) of the proposition requires the Council of Ministers to bring back proposals for a sustainable funding mechanism in 2014. The Council of Ministers	September 2014

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
				agrees with the Panel's recommendation and intends to bring these proposals forward by the end of September 2014.	
19	Regarding the Primary Care model, any changes in the funding mechanism should be justified in terms of better outcomes for the patient and patient satisfaction.		Accept in principle	▪ The White Paper recognises the need to ensure that there is effective and affordable Primary Care. Both Primary Care and funding are specific work-streams. ▪ The Department will be working with Treasury, Social Security and Primary Care providers to ensure that any new or changed primary care funding arrangements have the intended outcomes. ▪ This is covered in part (b)(ii) of the Proposition (Primary Care) and part (b)(iii) of the Proposition (sustainable funding).	
20	Every effort should be made to allay costs for patients in homecare. Savings on the non-usage of hospital or nursing home beds should be recognised and nursing care, dressings, needles, appliances and so on should not be subject to charges.		Reject	SEE KEY FINDING 33 Financial implications for individuals will be considered in full and will be checked through the sustainable funding model. Important to note that some services such as dressings, are currently charged for; it is not envisaged that this will change. Some patients who are cared for in their own homes will need to pay for some services, as they currently if they are treated in their own homes.	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
21	The Panel expects the Health Department to focus on protecting patients from incurring any additional costs as the FBCs are worked up. The Panel recommends that, if any additional costs are introduced, these should be made clear to the patient from the outset and closely monitored.		Accept in principle	SEE KEY FINDING 33 AND RECOMMENDATION 20 Any new charges proposed in the future will need to come before the States Assembly for approval. Important to note that some charges, such as those for dressing, already exist and it is envisaged that this will continue.	