States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health, Social Security and Housing Scrutiny Panel

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

Presented to the States on 15th October 2012

S.R.7/2012

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CHAIRMAN'S FOREWORD

The recurrent message we have heard throughout our work has been the urgent need to see reform of our Health Services and a general willingness to engage with this process.

For too long investment and change in this key public service has fallen short, or to quote one of our witnesses there has been "misinvestment". An illustration of the delay became clear when we discovered the Raftery Report, which was published in 2003 and warned the States of Jersey of the necessity to invest and plan for the future. It is surprising that we are only now, nine years later heeding this advice.

The Report and Proposition, "Health and Social Services: A New Way Forward", comes to the Assembly with a series of proposals to introduce new services. These are brought to the Assembly in outline form, alongside a number of projects that are intended to be funded at a later stage and phased in over the next ten years.

Although the States have not yet agreed the Report and Proposition, work is already underway to "work up" the business cases so that the necessary investments can be made in 2013 and new services can be delivered as soon as possible.

As a Panel, we would have liked to have seen the detail of the programme of change for the first three years, at least. Therefore, we intend to continue to meet with the Minister and to follow the progression of this process. There are many concerns over the details which will need to be addressed once it is published and the Health, Social Security and Housing Panel will play its part to ensure the best possible outcome for the public.

We are especially grateful to our advisors, Professor Gerald Wistow, Mr Michael Gleeson and Mr Seán Boyle who have provided us with their invaluable input. It has been a pleasure to work alongside such good people with a breadth of experience. And as always, our Scrutiny Officer, Kellie Boydens has worked extremely hard to get this report ready within the timeframe, we thank her most sincerely for her input.

Deputy Kristina Moore
Chairman, Health, Social Security and Housing Scrutiny Panel

TERMS OF REFERENCE

The Panel aimed to review the work undertaken by the Health department and consider the proposals contained in the White Paper with the following Terms of Reference:

1. To determine whether the options included in the Green Paper were appropriate and wide-ranging.
2. To examine how the responses to the Green Paper were analysed and reported.
3. To determine what extent the views expressed during the Green Paper consultation influenced the process of developing the White Paper.
4. To consider the implications of the proposals contained in the White Paper.
5. To examine what effect the changes will have on the community and in particular the impact on existing providers including the private and third sector.
6. To explore the manpower and financial implications of all the proposals. In particular:
    a. How the department will implement the changes.
    b. How the plan will be delivered.

PANEL MEMBERSHIP

The Health, Social Security and Housing Panel comprised the following Members:

Deputy Kristina Moore, Chairman

Deputy Jacqueline Hilton, Vice-Chairman

Deputy James Reed

EXPERT ADVISORS

Professor Gerald Wistow

Gerald Wistow is Visiting Professor in Social Policy at the London School of Economics. He also holds a visiting chair in the School of Applied Social Sciences at the University of Durham. He has previously been Co-director of the Centre for Social Policy Research at Loughborough University, Professor of Health and Social Care and Director of the Nuffield Institute for Health at Leeds University and Chair of Hartlepool Primary Care Trust. He is currently a specialist advisor to the House of Commons Health Committee in the UK, a post he also held for ten years from1991. He has published extensively on a wide range of health and social care issues.

Mr Michael Howard Gleeson MB.ChB. (Manc.) FRCP. (Lond.)

Michael Gleeson is a retired Consultant Physician and Gastroenterologist, Jersey General Hospital (1976 – 2006). He has been past Chairman of the Medical Staff Committee, and past Chairman of the Division of Medicine. He has conducted research and publications on adverse side effects of drugs in the alimentary tract.

Mr Seán Boyle

Seán Boyle is a health planning and policy consultant with experience of working at senior level with public and private sector managers, civil servants and politicians (both local and national), and a detailed knowledge of the public policy environment in the UK. He is also a Senior Research Fellow in Health and Social Care at the London School of Economics. His clients have included the Department of Health, the Scottish Parliament, the House of Commons Health Committee, the King's Fund, the Department for Work and Pensions, Chichester District Council, and the Criminal Justice Performance Directorate of the Home Office.

EXECUTIVE SUMMARY

The final Report and Proposition asks States Members to decide whether proposals for a redesign of health and social care services by 2021 should be co-ordinated by the Council of Ministers. By the end of 2014, the proposition calls for proposals to be developed for: investment in hospital services and detailed plans for a "new" hospital; a new model of primary care and a sustainable funding mechanism.

The Panel has reviewed both the Green and White Paper process, the KPMG analysis and the Report and Proposition. The Green Paper presented three scenarios for consideration, although the Panel found that only scenario three was presented for serious consideration. The Panel considered that scenario one could have been examined in more depth and variations of this option could have been offered. Scenario two proposed keeping funding the same or with a slight increase and was, in the Panel`s view, an unrealistic or "straw man" proposal without any credence.

Scenario three was the option that received the most public approval and was developed in the White Paper: "Caring for each other, Caring for ourselves". It constituted the guiding principle for change and a new way forward for health and social services over the next ten years.

The White Paper emphasised re-designing health and social care services to enable more care in community settings, including that provided through the primary care sector. A section on sustaining acute services was also included but it did not appear to have an equal priority in terms of timing, as a review of hospital was proposed for the period 2016 – 2018. The Panel was concerned that this approach to acute services lacked the urgency and priority it deserved, it now welcomes the greater emphasis on acute services in the Report and Proposition.

The Panel was told that one of the main reasons behind the development of intermediate care was to reduce pressure on hospital beds. This seems logical, but may not achieve the desired result as pressure on the hospital may continue to grow.

The Panel was told that the winter period is of particular concern because the hospital is running at virtually 100% occupancy throughout the year. If Jersey were to have a particularly bad winter with outbreaks of infectious diseases the hospital could run out of beds. Therefore, acute services need urgent consideration. Whether a new hospital or a rebuilt hospital is decided upon, upgrading of the present deteriorated fabric will be necessary now.

The Panel found that the potential costs of redesigning health and social care services are difficult to quantify accurately and thus present a risk to the ten year strategy. Phase one may well be affordable but it is unclear whether funding can be guaranteed for phases two and three. It is for this reason the Panel has lodged an amendment for the current States Assembly to approve a sustainable funding mechanism for health and social care before the end of September 2014.

Furthermore, the funding of a new model of primary care must be addressed as GPs are currently remunerated on a "fee per service basis". If a new model of primary care is evolved, it is hoped that it will be with the involvement and support of the GPs.

The Panel felt that this issue was of such significant importance that it lodged an amendment to the Report and Proposition (b(ii)) to bring forward proposals to develop a new model of primary care by the end of 2013, rather than 2014 in order to advance this process. Moreover, further consideration should be given to the proposed changes and how affordable they will be for individual patient groups. If additional costs are introduced, these should be made clear to the patient from the outset.

The proposals to introduce monitoring of a patient in their home such as telecare and telehealth will be new to Jersey but the benefits of which are still unproven. In the Panel`s view, these methods should be brought in cautiously by means of a pilot study. If new technologies are going to be implemented, informatics will also play a major role if they are to be successful. The Panel

was informed during the review, that the Health Department's I.T systems are not integrated between primary and secondary care, and therefore this requires urgent attention.

The third sector will play an important role if more care in the community is enabled. Evidence from written submissions received by the Panel highlighted a degree of enthusiasm for the proposals but also with an element of caution. Some third sector organisations expressed the desire to be treated as equals and enter into medium to long term Service Level Agreements. The Panel has observed that at times there has been scope for greater communication with the third sector. Therefore, before new programmes are rolled out, the Health Department should work in partnership with third sector and other organisations to agree how services are managed in order to deliver efficiency improvements.

The Panel has identified that the proposition should be welcomed in general terms. The changes proposed in the Report and Proposition would amount to a major re-design of health and social services on the Island. However, the synchronous introduction of so many new services reliant on the recruitment of many specialised and experienced staff in 2013 - 2015 will, in the Panel's view, prove challenging. The proposals are intended to substantially update buildings, facilities, skills and service models so that Islanders' service and experiences of them can be improved. They are, however, both costly and, in some respects, depend on approaches to delivering health and social care which are, by definition, untested in Jersey even though this may not be the case in other health systems.

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.

KEY FINDINGS

KEY FINDING 1:

The proposals contained in the Report and Proposition: "*A new way forward for Health and Social Services*" require significant additional funding.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 5:

Although KPMG recommended that Jersey should work towards scenario three, 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.

KEY FINDING 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 three scenarios.

KEY FINDING 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 three was preferable, many had concerns over the implementation of the plan, the costs and associated risks. Therefore, they concluded that more information was required before they could conclusively endorse the option.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 11:

Although the White Paper suggests that the cost of scenario three is likely to be less than scenario one (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.

KEY FINDING 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.

KEY FINDING 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 deserved greater attention than it was given in the White Paper, as the Report and Proposition recognises to some extent.

KEY FINDING 14:

The Panel question whether there is sufficient GP capacity to deal with an extra 75% of A&E cases which has been suggested could have been dealt with in primary care.

KEY FINDING 15:

The Panel noted that some of the Green Paper respondents suggested that people should be charged to access A&E services.

KEY FINDING 16:

A Workforce Planner has been appointed to facilitate the development of the Full Business Cases. 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.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 19:

Primary and secondary care on the Island have tended to be too isolated from each other.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 23:

The newly established Third Sector Forum is a positive move to improve communication between the Health Department and third Sector.

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 26:

Some third sector organisations felt that the new services would duplicate those they are already providing.

KEY FINDING 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.

KEY FINDING 28:

The long-term funding is difficult to identify and therefore funding of the proposed changes has not been identified after 2015.

KEY FINDING 29:

The different phases in the ten 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.

KEY FINDING 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

KEY FINDING 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.

KEY FINDING 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.

KEY FINDING 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.

RECOMMENDATIONS

Please note: Each recommendation is accompanied by a reference to that part of the report where further explanation and justification may be found.

The Minister for Health and Social Services should ensure the following –

RECOMMENDATION 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 [section 1.3].

RECOMMENDATION 2:

The Panel welcomes the intention under proposition b(iii) 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 [section 2.2].

RECOMMENDATION 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 three, 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 [section 2.4].

RECOMMENDATION 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 [section 3.3].

RECOMMENDATION 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 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 [section 3.3].

RECOMMENDATION 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 [section 3.4].

RECOMMENDATION 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 [section 3.5].

RECOMMENDATION 8:

The Panel recommend that GPs 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 [section 3.6].

RECOMMENDATION 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 [section 4.3].

RECOMMENDATION 10:

It may be necessary to phase in new services over a longer timescale due to current difficulties with recruiting and retaining staff [section 4.4].

RECOMMENDATION 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 [section 4.4].

RECOMMENDATION 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 [section 5.3].

RECOMMENDATION 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 [section 5.3].

RECOMMENDATION 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 [section 5.4].

RECOMMENDATION 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 [section 5.5].

RECOMMENDATION 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 [section 6].

RECOMMENDATION 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 [section 6.1].

RECOMMENDATION 18:

The Panel strongly support the intention behind proposition b(iii) 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 [section 6.2].

RECOMMENDATION 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 [section 6.3].

RECOMMENDATION 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 [section 6.5].

RECOMMENDATION 21:

The Panel expects the Health Department to focus on protecting patients from incurring any additional costs as the Full Business Cases 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 [section 6.5].

1. Introduction

1.1 Background

The Panel had been aware that the Minister for Health and Social Services was developing a White Paper to suggest a reform of Jersey's health system. Initially, a Green Paper was published in 2011 which outlined three scenarios and asked for the views of Islanders on these and health and social care services. Following almost 1,350 responses to the Green Paper consultation, the results were analysed and developed into a White Paper: Caring for each other, Caring for ourselves.

The White Paper was also put out for public consultation and the final Report and Proposition (hereafter known as R&P) was lodged on the 11th September by the Council of Ministers. The debate will take place on the 23rd October and asks Members:

a) to approve the redesign of health and social care services in Jersey by 2021 as outlined in Sections 4 and 5 of the Report of the Council of Ministers dated 11 September 2012;

b) to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval –

   i. proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), by the end of 2014;

   ii. proposals to develop a new model of Primary Care (including General Medical Practitioners, Dentists, high street Optometrists and Pharmacists), by the end of 2014;

   iii. proposals for a sustainable funding mechanism for health and social care, by the end of 2014.

The Panel began its review in April 2012 by looking at the Green Paper, responses to it and the subsequent White Paper, which consulted from 28th May until 20th July. The Panel undertook the bulk of its work whilst the White Paper was out for consultation, as there would have been little time to carry out a thorough review from when the R&P was lodged in September to the date of the debate in October.

Proposals in the R&P require significant additional funding and the Panel understands that the Health and Social Services Department has bid for growth through the Medium Term Financial Plan (MTFP). As a result the White Paper is to be debated prior to the debate on the MTFP while the latter does contain proposals which assume the R&P is approved.

KEY FINDING 1: The proposals contained in the Report and Proposition: "*A new way forward for Health and Social Services*" require significant additional funding.

1.2 The Review

During the course of its review, the Panel held numerous Public Hearings which included Ministers, some third sector organisations and health care employees of the States of Jersey. It also requested written submissions from charitable and third sector organisations. Some were encouraged by the Health Department's proposals but had reservations about whether they would actually come into fruition. It appeared that the main concern was that the extra monies required to implement the proposals in the White Paper would not be available. A full summary of the responses can be found in appendix one.

The Panel visited the General Hospital and Overdale and St Saviour's Hospital sites. Whilst at St Saviours Hospital, the Panel was able to go into Clinique Pinel and walk around the entire St

Saviours site. In order to understand cross-island relationships, the Panel also visited Guernsey Hospital and met with its Minister for Health and Social Services, Chief Officer and Director of Corporate Services. There were many similarities between the two Islands in terms of future economic difficulties and the need to tackle health issues such as the ageing population, obesity and alcoholism.

KEY FINDING 2: Some third sector organisations had reservations about whether the proposals contained in the White Paper would come into fruition and whether the extra monies required to implement the changes would be available.

The aim of this report is to inform the States debate to ensure that what is being proposed in the R&P is relevant to the needs and resources of the Island while also being capable of implementation in ways that deliver better outcomes for local people. The scope of the proposed reforms is so significant that they will have major consequences for all Islanders. It is of paramount importance, therefore, that Islanders are confident that these proposals are both appropriate and cost effective whilst meeting the changing demands of the community.

KEY FINDING 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.

The Panel commissioned a study by Seán Boyle, which sought to address a number of objectives in relation to the Green and White Paper process, the analysis by KPMG and a comparison with other jurisdictions. This report is referred to as the "Boyle report" (see appendix three).

1.3 The Health and Social Services Department

One of the main themes from the majority of Hearings was "doing nothing is not an option", in particular because there are serious capacity pressures on hospital services and community services are underdeveloped. Consequently, the Panel has sought to assess whether the proposed new direction for health and social care is robust enough to address these issues.

The need for increased investment was recognised as early as 2003 when the University of Birmingham produced a report for the Health Department highlighting a number of key issues. In particular, it recommended that Jersey should increase its public healthcare funding by between 3% and 7% per annum in real terms over the subsequent five years to 2007[1].

Evidence from past Annual Business Plans and Financial Reports and Accounts suggests that funding has increased year on year. However, as the Panel has noted in a previous review[2], it is not readily possible to provide real terms time series because of the change in the way figures are presented, and because of the complexity of backtracking decisions relating to spend.

A further issue which is difficult to address in the absence of such data is whether the funding available was adequate to meet changing needs over time and spent appropriately in the right areas. Therefore, over the 10 year period of the proposed strategy it will be essential that the States is in a better position to monitor changes in the level of funding and its allocation to individual services over time.

KEY FINDING 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.

[1] Health Services Management Centre, University of Birmingham, "Funding healthcare in Jersey; Criteria, Comparisons and options, January 2003, page 2

[2] Respite Care for Children and Young Adults, S.R.2/2012 – the Panel requested information on how much money was allocated to Children's Services resulting from the Kathy Bull report and was advised that HSSD were unsure whether they could collate this information because of the complexity of back tracking decisions relating to spend.

RECOMMENDATION 1: The initiation of the 10 year strategy should be accompanied by the provision of routine data on a consistent and comparable basis to permit the ready monitoring over the full period of implementing the new strategy.

1.4 Drivers for Change

The Green and White Papers describe the challenges which Jersey will be facing in the future. These "drivers for change" are the main justifications for why substantial redesign of health and social care is necessary:

Population changes: According to a study by KPMG which underpinned the White Paper, between 2010 and 2040 there will be a 95% increase in the number of people over 65[3]. Since that study, the 2011 Census results have begun to become available and the Panel discusses the implications further on in the report.

Increased demand: KPMG estimated that, if services continue to be provided in the same way, Jersey would have to spend 76% more on health and social care services in 2040 than it does currently[4].

Capacity of hospital beds: An increase in the numbers of older people, coupled with an increase in demand would mean that Jersey will use up any spare capacity of hospital beds in the current system[5].

Capacity of healthcare professionals: Many Health and Social care staff are approaching retirement age. Many of these are "generalists" who can treat a wide range of conditions, however, new health professionals are being trained to be "specialists" who focus on specific areas[6]. So recruiting on a "like for like" basis will be difficult[7].

[3] Health and Social Services Department, Green Paper: Caring for each other, Caring for ourselves, page 6
[4] Health and Social Services Department, Green Paper: Caring for each other, Caring for ourselves, page 7
[5] Health and Social Services Department, Green Paper: Caring for each other, Caring for ourselves, page 7
[6] Health and Social Services Department, Green Paper: Caring for each other, Caring for ourselves, page 8
[7] Public Hearing with the Minister for Treasury and Resources, 6th July 2012, page 8

2. The Green Paper

2.1 Background

KPMG was commissioned by the Health Department to review how services are provided and what steps will be required to ensure that Jersey can offer quality care. The findings of the KPMG review were shared and a Green Paper was published[8] seeking views from Islanders on the future of health and social services.

Responses to the Green Paper were collected and independently analysed by Involve (experts in public engagement, participation and dialogue). Involve summarised the responses to the consultation which was held between 31st May and 19th August 2011.

2.2 The Three Scenarios

From the work undertaken by KPMG, the Green Paper outlined three scenarios[9]:

Scenario One: "Business as usual"

We keep the same structure for providing services as we have today, and increase spending so that services can be provided to meet growing demand.

Scenario Two: "A small increase in funding"

We keep funding almost the same, and provide what services we can within this budget and accept that many services will be subject to 'means testing'.

Scenario Three: "A new model for health and social care"

We change the way services are provided. For every option, the review assessed whether it would be safe and affordable for Jersey.

The third scenario was the favoured option as it was described as being "safe, sustainable and affordable[10]". Scenario one was described as "unaffordable and unsustainable[11]" and Scenario two was deemed as "potentially unsafe[12]". The Boyle report commented upon scenario two: "*This is not a realistic option. It is not clear why this was put forward other than as a straw man[13]".*

The KPMG report claims that Jersey will not be able to sustain the increased expenditure that will result from a population whose age structure is ageing rapidly. The Boyle report explains that often financial sustainability is assessed by looking at total expenditure per head of population, and as a proportion of Gross Domestic Product. Some measures are presented in an appendix to the KPMG report, although this issue does not seem to have been discussed to any extent in the main text[14].

The Boyle report estimated that, in 2010, expenditure as a proportion of Jersey's gross national income was 4.2%, which is considerably less than public expenditure on healthcare in the rest of the UK[15]. The Jersey figure can recalculated at 5.9% when private, user payments and third sector are included. Even with these additions, the total is considerably less than the 8.7% spent on healthcare in England[16].

[8] The Green Paper was published on the 31st May 2011
[9] Health and Social Services, Green Paper: Caring for each other, Caring for ourselves: Public Consultation, pages 9-18
[10] KPMG report: "A Proposed New System for Health and Social Services" – States of Jersey, page 10
[11] KPMG report: "A Proposed New System for Health and Social Services" – States of Jersey, page 6
[12] KPMG report: "A Proposed New System for Health and Social Services" – States of Jersey, page 8
[13] Panel advisor report, Mr S. Boyle, September 2012
[14] Panel advisor report, Mr S. Boyle, September 2012
[15] Panel advisor report, Mr S. Boyle, September 2012
[16] Panel advisor report, Mr S. Boyle, September 2012

The Boyle report questioned whether the level of expenditure under scenario one could accurately be described as financially unsustainable. Since the difference in expenditure between scenario one and the preferred scenario three is £28 million (9%)[17]. The Boyle report said: *"given the uncertainty involved in these calculations, we would not regard this as decisive in itself"*[18].

The Boyle report also questions whether sufficient options were identified for consideration and consultation. For example, of scenario three it suggests:

> *"This is an option that bears consideration. However, in our view, a wider range of options should have been considered. It would have been possible to look at various combinations of the elements of this option. Another alternative would have been to consider a phased introduction of different elements giving time to examine the outcome of changes before pushing forward with more".*[19]

Although KPMG recommended that Jersey should work towards the scenario three model, it outlined various risks[20] with this option. One of these included the risk that existing funding mechanisms might create financial disincentives for the public to access primary care or community pharmacists.

KEY FINDING 5: Although KPMG recommended that Jersey should work towards scenario three, 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.

RECOMMENDATION 2: The Panel welcomes the intention under proposition b(iii) 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.

The Survey

The public were asked whether they strongly or slightly agreed or strongly or slightly disagreed with scenarios one, two and three (there were also options "don't know" and "skip question"). The consultation did not force people to make a choice between the scenarios and ask them which one they most agreed with. There is the possibility that people slightly agreed with one scenario and strongly agreed with another.

Scenario	Strongly Agree	Slightly Agree	Slightly Disagree	Strongly Disagree
Scenario One	12%	16%	27%	26%
Scenario Two	6%	15%	28%	31%
Scenario Three	66%	20%	3%	3%

Table one

Therefore, the survey itself was not designed in such a way that the answers to the questions on scenarios can be interpreted as strong support one way or the other. When no detailed choices are provided the outcome of favoured scenario three is not surprising[21].

KEY FINDING 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 three scenarios.

[17] Panel advisor report, Mr S. Boyle, September 2012
[18] Panel advisor report, Mr S. Boyle, September 2012
[19] Panel advisor report, Mr S. Boyle, September 2012
[20] KPMG report: "A Proposed New System for Health and Social Services" – States of Jersey, page 116
[21] Panel advisor report, Mr S. Boyle, September 2012

2.3 Involve report

The consultation report by Involve analysed the responses and provided statistical data about the survey respondents. The report concluded that most Islanders agreed that scenario three was preferable, although many had concerns about the implementation of the plans, its costs and associated risks[22]. The Panel noted that some Islanders found it difficult to give their opinion because the costs of specific options and services in scenario three were not specified[23]. Although the analysis found Islanders are willing to accept new ways of working[24] it is important to note that some felt that they needed more information and detail to understand scenario three[25].

KEY FINDING 7: Some of the information provided in support of the various scenarios lacked details and was open to challenge. Although most Islanders seemed to agree that scenario three was preferable, many had concerns over the implementation of the plan, the costs and associated risks. Therefore, they concluded that more information was required before they could conclusively endorse the option.

The other key findings of the consultation were that capping free healthcare for individuals was wrong, that paying more for health and social care was inevitable, and that some services will have to be offered off-island[26].

2.4 Population: demographic data and projections

The KPMG report was based on the most up-to-date data available at the time it was written but has been superseded by data from the 2011 census. The latter, for example, shows that between 2001 and 2011 the population increased by 10% (9,100). In 2011, the population figure was 97,857, some 9% difference from the KPMG figure (8,038[27]). The current population is in fact greater than the projection used by KPMG for 2040 (97,144)[28].

Population Projection	KPMG[29]	Census 2011[30]
Children (0 – 18 yrs)	17,260	19, 515
Adults (19 – 64 yrs)	57,762	63, 869
Older people (65+yrs)	14,797	14, 473
Total	89,819	97, 857

Table two

It is clear that there are some significant differences between the 2010 base line population data used by KPMG and the results of the 2011 Census (see table two)[31]. It is significant that in 2011 the working population is some 6,107 greater than the KPMG estimate and the 2011 figures for older people is slightly smaller. The number of younger people under 19 is greater in the Census than the KPMG estimate (2,225).

The Statistics Unit have recently published an updated set of population projections based on the 2011 Census baseline. The data which has been published is sufficiently different to the KPMG figures used by the Department in preparing the White Paper and justifies a careful review of their implications for the demand for services and the size of the working population which will be called upon to meet those demands. In effect, the most important decisions about the future patterns and

[22] Involve: Health and Social Services Review, Public consultation on the Health and Social Services Green paper, page 47
[23] Involve: Health and Social Services Review, Public consultation on the Health and Social Services Green paper, page 48
[24] Involve: Health and Social Services Review, Public consultation on the Health and Social Services Green paper, page 3
[25] Involve: Health and Social Services Review, Public consultation on the Health and Social Services Green paper, page 10
[26] Involve: Health and Social Services Review, Public consultation on the Health and Social Services Green paper, pages 4 and 5
[27] KPMG: New system for Health and Social Services Department, Main Document, page 24
[28] Panel advisor report, Mr S. Boyle, September 2012
[29] KPMG: New system for Health and Social Services Department, Main Document, page 24
[30] Figures taken from the Report on the 2011 Jersey Census, Statistics Unit, pages 58 and 59
[31] These figures are not wholly comparable because the 2011 figures include the 1600 estimated undercount in the 2001 Census which was not included in the 2010 estimate: as per advice receive from the Statistics Unit 28th September 2012

totals of spending on health and social care for at least a decade was taken before all the most recent and relevant demographic data was available.

KEY FINDING 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.

RECOMMENDATION 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 three, their funding and the pressures driving service development. It will also be necessary to review the Health and Social Care Strategy in light of any decisions that are made in 2013 regarding future population policies.

2.5 Concluding remarks on the Green Paper

The Green Paper put forward only one scenario for serious consideration (scenario three) as the others were presented in a way that clearly gave the impression they were not viable and hence easily dismissed[32]. This was recognised by many of the people who responded to the consultation, which was a point highlighted in the Involve report.

The Panel formed the view that the consultation process was less well designed than it might have been, if not seriously flawed. As a result, the Panel has serious reservations about the range of options presented, the process by which they were reviewed and the weight that can be placed on the results of the consultation.

Since KPMG produced its report, the results of the 2011 Census have been published and the Statistics Unit have very recently published an updated set of population projections. It is important to examine the impact of these results on the analysis presented in the White Paper[33].

The Health Department explained that the demand on services was not purely dependent on demography, and as a result had based its future planning for hospital service on current utilisation rates in order to provide a realistic and up-to-date indicator of demand "*obviously the up-to-date census figures will be important but suffice to say that, with the KPMG modelling, it was based on current usage of the hospital. I think that is an important message that we need to get across because we know that there is an increase in demographics, an increase in the number of people, but we based it on our current use. So we had a realistic figure*[34]*…"*

In practice, future demand for services will be determined by a complex balance of factors including demographic change and the impact of the White Paper strategy itself. To the extent that policies for prevention, early intervention and care at home are successful in changing the level and shape of demand, then current usage of hospital services will be a relatively incomplete predictor of future demand for hospital beds and procedures. The Panel will look therefore, to the Department to provide a full analysis of future demand for all health and social care.

[32] Panel Advisor Report, Mr S. Boyle, September 2012
[33] Panel Advisor Report, Mr S. Boyle, September 2012
[34] Public Hearing with the Minister for Health and Social Services, 17th September 2012, pages 17 and 18

3. The White Paper

Following the analysis of responses to the Green Paper, the Health Department drafted a White Paper based on the preferred scenario of redesigning Health and Social Services. This approach implies strategic change of an unprecedented scale for Jersey and the document also included a staged Transition Plan to provide a sequence and timetable for an implementation plan over the 10 years to December 2021.

3.1 The Strategy for Change

The White Paper and the subsequent R&P set out a ten year programme of change to meet what were seen to be pressing challenges to the sustainability of health and social care services. Increasing demand is combining with inappropriate estate, workforce pressures and restricted supply to create a system that will not be fit for future purposes and is reaching the limits of its existing capacity. Notable weaknesses are identified as models of care which are 'relatively medically dominated', have 'low levels of team-based practice' and, in the absence of 24 hour community services, 'relatively institutionalised[35]'.

This reliance on 'medicalised and institutionalised' services is considered more costly than, and inconsistent with, the population's preference 'to live in their own homes for as long as possible, providing they have the right health and social care support from the States of Jersey, the third sector and Parishes'[36].Thus the limited availability of services in the community, together with the co-payments system for primary care, were judged to result in higher than necessary use of hospital and care home services.

The overall strategy was sub-divided into a number of workstreams to be implemented in three stages. These workstreams as outlined in the White Paper included four priority service changes: services for children; services to encourage healthy lifestyles; services for adults with mental health issues; and services for older adults. In addition, eight enabling or crosscutting workstreams were identified which impact on each of the service development priorities.

Finally, a fifth service development workstream was identified within the body of the report: 'sustaining acute services'[37]. This seems to be of a slightly different priority from the other four in that its objectives were essentially short term and temporary in maintaining patient safety services while services were developed in the community and a new or re-furbished hospital could be built and commissioned, but this was due to take place as a review of hospital services "during 2016 – 2018"[38].

3.2 The Three Phases

The Transition Plan is an operational document which provides further details on the service models to be developed. It divides the implementation strategy into three phases each coinciding with a three year cycle of the MTFP.

<u>Phase 1: 2013 – 2015</u>

The first phase will centre on intermediate care and early intervention with a focus on children's health, social wellbeing and educational attainment[39]. Emphasis will also be put on addressing alcohol misuse and accessing rapid support which will begin in 2013[40]. Improving Access to Psychological Therapies (IAPT) will be introduced in 2013 for adults over the age of 18 who need treatment for common mental health issues[41]. Enhanced and integrated older adults services will

[35] Final Report and Proposition: A new way forward for Health and Social Care, page 14
[36] Final Report and Proposition: A new way forward for Health and Social Care, page 27
[37] Health White Paper: Caring for each other, Caring for ourselves, page 24
[38] Health White Paper: Caring for each other, Caring for ourselves, page 25
[39] Health White Paper: Caring for each other, Caring for ourselves, page 13
[40] Health White Paper: Caring for each other, Caring for ourselves, page 16
[41] Health White Paper: Caring for each other, Caring for ourselves, page 18

also commence in 2013. It is also expected that oncology and renal patients will receive services through improved links with non-Jersey based providers[42].

Phase 2: 2016 – 2018

This phase aims to focus on diet, exercise and tobacco, which are the key risk factors in the development of chronic conditions such as cardiovascular disease, respiratory disease and diabetes[43]. Screening for key risk factors will be carried out in primary care settings and a prevention and intervention approach will be rolled out to Sexual Health services[44]. Phase two also follows on from phase one with early intervention. With regard to children phase one concentrates on "school readiness", whereas phase two will focus on "life readiness" for children aged 5 – 11[45]. Also during this phase, the Department aims to focus on Mental Health with a Community Wellbeing Centre being established as well as an enhanced Community Services team. Residential Services will also be improved for people experiencing poor mental health[46] and supported housing will also be developed[47].

Phase 3: 2019 – 2021

The proposals for development and redesigning are less detailed in this phase than in phases one and two. The White Paper does state that there will be a focus on Mental Health, Cancer Prevention, Healthy Ageing and Illegal Drugs[48], and care pathways for long-term conditions will be introduced but there are no full explanations as to what these will be. It does explain, however, that phase three is planned to be a consolidation period, where the significant changes introduced during 2016 – 2018 have time to stabilise[49].

3.3 Enhanced Community Services

Although an acute services workstream was subsequently established, the White Paper's development plans were predominantly focussed on enhancing community services within the four priority workstreams identified above together with a number of enabling strategies (which included primary care) that applied across all of those priority areas. It was explained to the Panel that the first three years is majored in push starting the development of a broad range of community services including intermediate care services.[50] The latter were justified in terms of relieving pressure on the hospital services from the growing population of older people. These developments, together with investment in new technologies like telehealth and telecare would enable people to be cared for in non-hospital settings, while also reducing costs and improving care. If they were not implemented, the hospital was expected to run out of capacity by 2017[51].

KEY FINDING 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.

Telehealth can be defined as the remote exchange of data between an individual and a healthcare professional. It aims to assist in the diagnosis and management of health care conditions. Examples include blood pressure monitoring, blood glucose monitoring and medication reminders[52].

[42] Health White Paper: Caring for each other, Caring for ourselves, page 25
[43] Health White Paper: Caring for each other, Caring for ourselves, page 17
[44] Health White Paper: Caring for each other, Caring for ourselves, page 17
[45] Health White Paper: Caring for each other, Caring for ourselves, page 15
[46] Health White Paper: Caring for each other, Caring for ourselves, page 19
[47] Health White Paper: Caring for each other, Caring for ourselves, page 23
[48] Health White Paper: Caring for each other, Caring for ourselves, page 17
[49] Health White Paper: Caring for each other, Caring for ourselves, page 19
[50] Public Hearing with the Minister for Health and Social Services, 3rd July 2012, page 7
[51] Final Report and Proposition: A new way forward for Health and Social Care, page 16
[52] "The impact of telehealth and telecare: evaluation of the Whole System Demonstrator project", Nuffield Trust, website found at www.nuffieldtrust.org.uk

Telecare can be defined as the remote monitoring of an individual's condition or lifestyle, and aims to manage the risks of independent living. Examples include automatic movement sensors, falls sensors, and bed occupancy sensors[53].

The Kings Fund published a study in March 2012 which had investigated the impact of telehealth on the management of long-term conditions. It identified 64 studies, measuring the impact of telehealth across several health conditions. The report concluded that the evidence currently available is promising but mixed, and mainly limited to specific conditions such as diabetes and heart failure. Statistically significant levels of benefit have yet to be demonstrated[54].

Telehealth and telecare are integral to several of the Outline Business Cases but the evidence base is not yet established[55], particularly in a small jurisdiction such as Jersey. The British Medical Journal questions the advisability of a "full scale roll out"[56] at present. If rigorous cost benefit analysis and review should accompany any introduction of telehealth and telecare in Jersey, it should be as a pilot trial and subject to rigorous cost benefit analysis.

KEY FINDING 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.

RECOMMENDATION 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.

The Health Department explained to the Panel that the enhancement of community services is about offering Islanders a greater range of options and enabling cost containment in a context of growing demand rather than cost saving[57]. The Panel accepts the case for such a strategy and recognises that costs would increase if nothing was done. Some level of increased investment in community services is, therefore, likely to be necessary and beneficial but the return on such investment is not clear, including its impact on the cost and level of hospital services required (see below).

During its visits, the Panel was briefed that the early experience of piloting intermediate care is indeed helping to reduce the pressure on hospital beds. However, it is also possible that better designed community services will, as the consultant Paediatrician told the Panel, merely reduce the rate of growth in demand for hospital beds rather than compensate for it in totality[58].

KEY FINDING 11: Although the White Paper suggests that the cost of scenario three is likely to be less than scenario one (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.

RECOMMENDATION 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 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.

[53] The impact of telehealth and telecare: evaluation of the Whole System Demonstrator project", Nuffield Trust, website found at www.nuffieldtrust.org.uk
[54] "What impact does telehealth have on long-term conditions management?" Telehealth study by the Kings Fund, March 2012 website found at www.kingsfund.org.uk
[55] Currell R, Urquhart C, Wainwright P, Lewis R. Telemedicine versus face to face patient care: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2000, Issue 2.
[56] BMJ: "Telehealth can reduce deaths and emergency hospital care, but estimated cost savings are modest", 21st June, 2012
[57] Public Hearing with the Minister for Health and Social Services, 3rd July 2012, page 11
[58] Public Hearing with the Clinical Directors Group, 13th July 2012, page 6

3.4 The Hospital

The R&P asks the States to decide whether detailed plans should be produced by the end of 2014 for a new hospital, either on a new site or through rebuilding and refurbishment on the existing hospital site. The reason for the need for a "new" hospital is due to the fact that the current hospital is not fit for purpose.

The building is deteriorating and does not meet modern standards. Space allocation on wards is about half of what would now be expected for the number of beds. The configuration of six-bed bays is not consistent with the requirements of infection control and does not promote privacy and dignity for patients[59].

The Panel was told that the winter period is of concern because the hospital is running at virtually 100% occupancy. If Jersey were to have a particularly bad winter with respiratory diseases or outbreaks of infection such as diarrhoea and vomiting, the hospital could run out of beds[60]. During a recent site visit to the hospital the Panel was advised that the Renal Unit was at full capacity.

KEY FINDING 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 reasonable be required of it.

Sustaining and Developing Acute Services

The Panel noted in the previous section that the emphasis of the consultation documents was on re-designing health and social care services to enable more care in community settings, including that provided through the primary care sector. The White Paper did also include a separate section on sustaining acute services[61] but the Panel is inclined to accept Seán Boyle's view that this almost has the appearance of being 'an afterthought'[62], not least because it does not feature as one of the four priority service changes in the key areas identified for implementation between 2013 and 2021.[63]

The Panel wishes to be absolutely clear at this point that it fully supports the evidence-based development of a more comprehensive range of high quality services which enable islanders to live at home wherever possible. The public consultations demonstrated substantial support for this concept including a shift towards prevention. The R&P is, therefore, worthy of support for setting a radical and necessary change in direction for health and social care on the Island.

However, there are a number of respects in which the Panel thinks the R&P requires amendment, including its approach to hospital services. The Panel recognises that the current management of the hospital has enabled substantial improvements to its fabric and to patient safety. However, the leadership and investment needed to effect these refurbishments appears to have been slow in coming.

Similarly, the Panel understands that a continuing programme of refurbishment is necessary to continue to bring hospital standards to an acceptable level and that such a programme is underway. The sums required are considerable. The Panel was told that they amounted to between £5 million to £8 million per year over ten years[64]. Such sums are apparently additional to that of perhaps £300m[65] for full replacement of the existing hospital either by a new build on a different site or phased rebuild on the current site.

[59] Final Report and Proposition, "A new way forward for Health and Social Services, page 12
[60] Public Hearing with the Minister for Health and Social Services, 17th September 2012, page 35
[61] Health White Paper: Caring for each other, Caring for ourselves, page 24
[62] Panel Advisor Report, Mr S. Boyle, September 2012
[63] Health White Paper: Caring for each other, Caring for ourselves, page 13
[64] Public Hearing with the Minister for Health and Social Services, 17th September 2012, page 33
[65] Health White Paper: Caring for each other, Caring for ourselves, page 31

The Panel has drawn four conclusions from its evidence about hospital services in Jersey:

1. Hospital services and services outside of hospital are part of a continuum of care which should be planned as a whole system in which the level and range of services in one part are seen to be dependent on the level and range of services in another if needs are to be met 'in the round' and without gaps or discontinuities of timing. Any tendency to plan hospital and other services separately should be resisted if the 'right' services are to be available in the 'right' places at the 'right' time.

2. Improvements to both hospital and community services are necessary simultaneously and at substantial cost. There is an urgent need to continue improving hospital services while also developing community services which reduce the demand for hospital beds. Unfortunately, the longer it takes to completely replace existing hospital services, the more resources will have to be invested in the current hospital fabric and services to sustain their quality and viability but with increasingly short term returns.

3. The decision between new build and rebuild should be part of the final approval process for the R&P and MTFP. It is the Panel's view that there is a strong case for rebuild but the States should see the results of the pre-feasibility before coming to a final decision on this issue or the remainder of the strategy.

4. It is also the Panel's view that there is strong case for the intermediate care service to be developed urgently with a step down facility and associated primary and community care services. This would demonstrate in practical terms the benefits of investing in both hospital and in the community as part of a mutually reinforcing whole while also minimising short term investment of only short term value.

KEY FINDING 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 reconfigured services deserved greater attention than it was given in the White Paper, as the Report and Proposition recognises to some extent.

Accident and Emergency

Figures provided by the KPMG report suggest that there were 37,468 A&E attendances in Jersey in 2010[66]. The Boyle report calculated, using the most recent Census population data, that this would suggest a figure of 383 per 1,000 population. However, contrary to the claim in KPMG report[67], this is not more than the equivalent figure for England as a whole, which is 402 (based on 21.4[68] million attendances)[69].

It was noted that 75% of A&E attendances in 2010 were classed as "standard" which means the patient was seen by a nurse only or it was non-urgent. As a result, some patients (75% as proposed by the White Paper[70]) could potentially have been treated in primary care. Therefore, the additional knock-on effect of this must be taken into account. If, as it is claimed, 75% of current A&E attendances should be dealt with by a GP and all of these people do indeed go to their GP, will there be sufficient GP capacity to deal with this?

Some of the Green Paper respondents suggested that people should be asked to pay to access A&E services in order to prevent the cost-avoidance strategies (i.e. avoiding GP charges). If this is to be considered, where the burden is likely to fall and how affordable it will be for individual patient groups needs to be examined.

[66] KPMG main report: A New System for HSSD, 2011, page 39
[67] KPMG main report: A New System for HSSD, 2011, page 38
[68] Includes minor injury units and walk-in centres
[69] Panel Advisor Report, Mr S. Boyle, September 2012
[70] Health White Paper: Caring for each other, Caring for ourselves, page 24

If people are only expected to pay for inappropriate attendances, it is unclear how easy it will be to distinguish between appropriate and non-appropriate post-visit. Furthermore, one must ask whether patients can really be expected to make this decision[71].

KEY FINDING 14: The Panel question whether there is sufficient GP capacity to deal with an extra 75% of A&E cases which has been suggested could have been dealt with in primary care.

KEY FINDING 15: The Panel noted that some of the Green Paper respondents suggested that people should be charged to access A&E services.

RECOMMENDATION 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.

3.5 Shaping a New Hospital

The range and scale of future hospital services depends on a complex mix of factors including:

- the volume and kinds of needs that emerge in coming years;
- the volume and kinds of services provided outside hospital by health, social care and other services such as housing, social security and the third sector;
- the respective roles of primary care and community health services including the third sector;
- the implications of increasing specialisation and technological developments;
- the costs, effectiveness, risks and acceptability of providing services on-island or off-island.

Such factors are common to most jurisdictions but they present particular challenges to small island communities. As a result, a range of choices may have to be made between, for example, magnitude of acceptable risk, the degree of specialisation and local access compared to larger jurisdictions closer to other areas of greater population.

One way of addressing such tensions is through strategic partnerships with other jurisdictions and service. This could involve the subcontracting of service provision to providers off-island by their staff travelling to the island and/or islanders travelling to the providers. This already happens in the case of more specialist treatment, as it does on the mainland where regional and national specialty services are formally designated. In the modern era, complete self-sufficiency is not an option: rather the issue is the extent of self-sufficiency and shared provision; and in the latter case the provision of which services, with which providers and through what funding arrangements.

The White Paper stated that opportunities for strategic partnerships had been examined and would be explored further. The Panel has been provided with no formal details about which strategic partnerships have been explored and in what detail[72]. Nor has it seen detailed work about the level and range of services that could be provided in the new build or re-build replacement for the current hospital. It has been told, in general terms, that the "new" hospital should contain a similar number of beds to the current one.

> **Chief Officer:**
> *"…because there is not going to be a fall-off in patients accessing the hospital. With the demographic growth that we are seeing, as we take patients from the hospital who should not really be there and put them into more appropriate options (whether it is in the home or in intermediate care facilities) those beds will be filled by new patients coming in from the community who need the services of the hospital. So there is no transfer of money from the hospital to anywhere else[73]."*

[71] Panel Advisor Report, Mr S. Boyle, September 2012
[72] Public Hearing with the Minister for Health and Social Services, 3rd July 2012, page 7
[73] Public Hearing with the Minister for Health and Social Services, 17th September 2012, page 13

RECOMMENDATION 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.

3.6 Primary Care

The Department explained that within the GP body there are a range of different views regarding the White Paper and its proposals. Two GPs sat on the Steering Group for the Green Paper, White Paper and final R&P. Consideration should be given as to whether this small number of GPs adequately represented the whole GP body.

The Department has held quarterly meetings with GPs to keep them up-to-date on the proposals and service models. It is unclear however, whether these have taken place since the beginning of the process, or whether this is a recent development.

The role of the GP in the new community services is not yet clearly defined. The Boyle report concludes that, regarding the new set of services, general practice will play a key role, one way or another and that it is not clear "that this is reflected in the plans we have reviewed[74]". It is stated in the R&P, however, that a Primary Care Governance Team will be established by the end of 2012, led by a Primary Care Medical Director. The team will work with GPs and other Primary Care professionals, with a view to producing a Primary Care strategy by the end of 2014[75].

RECOMMENDATION 8: The Panel recommend that GPs 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.

3.7 Concluding remarks on the White Paper consultation

Each of the proposals contained in the White Paper consultation document on re-designing health and social care may have merits in their own right, but they are different in nature and scope from what the Panel sees as the main purpose of the consultation – to consult on the future funding arrangements for the health care system and the future configuration of acute hospital services[76].

There is also concern of how easily it will be to implement these investments in service. The Panel was told of the difficulties in recruiting the traditional caring services (doctors/nurses) so recruitment may prove to be an obstacle[77].

[74] Panel Advisor Report, Mr S. Boyle, September 2012
[75] Final Report and Proposition: A new way forward for Health and Social Services, page 63
[76] Panel Advisor Report, Mr S. Boyle, September 2012
[77] Panel Advisor Report, Mr S. Boyle, September 2012

4. Implementation of a New Model

4.1 Outline Business Cases

The White Paper proposes changes to services in four key areas[78] and each of these is supported by an Outline Business Case (OBC) which puts forward a case for a particular service investment. The OBC's will be developed into Full Business Cases (FBC) which will be facilitated by a recently-appointed Workforce Planner[79]. It was explained that her role is to transform the OBC's into FBC's in the coming weeks. The Panel note that work has begun in advance of the proposition being approved by the States.

KEY FINDING 16: A Workforce Planner has been appointed to facilitate the development of the Full Business Cases. 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.

4.2 Cross Departmental Working

The Minister for Social Security was concerned about the impact the White Paper and its implementation will have on his Department, because it will require extra work from officers and additional resources[80].

One risk that was associated with scenario three was increased costs for home adaptations and equipment, due to more care being administered in the home and not in a hospital setting. An example of how this might have an effect on resources could be the benefit for home adaptations which is funded by the Social Security Department. In the first instance, any person who may be eligible for the grant is required to contact an Occupational Health Therapist. The Occupational Therapist determines the type and cost of the adaptation and works with two Departments. The Housing Department administers a scheme for its own tenants and the Social Security Department carries out a means test and assesses the financial circumstances of those in private rental accommodation and homeowners.

The relevant Ministers should be mindful of the impact the White Paper will have on their Departmental resources and whether enhanced community services will interact with the services their Departments currently provide. Communication between the Health Department and all other Departments and stakeholders is key.

KEY FINDING 17: Enhanced community services will be required to interact with the services already being approved by the States Departments. Therefore, the delivery of a new model of health and social care will be dependent on close collaboration between all relevant parties.

4.3 Information Technology

The Panel was informed that the Health and Social Services I.T system is not up to speed. According to one clinician there is no future budget for the programmes that were embarked upon to expand I.T or a maintenance budget for those that have been put in place[81]. If new technologies are to be brought in, such as telehealth and telecare care, a new and improved I.T system should be developed and funded as a matter of urgency.

One GP explained to the Panel that it will be a huge challenge to get secondary care I.T systems to talk to primary care I.T systems[82]. When asked when this would be developed, she said: "*I think it has gone from being on a pilot that did not work to being now in a problem box nobody wants to*

[78] Services for children; services to encourage healthy lifestyles; services for adults with mental health issues; and services for older adults.
[79] Public Hearing with the Minister for Health and Social Services, 17th September 2012, page 3
[80] Public Hearing with the Minister for Social Security, 6th July 2012, page 19
[81] Public Hearing with Clinical Directors Group, 13th July 2012, page 18
[82] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 26

open[83]." In the past, there has been an isolated relationship between primary and secondary care on the Island. Therefore, it is important that primary and secondary care feed into one another, including the respective I.T. systems in order to benefit the patient[84]. Furthermore, integration of information technology is also important to support the whole process of integrated healthcare[85].

Without integrated I.T systems the development of best practice in Community Health will be hampered. At the same time, patient data protection should be addressed prior to the introduction of multidisciplinary teams handling patient information.

KEY FINDING 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.

KEY FINDING 19: Primary and secondary care on the Island have tended to be too isolated from each other.

RECOMMENDATION 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.

4.4 Recruitment

There are challenges in terms of recruitment and retention, particularly in certain staffing groups[86]. The White Paper proposes an expansion of some services and it is unclear whether additional needs of staffing can be met if recruitment is already a challenge. One GP said "*we do not shake a tree and they fall out*" training and recruiting are important factors[87].

The KPMG analysis reported that Jersey has significantly more GPs than most similar rural or isolated health systems:

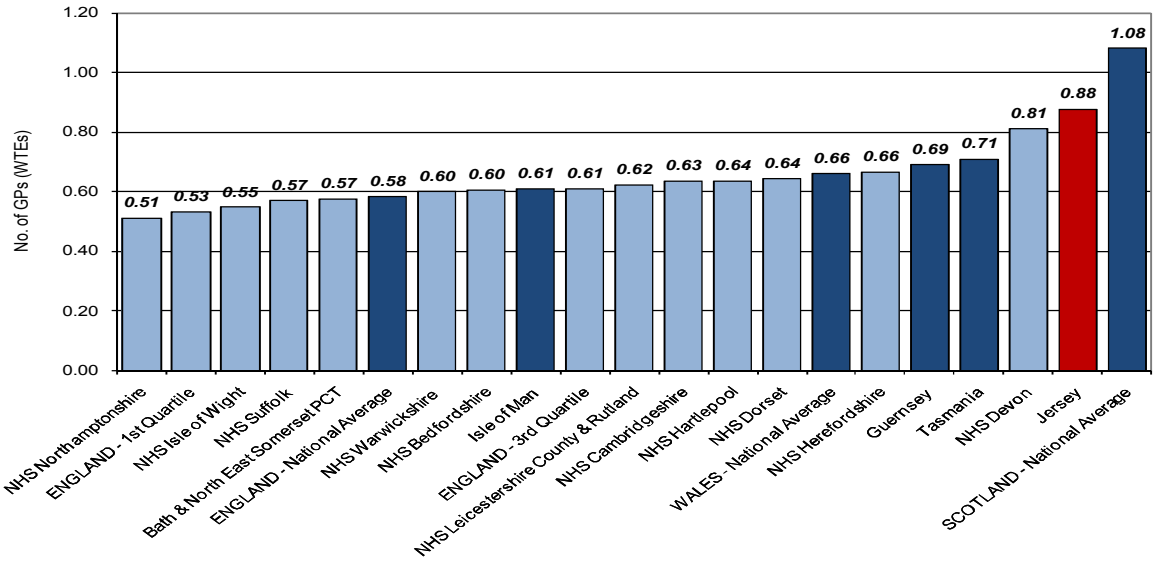

Figure 1[88]: No. of General Practitioners per 1,000 population (UK and Island Jurisdictions)

[83] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 27
[84] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 28
[85] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 5
[86] Public Hearing with the Minister for Health and Social Services, 3rd July 2012, page 27
[87] Public Hearing with Dr. P. Venn and Dr B. Perchard, 13th July 2012, page 9
[88] PowerPoint presentation provided by the Health and Social Services Department, received 13th February 2012 – source: *NHS Information Centre 2009/10; KPMG Analysis*

However, Jersey has very low numbers of community nurses:

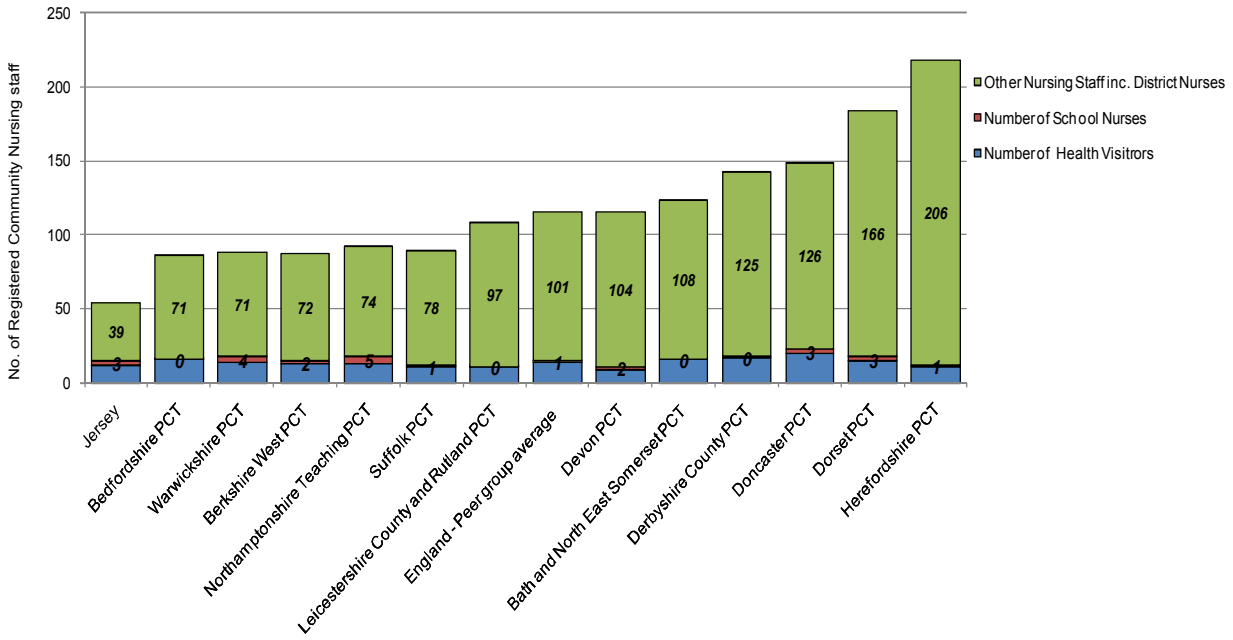

Figure 2[89]: No. of Registered Community Nurses per 100,000 population (England)

Jersey also has very low numbers of Hospital Doctors:

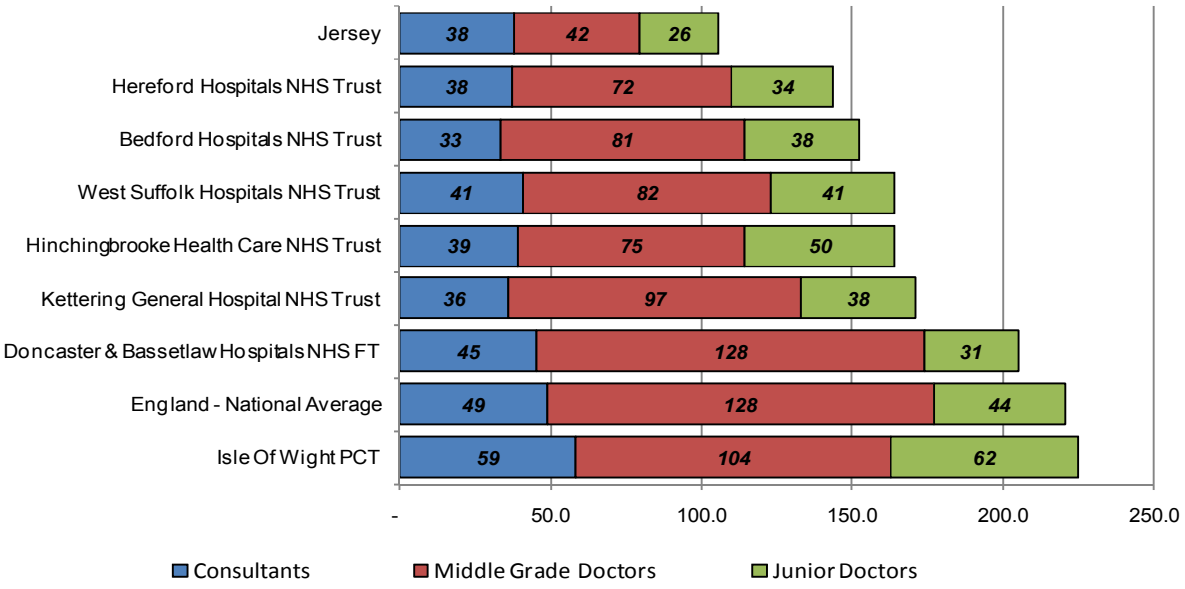

Figure 3[90]: Workforce – Medical staff by grade per 100,000 population (England)

It is understood that the three phased approach is required because of the significant workforce challenges in attracting people to the posts and getting services set up and well established[91]. The Panel questioned whether the States could realistically recruit the numbers of staff within each timeframe (of phases one, two and three) and heard from the Chief Nurse:

[89] PowerPoint presentation provided by the Health and Social Services Department, received 13th February 2012 – source: *NHS Information Centre 2009/10; KPMG Analysis*
[90] PowerPoint presentation provided by the Health and Social Services Department, received 13th February 2012 – source: *NHS Information Centre 2009/10; KPMG Analysis*
[91] Public Hearing with Head Nurses, 27th July 2012, page 6

> *"I think there are 2 things: one is, if we stand still, then we are not going to be able to sustain the services anyway, so we have to change something. In relation to nurse recruitment and retention, as a department we have done a huge amount of work, certainly over the past 6 years, in relation to doing more about growing our own*[92]*…"*

She went on to say that there is a recognition that the issue around nurse recruitment and retention needs to be fixed. She said that the Department is stuck in a position where there are generally about 40 registered nurse vacancies across the board, with an additional 20 (approximate) that are waiting to come into the service. This results in an overall position of about 60 unfilled posts[93].

The issue around nurse recruitment and retention is complex because of the cost of rentals, partners finding employment and the added difficulty of selling or renting a home in the UK[94]. This places doubt around the feasibility of the plans for staffing the new services and the Panel wonders whether the transition phase for the introduction of new services should be phased in gradually over a longer timescale.

KEY FINDING 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.

RECOMMENDATION 10: It may be necessary to phase in new services over a longer timescale due to the current difficulties with recruiting and retaining staff.

Despite the large numbers of staff to be recruited in 2013 to initiate the Intermediate Care Services[95], it is surprising that the appointment of a Community Physician[96] is not envisaged until June 2014[97]. This physician would lead the developed service across the two boundaries between primary and secondary care and as a resource available to GPs, community nurses and people in Hospital[98]. Therefore, this appointment is a crucial one that should not be delayed. When questioned on this appointment, the Department explained that an existing member of staff will be working for a fixed period of time initially to get the service up and running, and working closely with the GPs[99].

KEY FINDING 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.

RECOMMENDATION 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.

[92] Public Hearing with Head Nurses, 27th July 2012, page 9
[93] Public Hearing with Head Nurses, 27th July 2012, page 10
[94] Public Hearing with Head Nurses, 27th July 2012, page 10
[95] Outline Business Case: Intermediate Care, page 33
[96] Physician for the Care of the Elderly
[97] Outline Business Case: Dementia, page 38
[98] Public Hearing with Dr. P. Venn and Dr B. Perchard, 13th July 2012, page 18
[99] Public Hearing with the Minister for Health and Social Services, 3rd July 2012, page 24

5. The Third Sector

The 'third sector' is the general term used to describe the range of organisations that are not public sector, private sector or parishes. It includes voluntary and community organisations both registered charities and other organisations such as associations, self-help groups and community groups[100].

If the States of Jersey is committed to transforming public healthcare services, involving organisations from the third sector will be an essential part of achieving this service redesign. As the White Paper focuses mainly on community services, the third sector as well as the parishes and private sector should play a crucial role in the delivery of these services.

5.1 The benefits of the Third Sector

According to the National Audit Office, the benefits vary but some of the common themes and special qualities of the third sector are as follows:

- **Understanding of the needs of service users and communities** that the public sector needs to address;
- **Closeness to the people** that the public sector wants to reach;
- **Ability to deliver outcomes** that the public sector finds hard to deliver on its own;
- **Innovation** in developing solutions; and
- **Performance** in delivering services[101]

5.2 Silkworth Lodge

During the review, several issues became apparent after the Panel had spoken to Silkworth Lodge, a drug and alcohol charity that helps people to abstain from substance misuse. Although the Panel's terms of reference (ToR) sought to examine how the changes would impact on existing providers which include the third sector, some issues that were uncovered fall outside the ToR, therefore, have been examined in appendix two of this report.

Evidence suggests that there was, and has been a breakdown of communication between Silkworth Lodge and the Health Department due to a variety of reasons which the Panel sets out below:

- **Slow communication**: there had been long periods of time before queries from Silkworth Lodge had been answered by the Health Department. This is not acceptable if good working relationships are to be maintained.
- **Service Level Agreement payment:** there was a delayed payment at the end of 2011 from the Health Department for which Silkworth Lodge received an email apology.
- **Service Level Agreement management:** Silkworth Lodge used to provide information on bed data on a monthly basis. When this information stopped being received, it was not followed up or questioned by the Health Department.
- **Silkworth Lodge closed to new admissions:** when the Health Department was advised that Silkworth was closed to new admissions, it should have questioned and followed it up.

These issues have been explored in further detail in appendix two, but they do highlight a general lack of communication between the two parties. They should be managed and addressed as a matter of priority, particularly if the third sector are going to have a bigger part to play.

[100] National Audit Office "What is the third sector and its benefits for commissioners" website at www.nao.org.uk accessed 20 August 2012
[101] National Audit Office "Benefits that the third sector can give commissioners" website at www.nao.org.uk accessed 20 August 2012

In discussions with the Chairman of the Third Sector Forum, the Panel heard that other charities had experienced issues when dealing with the Health Department in the recent past, but during the last 12 months, those matters had been resolved and relationships were much improved.

5.3 Service Level Agreements

A Service Level Agreement can be defined as *"An agreement between the provider of a service and its users which quantifies the minimum quality of service which meets business needs*[102]*."* Service Level Agreements (SLAs) should be used to maximum effect to deliver corporate aims.

At the moment, because of the way the budget system works with funding being given to Departments on an annual basis, SLAs are short term (i.e. yearly) with some third sector organisations.

The Chief Officer of the Health Department admitted that she would like to see longer term SLAs. She said that if the States move to a 3 year funding envelope, such as what is proposed with the Medium Term Financial Plan, it would help with having longer-term agreements with third sector organisations[103]. Annual SLAs provides uncertainty for third sector organisations as it makes it difficult for them to expand and develop their organisations.

KEY FINDING 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.

RECOMMENDATION 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.

Following the communication breakdown between Silkworth Lodge and the Health Department it would be beneficial if Service Level Agreements were more robust and monitored by a nominated lead officer. The Chairman of the Third Sector Forum said that the problem in the past has been that the professionals within Health and Social Services tended to dictate to the third sector what they would do and how they would do it[104]. He said: "*You need a real partnership, a partnership of equals*[105]". A lead officer would ensure delivery and the development of a sound working relationship that assists adaptation to changing needs.

RECOMMENDATION 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.

5.4 Third Sector Forum

In 2011 it was announced that the States were to provide 2 years of start-up funding for a professional coordinator to manage the launch and development of a new Third Sector Forum. The need for a Third Sector Forum was recognised by the Association of Jersey Charities, as well as by existing agencies and States Departments[106].

A specially constituted working group was established to develop proposals for the Third Sector Forum, whose aim would be to support the professionalism of the organisations, enhance

[102] Andrew N. Hiles - Institute of Management Checklist 007, Implementing a Service Level Agreement
[103] Public Hearing with the Minister for Health and Social Services, 10th August 2012, page 5
[104] Public Hearing with Chairman, Third Sector Forum, 20th July 2012, page 9
[105] Public Hearing with Chairman, Third Sector Forum, 20th July 2012, page 9
[106] Funding announced for Third Sector, website at www.gov.je accessed 22nd August 2012

governance and standards and support the diverse range of voluntary, charitable and non-profit organisations that work to promote community values[107].

KEY FINDING 23: The newly established Third Sector Forum is a positive move to improve the communication between the Health Department and third Sector.

RECOMMENDATION 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.

The States will be funding a professional coordinator post for 2 years. 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[108].

Clearly, this is what is needed in order to benefit the working relationship between the States of Jersey and the third sector, but how this will be carried out was not clear from the discussions during the Hearing with the Minister for Health and Social Services. In earlier discussions the Panel was told by the Chief Executive Officer that the appointment was there to support the third sector in terms of how they wanted to develop themselves. Furthermore the Assistant Minister said the strength would be from one person overseeing the third sector[109]. No mention was made of establishing partnership models for government.

The Panel followed this up in more recent discussions, and asked whether the Department saw the post as a co-ordinator between Departments and the third sector, to get involved in commissioning and advocacy, as well as resolving issues. The Director of System Redesign and Delivery said: "*My understanding is that this co-ordinator post is going to be either an executive officer or a chief executive officer looking, as the Minister said, across the third sector not just for Health and Social Services*[110]."

KEY FINDING 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.

KEY FINDING 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. Discussions with the Health Department left the Panel unclear how this complex set of tasks would be fulfilled.

5.5 Will there be a duplication of services?

Some services which third sector organisations already deliver are mentioned in the White Paper. One example is the proposed "Maternal Early Childhood Sustained Home" (MECSH) visiting programme. This programme starts with a mother who is potentially at risk completing a research based well-being questionnaire. Brighter Futures provides many of the aspects of the work identified in the MECSH Early Intervention programme including working with mothers in pregnancy to provide the best environment for the foetus. They said that they are working with mothers who are potentially at risk and carry out a full assessment on accepting the referral and complete a psychological/depression questionnaire[111].

[107] Funding announced for Third Sector, website at www.gov.je accessed 22nd August 2012
[108] Funding announced for Third Sector, website at www.gov.je accessed 22nd August 2012
[109] Public Hearing with the Minister for Health and Social Services, 3rd July 2012, page 21
[110] Public Hearing with the Minister for Health and Social Services, 10th August 2012, page 36
[111] Written Submission, Brighter Futures, received 27th June 2012

Before new programmes are rolled out, the Health Department should rethink how best a service can be delivered, and whether it could team up with the third sector in order to increase efficiency. Brighter Futures felt that they had not been given serious consideration when the review of services took place. Furthermore, during the consultation process, Brighter Futures attended the meeting to look at services, but said there was no opportunity for them to provide evidence of their work or submit outcomes of their successes[112].

KEY FINDING 26: Some third sector organisations felt that the new services would duplicate those they are already providing.

RECOMMENDATION 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.

The Local Government Delivery Council has researched the issue of how local governments can work efficiently with third sector organisations. It found that shared services represent a better use of time and effort and said that joining up local services provides better service user experience, whilst at the same time reducing costs[113].

5.6 Parish Involvement

The Panel visited a Comité des Connétable meeting to discuss what community support is provided by each Parish. Previously there was a Parish-based Welfare system but this was replaced by a centrally-administered Income Support System in 2008.

The demise of the Welfare system based locally in each Parish left a number of Islanders without the services which were previously provided at Parish level. Both St Helier and St Clement Parish Halls said that the Constables and staff lost touch with many people it had been helping before the change[114].

In 2009, the St Clement Community Support Team was formed which offers assistance to parishioners, enabling them to stay living independently in the Community. The team has 30 voluntary members including a co-ordinator for the scheme.

The St Helier Parish Hall runs similar support but with a much smaller team with one full time and one part time employee with 5 volunteers comprising the team.

Parishes are perhaps more easily accessible than visiting the Social Security Department, therefore there are advantages in parishes playing a key role in administering community support, such as those services offered by the St Clement Community Support Team. It is noted, however, that the additional financial and manpower resources would be required.

The White Paper notes the importance of Parish support, which the Panel fully supports, and explains that Jersey has a vibrant third sector and a strong Parish-based system[115]. The White Paper recognises that the third sector requires additional support in order to fulfil its potential but this support should also be extended to the Parishes. With St Helier comprising of about 32,000 residents, a team of one full time and one part time employee (with 5 volunteers) appears to be minimal and at times the team struggles to provide the services it wants to.

KEY FINDING 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.

[112] Written Submission, Brighter Futures, received 27th June 2012
[113] Delivering Public Service Transformation 2010, Local Government Delivery Council
[114] File note: Meeting at St Clement Parish Hall, 18th September 2012
[115] Health White Paper, P.82/2012, page 15

6. What are the financial implications?

In the White Paper it was stated that no new taxes or charges are envisaged to fund phase one[116]. The funding of subsequent phases will be determined by the proposed review of a sustainable funding mechanism. The full cost of implementing the ten year strategy, including the replacement of the hospital has yet to be made public. Thus the States are in the position of being asked "to will the ends but not the means".

States Members have yet to decide how the new system will be paid for after 2015. Long-term health funding is an issue as it is difficult to identify where it will come from after the first phase. The Minister for Social Security told the Panel that he believes that the public should understand fully the cost implication of the new service and how it is going to be provided *before* it is developed[117].

KEY FINDING 28: The long-term funding is difficult to identify and therefore funding of the proposed changes has not been identified after 2015.

RECOMMENDATION 16: The introduction of systems for monitoring service costs and outcomes should dovetailed with the roll out of each new service. Therefore, baseline data should be established in order for this system to be developed.

6.1 Medium Term Financial Plan

The States of Jersey is planning to set budgets three years in advance thereby moving towards long-term planning. The Medium Term Financial Plan (MTFP) explains how Ministers are proposing to meet the objectives set out in the States Strategic Plan, and manage the Island's resources from 2013-2015 which is known as the first phase of the MTFP[118]. A key priority related to health includes plans to invest a further £26 million ongoing annual funding in Health and Social Services.

The longer-term approach to budgeting in the MTFP is intended to provide better value for money by allowing Departments to plan ahead for service development and improvement. This change aims to provide better flexibility and deliver better efficiencies[119].

There was a promise not to increase any taxes or Social Security in the first three year phase[120]. However, it is unclear what will happen in terms of funding in the next phases. The States Assembly must be confident that the next Government will accept the policy and proceed with it. As the White Paper phases link so inextricably with one another, there must be political will to make it continue.

KEY FINDING 29: The different phases in the ten 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.

RECOMMENDATION 17: The value and cost of services must be assessed objectively by a robust monitoring system. Where services are not sufficiently cost effective or gaining acceptance from the public, their continuation should be publically reviewed.

The public must be assured that funding can be continued to carry on phases two and three, but political commitment in the future cannot be guaranteed. The Minister for Social Security could not answer whether he was satisfied that the White Paper's vision was affordable. His concern was

[116] Health White Paper: Caring for each other, Caring for ourselves, page 31
[117] Public Hearing with the Minister for Social Security, 6th July 2012, page 17
[118] The Council of Ministers' proposals for the Medium Term Financial Plan were presented to the States on 23th July and debated on 6th November.
[119] "First Medium Term Financial Plan proposed" accessed from www.gov.je on 15th July 2012
[120] Health White Paper: Caring for each other, Caring for ourselves, page 31

that there was no indication in the White Paper of the funding required beyond the first Medium Term Financial Plan[121].

6.2 Long-Term Care

In July 2011 a new Long-Term Care (Jersey) Law 201- was approved by the States. The principles of the Law were to collect money from both working age and pensioner contributors to be paid into a new ring fenced fund and to use the money to help adults pay for long-term care. The new benefit was going to be available to people receiving care in their own home as well as to those living in a care home[122]. The new scheme was originally supposed to be implemented in 2013.

The Minister told the States that he had decided to delay the implementation of the Long Term Care Funding Law in order to ensure that contributions to pay for the change to a new benefit were fair and did not impose too high a financial burden on younger generations or vulnerable groups. He said that his Department was now exploring options with the Income Tax Department to explore the possibility of contributions being collected using existing income tax methods and collected from both earned and unearned income.

The Treasury Minister told the Panel that the Long-Term Care scheme was an important part of redesigning the health system and that, in some ways, he regretted the fact that it had been deferred for a year[123].

As the long-term care charge will be introduced in 2014, understanding how this will underpin some of the existing costs of the health service is unclear at present. Once this is established, the decision to introduce additional charges can be taken[124]. Unfortunately, this generates uncertainty for the public as to how the monies beyond 2015 will be generated:

> **Treasurer**
> *"We have not done all the work yet between Health and Social Security to determine just what pressure will be taken off Health costs by the introduction of the long-term care arrangements. We know it will help[125]."*

KEY FINDING 30: The new long-term care benefit was originally supposed 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.

RECOMMENDATION 18: The Panel strongly supports the intention behind proposition b(iii) that there should be a sustainable funding mechanism for health and social care by the end of 2014 and the Panel recommends 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.

6.3 Silo-Funding

Two GPs explained that at the moment, there are silo-differentiated funding i.e. patient fees, Health Insurance Fund, Health and Social Services funding allocated to various organisations. This made integration difficult. They said how funding flows around the system was something that needs to be addressed as soon as possible and the ability to address the integration of funding schemes was really important[126].

In addition, the Chief Nurse explained that, because of the way in which the money flowed around the system, practice nurses were currently operating below their skill-set[127]. Because the GP had

[121] Public Hearing with the Minister for Social Security, 6th July 2012, page 3
[122] Statement from the Minister for Social Security, 15th May 2012
[123] Public Hearing with the Minister for Treasury and Resources, 6th July 2012, page 20
[124] Public Hearing with the Minister for Treasury and Resources, 6th July 2012, page 24
[125] Public Hearing with the Minister for Treasury and Resources, 6th July 2012, page 28
[126] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 5
[127] Public Hearing with Head Nurses, 27th July 2012, page 10

to see the patient in order to access the payment, this meant nurses were not able to practice autonomously.

The Panel heard evidence that some GPs were frustrated that they were tied to seeing patients in order to deliver a service. If GPs did not have the patients the income was not generated which made it difficult for them to develop and lead services[128]. GPs would welcome some "uncoupling" of the need to see a patient to generate income into practices[129] . One GP said: "*I would be very sad to see the White Paper with all it suggests without that piece of work supporting it because that would be really futile and a waste of lots of people time*[130]"

The GPs were looking forward to discussions regarding what a funding mechanism would look like[131]. These discussions would be important as the GP's told the Panel that it was difficult for them to step back and develop and lead services[132]. Similarly with GP visits to patients in homecare, step up or step down facilities, attention needed to be given to the funding stream to support that so that accessing GPs is not a barrier[133].

In relation to the proposal to develop a new model of primary care (b)(ii) of the R&P it is important that the Terms of Reference are discussed with and have the support of the primary care clinicians. The Panel welcome the additional details provided in the R&P and shares the view that all stakeholders should be included in the development.

A Primary Care model is likely to incorporate appropriate long-term funding flows and payment and incentivisation mechanisms[134]. The change in funding mechanism from current fee per service practice to sessional contracts or capitation fees could prove to be costly and will need to be justified in terms of better outcomes for the patient and patient satisfaction.

KEY FINDING 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.

RECOMMENDATION 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.

6.4 Health Insurance Fund

The Minister for Social Security has responsibility for the Health Insurance Fund which is held within the Social Security Department and is financed by Social Security contributions. It is designed to provide financial assistance for people who need to access their GP or prescription drugs[135]. Some of the Outline Business Cases and specifically the Business Case for Alcohol Pathways mentions that screening in Primary Care will be covered by the Health Insurance Fund[136].

However, there appears to be scope for greater communication between the Minister for Social Security and both Ministers for Health and Social Services and Treasury and Resources regarding some of the Outline Business Cases being funded by the Health Insurance Fund[137]:

[128] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 6
[129] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 6
[130] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 6
[131] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 5
[132] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 6
[133] Public Hearing with Dr. P. Venn and Dr. B. Perchard, 13th July 2012, page 12
[134] Final Report and Proposition: A new way forward for Health and Social Services, page 64
[135] Government Actuary's Department, "Report by the Government Actuary on the financial condition of the Health Insurance Fund as at 31 December 2007, page 1
[136] Outline Business Case: Alcohol Pathway, 13th June 2012, page 50
[137] Public Hearing with the Minister for Social Security, 6th July 2012, page 14

Deputy J.A. Hilton:
"So you have not had any discussions with the Minister for Health or the Minister for Treasury and Resources over some of the outline business cases being funded by the Health Insurance Fund? So that has not happened yet?"

The Minister for Social Security:
"I have not, no".

Chief Officer:
"No, not to any level of depth have we ever had conversations about what the Health Insurance Fund would cover. I am sure there are conversations that have taken place but not a specific measure to say: "Will the Health Insurance Fund this specific instance?" "[138]

The Outline Business Case for End of Life Care recognises that discussions need to be held with the Social Security Department regarding the Health Insurance Fund, prescription charges and the Long Term Care Benefit[139]. The White Paper has an effect on every other Department within the States of Jersey, therefore it is important that funding and service developments are aligned across all Departments.

The issue of a funding mechanism is considered a key part of proposition b)iii which asks the States to approve a sustainable funding mechanism by the end of 2014, the Panel hopes the States will accept its amendment to bring this forward to the end of 2013. The Panel welcome the recognition in the R&P that work to review and develop proposals for a funding mechanism will be led by Treasury and Resources and include Social Security and Health and Social Services during 2013 and 2014[140]. In this context it must be remembered that whilst Outline Business Cases for the period to 2015 are funded through the MTFP, the HIF will have contributed £26m by 2015 to the funding of Health and Social Services (£12m to end of 2012 and a further £14m if the MTFP is approved).

KEY FINDING 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 regarding 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.

6.5 The Public

It is noted that any new user-pays charges would have to be approved by the States, however, the Panel questioned whether the smaller items (such as dressings) would have to be paid for by the patient. A patient normally received three days' supply of dressings if they have a wound that requires dressing. Family Nursing and Home Care would be used to remove the suture, if necessary, and patients were entitled to one free appointment with FNHC after discharge (if it is for the removal of dressings or sutures). The Department told the Panel that patients were advised to join FNHC if they were going to need ongoing care after discharge[141].

When asked whether patients would have to pay an additional charge for their care following implementation of the new proposals, the Chief Executive said: *"In the same way as there already is. It is not a new charge*[142]". However, it remains unclear whether patients are likely to face an additional cost if they are cared for (for a longer period of time) in their own homes instead of in hospital.

[138] Public Hearing with the Minister for Social Security, 6th July 2012, pages 14 and 15
[139] Outline Business Case: End of Life Care, 13th June 2012, page 34
[140] Final Report and Proposition: A new way forward for Health and Social Care, page 65
[141] Public Hearing with the Minister for Health and Social Services, 17th September, page 13
[142] Public Hearing with the Minister for Health and Social Services, 17th September, page 13

The Department explained to the Panel that no assumptions regarding additional costs to the patient have been made as the Outline Business Cases do not go into that level of detail.

KEY FINDING 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.

RECOMMENDATION 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 should not be subject to charges.

RECOMMENDATION 21: The Panel expects the Health Department to focus on protecting patients from incurring any additional costs as the Full Business Cases 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.

7. Conclusion

The Panel has concluded that the proposed redesign of health and social care in Jersey is to be welcomed in general terms. It has received evidence that if at least some of these proposals had been introduced some years ago, the Island would today have services under less substantial pressures, more modern facilities and a balance of services which allowed more Islanders to be cared for in their homes and the communities where they live.

Against this background of suboptimal past investment, current pressures and service gaps, it would be wrong to reject the Department's vision for changes which aim to redesign the health and social care system to produce better outcomes for Islanders; improve the efficiency and effectiveness of resource use, cater for demographic change and relieve pressures on services which are apparently at risk of becoming over extended. Providing care and support for people in their home environment wherever feasible is also a laudable aim which the Panel supports.

The question is whether the proposals contained in the R&P will deliver the anticipated improvements in health and social services at a cost that is affordable and with the degree of effectiveness Islanders are right to expect. Despite its overall support for the Department's vision, the Panel is concerned that it cannot yet provide as clear-cut and positive a response to that question as it would like. As in much implementation, the 'devil is in the detail'. Although more information has been appearing during the process of this review and is promised, there remain many areas of uncertainty.

For example, even the basic choice of options for development has been criticised for the narrowness of range and a process that felt to some participants as though it was designed to guide them towards a single solution rather than to debate the merits of several potentially well-founded options. As a result, the Panel is compelled to conclude that the Green Paper and subsequent consultation processes were less well designed than they might have been as only one of the three scenarios was presented for serious consideration. The Panel has, therefore, serious reservations about the range of options presented, the process by which they were reviewed, and the weight that can be placed on the results of the consultation.

The Panel noted that the KPMG report was based on the most up-to-date demographic data available at the time, but has since been superseded by data from the 2011 Census. The overall impact of these changes may or may not be significant but the Panel was not fully convinced by the approach adopted by the Department in its evidence. It has concluded, therefore, that an impact analysis of the most recent data for affordability and demand should be conducted to reassure the public about the viability of the proposed model.

Generally speaking, each of the proposals contained in the White Paper can be seen to have merits in its own right and to be consistent with developing ideas about what constitutes good practice in modern health and care systems. It is less clear to the Panel however, that sufficient attention has yet been given to modelling the interdependence of different elements of the proposed services and to their interaction as a whole system. In this connection, the Panel also noted the view of the Minister for Social Security that there will be a significant impact on services provided by third sector organisations and other States Departments in terms of resources and manpower implications. The delivery of the new service model will depend on close collaboration not only within the health and social care system but also between it and all relevant parties. The Panel considers further work is likely to be necessary to understand and communicate how the leadership and operation of the care system can provide the continuity of care and full range of services envisaged at the appropriate times and places.

Throughout its report, KPMG highlighted a lack of data available in many areas and the Panel shared this concern. This deficiency will cause difficulty in measuring the costs and outcomes of new services. New service models should be evidence based so far as possible and systematically monitored to ensure the delivery of predictable costs, outcomes and public acceptance. Hence there is an urgent need for better baseline information.

Informatics will play a major role if new service models are to be successful. The drive to develop community services will be reliant on good quality I.T systems which ensure the highest standards of patient data handling especially if multidisciplinary teams are to manage patient information. There is no doubt that the current Health I.T system is not integrated between primary and secondary care and this problem requires urgent resolution and to be funded as a matter of priority.

The Panel also has concerns about the probable difficulties in recruitment of suitably qualified staff, in the considerable numbers envisaged, in order to implement the introduction of the new services. The Panel noted the recent difficulties in recruiting the traditional health care staff. Although there has been some very recent easing of recruitment pressures in nursing, the Panel is concerned that recruitment may prove to be a stumbling block over the medium to long term.

The Panel would also like to have seen fuller information about costs and funding mechanisms. Though it recognises that more details are to be provided and a review proposed to develop a sustainable funding mechanism, it does not believe that current situation is satisfactory for the States and the public of Jersey. It has sometimes seemed to the Panel as though it is being asked to will the end but not the means. It has concluded that it would be wrong to ask the current States to address only the first part of the ends/means equation and has made recommendations to that effect. The issue of affordability is absolutely fundamental.

The Panel has no doubt that the public would like access to a new hospital funded to provide the latest equipment and best trained staff. They would also opt, no doubt, for a well coordinated system of primary care, community health and social services integrated with other States Departments and the community sector. Whether such a service is affordable is to some extent a matter of political choice. The public and the States need to be more fully informed about the costs of the option with which they are now being presented in order to make that choice.

Otherwise, the Panel will continue to be concerned that the States is effectively being asked to adopt an attractive vision for change without being in a position to balance that vision against its implications for costs and outcomes over the medium to long term. The Panel concluded that there is a fundamental issue underpinning all these considerations about costs and affordability: do Islanders want both a comprehensive high quality health and social services and current levels of taxation. If so, are they prepared to give up other services and if not, how do they propose to fund additional health and social care services with a population structure that will continue to change over time. The Panel commends the funding review proposed in the report and proposition but does not feel able to wholeheartedly commend the full vision for reform in the absence of fuller information about costs and affordability together with an opportunity for wide public debate.

Therefore, in reaching this conclusion, the Panel recognises that some changes are urgent, particularly in maintaining a safe hospital environment. This is why it sees advantage in a staged re-build which also has the effect of minimising the amount of resources which effectively have to be spent twice, first to sustain existing services and again on a new build. In addition, decisions about the volume and range of new hospital services will be influenced to some extent by the impact of the changes in community and intermediate care and primary care on demand such as beds and out patient referrals. A staged re-build will help to facilitate such decisions. The assessment of the future size of the hospital services will take account of the need to retain all the essential main specialty services currently provided. There will be an ongoing requirement for service level agreements with mainland providers of the highly specialised therapeutic and investigative services that would only be feasible in larger institutions. Whether the balance between on and off island services should change is also an issue for careful consideration. The Panel hopes the pre-feasibility study will provide sufficient information to enable properly informed decisions to be made about the costs, affordability and mix of hospital provision.

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Review Hearings

The Panel held the following Public Hearings:

Monday 3rd July 2012

Session 1: Deputy A.E. Pryke, Minister for Health and Social Services
Connétable J.M. Refault, Assistant Minister for Health and Social Services
Ms J. Garbutt, Chief Executive Officer, Health and Social Services
Ms R. Williams, Director of System Redesign and Delivery
Mr J. Turner, Director of Finance and Information, Health and Social Services

Friday 6th July 2012

Session 1: Senator P.F.C. Ozouf, Minister for Treasury and Resources
Deputy E.J. Noel, Assistant Minister for Treasury and Resources
Ms L. Rowley, Treasurer of the States

Session 2: Senator F. du H. Le Gresley, Minister for Social Security
Deputy S. Pinel, Assistant Minister for Social Security
Mr R. Bell, Chief Officer, Social Security
Mrs S. Duhamel, Policy and Strategy Director

Friday 13th July 2012

Session 1: Dr. B Perchard, GP Primary Care Group
Dr. P. Venn, GP Primary Care Group

Session 2: Clinical Directors Group:
Dr. A. Luksza, Consultant, Respiratory Medicine
Dr. R. Downes, Consultant, Ophthalmology
Dr. N. Payne, Consultant, Emergency Department
Dr. C. Hare, Consultant Radiologist
Dr. M. Jones, Consultant, Paediatrics
Dr. P. Southall, Consultant Histopathologist
Dr. M. Richardson, Consultant Physician

Friday 20th July 2012

Session 1: Mr. J. Hopley, Chairman, Third Sector Forum

Session 2: Mr. J. Le Feuvre, Chairman, MIND

Friday 27th July 2012

Session 1: Ms. R. Naylor, Chief Nurse, Health and Social Services
Ms. M. Leeming, Head of Nursing, Adult Mental Health Services
Ms. E. Torrance, Deputy Director of Operations, and Divisional Lead Women's and Children's Services
Ms. J. Mesny, Head of Nursing and Midwifery Education
Ms. H. Blain, Senior Manager Workforce Planning

Monday 30th July 2012

Session 1: Mr. R. Jouault, Managing Director of Community and Social Services
Mr. I. Dyer, Directorate Manager, Mental Health Services
Ms. G. Rattle, Head of Occupational Therapy Services

Session 2: Silkworth Lodge:
Mr. J. Wyse, Chief Executive Officer
Mr. F. Laine, Chairman

Session 3: Family Nursing and Homecare:
Ms. J. Gafoor, Chief Executive Officer
Ms. J. Le Ruez-Lane, District Nurse Team Leader

Ms. J. Hinks, Operational Lead Home Care Support Team

Friday 10th August 2012

Session 1: Deputy A.E. Pryke, Minister for Health and Social Services
Connétable J.M. Refault, Assistant Minister for Health and Social Services
Ms J. Garbutt, Chief Executive Officer, Health and Social Services
Ms R. Williams, Director of System Redesign and Delivery
Mr. C. Dunne, Director of Adult Services
Mr. I. Dyer, Director of Older People's Services
Mr. M. Gafoor, Director of Drug and Alcohol Service

Monday 17th September 2012

Session 1: Deputy A.E. Pryke, Minister for Health and Social Services
Connétable J.M. Refault, Assistant Minister for Health and Social Services
Ms J. Garbutt, Chief Executive Officer, Health and Social Services
Ms R. Williams, Director of System Redesign and Delivery
Mr. R. Jouault, Managing Director of Community and Social Services
Mr. A. McLaughlin, Hospital Director
Mr. T. Riley, Human Resources Director, Health and Social Services

Written submissions

The Panel received the following written submissions:

- MIND Jersey
- Silkworth Lodge
- Jersey Alzheimer's Association
- Meals on Wheels
- The Stroke Association
- Citizens Advice Bureau
- Brighter Futures
- Chamber of Commerce
- St John Ambulance
- Primary Care Body

Panel Visits

The Panel made the following evidence-gathering visits:

Friday 15th June 2012

Tour of the Jersey General Hospital and meeting with:

- Deputy A.E. Pryke, Minister for Health and Social Services
- Mr. A. McLaughlin, Hospital Director
- Ms J. Garbutt, Chief Executive Officer, Health and Social Services
- Ms R. Williams, Director of System Redesign and Delivery

Friday 22nd June 2012

- Tour of the Overdale Hospital site
- Tour of Clinique Pinel
- Tour around the outskirts of St Saviour's Hospital

Monday 23rd July 2012

Fact-finding visit to Guernsey and meeting with:

- Deputy H. Adams, Minister for Health and Social Services, Guernsey
- Mr. M. Cooke, Chief Officer, Health and Social Services, Guernsey
- Mr. R. Evans, Director of Corporate Services, Guernsey

Monday 30th July 2012

Professor Wistow and Mr Gleeson attended a meeting with:

- Ms J. Garbutt, Chief Executive Officer, Health and Social Services
- Ms R. Williams, Director of System Redesign and Delivery

Tuesday 31st July 2012

Professor Wistow and Mr Gleeson attended site visits to:

- Overdale Hospital
- Clinique Pinel site
- St Saviour's Hospital site
- General Hospital – meeting with Mr. A. McLaughlin, Hospital Director

Monday 17th September 2012

The Panel attended a Comité des Connétable meeting to discuss Parish voluntary community services:

- Connétable J. Le Sueur Gallichan
- Connétable D .J. Murphy
- Connétable A. S. Crowcroft
- Connétable L. Norman
- Connétable J. M. Refault
- Connétable D. W Mezbourian
- Connétable J. Gallichan
- Connétable P.J. Rondel
- Connétable S.W. Pallett
- Connétable M. P. S. Le Troquer

Tuesday 18th September 2012

The Panel attended a meeting at the St Clements Parish Hall to discuss the Community Support Team:

- Chris Le Cornu (Chairman of St Clement Community Support Team)
- Julie Martin (Co-ordinator of the Team)

Wednesday 19th September 2012

The Panel attended a meeting at the St Helier Town Hall to discuss the community support:

- Julie Garrod, St Helier Support Team
- Marguerite Wilson, St Helier Support Team

Thursday 27th September 2012

The Chairman, Professor Wistow and Mr Gleeson attended a site visit to the Jersey General Hospital.

9. Appendix One: Written Submissions: What does the Third Sector think?

The Panel sought the views of the Third Sector asking different organisations what they thought about the White Paper and what impact the proposals would have on their organisation[143].

The overall message of the submission from **Jersey Chamber of Commerce**[144] relate to the lack of particular information contained in the White Paper. Whilst the Chamber acknowledges that a significant amount of research was carried out, it is unclear how conclusions were reached. The Chamber sought clarification on a number of issues:

- Concern was given to the lack of information as to how the partnership between civil servants and/or private agencies will be implemented. They said that the relationship needs to be one of "equal partnership" and it is crucial that the independence of charitable organisations is not lost.
- The Chamber would like further information of discussions that have taken place between Guernsey and Jersey for a joint-Island partnership.
- The Chamber believe that a feasibility study for a new hospital should have been carried out prior to the White Paper. They are concerned that the capital cost figure will impact on the final plan.
- The Chamber also felt that there was a lack of information with regard to cost implications of the plans on businesses in the future. It believes that that the new plan cannot go ahead if underlying structural problems regarding funding are not dealt with beforehand.

The **Jersey Citizens Advice Bureau**[145] mainly provides suggestions of how services can be improved and therefore offered possible changes to the White Paper. There was a positive message about the White Paper in that it was well thought out, detailed and comprehensive. Some of their queries were:

- It is not clear who will be responsible for carrying out the changes to the service delivery to the public. It questions whether duties will be "as well as" or "instead of" and whether extra staff will be needed.
- Regarding s*ervices for children*, the Bureau highlighted that the report stresses the need to attract more foster parents but it questions how this can be done in an Island so small. It said that this is made even harder by the high cost of renting and buying in Jersey which means there is rarely a spare room.
- Regarding *services for adults, especially older adults* the Bureau felt that there needs to be an increase in the number of housing units for elderly and disabled with a 24 hour supporting service. Furthermore, they said that recruitment and retention of nurses remains a problem in Jersey and the States need to look at ways of improving pay and conditions.
- Regarding *funding* the Bureau quoted "no increases in charges or taxes are envisaged in Phase 1" and said that it has concerns with regard to the funds and how they will be found, particularly with the costs of a new hospital to consider.

The overall message of the **Jersey Alzheimer's Association**[146] was that they are concerned that the new plans, proposed in the White Paper, will not be executed. Their main concerns were as follows:

[143] Some were duplicate submissions also sent to the Health Department during its consultation
[144] Written Submission, Chamber of Commerce, dated 18th July 2012
[145] Written Submission, Jersey Citizens Advice Bureau, received 27th June 2012
[146] Written Submission, Jersey Alzheimer's Association, received 9th July 2012

- The monies needed to implement the White Paper will not be available.
- A number of States run initiatives, in which Jersey Alzheimer's Association have been involved in, have petered without any action being taken, for example 'New Directions', 'Carers Strategy' and 'National Dementia Strategy'.
- The majority of people attending previous workshops set up by the Health Department were Civil Servants, Managers and professional care staff. Due to the lack of carers and charities present, the Association are concerned that plans are being made based on what Civil Servants 'think' carers want and need.
- Jersey Alzheimer's Association is a small charity and they are concerned that they will be unable to expand in a short time space with the lack of infrastructure and manpower that they have.
- Regarding *awareness raising* the Association does not feel that it is necessary for more money to be invested in awareness-raising.
- Regarding *home support* the Association feels that more should be done by the Health Department to enable people with dementia to stay in their own homes as long as possible. They said it should be a priority of the Department to facilitate Home Care Support Packages. Furthermore, the White Paper does not mention respite care for old people and the Association said that a carer's ability to care for a person with dementia in their own home would be prolonged if this was introduced.

The overall message in the submission from **Family Nursing and Home Care**[147] (FNHC) recognised the potential benefits of the new model in enhancing care. However, it also acknowledges that some challenges will need to be overcome if the model is to be successful. The challenges they envisage relate to: Recruitment of staff, partnership agreements, technology support systems and advanced nurse practice:

- *Recruitment of staff*: the new plan will require an increase in the workforce of trained and untrained nurses in the community. FNHC believe it would be very helpful if they could access incentive payments (like the Health Department) in order to attract skilled nurses from off the Island.
- *Partnership Agreements:* to achieve partnership working, some areas will require a cultural shift in working practices and mind sets.
- *Technology support systems*: in order to evaluate the care delivered by staff efficiently there needs to be a considerable infrastructure in computer support and systems. FNHC would like the Health Department to offer financial support for this development.
- *Advanced nurse practice:* FNHC believe that it is essential that community nurses are included in advanced nurse prescribing courses (within the existing model they are not).
- *Implementation:* the transfer from old to new model will incur some overlap and may incur doubling of the cost over this period. FNHC believe this needs to be acknowledged in project planning and financial planning.

FNHC also said that the concept of the model sits favourably with FNHC visions and aims and that the development of services in the community will enable enhanced care to be delivered to patients.

[147] Written Submission, Family Nursing and Home care, dated 17th July 2012

The overall message of the submission from the **Meals on Wheels**[148] Service in Jersey related to the priority to support people to live independently in their homes for longer. For Meals on Wheels, this will mean expanding its services. Meals on Wheels believe that they would currently be able to cope with an increase in recipients, but in the long term they may require more room to work to prepare food. They would like the Health Department to consider their work place and the need for expansion in the long term in order to facilitate a substantial increase in meal recipients.

The submission from **Mind Jersey**[149] welcomes the White Paper and especially the priority of Mental Health issues. However, it waits to see whether the States Assembly will be prepared to identify and secure the resources that will be required if these plans are to be implemented in a timely fashion. It main concerns are set out below:

- Mind Jersey said that, in order to help deliver the new plan, greater resources are needed, for example a carers support budget.
- Mind Jersey believes that greater attention should be given to the families at time of crisis.
- In the UK early intervention and crisis intervention teams have been established and Mind Jersey would like to see this as a high priority for early implementation. However, it notes that this development is not included in the White Paper.
- Mind Jersey feels that support for Young Carers has been overlooked in the White Paper and that Jersey should follow a UK approach.
- Regarding the *Dementia Strategy* Mind Jersey believes that, given additional resources, it would be most logical for them to extend the valuable work of their independent Mental Health Advocate to encompass older and increasingly vulnerable clients.
- Those suffering from Long Term Conditions (LTCs), including those with mental illness, are often deterred from regular contact with their GP's because of the high costs which impacts adversely on their health and wellbeing. Mind Jersey feel that this dilemma could be tackled by: encouraging practices to manage LTC patients for a 'fixed' annual sum (to be funded by social security); employing a range of lower cost health and social care professionals working in Primary care practices and possibly delivering care from the Community Wellbeing centre, should it be cost effective to establish such a facility.

The overall message from the submission from the **Silkworth Charity Group**[150] was that there is a lack of trust and confidence in the White Paper due to past experiences. In order for the new plan to work the Health Department need to demonstrate that they are able to work in equal partnership with third sector organisations and allow them to work to the best of their ability. One of its main concerns was that the White Paper emphasises the importance of building new relationships with community organisations as one of its key objectives. However, Silkworth believe that if they are not doing it now then why is the White Paper going to make any difference. It is also concerned that there is no mention within the White Paper of the extent of the drug problem in Jersey.

The submission received from **St John Ambulance Jersey**[151] was generally supportive of the Paper and The Pathway to Change. They also said they would welcome the opportunity to work more closely with the Health Department, with the aim of forming a true partnership to play their part in the White Paper reforms to achieve greater efficiency and integration of services.

Many of the proposals made in the White Paper are supported by the **Stroke Association**[152]. The focus in the plan of Improving Access to Psychological Therapies is welcomed as is the call for a redesign of services in Jersey. Their main concerns are as follows:

[148] Written Submission, Meals on Wheels, received 2nd July 2012
[149] Written Submission, Mind Jersey, received 2nd July 2012
[150] Written Submission, Silkworth Charity Group, received 24th July 2012
[151] Written Submission, St John Ambulance Jersey, 19th July 2012
[152] Written Submission, Stroke Association, 2nd July 2012

- The Stroke Association believe that stroke is not given the priority it requires in the plan considering its significance, as they believe that with an increasing ageing population, stroke will become an even more significant problem for Islanders over the next 30 years.
- The Stroke Association believe that the planned stepped approach to health promotion seems to be inefficient and that they would advocate a comprehensive approach to health promotion rather than targeting specific issues in a staged manner.
- The lack of reference to stroke or any other cardiovascular diseases in the consultation is of major concern to the Stroke Association.
- The Stroke Association would like appropriate resources to provide support for stroke survivors with communication disability for example.
- The Stroke Association highlight that there are no plans of how third sector involvement will take place or any mention of statutory funding for vital services from the sector.

The main message from **Brighter Futures**[153] was that it believes that it is already providing the services that have been proposed in the Maternal Early Childhood Sustained Home Visiting (MESCH) Programme.

[153] Written Submission, Brighter Futures, received 27th June 2012

10. Appendix Two: Silkworth Lodge

The Panel met with the Chairman and the Chief Executive Officer of Silkworth Lodge on 30th July 2012. During the Hearing, several issues arose which were covered extensively by the media. In order to address some of these issues, an urgent public hearing was held with the Minister for Health and Social Services on 10th August 2012.

Silkworth Lodge

Silkworth Lodge provides a drug and alcohol rehabilitation programme, which is funded partly by charitable donations and by a Service Level Agreement with the Health Department. The Lodge currently has 12 beds – 6 are charged for private service users and 6 are allocated to the States, charged at £600. During the Public Hearing, Silkworth Lodge raised a number of issues concerning its dealings with the Health Department:

- **The Service Level Agreement (SLA) payment in December 2011 was either deferred or cancelled.**
- **There had been no referrals from the Drug and Alcohol Service since October 2011.**
- **Silkworth Lodge had not been consulted on the White Paper, despite a focus on alcohol as a priority service area.**
- **There were long periods of time before queries from Silkworth Lodge had been answered by the Health Department.**

Health and Social Service Department

It was only natural that questions were raised following the Public Hearing with Silkworth Lodge. The Panel raised these questions during the Hearing with the Minister who was accompanied by senior officers from her Department.

The Service Level Agreement (SLA) payment in December 2011 was either deferred or cancelled - The payment was delayed due to an administrative error by the Director of Adult Services. The invoice was received in January 2012 but was filed and forgotten about due to a meeting with Silkworth Lodge not coming into fruition. Once this was realised, the invoice was processed with immediate effect. Silkworth Lodge received an email apology from the Director of Adult Services on 28th February 2012.

There had been no referrals from the Drug and Alcohol Service from October 2011 - The Department told the Panel that between October 2011 and July 2012 the Drug and Alcohol Service made 18 referrals to Silkworth Lodge. Of the 18, 8 were admitted, 4 were declined, 3 were declined by the client, 2 did not attend and 1 was currently being assessed by Silkworth.

The Department explained that it had been advised that Silkworth Lodge was closed to new admissions in the latter part of 2011 between November and December. Referrals were still being made but there were no admissions accepted by Silkworth Lodge during that period. It is noted that there was no evidence in receipt from Silkworth Lodge advising of no admissions, but there was evidence on individual client records where staff recorded that was the case.

Silkworth Lodge had not been consulted on the White Paper, despite a focus on alcohol as a priority service area - In November 2011 a “U-Collaborate” event was organised, which is a technical term to mean 100+ people getting together to discuss challenges in services. The Department explained that one of the previous directors from Silkworth Lodge was involved in that meeting.

The Panel also received a copy of email correspondence from Silkworth Lodge to the Health Department which said that they would be unable to provide constructive feedback on the Department's White Paper in the specified 8 week timeframe.

There were long periods of time before queries from Silkworth Lodge had been answered by the Health Department - The Department explained that a meeting was held at the beginning of June 2012 with Silkworth Lodge. At that meeting, the Director of System Redesign and Delivery undertook that she would find out the information relating to Silkworth's queries. She explained that one of the reasons for delay was because obtaining the most up-to-date information took longer than she expected.

Conclusion

These issues would point towards a breakdown of communication between the two parties. It was noted during the Hearing with the Minister that Silkworth Lodge used to provide information on bed data on a monthly basis. When this information stopped being received, it was not followed up or questioned by the Health Department. Furthermore, in whatever way the Department was advised that Silkworth Lodge was closed to new admissions, the Department should not have accepted this and it should have questioned and followed it up.

The Panel sees this episode as an example of a low trust environment when communications are poor. These should be managed and addressed as a matter of priority particularly if the third sector are going to have a bigger part to play.

11. Appendix Three: The Boyle Report

Review for the Scrutiny Panel of the States of Jersey

September 2012

Seán Boyle
London School of Economics

The States of Jersey is currently considering a major programme of change to the healthcare system in Jersey. In this paper, we consider:

- the proposed changes;
- the basis for these changes;
- any alternatives considered and why these were rejected;

We also assess the robustness of the analysis looking at the range of assumptions and the evidence base for these; and point to some important elements that have not been considered. Finally we present some conclusions.

The description and detail that follows relating to Jersey health services is based mainly on the KPMG reports (KPMG 2011a, 2011b) and the White Paper, *Caring for each other, Caring for ourselves* (States of Jersey 2012a). Where it is not, then appropriate references are provided.

1 Background

Responsibility for health services within Jersey lies with the Health and Social Services Department (HSSD). Acute health services are provided by Jersey General Hospital operating within a separate management structure, primary care is provided by independent GPs and there are also separate community nursing services. Social care and care for people with mental health issues are provided in both residential and community settings.

Public funding of health services comes from two sources: the HSSD funds primarily hospital services, community and social services, public health and central administrative functions; and social security provides some funding for care homes, medical, optical, dental and pharmaceutical services and subsidy payments for GP consultations. In addition there are individual private contributions to the hospital sector as well as GP co-payments (user charges).

2 What are the issues with the Jersey healthcare system?

A number of proposals have been put forward for consultation representing some major changes to the health system in Jersey. The crucial question is: what are the issues that these proposed changes are intended to address. Although the 'challenges' have been described in various ways in different documents, we do not feel a clear answer in terms of the key high-level issues has been offered in any of the documents we have looked at.

In our view, the key issues relate to:

1. financial sustainability i.e. ability to finance healthcare;
2. efficiency with which healthcare is delivered;
3. access / delivery of care in appropriate settings;
4. ability to ensure that people receive high-quality care in a safe environment; and,
5. fairness / equity.

2.1 Financial sustainability

In our view the most important issue is financial sustainability. To some extent this is a matter of political will. However the key question is what the level of funding (or expenditure) is now compared with other countries / islands / areas with small population size, and how much this is likely to increase in future years. There is also a secondary question of what the time-period should be for any future-looking analysis. It is not always appropriate given the uncertainties that exist around demography, technology, availability of funding, to base current policy on some point in the distant future. But for the purpose of this paper, we

accept the question as implicitly posed: **what is an acceptable level of increase in expenditure over the next 30 years?**

2.2 Efficiency of the system

Clearly there are bound to be issues arising from the fact that the population of Jersey is small in number and relatively isolated; in addition Jersey appears to be a high-cost environment (in terms of wages / salaries and other inputs). This leads almost inevitably to higher unit costs. The question is: **what cost differential is acceptable; what other alternatives are there?**

If alternatives are put forward (as is the case here), then there needs to be a clear risk analysis showing what happens if these alternatives do not work. Otherwise what works now may be better even if the associated cost is a little higher – it all depends how much higher.

2.3 Access / delivery

There are issues around delivery of care in appropriate settings. It is claimed that there is inappropriate use of A&E and that this may be due to individuals avoiding the cost of consulting GPs. There may be other reasons e.g. lack of 24-hour access to GPs – even though there are relatively more GPs per head on the island than in other jurisdictions, ease of access can depend on matters such as opening hours, distance, etc.

There are also concerns around the future capacity of the acute hospital. However there should not be an over-eagerness to leap to a 'new hospital' solution with all the extra costs that this will entail. The required capacity should be looked at very closely and alternative solutions considered.

A lack of capacity for social and clinical care in the community also seems to be an issue. This will have to be addressed if it is proven to be the case.

2.4 Quality of care

It is likely that there is not sufficient activity in some specialties to ensure the volume of activity that would maintain the skills of surgeons. Already some work is done off island. The question is what other work is best done off island – in the interests of patients – and what extra costs if any would be involved, or avoided.

Wrapped up in this is an apparent shortage of clinicians that it is claimed will worsen in the next ten years. There is also a shortage of nurses. This needs close examination as a different case-mix from elsewhere can mean that less staff are required – especially in the future. There may also be issues around the availability of training places meaning that there is a shortage of non-consultant staff in training.

Salary levels should also be examined to see if these are playing an important role in these perceived shortages.

2.5 Fairness /equity

We have seen little in the formal documents about fairness and equity but presumably it is the case that some people contribute more to payments for the system than others as it is still essentially a tax-based system. In addition there are user charges for some services. Also the issue of fair access for all to care should be considered. This was a concern that came up in the consultation on the Green Paper, *Caring for each other, Caring for ourselves* (States of Jersey 2011) and is mentioned several times in the INVOLVE report (Involve, 2011).

It has been suggested that people should be asked to pay to access A&E services so as to prevent the cost-avoidance strategies that it is claimed occur at the moment – although we note that the White Paper does

not propose this. Before considering this, it would be well to examine where the burden is likely to fall and how affordable it will be for individual patient groups.

Also, if people are only expected to pay for inappropriate attendances (as we believe has been proposed), we would query how easy it will be to distinguish between appropriate and non-appropriate post-visit, and also ask if patients can really be expected to make this decision. Will this act as a disincentive to patients seeking care that may have bad consequences down the line, as patients eventually present with a higher level of sickness?

There is an additional knock-on effect that must be taken into account. If as is claimed 75% of current A&E attendances should be dealt with by a GP, and all of these people do indeed go to GPs, then will there be sufficient GP capacity to deal with this? Or is this just a way of restricting availability of care?

3 The White Paper

The White Paper, *Caring for each other, Caring for ourselves* (States of Jersey 2012a) identifies five key issues that the Jersey health system will have to address in the near future:

1. population – in particular that the age structure is rapidly getting older;
2. increasing demand for services;
3. increasing costs – presumably total and unit;
4. difficulty recruiting staff; and,
5. buildings and facilities that need replacement.

It goes on to conclude that health and social services must be redesigned to address:

1. lack of 24-hour services that causes patients to attend hospital and spend longer there;
2. increased waiting times, especially for residential and nursing care;
3. staff shortages, which will be exacerbated by the fact that 60% of consultants will retire within 10 years; and,
4. deterioration of buildings resulting in the need for a new hospital within 10 years.

It also points to the need for improvements in what are termed 'enablers' ie back-of-office services that ensure that better care is delivered across the system: primarily these consist of workforce, finance, estates and IT.

Finally the White Paper re-emphasises the principles of improving quality and productivity, and the need to reduce costs and manage down the demand for hospital beds. In what follows we consider these priorities, and how great the need is for change.

3.1 Changes to the healthcare system

The White Paper proposes a 10-year programme of change in five key areas:

1. services for children;
2. services to encourage healthy lifestyles;
3. services for adults with mental health issues;
4. services for older adults (mental health, long-term conditions, intermediate care and end-of-life care); and,
5. acute services.

However, the emphasis of the White Paper seems to be only on the first four. '*Section 4e – sustaining acute services*' appears almost as an afterthought. However, in our view, this is one of the key elements of the changes and therefore deserves greater attention than it is given in the consultation document – some critical discussion of this document is provided at the end of this section. We therefore start with the proposed changes to acute services.

3.1.1 Acute services

Assumptions / propositions:

1 Demand for acute services is increasing i.e. patient spells and bed days, implying that current capacity will be insufficient to meet demand, especially in general medicine.

2 Emergency department (A&E) usage is greater than in England, and 75% of attendances could potentially have been treated in primary care (according to an analysis of 2010 data).

3 Certain procedures are not undertaken in Jersey due to complexity and costs of equipment but there are few formal contracts or SLAs with UK providers, and few quality standards or clinical outcomes agreed.

4 In addition low volumes for certain operations make it risky to operate without linking to clinicians in other providers in speciality clinical networks (to ensure skills maintained in line with Royal College guidelines).

5 Almost 60% of consultant workforce is due for retirement over next 10 years.

6 The deterioration of the hospital buildings means that refurbishment is required if patient safety is to be maintained, and new guidelines are to be met e.g. single en-suite rooms.

7 The cost of maintenance of buildings is increasing as the condition of buildings deteriorates. Deterioration and increased maintenance costs imply that a new hospital is required within the next 10 years.

8 Changing demands on acute services means that changes to working practices are required.

The evidence for these statements is examined in the next section where we consider the KPMG report.

3.1.2 Changes for specific services

The White Paper proposes changes to services in four key areas; each of these is supported by an OBC (there are four OBCs for services for older adults) which basically makes the case for a particular service investment. If there is any link between these proposals and the overall changes to the health system that are being consulted on, it is their estimated impact on demand for other services such as hospital care, although this is not always made clear (Anonymous 2012a, b, c, d, e, f, g).

However, we find this aspect of the White Paper particularly puzzling. Each of these service schemes may have merits in its own right, but they are different in nature and scope from what we see as the main purpose of this consultation – to consult on the future funding arrangements for the healthcare system and the future configuration of acute hospital services. Nevertheless we provide some brief comments below.

Services for children

The intention is to develop an early intervention service for children. The issue seems to be that GPs are not identifying problems early to social services; that parents may be avoiding GPs because of the charges; that there are more presentations to A&E as a result; and that interventions are coming later than they should.

The suggested solution is the creation of a new service for new mothers to help to identify problems early. This seems plausible but whether the return will justify the investment is not wholly supported by evidence. Savings are rather speculative.

It is intended that there should be increased joint working between GPs and maternity services with more pregnant women being able to see midwives in their GP practices. In addition, there is a desire to reduce use of A&E by children < 5 years by increasing access to GPs, but there is no indication how this will be achieved. It is claimed 1,200 – 1,400 A&E attendances per year by children < 5 years could be dealt with in primary care.

Implementation costs are £8,000, by 2015 the recurrent revenue costs will be £858,000, and an extra 11.1 WTE staff will be employed. Thus, this is a bid for £623,000 in 2013, £736,000 in 2014, and £858,000 in 2015 (in total £2,217,000). The OBC claims there could be associated savings of £244,000 per year through reduced caseload for health visitors, and reduced case management by Children's Services. We note there

is a discrepancy between the recurrent revenue figure in 2015 in the OBC (£637,000) and that in the White Paper (£858,000).

Services to encourage healthy lifestyles

This is a bid for funds to focus on community-based alcohol dependency services. It is not clear what other options have been considered. Implementation costs are £52,000, by 2015 the recurrent revenue costs will be £530,000, and an extra 6.8 WTE staff will be employed. Thus, this is a bid for £300,000 in 2013, £435,000 in 2014, and £530,000 in 2015 (in total £1,265,000). The OBC claims there could be associated savings of £264,000 per year through reduced admissions to hospital, and reduced admissions to hospital for detox. The economic case for this change is by no means proven.

Services for adults with mental health issues

This is a bid for funds to establish an expanded Improving Access to Psychological Therapies (IAPT) service working in community settings. Implementation costs are £176,000, by 2015 the recurrent revenue costs will be £1,132,000, and an extra 14 WTE staff will be employed. Thus, this is a bid for £344,000 in 2013, £736,000 in 2014, and £1,132,000 in 2015 (in total £2,212,000). The OBC claims there could be associated savings of £1.2 million per year by 2015 through reduced social security payments for visits to GPs, reduced benefits payments, reduced medication costs, and a reduction in demand for inpatient and outpatient mental health services. However, this seems to be a rather optimistic estimate and would need to be monitored closely.

Services for older adults (mental health, long-term conditions, intermediate care and end-of-life care)

This is a series of bids for a range of services for older adults – mental health, long-term conditions, intermediate care and end-of-life care. The overall bid is for £3,167,000 in 2013, £6,301,000 in 2014, and £7,802,000 in 2015 (in total £17,270,000). A range of different recurrent cost savings are suggested once the services are up and running.

Essentially these are bids to move aspects of chronic disease management out into the community. Taking as an example the one on chronic obstructive pulmonary disease (COPD), it reads as a bid for the expansion of a community-based COPD team. Implementation costs are £299,000, by 2015 the recurrent revenue costs will be £1,652,000, and an extra 8.67 WTE staff will be employed. Thus, this is a bid for £701,000 in 2013, £1,344,000 in 2014, and £1,652,000 in 2015 (in total £3,697,000). The OBC claims there could be associated savings of £1.1 million over the period between 2013 and 2015 through reduced hospital bed days, reduced A&E attendances, and reduced outpatient appointments. This is an optimistic estimate.

The stated objective is to deliver a community-based COPD service rather than to deliver a high-level objective such as safe, sustainable and affordable health services in Jersey. Other options for delivering this objective are not discussed. For example GPs might provide many of the services without using specialist teams. In our view although there are potential benefits in implementing or expanding each of these services we would be wary that the savings may prove to be illusory. The result could be extra costs incurred for little in the way of results that could not be obtained more cheaply in other ways.

3.2 Concluding remarks

The thinking behind the developments in each of these specific service areas often reflects what would be considered good practice in the UK, and in other parts of the world. IAPT is certainly an area that has been addressed recently by mental health services in England (Department of Health 2011); similarly alcohol abuse and dependency is a key concern for public health policy (Department of Health 2010; NICE 2011); over many years there have been attempts to develop effective intermediate care services in the UK (Department of Health 2002); and end-of-life services are also on the UK agenda (Department of Health 2008). However, although in theory what is suggested in the White Paper is not in question in terms of improved practice, what is less evident is the impact that any of these measures will have in terms of

savings in other parts of the health system, and even what the effect on overall health outcomes will be. There is some evidence but when we look at systematic reviews in these areas we find examples of good and bad (Purdy *et al.* 2012). So, we would advise relatively modest expectations for the impact of these on overall costs in the Jersey healthcare system.

How easily it will be to implement these investments in service is also an issue that concerns us a little. All of them require investment in what are often new types of human resources, and yet we are told that it is difficult to recruit into the traditional caring services (doctors, nurses), so we have concerns that recruitment may prove to be an obstacle.

In addition, these services also tend to require good coordination with existing services and professionals, and cooperation with what we are told is a currently fairly stretched set of services. In most cases, general practice will play a key role in one way or another. We are not clear that this is wholly reflected in the plans that we have reviewed.

Nevertheless, from a service planning perspective, we would not wish to call any of these proposals into question. What we do question is why these are included in the current consultation. In our view, if there is a need at all to consult at a population level on such matters (which we doubt) then this should have been separated out from the main consultation which we have identified to be about the financial sustainability of the Jersey health system.

4 The KPMG report

4.1 Introduction

In this section of our paper we examine critically the KPMG report (KPMG 2011) which puts forward a new health and social care system for Jersey – although this may be to exaggerate its potential impact. The KPMG report sets out some of the reasons for change, puts forward three options (which it calls scenarios), and recommends a way forward.

The report (p2) highlights two key challenges for Jersey: it is small and isolated in the sense that services are provided to a small population base with some difficulties in accessing services further afield; and, there will be a particular type of demographic change with slow population growth but a large increase in the number of older people. In our view, neither of these is particularly unique to Jersey. These issues are examined below.

We first set out some of the key issues identified by KPMG. We provide a brief outline of the three 'options' that KPMG report discusses. We then provide an analysis of some of the evidence in four key areas: Jersey demographics, the financial position, levels of activity, and resources and their use. Finally in a concluding remark, we provide some observations on the White Paper and on the proposals in the KPMG report.

4.2 Key issues

The KPMG report (p2) states that the changes to the Jersey healthcare system that are being consulted upon are intended to:

- limit the rate of increase of spend (although realistically expenditure will continue to grow in real terms due to demographic pressure);
- begin to reduce the levels of dependency of (mainly older) people such that they are supported to live independently, receiving effective care in lower cost settings; and,
- mitigate the effect of increasing demand because of demographic changes, and at least postpone the date at which some capacity constraints are reached, particularly for residential and hospital-based care.

The timeframe under consideration is the 30-year period to 2040.

So the report views the issue as one of containing costs. The preferred solution seems to be to reduce future demand on presumably more expensive hospital services for older people by implementing a series of changes to community and primary care that will allow people to be treated within 'cheaper' settings outside of hospital. In addition it is envisaged that people will be enabled to self-care where appropriate.

The report in Chapter 4 (pp 21-55) goes on to make a number of important claims (repeated in the White Paper) that are the foundation of the recommendations that seem to have led to the current consultation:

1. Jersey's geographic isolation and small numbers of people inevitably leads to diseconomies of scale: hence the unit cost of delivering hospital and social care is higher compared with systems serving larger populations. Higher costs are attributed to higher average fixed cost plus higher variable cost due to cost of living (land and buildings included) that adds a premium of 15-20%.
2. acute hospital workforce is understaffed and dependent on small numbers of individuals; maintenance of specialist skills is difficult given small patient numbers.
3. the population of Jersey is growing slowly but the age structure is ageing quickly: from 2010 to 2040 people > 65 years by 95% and by 2020 by 35%. This will lead to increased demand for care.
4. the capacity of the hospital is not sufficient to meet increased demand in terms of bed, theatres.
5. residential and nursing care bed capacity is insufficient to meet increasing demand.
6. community services are insufficient to meet increased demand.

7. the deterioration in the support ratio - from 3.9 to 1.8 - will lead to an issue of who actually provides care.
8. the deterioration in the support ratio will also lead to an issue of who pays for costs of care required.

4.3 KPMG's options

In chapters 6 to 8, the KPMG report puts forward what it terms three scenarios. These are essentially the options upon which the States of Jersey consulted – the Green Paper consultation (States of Jersey 2011).

- 'Business as usual';
- 'Live within our current means'; and,
- 'new model of care'.

4.3.1 Option 1 – 'Business as usual'

This is essentially the status quo i.e. no change with some assumptions about the growth in population over the next 30 years.

The KPMG report estimates the total additional cost (HSSD net expenditure) of Option 1 by 2020 at £40 million (24%), and by 2040 at £147 million (87%) – in real terms at 2010 prices: from a baseline of £171 million in 2010. In addition other expenditures (contributions from other parties, third sector, user charges, social security payments) would increase.

Partly these increases are required to fund developments in hospital estate, district nursing and home care, primary care, acute care. It would have been helpful if KPMG had shown the estimated increases by sector of care.

In addition, the KPMG report states that the service model would be unviable as it will be impossible to recruit general and specialist staff.

This is a possible option and one that should always be examined. We note that this may be intended to be the 'do minimum' option, i.e. make those changes required to continue with the current model. If this is the case then it should be made more clear.

4.3.2 Option 2 – 'Live within our current means'

This is essentially an option of doing what is possible within a very restricted budget i.e. reducing publicly funded services with some assumptions about the growth in population over the next 30 years.

The KPMG report estimates the total additional cost (HSSD net expenditure) of Option 1 by 2020 at £7 million (4%), and by 2040 at £7 million (4%) – in real terms at 2010 prices: from a baseline of £171 million in 2010. Information is not provided on estimates of other expenditures (contributions from other parties, third sector, user charges, social security payments), although the KPMG report suggests that these costs would have to increase substantially.

This is not a realistic option. It is not clear why this was put forward other than as a straw man.

4.3.3 Option 3 – 'New model of care'

This is essentially the model of care that the KPMG report is proposing with some assumptions about the growth in population over the next 30 years, and about the impact of various changes to service provision.

The KPMG report estimates the total additional cost (HSSD net expenditure) of Option 1 by 2020 at £36 million (21%), and by 2040 at £119 million (70%) – in real terms at 2010 prices: from a baseline of £171 million in 2010. In addition other expenditures (contributions from other parties, third sector, user charges, social security payments) are likely to increase (although these figures were not presented in the report).

This is an option that bears consideration. However, in our view, a wider range of options should have been considered. It would have been possible to look at various combinations of the elements of this option. Another alternative would have been to consider a phased introduction of different elements giving time to examine the outcome of changes before pushing forward with more.

We go on in the next section to look at the evidence underlying the arguments for change produced in the KPMG report.

5 The evidence

In this section we examine the evidence underlying the KPMG report's recommendations. For this purpose, our analysis is presented in four sections: Jersey demographics, the financial position, levels of activity, and resources and their use.

Before doing this, we draw attention to the Outline Business Cases (OBCs) that have been produced to support change in a number of service areas (Anonymous 2012a, b, c, d, e, f, g). These feed into the overall option planning in as much as they provide some of the assumptions about the changes that will take place as a result of the implementation of these new service models. The overall model assumes that all of the changes for which OBCs have been produced will be implemented with the results as outlined.

In essence, as already stated in section 3, these OBCs are more like bids for service funding. The key factors to be taken from them is the reliability of the evidence supporting change i.e. how robust the parameters are that are taken from these documents. In our view, while many of the changes to service are probably in the right direction, it is unwise to give too much credence to their cost-saving implications as these are not sufficiently well-based in evidence.

5.1 Jersey demographics

5.1.1 Key KPMG propositions

1. the population of Jersey is growing slowly but the age structure is ageing quickly: from 2010 to 2040 people > 65 years by 95% and by 2020 by 35%. This will lead to increased demand for care;
2. deterioration in the support ratio – from 3.9 to 1.8 – will lead to an issue of who actually provides care; and,
3. deterioration in the support ratio will also lead to an issue of who pays for costs of care required.

So what emerges from the analysis in the KPMG report is:

- an increased demand for care;
- questions about the availability of staff; and,
- questions about who will pay for care?

5.1.2 What does the evidence show?

KPMG have assumed:

1 net inward migration of 150 households per year to Jersey. This seems to be based on the level of increase assumed by the *States of Jersey Strategic Plan 2009-14* (States of Jersey 2009); and,

2 increase in proportion of older population: those aged 65+ will almost double (14,797 to 28,882) between 2010 and 2040; those aged 80+ will more than triple. On the other hand children will decrease from 17,260 in 2010 to 15,999 in 2040 and adults (19-64) will decrease from 57,762 to 52,263. So the support ratio goes from 3.9 to 1.81 and the dependency ratio from 3.35 to 3.27 (note this is the figure for the dependency ratio given in the KPMG report (p24) but this is not the figure we calculate below).

Key differences between KPMG and Census 2011

1 the population of Jersey is greater than the figure given in the KPMG report (which was based on what was available when the report was written): between 2001 and 2011 the population increased by 10% (9,100);

2 around 75% of this change was due to net inward migration of 6,800 people; and,

3 structure of population: the dependency ratio has fallen from 0.53 to 0.52, the support ratio has fallen from 3.9 to 3.7, and the proportion of people of working age has increased from 65% to 66%.

Thus, in 2011 the population of Jersey was 97,857, some 9% difference (8,038) from the KPMG figure (States of Jersey 2012b). The current population is in fact greater than the projection used by KPMG for 2040.

The 2011 Census suggests a higher rate of net inward migration than that which has been included in the model. If net inward migration continued at this rate then the total population of Jersey by 2040 would be some 120,000 (using figures from the old projection model). This needs to be checked with Jersey statisticians (States of Jersey Statistics Unit 2009).

The projections indicated there will be a substantial increase in people aged > 65 years: from 2005 to 2035 by 100% (13,400 to 28,300) and the KPMG report states by 95% between 2010 and 2040. However, these projections must now be recalculated based on the more recent information from the 2011 Census.

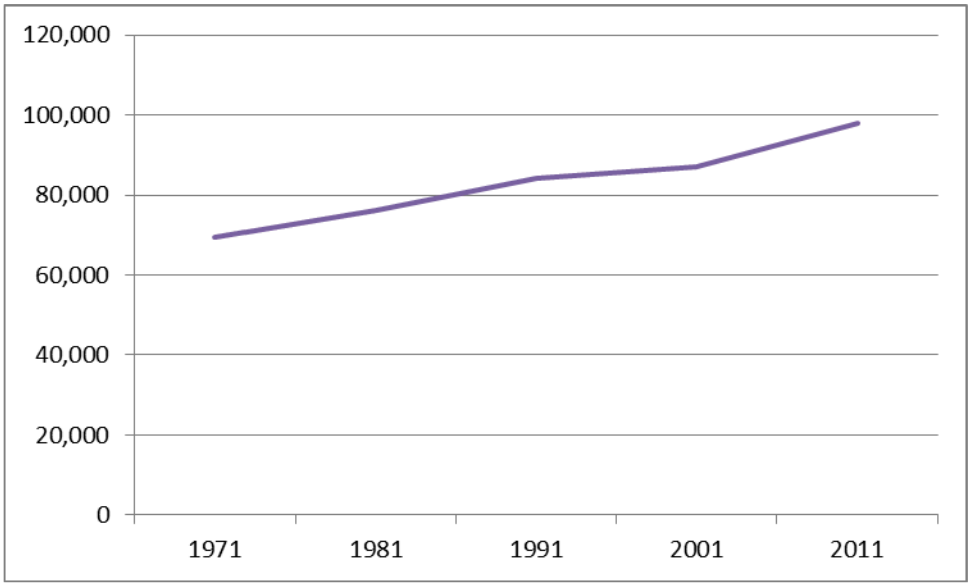
We also note that the support ratio in other countries is not dissimilar to that in Jersey. Thus in 2010, the figure for the EU(27) was 3.86, and for the UK it was 4.02. By 2040 it is projected to fall to 2.20 in the EU(27) and 2.57 in the UK – based on the most recent Eurostat figures (Eurostat 2012).

The impact of this is:

- the population of Jersey in 2040 is likely to be greater than estimated;
- there may be benefits in terms of dependency and support ratios if net inward migration continues as it has in the last 10 years; and,
- current activity rates (service use) and staff-population ratios need to be recalculated on the basis of these revised population figures.

Figure 1 shows the growth in the population of Jersey since 1971.

Figure 1: Growth in the population of Jersey, 1971 - 2011



Based on the Jersey Census 2011 (States of Jersey 2012b).

Some Questions:

1. **What is the basis of the assumption on net inward migration in the Strategic Plan?**
2. **Should this assumption be changed in the light of the level of net inward migration in the last 10 years?**
3. **Or is this something that is policy-determined and therefore can be treated as a given?**
4. **What is the impact on key demographic measures if net inward migration varies?**

5.1.3 Initial conclusions

Since KPMG produced its report, the results of the 2011 Census have been published. It is important to examine the impact of these results on the analysis presented. The KPMG model should be run again including these updated figures.

If a higher level of net migration were assumed / achieved this would improve the support ratio i.e. there would be more people of working age per people aged > 65 years but could make worse the dependency ratio i.e. there may be less people of working age per people aged > 65 years and children aged 0-15 years.

5.2. The financial position

5.2.1 Key KPMG propositions

1. Jersey's geographic isolation and low population inevitably leads to diseconomies of scale: hence unit cost of delivering hospital and social care is higher compared with systems serving larger populations. Higher costs are attributed to higher average fixed cost plus higher variable cost due to cost of living (land and buildings included) that adds a premium of 15-20% to costs.
2. increases in demand imply that future expenditure in Jersey is unsustainable.

5.2.2 What does the evidence show?

Considering differences in unit costs, we would expect there to be higher unit costs for some services where the volume of activity is low. The key distinction to be made is between areas of care where costs are inherently high due to low volume and those where there are inefficiencies that imply that costs can be managed down.

Comparative unit costs

There are a number of factors that may lead to excess costs. These include:

1. Low volume overall or within the service area which leads to higher average costs (and hence lower productivity) through for example minimum staff levels;
2. Low productivity in terms of output per consultant, per nurse, per bed (linked to longer LOS);
3. Low productivity due to knock-on effects of other services or demands, e.g. poor community care, primary care;
4. Low productivity due to different patient profile e.g. older than some low-volume hospitals;
5. Less efficient division of activity between specialties or between care settings, e.g. daycase or inpatient or outpatient; and,
6. Coding issues e.g. undercoding of complexity, wrong coding.

We would expect KPMG to have examined the position in Jersey on this basis to establish where if any there are excess costs. However, we have not found any unit cost figures in the KPMG analyses that we have considered. Financial figures are either presented at an aggregated level (in the reports) or some breakdowns by input are given (in the reports and the KPMG model).

Certainly, six areas should be looked at in some detail:

1. A&E services;
2. Elective inpatients and daycases;
3. Outpatient appointments;
4. Outpatient procedures;
5. Adult critical care; and,
6. Maternity care.

Where a service area appears not to be financially viable due to volume issues, and it can safely be decoupled from other activity, then it may make sense to contract for the delivery of that service elsewhere which probably means off island. But where the service is integral to the delivery of other care

within the hospital, or where the indivisibility of overall provision of healthcare would result in destabilisation of the hospital, then it may make sense to tolerate an extra cost (premium) to maintain services on the Island.

Comparing with NHS performance

We propose that comparisons are made with NHS unit costs in these six areas, looking in particular at performance by volume of activity, considering the average in the bottom NHS decile and bottom NHS quartile by volume. Comparisons with a group of NHS hospitals could also be considered (using for example the group that KPMG has selected for other parts of the report).

This would allow a view on how much activity could be moved off island and whether there are inherent inefficiencies that cannot be explained by small volume. We have NHS reference cost figures but we do not have Jersey unit costs at the moment.

Some questions:

- **What are the unit costs for a range of services?**
- **What are individual salary costs?**
- **What are the costs of using external providers of care?**
- **For each of these, how have these changed over time? Is there a recognisable trend?**

Financial sustainability

The KPMG report is unequivocal in claiming that Jersey will not be able to sustain the increased expenditure that will result from a population whose age structure is ageing rapidly. However, in our view this is more likely to be a decision based on political will.

Often financial sustainability is assessed by looking at total expenditure per head of population, and as a proportion of GDP. Some such measures are presented in an appendix to the KPMG report, although this issue does not seem to have been discussed to any extent in the main text.

We estimate that in 2010 expenditure as a proportion of Jersey's gross national income was 4.2% (based on a GNI of just over £4 billion), although these figures would need to be checked by Jersey statisticians. We calculate that HSSD expenditure per head is approximately £1,750 (States of Jersey Statistics Unit 2011).

This figure of 4.2% is considerably less than public expenditure on healthcare in the rest of the UK. An alternative figure is given by combining HSSD and social security expenditures. Taking these together gives a figure of £2.07 million (or 5.1% of GNI). Even when other expenditure (private, user payments, third sector) is included, just 5.9% is currently spent on healthcare. This does not however include other private expenditure by individuals. We do not have a figure for that although one may be available from surveys.

However 5.9% is considerably less than what is spent for example by the public sector in England (8.7%), and overall in most other developed countries e.g. the EU (15), USA, Canada. However, as stated previously, there is no right or wrong number; what this figure should be is more a matter of political will.

Some questions:

- **What is the current level of expenditure on healthcare in Jersey and how does this compare with other countries / geographic areas?**
- **What is likely to be the impact of KPMG's preferred model on the level of expenditure, and how robust are these estimates?**
- **What will be the estimated proportion of GNI spent on healthcare in 2010, in 2020, in 2040?**
- **What would be the impact of alternative changes in the healthcare system?**

5.2.3 Initial conclusions

It is not clear that the level of expenditure under option 1 is unsustainable financially. Moreover, the difference in expenditure between option 1 and the preferred option (option 3) is just £28 million (9%). Given the degree of uncertainty involved in these calculations, we would not regard this as decisive in itself.

5.3 Levels of activity

5.3.1 Key KPMG propositions

1. emergency department (A&E) usage is greater than in England, and 75% of attendances could potentially have been treated in primary care (according to an analysis of 2010 data).
2. demand for acute services is increasing ie patient spells and bed days, implying that current capacity will be insufficient to meet demand, especially in general medicine.
3. certain procedures are not undertaken in Jersey due to complexity and costs of equipment but there are few formal contracts or SLAs with UK providers, and few quality standards or clinical outcomes agreed.
4. in addition low volumes for certain operations make it risky to operate without linking to clinicians in other providers in speciality clinical networks (to ensure skills maintained in line with Royal College guidelines).
5. high use of institutional social care and low number of older adults living independently in the community.

5.3.2 What does the evidence show?

We consider three areas for comparative purposes.

A&E attendances

The figures provided by the KPMG report suggest there were 37,468 A&E attendances in Jersey in 2010. Using the most recent Census population data, this suggests a figure of 383 per 1,000 population. However, contrary to the claim in the KPMG report, this is not more than the equivalent figure for England as a whole, which is 402 (based on 21.4 million attendances). This may be due to use of experimental incomplete data (15.8 million); with this incorrect figure England would have an attendance rate of just under 300 per 1,000 population. The England figure quite appropriately includes minor injury units and walk-in centres (Information Centre 2012a).

Outpatient appointments

The figures provided by the KPMG report suggest there were 136,720 outpatient attendances in Jersey in 2010. Using the most recent population data, this suggests a figure of 1,397 per 1,000 population. Assuming this refers to all outpatient appointments (and not just first attendances) the comparable figure for England is 1,325 per 1,000 population (Information Centre 2011a). So Jersey has just 5.4% more attendances than the England average.

Inpatient spells

The figures provided by the KPMG report suggest there were 29,577 inpatient spells in Jersey in 2010. Using the most recent population data, this suggests a figure of 302 per 1,000 population. The comparable figure for England is 281 per 1,000 population (Information Centre 2011b). So Jersey has just 7.6% more inpatient spells than the England average.

5.3.3 Initial conclusions

On the basis of our analysis, Jersey does not seem to make excessive use of acute hospital services when compared with England. This is an issue that should have been considered in more detail before suggesting that there was over-use of hospital services.

If indeed 75% of A&E attendances are more appropriate to a walk-in clinic or minor injuries unit, then this would suggest the level of appropriate A&E attendances is much less than that of England. This result should also be looked at more closely.

5.4 Resources and their use

5.4.1 Key KPMG propositions

1. the acute workforce is understaffed and dependent on small numbers of individuals; maintenance of specialist skills is difficult given low patient numbers.
2. 60% of consultants will retire in next 10 years, and very few will be replaced on like-for-like basis.
3. consultants are relatively 'generalist' with low levels of sub-specialisation.
4. low numbers of 'junior grade medical staff'.
5. difficulty in recruitment and retention of nursing staff.
6. poor liaison between specialists, GPs and tertiary sector.
7. changing demands on acute services means that changes to working practices are required.
8. the capacity of the hospital is not sufficient to meet increasing demand in terms of beds, theatres which are rapidly approaching capacity.
9. residential and nursing care bed capacity is insufficient to meet increasing demand.
10. community services are insufficient to meet increasing demand.
11. high number of GPs per head and low level of nursing support and allied professions in primary and community care settings.
12. limited integration with social care and third sector.
13. key performance indicators suggest Jersey performs well compared with similar international jurisdictions.
14. the deterioration of the hospital buildings means that refurbishment is required if patient safety is to be maintained, and new guidelines are to be met e.g. single en-suite rooms.
15. the cost of maintenance of buildings is increasing as the condition of buildings deteriorates.
16. deterioration and increased maintenance costs imply that a new hospital is required within the next 10 years.

5.4.2 What does the evidence show?

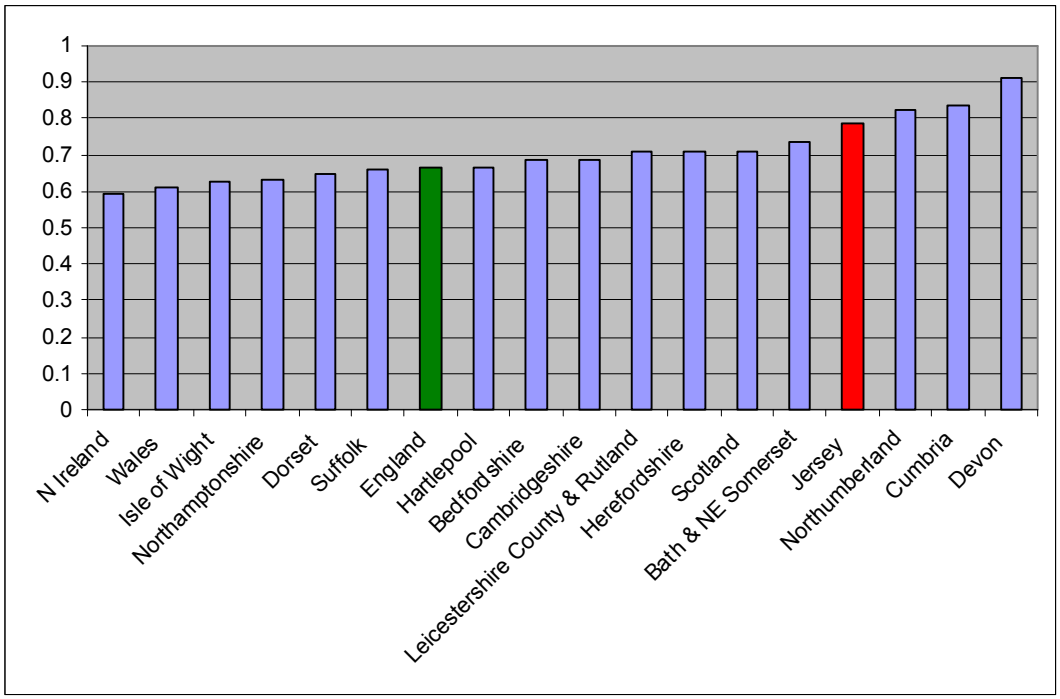
Examination of most of these propositions requires detailed on-the-ground knowledge of the functioning of the healthcare system in Jersey. KPMG have been involved in extensive interviews with the key stakeholders in Jersey so we would expect most of these statements to be an accurate reflection of the reality. In this section we consider some of the comparative statements about resources, looking at numbers of GPs and at acute beds.

Numbers of GPs

We have recalculated the figures for WTE GPs per 1,000 population using 2011 figures and more recent population figures (Figure 3 of KPMG report, p29). There are key differences: our figures are based on resident population not list size; also we have added GP registrar trainees to the English figures. There seems to be an issue about there being no trainees in Jersey but we note that English practices would probably require more qualified GPs if these trainees were not available (Information Centre 2012b).

Based on these recalculations, as Figure 2 shows, we now find that three English counties exhibit more GPs per head than Jersey. This is not to say that Jersey is not relatively well provided compared with for example the England average.

Figure 2: GPs per 1,000 resident population, 2011



Based on analysis of NHS Information Centre data (Information Centre 2012b).

Acute beds

Using the most recent population data, we find there were 2.2 acute beds per 1,000 population in Jersey (219 beds[154]) in 2010 compared with 1.9 beds in England (Department of Health 2012). Although this suggests that Jersey has relatively more beds when compared with England, two factors bear consideration. First England has one of the lowest levels of acute beds per head of population among key developed countries; and second, there has been a recent sharp decline in the number of acute beds in England.

The relatively higher number of beds per head in Jersey suggests there may be a different pattern of usage of beds. There is certainly likely to be a different case-mix with more complex cases going off island. The KPMG report states that patients in general surgery have a considerably shorter length of stay in hospital than the England average (3.4 days compared with 4.8 days), and than many comparator hospitals in England, Scotland and Wales. In general medicine, the length of stay in Jersey is similar to the England average (6.6 days compared with 6.7 days) and lies somewhere in the middle of comparator organisations. On the other hand, length of stay in obstetrics appears to be higher than average in Jersey (3.1 days compared with 1.7 in England). The results reported would suggest that Jersey has relatively low bed occupancy rates taking the acute sector as a whole. However, occupancy rates are likely to vary between specialties, and general medicine in particular has been highlighted as an area where occupancy rates are currently high and likely to rise substantially in the future (see p73 of the KPMG report).

[154] Obstetrics beds are not included in the total acute figure. Also some 13% of these acute beds in Jersey are designated for private patients compared with just over 1% in England. If these private beds were excluded, the difference between Jersey and England would be considerably less.

5.4.3 Initial conclusions

There appears to be a different pattern of resources in Jersey to that in England or other comparable jurisdictions. Whether this is justified is not clear from the analyses we have considered but there are likely to be benefits from some readjustments to resource levels and how care is delivered. However, all of the comparator figures should be recalculated to take account of the new 2011 Census population figures.

6 Comments on the INVOLVE report

We were asked to comment on the INVOLVE report, an analysis of the survey and other responses to the Green Paper (Involve 2011). Overall the report provides a fair summary of the responses. It might have been interesting to provide some cross-sectional analysis on certain questions against age, for example would self-care response vary by age, although the small sample size means that this may not have revealed much. We also note that the age distribution given on p13 for Jersey residents is incorrect. In fact around 18% are currently aged 65+. This suggests that the survey (12% aged 65+) was not wholly representative of older people.

A key point that emerges, and which perhaps could have been given greater weight in the report, is that although most people said that Scenario 3 was preferred, there was some concern that Scenario 3 was not giving enough detail to make a real choice, and others felt that the consultation was leading and biased towards this scenario. The issue of lack of detail on costs was also raised by respondents.

Another theme that emerged at several points is the concern of respondents for fairness and equity in terms of availability of healthcare and how it is paid for – although it was also clear that there were different views on what these mean.

The survey provides answers to a series of general questions which the INVOLVE report faithfully addresses. We are not convinced that these give much in the way of useful information often just confirming a general view that for example mental health is as important as physical health, or that most people are willing to go off island if it is necessary for certain treatments.

To conclude, the INVOLVE report provides an adequate account of the survey results (noting the issue of incorrect age distribution for Jersey). What comes over is that the survey itself was not designed in such a way that the answers to the questions on scenarios can really be interpreted as strong support one way or the other. When no detailed choices are provided the outcome is not surprising.

7 Concluding remarks

We are puzzled by the structure of the White Paper. It seems to be a series of bids for what are essentially small levels of investment in community-based services, but with major changes in the pattern of acute services added on almost as an afterthought. Perhaps this was the intention.

In our view, the Green Paper (based on KPMG's analysis and reports) really only put forward one scenario for serious consideration: scenario 3; the others were presented in a way that clearly gave the impression they were not viable and hence easily dismissed. It appears this was understood by many of the people responding to the survey accompanying the Green Paper, who complained both of bias and of lack of detail especially around costs.

The key question is what combination of changes is best. Unfortunately there is a lack of detail on this in the papers that I have reviewed. For example, KPMG could have put forward a range of scenarios based on various assumptions – in the manner of the Wanless report in England. Various assumptions could have been tried, e.g. three levels of engagement by individuals with their own health, three levels of efficiency improvement, three levels of demographic change. This would give a much more robust feel to the scenarios being put forward and more confidence in what emerges in terms of a change programme.

It is clear that the assumptions around population change will have to be re-examined in the light of the 2011 Census population figures. This rather supports our point that the difference in expenditure between option 1 and the preferred option (option 3) is not decisive given the degree of uncertainty involved in these calculations. Moreover the increased levels of expenditure under option 1 and option 3 or indeed under some other combination of changes are not in and of themselves financially unsustainable.

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