STATES OF JERSEY

MEDIUM TERM FINANCIAL PLAN 2016 – 2019 (P.72/2015): FIFTEENTH AMENDMENT

Lodged au Greffe on 22nd September 2015
by Deputy G.P. Southern of St. Helier

STATES GREFFE

MEDIUM TERM FINANCIAL PLAN 2016 – 2019 (P.72/2015):
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PAGE 2, PARAGRAPH (b)(i) –

After the words "Summary Table C" insert the words –

> "except that the revenue expenditure of the Health and Social Services Department shall be increased by £500,000 in 2016 in order to provide additional funds for improvements in dental services with this additional expenditure being dependent, in accordance with the provisions of Article 16(4) of the Public Finances (Jersey) Law 2005, on the approval by the States of the transfer of the sum from the Health Insurance Fund to the income of the Health and Social Services Department in 2016 and to request the Minister for Social Security to bring forward for approval before 1st January 2016 the necessary legislation to give effect to this transfer".

DEPUTY G.P. SOUTHERN OF ST. HELIER

REPORT

The Council of Ministers has announced that it wishes to transfer funds from the Health Insurance Fund (HIF) as one of the short-term measures required to prop up Health spending while waiting for the creation of the new "Health Charge" by 2018. This transfer consists of 2 tranches of £15 million in 2017 and 2018. These items do not appear in the summary tables, but can be found on page 93 of the MTFP, and itemised in Figure 38, as follows:

> "Contributions from the Health Insurance Fund (HIF)
>
> The Council of Ministers is proposing that a sustainable funding mechanism ("Health charge") is introduced during this MTFP period which by 2019 would raise £35 million towards the increasing costs of health care in the island, in addition to the £30 million per annum currently raised through the existing Health Insurance Fund.
>
> The introduction of the new mechanism in 2018 will raise an additional £15 million, increasing to the full £35 million in 2019. However, as the cost of additional health services will also need to be met in earlier years, the Council of Ministers is proposing transfers from the Health Insurance Fund (HIF) of £15 million in 2017 and £15 million in 2018. The Council of Ministers intention is to introduce a health charge at the earliest opportunity, so if it were possible for an earlier introduction, perhaps in 2017, this could be used to partly offset the proposed level of HIF contributions.
>
> The balance on the HIF at the end of 2014 is £85.1 million and any transfer to the Consolidated Fund requires a change to primary legislation. The Council of Ministers will request the Minister for Social Security to bring such a proposition to the States in due course and the plan to make these transfers will be confirmed in the MTFP Addition in June 2016.
>
> The Council of Ministers is therefore proposing the funding measures summarised in **Figure 38."**

The precedent for using the MTFP to cover some expenditure was set by the previous Council of Ministers in the 2013 – 2015 MTFP, where the expenditure paragraph read as follows –

"(c) to approve the following amounts (not exceeding in the aggregate the total amount set out in paragraph (b) above) –

(i) the appropriation of an amount to a revenue head of expenditure for each States-funded body (other than the States trading operations) being the body's total revenue expenditure less its estimated income for each of the financial years 2013 to 2015 as set out in Summary Table B with, in relation to the head of expenditure of the Health and Social Services Department, the approval of £2,000,000 in 2013, £6,000,000 in 2014 and £6,000,000 in 2015, dependent, in accordance with the provisions of Article 16(4) of the Public Finances (Jersey) Law 2005, on the approval by the States of the transfer of these sums from the Health Insurance Fund to the Health and Social Services Department;".

Figure 38: Summary of proposed short-term funding measures

Summary of Funding Proposals	2015 Forecast £'000	2016 Forecast £'000	2017 Forecast £'000	2018 Forecast £'000	2019 Forecast £'000
Forecast Consolidated Fund balance b/fwd	**4,707**	**45,742**	**21,155**	**23,259**	**24,556**
Shortfall from Financial Forecast	(28,965)	(74,278)	(54,169)	(13,702)	25,256
Funding Requirement for Other Capital Projects	-	(1,000)	(39,000)	(8,233)	-
Revised Funding Requirements	(28,965)	(75,278)	(93,169)	(21,935)	25,256
Proposed Short-term measures					
Accounting Policy	-				
Change in Accounting Policy for Income Tax	60,000				
Transfers (to)/from Strategic Reserve					
Other Capital Project funding - Les Quennevais	-	1,000	39,000	-	-
Annual Capital propgramme funding	-	25,691	26,273	-	-
Funding requirement for Committee of Inquiry	10,000	4,000	-	-	-
Funding requirement for Economic and Productivity Growth Drawdown Provision	-	5,000	5,000	-	(10,000)
Funding requirement for Redundancy Provision	-	10,000	10,000	-	(20,000)
Consolidated Fund Working balance from Strategic Reserve	-	5,000	-	-	-
	10,000	50,691	80,273	-	(30,000)
Transfers from Health Insurance Fund					
Transfer from Health Insurance Fund			15,000	15,000	
Transfer from COCF					
Transfer for Prison Improvement - Phase 6				8,233	
Forecast Consolidated Fund balance c/fwd	**45,742**	**21,155**	**23,259**	**24,556**	**19,812**

The intention to transfer funding in 2012 found its way to Article 2A of the Health Insurance Fund (Miscellaneous Provisions) (Jersey) Law 2011 to be found in **Appendix 1** to this amendment.

Appendix 2 to this amendment contains a previous proposition (P.127/2013) intended to improve the delivery of dental services to the Public. It was in turn derived from the findings of Scrutiny Report S.R.12/2010, Dental Health Services Review, published in November 2010, which came to some stark conclusions:

> *"This report evidences that Ministers have neglected their remit in relation to dental health..... dental health care provision in Jersey (is)outdated and insufficient."*

The Scrutiny Report bore witness to the fact that the Dental Fitness Scheme, which was targeted at 11–18 year-olds, had not been upgraded since its creation in 1991, with the result that it was scarcely reaching a fraction of its potential clientele. P.127/2013 illustrated a sorry tale of prevarication and inaction on the part of Ministers.

The Minister did agree to bring to the States a report on dental services. This has now been published as R.91/2015, Dental Health Services and Benefits: Review – June 2015. The Key Findings and Action Plan from that report are reproduced here at **Appendix 3**.

As members will note, the review is somewhat heavy on governance and management information and rather less clear on actions. I wish to draw attention to one vital phrase under the section entitled ‘Outcome: Future delivery system’ –

> *“State funded support based on need will be an important principle, …”.*

My concern is that the current system in place to deliver state-funded support, the JDFS, which clearly is a community service and soundly based on preventative medicine and delivered to a high standard –

> *“The dental health of children on the scheme is exceptionally high – suggesting that services are provided to a high standard by the community dentists.”.*

Despite all the fine words dispensed on this subject, the fact is that the slow decline of the JDFS, noted in 2010 and 2013, is continuing.

The number of eligible young people on the scheme has fallen from 1,660 in 2001 to 1,238 in 2010. In June 2014 this had fallen further to 1,134. What is worse is that along with this lack of penetration, many community dentists are losing faith in the scheme, as the state support for the scheme has not been uprated and stands at £6 for the monthly payment. On average, dentists charge £13.82 monthly to maintain dental fitness. This almost exactly matches the impact of inflation since 1991.

Financial and manpower implications

This amendment does not increase net revenue expenditure, as the increase in expenditure is offset by the transfer from the Health Insurance Fund which, as with previous transfers, will be treated as income to the Health and Social Services Department.

APPENDIX 1

HEALTH INSURANCE FUND (MISCELLANEOUS PROVISIONS) (JERSEY) LAW 2011

A LAW to withdraw money from the Health Insurance Fund for 2011, 2013, 2014 and 2015, to enable the withdrawal of money from that Fund for 2012 and to authorize the withdrawal of certain expenses from that Fund.

Commencement [see endnotes]

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1 Withdrawal of money from Health Insurance Fund for 2011

(1) Notwithstanding Article 21(1) of the Health Insurance (Jersey) Law 1967, there shall be withdrawn from the Health Insurance Fund and credited to the consolidated fund the sum of £6,131,100, for the purpose of funding primary care services in 2011.

(2) Money credited to the consolidated fund pursuant to paragraph (1) is, for the purposes of the Public Finances (Jersey) Law 2005, to be treated as income of, and paid into the consolidated fund by, the Health and Social Services Department.

2 Authority to withdraw money from Health Insurance Fund for 2012

(1) Notwithstanding Article 21(1) of the Health Insurance (Jersey) Law 1967, there shall be withdrawn from the Health Insurance Fund and credited to the consolidated fund, for the purpose of funding primary care services in 2012, such sum (if any) as is specified in a proposition lodged by the Minister for Social Security and adopted by the States.

(2) Money credited to the consolidated fund pursuant to paragraph (1) is, for the purposes of the Public Finances (Jersey) Law 2005, to be treated as income of, and paid into the consolidated fund by, the Health and Social Services Department.

2A Withdrawal of money from Health Insurance Fund for 2013, 2014 and 2015

(1) Notwithstanding Article 21(1) of the Health Insurance (Jersey) Law 1967, there shall be withdrawn from the Health Insurance Fund and credited to the consolidated fund –

(a) £2,000,000, for the purpose of funding primary care services in 2013;

(b) £6,000,000, for the purpose of funding primary care services in 2014;

(c) £6,000,000, for the purpose of funding primary care services in 2015.

(2) Money credited to the consolidated fund pursuant to paragraph (1) is, for the purposes of the Public Finances (Jersey) Law 2005, to be treated as income of, and paid into the consolidated fund by, the Health and Social Services Department in the year for the purposes of which the withdrawal and credit is made.

3 Authority for Minister to withdraw expenses from Health Insurance Fund

Notwithstanding Article 21(1) of the Health Insurance (Jersey) Law 1967, the Minister for Social Security may pay out of the Health Insurance Fund expenses incurred in developing an infrastructure (to include a system for data-gathering) and establishing arrangements for –

(a) primary care governance; and

(b) the assessment and monitoring of primary care standards.

4 Citation

This Law may be cited as the Health Insurance Fund (Miscellaneous Provisions) (Jersey) Law 2011.

APPENDIX 2

DENTAL HEALTH SERVICES: IMPROVEMENTS (P.127/2013)

PROPOSITION

THE STATES are asked to decide whether they are of opinion −

to request the Minister for Health and Social Services and the Minister for Social Security to work together to improve the dental health of the Island by undertaking the following actions by the end of 2014 –

(a) to transfer the funding of the Jersey Dental Fitness Scheme from the budgets of the Health and Social Services and Social Security Departments to the Health Insurance Fund with the Fund also being used to fund the other measures below as required;

(b) to uprate the monthly payment to dentists to bring children to, and then maintain, dental fitness and to ensure that the value of the payment is index linked in future;

(c) to raise the upper earnings limit for qualification for the Jersey Dental Fitness Scheme to the upper boundary of the 4th quintile of annual household income and to ensure that this is index linked in future;

(d) to undertake a publicity campaign to promote dental health services provided in Jersey;

(e) to ensure that that the need for upfront payments for dental treatment required by the Westfield scheme is eliminated;

(f) to ensure that adequate training is provided by the States to all carers working in public or private residential care so that they are properly trained in the delivery of oral hygiene including training in relation to the benefits of the use of high-dose fluoride toothpaste for those in residential care;

(g) to examine the potential of expanding the range of those eligible to partake in the Jersey Dental Fitness Scheme and to report back to the States with recommendations.

DEPUTY G.P. SOUTHERN OF ST. HELIER

REPORT

The following is taken directly from the introduction of S.R.12/2010, Dental Health Services Review, published in November 2010 –

> *"This report evidences that Ministers have neglected their remit in relation to dental health. The Panel identified that the Health Insurance (Jersey) Law 1967 made provision for the introduction of a dental health scheme. It was obviously the intention of the States to introduce a dental provision as part of the Health Insurance Scheme which to date has been ignored.*
>
> *The evidence received shows dental health care provision in Jersey to be outdated and insufficient. Problems also appear to exist in Ministers taking responsibility for dental health. This may be due to overlaps between the Minister for Health and Social Services and the Minister for Social Security."*

Deputy D.J. de Sousa of St. Helier, the then Chairperson of the review, was shocked to witness the neglect of dental health –

> *"I was aware that the Dental Fitness Scheme had not been updated for 18 years and that the existing provision of dental schemes offering financial assistance excluded a large proportion of the population between the ages of 18 and 65.*
>
> *However, I was surprised to learn that neither of the Ministers with a remit for dental healthcare had looked at the difficulties people are facing when it comes to affording basic dentistry. More concerning was that those Ministers have not fulfilled their function in providing a modern dental health service as part of the primary health care system.*
>
> *The evidence we have received suggests that Jersey residents are having a serious problem affording dental treatment. This is particularly frustrating because the Health Insurance (Jersey) Law 1967 makes provision for assistance with dental costs. That provision in the law has simply not been enacted. The Health Insurance Fund does have an annual surplus, so there is absolutely some scope for this to be done.*
>
> *I am pleased to present this report, which evidences issues in service provision and cost of dental treatment that have been highlighted to us from a broad cross section of Jersey residents. The Ministers must now fulfil their remit by undertaking the eighteen recommendations made by the Health, Social Security and Housing Scrutiny Panel."*

After 3 years of inaction and false promises on the part of both Ministers this proposal concentrates on just 6 of the original 18 recommendations, each of which could make a significant improvement to the standard of dental health on the Island. I believe that all can be put in place in the short-term to deliver long-term benefits.

Recommendations (taken from SR.12/2010)

"1. The Minister for Social Security should provide an incremental means tested system within the Dental Fitness Scheme to accommodate families with more than one child. (Para 5.3)

2. The Minister for Health and Social Services together with the Minister for Social Security must deliver an updated Dental Fitness Scheme before 8th July 2011. (Para 5.5)

3. The Minister for Social Security must remove the necessity for (upfront payments at the point of treatment within the Westfield 65+ Plan by 8th July 2011. (Para 5.7)

7. The Minister for Health and Social Services must provide adequate oral hygiene training provision for all carers working in public or private residential care by 8th July 2010. (Para 5.17)

8. The Ministers for Health and Social Services should discuss the introduction of fluoride toothpaste for those in residential care with the relevant professionals. (Para 5.18)

11. The Ministers for Health and Social Services and the Minister for Social Security should immediately undertake a publicity campaign to promote dental health services provided in Jersey. (Para 5.29)

16. The Minister for Social Security must consider the introduction of a dental benefits scheme as outlined within the Health Insurance (Jersey) Law 1967 by 8th July 2010.(Para 7.11)"

In their response to recommendations 1 and 2 in particular, delivered on the 8th December 2010, the Minister for Health and Social Services together with the Minister for Social Security had the following to say –

"The Minister for Health and Social Services is currently undertaking a major review of health strategy. It is recognised that all practitioners should be encouraged to provide appropriate preventative care. Until this review is complete, it would be a poor use of public resources to initiate separate reviews of parts of the health system.

However, it is accepted that a review of the JDFS should be undertaken at an appropriate time. This will be before the end of 2012. No additional funding is available for this scheme at present and any enhancements to the scheme will need to be achieved within the current funding envelope. The review will include the eligibility conditions for the benefit and investigate the reasons given for parents leaving the scheme."

What happened? Nothing.

Furthermore, one year on from this response, the Minister for Social Security made a statement in the Assembly as follows –

Senator F. du H. Le Gresley (The Minister for Social Security):

> *"I have recently met with Senator Breckon to discuss his proposition P.170/2011, which seeks to improve access to dental services for local residents. After a positive discussion, Senator Breckon has agreed to withdraw his proposition on the basis that I will undertake to ensure that 2 issues identified by the Scrutiny Panel review of dental health services will be prioritised within my departmental business plan for 2012.*
>
> *I am pleased that one of my first acts as Minister has been to make this agreement in the spirit of co-operation confirming the importance of the Scrutiny function and that of independent back-benchers. The dental health services review was undertaken by the Health, Social Security and Housing Scrutiny Panel under the chairmanship of the former Deputy de Sousa.*
>
> *The report S.R.12/2010 was published on 8th November 2010. A joint response from the Ministers for Health and Social Services and Social Security was published on 20th December 2010. The review noted that support with dental costs was available to teenagers through the Dental Fitness Scheme and to pensioners through the 65-plus Health Scheme. However, neither of these schemes has been reviewed for a number of years.*
>
> *I will undertake to review the provision of assistance with dental costs under both these schemes during 2012. The reviews will also consider the administration of the 2 schemes. Senator Breckon has agreed to play an active part in the 2 reviews that will take place in 2012 and I look forward to working with him during the year."*

I recently asked Senator A. Breckon what had happened. He replied "*Nothing*".

Eighteen years of neglect of the Dental Fitness Scheme has now turned into 21 years of neglect.

Proposals (a) and (g): Use of the Health Insurance Fund (HIF)

Recommendation 16 of the 2010 Review proposed that the Health Insurance Law be used to create a dental benefit scheme, pointing out that such a scheme could be created by regulation –

> **"Health Insurance (Jersey) Law 1967**
>
> *7.5 In 1964, the States of Jersey adopted P.69/1963 thereby creating the Health Insurance (Jersey) Law 1967. This legislation created a system whereby a percentage of earnings was taken from both employees and employers to fund certain health benefits for insured members of the scheme. The descriptions of the benefits are contained within article 7 of the Law:*

The description of the benefit provided by this law is as follows –

(a) medical benefit;

(b) dental benefit;

(c) ophthalmic benefit;

(d) pharmaceutical benefit.

7.6 Dental benefit is afforded the same importance as medical and pharmaceutical benefits throughout the Health Insurance (Jersey) Law 1967. It is clear that the intention of the law was to provide residents not only with medical and pharmaceutical benefits but also with dental and ophthalmic benefits.

7.7 The Health Insurance (Jersey) Law 1967 provides for the introduction of each of these benefits by regulation.

7.8 Subordinate regulations for medical and pharmaceutical benefits were introduced, however, dental and ophthalmic benefits were omitted."

The report pointed out that the HIF was in a healthy financial state. It remains so today.

"7.9 Each year the Health Insurance Fund pays out in benefits approximately three quarters of the money it collects from Social Security contributions. The balance of that fund, as at December 2009, was £77,476,000. Medical Benefits paid for that year were in the amount of £5,785,000. The surplus of income over expenditure for that year was £5,378,000. The Panel believes that in view of those figures there is the potential to develop a dental benefit scheme of similar cost to the provision of medical benefits. As previously stated, this clearly was the original intention of the States."

The JDFS is funded from general tax revenues made up of £28,000 per year from HSS funds to bring children up to dental fitness and up to £140,000, held by the Social Security Department towards the monthly payments to maintain the dental fitness of those in the scheme.

Part (a) of this proposition suggests that this funding for JDFS be sourced from HIF.

Part (g) then goes further and requires the investigation of the potential for funding a wider scheme using HIF funding. Transfer of funding to HIF is designed in the first instance to avoid wrangling over health department funding priorities through the use of HIF which is in a healthy state despite the 2 large contributions to the funding of primary care in the past 2 years. In 2009 the HIF contained around £77 million of reserves and had a £5 million excess of income over expenditure.

(b): Uprating monthly payments

Dental Fitness Scheme funded by health

When it was initiated in 1992, the JDFS was aimed at all 11 to 18 year olds and those 18 to 21 year olds in full-time education. Where a child is presented to the dentist, that dentist will examine the child's teeth and undertake any treatment required to bring that child to 'Dental Fitness'. The £28,000 funding for this treatment comes from the Health and Social Services Department. It is a taxpayer funded benefit and there is no cost to the family, providing that they fall below the income bar of £43,197. Once the child reaches 'Dental Fitness' they become eligible for the Dental Fitness Treatment Scheme.

Dental Fitness Scheme funded by Social Security

At this point, the arrangements change. The scheme began in 1992 when the arrangement was that a dentist taking on a 'Dentally Fit' child would receive £6 per month for the maintained treatment of that child. If the work were expected to cost more than the monthly-accrued amount agreed with the parents, then a payment plan would be agreed with those parents for the outstanding amount. At that time, £6 per month was usually sufficient to cover the costs involved.

Although the Minister for Social Security asserted (to the Scrutiny panel) that the scheme has been reviewed over the years, the payment to dentists has remained at £6 per month since the inception of the scheme 18 (now 21) years ago. This was confirmed by the Consultant in Restorative Dentistry, stating that –

> *"£6 per month is what the States provides and that £6 per month comes from the £140,000 held by Social Security."*

Worryingly, he went on to say –

> *"I think what is more noticed by the providing dentist is the £6 per capita which was introduced in 1992. The States pay the dentist £6 per month per child enrolled by that dentist and that has not gone up. That is the bit, I have to say, that there is a level of concern and disquiet by the providing dentists."*

Obviously 21 years of inflation has eroded the value of the monthly £6 payment. In each of the last 2 decades the R.P.I. has risen by approximately 50%, which means that to retain its value this monthly payment should be £13.50. Indexing the costs of the scheme would result in the initial work to get children dentally fit would raise the original £28,000 to £63,000. Index linking the sum of £140,000 for the maintenance of dental fitness would raise this cost to £315,000.

(d): Jersey Dental Fitness Scheme – scope and uptake

After 2 decades of neglect the JDFS has limited reach currently. It is interesting to note that some time the original sum for getting children to dental fitness was 335,00. This budget was reduced to the current £28,000 because of low numbers participating. Almost from the outset there was insufficient publicity given to the scheme. Further exploration of the numbers indicates the importance of part (d) of the proposition, the need for wide promotion of any scheme.

Examination of the Annual reports of the Social Security department show uptake of the scheme has been low, and that these low numbers have reduced over time –

Dental scheme members

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
1,663	1,415	1,346	1,305	1,320	1,309	1,331	1,255	1,214	1,238

This is reflected in the costs of the scheme over this decade –

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
£, k	100	101	106	101	97	95	92	92	87	88

As can be seen, the nominal £140,000 held for the scheme has not been fully expended. This limited reach must be seen in the context of the total numbers who are eligible for membership. Covering the 8 years from 11–18 would encompass around 8,700 children. The cap I propose would reduce this by the number of 11–18 year olds in the upper quintile, 15% to 7,400. To this one has to add those aged under 21 in education, that is 1,250, giving a total of 8,600 children and young people eligible to join the scheme. If 100% coverage were achieved (which is highly unlikely) the total cost of the maintenance of dental fitness might add up to a total of £1.3 million.

(e), (f) and (g): Dental care for the elderly

Again, these parts come from the scrutiny report S.R.12 2010. The first deals with the need for members of the Westfield scheme for over-65s to pay for their dental treatment up front and then claim this back from the scheme. The sums available for dental treatment are as follows –

Dental

- every year, up to £22 towards a dental check-up
- every year, up to £250 towards dental treatments or dentures.

How do I make a claim?

- visit the dentist / optician / State registered chiropodist
- receive treatment
- pay for your treatment
- obtain a receipt (please note, credit card receipts are not acceptable)
- forward this receipt plus the completed claim form to Westfield.

It was reported that some members of the scheme found it difficult to pay the entire cost of their dental treatment up front. I do not know when the figures in the Westfield scheme were last uprated and whether they are realistic, but I am sure there are some who would have difficulty paying out £250 or more before getting reimbursed. Two hundred and fifty pounds is around the cost of an extraction, but far short of the cost of a cap, for example. It would, however, seem a simple step to obtain an estimate

for treatment from the dentist and to have the £250 contribution towards the cost paid direct to the dentist.

Residential Care

Again I quote directly from the scrutiny report S.R.12/2010 –

"5.15 The Panel has found that there is a further vulnerable group who require particular care within society. People in high risk groups who are in residential care require particular services. During the discussion with the Minister for Health and Social Services, the following issues were raised:

(i) The Minister has given no thought to the people in these groups:

'No, to be blunt. Until we had this review it had not been on my radar, so to speak. But it is interesting and full marks to the Consultant in Restorative Dentistry and his team too. I think it is those areas that perhaps Health and Social Service do not fly the flag saying this is what we do. But obviously we do it.'

(ii) The Consultant in Restorative Dentistry considered that large improvements could be achieved in residential care if patients mouths were cleaned with a fluoride toothpaste."

(Here the consultant is referring not to fluoride toothpaste that can be bought over the counter to special high strength (x3) toothpaste which can make significant and rapid improvements in oral health.)

"(iii) Cleaning inside the mouth can be considered invasive, and as recognised by the Panel Members, carers are reluctant to engage in this activity . The Consultant confirmed this saying:

'Yes. I came into conflict with the manager of one of the homes over that precise issue. When a carer brought a patient in to see me at the hospital and I was frankly appalled at the poor oral hygiene. It was not the patient's fault, the patient does not know what to, they cannot do it, the patient has lost their self-awareness and it is the responsibility of the carer.…'

5.16 It has not taken the Panel a great deal of effort to establish that the local guidelines on dental care within residential communities are not clear. The Consultant in Restorative Dentistry further stated:

'They [persons in care] are not getting their teeth cleaned because people fear that it infringes their human rights; that really needs to be addressed.'

5.17 *United Kingdom's Mental Capacity Act 2005 Code of Practice offers a best practice model for professional carers working in a residential care environment in the absence of any local legislation. The Code of Practice makes it clear that care should be in the interest of the patient, not the interest of the staff or carer. Insufficient training appears to have created an environment of caution with regard to delivering oral hygiene which can be viewed as invasive."*

Financial and manpower implications

As stated in the body of the Report, at best the scheme only achieved around 20% coverage in 2001, and was only funded to reach around 27% of those potentially eligible. Simply maintaining this level of coverage and uprating the funding by inflation over the past 2 decades would result in the following costs, to be met from the HIF –

Reaching dental fitness	original	£35,000	today	£73,000
Maintaining dental fitness	original	£140,000	today	£290,000
Total				£363,000

If we were to raise the target above the previous 27% coverage to around 50% coverage, these costs would be increased to around £670,000.

In addition, to administer the scheme and in particular to deliver the improvements in residential and elderly dental health, this proposal would require additional staffing of a community dentist (grade 13) and a dental nurse (grade 6) at an annual cost of around £100,000, giving total costs of £770,000.

The Health Insurance Fund (HIF), despite 2 years when a £6 million annual contribution was taken from the fund to deliver the costs of primary health care through the hospital, has seen its reserves rise from £77 million in 2009 to £80 million in 2011.

APPENDIX 3

Extracts from 'Dental Health Services and Benefits: Review – June 2015' (R.91/2015)

Key findings – Dental services and benefits

The OCC review of spending on dental services and benefits proposed a number of recommendations, scalable from short term tactical actions up to challenges which impact system wide. The review identified three areas of concern which should be addressed as a priority to facilitate the development of oral health care across Jersey.

1. Management information: the review suggested that existing management information was insufficient to be able to fully determine the extent to which the States achieve value for money against an estimated £1 million per annum spend. A key recommendation is to improve our intelligence around demand, capacity, service delivery, quality and care outcomes.

2. Governance: the review identified gaps and inadequacies in governance across all services. The roles played by bodies, departments and stakeholders needed to be clarified and strengthened and it was not possible to easily demonstrate adherence to GDC requirements. Governance surrounding initial and ongoing eligibility for the dental schemes and for reimbursement of dental charges should be strengthened.

3. Strategy: The review identified a lack of strategic direction for oral health services and recommended that a cohesive strategy, involving all stakeholders is developed. Since the fieldwork underpinning the review was undertaken, considerable progress has been made on developing a primary care strategy and an acute services strategy, both in line with the overarching strategy agreed by the States in 2012 (P.82/2012). The future of dental services must be considered in line with these other strategies.

Action Plan

The original intention was to use the external reviews to help to shape an implementation plan to deliver a new system. However the research has identified challenges in our current management information and governance which must be addressed before further development can take place.

Our commitment to deliver an 'implementation plan' has therefore been superseded by a commitment to develop and commence implementation of an Action Plan which will address the recommendations of the review. The plan contains six elements comprising four enablers (required to take the service forward) and two directionally correct initiatives, (which can be tackled in the short to medium term). The evaluation and learning from these will then influence the content of an Oral Health Strategy.

The elements of the Action Plan are:

Enabler: Strengthen Governance

The OCC review identified gaps in local governance arrangements and highlighted this as a pressing concern. As a result of their observations this Action Plan suggests that the service is offered strong leadership (by the Primary Care Governance Team or a Head of Profession). The aim would be to further the quality of care and monitor adherence with the requirements of the General Dental Council, contributing clinical expertise to the delivery of a sustainable strategy.

The Governance stream of work also calls for greater clarity in the roles and responsibilities of departments, bodies and other stakeholders, these will be agreed and clarified. A new Dentistry (Jersey) Law has recently been developed by HSSD to provide for the local registration of all types of professional involved in providing dental care. The implementation of this new law will be a useful step in the future development of an appropriate governance system.

Enabler: Workforce Development

Workforce development is key to delivering good governance, an efficient and value for money service and to develop a service which is sustainable. The review did not complete a workforce survey but anecdotal reports suggest a sizeable cohort of clinicians are due to reach retirement age within short succession of one another. There is an opportunity to ensure that the most appropriate practitioners are identified, via workforce strategy development, to enable Jersey to attract and develop the right mix of skills for a sustainable service. The Action Plan should also consider mechanisms to invest in the workforce so they may develop the skills to manage dental data and regulatory compliance.

Enabler: Develop a needs assessment

The OCC review recommended that a needs assessment be conducted, offering better intelligence on the demands placed on Jersey's oral health system. While the value of epidemiology surveys was questioned, the review identified opportunities to collect information by recording the oral health of children examined as part of the Community Dental Service school visits. Further opportunities may be found in the school survey conducted by Education among children in years 6, 8 and 10. The opportunity has already been taken to include questions in the 2015 Jersey Annual Social Survey to collect data on the experience of dental disease among adults.

Enabler: Develop management information

The review encountered difficulties in quantifying the service currently offered and identified gaps in management information, particularly in the Dental Department. As a priority the Action Plan should seek to identify opportunities to improve the functionality of the current IT systems as part of the HSSD IT strategy and to integrate this, possibly via future upgrades, to its Patient Management systems.

Initiatives: Public Health Education

In 2013, the Ministers for Health and Social Services and Social Security gave a commitment to develop a business case for dental education. Independent of this commitment the OCC review recommended the introduction of an education programme. The review stressed, however, that this programme should not be isolated and badged as 'Dental' or 'Oral Health' but that it be fully integrated into the Public Health agenda, arguing that common determinants of disease cut across issues such as obesity, diabetes, alcohol misuse. The education plan should also recognise a life course approach and initiate interventions and messages appropriate to specific life stage.

Initiatives: Improve existing delivery systems

The OCC review suggested the island will struggle to move forward with our provision of dental services and benefits without putting in place improved management information and governance. However it is possible to identify some short and medium term activities which are directionally correct. These activities will be identified and championed by a working group and are likely to include a rationalisation of administration cost (creating savings which might be diverted to revise existing services), prioritisation of dental hospital services and changes to the process for identifying and supporting people wishing to receive benefit.

Some activities have already been completed. The Jersey Dental Fitness Board of Management has looked at how its scheme is advertised, and has financially supported direct mailing to eligible school children and attended open evenings where packs promoting the scheme were distributed directly to parents. Over a thousand information packs have been distributed to children and their parents during 2014. Social Security has also increased communications with pensioners. Each August a leaflet has been sent to pensioners informing them of the benefit schemes they may be entitled to. A second leaflet was sent in January, these communications are being redesigned and will become part of the regular programme of communications.

Social Security has also surveyed pensioners who are members of the 65+ healthcare scheme but have not made any claims for benefit. Contact was made with 20% of non-claimers and half of those interviewed said they had not made a claim because they'd forgotten they were entitled. This is being taken forward in discussion with the company who administer the scheme.

These actions are in line with the agreement in the 2013 debate "to undertake a publicity campaign to promote dental health services provided in Jersey." The other action agreed at that time was to examine "the potential for expanding the range of those eligible to partake in the Jersey Dental Fitness Scheme." The future development of that scheme will be considered, alongside the 65+ Healthcare scheme and other dental spend, as part of the Action Plan and in conjunction with the development of the primary care strategy.

Outcome: Development of a Sustainable and Coherent Oral Health Strategy

The OCC review recommends that Jersey develop an oral health strategy. In order for this to integrate with the strategic direction and development of other services, this strategy should be formed mindful of wider developments across the Island's healthcare. For example oral health should feature in the Public

Health Strategy, acute dental care should be encompassed in the Acute Service Strategy and all other dental services within the Primary Care Strategy. In particular, the Acute Service Strategy has identified the requirements and clinical model for the complex dental services requiring hospital facilities and/or expertise. The Acute Service Strategy does not currently envisage making provision for any other dental services as, in line with the strategic principles agreed by the States, these should be located and managed within Primary Care.

It is proposed that an oral health service model is developed by a cross department/multi-discipline working group informed by a series of lower level tactical and information gathering projects. The group will work with the authors of the public health, acute services and primary care strategies and identify, prioritise, initiate and monitor projects that support an oral health service plan for the island.

Outcome: Future delivery system

The OCC review, drawing on models of dental care in other jurisdictions, suggested that our future delivery system consider contracting out services from the existing Community Dental Service and that these contracts are based on a reduction of treatment need, with payment through capitation schemes or insurance schemes. State funded support based on need will be an important principle, as will interventions to tackle the determinants of disease.

Next steps

All Departments are facing significant funding challenges at present and any new initiatives must be carefully prioritised against a range of competing demands. Whereas actions have been identified in this report, it has not been possible to allocate a clear timetable to their completion. Both departments will use their best endeavours to address these actions as resources allow, and to ensure that the ongoing development of other areas of health strategy fully reflect the need for the introduction of a sustainable and coherent oral health strategy.