Submission of the Primary Care Body received 24th January 2020

HIGH LEVEL

- We need a definition of an acute hospital and what it will do.
  How will it integrate ('campus model') with a co-located mental health facility to reduce stigma?
  If there are precedents how are they faring?
  What are their pros and cons/pitfalls?
- It needs to be modular, irrespective of site – as stated.
- The new model may allow it to remain a similar size, but we consider it dubious that a reduction is feasible.
- Devolvement of care to the community, with the approaching change in our demographic profile, will not be cheaper (See Cochrane database references below) but may be more cost effective in selected cases or clinically desirable long-term.
- Significant extra funding for primary care will be required and will need to be proportional to **tolerable** workload.
  GP Indemnity, training and pensions will need to be components.
- Consequently, after the HIF (Health Insurance Fund – already actuarially predicted to have a life span of < 10 years) is reduced by a projected £50m a supplementary income stream for Primary Care will need to be identified.
  Currently the government spends approximately £9m on GP services/infrastructure which is less than drug expenditure (£20m) and considerably less than the £209m it spends on the rest of the Health economy.
  Patient out-of-pocket expenses amount to just over another £10m – equating to an average of £27/consultation, which is considerably less than the headline figure of >£40 and represents significant discounting.
  Jersey pension reserves are extremely healthy, and a tiny diversion of funds could obviate the need for a Health Tax or similar- we suggested this Q2 2019.
  Such use, according to recent media headlines, does not appear to have been entertained by the government to date.
- Any local introduction of what are now tertiary services, provided in the UK, will need careful economic analysis and the funds necessary will need to considered against a host of current essential services, which are increasingly overstretched.
- A Clinical Senate and underlying operational group need to be established early on to determine priorities and how these will be addressed.
  In progress. (There have been repeated concerns expressed, based on precedent, that the stretched resources of our civil service will be capable of enabling large scale change.)
- Collaboration rather than commissioning would provide a better way forward.
  Commissioning has not proved beneficial in even a large jurisdiction with much competition, such as the UK, and there are moves away from it.
  In a small island competition is not always possible or a desired outcome.

COMMUNITY CARE

- Length of stay in Jersey, according to the document, is approximately 4.6 days, which is already better than the comparators of the UK and France, so one needs to question what further improvements can be made.
- Readmissions are a risk but have begun to reduce with 'In Reach' frailty pilots.
    - There is provision for a centrally funded community follow up visit post discharge by a GP/ Nurse/Pharmacist. This is determined by a discharge team - potentially including Geriatrician/Nurse/Pharmacist/GP

It should also include:

- MUR (Medicines Use Review) – Previous successful Pharmacy pilot but not reintroduced
- Resource to signpost services ranging from e.g. Third sector/Voluntary workers/Mental health through to bed availability
  – Possibly an extension of JOD (Jersey Online Directory) which could filter services island wide and by Parish.
- This could encapsulate self-help information and phone support services (See on-line portal below)

- Shift of services into the community will require commensurate investment in infrastructure which includes bricks and mortar, IT and workforce development/education and administrative support.
  Infrastructure costs already approximate to 50% of turnover and will increase with movement of personnel to the community
  Primary care estates were supposed to have been audited with P82 funding but there is little evidence this occurred.
- The idea that care in the community, and particularly at home, is always cost effective will need to be challenged. High cost packages of care are not sustainable fiscally or by a limited workforce; particularly if an immigration policy to moderate population growth is envisaged with an anticipated dependency ratio of circa 2:1 by 2035
  Contrary to popular dogma, particularly in an island where family support may not necessarily be close at hand, some form of institutional care may well be the way forward for many. (Financial threshold approximately £110/day)
  (£110/day Residential vs £170/day Nursing vs £285 high level POC)
  There is a precedent of small homes for special needs patients (Les Amis model). Some, previously reclusive, patients also thrive in a residential environment.
- Similar principles apply to intermediate care, whether 'step-down' or 'step-up'
  A 'Cottage Hospital' type arrangement with Interface Physician/dedicated GP oversight and own GP visits for continuity and transfer on is envisaged -
  Perhaps an on-hospital site to facilitate care in case of deterioration of clinical condition and aid flexible/modular design of the hospital itself.
- A community nursing response service with technological support (e.g. AI prediction of increased risk and GPS tracking) in order to focus limited resources has also been discussed.
- This support will have to be 24/7, possibly with extended roles for practice nurses
  There may be scope to link this to 'Practice Clusters', as other services, to prevent complete decentralisation with attendant inefficiencies
  Currently Hospice and FNHC have no ability to provide overnight support in the community –provided solely by GPs and paramedics at this point in time.

IT

- Shared IT, with '**Data appropriately wrapped around the patient**' is of extremely high priority and primary care is streets ahead of secondary in its clinical use, homogeneity and use of decision support software.
  Poor processes with delayed communication of discharge/outpatient reports, iatrogenic (drug related) admissions and recent deaths make this even more pressing.
  There may be progress before the panel meets but it will only partially solve the problem of transcription errors and concomitant clinical risk
- Priorities in a development path include:
  - a shared drug database across acute/community care and community pharmacies,

    - a summary care record (UK precedent - More detailed data to be made available as confidence in governance allows) and
    - coded electronic data (CDA preferably) for results/discharge summaries leading to
    - data being shared dynamically in particularly ED, EAU and outpatient departments.

  In the case of health data, it is important that patients, ultimately, should be the ones who know who has accessed their data and control such access.
  Work on governance has been slow but there is potential for assistance from Digital Jersey.
  We are given to understand a hospital IT strategy has not yet been finalised.
- A link to the 'UK Spine' with a unique identifier (still not clearly established in routine practice in Jersey) would serve to simplify data interchange/interfaces, including across primary care. ('GP to GP' transfer of notes)
  Use of the NHS number for this and to facilitate tertiary care was suggested many years ago and our understanding is that negotiations are ongoing.

LONG TERM CONDITIONS (LTCs)

- Centralised recall for population screening - mirroring immunisation, now above UK levels
  Inclusions/Exclusions and methods may require further discussion to improve services/processes e.g. Mammography, bowel and aneurysm screening.
- Some lower level outpatient care can undoubtedly be devolved to the community.
  The 'new to follow up ratio' in Jersey is far higher than most CCGs in the UK, as stated
- 40,000+ outpatient appointments have been cited but it turns out a large proportion of these relate to physiotherapy. We need more granularity on which to base decisions.
  What % of total outpatient appointments does the actual figure represent?
  Which, and what proportion, are suitable for devolvement to the community?
  Will bureaucracy associated with central funding be stifling and all accountability lie with general practice, despite (historically) poor governance?
- Pathways of care will need to be established with triggers for referral accompanied by appropriate data (See shared IT above) and then OP or ambulatory assessment/admission. Complex patients will need to be retained in the hospital/intermediate system until stable and then passed back to the community with appropriate, timely provision of data which should include options for alternative care and triggers for re-referral.
- Better GP access to diagnostics (via such pathways/ambulatory care), reducing the clinical uncertainty with which they live every day, would also aid reduction of pressure on hospital-based services.
  Simple cost-effective developments have not been sanctioned
- Concurrently, our presently excellent availability/continuity of GP appointments needs to be preserved. Consequently, any extra workload (seemingly up to 10%) will need to be tempered by the introduction of viable multidisciplinary working to provide 'one-stop-shops' in terms of multiple, long-term condition management.
  Mirroring of the UK model would simply increase the evolving recruitment crisis which will be exacerbated by the retirement of a large cohort of senior GPs in less than a decade.
  'Portfolio careers' will also add to the numbers needing to be recruited to sustain adequate provision of care.
  Island based training is actively being pursued but will take several years to mature.

- If care, now provided free of charge in hospital for long term conditions (LTCs), is to be provided in practice then it will also need to be free at the point of delivery - together with care for which patients currently pay in general practice.
  This will be another source of expenditure.
  What and how many conditions should be covered?
  Initial thoughts are that the focus should be on those leading to frequent hospital admission.
- People from lower socioeconomic groups are disproportionately represented in respect of LTCs so, if we are to identify potentially serious problems in a prompt fashion, the level of focussed governmental financial support for financial vulnerable individuals will need to increase from approximately 10% of the population to circa 30% - mirroring similar jurisdictions such as Ireland and consistent with Jersey Consumer Council surveys carried out previously.
  This does not necessarily mean care would be free at the point of delivery, but fees could be related to income
  Associated bureaucratic costs associated with means testing should be kept low and utilise current arrangements, where possible.

URGENT TREATMENT CENTRE (UTC)

- The UTC requires more thought. On the surface, it seems not too dissimilar from what is in place at present – a safety net (albeit with different parameters) for acute physical and mental health problems outside the remit/expertise of primary care.
  It should be noted there are conditions (e.g. sprains and lacerations) which could be deemed to be appropriate for either setting. Demarcation will be required.
  If improved funding mechanisms and pathways of care are implemented it should mean less patient exposure to such a service for low level problems.
- A financial disincentive (in the context of focussed financial support) should be applied
  - i.e. it should be more expensive for patients with what are deemed as 'primary care problems' to be seen in the UTC (mirroring Guernsey ED). Without this there is a risk of a two-tiered service.
  A JDOC (out of hours) survey last year found 70% of primary care type presentations occurred in normal working hours
  Local GPs could, if considered necessary, be rostered to work in the UTC during the day and out of hours be co-located, again with charges above day charges to reflect the increased cost of OOH provision of services.
  Application of the Irish model to ensure 'free' care for truly urgent cases would also seem worth considering.
  Any centralised service risks wholescale movement of patients to that centre and discontinuity of care – to date something Jersey has managed to avoid.
  So-called Darzi Centres in the UK were not deemed a success.
  A separate UTC critique is available, if required.

MENTAL HEALTH

- Psychological services such as IAPT are crucial for early intervention but even earlier intervention is warranted and evidence based
  The feedback from psychologists is that issues in Jersey tend to be more complex than anticipated and have therefore required greater resource than predicted.
  JTT emanated from IAPT (Increased Access to Psychological Therapies), which was modified to include other modalities of treatment so that care could be tailored to individual needs and our understanding is that this has been preserved.
  Recruitment problems have resulted in waiting lists of up to 9 months and so the 'Listening Lounge' has been instituted.

- For more acute problems a responsive psychiatric service is essential.
  There have been improvements and a recent increase in consultant numbers will hopefully translate into a better service
  We are not sure if CPN numbers have also been increased as there have again been recruitment problems.
  Dedicated telephone support would be useful.
  More focus on the psychosocial model would be welcome.
- Patients who present with suicidal ideation have rapid access to specialist nurse care via the ED but it is not clear that this has affected the suicide rate, which is approximately 10 people a year.
  Bolstering of the community offering is required including 3rd sector e.g. 'Buddies' and Family/Carer Support

ANCILLARY SERVICES

- Social Care is a crucial component of both mental and physical health assessment, but recruitment has proved difficult.
- Pharmacist recruitment is also difficult as the training/role of pharmacists has changed. Consequently, newcomers seek to replicate the increased career satisfaction they can achieve elsewhere.
  Introduction of clinical pharmacists has proved to be effective and a demarcation between these and retail pharmacists is emerging.
  A Prescribing support scheme for primary care would be useful and cost-effective.
- Overall recruitment needs to be linked to immigration policy and help with housing/family for essential staff
  The disconnect between Population and Housing is purportedly being addressed but resources will never be enough unless some of the other components of this paper are considered – Community care fiscal/workforce planning.
- A Patient group should be established plus a patient portal for Health and other States departments.
  Self-help can be supplemented by evolving locality/parish-based services
  Before the segment of the population constituting the 'baby bulge' becomes frail it is likely that it will be a significant resource.
  What happened to 'Tell us Once' ? (? £7m expenditure)
  We understand there has been some recent progress with 'One Gov' which should prove useful.

Additional information/references

New Zealand integrated care. Currently held up to be one of the best in the world, although there are other models:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf

https://www.kingsfund.org.uk/blog/2017/08/lessons-canterbury-reasons-for-hope

Cochrane Database References – Effectiveness and costs of community care

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000356.pub4/full?highlightAbstract=discharge%7Cwithdrawn%7Cearly%7Cearli%7Cdischarg

‘Despite increasing interest in ‘hospital at home’ services as a less expensive alternative to inpatient care, this review provides insufficient evidence of economic benefit (through a reduction in hospital length of stay) or improved health outcomes’.

https://www.cochranelibrary.com/content?templateType=full&urlTitle=/cdsr/doi/10.1002/14651858.CD000356.pub4&doi=10.1002/14651858.CD000356.pub4&type=cdsr&contentLanguage=

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC28300/

https://www.ncbi.nlm.nih.gov/m/pubmed/24820131/?i=39&from=/19160179/related&filters=y_5

https://www.ncbi.nlm.nih.gov/m/pubmed/28369687/?i=22&from=/19160179/related&filters=y_5

https://www.ncbi.nlm.nih.gov/m/pubmed/26854816/?i=31&from=/19160179/related&filters=y_5

https://www.ncbi.nlm.nih.gov/m/pubmed/29902471/?i=10&from=/19160179/related&filters=y_5

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