HEALTH & SOCIAL SERVICES

A Sustainable Primary Care Strategy for Jersey

2015 – 2020

States of Jersey

R.1/2016

States of Jersey

SUSTAINABLE PRIMARY CARE

STRATEGY

2015-2020

.

CONTENTS

1 Ministerial Foreword

Primary Care must remain central to our health and social care system; it looks after us from cradle to grave providing General Practice, Dentistry, Optometry, Pharmacy and Community Nursing services in our local communities; the services that are critical in keeping us well and supporting us at home.

Primary care services in Jersey have been developed locally over many years and are different from other jurisdictions but, like other jurisdictions, high quality safe and effective Primary Care is essential to promote health and well-being and to protect our very young, vulnerable and elderly populations.

The White Paper 'Caring for each other, caring for ourselves' (2012)[1] and the subsequent Proposition to the States, *'A New Way Forward for Health and Social Care' (P82/2012)*[2], outlined a vision for health and social care which is safe, sustainable and affordable, with integrated services delivered in partnership. As a result of P82, more services are now provided in local community settings for example midwifery, re-ablement and sustained home visiting. But we could do even more, so that the right care is provided, in the right place, by the right person, at the right time – and at the right cost. This strategy sets out our vision for achieving this aim.

I know that there has already been a considerable amount of work undertaken in producing this strategy. I would like to thank everyone involved in contributing to its contents and look forward to their support in the future as we begin the journey of implementation. With your help I am confident we can make a positive difference to people's lives.

Senator Andrew Green MBE

Health and Social Care Minister

States of Jersey

[1] White Paper – 'Caring for each other, caring for ourselves', States of Jersey, 2012
http://www.gov.je/SiteCollectionDocuments/Health%20and%20wellbeing/C_CaringforYourselfCaringforEachOtherWhitePaper_CS_20120524.pdf

[2] States of Jersey 'A New Way Forward for Health and Social Care' P82, 2012
http://www.statesassembly.gov.je/AssemblyPropositions/2012/P.082-2012.pdf

2 Executive Summary

This strategy outlines the direction of travel for developing primary care in Jersey as part of the transformation of the whole health and social care system. The document outlines, through robust evidence review, the best practice principles of delivering improved health outcomes, but does not mandate how to deliver them. How this is achieved will be developed in partnership with stakeholders (including patients, practitioners and community and voluntary sector) through options assessment, review and pilot during the planning and implementation stages.

2.1 What is Primary Care?

Primary Care is pivotal to the high quality, integrated holistic care provided for Islanders. It aims to maintain all Islanders in optimal health and care, for their entire lives. This includes delivering care to individuals with both acute and chronic disease, both physical and mental welfare being central to the diagnosis, management and ongoing care of patients.

From a patient perspective, Primary Care should be the first point of contact in the health and social care system, central to diagnosis, management and ongoing care; inclusive, that is available regardless of age, gender, disability, language and socioeconomic class and accessible to all, both in terms of physical access and in terms of being available, and in appropriate settings for all sections of the population.

The literature review shows that the evidence is overwhelming that health care systems configured around primary care produce healthier populations at lower cost: they are more effective, equitable and efficient.

2.2 The case for change

The White Paper, P82 (2012), outlined a need for the health system to change and transform. Primary care has been recognised as a key part of this change as it will ensure that care is safe, sustainable and affordable providing more integrated and holistic care for patients. The health system needs to transform because:

- The elderly population is rising disproportionately, Jersey could have as many as 28,000 people aged over 65 by 2035, compared to 14,000 in 2010 and will also see the number of people aged over 85 increase from 2,000 to 5,000
- There is a clear pattern of increasing multiple-morbidities with age in the Jersey population, with over half of the population being found to have at least one of 40 long term conditions. Existing capacity is due to be exceeded in some services across the whole health system
- Pressures created by demographics are no longer affordable using current funding mechanisms
- Perverse incentives built up over many years mean that patients and providers can be hindered from making correct choices
- A lack of integration reduces efficiency and damages patient experience

- There are workforce recruitment issues across the health and social care system

Change is required now to ensure that the health and social care system can continue to meet the demands placed on it and that it is sustainable for the future whilst adding value to patients and supporting them to keep well for longer.

2.3 The Strategy

The five ambitions of the Sustainable Primary Care Strategy are illustrated below. These have been developed with key stakeholders involved throughout the process including patients[3],[4], professionals and the voluntary and community sector[5]. The ambitions set the direction of travel for Primary Care for the next 5 years working towards improved sustainability and a safe, effective and affordable system.

2.3.1 Ambition 1: Patients

Develop an understanding of the population health needs of islanders to enable design of services which most closely meet that need. Support the people of Jersey to lead healthy lives and empower patients to understand and manage their conditions themselves.

[3] Primary Health Care Matters, Jersey Consumer Council, 2015
[4] Island Café, 2015
[5] Workshops, 2014/15

2.3.1.1 The Supporting evidence from the literature

- People use markedly different amounts of health care services. The distribution of health care use across a population tends to be highly skewed, with a small number of people accounting for a large share of total resources[6]

- Around 70% of health care expenditure is for people with long term conditions[7]. Multi-morbidity is common in the Jersey population. There is a strong correlation with age, and physical and mental conditions are frequently co-morbid

- Promoting good health and preventing ill health saves money; a small shift in resource towards public health prevention activity would offer significant short, medium and long term savings to the service and to the taxpayer[8]

- Patients need to be able to access affordable primary care, and to believe that it will meet their immediate needs more effectively than the other options available to them [9]

- Better health information can have significant impacts on service use and reduce costs[10]

2.3.1.2 What we will do

- Develop a population needs assessment to understand the health needs of our population to support the development of targeted and needed services.

- Provide a new emphasis for Public Health initiatives within primary care to support the health and wellbeing of islanders.

- Engage with the public to better understand their needs on accessing primary care services

- Scope possible solutions to improve information and accessibility to information

2.3.2 Ambition 2: Payment

Explore payment models which incentivise outcomes but maintain the strengths of the current system.

2.3.2.1 The Supporting evidence from the literature

- Primary Care is a cost effective means of delivering healthcare[11]

- No one organisational model of primary care provision should be advocated. Local context plays an important role in determining organizational form, and the precise mix of function will likewise depend on the nature and priorities of the local population[12]

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[6] Combined Predictive Model, Final Report & Technical Documentation, Health Dialogue UK, 2006
[7] Delivering better services for people with Long Term conditions, The Kings Fund, 2013
[8] Using NICE guidance to cut costs in the down turn, NICE, 2009
[9] Primary and Community Services: Improving GP Access and responsiveness, DOH, 2012
[10] Making the Case for Information The evidence for investing in high quality health information for patients and the public, Patient Information Forum, 2014, www.pifonline.org.uk
[11] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

- Research suggests that too heavy a reliance on fee-for service or capitation is likely to reduce efficiency – a blend of these different approaches is most likely to strike a better balance between incentivising responsiveness to patient needs and quality with cost-efficiency and budgetary control [13]

- Recently published NICE Clinical Guidance[14] supports the development of the roles of primary care pharmacists

2.3.2.2 What we will do

- Patients and providers value the co-payment in General Practice as it gives a sense of worth to services being provided. The co-payment will continue to exist in General practice.

- Different GP payment systems will be assessed jointly with stakeholders, with the support of a Health Economist. Options will be developed and evaluated and a preferred approach taken forward which may be a blend of systems. Pilots will be run to test new payment mechanism prior to implementation.

- The Health Insurance Law has recently been amended to allow the States to enter into contracts with providers. Using this new facility the States would like to explore the option of a pharmacy contract where a range of services could be "commissioned"

- The future development of the Jersey Dental Fitness Scheme will be considered, alongside the 65+ Healthcare scheme and other dental spend

- Funding of community nursing will be considered in the context of the other services covered in this strategy, HSSD funding, charitable funding and patient co-payment

2.3.3 Ambition 3: Partnerships

Develop more integrated working across the whole system to enable improved efficiency and safety.

2.3.3.1 The Supporting evidence from the literature

- "The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to impose the patient's perspective as the organising principle of service delivery[15]"

- Achieving the benefits of integrated care requires strong system leadership, professional commitment, and good management. Systemic barriers to integrated care must be addressed if integrated care is to become a reality

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[12] Securing the future of general practice: new models of primary care, Judith Smith, Holly Holder, Nigel Edwards, Jo Maybin, Helen Parker, Rebecca Rosen and Nicola Walsh, The Kings Fund/Nuffield Trust, 2013

[13] Reforming payment for health care in Europe to achieve better value Research report Anita Charlesworth, Alisha Davies and Jennifer Dixon August 2012 Nuffield Trust

[14] Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE, 2015

[15] Integrated care for patients and populations: Improving outcomes by working together, Goodwin et al, The Kings Fund,2011

- Integrating budgets combines funds from different organisations to purchase integrated support to achieve shared outcomes. This will enable organisations to build on previous joint working experience in order to fund truly integrated care services[16].

- In New Zealand, the development of 'Health Pathways' is cited as one of Canterbury's most innovative and most effective changes[17]. They are created by bringing together hospital doctors and GPs in order to discuss what the patient pathway for a particular condition should be

2.3.3.2 What we will do

- Assess the role of Primary Care Leadership within the Health and Social Care system as a whole, including how Primary Care continues work with HSSD along with accountability and leadership for the Primary Care Strategy

- The various funding streams within primary care will be reviewed and recommendations made to amlgamate budgets where possible, to simplify integrated working across primary care

- Develop a Clinical Forum which will be the vehicle for building closer clinical working relationships between primary and secondary care, with clinicians from the hospital and a range of primary care providers.

- Alignment between strategic developments in health and social care to support the development of multidisciplinary working with primary care.

2.3.4 Ambition 4: People

Assess and develop the primary care workforce and to provide career opportunities for people to develop the skills required to meet future challenges.

2.3.4.1 The Supporting evidence from the literature

- Many EU countries report difficulties both in retaining and recruiting health staff. Reasons vary between EU countries. It can be due to unattractive jobs, poor management or few opportunities for promotion[18]

- In all the case studies in the Global Health Policy Summit report[19], there was a deliberate reshaping of the workforce away from the traditional hierarchical medical model, and towards a wider skill-based team approach. This reshaping increased the capacity of the system to respond to demand, and enabled quality to be delivered at a lower cost

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[16] North West London Integrated Care, http://integration.healthiernorthwestlondon.nhs.uk/section/what-do-we-want-to-achieve-by-pooling-budgets

[17] The quest for integrated health and social care: A case study in Canterbury New Zealand, The Kings Fund 2012

[18] Recruitment and Retention of the Health Workforce in Europe, European Commission 2015

[19] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

2.3.4.2 What we will do

- Conduct a workforce survey and training needs analysis across primary care in order to produce a workforce strategy to assess the options to; Develop primary-care structures to encourage the appropriate range of healthcare professionals to enter and remain in primary care sector, fully utilising their professional training; Ensure that training and CPD opportunities fully support a sustainable primary care sector

2.3.5 Ambition 5: Processes

Develop governance and IT processes to support quality, safe, and efficient delivery of care.

2.3.5.1 The Supporting evidence from the literature

- Brinkenhoff[20] outlines a helpful description when thinking about accountability for public services with them having three, inter-related elements: 1. Accountability for strategic decisions on provision and the allocation of resources, particularly which services are provided and to whom 2. Accountability for the quality of services delivered – such as access, clinical quality, safety and outcomes 3. Accountability for the management of resources – including value for money, probity and fairness

- The report from the International Global Forum for Health care innovators (2015)[21] stated that a comprehensive electronic record that allows data sharing across both providers and patients is the cornerstone and a key enabler for integrated working.

- In addition to providing patient records and provider performance data, technology can also benefit healthcare by improving services and delivering care remotely[22]

- The global Health Policy Summit Recommends[23] sharing information across all clinicians in contact with patients, creating transparency in primary care quality, providing transparent information to clinicians about cost and quality of specialist facility referrals and addressing information governance issues.

2.3.5.2 What we will do

- Continue with the current governance arrangements for General Practice. Consider expanding the existing Primary Care Governance Team in order to incorporate Pharmacists , Dentists and Optometrists

- Introduce 2-yearly patient satisfaction surveys with primary care services

- The IT systems will move towards using the JY number as the unique patient identifier in line with the e-gov strategy

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[20] Brinkenhoff D (2003) Accountability and Health Systems: Overview, Framework, and Strategies. Abt Associates
[21] The population Health Enterprise International Global Forum for Health Care Innovators, 2015
[22] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[23] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

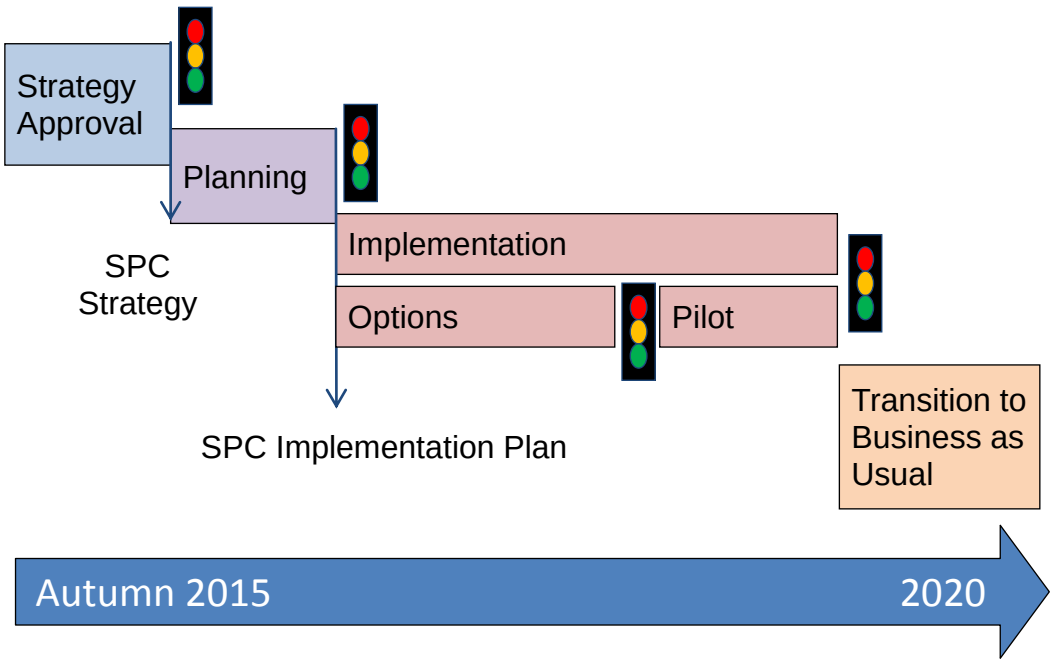
- To enable this work, compulsory registration will be introduced whereby all patients will have to register with a preferred GP practice. Patients will still be allowed to move or change between practices

- The Informatics Strategy[24] states a number of aims for developing integrated record sharing between primary and secondary care. We will support these aims and ensure Primary Care is prioritised

2.4 Implementation Plan

The strategy has been developed in collaboration between government departments (Health and Social Services Department (HSSD), Social Security Department (SSD) and Treasury) and key stakeholders including provider groups across primary care, community and voluntary and patient groups. This will continue to be the case through the development and assessment of options and piloting to understand how these options work in practice.

The process of approval will see the strategy presented to politicians at the Ministerial Oversight Group, and the Council of ministers during the Autumn of 2015. If approved, a public communication will be held to gather views on the strategy to support the planning phase. The implementation of the strategy will take the full time period of the strategy to 2020 and changes will not be implemented before being thought through, assessed and tested.



[24] Health and Social Services Department Informatics Strategy 2013-2018, States of Jersey, 2013

3 Introduction and Background

3.1 What is Primary Care?

Primary Care is pivotal to the high quality, integrated holistic care provided for Islanders. It aims to maintain all Islanders in optimal health and care, for their entire lives. This includes delivering care to individuals with both acute and chronic disease, both physical and mental welfare being central to the diagnosis, management and ongoing care of patients. Traditionally, it is defined as *"services provided by GP practices, dental practices, community pharmacies and high street optometrists"*. However, other services can also be classified as 'primary care' such as District Nursing and Health Visiting.

From a patient perspective, Primary Care should be the first point of contact in the health and social care system, central to diagnosis, management and ongoing care; inclusive, that is available regardless of age, gender, disability, language and socioeconomic class and accessible to all, both in terms of physical access and in terms of being available, and in appropriate settings for all sections of the population.

> The World Health Organisation Declaration of Alma-Ata (1978)
>
> *"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."*

[25]

Primary Care is the gatekeeper for community and secondary care services. Primary Care staff are the lead professionals for supporting self-care, self management, health promotion and health education as well as making sure that the patient's needs remain central to their treatment, ensuring that treatment is always appropriate and that care is planned and co-ordinated.

3.1.1 Features of an effective primary care system from the Literature

Strong and effective primary care is typically considered to be critical to a high performing health care system because of its role in improving outcomes and containing costs[26],[27]. Recent research has concluded that strong primary care is associated with lower rates of avoidable admissions to hospital

[25] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham, 2012

[26] Contribution of Primary Care to Health Systems and Health, Barbara Starfield, Milbank Q. 2005 Sep; 83(3): 457–502.

[27] Securing the future of general practice: new models of primary care, Judith Smith, Holly Holder, Nigel Edwards, Jo Maybin, Helen Parker, Rebecca Rosen and Nicola Walsh, The Kings Fund/Nuffield Trust, 2013)

and fewer potential years of life lost for most of the conditions that were studied; yet requires higher levels of health spending to achieve such benefits, with likely savings accruing in the longer term[28]. The evidence is overwhelming that health care systems configured around primary care produce healthier populations at lower cost: they are more effective, equitable and efficient. Current models of healthcare focused on hospitals as the main location for care giving, are unsustainable. Chronic diseases are already the major cause of death across the world and the impact is set to worsen by 2030[29].

"In England an increase of 1 primary care doctor per 10,000 population is linked to a 6% decrease in mortality[30]"

Ten priorities for action were identified by a Kings Fund report in 2010 for transforming our health care systems[31]. A striking feature of all the priorities is the degree to which they call for change within primary care and the way in which primary care relates to the rest of the system.

A recent report from the Nuffield Trust outlined what an effective primary care would look like[32]. It should be comprehensive, Person-centred, population oriented, coordinated, accessible, safe and of high quality:

- Primary Care co-ordinates the care of many people with multiple complex health needs in a way that individual specialists cannot. It delivers care closer to people, increasing convenience; is a first point of contact for patients and facilitates the early detection of illness and thereby improved outcomes. Primary Care also takes a long term perspective to support prevention and healthy lifestyles
- Primary Care practitioners are critical to understanding the needs, preferences and social circumstances of the individual (and, where appropriate, their carers and families) and making sure the patient is at the centre of care delivery
- Primary Care must work as a true partner in multidisciplinary teams, with trusted professional relationships and mutual respect, supported by shared information and decision making
- Primary Care must be sustainable, with the most appropriate workforce and skill mix working effectively and in particular, with funding systems that offer fair reward and encourage and incentivise the right behaviours from both patients and clinicians

[28] Europe's strong primary care systems are linked to better population health but also to higher health spending. Kringos DS, Burma W, van deer Zee J, Groenewegen P
[29] The population Health Enterprise, International Global Forum for Health Care Innovators, 2015
[30] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[31] Transforming our health care system: Ten priorities for commissioners, Chris Naylor et al. The Kings Fund, 2015
[32] New models of primary care: practical lessons from early implementers, Nuffield Trust, 2013

3.2 Measures of health system performance

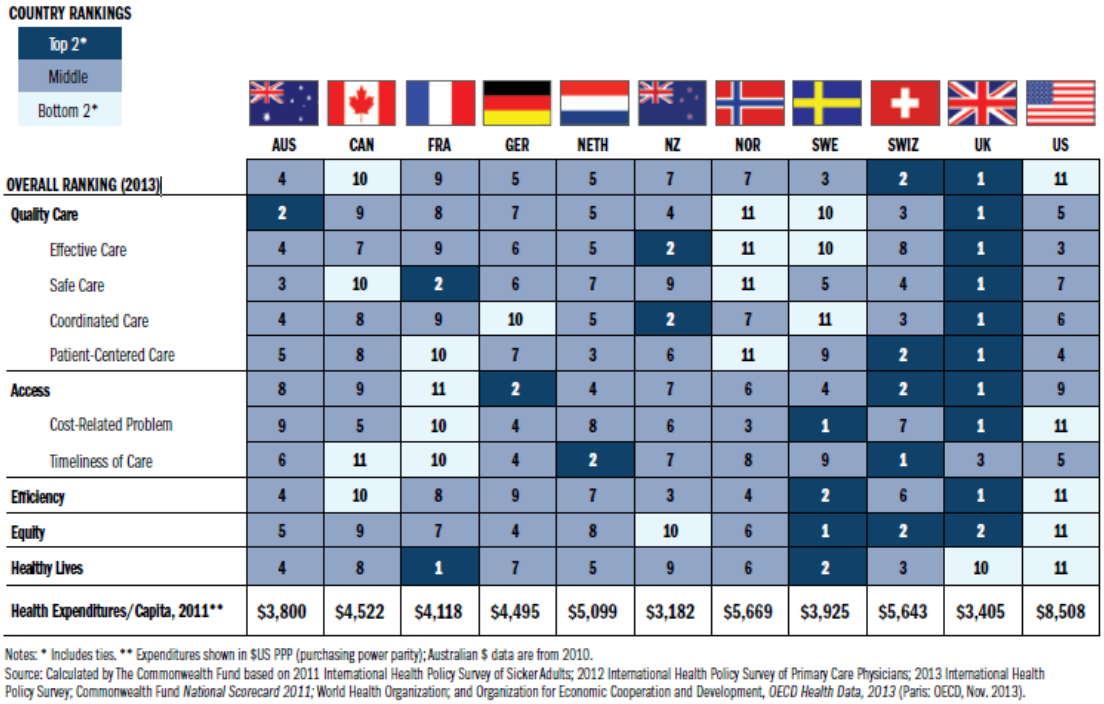
In The Commonwealth Fund: Mirror, Mirror on the Wall (2014)[33] report, 80 indicators of health system performance are grouped into 5 dimensions of performance as seen in figure 1.

1. Quality	High-quality care is defined in the Fund's *National Scorecard* as care that is effective, safe, coordinated, and patient-centred. **Effective** An important indicator of quality is the degree to which patients receive *"services that are effective and appropriate for preventing or treating a given condition and controlling chronic illness."* **Safe** The Institute of Medicine describes safe care as *"avoiding injuries to patients from the care that is intended to help them."*
2. Access	Patients have good access to health care when they need it, can obtain affordable care and receive attention in a timely manner.
3. Efficiency	In the first National Scorecard report, efficiency is described in the following way: *"An efficient, high-value health care system seeks to maximize the quality of care and outcomes given the resources committed, while ensuring that additional investments yield net value over time"*
4. Equity	The Institute of Medicine defines equity as *"providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."*
5. Healthy Lives	The goal of a well-functioning health care system is to ensure that people lead long, healthy, and productive lives.

Figure 1: Internationally recognised health care comparator measures

As shown in Figure 2, the U.S. ranked last of 11 nations overall. Findings in this report confirm many of those in the earlier four editions of *Mirror, Mirror,* with the U.S. still ranking last on indicators of efficiency, equity, and outcomes. The U.K. continues to demonstrate strong performance and ranked first overall, though lagging notably on health outcomes. Switzerland, which was included for the first time in this edition, ranked second overall.

[33] The Commonwealth Fund: Mirror, Mirror on the Wall (2014)



COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Figure 2: Comparison of health care systems from around the world

3.2.1 Measuring Outcomes of the strategy

It is proposed that these five dimensions of performance are used to assess how the implementation of the strategy will benefit the patients in the Primary Care System. Indicators will need to be developed that would be monitored to show progress, as well as identifying gaps in data or information that need to be developed for ongoing monitored. During the first year of implementation, a baseline measure against these indicators would need to be taken in order to benchmark progress both internally and allow international comparison. It is also proposed that an external Body would measure success against these indictors on a 3 year basis.

Figure 3 highlights the relationship between spend and quality of outcomes in Small Islands[34]. The trend line shows the expected relationship between cost per capita and average life expectancy at birth. Those jurisdictions falling below the curve could improve the value they derived from their healthcare expenditure. The trends seen on a global scale indicate that those countries who spend very little on healthcare can see significant improvements in outcomes by spending more (i.e. there is a steep rise at the far left of the curve*). (Jersey - JEY on the graph).*

[34] key issues in healthcare - an Island HealthCare perspective, July 2015, KPMG, kpmgislandinfrastructuresummit.com

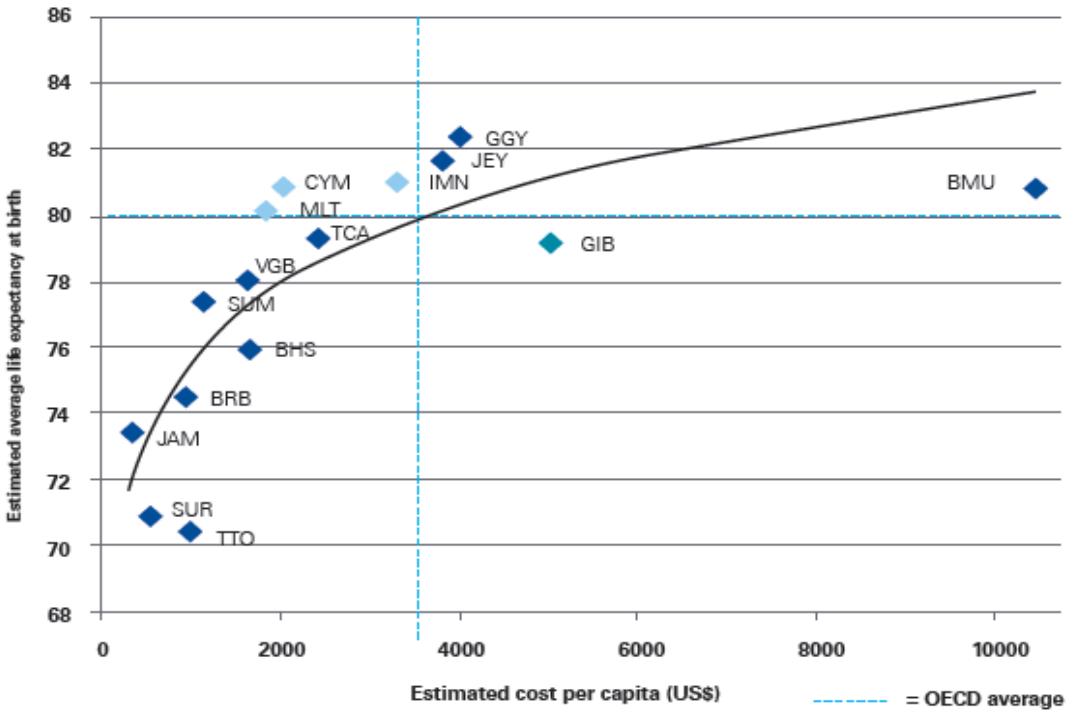


Figure 3 Healthcare spend per capita against average life expectancy at birth

3.3 The White Paper: A New Way Forward for Health and Social Care (P82) (2013 – 2021).

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. '*A New Way Forward for Health and Social Care'* (P82, 2012), demonstrated that health and social care services in Jersey were at a crossroads. Existing capacity was due to be exceeded in some services, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 7 years. P82/2012 clearly stated that services must be safe, sustainable and affordable. This was debated in the States in October 2012, and endorsed.

The States Strategic Plan 2015 – 18[35] clearly outlines the objective of the Council of Ministers to *'promote health and social wellbeing for the whole community, providing prompt services for all and protecting the interests of the frail and the vulnerable'*.

This provides ongoing focus and support for primary care as part of a redesigned health and social care system.

[35] States Of Jersey, Strategic Plan, 2012-2014
http://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R%20AnnualBusinessPlan2012%2020110915%20JN.pdf

3.3.1 Sustainable Primary Care Project Board

In order to develop and deliver a primary care strategy as part of the overall States objective, a Sustainable Primary Care Project Board was set up in 2014 with a wide ranging membership:

Table 2: Membership of the Sustainable Primary Care Board

Name	Role
Julie Garbutt (Chair)	Chief Officer, Health and Social Services
Rachel Williams	Director of System Redesign & Delivery
Jo Yelland	Deputy Director Commissioning (Until December 2014)
Lorna Hall	Sustainable Primary Care Project Director (March 2015-August 2015)
Andrew Morvan	Sustainable Primary Care Project Manager
Karen Paul	System Redesign and Delivery Implementation Lead
Nick Lyons	Primary Care Medical Director
Susan Turnbull	Medical Officer of Health
Andrew Heaven	Deputy Director Commissioning
Bernard Place	Future Hospital Project Director
Ian Burns	Chief Officer Social Security
Sue Duhamel	Policy & Strategy Director Social Security
Richard Bell	Treasurer of the States
Alison Rogers	Director of Treasury Operations
Alan Ferguson	Dentist
Kiran Kumar	Dentist
Philippa Venn	GP
Nigel Minihane	GP
Paul Grey	Optometrist
Phil Romeril	Pharmacist
Mel Boleat	Pharmacist
Julie Gafoor	Chief Executive Officer FNHC (Nursing)
Jim Hopley	Voluntary Sector

The Project Outcomes and Objectives were:

Develop a strategy to deliver the optimal blend of payments and outcomes in Primary Care, to incentivise health seeking behaviour and appropriate resource use across the whole system in States of Jersey.

This scope for the project was endorsed by the Ministerial Oversight Group on 21st July 2014. The Sustainable Primary Care project outcomes were to deliver:

- **A strategy which integrates Primary Care into the transformed health and social care system**
- **An agreed proposed model for safe, sustainable and affordable Primary Care**
- **A proposed preferred approach for contractual and governance mechanisms to deliver the agreed Primary Care strategy**

The Sustainable Primary Care Project Board is one of three programmes that forms the transformation plan for the health and social care system and formally reports to a Ministerial Oversight Group, as shown in Figure 4.

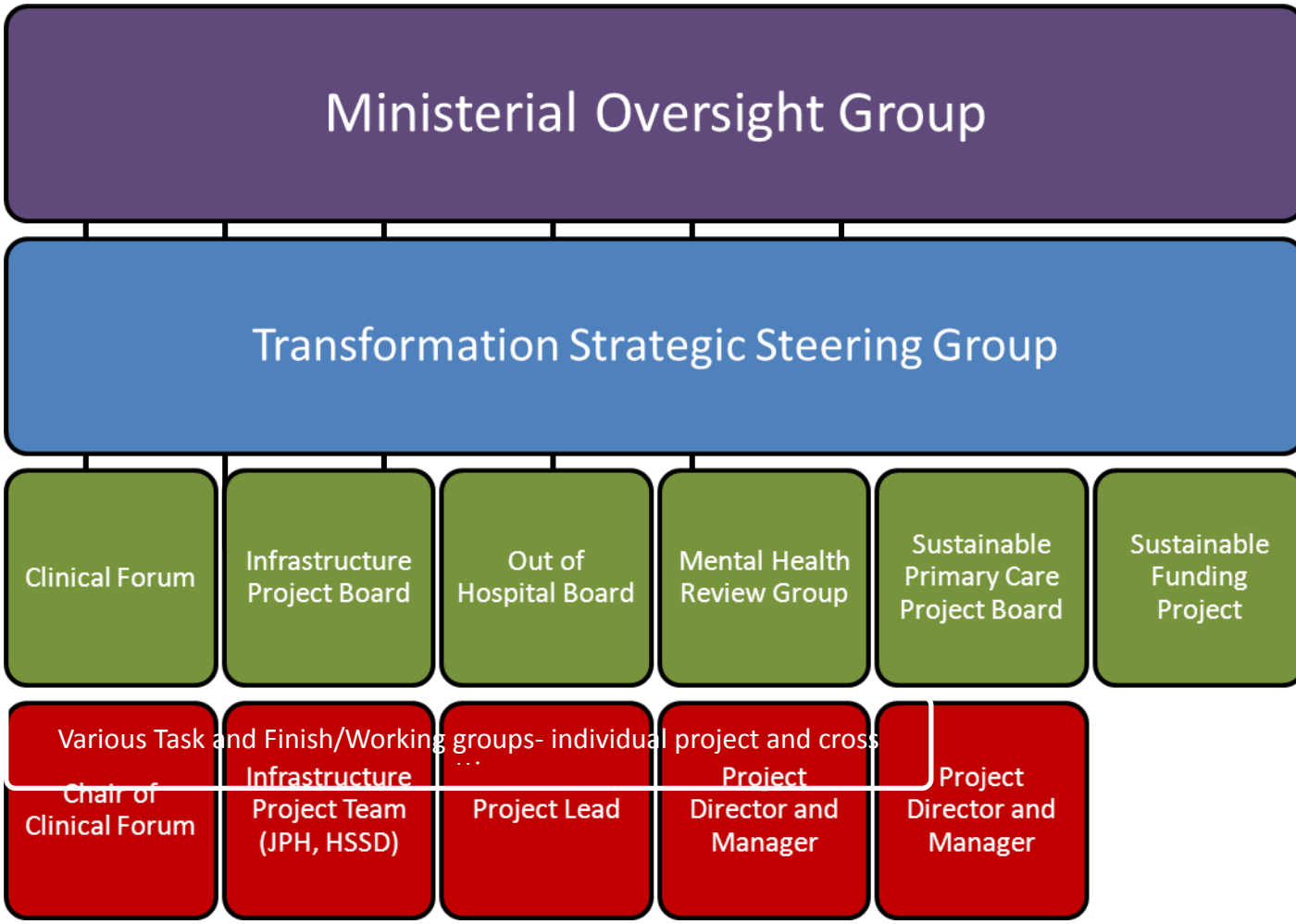


Figure 4: Overview of the integrated strategic context

In developing this strategy, consideration has been paid to a number of policy and reform objectives and imperatives. Figure 4 shows the boundary of the sustainable primary care strategy, and how parallel strategies are delivering change across the whole of the health and social care system in line with P82/2012 principles. A short summary of the relevant areas is set out in Table 3 below. It is not an exhaustive list but is intended to provide a broad view of the strategic context.

Table 3: Alignment with Other Strategies

Mental Health Strategy	The Mental Health Strategy is aiming to transform approaches to: • Social Inclusion and Recovery • Prevention and Early Intervention • Service Access, care coordination and continuity of care • Quality Improvement and Innovation • Leadership and accountability
Out of Hospital System	The overarching aim is deliver a person-centred approach which: • Re-ablement • Care Hub • Community equipment • EDL
Acute Services Strategy	An Acute Service Strategy sets out a high level 'direction of travel' for Jersey General Hospital and how it will meet the challenges it faces in the coming years: It acknowledges both the opportunities and limitations in providing acute hospital care on an Island with a relatively small population.

Primary care is different from other areas of health and social care in that it is mainly provided by non-States organisations. The primary care strategy is a co-production between those organisations and The States and relies on both sides working together to develop sustainable primary care facilities in Jersey that support and are supported by other areas of health and social care provision which are funded directly by the Government.

A key foundation of the new strategy is that this situation will continue and non-States organisations will carry on exercising considerable autonomy in the services that they provide and how they choose to provide them.

The purpose of this document is:

- To set a strategic direction for development of the sustainability of primary care services for the future and within the new Health and Social Care System vision
- To outline how primary care will be delivered against quality, access, efficiency, equity, healthy lives criteria
- To describe the current situation in Primary Care and make the case for change
- To review the literature in order to set the context of the strategy within international evidence and best practice
- To gather views and the voice of stakeholders including patients, professionals and the voluntary and community sector

4 Structure of the Current Provision of Primary Care Services in Jersey

4.1 Profile of Primary Care Providers in Jersey

The current health system in Jersey is based on 1960's laws which have not changed significantly but have been progressively amended. This system has served Jersey well delivering good quality care for many years, however the model of provision is based on individual contractors with little integration and provides incentives which reward reactive rather than proactive care.

The system funding and activity is illustrated in Figure 5 and a description of services provided is in Table 4.

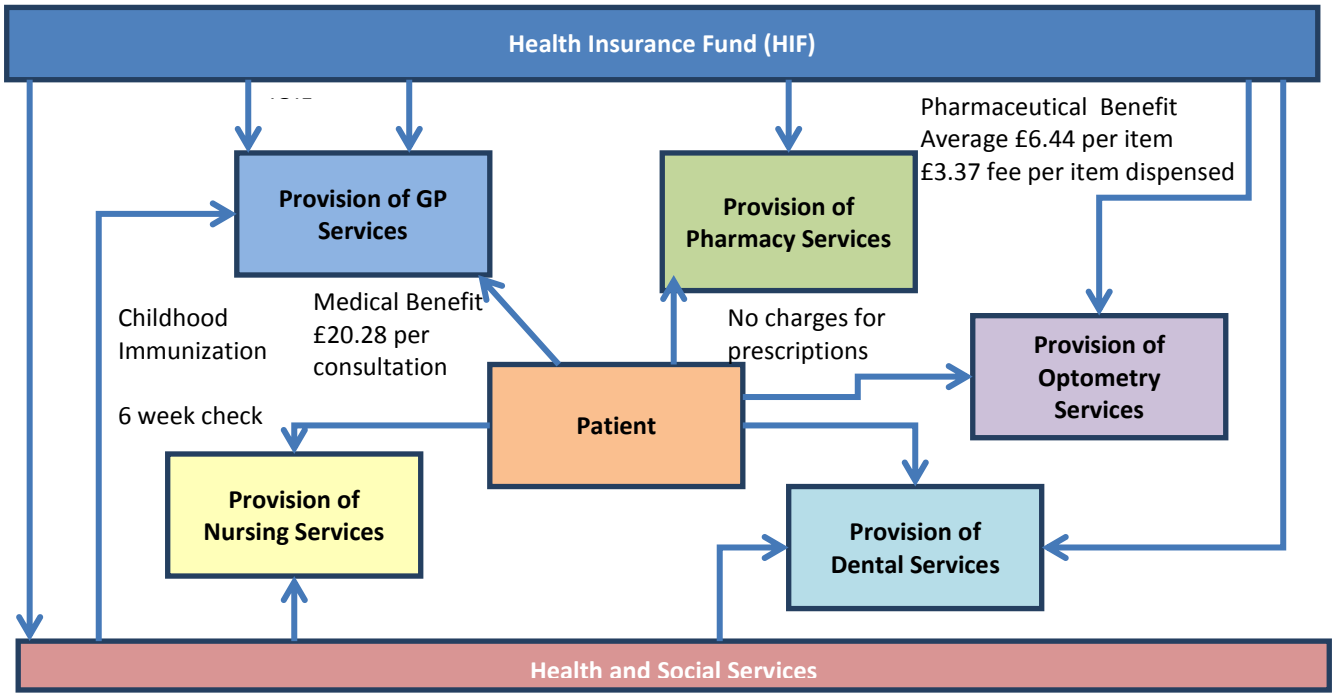


Figure 5: Overview of the funding model and activity within Primary Care in Jersey (2013 figures)

Table 4: Descriptions of services for Primary Care provider groups

Provider	Numbers	Funding	Governance	Services
General Practitioners	Estimated (2015) 103 GPs (88 Full Time Equivalents (FTE) 0.88 FTE GPs per 1,000 population Comparators per 1000 population: England 0.70*; Scotland 0.80*; Wales 0.65; Northern Ireland 0.65; Isle of Man 0.61; Isle of Wight 0.55; Guernsey 0.69 and Tasmania 0.71[36] **UK numbers do not include trainee GP's which compromises 7% of workforce*	The health and social care system in Jersey features a high level of patient payment in primary care. GP's set their own consultation fees and choose how much to charge each patient. These fees are on top of contract and quality payments to GP practices and a medical benefit subsidy (currently £20.28 in 2015) per consultation. This is managed by the Social Security Department and is currently (2015) funded from a ring- fenced Health Insurance Fund (HIF).	All medical practitioners who are in, or who intend to, practise in Jersey must be registered under the Medical Practitioners (Registration) (Jersey) Law 1960. Registration under this Law is, in turn, dependent on registration with a licence to practise with the General Medical Council (GMC) in the UK. Therefore, the GMC provides the primary licensing and any licence held in Jersey is secondary to that. Registered GP's can apply to be included on the performers list for general medical practitioners if they wish to be an approved medical practitioner for the purposes of the Health Insurance Law entitling practitioners to claim medical benefit. The Primary Care governance teams supports and administrates the process of GP revalidation and applications for the performers list.	Most GPs provide appointments 8 am-6 pm on weekdays and Saturday mornings, with some providing longer hours. Patients are usually able to be seen on the same day. GPs provide childhood immunisations and adult vaccinations; some offer specific clinics for Long Term Conditions, occupational health and specialist clinics including rheumatology, dermatology and sports injury. JDOC (Jersey Doctors on Call), is a co-operative model provided by a rota of Jersey GPs, providing Out of Hours services (6.30 pm – 8 am on weekdays, 12 noon Saturday – 8 am Monday and Bank Holidays).

[36] *Healthcare across UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland, National Audit Office, 2012*

Provider	Numbers	Funding	Governance	Services
Dentists	71 Dentists 0.71 FTE per 1000 population Comparators per 1000 population: EU countries 0.68; UK 0.42[37]	Community dental provision is largely provided by independent private practices and funded by patients. Dentists set their own fees. The States of Jersey provide some subsidised care through defined schemes to particular groups of patients: • Jersey Dental Fitness Scheme • Jersey 65+ Health Plan • Income support special payment	All dental practitioners and clinical staff (dental care professionals) are required to register with the Courts of Jersey and in turn with the General Dental Council in the United Kingdom. New legislation has been drafted to reflect modern dental practice and the range of health professionals who now undertake dental work. This overseen by the Head of Professional Care Regulation. All Dentists adhere to the General Dental Council guidelines.	The Community Dental Service provides care for pre-school and primary school children, people with special needs, restorative dentistry problems referred from other hospital departments and primary care practitioners, dental health promotion within the CDS and wider community, regular screening programmes for school children, epidemiological surveys and participation in the monitoring the effectiveness of the Jersey Dental Fitness Scheme. The majority of general dental services are provided by private practices 8am - 6pm on weekdays and some Saturday mornings. The Hospital Dental Department provides orthodontic care, oral surgery and special needs care on referral only along with the aforementioned community dentistry for primary school children by appointment. A Dental Health Review was published in Summer 2015.

[37] OECD (2011) stats in: An analysis of the dental Workforce in Wales; National Leadership and Innovation Agency for Health Care, 2012

Provider	Numbers	Funding	Governance	Services
Pharmacy	80 pharmacists 0.8 FTE per 1000 Comparators per 1000 population: England ~0.8 (2010 figures), Singapore ~0.39 (2012 figures), Japan ~1.06 (2008 figures) [38]	Pharmacists are funded through the Pharmaceutical Benefit, and their private retail business. The pharmaceutical benefit pays a dispensing fee and reimburses the cost of drugs.	Registration is required with both the General pharmaceutical Council (GPhC) and under the Pharmacists and Pharmacy Technicians (Registration) (Jersey) Law 2010 which is administered by the Chief Pharmacist based in HSSD	Pharmacies provide over the counter medicines and advice through their retail businesses, dispense prescriptions and deliver enhanced services funded by the States e.g. smoking cessation. Approximately 12 community pharmacies provide basic health checks such as blood pressure, cholesterol and diabetic screening. Average opening times are 9am -6pm Monday –Friday and Saturday morning with some pharmacies opening on Sundays.

[38] Workforce Report, International Pharmaceutical Federation, 2012, http://www.fip.org/files/members/library/FIP_workforce_Report_2012.pdf

Provider	Numbers	Funding	Governance	Services
Optometrists	~30 ~0.3 FTE per 1000 Comparator per 1000 population: England 0.1[39]	Optometrists are independent private businesses and are funded by patients. For people receiving income support benefit, currently the level of benefit is set to include money to allow the individual to manage to pay for regular sight examinations and spectacles. The States of Jersey provide some subsidised care through defined schemes to particular groups of patients.	All Optometrists or Dispensing Opticians are required to register with the Royal Court and with the General Optical Council (GOC).	Optometrists provider routine eye examinations for adults and children. Domiciliary visits for examinations & dispensing are offered in some practices to those individuals that are unable to attend. Stand alone appointments for Glaucoma monitoring & Diabetic Retinopathy (Fundus photography) can be offered at the request of the patient, GP or by the Eye Department. There is increasing use of colour assessment & colour therapy (by using overlays/tinted spectacles) for patients presenting with visual stress disorders. Dispensing following the eye examination or as walk in patient with a valid prescription, resulting in the supply of prescription spectacles The majority of the Practices are open 6 days a week.

[39] Ref: Local Government Information; http://lginform.local.gov.uk/

Provider	Numbers	Funding	Governance	Services
Nursing	36 District nurses, 13 Health Visitors, 4 School nurses and 4 Children's community nurses. There are approximately 5 practice nurses employed by GP practices. 0.52 FTE per 1000 Comparators per 1000 population: England 0.846; Scotland 1.124; Wales 1.052; Northern Ireland 1.003[40]	Community nursing services are provided by Family Nursing and Home Care (FNHC), a Government subsidised organisation with charitable status. Some GP practices employ a practice nurse, which is funded directly by patient visits.	Registered nurses working in Jersey are required to be registered with the Nursing & Midwifery Council (NMC UK) and locally with the department of Health & Social Services under the provisions of the Health Care (registration) (Jersey) law 1995.	FNHC provides district nursing, health visiting School nursing and Home Care, as well as out of hospital services (rapid response and re-ablement).

[40] Ref national audit office 2012

4.2 What Works well in Jersey and What has been Achieved?

There are a number of very positive features within the current system that we need to maintain in order to ensure the best possible value for islanders is delivered through the health and social care system.

4.2.1 General Practice

Primary care providers, as independent businesses, value their freedom to respond to customer needs without complex contractual restrictions. As reported by the Jersey Consumer Council[41], patients value the continuity of seeing the same doctor in primary care, with the majority of primary care facilities being very good. Telephone advice is readily available across all GP practices and is free of charge. Patient access to see a GP is good and appointments can usually be made on the same day. Patients are usually able choose to see their own GP, with many having built up family relationships over a number of years with their practitioner who provides holistic care.

4.2.2 Formation of Primary Care Governance Team

The Primary Care Governance Team (PCGT), formed in 2012 is a small team whose role is to provide governance of General practitioners ensuring practices offer the very best standards of patient care. Their role includes the following:

4.2.2.1 Revalidation and GP performers list

In October 2014, the Health Insurance (Performers List for General Medical Practitioners, Jersey Regulations 2014) was introduced, alongside revalidation for GPs, the Performers List and changes to the registration process. This was a significant step, and one which will help ensure confidence from the General Medical Council, and from patients, regarding the quality of general medical practice care in Jersey. At the same time, the Medical Practitioners (Registration) (Responsible Officers) (Jersey) Order 2014 was also introduced setting out the responsibilities of the Responsible Officer.

4.2.2.2 Complaints Process in General Practice

There is a robust complaints process in place to investigate complaints and the Health Insurance (Performers List for General Medical Practitioners) (Jersey) Regulations 2014 has established a formal process by which concerns about a GP can be addressed. The Primary Care Governance Team will undertake investigations into complaints and concerns and respond within 28 days. There may, on occasion, be a requirement to refer a complaint to an external agency for investigation. Such referrals would usually be made to a specialist investigation team co-ordinated and led by NHS England (Wessex Area Team) but may also be referred to the National Clinical Assessment Service (NCAS) or, in more serious cases, to the appropriate regulator, usually the General Medical Council (GMC).

[41] Primary Health Care Matters, Jersey Consumer Council, 2015

4.2.3 Jersey Quality Improvement Framework (JQIF)

Jersey has adopted a Quality Improvement Framework (JQIF), and this has been embraced as an effective mechanism for incentivising GPs, alongside the reshaped rebate. This has resulted in co-ordinated collection of data which should lead to improvements in the care offered to our patients and is a foundation for developing the quality agenda in years to come. Currently JQIF provides payment based on list size, recording clinical indicators and for demonstrating that the practice is working towards standards in practice organisation. The clinical indicators are agreed with local GP's and based on indicators from UK Quality Outcomes Framework (QOF) whilst the organisational indicators are bespoke to Jersey.

4.2.4 EMIS IT System in Primary Care

EMIS Web is the patient information system used across all Jersey GPs including Jersey Doctors 'On Call' (JDOC) who provide the Out of Hours Service. EMIS is also used by the Health Intelligence Unit and the Primary Care Governance Team to support Jersey Quality Improvement Framework (JQIF). This will provide accurate disease registers that will in turn, inform health service planning.

Work is in progress to roll out EMIS Web to other services in primary care which will further enhance patient quality of care.

4.2.5 Childhood Immunisation

There are two contracts for services, placed by the Public Health Department, for specific immunisation programmes and screening within primary care, namely the childhood immunisation programme and the six week infant development check. The six week check is funded through a payment to the practice for each developmental check performed and outcome results received. Childhood immunisation is funded through a quarterly payment to the practice for each immunisation consultation (known as an immunisation 'visit') performed in accordance with the Jersey has a high coverage of childhood immunisations, consistently higher than the average reported for England and for immunisation given at 2,3,4 and 12 months of age, coverage is above the World Health Organisation target of 95%[42].

4.2.6 Dentists

The epidemiological survey in March 2014, reported that the oral health of the children reviewed was generally good and comparable to regions in England with the highest levels of good oral health. As in previous years there was disparity in the level of dental health between schools.

4.2.7 Pharmacists

In January 2013, pharmacy based smoking cessation services were launched under contract with Health and Social Services Department. Initial funding enabled smokers to access five support sessions with the provision of single nicotine replacement therapy (NRT). For the period April 2013 to March 2014, 871 smokers set a quit date and 35% were quit after four weeks. In January 2014, additional funding was approved by the health minister, enabling the service to gradually expand to

[42] Health Profile for Jersey 2014, Health Intelligence Unit, Public Health Directorate, HSSD, States of Jersey

its current level of service provision; nine support sessions with dual NRT offered for up to 12 weeks. The enhancements to the service are now aligned with best evidence for smoking cessation. During the period April 2014 to March 2015, 754 smokers set a quit date with a 42% quit rate achieved at four weeks. The reduction in numbers may possibly be attributed to a rise in the use of vapourisers and this has also occurred in UK services. However, the quit rate for 2014/2015 was higher than in the first year and represents an outcome of the enhanced service provision and an increased level of competency in delivering cessation support.

4.2.8 Optometrists

The nature of working on a small Island has led to a profession that works and interacts very well together. Information, such as patient prescriptions or GP referral letters can be easily sent to other practices upon request with more using email for speed and convenience. There exists a very good relationship between Optometrists, GP's, the Eye Department, Consultants privately and the Orthoptic Department. The private industry within Optometry has enabled the profession to offer above UK standard of care with better equipped practices i.e. all have fundus cameras', some now invested in Optical Coherence Tomography (OTC) and many conduct digital dispensing.

4.2.9 Nursing

Family Nursing and Home Care (FBHC), are the only provider of general community nursing on the Island. The services are commissioned through a Service Level Agreement (SLA) with HSSD. There are areas of good joint working with other charities and state departments. There is an ability to develop new initiatives such as the implementation of the Gold Standard framework to improve patient care.

4.2.10 Out of Hospital Care

The aim of the Out of Hospital system and services is to ensure that many more people will have increased independence and the choice of being cared for in their own home for as long as possible. This is achieved by delaying or reducing the need for entry into long term care, avoiding hospital admission where clinically appropriate and facilitating early transfers of care from hospital. Patients will experience a person-centred care approach that is delivered by a range of professionals in well-co-ordinated, integrated, multidisciplinary team(s). The focus of care will be on achieving agreed outcomes, for patients, for the service and for the whole system.

The provision of community nursing services in Jersey up to 2014 has been through traditional models of District Nursing and Home Care services therefore Out of Hospital care has required a new approach, enabling the opportunity for clinical staff to influence the development of the services, to be creative and innovative and to ensure that the services are responsive and delivered by the right person in the right place at the right time. The contract to provide the Step Up /Step down service has been awarded and commenced in May 2015.

5 Why Do We Need to Change?

The Global Health Policy Summit in its report "*Primary Care, the Central Function and Main Focus*"[43] identifies seven Common issues faced by primary care across the world. Some, but not all, are reflected in our own Health and Social Care system in States of Jersey to varying degrees:

1. Poor patient access and perceptions
2. Insufficient coordination and integration
3. Low professional prestige and limited availability of the workforce
4. Lack of infrastructure investment
5. Misaligned incentives
6. Under-utilisation of information and technology
7. Variable quality standards and regulation

The following are the main drivers for the need to change in Jersey:

5.1 Funding Options for Health

In 2011 KPMG were commissioned to explore the funding options available to the States of Jersey, drawing on their international database of knowledge and experience of existing Health funding methods in countries such as Singapore, the Netherlands, the USA and Guernsey. Their report highlighted the three main types of policy options available: insurance contributions (either mandated or through encouraged private insurance), taxes and charging health care users to pay at the point of delivery.

There are a number of practical policy variations and considerations around these mechanisms, and whilst all options have their respective benefits and drawbacks, ultimately the gap is most easily bridged by the public of Jersey making a greater contribution in funding, or electing to reduce services elsewhere. KPMG made a recommendation that they reached based on analysing existing literature on health and social care financing methodology in other jurisdictions around the world, consultations with health and social care and financing experts from within the Global KPMG network, as well as direct discussions with stakeholders in Jersey as to what is feasible in the local environment.

In 2014 The Kings Fund commissioned a review[44] into people's entitlement to health, care and support and how these could be funded. The report expressed their view that there should be a *"single ring-fenced budget for health and social care which is singly commissioned and which entitlements are much more closely aligned"*. Jersey is ahead of the UK in this respect, we already

[43] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[44] A new settlement of health and social care: "The Barker Report", Kings Fund, 2014

have this in place. However, we are facing the same issues as the UK in terms of affordability of a 21st century health and social care service. The King's Fund report also acknowledges there are some hard decisions to be faced with regards to funding, that there will be a requirement of a combination of higher taxation, charges or cuts in other areas of public spending. They also suggest that some of the funding should come from a pensioner population that is on average better off than its preceding cohort.

With the political support in place, an officer group was convened, with representatives across all areas of the States affected, with a remit to look at how the gap might be funded. Any solution should aim to provide a mechanism that provides funding for primary care, increases in secondary care and the demographically driven changes.

When making a decision as to how the additional health and social care costs should be funded certain characteristics of the system are key:

- Equity – The system must be fair. People in similar circumstances must be treated equally with those best able to bear the burden making the largest contribution
- Efficiency – The system must be easy to administer
- Simplicity – The system must be easy for the public to understand
- Predictability – The public must know what they will have to pay in the short and medium term without unexpected changes

A proposal (Figure 6) to fund the priorities has been put forward including the introduction of a health charge by 2019.The charge is likely to be introduced in a phased way with the £35 million target by 2019 at the latest. The solution will need to be cognisant of the Fiscal Strategy and may be a mix of new contribution charges for individual as well as point of service charges.

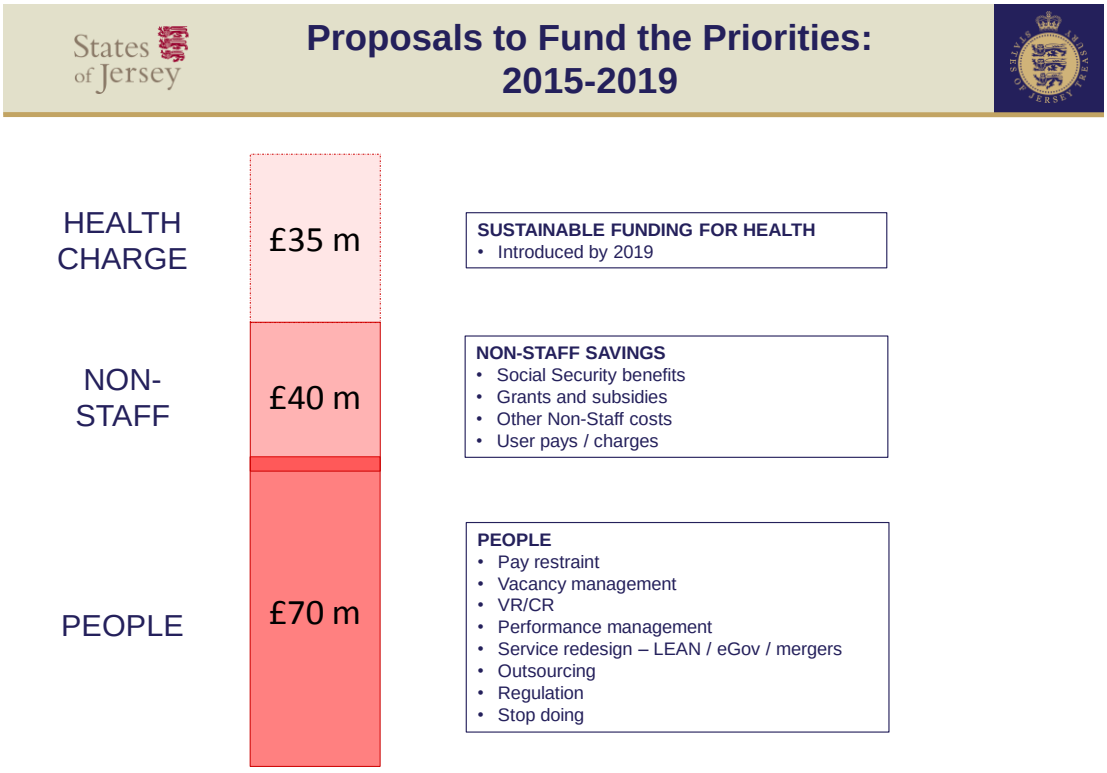


Figure 6: States of Jersey Proposals to fund strategic priorities 2015-2019[45]

5.2 Strategic Planning and Population Policy

The White Paper '*A New Way Forward for Health and Social Care'*, (P82/2012)[46] demonstrated that health and social care services in Jersey were at a crossroads. Existing capacity was due to be exceeded in some services, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 7 years.

Figure 7 shows that Jersey is facing demographic challenges in the years ahead. More people are reaching retirement age and people are living longer. In 2014, there were more pensioners living in Jersey than ever before and the total number of deaths in the Island was the lowest since 1952. This is something to celebrate, but we must also plan and prepare. The population projections produced by the States Statistics Unit highlight that[47]:

[45] Draft Medium Term Financial Plan2016-2019, States of Jersey, http://www.gov.je/government/planningperformance/strategicplanning/siteassets/pages/statesannualbusinessplan/r%20draft%20medium%20term%20financial%20plan%202016-2019%20vp%2020150714.pdf

[46] States of Jersey 'A New Way Forward for Health and Social Care' P82, 2012 http://www.statesassembly.gov.je/AssemblyPropositions/2012/P.082-2012.pdf

[47] Draft Medium Term Financial Plan2016-2019, States of Jersey, http://www.gov.je/government/planningperformance/strategicplanning/siteassets/pages/statesannualbusinessplan/r%20draft%20medium%20term%20financial%20plan%202016-2019%20vp%2020150714.pdf

- We could have as many as 28,000 people aged over 65 by 2035, compared to 14,000 in 2010
- We will also see the number of people aged over 85 increase from 2,000 to 5,000

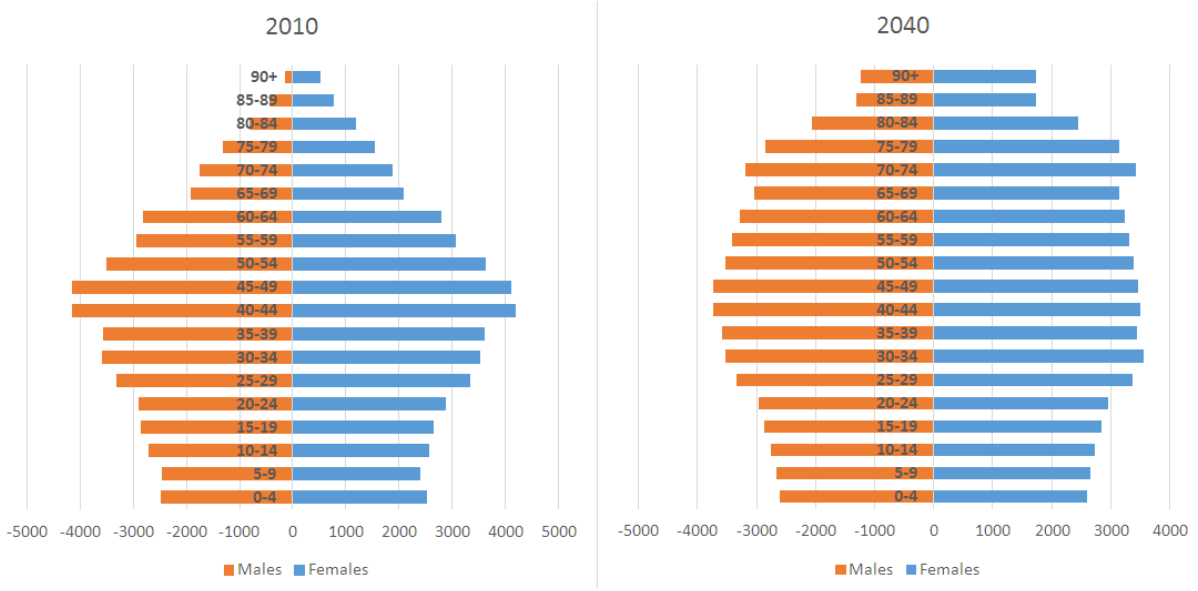


Figure 7: Predicted population demographic change in Jersey between 2010 and 2040 based on +325 net inward migration

In addition, the decrease in number of 'working age' people will produce:

- Reduced income tax
- Decreased available workforce able to support increasing care needs
- Even more pressure on carers

The demographic pressures place additional demand on both hospital and community services but also change the nature of the service, placing more emphasis on the need for prevention, long term management, developing new models of care and taking advantage of advances in technology.

5.3 Increase in Number and Complexity of people with Long Term Conditions

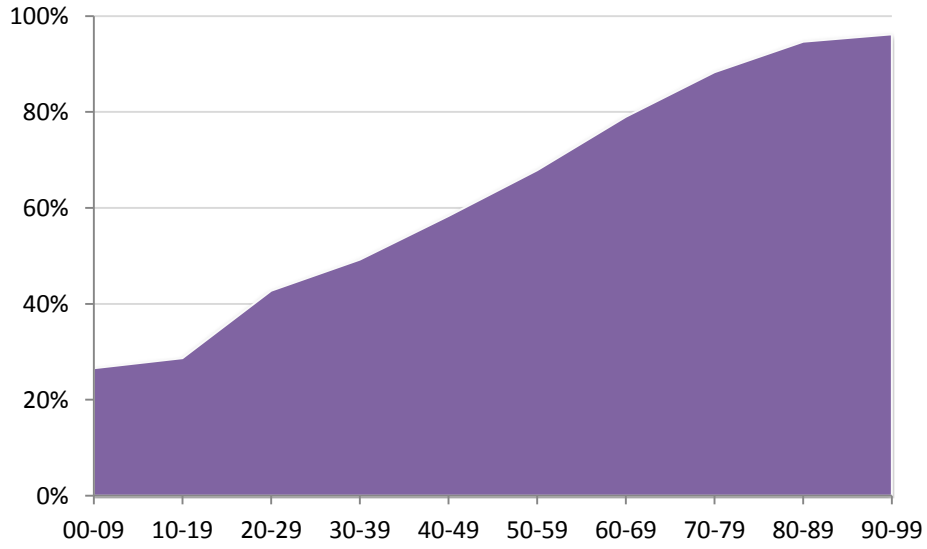
"A long term condition is one that cannot currently be cured but can be controlled with the use of medication and/or other therapies"[48]

Not only is the population changing, but the profile of the population is changing too as can be seen in Figure 7. One of the main challenges facing health systems and governments today is the rising

[48] DOH Improving the health and well-being of people with LTC, 2010

prevalence of long term conditions in patients, especially multi-morbid patients (i.e. patients with two or more long term conditions) who use more inpatient and ambulatory health and social care than people who suffer from a single condition. A great success story of modern health care systems is that people are living longer; however, this means that they are also living with more and more long- term conditions, meaning that people will have a greater need for health care. In a report from England[49], it was found that multi-morbidity, specified by different measures, consistently shows a significant and positive association to health service use in terms of GP visits, outpatient visits and number of nights spent in hospital. People with two or more long term conditions use health services more than people without multi-morbidity.

However, in Jersey disease registers are at a very early stage of development, which has made it hard to understand the prevalence of long term conditions and how many of our population are living with two or more long term conditions. This also means we have had very little data about our population health in order to support decision making to support integration of services. This has made it difficult to design services to best meet patient need. However, more recently the impact of multiple morbidities on the Jersey GP registered population has been investigated using the new GP central server. This has allowed population wide data to be examined for the first time. There is a clear pattern of increasing morbidities with age in the population, with over half of the population being found to have at least one of 40 chronic conditions. Health Intelligence have produced some preliminary data showing the extent of multimorbidity in Jersey (2015). Figure 8 shows Jersey distribution of multiple conditions within the population using data for 40 common long –term conditions.[50]



[49] Modelling the effect of multi-morbidity on the demand for health services in England, Centre for Workforce Intelligence, March 2015

[50] Multimorbidity Briefing Note Health Intelligence Unit, Public Health Directorate, August 2015

Fig 8: Shows Proportion of population with at least 1 chronic condition by age group (based on 40 condition study)

5.4 Acute Hospital Care in Jersey

Acute hospital care is expensive. It costs around £550 per day to stay in Jersey General hospital. Inpatient spells are projected to increase by 33% by 2040. This increase in activity will lead to a more significant need for Hospital medical beds – a projected increase of 25% by 2020 and 72% by 2040. This significant increase in demand for hospital beds will mean that hospital capacity is insufficient within the current model of health and social services, and will start to be exceeded in the very near future. In 2013 there were 6,918 non-elective hospital admissions. 3,153 of these were for people aged over 65, of which 2,219 were medical. Primary Care needs to be able to adapt to the increasing long term conditions and demographic bubble.

5.5 Perverse and Misaligned incentives

Table 5: Description of perverse incentives identified

Patients
There are perverse incentives for patients to seek hospital care for conditions that can often be more cost-effectively cared for in primary care. Islanders are required to pay towards the costs of seeing a GP (co-payment) and most adults are expected to pay the full costs for primary dental care and optometry, but hospital care is free at the point of delivery and currently prescriptions are free. Patients with multiple long term and complex conditions pay more for their care as they generally need more frequent visit to the GP and pay for each visit.
General Practice
The current health insurance law permits the payment of Medical benefit only to GP's. This stifles innovation and hinders practices from developing models of care which encourage multidisciplinary working and delivery of care through lower cost alternatives at equivalent quality. There is very limited co-located multidisciplinary working in GP practices and limited shared care pathways between Primary and Secondary care, with a perception by the GPs that the hospital is delivering a number of services which could be provided at the same or better value for money in Primary and Community settings. Due to the funding mechanism, the current model of care is provided by doctors, with limited care offered by other professionals. The skills of GPs are deployed on tasks that, elsewhere, would be delegated safely to other professionals, such as ear syringing and blood pressure monitoring.
Pharmacists
Prescriptions in primacy care are free. Pharmacists are paid to dispense prescriptions and the full cost of prescribed items is reimbursed. Therefore there are few incentives within the current system for clinicians or patients to modernise prescribing behaviours. Pharmacists are not incentivised to change or recommend lower cost prescription drugs. There is no mechanism for medicines management.

Dentists
As a private industry relying on Patient direct funding, the incentive to provide up to date superior services rely purely on market forces, i.e. what the individual is willing to pay.
Optometrists
As a private industry relying on Patient direct funding, the incentive to provide up to date superior services rely purely on market forces, i.e. what the individual is willing to pay. Additional advanced machinery, such as OCT, must have a demonstrable benefit to warrant investment. Current additional screening, such as diabetic screening is cost to the patient in practice. Under the HES, it is free at the point of use. The incentive here would be a switch from secondary to primary care.
Nursing
There is currently limited interaction between primary and community services, specifically between GP-led services and Family Nurse Home Care (FNHC). Best practice can be compromised by patients' payment for consumables.
Hospital
There are perverse incentives for patients to seek hospital care for conditions that can be more cost-effectively cared for in primary care. Due to the size of the hospital in Jersey, the benefits of economies of scale are not as strong as for a similar sized hospital in the UK. This means that to maintain clinical viability, there is a higher demand in the hospital for Primary Care-type services (in ED, Outpatients, JGH Dental Department and JGH Eye Department), with hospital-issued prescriptions and repeat prescriptions. Compared to the UK and other jurisdictions, more long term conditions are managed through Hospital Departments rather than in Primary Care, which can also lead to de-skilling in Primary Care. Currently, the barrier to accessing GP care by those who cannot or are unwilling to pay leads to increased demand on hospital services as these are 'free at the point of delivery'. This increases demand on A&E services and outpatient clinics. This impacts on waiting lists and in time it may lead to patients presenting with more advanced disease as they are unwilling or unable to pay for GP appointments and/or diagnostics. There is very limited co-located multidisciplinary working in GP practices and limited shared care pathways between Primary and Secondary care, with a perception that the hospital is delivering a number of services which could be provided at the same or better value for money in Primary and Community settings.

5.6 Information (IT) and Data Across Primary Care

EMIS Web is the patient information system used across all Jersey GP's including Jersey Doctors 'On Call' (JDOC) who provide the Out of Hours Service. EMIS is also used by the Health Intelligence Unit and the Primary Care Governance Team to support Jersey Quality Improvement Framework (JQIF). This will provide accurate disease registers that will in turn, inform health service planning.

Work is in progress to roll out EMIS Web to other services in primary care and the community such as Jersey Talking Therapies, FNHC and Jersey Hospice, which will further enhance patient quality of care.

5.6.1 What are the problems with the current IT and Data collection systems?

There is a system issue in that none of the IT systems link i.e. EMIS IT system has no direct link to either the hospital IT system, the social care IT system nor to dentists, optometrists and pharmacists. The IT systems used by Dentists, Optometrists and Pharmacists are independent of any other systems. There are several differing IT systems within each of these contractor groups.

This means that there is no consistent information transfer mechanism between providers. Most practices store all patient information electronically and much of this is scanned from paper copy letters received from a range of other providers. The acute hospital system is still mainly using paper records. Some departments within the hospital accept electronic referral forms while others require a letter. This is not an efficient system for patients or providers.

There is very little collection of high quality data to support decision making and where there is data, it is not collected and analysed centrally to support integration of services. This makes it difficult to design services to best meet patient need. This is supported by the fact that the central disease registers in Jersey are at a very early stage of development which is making it hard to understand the prevalence of conditions.

Where data does exist, although there is strong information governance protection, there are few information sharing agreements to allow that data to be shared for the benefit of patient care, preventing a holistic view of the health needs of the population to support development of services relating to need.

5.7 Clinical Sustainability of Primary Care

There are workforce issues in particular across General Practice, Pharmacy and Nursing in Jersey. Specifically there are issues are around recruitment and maintaining a skilled workforce as shown in Table 6.

Table 6: A summary of the workforce issues across the professional groups

General Practice	The GP Taskforce Final Report[51] concluded that there is a GP workforce crisis which must be addressed immediately. This crisis in GP workforce and training in the UK could have an effect in Jersey with difficulties in recruitment.
Pharmacy	The pharmacy workforce is suffering from skills fade as they mainly dispense and are not able, due to system rules and incentives, to use the full breadth of their training. This is leading to a recruitment issue as newly qualified Pharmacists are unable to use their full skills in Jersey.
Dentists	The Dental health Review (2015) review did not complete a workforce survey but anecdotal reports suggest sizeable cohorts of clinicians are due to reach retirement age within short succession of one another. There is an opportunity to ensure that the most appropriate practitioners are identified, via the workforce strategy development, to enable Jersey to attract and develop the right mix of skills for a sustainable service. The Action Plan should also consider mechanisms to invest in the workforce so they may develop the skills to manage dental data and regulatory compliance.
Optometrists	Under Jersey law, Optometrists (OO's) and Dispensing Opticians (DO's) are required to be qualified and registered. This involves registration with the governing professional body, the General Optical Council (GOC), and as a consequence, registration at the Royal Court. This naturally places a barrier on the local workforce. Therefore most positions, when they arise, are filled with individuals from outside of the Island. Recruiting practices are required to advertise locally first and, if unsuccessful, advertise nationally, usually in the trade publications or by using specialist employment agencies. The main issues in obtaining staff are: • Accommodation: The individual will normally be residentially non-qualified, therefore renting can be expensive (especially for families) and as non-qualified, will be unable to purchase a house. • Businesses are restricted to the number of licences and type of

[51] Securing the Future GP Workforce Delivering the Mandate on GP Expansion GP Taskforce Final Report, NHS England ,March 2014

	individual they are allowed to employ. Licences are not easy to obtain. Some practices offer in house training for dispensing staff and this allows a pathway to become a qualified DO. The course can be done as distance learning diploma or as day/block release. Only one practice offer the facility for pre-reg OO's to work in practice in Jersey. However, hardly any have remained following completion of the pre-registration year.
Nursing	Nursing is another area of serious concern, with an ageing workforce in general practice nursing and similar problems of recruitment and retention to GP's

5.8 Integration

The White Paper noted that there is limited integration with secondary care, social care and Voluntary and Community Sector provision. Once patients are referred to another service, the GP is often excluded and does not always receive ongoing follow up details. This makes it difficult for the GP to provide holistic, co-ordinated care. Lack of co-ordination can result in a poor experience for the patient and costly duplication. Teams are not fully integrated or embedded in Primary Care. There is limited hosting of services within practices, and District Nurses and Health Visitors are not attached to GP practices or co-located. This means that all the practitioners are isolated.

5.9 The Case for Change: Conclusion

Therefore in summary, the ageing population along with the rise in patients with two or more long term conditions, the difficult financial climate, lack of joined up IT and data systems, the concerns around the sustainability of our primary care workforce, perverse incentives across the health and social care system, poor understanding of our population health needs and lack of integration across the whole system, supports the 'Case for Change'. We need a new model of sustainable primary care in Jersey that forms part of an integrated approach, within the new Health and Social Care System.

Therefore, change is required now to ensure that the health and social care system can continue to meet the demands placed on it and that it is sustainable for the future whilst adding value to patients and supporting them to keep well for longer.

5.10 What are the implications of doing nothing?

Table 7 outlines the implications of doing nothing across the contractor groups and systems

Primary Care area	Implications on doing nothing
Patients	Patients will pay more both through taxes and in GP fees for increasingly inefficient services. Patients will experience delays in treatment as services are not joined up and are experiencing greater volumes of patients.
General Practice	Recruitment to Practices will become increasingly difficult. It will become difficult and costly to retire and GPs will have to work harder for less money to manage an increasing number of patients with complex long term conditions.
Pharmacy	It will become difficult to recruit pharmacists and those already here and practicing will become deskilled due to the narrow remit of their work.
Dentists	Not addressing the governance issues highlighted in the Dental Health Review could cause further interest from the relevant regulatory bodies and lead to decreased confidence in the system from the public and patients.
Optometrists	Increased demand for age-related Ophthalmology services such as cataracts and macular degeneration. Cataract surgery is busier than ever. With regard to screening services such as diabetic and IOP monitoring, to enable a switch from secondary to primary care, there will need to be inclusive discussion between optometrists, the Eye Department and the States to calculate the feasibility and cost effectiveness.
Out of Hospital Care	Greater demand for musculoskeletal and orthopaedic services, and for the community re-ablement and rehabilitation that is subsequently required
Nursing	Decrease in skills and difficulties in recruiting
Hospital	Increased pressure on services will require greater funding and a new hospital will need to be larger with more beds. The Emergency Department will be overrun and waiting times for clinics and appointments will increase.

A new approach to primary care is needed that will need to be safe, sustainable and affordable offering value for money for taxpayers and Islanders.

6 Detail of the Strategy

6.1 The 5 Ambitions of the Sustainable Primary Care Strategy in Jersey

The five ambitions of the Sustainable Primary Care Strategy are illustrated in Figure 9. These have been developed with key stakeholders involved throughout the process including patients[52],[53],[54], professionals[55] and the voluntary and community sector[56]. The ambitions set the direction of travel for Primary Care for the next 5 years working towards improved sustainability and a safe, effective and affordable system.

The ambitions will impact on patients, the different professionals and services in different ways. The ambitions will be confirmed and expanded as the model develops during the 5-year implementation phase. All stakeholders will continue to be involved throughout development of detail and implementing the direction of travel to ensure that the implementation is the best solution for Jersey.

Figure 9: The 5 Key ambitions for Primary Care in Jersey.

[52] Jersey Consumer Council, 2012
[53] Jersey Consumer Council, 2014
[54] Island Café, 2015
[55] Workshops, 2014/15
[56] Island Café, 2015

6.2 Ambition 1 – Patients

6.2.1 Outline of Ambition

Ambition 1 is the central theme of this strategy and focuses on delivering better outcomes for patients. This means putting our patients at the heart of care delivery. Enabling the people of Jersey to lead healthy lives and empowering patients to understand and manage their conditions themselves. This will be achieved through us understanding patient needs and developing service packages to wrap care around the patients and to better meet their needs.

6.2.2 Emerging themes from Professional Workshops

- Patients need to be able to access affordable primary care and believe that it will meet their needs more effectively than other options available to them
- Access should be more closely related to need rather than ability to pay
- There should be a greater emphasis on health promotion and prevention and a greater responsibility for self care
- Government policy should shift care from secondary to primary
- HSSD will use data to identify population needs and drive up performance
- Patients will be encouraged to use ICT to manage and improve their own care

6.2.3 Patient Voice

On Access:
"difficult to find where the health visitor clinics were- even the GP didn't know"
There was very poor knowledge of the children's dental scheme for under 12's and concerns about the long wait to be seen by the dentist
There was mixed awareness about the JDOC service out of hours:
"no transparency, no terms and conditions and no notification of price rise"
Issues about sources of information:
"lack of information online- people are IT savvy so would use it"
"more opening times in different parishes as some people need chemist and cannot get to them"
"need for more recognition of carers and the development of a Carers strategy would help this"

6.2.4 Principles

- Understand local health needs by collecting local health data across all health sectors
- This local data will be used to identify groups that need additional support and primary care services will be developed to reflect these needs
- Primary care services will be developed with the patient at the centre so that patients, families and carers receive care in the way that is important to them
- Defining the value of healthcare around outcomes that matter to patients including health and wellbeing
- Primary care services will be developed with a focus on patient outcomes and patient reported quality
- Primary care services will be developed with a simple structure, clearly linked to other parts of the health system and information about all aspects of healthcare will be easily accessed by the general public and practitioners
- Primary care services will emphasise health promotion and individuals will take on more responsibility for maintaining a healthy lifestyle

6.2.5 The supporting evidence from the Literature: Understand the needs of the population

People use markedly different amounts of health care services. The distribution of health care use across a population tends to be highly skewed, with a small number of people accounting for a large share of total resources as illustrated in the Kaiser Permanente Model Figure 10. This distribution has important implications for how preventive services are targeted, how budgets are set, and how health services are regulated and evaluated.

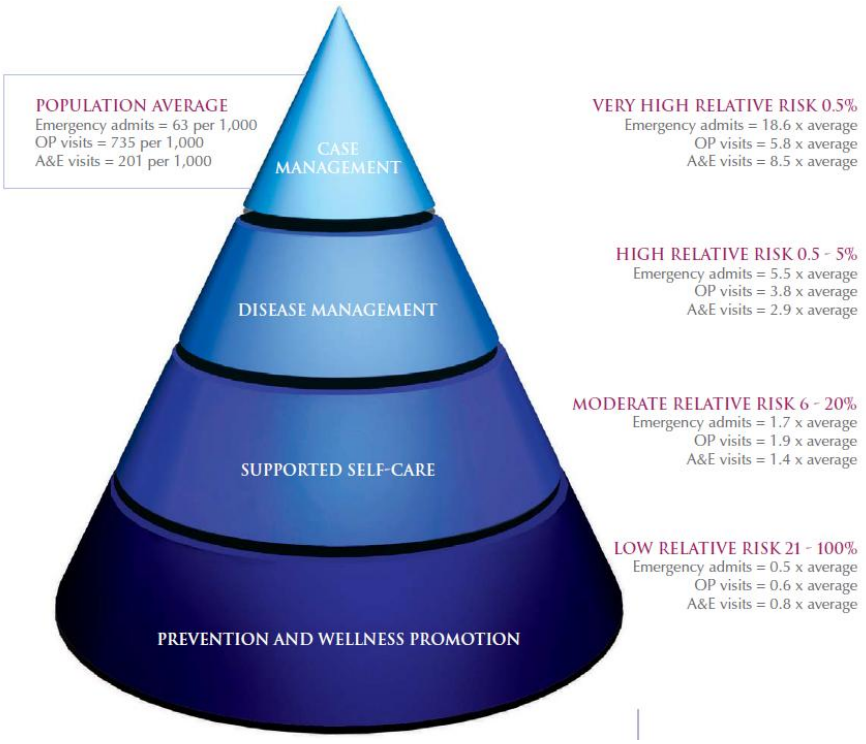


Figure 10: Assessment of segmented population healthcare usage[57]

Health care providers around the world are now using data to understand their population needs[58]. Data is collected from a variety of sources and linked. This linked data is then run through software to determine, based on current need, what the needs of patients will be for the next 12 months. Services are then targeted based on predicted patient need. This process is called risk stratification.

6.2.5.1 Long Term Conditions (LTC)

Due to the increase in proportion of older people in the population, the number of people living with a single or multiple long term conditions will increase.

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[57] Combined Predictive Model, Final Report & Technical Documentation, Health Dialogue UK, 2006

[58] 'How to' Guide: The BCF Technical Toolkit, Section 1, Population Segmentation, Risk Stratification and Information Governance, NHS England, 2014
http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/tech-toolkit/

Definition

"A long term condition is one that cannot currently be cured but can be controlled with the use of medication and/or other therapies.[59]*"*

In total it is estimated by Department of Health in the UK[60] and by Kings Fund[61] that around 70% of health care expenditure is for people with long term conditions. The issue will only get worse as the demographic change increases the proportion of people aged over 65. Figure 11 shows the proportion of people with one or more long term conditions in Scotland. The Department of Health estimates that although the number of people with one long term condition will remain fairly stable, the number with multiple long term conditions will increase.

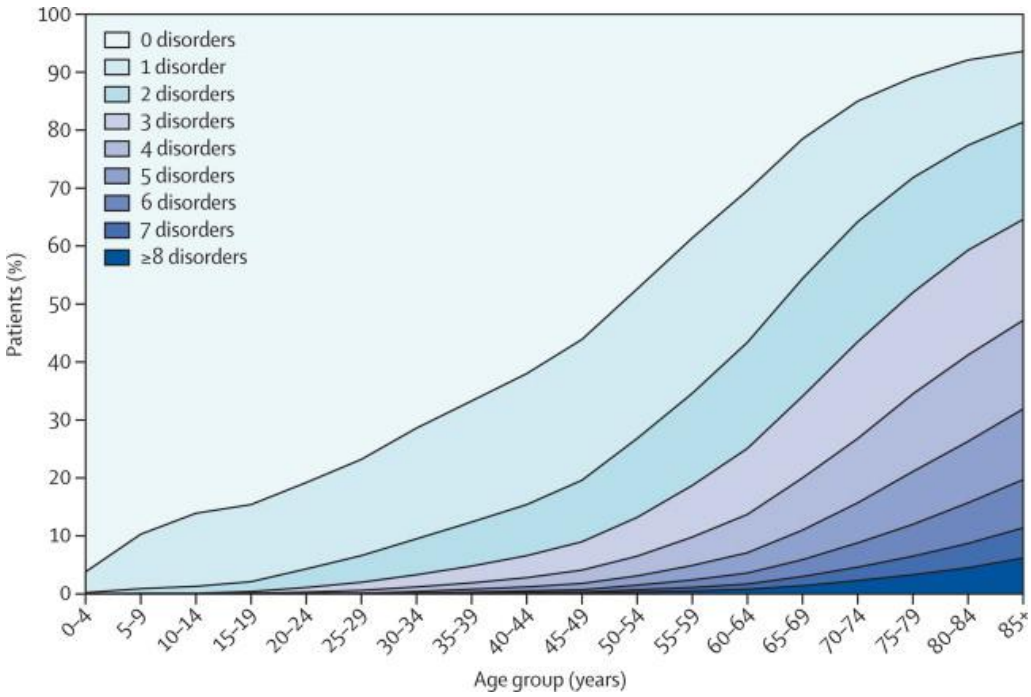

Figure 11: Proportion of long term conditions by age in Scotland[62].

[59] Improving the health and well-being of people with Long Term Conditions, Department of Health,2010
[60] Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition
[61] Delivering better services for people with Long Term conditions, The Kings Fund, 2013
[62] Barnett K,, Mercer ST,, Norbury M,, Watt G,, Wyke S,, Guthrie B., *Epidemiology of Multimorbidity and implications for health care, research, and medical eduction: a cross-sectional study*, The Lancet, 2012: DOI:10.2016/S0140-6736(12)60240-2

The burden of disease is reflected in Figure 12 showing the percentage of people with one long term physical or mental disorder that also have another one or more long term conditions.

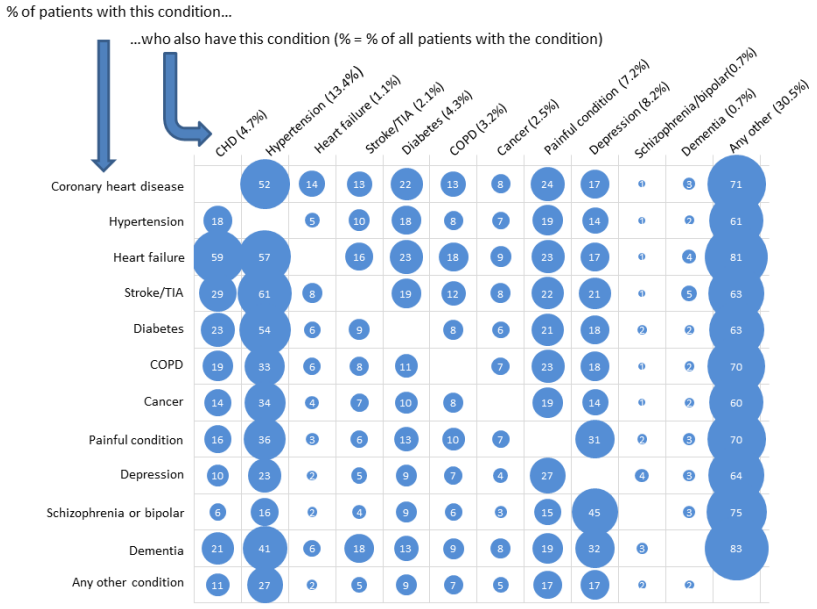

Figure 12: Percentage on patients with one long term condition who also have another one or more long term conditions [30]

In Jersey, further analysis was carried out by the Health Intelligence Unit across 40 conditions based on Professor Stewart Mercer et al work[30] and is shown in Figure 13. Further work is needed to consider whether these are the 40 most appropriate conditions for our Jersey population as these were based on a Scottish population.

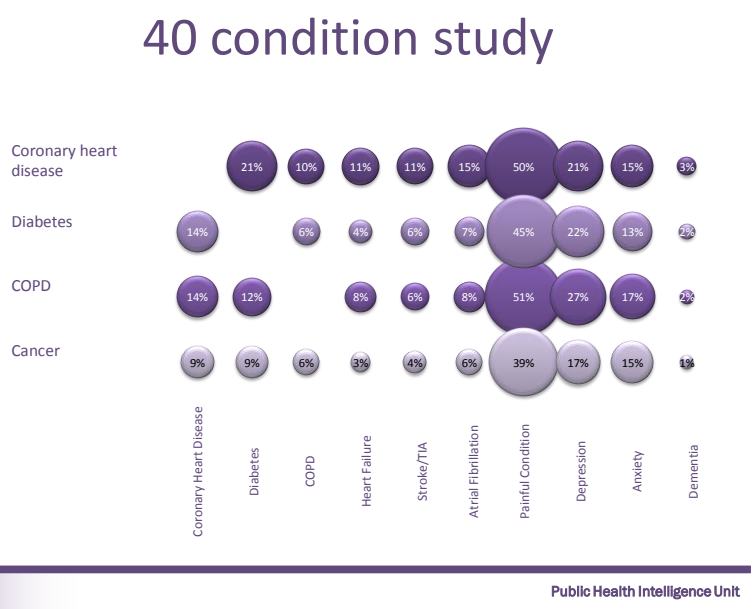

Figure: 13: Shows selected co-morbidities in people with 4 common disorders in Jersey.

These results indicate that multi-morbidity is common in the Jersey population. There is a strong correlation with age, and physical and mental conditions are frequently co-morbid. This work is the first look at multi-morbidity in the Jersey population and is the foundation to further work to map the burden on the population. The findings fit the pattern of multi-morbidity found in Scotland by the 2012 Lancet[30] study that this work is based on. Replicating these finding for Jersey raises similar questions to those being addressed by the health care system in Scotland, but also raises the question of whether there are other chronic conditions that affect the Jersey population that have not yet been considered and this is where the focus of future work in this area should first start.

The model below in Figure 14, illustrates that approximately 70% - 80% of people living with a long term condition are supported by mainstream services or manage their own condition; 20% – 30% of people would be regarded as at risk of exacerbations leading to unplanned hospital admission, and the remaining (approximately 5%) patients are highly complex and require additional support through specialist teams in order to manage their condition and maximise potential for independent living.

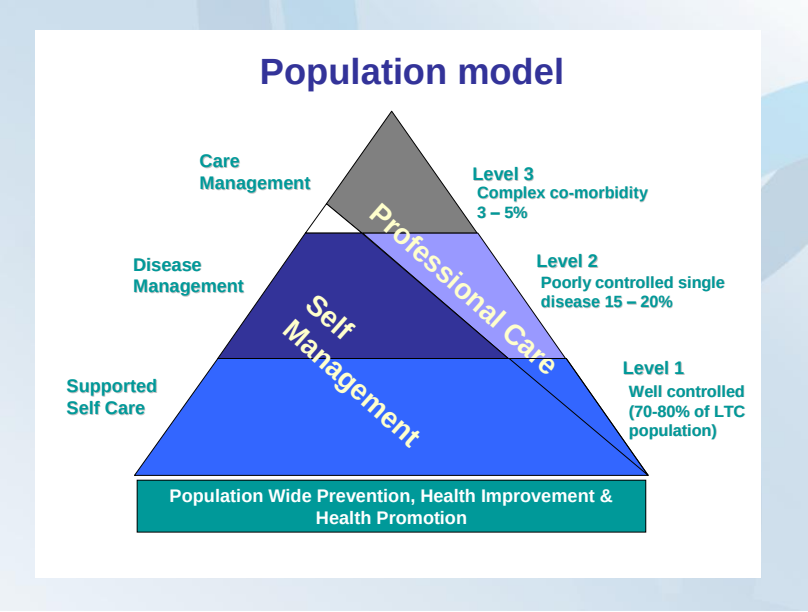

Figure 14: population model for Long Term Conditions Management[63]

6.2.5.2 Integrating the management of patients with both mental and physical health needs

This means developing a more integrated response to people with both mental and physical health problems, in particular supporting people with common mental health problems (such as, depression or anxiety) alongside a physical long-term condition[37]. At least half of all people with long-term conditions suffer from multiple co-existing conditions. Mental health problems are one of

[63] Long Term Conditions Collaborative: Improving Complex Care Scottish Government, 2009

the most common forms of co-morbidity, particularly among people from the most deprived population groups.

Mental health problems interact with physical health and can trigger or severely exacerbate other conditions. For example, depression has been associated with a four-fold increase in the risk of heart disease and a three-and-a-half-fold increase in mortality rates after heart attack[64].

Between 12 and 18 per cent of all NHS expenditure on long-term conditions is estimated to be linked to mental health problems. Across a range of conditions, each patient with co-morbid depression costs health services between 30 and 140 per cent more than equivalent patients without depression. Unidentified mental health problems often underlie 'medically unexplained symptoms', which cost the NHS around £3 billion each year and cause significant distress to patients. Improving the way we respond to co-morbid physical and mental health problems would have a high impact in terms of patient experience and clinical outcomes, since both of these are substantially poorer relative to those for people with a single condition.

6.2.6 What We Will Do: Understand the needs of the population

6.2.6.1 Develop a population needs assessment

It is important that we understand the needs of our population so that services can be designed and targeted to meet these needs. Organisations across the health and social care system in Jersey collect and handle vast amounts of data about patients. Information will be collected, linked and processed across the Whole Health System in order to understand the historical health needs of the population of Jersey. This assessment will then be used to predict future health needs for two specific reasons:

- To support funding services based on predicted future need, derived from an understanding of the current and historic patient needs
- In the near future, to support identification and proactive intervention with patients identified as high risk of requiring intense care

The Dental Review (2015)[65] recommended that a needs assessment be conducted, offering better intelligence on the demands placed on Jersey's oral health system. While the value of epidemiology surveys was questioned, the review identified opportunities to collect information by recording the oral health of children examined as part of the Community Dental Service school visits. Further opportunities may be found in the school survey conducted by Education among children in years 6, 8 and 10.

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[64] Providing integrated care for older people with complex needs: lessons learnt from seven international case studies, The King's Fund, 2014

[37] Transforming our health care system: Ten priorities for commissioners, Chris Naylor et al. The Kings Fund, 2015

[65] Review of Dental Health, Services and Benefits in 2014, States of Jersey, 2015

6.2.6.2 Strengthen Data Governance

The collection and exchange of data will be carefully controlled and managed within the relevant information governance laws. A regulation, to be approved by the States, will be developed against Schedule 3 of the Data Protection Act to provide the democratic mandate to process the data.

The population needs can typically fit into one of 3 categories as shown in Figure 15. This data will provide information on disease prevalence, social determinants and activity. This will support the design of new systems of care delivery. There is an inverse relationship with demand on health services, with the complex 5% using a lot more services than the healthy majority.

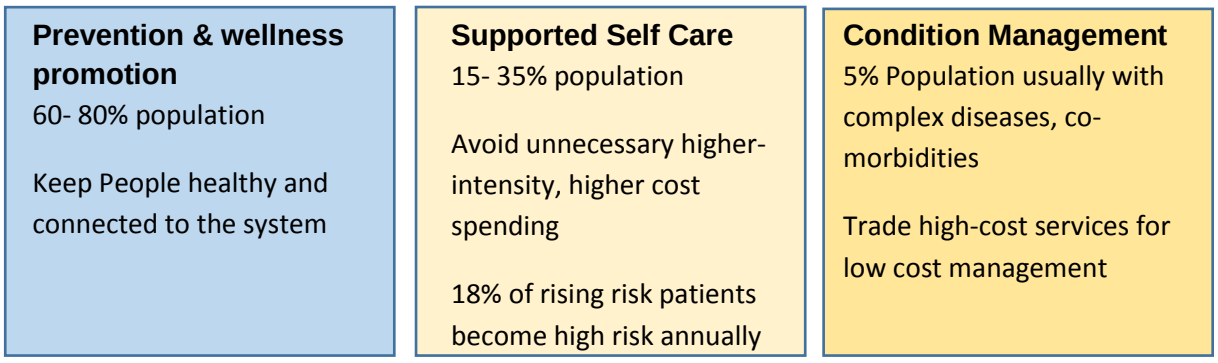

Figure 15: Categories of population needs

6.2.6.3 Define vulnerable groups

The WHO pinpoints four different ways that a vulnerable population lacks equity: economically, socially, demographically, and geographically. More often than not, a combination of these four factors contributes to inequitable health care. De Chesnay[41] adds to this by defining vulnerable groups as having greater than average risk of developing health problems because of their marginalised social status, limited access to economic resources, or personal characteristics such as age and gender[66].

Once the health needs of the population have been established, a definition of vulnerability can be set. The definition will be multi-dimensional based on clinical, financial and social need. This definition will allow vulnerable groups within the population to be identified and care to be targeted to support these groups. Targeted support will have to take cognisance of the capability and capacity to provide services, such as the extent of available budgets, which will involve political input and decision making. The definition will reviewed periodically and will be updated as required as the population needs change and evolve. This will be carried out in a framework that is safe, sustainable and affordable in Jersey.

[66] Sustainable Primary Care in Jersey – Defining vulnerability, Rachael Addicott (King's Fund), 2015

6.2.7 The supporting evidence from the Literature: Promote Prevention and Well Being

General practice is the cornerstone of primary health care, with population health and well being described as one of its key pillars[67]. Improving health and well being has a very wide scope and many of the determinants of health are, of course, not under the direct control of general practices.

"Promoting good health and preventing ill health saves money…a small shift in resource towards public health prevention activity would offer significant short, medium and long term savings to the service and to the taxpayer"[68]

Action is required now to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups. The World Health Organisation (WHO) has estimated that seven risk factors; tobacco, alcohol, low fruit and vegetable intake, physical inactivity, high blood pressure, high cholesterol, overweight and obesity account for 60 % of the disease burden in Europe[69]. A major review of the quality of general practice conducted by The King's Fund in 2011[70] concluded that:

"*General practice is regarded as uniquely well placed not just to provide medical care, but also to promote the health and well-being of the practice population and to address health inequalities. However, there has been little success in drawing GPs 'beyond the surgery door'. GPs still concentrate on what are essentially clinical activities. Generally, GPs focus their prevention-related actions on patients at high risk rather than taking a whole population approach or maximising opportunities for health promotion advice to all patients who might benefit".*

6.2.7.1 Primary Prevention

Primary prevention means taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups[71]. The goal of prevention and promoting wellbeing is to support and build an environment where people are able to realise their potential and live healthy and productive lives for as long as possible. The prioritisation of Healthy Lifestyle was identified in P82 (2012). This entails us to focus on preventing what we know is preventable, such as infectious diseases, chronic ill health and premature death. The emphasis needs to be on prevention rather than treatment. To do this there is a need to get further upstream of disease and illness to tackle and change the health damaging behaviours such as smoking, harmful alcohol consumption, poor diet and sedentary lifestyles.

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[67] What is good general practice? A philosophical study of the concept of high quality medical care, P.D.Toon, Occas, Pap R, Coll, Gen, Pract. 1994 Jul; (65): i-viii, 1-55.
[68] Using NICE guidance to cut costs in the down turn, NICE, 2009
[69] The European Health Report, WHO, 2009
http://www.euro.who.int/__data/assets/pdf_file/0009/82386/E93103.pdf
[70] Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund, 2011
[71] Transforming our health care system: Ten priorities for commissioners, Chris Naylor et al. The Kings Fund, 2015

Primary prevention is an excellent use of resources compared with many treatments. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80 per cent cost less than the £30,000 threshold used by the National Institute for Health and Clinical Excellence for cost-effectiveness[72]. More systematic primary prevention has the potential to improve health outcomes and save costs[73]. Prevention and promotion of health behaviours needs to move beyond simplistic information provision and begin to engage with and better understand patients and the wider communities' insights and expectations about health and health behaviour. New approaches drawing on commercial marketing techniques alongside understanding from behavioural and social sciences can be effectively used to engage the public in taking an increased interest and involvement in their own health. These approaches can not only be used to target the right information and key messages but also to shape the development of fit for purpose preventative interventions and programmes. Within this positive health environment primary care can be part of an effective multi-sector approach to selling the life enriching elements of health rather than a more narrow focus on preventing illness.

6.2.7.2 Secondary Prevention

Secondary prevention involves systematically detecting the early stages of disease and intervening before full symptoms develop. Secondary prevention is based on a range of interventions that are often highly cost-effective and that, if implemented at scale, would rapidly have an impact on life expectancy. There is substantial variation between practices in the systematic implementation of approaches towards secondary prevention, for example, use of disease registers. Only a minority of patients receive all recommended interventions.

Evidence suggests that this is an area where the *'inverse care law'* applies and those in greatest need are least likely to receive beneficial services. Identifying those at risk and intervening appropriately is one of the most effective ways in which GPs can reduce the widening gaps in life expectancy and health outcomes[74]. Successful secondary prevention would have a major impact on health outcomes, in terms of improvement in life expectancy and reduction in complications. Modelling by the Department of Health[75] has shown that systematic and scaled-up secondary prevention is a cost-effective, clinically significant and fast way to tackle inequalities in health in local areas. While prevention in childhood provides the greatest benefits, it is valuable at any point in life. It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated[76]. Common lifestyle risk factors cluster in the population, which has a dramatic effect on life expectancy. Addressing this clustering, and its socio-economic determinants, is likely to reduce inequalities and improve overall population health.

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[72] Supporting investment in public health: Review of methods for assessing cost effectiveness, cost impact and return on investment, Proof of concept report, NICE, 2010

[73] A pro-active approach. Health Promotion and Ill-health prevention Tammy Boyce et al, The Kings Fund,2010

[74] Marmot, Michael Author (2010) Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. London: Marmot Review.

[75] Primary Care In The Driver'S Seat: Organzational Reform in European Primary Care, Saltman H, Open University Press 2006

[76] The World Health Report 2005 - make every mother and child count, WHO, 2005

One of the more modern and increasingly common risk factors for disease which is affecting the largest proportion of our population is that of diet related disease and more particularly overweight and obesity. Effective interventions to reduce diet-related risk factors, such as Body Mass Index (BMI), could have an important impact upon the future burden of long term conditions. Reversing trends to 1993 levels, through effective policy responses, would result in a 28% reduction in type 2 diabetes and a total of £77 million costs avoided by 2034[77].

6.2.8 What We will do: Promote Prevention and Well Being

6.2.8.1 Primary and Secondary Prevention

Primary care professionals have a key role in engaging with, encouraging and supporting their practice populations to recognise the significant contribution they can make to improve their own health, that of their family and the wider community. In the current States of Jersey Strategic Plan[78] there are opportunities for a redesigned health and social care system, appropriately and effectively incentivised, to support patients towards improved health outcomes, living healthy and active lives, avoiding preventable illness whilst recognising that some people will still develop long term conditions. This could provide a new emphasis for Public Health Support within primary care. This could entail:

- Promoting a proactive approach to care, collaborating with patients to build their resilience and increase their capacity for self-care
- Ensuring systems are designed to provide care based on an individual's health and wellbeing goals
- Promoting healthy and active ageing and a salutogenic approach

In 2013, the Ministers for Health and Social Services and Social Security gave a commitment to develop a business case for dental education. Independent of this commitment the Dental Health Review (2015)[79], recommended the introduction of an education programme. The review stressed, however, that this programme should not be isolated and badged as 'Dental' or 'Oral Health' but that it be fully integrated into the Public Health agenda, arguing that common determinants of disease cut across issues such as obesity, diabetes, alcohol misuse. The education plan should also recognise a life course approach and initiate interventions and messages appropriate to specific life stage. We will discuss with Dentists how this can be progressed as part of this workstream along with Public Health.

6.2.9 The Supporting Evidence from the Literature: Patient Access to General Practice:

Most people, most of the time, report good access to care. However, there are wide variations across all dimensions of access. Since people's preferences about access to general practice vary,

[77] Public Health England, Our priorities for 2013/14 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

[78] Strategic Plan 2015-2018, States of Jersey, 2015

[79] Review of Dental Health, Services and Benefits in 2014, States of Jersey, 2015

retaining a set of measures to examine the broad picture appears reasonable. General practice needs to reach out to all those in their local community who need care but who are not currently receiving care.

Patient experience of access can be gauged through formal surveys, or informally in individual or group conversation. It can also be understood by gathering data and impressions from the patient experience of interacting with GP practices. Three components affect a patient's perception of access: patient context, technical access and practice responsiveness. The measures identified in a DOH report, *'Primary and Community Services: Improving GP Access and responsiveness' (2012)*[80] cut across three broad domains of quality of access[81]:

1. Availability and proximity of general practice
2. Timeliness (speed of access)
3. Choice (ability to see a preferred doctor or nurse)

Patients need to be able to access affordable primary care, and to believe that it will meet their immediate needs more effectively than the other options available to them. Lessons on patient access and perceptions from the case studies include[82]: Access to treatment is best offered in the most convenient and cost-effective setting *(ChenMed, Alaska);* Access need not be face-to face; phone based primary care services might provide the most cost-effective delivery model (*Medicall, HMRI, Geisinger)*; In high income countries, maximising opening hours, and offering same-day appointments will make access easier and more convenient for patients *(ChenMed, Alaska).*

6.2.10 What we will do: Patient Access to Primary Care Services

There will be a work stream which will engage with the public to better understand their needs on accessing primary care services. This will include issues such as availability and proximity of general practice, speed of access and choice (ability to see a preferred doctor or nurse).

6.2.11 The Supporting Evidence from the Literature: Improved access to information on health and services

A research report from the Patient Forum[47] summarises the best evidence available – from both research and practice – on what approaches are most effective in ensuring the accuracy, readability, relevance and impact of consumer health information. The research shows[47] that engagement improves patients' knowledge, experience and satisfaction, reduces costs through greater self-care/self-management and more appropriate use of services, and leads to improved health behaviours and adherence to treatment. Patients' ability to engage depends on finding and using health information to increase their understanding, and being supported to develop the motivation, confidence and care skills needed to actively manage and improve their own health. Providing

[80] Primary and Community Services: Improving GP Access and responsiveness, DOH, 2012
[81] Improving the quality of care in general practice: Report of an independent inquiry commissioned by The King's Fund Dr Nick Goodwin Dr Anna Dixon Teresa Poole, Dr Veena Raleigh 2011
[82] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

consumers with high quality and accessible health information helps to enhance patients' experience of care. Figure 16 shows a simplified model of the case for Information produced by the Patient Information Forum[47] and adapted here (2014).

	Quality Consumer health information **Available in a variety of formats, throughout the health and well-being journey**	
	Increased satisfaction and reduced anxiety and stress	
Greater patient engagement		
More self-care of minor ailments	**More shared-decision making**	**More self-management of long-term conditions**
Better quality care		
Greater clinical effectiveness	**Ehanced patient experience**	**Improved patient safety**
Lower costs ✓ **Reduced demand for GP services and unplanned care** ✓ **More appropriate use of services, including screening rates** ✓ **Fewer hospital admissions and less time in hospital** ✓ **Reduced variation in procdedures** ✓ **Safer, more efficient use of medicines** ✓ **Greater productivity, lower staff turnover, less abenteeism**		**Better Outcomes** ✓ **Treatment in line with patient preferences** ✓ **Better adherence to treatment** ✓ **Safer, more effective use of medicines** ✓ **Healthier behaviours** ✓ **Improved health, quality of life and psychological well-being** ✓ **Increased self-monitoring** ✓ **Greater health literacy** ✓ **Reduced health inequlities** ✓ **Fewer complaints**

Figure 16: The benefits of better patient information (adapted from the Patient Forum)[83]

Issues which should be addressed are:

- Making sure information works for users
- Formats for information products
- Accuracy, readability, relevance and impact
- Evaluation and measuring impact

[83] Making the Case for Information The evidence for investing in high quality health information for patients and the public, Patient Information Forum, 2014, www.pifonline.org.uk

Better health information can have significant impacts on service use and reduce costs[84].This includes reducing the numbers electing for major surgery, wasted medications, demand for GP consultations, A&E attendances, emergency admissions and re-admissions. Increasing the self-management of long-term conditions can yield significant returns on investment.

In giving rise to the greatest pressure on health resources, it also presents the greatest scope for reducing costs. Evidence from the Expert Patients Programme found that in England, 50% of participants reported having subsequently made fewer GP visits, while 35% reported having reduced their medications. Overall, for an investment cost of £400 per attendee, the research estimated an average net saving of £1,800 per chronically ill patient per year. Evidence from the United States[85] shows that more active patient participation in treatment decisions and patient self-management incurs significantly lower costs overall for many different long-term conditions. A study for the Commonwealth Fund[86] found the cost of health care to be 21% higher for the least activated patients than for the most activated.

6.2.12 What We Will Do: Improved access to information on health and services

We will review current sources of information and accessibility. We will scope out possible solutions to improve information and accessibility to information. We will ensure that the system will be simple to understand and administer with easily available and accessible public information and education about services, and how to access them through various media.

AMBITION BENEFITS – PATIENTS

- Understand our population needs in order to support planning and targeting services to patients with the greatest need
- Understanding the needs of vulnerable groups will improve equity in the system
- Developing population needs will make the system more efficient and equitable
- Patients will be at the centre of their care and better informed and empowered to make decisions about their care supporting quality and access
- Promotion of health and wellbeing will encourage self-responsibility and promote healthy lives
- Improve access to high quality and accurate health and services information which will improve quality, access and healthy lifestyle

[84] Making the Case for Information The evidence for investing in high quality health information for patients and the public, Patient Information Forum, 2014, www.pifonline.org.uk
[85] Making the Case for Information The evidence for investing in high quality health information for patients and the public, Patient Information Forum, 2014, www.pifonline.org.uk
[86] Making the Case for Information The evidence for investing in high quality health information for patients and the public, Patient Information Forum, 2014, www.pifonline.org.uk

6.3 Ambition 2 – Payment

6.3.1 Outline of Ambition

Ambition 2 will Review the way in which public money is used to subsidise or fully fund primary care services in order to encourage delivery of better outcomes through innovation and quality care and through assessing options for a more outcomes based care delivery focussed on meeting population health needs.

6.3.2 Emerging themes from Professional Workshops

- There will be a structured mechanism to ensure sustainable funding flows into the system so that care can be provided when it is needed.
- We will remove perverse incentives such as the rebate only being able to be paid to GP's to support innovation and new models of care
- There will be a co-payment for primary care and other specific health and social care services. The co-payment will be fair, based on the ability to pay but also designed to make sure that all patients and particularly vulnerable groups are helped to access the system at the right time and in the right place.
- There will be contracts and quality payments aligned to system objectives such as keeping people out of hospital and improving health and well being which will encourage innovation flexibility in the way care is delivered.
- Encourage transparency of pricing across all providers in order for patients to understand how much they will need to pay for a service
- Link the payment system in to the needs of the population and base it on outcomes
- Government policy should drive strategy to shift care from secondary to primary care services. This should include introducing charges for ambulatory care e.g. out patients, some emergency department attendances, hospital blood tests
- Patients will have to be registered with a General Practice

6.3.3 Patient Voice

Co-payment should stay as it gives a sense of value to service provision and it prevents the system from getting clogged up

There was an overwhelming request from patients for an increase in transparency of pricing with suggestions of a guide to prices that was visible:
"price list available in all professions so you know what you are going to pay and what you are paying for"

Confusion over services where some are paid for and others not:
"cervical screening you can pay or get free"

There were some views that children under 5 should be free for some services

6.3.4 Principles

- The general public will continue to make payments towards primary care services and will exercise choice in what service they purchase from which provider
- Public funding of primary care services will encourage primary care practitioners to work proactively to improve health care within primary care
- Public funding of all health care services will encourage primary care practitioners and other (HSS funded) health practitioners to work together to develop a comprehensive cost-effective health service and to establish an effective balance between primary, secondary and out of hospital services
- Public funding of primary care services will acknowledge additional support required by vulnerable groups
- Public funding of primary care services will develop methods for appropriate risk sharing between government and primary care practitioners
- Public funding of services will include contractual and target related payments to encourage improved data collection and care management (JQIF)

6.3.5 What We Will Do: General practice Co-payment

Patients and providers value the co-payment in General Practice as it gives a sense of worth to services being provided. The co-payment will continue to exist in General practice.

6.3.6 The supporting evidence from the Literature: Models of Systems and Funding in General Practice

Improving value for money in health care is a high priority for policy-makers across Europe and beyond. Since in most countries a large proportion of health care is funded by government, two important options available are: to change the prices paid for care; and to change the way of paying for care (the structure of payment).

A literature review was undertaken which sourced, assessed and contextualised global research on primary care service provision. *The Global Health Policy Summit (2012)*[87], highlighted the overwhelming evidence that Primary Care is a cost effective means of delivering healthcare. Yet many countries struggle to give primary care the emphasis that the evidence demands, even though current models of healthcare focused on hospitals as the main location of care giving are unsustainable.

6.3.6.1 Health Systems

Whilst every health system is unique, all face similar challenges on cost and quality. There are basically four types of funding models around the world - Beveridge, Bismarck, National Health Insurance and Out of Pocket[88] and all of them are complex[89].

[87] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[88] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[89] Securing the future of general practice: new models of primary care, Judith Smith, Holly Holder, Nigel Edwards, Jo Maybin, Helen Parker, Rebecca Rosen and Nicola Walsh, The Kings Fund/Nuffield Trust, 2013

"..no one organisational model of primary care provision should be advocated. Local context plays an important role in determining organizational form, and the precise mix of function will likewise depend on the nature and priorities of the local population"

6.3.6.2 Funding Models

Across Europe[90], a common form of payment for doctors is a blend of fee-for-service and/or capitation (for primary care doctors) and/or salary (for doctors working in hospitals). A description of different payment types if shown in Table 8. Some countries, notably the Netherlands, are experimenting with episode-based payment – a fixed amount intended to cover the costs of providing some or all services delivered to a patient for a complete episode of care. Episode-based payment generally means the payment is made to two or more providers: for example, a hospital and its affiliated primary care doctors. Episode-based payment is intended to reward a pathway of care for an individual across providers , promoting more efficient use of expensive services (for example, hospital care, acute services), coordinated care and better quality outcomes by reducing complications and readmissions.

Table 8: Types of bundled payments to providers[91]

Types of bundled payments to providers						
Bundled				**Unbundled**		
Block/ Budget Salary	**Capitation**	**Per period**	**Per patient pathway**	**Per case/ diagnosis/ procedure**	**Per day**	**Fee for service**
Periodic Global						
Periodic global lump sum- independent patients	Periodic lump sum per enrolled patients for a range of services	Periodic lump sum per patient diagnosed with a particular condition	Lump sum for all services required for a defined pathway of care	Payment per case based on grouping of patients with similar diagnosis's/procedures or resource needs	Payment per day of stay in hospital or other facility	Payment for each item of service and patient contact

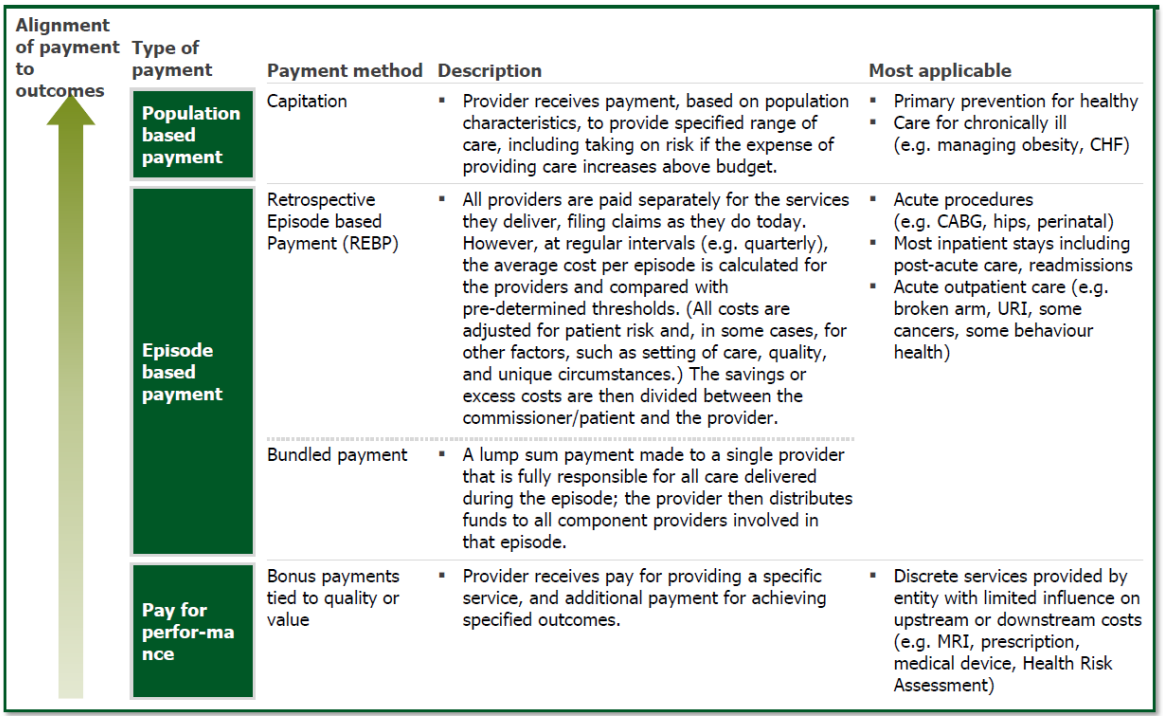
Traditional methods for funding health care provision are activity based, which is the current model in Jersey. These methods can create perverse incentives whereby it is in a provider's best interest to see patients more often[92],[93],[94].

[90] Paris, V., M. Devaux and L. Wei (2010), "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", OECD Health Working Papers, No. 50, OECD Publishing. http://dx.doi.org/10.1787/5kmfxfq9qbnr-en

[91] Reforming payment for health care in Europe Nuffield Trust 2012

[92] Commission and funding general practice: making the case for family care networks. Adicott R et al, The Kings Fund, 2013

Modern incentive systems for health care are moving more towards payment systems that are aligned to outcomes as in Figure 17. The benefits of this are that providers are freer to deliver services that are best for their business and their patients. These types of models are also more relevant to managing long term conditions.



Type of payment	Payment method	Description	Most applicable
Population based payment	Capitation	▪ Provider receives payment, based on population characteristics, to provide specified range of care, including taking on risk if the expense of providing care increases above budget.	▪ Primary prevention for healthy ▪ Care for chronically ill (e.g. managing obesity, CHF)
Episode based payment	Retrospective Episode based Payment (REBP)	▪ All providers are paid separately for the services they deliver, filing claims as they do today. However, at regular intervals (e.g. quarterly), the average cost per episode is calculated for the providers and compared with pre-determined thresholds. (All costs are adjusted for patient risk and, in some cases, for other factors, such as setting of care, quality, and unique circumstances.) The savings or excess costs are then divided between the commissioner/patient and the provider.	▪ Acute procedures (e.g. CABG, hips, perinatal) ▪ Most inpatient stays including post-acute care, readmissions ▪ Acute outpatient care (e.g. broken arm, URI, some cancers, some behaviour health)
	Bundled payment	▪ A lump sum payment made to a single provider that is fully responsible for all care delivered during the episode; the provider then distributes funds to all component providers involved in that episode.	
Pay for perfor-ma nce	Bonus payments tied to quality or value	▪ Provider receives pay for providing a specific service, and additional payment for achieving specified outcomes.	▪ Discrete services provided by entity with limited influence on upstream or downstream costs (e.g. MRI, prescription, medical device, Health Risk Assessment)

Figure 17: Capitation aligns payment to outcomes and incentivises primary and secondary prevention Source: London Health Commission[95]

Peckham and Gousia (2014)[96] carried out a comprehensive review of different GP payment structures, including capitation. Interestingly, no papers from the UK were included. Despite this, the review indicated that capitation models increase preventative care (Canada) and reduce total costs for all services (USA), but may increase referral rates to hospitals and specialists (Norway) and shorten consultation times (USA).

Another example is the Alzira public–private partnership in Spain[97]. The Alzira contract has been operating under a capitation budget covering hospital and primary care since 2003. The cost per

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[93] GP payment schemes review, PRUComm Policy Research unit in commissioning and the health care system, Professor Stephen Peckham, Dr Katerina Gousia, 2014

[94] Self-care and Case Management in Long-term Conditions: The Effective Management of Critical Interfaces Report for the National Institute for Health Research Service Delivery and Organisation programme, David Challis, University of Manchester, April 2010

[95] Allocation and payment innovation, The London Health Commission, Technical pack October 2014 http://www.londonhealthcommission.org.uk/wp-content/uploads/Allocation-and-payment-innovation.pdf

[96] GP payment schemes review, Professor Stephen Peckham, Dr Katerina Gousia, October 2014 Policy Research Unit in Commissioning and the Health Care System http://www.kent.ac.uk/chss/docs/GP-payment-schemes-review-Final.pdf

[97] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

patient is 80 per cent less than in districts with a traditional model of provision and reimbursement, Payment systems for doctors working outside hospitals are usually a blend of fee-for service and capitation funding. Research suggests that too heavy a reliance on fee-for service or capitation is likely to reduce efficiency – a blend of these different approaches is most likely to strike a better balance between incentivising responsiveness to patient needs and quality with cost-efficiency and budgetary control. Most countries are continuing to experiment to find the right blend in line with changing circumstances and priorities. Table 9 shows how payment methods can influence provider behaviour.

Table 9: How payment method influences provider behaviour[98]

Payment methods	Provider behaviour			
	Prevent health problems	Deliver services and solve health problems	Respond to people's legitimate expectations	Contain health care and transaction costs
Global budget (and salary)	++	−−	+/−	+++
Capitation (with competition)	+++	−−	++	+++
Diagnostic-related payment	+/−	++	++	++
Fee-for-service	+/−	+++	+++	−−−

Key: +++ very positive effect; ++ some positive effect; +/− little or no, or variable, effect; − − some negative effect; − − − very negative effect.

Figure 18[99] illustrates how the widely used fee for service payment mechanism, with a low level of accountability and financial risk for the provider may lead to sub-optimal outcomes. Instead the system should move towards payment mechanisms that create accountability and incentivise correct behaviours.

[98] Reforming payment for health care in Europe to achieve better value Research report Anita Charlesworth, Alisha Davies and Jennifer Dixon August 2012 Nuffield Trust

[99] Key Issues in healthcare: Island Healthcare Perspective, KPMG, 2015

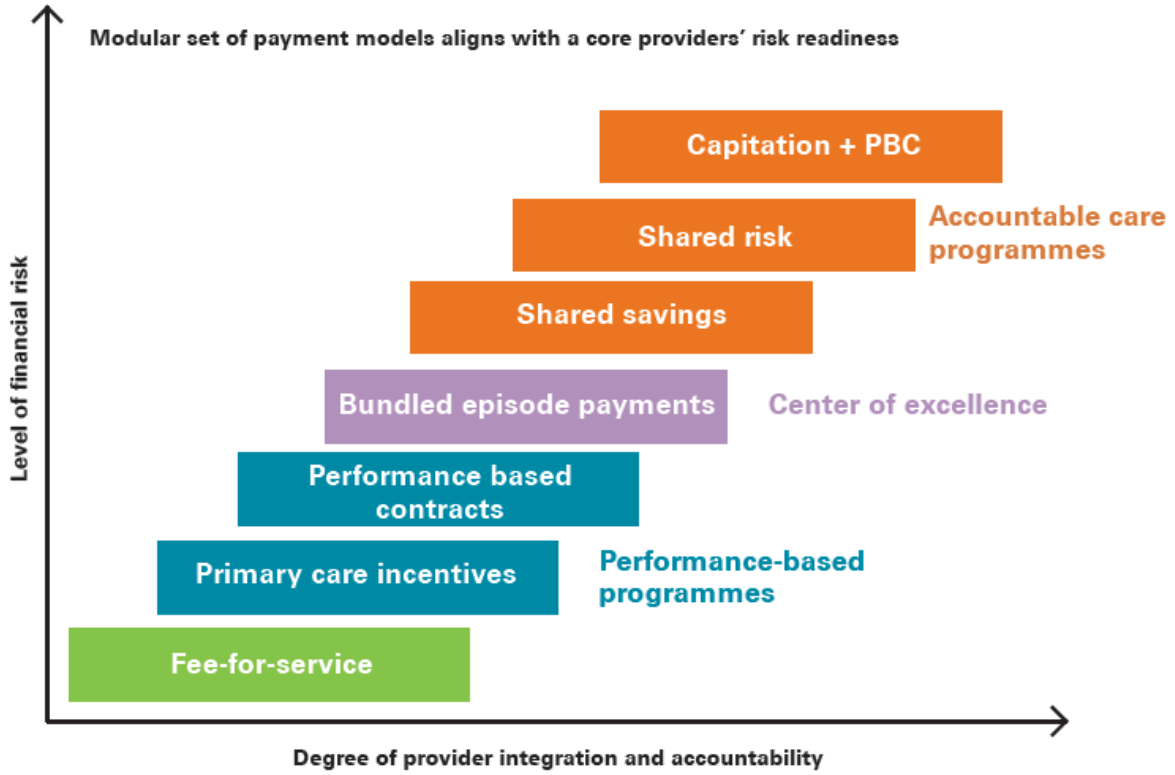

Figure 18: Value based payment continuum

The New Zealand Independent Practitioner Association (IPA) experience[100] highlights the importance of primary care organisations being clinically led and owned. Some of these organisations have evolved into important and influential bodies, enabling significant capacity for the planning, development and support of local primary care providers. As IPAs have expanded, the retention of strong links to front-line practices and practitioners has been critical to their success. IPAs demonstrate the potential of GP-owned provider networks to deliver benefits for member practices, while becoming sophisticated primary care development and management organisations at the heart of new integrated health care networks.

A review of paying for integrated care[101] concluded that there is limited evidence on the effects and effectiveness of financial incentives and other payment models in integrated care. Most of the incentives have been applied in very specific settings or are at an early stage of implementation, with little or no evaluation available as yet. Countries should therefore take a cautious approach when designing and implementing integrated care schemes with the use of financial incentives and innovative payment models, particularly as success in one setting may not be transferable elsewhere due to different cultural and organisational contexts across systems.

[100] Primary Care for the 21st Century, Ruth Thorlby, Judith Smith, Pauline Barnett and Nicholas Mays, Nuffield Trust, 2012
[101] Cristina Hernández-Quevedo, Rayden Llano and Elias Mossialos, Eurohealth Observer 19;2;2013

A key requirement for the development of effective payment schemes is the availability of information systems that can be used to measure and assess the structure, processes, and outcomes of care. If used, financial incentives need to be designed carefully so as to reduce the likelihood of unintended negative consequences. This requires careful selection of incentive-linked, risk-adjusted performance measures, which should be closely associated with improvements in health. A combination of both process and outcome measures may represent the best approach. In addition, the size of the incentive is likely to be important in influencing provider behaviour in integrating care. Ultimately, however, financial incentives in isolation are unlikely to be a sufficient condition for success. The successful uptake and on-going viability of integrated care models is more likely to depend on the complementary use of financial and non-financial incentives.

6.3.7 What We Will Do: Payment in General Practice

Different payment systems will be assessed jointly with stakeholders, with the support of a Health Economist. Options will be developed and evaluated and a preferred approach taken forward. Pilots will be run to test a new payment mechanism. This will also allow us to identify and assess any unintended consequences prior to full roll-out. The outcomes delivered under a new public funding scheme will be defined and agreed between GP's, Health and Social Services (HSSD) and Social Security Department and The States of Jersey Government, whereas how services are delivered will be up to the providers themselves. To enable this work, compulsory registration will be introduced whereby all patients will have to register with a preferred GP practice. Patients will still be allowed to move or change between practices.

6.3.8 The supporting evidence from the Literature: Models of Funding in Pharmacy

Primary care pharmacists have a significant role to play in improving the quality of services and access for patients through commissioning support regarding which medicines should be publicly funded to ensure cost-effective use of resources when decisions are required. They also support clinical governance through review of prescribing data and providing support and feedback to individual prescribers to ensure safe and cost-effective prescribing strategies are adopted[102].

The medicines optimisation agenda aims to ensure the safe and effective use of medicines to enable the best possible outcomes. The recently published NICE Clinical Guidance[103] supports the further development of the roles of primary care pharmacists.

Medicines management supports better and more cost-effective prescribing in primary care, as well as helping patients to manage medications better. Good medicines management can help to reduce the likelihood of medication errors and hence patient harm. There is a considerable body of evidence from the point of view of patient safety, service efficiency and cost that medicines management needs to be improved. In 2011, in the UK, 961.5 million prescription items were

[102] Now or Never: Shaping Pharmacy for the future, Judity Smith, Catherine Picton, Mark Dayan, The Report of the Commisssion of future models of care delivered through pharmacy, Royal Pharmaceutical Society, 2013
[103] Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE, 2015

dispensed in primary care alone at a cost of £8.8 billion. Medication errors occur in up to 11 per cent of prescriptions, mainly due to errors in dosage[104].

The average number of medicines prescribed for people aged 60 years and over in England almost doubled from 21.2 to 40.8 items per person per year in the ten years to 2007. Between one-third and one-half of all medication prescribed for long-term conditions are not taken as recommended[105].

6.3.9 What We Will Do: Models of Funding in Pharmacy

Currently the majority of drugs and medicines prescribed in the community by a GP are provided free of charge; prescription fees of £2.10 per item have been levied historically but were set to zero in 2008. It is likely that the States will consider reintroducing a fee.

The Health Insurance Law has recently been amended to allow the States to enter into a contract with Pharmacists. Using this new facility the States would like to explore the option of a pharmacy contract where a range of services could be commissioned, to the benefit of the wider primary care system and to draw on the range of skills and services pharmacists could offer islanders.

An independent advisor will be commissioned to assist in the exploration of options, to offer expert insight, international comparisons, clinical and financial analysis and to draft the contract.

6.3.10 What We Will Do: Models of Funding in Dentistry

The Dental review[106] suggests the island will struggle to move forward with our provision of dental services and benefits without putting in place improved management information and governance.

An action that has been agreed is to examine *"the potential for expanding the range of those eligible to partake in the Jersey Dental Fitness Scheme."* The future development of that scheme will be considered, alongside the 65+ Healthcare scheme and other dental spend, as part of the Action Plan and in conjunction with the implementation of the primary care strategy. These activities will be identified and championed by a working group and are likely to include a rationalisation of administration cost (creating savings which might be diverted to revise existing services), prioritisation of Dental Hospital services and changes to the process for identifying and supporting people wishing to receive benefit.

6.3.11 What we will do: Models of funding in Community Nursing

To support integration of primary care services and the provision of nursing in the community, funding of community nursing will be considered in the context of the other services covered in this strategy and HSSD funding, Charitable funding and patient co-payment.

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[104] The frequency and nature of medical error in primary care: understanding the diversity across studies. Sandars J; Esmail A; Fam Pract. 2003 Jun;20(3):231-6

[105] Medicines adherence Involving patients in decisions about prescribed medicines and supporting adherence, NICE, 2009 http://www.nice.org.uk/guidance/cg76/resources/guidance-medicines-adherence-pdf

[106] Review of Dental Health, Services and Benefits in 2014, States of Jersey, 2015

AMBITION BENEFITS – PAYMENTS

- Patient co-payment will remain and will support patients to receive the right care in the right place at the right time. This ensures high quality, efficient safe and effective care
- Payment will be linked to outcomes incentivising preventative care, improved quality and efficiency
- Providers will be able to deliver services in the best way for patients improving all of the performance measures (Quality, Access, Efficiency, Equity and Healthy lives)
- Funding flows will encourage integration between professionals improving system efficiency
- A new Pharmacy contract will be developed in order to draw on the range of skills and services pharmacists could offer islanders
- The Dental Health Review will form the focus of a working group to review current contracts and payment systems in Jersey

6.4 Ambition 3 – Partnerships (Integration)

6.4.1 Outline of Ambition

Ambition 3 is to efficiently and effectively co-ordinate and integrate patient care across the whole health and social care system.

6.4.2 Emerging themes from Professional Workshops

- The system needs to be evidence based on proven integrated care pathways between providers and parts of the system, leading to effective collaboration between clinicians, patients and others
- Clinical service developments should be designed and implemented in collaboration across the whole system through the Clinical Forum
- There will be a mechanism for integrating patient care records across the whole system

6.4.3 Patient Voice

Comments particularly from older people and carers about the lack of continuity with their health records and having to tell their story each time to a different person in health care:
"no patient held records- need to pull records together"

On patient records
"development of health passports"

6.4.4 Principles

- The strategy will require strong leadership along with expert project management support
- Funding streams to support the implementation will need to be clearly identified
- Closer clinical working relationships between primary and secondary care will be developed through the Clinical Forum
- The system will be underpinned by clear, evidenced based care pathways delivered by integrated multidisciplinary teams ensuring seamless delivery of care to the right person, at the right time and in the right place.
- There will be a single care record for each citizen, accessible (with appropriate safeguards) to the individual and the health and social care professionals involved in their care and support

6.4.5 The supporting evidence from the Literature: Support primary care providers to develop new, integrated ways of working

Integrated care means different things to different people:

"The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to impose the patient's perspective as the organising principle of service delivery[107]*"*

Integrated care does not evolve naturally, it needs to be nurtured. Integrated care does not appear to develop as a normal response to emerging care needs in any system of care whether this is planned or market-driven. Achieving the benefits of integrated care requires strong system leadership, professional commitment, and good management. Systemic barriers to integrated care must be addressed if integrated care is to become a reality.

The move away from a disease-centric model of care towards a patient-centred multi-morbid system raises several challenges for those working to deliver structure care:

- Moving away from incentivisation that is disease specific
- Development of multi-morbid disease management templates which are geared towards the individual patient and take into account common psychosocial factors such as depression and the needs of carers
- Development of integrated care pathways which are not disease specific

6.4.6 The supporting evidence from the Literature: Integrated leadership for primary care

Clinical leaders are defined as those who retain their clinical duties in some capacity, but at the same time hold responsibilities for *"strategic direction, resource management and collaborative learning*[108]*"*. A recent report by the Nuffield Trust[109], commented on the need to support GPs in leadership roles, providing the resources, support and protected time to be better placed to influence key decisions. In scaled-up general practice organisations there will be a growing requirement for primary care clinicians to 'step up' to more formal administrative posts, becoming equally accountable for clinical and financial outcomes.

Clinicians (Including medical, Allied Health Professionals and nursing) bring front-line knowledge about their organisation and credibility among their peers. A critical factor for sustainable change is ensuring front-line professionals *'own'* the improvement agenda[110]. Implementing new ways of

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[107] Integrated care for patients and populations: Improving outcomes by working together, Goodwin et al, The Kings Fund,2011

[108] John Edmonstone, (2009) "Evaluating clinical leadership: a case study", Leadership in Health Services, Vol. 22 Iss: 3, pp.210 - 224

[109] Transforming general practice: what are the levers for change? Rebecca Rosen Nuffield Trust 2015

[110] How Intermountain trimmed health care costs through robust quality improvement efforts. James BC1, Savitz LA. Health Aff (Millwood). 2011 Jun; 30(6):1185-91. doi:

learning, working and improving care requires skills in understanding, motivating and leading teams, as well as in planning, tracking and evaluating organisational strategies. However, one survey of GPs attending NHS Institute for Innovation and Improvement training in 2010 reported that 96 per cent described *'how to engage and lead their colleagues in new ways of working'* as one of their chief unmet learning needs[111].

A critical question is how general practice will be encouraged, incentivised and supported to form new networks or organisations that can enable the delivery of redesigned primary care. Reliance on a *'heroic'* model of leadership, where an individual drives the development of an organisation (the most frequently found approach in general practice innovation to date), will no longer suffice in a context of a majority of part-time and sessional practitioners[112].

6.4.7 What We Will Do: Integrated leadership for primary care

We will assess the role of Primary Care Leadership within the Health and Social Care system as a whole, including how Primary Care continues work with HSSD along with accountability and leadership for the Primary Care Strategy. This will have strong links with the Primary Care Governance Team. There will be a project team appointed to support the implementation phase of the Sustainable Primary Care Strategy. Providers and clinicians will continue to be involved in primary care strategic development through the continuation and development of the Sustainable Primary Care Implementation Board. The aim is to transition this to become business as usual.

6.4.8 The supporting evidence from the Literature: Integrated sustainable funding for health and social care

Health and Social Care in Jersey is already integrated under HSSD, but does not include primary care. In NHS England and other jurisdictions, significant improvements have been seen in pulling together health and social budgets- this is terms "*pooled budgets*". "*Pooled budgets*" combine funds from different organisations to purchase integrated support to achieve shared outcomes. This will enable organisations to build on previous joint working experience in order to fund truly integrated care services[113].

The most important advantage to commissioners of a "*pooled budget*" is the ability to align providers against a common set of outcomes for their population. This should support an improvement in the quality of care delivered and a reduction in the duplication of functions, which in turn will represent better value for the system. This is because "*pooling budgets"* makes it easier for providers to deliver the care people need. Instead of having to deliver highly specified services targeting narrow outcomes against fragmented budget codes, providers can personalise interventions according to the best interests of individuals and respond much faster when needs change. In Torbay, for example, "*pooled commissioning budgets*" enabled providers to create health-

[111] Quality improvement in general practice Paresh Dawda Richard Jenkins Robert Varnam, The Kings Fund, 2010

[112] Securing the future of general practice: new models of primary care, Judith Smith, Holly Holder, Nigel Edwards, Jo Maybin, Helen Parker, Rebecca Rosen and Nicola Walsh, The Kings Fund/Nuffield Trust

[113] North West London Integrated Care, http://integration.healthiernorthwestlondon.nhs.uk/section/what-do-we-want-to-achieve-by-pooling-budgets

and social-care coordinator roles to focus on services that helped individuals. They were able to take an overview of all the steps involved in the care process, and strip out those which were not necessary. By focusing on a shared set of goals across commissioners they were able to dramatically improve response times. A working group of providers, commissioners and service users believed that to achieve Whole Systems Integrated Care, budgets should be pooled whenever they fund services that are critical to achieving shared outcomes. They believed that "*pooled budgets*" had many benefits, including[114]:

- Flexibility for providers to invest in whatever keeps people well, whether it is more health or more social-care, rather than managing services separately against different contracts and budgets
- Innovation as funds can pay for other models of care and services that meet holistic health- and social-care needs. This could result in improved convenience for people who receive care and reduced duplication of cross-cutting services by using pooled funding for one multi-disciplinary team from across health- and social-care rather than separate services
- Closer working and collaboration as money is shared and decisions are made together
- Enabling use of capitation to fund providers to look after whole population groups and achieve shared outcomes rather than focusing on activity
- Faster decision-making as there are fewer steps in a process to agree the funding of care for individuals that cut across commissioners responsibilities. In Torbay, for example, pooled budgets enabled professionals to be able to stop doing *"two of everything"* in order to meet the requirements of different commissioners, which speeded up implementing care packages after a referral from weeks to hours.

6.4.9 What We Will Do: Integrated sustainable funding for health and social care

At a Government level, a proposal to fund the priorities has been put forward including the introduction of a health charge by 2019.The charge is likely to be introduced in a phased way with the £35 million target by 2019 at the latest. The solution will need to be cognisant of the Fiscal Strategy and may be a mix of new contribution charges for individual as well as point of service charges.

Within Primary Care, the various funding streams within primary care will be reviewed and recommendations made to integrate budgets where possible, to simplify integrated working across primary care.

[114] North West London Integrated care, http://integration.healthiernorthwestlondon.nhs.uk/section/what-do-we-want-to-achieve-by-pooling-budgets-

6.4.10 The supporting evidence from the Literature: Develop a Clinical Forum

In New Zealand, the development of 'Health Pathways' is cited as one of Canterbury's most innovative and most effective changes[115]. At a superficial glance, 'Health Pathways' looks very like a set of guidelines for treatment, or the Map of Medicine but in their application they are much more than that. Developed from 2008 on, Health Pathways are in essence local agreements on best practice. They are created by bringing together hospital doctors and GPs in order to discuss what the patient pathway for a particular condition should be. They identify which treatments can be managed in the community; what tests GPs should carry out before a hospital referral and where and how GPs can access such resources (including referral to other GPs whose practices have particular skills – spirometry, for example, or the removal of skin lesions or the insertion of IUDs.

6.4.11 What We Will Do: Develop a Clinical Forum

A Clinical Forum will be the vehicle for developing closer clinical working relationships between primary and secondary care, with clinicians from the hospital and a range of primary care providers. This Forum will have defined Terms of Reference, an agreed chair and agreed timetable of work with appropriate reporting and governance structures. It is envisaged that the Clinical Forum will report to the Transformation Strategic Steering Group and upwards to the Ministerial Oversight Group. It will make recommendations, after considering data and evidence, on service improvement based on clinical perspectives and what is best for the patient. The forum will agree standard, integrated clinical pathways for shared care services and for referral between primary and secondary care to the best interests of patients.

6.4.11.1 Models of Management for Long Term Conditions

There is a wealth of evidence regarding models of for managing long term conditions, and the management of long term conditions represents the most significant proportion of spend on health care services. The King's Fund estimates that around 70% of expenditure is related to people with Long Term Conditions. A King's Fund report [116] illustrated the whole-system approach needed to improve care, and emphasises the interdependency of each part. The Year Of Care Programme, using the 'House of Care Model [74,] Figure 19, found that effective care planning consultations rely on three elements working together in the local healthcare system: This model emphasises the importance and interdependence of each element – if one is weak or missing the structure is not fit for purpose.

[115] The quest for integrated health and social care: A case study in Canterbury New Zealand, The Kings Fund 2012

[116] Delivering better services for people with long-term conditions: Building the house of care, Authors Angela Coulter Sue Roberts Anna Dixon, Kings Fund October 2013

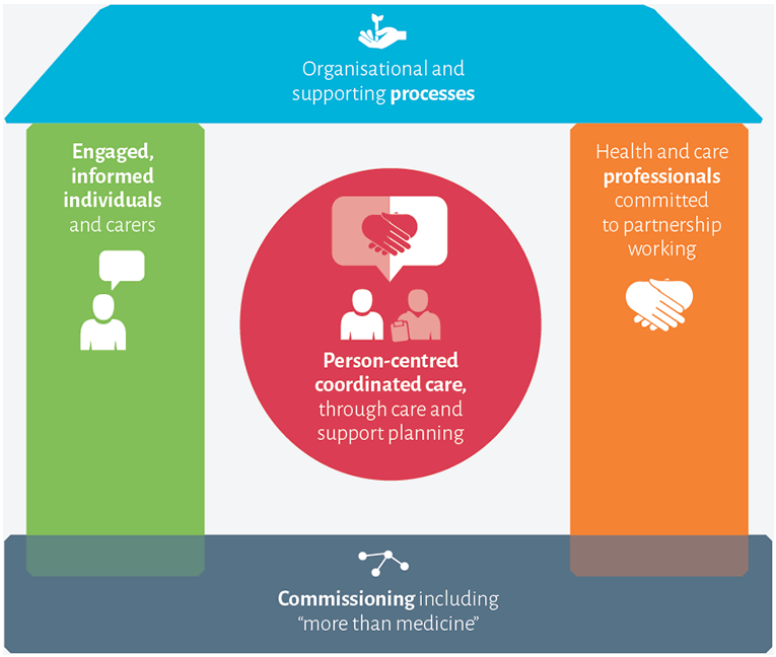

Figure 19: House of Care model[117]

The King's Fund [73] outlined key lessons for wider implementation. Culture and systems must change to support a new way of working. Ownership, local innovation and tailoring, and strong clinical (usually primary care) leadership –*'right from the top, right from the start, right the way through'.* This must be supported by local flexible commissioning, practice facilitation and tailored training – 'making it easy to do the right thing'. Staff must be clear about their roles, and where planning fits in the local pathway/model of care. Acting on these lessons requires the following four enablers to be in place[118]:

1. Payment systems and incentives that are aligned behind the purpose of integrated care
2. Specific objectives related to the improvements in quality and outcomes that will support the partner organisations to work together to deliver these objectives
3. Networks and alliances between providers with the leadership and other capabilities needed to work effectively
4. Commissioners able to use their leverage to support the development of integrated care through innovations in payment systems and contracting

[117] Ref: Personalised care and support planning handbook: The journey to person-centred care Executive Summary, NHS England 2015
[118] Accountable care organisations in the United States and England Testing, evaluating and learning what works, Stephen Shortell, Rachael Addicott, Nicola Walsh, Chris Ham. March 2014 Kings Fund

6.4.11.2 Community Care (Multi-disciplinary Working (MDT))

The working group convened by The King's Fund recommended that teams of community staff should be developed around groups of practices and forge very close working relationships with them. These teams need to include both generic and specialist staff. Appropriate multidisciplinary skill-mix is essential (GPs, nurses, generic support workers, therapists, social workers), with effective delegation of tasks to the right level. For example, advanced nurse practitioners should be freed up to support patients with complex conditions, and provide appropriate supervision and training for other clinicians. The team should also include integrated care co-ordinators who can support the management of patients with long-term conditions. The community team will need generic mental health skills due to the high level of anxiety among patients with long-term conditions (and its concomitant impact on readmissions) and the growing number of patients with dementia. In fact, it may be that this team will take on a significant amount of work currently done by specialist mental health providers. The team will also need access to more specialist support (see below)[119].

Shifting some of aspects of general practice work from doctors to nurses or clinical pharmacists is another approach to dealing with increasing pressures in primary care. A review by University of York [120] found two relevant systematic reviews addressing role substitution; a Cochrane review evaluating nurse-doctor substitution in primary care settings and a review of pharmacist services provided in general practice clinics.

The Cochrane review included 16 studies evaluating three different approaches to nurse-doctor substitution: nurse responsibility for first contact and ongoing care for all presenting patients; nurse responsibility for first contact of patients wanting urgent consultations during routine practice hours or out-of-hours; and nurse responsibility for ongoing care of patients with chronic conditions. The review found similar health outcomes for patients in the short-term whether they saw a nurse or GP in all three models of care. Patient satisfaction was higher when nurses rather than doctors provided first contact for urgent consultations. Doctor workload was reduced in the few studies that reported the outcome. While there was no appreciable difference in resource use between nurses and doctors, nurse productivity appeared to be lower, with longer consultations and a greater rate of recall than doctor consultations. Additional training and experience may help to counter the difference in productivity, however very few of the studies clearly reported the level of training nurses received to undertake these enhanced consultation roles[121].

In the same University of York review, clinical pharmacist services delivered in primary settings were evaluated in 38 randomised controlled trials included in a recent systematic review. The majority of the included studies were conducted in the USA and Canada, with six studies conducted in the UK. Pharmacist services included medication review, education, lifestyle advice, adherence assessment,

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[119] Community services: How they can transform care, Nigel Edwards, Kings Fund, 2014

[120] Enhancing access in primary care settings, The University of York, Centre for Reviews and Dissemination, 2015

[121] Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD001271. DOI: 10.1002/14651858. CD001271.pub2.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001271.pub2/abstract

monitoring and adjusting therapy, predominantly for patients with long-term conditions such as diabetes and hypertension. Positive effects were seen for medication adherence, resolution of medication-related problems and quality of life. There were limited or no effects on patient satisfaction and costs[122].

Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours; and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership[123]. There are a number of well-established self management programmes that aim to empower patients to improve their health. A review of the evidence has highlighted the importance of ensuring the intervention is tailored to the condition. For example, structured patient education can be beneficial for people with diabetes, while people with depression may benefit more from cognitive and behavioural interventions.

6.4.11.3 Managing Ambulatory Care-Sensitive Conditions (ACS)

Ambulatory care-sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension.

Maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes. Emergency admissions to hospital are distressing, so better management that keeps people well and out of hospital should lead to a better patient experience. According to The King's Fund[124] estimates, emergency admissions for ACS conditions could be reduced by between 8 and 18 per cent simply by tackling variations in care and spreading existing good practice.

Early identification of ACS patients is crucial if their management is to be successful. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices. The review also suggested that improvements in the quality of primary and secondary care are needed, for example:

- Increase continuity of care with a GP
- Ensure local, out-of-hours primary care arrangements are effective
- For those with acute aggravated conditions, ensure there is easy access to urgent care
- Conduct early senior review in A&E, and implement structured discharge planning

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[122] Tan EC, Stewart K, Elliott RA, George J. Pharmacist services provided in general practice clinics: a systematic review and meta-analysis. Research in Social and Administrative Pharmacy 2014; 10(4): 608-622 http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?AccessionNumber=12013063836&UserID=0#.VY0QNO1VhBd

[123] Transforming our health care system Chris Naylor Candace Imison Rachael Addicott David Buck Nick Goodwin Tony Harrison Shilpa Ross Lara Sonola Yang Tian Natasha Curry, Kings Fund, 2015

[124] Transforming our health care system: Ten priorities for commissioners, Kings Fund,2015

6.4.11.4 Care co-ordination

Co-ordination of care for people with complex chronic illness is a global challenge. Driven by broad shifts in demographics and disease status, long-term conditions absorb by far the largest, and growing, share of health care budget. Co-ordination of care for patients with complex needs and long-term illness is currently poor and those with long-term conditions have a lower quality of life. Robust evidence on health outcomes is limited, but improved care co-ordination can have a significant effect on the quality of life of older frail people and people with multiple long-term conditions.

Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience. Impact on costs and cost-effectiveness is less easy to predict and is likely to be low in the short term given the upfront investments required. However, health systems that employ models of chronic care management tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction[125].

Some of the key components are:

- A move to community-based multi-professional teams based around general practices that include generalists working alongside specialists
- A focus on intermediate care
- Case management and support to home-based care joint care planning and co-ordinated assessments of care needs
- Personalised health care plans and programmes with named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey
- Clinical records that are shared across the multi-professional team.

6.4.11.5 Improving primary care management of end-of-life care

Within primary care, improving the systematic identification of patients who are at the end of life, and then providing the appropriate support; in particular, improving the co-ordination of care, continuity, quality of communication, and the provision of bereavement care is important. Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do. Research by The King's Fund[126] has identified many examples of how improvements in end-of-life care can have a high impact on patient experience as well as the experience of family members and End-of-life care is provided in a variety of settings by a wide range of professionals.

[125] The King's Fund: Providing integrated care for older people with complex needs: lessons learnt from seven international case studies, 2014

[126] Providing integrated care for older people with complex needs: lessons learnt from seven international case studies, The King's Fund, 2014

To meet patients' needs, a whole-systems approach is needed that co-ordinates care across professional and organisational boundaries. GPs are in a central position to do this. Commissioners should drive a whole-systems approach that focuses on the availability of a range of services across the care pathway, such as: facilitation of discharge from the acute setting rapid response services during periods out of hospital centralised co-ordination of care provision in the community guaranteeing 24/7 care.

6.4.11.6 Improving the management of patients with both mental and physical health needs

A recent King's Fund report[127] identified that at least half of all people with long-term conditions suffer from multiple co-existing conditions. Mental health problems are one of the most common forms of co-morbidity, particularly among people from the most deprived population groups. Mental health problems interact with physical health and can trigger or severely exacerbate other conditions. For example, depression has been associated with a four-fold increase in the risk of heart disease and a three-and-a-half-fold increase in mortality rates after heart attack.

Across a range of conditions, each patient with co-morbid depression costs health services between 30 and 140 per cent more than equivalent patients without depression. Improving the way we respond to co-morbid physical and mental health problems would have a high impact in terms of patient experience and clinical outcomes, since both of these are substantially poorer relative to those for people with a single condition. There could also be a significant impact on costs. Integrated models of disease management have been found to deliver savings four times greater than the investment required, as have enhanced models of liaison psychiatry in acute hospitals.

6.4.12 What We Will Do: Support primary care providers to develop new, integrated ways of working

The role of Primary Care will be central to the 'out of hospital' system. This includes the management of long term conditions as outlined in the Out of Hospital Outline Business Case. Key features include: we will adopt the use of the 'House of Care' Model; we will develop integrated pathways of care through the Clinical Forum; we will develop multi-disciplinary teams (MDT) within primary care and with secondary care colleagues in order to create patient-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health and social care systems .

6.4.12.1 Improving primary care management of end-of-life care

Within primary care, we will improve the systematic identification of patients who are at the end of life, and then provide the appropriate support; in particular, improving the co-ordination of care, continuity, quality of communication, and the provision of bereavement care. We will support the current 'gold standard framework' work currently being led by Jersey Hospice Care, which includes funding for GP champions and pharmacists.

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[127] Transforming our health care system: Ten priorities for commissioners, Chris Naylor et al. The Kings Fund, 2015

6.4.12.2 Develop a more integrated response to people with both mental and physical health problems

We will align our strategy with the Mental Health strategy in order to develop a more integrated response to people with both mental and physical health problems, in particular supporting people with common mental health problems (such as, depression or anxiety) alongside a physical long-term condition.

AMBITION BENEFITS – PARTNERSHIP

- Development of Primary Care leadership will support improved quality and efficiency
- The integrating of budgets will provide improved efficiency
- Public funding of primary care services will develop methods for appropriate risk sharing between government and primary care practitioners.
- A Clinical Forum working across the whole system, with clinical leadership will support safer delivery of care contributing to improved quality, access, efficiency and equity
- We will develop multidisciplinary teams within Primary Care and Secondary care to case manage specific high-risk groups in order to provide effective integrated care

6.5 Ambition 4 – People

6.5.1 Outline of Ambition

Ambition 4 focuses on the staff within Primary Care. The aim is to ensure that there is a strong workforce now and for the future to support provision of primary care services.

6.5.2 Emerging themes from Professional Workshops

- Skills are being lost as they are not being used
- Recruitment of skilled staff will become increasingly difficult
- Professionals should be able to use the full range of their skills: cultural, legislative and funding barriers will need to be addressed
- The system will be designed to attract and retain a motivated, multi skilled workforce through the creative development of enhanced clinical roles offering career progression, attractive terms and conditions alongside appropriate remuneration based on skills, competencies and training

6.5.3 Patient Voice

Specific training issues were highlighted for some Contractor groups:
"midwives and health visitors should have regular training"
"appropriate mental health training for GP's"

6.5.4 Principles

- Understand the profile of current workforce in primary care –demographics, skills and training needs
- Develop primary-care structures to encourage appropriate range of healthcare professionals to enter and remain in primary care sector, fully utilising their professional training
- Ensure that training and CPD opportunities fully support a sustainable primary care sector

6.5.5 The supporting evidence from the Literature: Workforce and Training Needs Analysis:

Many EU countries report difficulties both in retaining and recruiting health staff. Reasons vary between EU countries. It can be due to unattractive jobs, poor management or few opportunities for promotion. In a number of EU countries, the economic crisis has increased the outflow of health professionals – the so-called *"brain drain".* These problems concern us all. Everybody is a patient at some point in their lives and patients deserve access to high quality care from a well-qualified workforce[128].

[128] Recruitment and Retention of the Health Workforce in Europe, European Commission 2015

In all the case studies in the Global Health Policy Summit report[129], there was a deliberate reshaping of the workforce away from the traditional hierarchical medical model, and towards a wider skill-based team approach. This reshaping increased the capacity of the system to respond to demand, and enabled quality to be delivered at a lower cost.

6.5.5.1 General Practice

The GP workforce demographic is changing. A Taskforce Report[130] identified that 65% of GPs currently in training in the UK are women and 40% of women who leave practice each year are under the age of 40, and it is not known how many of them rejoin the workforce. There is an increased trend for both men and women to work part time and be salaried. So increases in headcount do not translate into increases in whole time equivalent GP's.

The current UK general practice workforce has insufficient capacity to meet current demand and expected patient needs. A snapshot survey in February 2013 in NHS England of 220 practices, covering around 950 full-time positions, suggested that the number of unfilled GP posts had gone up fourfold in the last two years. The results showed vacancy rates of 7.9% of all GP posts in January 2013, almost double the 4.2% figure from the previous year's survey in January 2012, which itself was twice the DH baseline figure of 2.1% from the last survey in 2010[131].

An insufficient number of UK medical graduates currently want to become GP's. The 2014 recruitment round has seen a 15% reduction in the overall number of GP applications. In the UK, only around 20-30% of recent graduates indicate General Practice as their unreserved first choice career, a statistic that has remained relatively stable over the last 20 years. Too many indicate preferences for over-subscribed hospital-based specialties; Switzerland, Canada, America, France and Greece have all described similar problems recruiting GP's. This could have a 'knock-on' effect to recruitment of GP's in States of Jersey.

6.5.5.2 Pharmacists

Primary care pharmacists play a significant part in managing medicines. They have a strategic role to focus on maximising benefit and minimising risk of medicines, as well as making the best use of resources allocated for medicines.

In recent years there has been a focus on strengthening the role of primary care, preventing people from becoming ill and encouraging healthier lifestyles so as to keep them out of hospital. Prevention is better than cure and pharmacists are ideally placed to deliver improvements health outcomes and improve the efficiency of service delivery through medicines optimisation.

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[129] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

[130] Securing the Future GP Workforce Delivering the Mandate on GP Expansion GP Taskforce Final Report, NHS England March 2014

[131] In-depth review of the general practitioner workforce, Centre for Workforce Intelligence, July 2014

In *'Prescription for Excellence'*[132], published by the Scottish Government, a new role for Pharmacy was outlined in Scotland. It described new ways for Pharmacists to work in Primary Care stating that pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and eliminate adverse events whenever possible. With the increasing number and complexity of patients with multiple conditions, it stated:

"An essential role of the clinical pharmacist working within the team will be to initially assess the patient for potential issues to help inform the choice of medication. In addition they will be responsible for the continual monitoring of the effects and side effects of the medicines and making adjustments to dose and therapeutic agent within agreed parameters"

6.5.6 What We Will Do – Commission a Workforce and Training Needs Analysis in Primary Care

Conduct a workforce survey and training needs analysis across primary care in order to produce a workforce strategy to assess the options to:

- Develop primary-care structures to encourage the appropriate range of healthcare professionals to enter and remain in primary care sector, fully utilising their professional training
- Ensure that training and CPD opportunities fully support a sustainable primary care sector
- Develop the role of the pharmacist to deliver more care by creating a contract drawing on an experience of pharmacy contracts in other jurisdictions; identifying the services and outcomes which should be included in a Jersey pharmacy contract; creating the pharmacy contract which will assist in improving skills and coordination between pharmacist, GPs and other health professionals
- Develop the role of the nursing profession in Primary Care

Workforce development is key to delivering good governance and an efficient (VFM) service and people planning is required to develop a service which is sustainable. The Dental Health Review (2015) did not complete a workforce survey but anecdotal reports suggest a sizeable cohort of clinicians may reach retirement age within short succession of one another. The ability of Jersey to attract and develop the right mix of skills is a key factor in the ability of the future system to meet demands. The Strategy should also consider mechanisms to invest in the workforce so they may develop the skills to manage dental data, the activities of practitioners and develop their practice in line with future requirements.

[132] Prescription for Excellence: a vision and action plan for the right pharmaceutical care through integrated partnerships and innovation, The Scottish Government 2013

AMBITION BENEFITS – PEOPLE

- Improved understanding of workforce and skills base across Primary Care in order to be more efficient and effective
- Improved role development, which is more cost effective
- Increased staff satisfaction, which is more efficient
- Improved recruitment and retention, which is more efficient
- Improved understanding of Terms and conditions in private provider system to ensure the alignment needed to allow effective service integration

6.6 Ambition 5 – Processes

6.6.1 Outline of Ambition

Ambition 5 focuses on two processes, IT and Governance, which enable the system to run efficiently and to a high standard.

6.6.2 Emerging themes from Professional Workshops

- The system should include stringent governance standards, regulation and enforcement
- Standards should be set based on evidence
- Clear processes and quality standards to define access, accuracy, security, management, audit and reporting of the data in the system.
- There should be consistency and accuracy of data input
- The patient voice should be heard across the system
- There will be system-wide alignment of ICT investment to support service delivery in all settings and information technology will be used to improve patient care through the application of clinical management tools.
- There will be independent regulation, inspection (and sanctions for poor quality) aimed at ensuring patient safety across the whole system and quality of care and patient experience will be continually evaluated and improved.

6.6.3 Patient Voice

Confusion around how to make a complaint against any other contractors*:*
"call for an independent complaints system for dentist and GPs'"
"Trip Advisor type rating for GP's and dentists"

6.6.4 Principles

- Patient information across the whole system will be available to all clinicians involved in care and to patients
- Independent regulation and inspection (and sanctions for poor quality) aimed at ensuring patient safety across the whole system
- Information about patient satisfaction and experience of services will be published on a regular basis
- Single Island Complaints process to develop a cross –system learning culture. Emphasis still to be on resolution by the provider where possible.

6.6.5 The supporting evidence from the Literature: Primary Care Governance

An article by Brinkenhoff[133] outlines a helpful description when thinking about accountability for public services with them having three, inter-related elements:

[133] Brinkenhoff D (2003) Accountability and Health Systems: Overview, Framework, and Strategies. Abt Associates

1. Accountability for strategic decisions on provision and the allocation of resources, particularly which services are provided and to whom

2. Accountability for the quality of services delivered – such as access, clinical quality, safety and outcomes

3. Accountability for the management of resources – including value for money, probity and fairness

6.6.5.1 Patient Surveys and Feedback

Achieving quality, as perceived by the patient, is a central aim of quality improvement strategies, and requires the involvement of patients in evaluating care performance[134]. However, a historic shortcoming of the NHS and Jersey as a whole, is that too little attention is paid to data on patients' experience, and too little time devoted to involving patients in decision-making. The key point is that this data must not only be collected but must be acted on.

In the NHS, there is increasing use being made of patient-reported outcome measures, but their routine collection is currently limited to surgical procedures. Further work is needed to develop valid patient-reported outcome measures (PROMs) for use in general practice. Pressure from patients to drive higher-quality services is important, and needs to be encouraged.

For the practice, it means invaluable direct feedback that can be used to improve services[135].

- Why do this?: benefits (Figure 20)
- What do we need to think about?: key considerations for practices
- How do we make it happen?: resources available to practices

Benefits for the patient	Benefits for the Practice
Helps to improve communication between patients and staff	Builds trust and communication between patients and staff
Helps patient to shape the practice services that they use	Provides information about patient experience to help improve planning and services
Patents gain a better understanding of the services at the Practice and how to use the Health and Social Care service as a whole	Practice identifies people's needs and want and this can be used to develop accessible and responsive services
	Helps to grow patient confidence in the Practice

Figure 20: Benefits of patient surveys and feedback[136]

[134] Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund, 2011
[135] Improving access, responding to patients A 'how-to' guide for GP practices.DOH, 2012
[136] Improving access, responding to patients A 'how-to' guide for GP practices.DOH, 2012

6.6.6 What We Will Do: Primary Care Governance

- For General Practice, continue with the current governance arrangements
- Consider expanding the existing Primary Care Governance Team in order to incorporate Pharmacists , Dentists and Optometrists
- For Dentists, the Dental Health Review (2014)[137] identified gaps in local governance arrangements. The aim would be to seek to further the quality of care and monitor adherence with the requirements of the General Dental Council and contributing clinical expertise to the delivery of a sustainable strategy. The Governance stream of work also calls for greater clarity in the roles and responsibilities of departments, bodies and other stakeholders, these will be agreed and clarified. A new Dentistry (Jersey) Law has recently been developed by HSS to provide for the local registration of all types of professional involved in providing dental care. The implementation of this new law will be a useful step in the future development of an appropriate governance system.
- Introduce 2-yearly patient satisfaction surveys with primary care services

6.6.7 The supporting evidence from the Literature: Information Technology (IT)

The report from the International Global Forum for Health care innovators (2015)[138], stated that a comprehensive electronic record that allows data sharing across both providers and patients i.e. an integrated care record, is the cornerstone and a key enabler for integrated working.

The use of information and technology to improve care for patients also varies. In some places, IT is put to impressively wide use. A 2009 survey found that Australia, Italy, the Netherlands, New Zealand, Sweden, and the United Kingdom, have near universal usage of electronic health records with high functionality. By contrast, in that same year, only 20% of surgeries were making comparable use of health IT[139].

In addition to providing patient records and provider performance data, technology can also benefit healthcare by improving services and delivering care remotely. However, up to now, the use of technology in healthcare delivery generally, and primary care in particular, has tended to centre on improving the existing model, rather than on transforming the model, as has happened in other sectors, such as consumer banking.[140]

[137] Review of Dental Health, Services and Benefits in 2014, States of Jersey, 2015
[138] The population Health Enterprise International Global Forum for Health Care Innovators, 2015
[139] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[140] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012

The global Health Policy Summit Recommends[141]:

- Share information across all clinicians in contact with patient to support proactive care
- Create transparency in primary care quality to drive up performance of clinicians through peer pressure (e.g. through releasing balanced scorecard on the Web so patients can access it)
- Provide primary care clinicians with transparent information about cost and quality of specialist and facility referrals they make (e.g. a monthly report issued by payer that they can review)
- Address information-governance issues to ensure ability to share appropriately

6.6.8 What We Will Do: Information Technology (IT)

The Informatics Strategy[142] states a number of aims. We will support these and ensure Primary Care is prioritised. The specific deliverables of the Primary Care Integration Business Case are:

- GPs electronic ordering of Pathology, Radiology and Clinical Investigations requests.
- GPs receiving result reports electronically from Pathology, Radiology and Clinical Investigations.
- GPs referring patients electronically.
- GPs receiving discharge reports electronically.

This will lead to efficiency savings through more streamlined processes and removal of re-keying of requests/results, reducing headcount and savings on postage and stationery.

This will ensure that we can support the current and future health and social care operating model and the changes that will create. As health and social care services continue to grow and evolve, informatics will be key in managing and controlling expenditure and ensure we deliver effective and efficient health and social services.

In Dentistry, the Dental Health Review 2015[143] encountered difficulties in quantifying the service currently offered and identified gaps in management information, particularly in the Dental Department. As a priority the Action Plan should seek to identify opportunities to improve the functionality of the current IT systems as part of the HSSD Informatics strategy and to integrate this, possibly via future upgrades, to its Patient Management systems.

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[141] The Global Health Policy Summit: Primary Care - The Central Function and Main Focus, Sir John Oldham,2012
[142] Health and Social Services Department Informatics Strategy 2013-2018, States of Jersey, 2013
[143] Review of Dental Health, Services and Benefits in 2014, States of Jersey, 2015

6.6.8.1 *Introduction initiatives through JQIF to increase standardisation and data quality in general practice.*

- The IT systems will move towards using the JY number as the unique patient identifier in line with the e-gov strategy
- To enable this work, compulsory registration will be introduced whereby all patients will have to register with a preferred GP practice. Patients will still be allowed to move or change between practices

AMBITION BENEFITS – PROCESSES

- Governance and standards will give enhanced confidence in quality of care and will reduce risk, improve safety and quality
- Development of IT will provide efficiencies and will support clinicians to make patient centred decisions

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7 Implementation Plan

This section outlines how this Strategy will gain approval from stakeholders and Politicians, the communication process for the strategy and how the transition into implementation will happen once the strategy is approved.

7.1 Strategy Approval Process

The strategy has been developed as collaboration between government departments (HSSD, SSD and Treasury) and key stakeholders including provider groups across primary care, community and voluntary and patient groups. As this strategy has an effect and influence on government policy, it must be approved by ministers, for which there is a formal process which is summarised in Figure 21. This will determine whether a proposition to the states is required.

Figure 21: Strategy approval process

7.2 Targetted Communication

Consultation is based on the principle that people affected by a decision should be involved in the decision-making process. It is an exchange of views, which aims to identify issues, develop or change policies, test proposals or evaluate provision. The sustainable primary care strategy will be communicated to key user and stakeholder groups with an opportunity to feed back and influence. There are no options or questions being asked, however, feedback will be included in the scope of the implementation plan which will influence the direction of the strategy and the way it is applied in practice.

Targeted communications will be planned and facilitated by the Sustainable Primary Care Project Team and will involve all members of the primary care board to spread the content of the strategy and to collect comments and input.

7.3 Next Steps

Following the approval of the strategy, work will begin on planning the implementation using best practice project management principles (PRINCE2 and APM). Provisional work streams have been identified from the five ambitions in the strategy, shown in figure 22. The sustainable primary care project board will nominate a sponsor for each ambition; the sponsor will be the person or group with the authority to enable actions to be completed and any required change to be implemented. A central Sustainable Primary Care project team will support and facilitate.

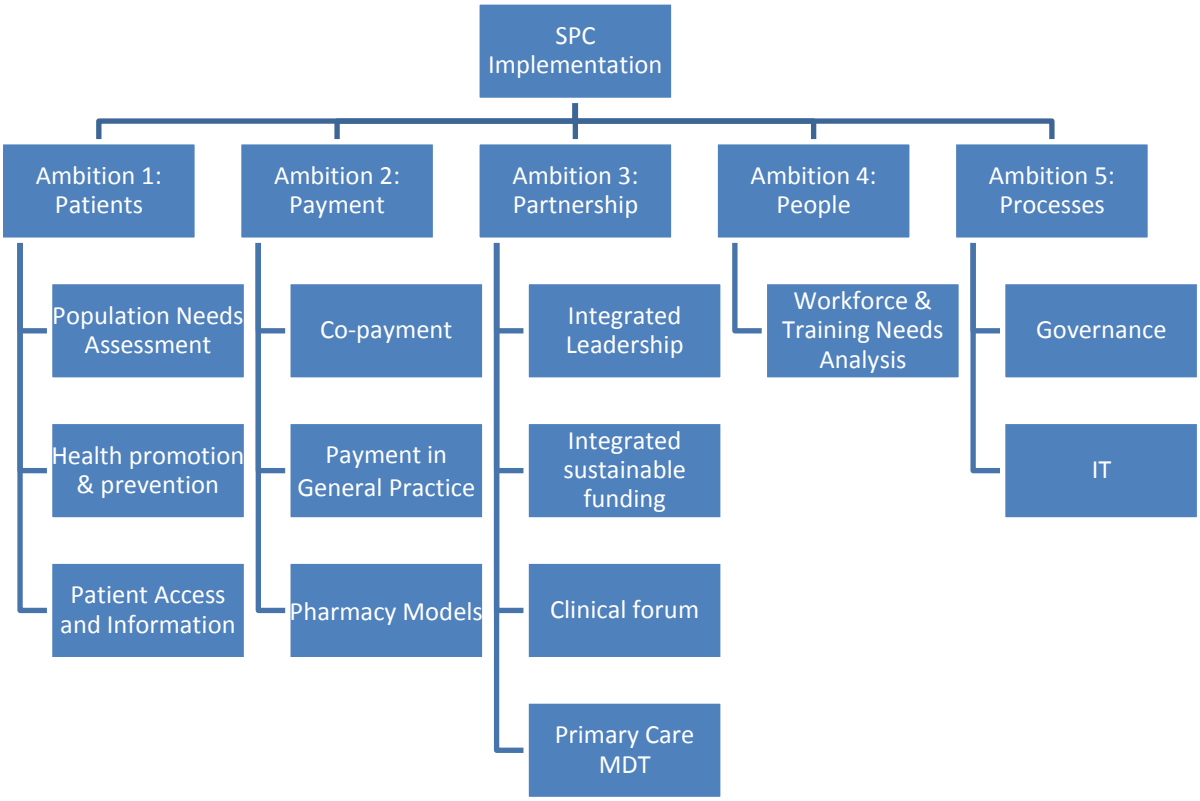

Figure 22: Provisional work steams for delivery of the Sustainable Primary Care Strategy

The work streams will be defined in depth to produce a project scope. This will be supported by the ambition sponsor, a work stream lead, the project team and other stakeholders that have knowledge, experience or challenge. From this scope, a budget, schedule and risk register will be developed and a further approval review process will be held involving board stakeholder groups ahead of commencing the implementation. Where the scope is too risky or costly, a decision on priorities will be made by the project board. Once developed, the implementation plan will integrate with other strategic projects to ensure alignment of deliverables and dependencies.

During implementation, the lead for each work stream will feed into the monthly primary care implementation board. Membership of each group will be widened out from the project board to include people with relevant skills and experience of each work stream subject. Experts will be commissioned where required to support identification and assessment of options e.g. a health economist for assessing potential payment and contracting models. Pilots will be used to review

preferred options in real situations and to ensure there are no un-intended consequences of change prior to a managed roll out.

The project lifecycle is shown in Figure 23. This shows the full extent of the project across the strategy timeline and shows the process from strategy approval, to planning, to implementation to business as usual. The traffic lights provide opportunities for review prior to moving to a subsequent phase. The implementation of the strategy will take the full time period of the strategy to 2020 and changes will not be implemented before being thought considered and tested.

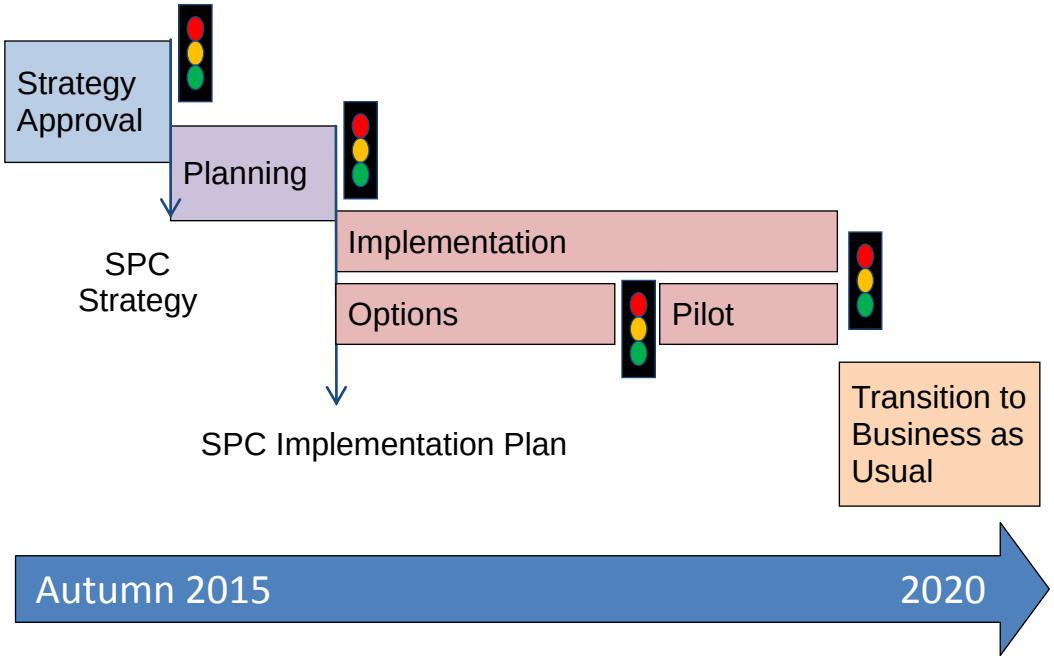

Figure 23: The Sustainable Primary Care Project lifecycle