STATES RESOURCE PLAN 2001 (P.124/2001): AMENDMENTS

Lodged au Greffe on 28th August 2001
by the Health and Social Services Committee

STATES OF JERSEY

STATES GREFFE

180 2001 P.124 Amd.

Price code: D

STATES RESOURCE PLAN 2001 (P.124/2001): AMENDMENTS

REVENUE EXPENDITURE

(1)(a) *in sub-paragraph (i) of paragraph (a) for the figure* £375,319,000 *substitute the figure* £377,106,000; and

(1)(b) *in paragraph (b) for the figure* £359,199,000 *substitute the figure* £360,986,000 *and after the date* 2002 *insert the words* except that the total net revenue expenditure for the Health and Social Services Committee shall be £103,239,000.

CAPITAL EXPENDITURE

(2) *At the end of sub-paragraph (ii) of paragraph (d) insert the following words* -

and to agree that, as stated on page 19 of the report, and subject to the necessary approvals being in place, the General and Acute Hospital Extension project be permitted to commence in 2005.

HEALTH AND SOCIAL SERVICES COMMITTEE

Note: The graphs included in the printed document are not available in this electronic version. The printed document can be obtained from the States Bookshop, Morier House, St Helier, Jersey, JE1 1DD Telephone (+44) 1534 502037

REPORT

Part A: Revenue

1. Introduction

1.1 Governments all over the world are wrestling with the need to invest heavily in health and social services. The need stems from an ageing population, advances in medical science and technology, an increasingly knowledgeable public with high expectations, and a call for greater accountability and openness in medical practice following some high profile disasters in the United Kingdom. The latter "clinical governance" issue will require significant investment, if we are to continue to be able to recruit first-class clinicians, meet the requirements for a continuing reduction in the working hours of junior doctors and respond to the effects of increased medical specialisation, clinical audit and revalidation.

1.2 During the course of the last two Health and Social Services Strategies for 1993 - 1997 (P.76/1992) and 1997 - 2000 (P.106/1996), the States approved in principle two per cent per annum real growth.[1] For clarity, real growth was defined as increases which are over and above those required for pay awards, inflation and capital servicing. Actual real growth has averaged only 1.1 per cent per annum during the period in question. This level of real growth is significantly less than that invested in health and social care by the United Kingdom and all our remotely comparable European neighbours. The table (included on page 4 of the printed document) illustrates the recent investment made in different jurisdictions.

Whilst comparisons of expenditure are notoriously difficult given the differences in healthcare systems, the general trend as indicated above is irrefutable. For information, recent investment in the United Kingdom NHS amounts to 7.3 per centper annum real growth (on average) during each of the last three years.[2]

1.3 Over the last decade, Health and Social Services manpower growth has been equally modest. The table (included on page 6 of the printed document) illustrates the cumulative percentage growth in States Manpower (8.7 per cent) compared with that of the Health and Social Services Committee (-0.3 per cent) for the period in question. These figures have been agreed with the States Human Resources Department.

1.4 The relatively modest increase in finance and the reduction in manpower needs to be seen against a back-cloth of significant growth in activity and a steady improvement in the range of health and social services available. If one considers the general hospital, the number of inpatients has increased by 32 per cent for the period 1990- 2000. Diagnostic tests have also increased considerably in number, for example radiology workload has increased by 58 per cent. The demand for renal dialysis has increased sixfold over the same period and continues to rise rapidly In 1996 the Committee also took on responsibility for social services, which required, and continues to require, a significant investment in services for older people, children, the mentally ill and those with physical and learning disabilities.

1.5 It can be seen from the graphs (included on pages 8 and 10 of the printed document) that very significant increases in the amount of work being done by Health and Social Services has been achieved with very modest increases in finance and no increase in manpower.
This increase in "productivity" as many would now call it, has only been achieved because those working in health and social care are extremely committed and prepared to go beyond the call of duty on a regular basis in order to meet patient needs. However, there is a limit to what can reasonably be expected of people.

Members are reminded that the States funded a service review of the Health and Social Services department which was completed in 1999 at a cost in excess of £250,000. The review confirmed the service offered value for money and was in need of investment in some areas. The Health and Social Services Committee was the first to establish an Audit Committee in 1995, that is, before the States Audit Commission was formed. Some significant savings have

been made but more recent audit reports are clearly stating the need for increased investment in services. The Committee believes it has done all it can to ensure cost-effective services and urges the States not to bury its head in the sand. The local service is trying desperately hard to respond to the needs and reasonable expectations of the public and of members of this House. Unless the investment requested is forthcoming, the service will not keep pace with the United Kingdom, let alone our closer European neighbours.

2. The current position

The Committee has developed a Strategic Plan for the period 2001 - 2005 which has been widely circulated for consultation and clearly identifies the issues which need to be addressed. It also identifies the need for five per cent per annum real growth at least during the early years of the strategy. A financial review, commissioned on behalf of the Policy and Resources, Finance and Economics, Employment and Social Security and Health and Social Services Committees, is about to commence. This review will determine -

(a) the increase in expenditure that government is likely to have to fund during the short to medium term;

(b) the means by which the funding might be provided;

(c) performance measures which will help to inform future funding decisions.

The review should help the States decide the level of investment in health and social services it wishes to make from 2003 onwards. Therefore, the only question that needs to be answered now is whether five per cent real growth is reasonable and affordable for 2002. Attached is a copy of the department's medical manpower plan, which complements the strategy for the period 2001 - 2005, (Appendix 1) and an overall development plan for 2002 (Appendix 2). The latter identifies the specific services which will be developed within a five per cent real growth framework. Included for comparison is a list of those projects which can be initiated within a 3.17 per cent real growth increase, as currently offered by the Finance and Economics Committee.

States members will note that five per cent real growth in finance will also require the Health and Social Services Committee's manpower establishment to be increased by a net 55 full-time equivalent posts. Whilst acknowledging this to be a very significant increase, these staff are essential and should be seen in the context of zero manpower growth over a period of more than ten years. Given the United Kingdom health service has budgeted for an additional 20,000 nurses and 10,000 doctors by the end of 2004, recruitment needs to be sooner rather than later, or the already diminished pool of skilled clinical staff will be empty. That is one of the reasons for requesting significant investment during the early years of the strategy.

The Resource Plan refers to the Health and Social Services Committee being afforded 7.5 per cent growth in real terms. This conclusion stems from the Finance and Economics Committees unilateral decision to redefine the notion of "real growth", without reference to any other Committee. Attached at Appendix 3 is a breakdown of the increase offered to the Health and Social Services Committee from 2001 to 2002. In this Committee's view real growth is the additional money available to enable the service to respond to -

(i) the increasing number of patients/clients who present each year for treatment and ongoing support;

(ii) advances in medical science and technology;

(iii) clinical governance issues.

In summary, the 11.4 per cent increase in budget proposed by the Finance and Economics Committee can be explained as follows: pay awards and Social Security contributions 5.93 per cent; inflation 0.94 per cent; Reciprocal Health Agreement contributions 1.54 per cent (only 0.44 per cent relates to 2002); a balancing transfer from Health and Social Services Committee's budget of -0.2 per cent and finally growth of 3.17 per cent. To claim that the Health and Social Services Committee has received 7.5 per cent "real growth" is totally misleading (see Appendix 3).

3. Conclusions

Governments throughout the world are recognising the need to respond to unprecedented growth pressures in health and social care. The United Kingdom health and social care system is undergoing significant change and enjoying substantial investment in order to improve the quality of services and ease access to them. Jersey faces the same pressures and, in the face of rising public expectations, it would be unacceptable if local standards were to fall

significantly below those of our near neighbours.

If the Health and Social Services Committee does not receive five per cent revenue growth in real terms, the quality and range of services will decline. It will be inevitable that waiting lists will rise and some services will be curtailed. The Committee will be compelled to consider increasing charges and introducing new charges for some services. It is likely there would be significant public dissatisfaction with the level of service provision. This is spelt out, not with the intention of 'shroud waving' but so that States members are fully aware of the consequences should they make a decision not to support the request for five per cent revenue growth.

This amendment represents an opportunity to make the most important investment in the health and social well-being of people in Jersey for many years. The additional sum requested amounts to £1.787 million and States members are urged to have the courage to seize this opportunity and to approve, for the year 2002, the level of funding necessary to deliver the health and social care that our community expects and deserves.

Part B: Capital

1. States members will be aware that facilities in the General Hospital outpatients department are becoming very cramped. It is impossible to offer good quality health care in an environment which prevents professional staff from using new, more effective equipment and makes respect for patient's privacy and dignity difficult to achieve. For these reasons the Health and Social Services Committee has proposed a capital project for 2005 which, with inflation, is likely to cost in the region of £20 million.

2. The Finance and Economics Committee, at page 19 of the Resource Plan 2001 Report, has proposed the project be scheduled for 2006 but, should the project be ready to begin earlier, that Committee has offered to bring funding forward to 2005.

3. The proposition which accompanies the report makes no reference to this proposal and the Health and Social Services Committees amendment simply asks the States to formally endorse the Finance and Economics Committees proposal, as outlined at page 19 of the Resource Plan Report.

APPENDIX 1

GENERATION OF A FUTURE MEDICAL MANPOWER STRATEGY FOR HEALTH AND SOCIAL SERVICES 2001-2005

Executive summary

The Health and Social Services Committee has approved a strategy "Improving Health and Social Care" which aims to shape the health care and social services in Jersey for the next five years, 2001-2005. As part of the development of the strategic plan it was recognised that a medium-term strategy for medical staffing is needed to build and consolidate the medical workforce in order to deliver the service-based objectives.

Jersey has and wants a core hospital service which offers -

> *An emergency service provided by an accident and emergency department with the core specialities of acute medicine, general surgery (including head and neck services), trauma and orthopaedics, paediatrics, obstetrics and gynaecology; a full anaesthetic service with ICU facilities; supported by clinical radiology, pathology and blood transfusion services; and an elective service provided by the same core specialities for planned investigations and operations.*

The proposals have been formulated by a working group with the aim of sustaining this pattern of care in the foreseeable future.

There are six main reasons for developing the medical skill mix and expanding the numbers of consultants in particular. These are -

- the requirements of best practice in acute care;
- the requirements of clinical governance;
- the rising demands for outpatient and inpatient services;
- unmet needs of the population;
- changes in conditions of service and training;
- and the trend to sub-specialisation.

The United Kingdom plans a 50 per cent increase in consultant medical staff which will give the NHS 61 consultants fo every 100,000 population by 2009. Currently Jersey has 41 consultants and this plan will increase that number to 52, a ratio of 57 consultants per 100,000 by 2005. In total, this strategy identifies the need for 18.5 extra career-grade posts (consultant or staff grade) over the next five years - an increase of 11 medical consultants, which is five per cent per year.

A number of tangible benefits for the service, and therefore to patients, can be identified. The total costs of this strategy are estimated to be £3.95 million over the next five years. These costs can be evenly divided on an annual basis over the period or investment can be phased to allow for immediate priorities to be met during the first part of the period.

The working group recommends accelerated investment as the way forward. The urgent needs of the services whose justification for expansion of medical staffing is largely to sustain a consultant-based service can be met with a high initial investment (about 50 per cent) in the first 24 months. This will stabilise the acute services and allow for a steady investmen over the later years of the period. (The full resource requirements are set out in Appendix 1.3.)

1.0 The strategic aims

The Health and Social Services Committee has approved a strategy which aims to shape the health care and social services in Jersey for the next five years, 2001-2005. The purpose of Health and Social Services is to promote the health and social well-being of individuals, families and the community, through the provision of services based on assessed need and agreed entitlement, and to protect the interests of those whose needs are greatest.

In order to achieve its purpose, two key aims are -

- to build on the potential, skills and strengths of our human resources;

- to provide the highest quality service with the resources allocated and one in which we can all take pride.

As part of the development of the strategic plan it was recognised that a medium-term strategy for medical staffing is needed to build and consolidate the medical workforce in order to deliver the service-based objectives. There is also a requirement to develop proposals that seek to address the external pressures, public and political expectations within the Island, whilst acknowledging broader States' policies. An extensive process of consultation was undertaken during 2000, and all clinical staff were given the opportunity to make both written and personal presentations to the Group as it considered the key issues. A record of this process is included as Appendix 1.2.

It should be noted that the patterns of medical staffing are changing rapidly and the strategy will have to be flexible enough to reflect those changes. For example, the impact for Jersey of increasing sub-specialisation in all disciplines will have to be assessed, and this will be especially important in acute medicine.

2. The current position

In Jersey, as in the United Kingdom, there are doctors working in primary care, community services, public health, and in the hospital. Including all these groups there are 2.3 practising doctors per 1000 population, compared with 3.1 per 1000 o average in Europe.[3] There are 1.8 doctors per 1000 population in the United Kingdom.

In order to compare the position in Jersey with the provision in the United Kingdom it is necessary to adjust for the number of GPs. In Jersey there is one GP to 900 people, compared to one GP to 1700 people in the United Kingdom on average. If Jersey had the same ratio of GPs to population as the United Kingdom, the overall numbers of practising doctors in Jersey would be 1.8 per 1000 population. i.e. the hospital and community medical staff ratios are similar to the United Kingdom This ratio is acknowledged in the United Kingdom to be a serious under-resourcing of the health service. The NHS plan published in 2000 states that the NHS will create 7,500 new consultant posts by 2004.[4] Recently the United Kingdom government announced plans to make new investment in training in order that between 2000-2009 the numbers of consultants will rise from 24,300 to 36,300[5] - **an increase of 50 per cent in nine years-** with significant rises in the priority areas of heart disease and cancer.

This strategy for Jersey identifies the need for 18.5 extra career grade posts (consultant or staff grade) over the next five years - an increase of 11 medical consultants, which is five per cent per year.

3.0 The challenges

There are six main reasons for developing the medical skill mix and expanding the numbers of consultants in particular.

3.1 The best practice in acute care requires that services such as maternity, paediatrics and trauma, are provided as consultant-based services. This means, for example, the numbers of consultants should be such as to be able to staff a rota which allows one consultant to be available to attend emergencies without other commitments. This usually means a minimum of three consultants. The benefits are clear, but the risk of not staffing at this level is not only to safety of care. It is that the Medical College responsible for approving training posts and consultant jobs in the speciality will withdraw recognition.

3.2 The statutory requirements of clinical governance in the NHS have set a benchmark which must be achieved in Jersey in order to minimise the risk of litigation as well as meet the clinical standards set by the medical colleges and speciality associations. In addition the imminent arrangements for revalidation of doctors set the same agenda. This is to allow doctors dedicated time to pursue continual professional education and clinical audit as an aid to monitoring and continually improving clinical quality. There are no shortcuts here, and every doctor should be able to set aside a minimum of one session a week. The process of annual appraisal is seen as a necessary part of these initiatives.

These requirements can best be realised by introducing a medical management structure. This would have the added benefit of strengthening the contribution that all doctors can make to management processes and improve dialogue between managers and clinicians.

3.3 There are rising demands on outpatients and inpatient services as a result of increasing specialisation and changes in medical technology. There is a justifiable public expectation that consultants or staff grade doctors should be at

the front line - seeing the new referrals or undertaking the major procedures. It is essential to plan to meet the increase in legitimate demand for core services without increasing waiting times. The strategy envisages improved access and this can only be provided with adequate resources.

3.4 There are some additional services required on the island in order to meet certain unmet needs. These include community dental services and community paediatrics.

3.5 There are also inescapable changes in conditions of service and standards of training which must be accounted for in terms of staffing numbers. The inclusion of doctors in training as subject to the 48 hours working week maximum set by the *European Council Working Time Directive (1993)* came into force in May 2000, with a nine year transition period. The subsequent revision of the United Kingdom policy [*New Deal (1991)*] targets from 56 hours to 48 hours per week will mean less hours' work can be expected per individual doctor. New standards for training and specialist registration set by the Royal Colleges and other professional bodies set out the expectation for dedicated teaching time and limit the clinical responsibilities of doctors in training to those which are consistent with their training. In addition new standards have been set to improve suitable career structures for non-consultant grades *(staff grades, associate specialists)*, and to improve career counselling and support arrangements for doctors in training.

The trend to increasing sub-specialisation is a particular problem for a small and geographically isolated community such as Jersey. The days of the generalist are passing, and this is accelerated by doctors emerging from training with specialist registration in a sub-speciality, such as neurology as a speciality within medicine. The implications are seen in practice in the United Kingdom. For example, orthopaedic departments in general hospitals will have someone specialising in upper or lower limbs, or back problems. In acute medicine, there are a number of areas of specialist care such as diabetes, or chest medicine. This imposes "dis-economics of scale" on the services of Jersey, but this is necessary to sustain the pattern of health care we enjoy.

4.0 The pattern of secondary health care in Jersey

The model of health care in Jersey is similar to the United Kingdom NHS. GPs are in private practice, but behave in terms of providing continuity of primary care and in referral to specialist care much the same as GPs in the United Kingdom. The main issue is that Jersey has and wants a core hospital service which offers -

> *An emergency service provided by an accident and emergency department with the core specialities of acute medicine, general surgery (including head and neck services), trauma and orthopaedics, paediatrics, obstetrics and gynaecology; a full anaesthetic service with ICU facilities; supported by clinical radiology, pathology and blood transfusion services; and an elective service provided by the same core specialities for planned investigations and operations.*

In seeking to sustain these core acute services with adequate on-call ratios it is recognised that consultants will have working time available to undertake elective procedures. However, there may be some procedures which could be carried out more efficiently as part of specific contract arrangement with external providers.

The proposals have been formulated with the aim of sustaining this pattern of care in the foreseeable future.

However, the working group recognised there are outstanding problems in acute medicine relating to deciding priorities for specialisation, which are compounded by the interfaces with care of the elderly and emergency medicine.

5.0 The resources required

5.1 Training posts

The following posts for junior doctors in training have been identified for early implementation in order to maintain existing services -

Orthopaedics/ General Surgery	1 Pre-registration House Officer	(PRHO)
Anaesthetics	1 Senior House Officer	(SHO)
Oncology	1 Senior House Officer	(SHO)

The NHS has now committed to an 11 per cent increase in training budgets across the board in order to meet the substantial demand for new consultant posts nationally. There is no doubt that a review of training posts will be needed to take account of the training standards set by the Colleges and the new terms and conditions of service and this should be carried out later this year.

This review should assess the value of continuing to provide training posts in medical specialities in Jersey. These doctors are not to be seen as merely an extra pair of hands, but offered substantial opportunities to learn by doing and from teaching.

The main benefits are -

- responsibility for teaching and training contributes to the continuing professional development of senior doctors;
- the continual influx of new junior doctors provides excellent cross-fertilisation of ideas and experience within the health care professional community, which is important in a potentially isolated island service;
- the junior doctors are major contributors to clinical governance activities such as audits and research into individual cases.

5.2 Additional resources

Staff: There will be a requirement for secretarial support for the consultants. This is estimated to be seven secretarial posts over the five years and more details of these resource requirements are contained in Appendix 1.3.

A number of nursing and therapist posts were identified as part of the development of individual services as a consequence of the medical appointments. In addition there will be an impact on investigative departments such as radiology and pathology. The requirements for extra administrative support including records, clinical audit, and in areas such as the Outpatients Department, have also been estimated.

Non-staff resources: The main revenue impact will be in terms of theatre time and the use of consumables (i.e. drugs and clinical supplies) and these have been costed. In addition, the costs of surgical equipment, information technology hardware and other capital costs such as office accommodation, will have to be assessed.

5.3 New career-grade posts required by 2005

Speciality	**Post**	**Justification**
Medical Director (part-time)	Consultant	2, 4
Anaesthetics	Consultant	1
Obstetrics and Gynaecology	Consultant	1, 4
Paediatrics	Consultant	1, 4
Oncology (combined with other speciality)	Consultant	2, 4
Orthopaedics - with special interest in spinal problems	Consultant	2, 3, 4
General surgery	Consultant	2, 3
Medicine - 6th consultant - to enable division to work on basis of three teams of paired consultants	Consultant	3
Dentistry	Community Dental Officers	3, 4
Anaesthetics	Consultant	2, 3
Ophthalmology	Staff grade	3
Psychiatry - child and family	Staff grade	2, 3

Psychiatry of old age	Staff grade	3
Radiology	Consultant	3
ENT	Staff grade	2
Medicine	Staff grade	3
Orthopaedics - upper limb	Consultant	2, 4

Key to justification -

1. The core services must be provided as consultant-based services/or meet specialist requirements.
2. The requirement to monitor and continually improve clinical quality.
3. The increased legitimate demand for core services.
4. The services to meet unmet needs have been identified as properly provided on the Island.

5.4 Costs

The total costs of this strategy are estimated to be £3.95 million over the next five years.

These costs can be evenly divided on an annual basis over the period or investment can be phased to allow the immediate priorities to be met in the first part of the period. In addition the opportunities for re-deploying existing clinical sessions have to be rigorously examined.

6.0 Benefits

A number of tangible benefits for the service, and therefore to patients, can be identified.

6.1 Benefits across the service

The service as a whole will benefit because this plan will enable considerable progress to be made towards -

- establishing a medical management structure starting with the appointment of a medical director in 2001;
- facilitating the full participation of career grade doctors in all the activities related to improving clinical quality;
- sustaining improvement in all waiting times to meet targets.

6.2 Benefits within specific services

Specific service areas will benefit because this plan will assist in achieving the following service objectives -

- A sustainable paediatric unit providing consultant-based neonatal care, with adequate junior staff, and a full community service.
- Consultant-based cover for the labour ward (maternity services).
- The development of cancer services in the Island as a “cancer unit” will gain dedicated clinical leadership.
- A consultant-led service on the Island for patients with back problems - one of the commonest causes of long-term illness.
- Increased consultant-based operating sessions for trauma patients.
- The introduction of a team approach to general medicine which integrates the care of older people.

- Improved access to general surgery, and a team approach to surgical oncology.
- More consultant sessions in anaesthetics.
- A service to identify and meet the dental needs of disadvantaged groups of the population who are known to have poor dental health.
- Senior day-to-day clinical management of the renal unit enabling it to achieve European standards of care.

7.0 Options

The working group identified three main options -

7.1 Yesterday's approach

In the past six years there has been no coherent medical staffing plan, yet eight consultant posts have been created. At the same time demand for services has increased and the expansion in work has led to an sustained rise in costs. There has not been a commensurate increase in funding, and the result has been major pressures on current limited budgets. Having no plan runs the risk of posts being created outside the agreed budgets in reacting to an unforeseen service pressure. The other major risk is that both consultant and training posts will not continue to have approval from the relevant medical college, and recruitment of high calibre doctors to Jersey will be seriously threatened.

7.2 Steady investment

The costs could be evenly staged over the period of five years. This would allow controlled development at a pace that could be easily managed, and may reflect a realistic view of the recruitment opportunities to both medical and other professional posts. The disadvantages are that the priorities today are for appointments to acute services where there are severe strains due to the demands on only two consultants. It is very difficult to choose one service as having a more urgent need than another. In addition the requirements of clinical governance are here now, and cannot be delayed.

7.3 Accelerated investment

The urgent needs of the services whose justification for expansion of medical staffing is largely to sustain a consultant-based service can be met with a high initial investment (about 50 per cent) in the first 24 months. This will stabilise the acut services and allow for a steady investment over the later years of the period. It also allows the service as a whole to begin to meet adequately the demands of clinical governance. Clinical governance sets the ultimate accountability for clinical quality with the Committee, not with individual clinicians. Another factor to consider is the predicted shortfall in potential candidates for consultant posts which will occur as the new investment in the United Kingdom will inevitably exhaust the current doctors in specialist training after 2004. It is likely that recruitment will be easier in the next two to three years before the full impact of the changes in the NHS happen.

8.0 Recommendation

The working group recommends accelerated investment as the way forward. The urgent needs of the services whose justification for expansion of medical staffing is largely to sustain a consultant-based service, can be met with a high initial investment of £2 million (about 50 per cent) in the first 24 months. This will stabilise the acut services and allow for a steady investment over the later years of the period. It is important to take advantage of the fact that recruitment will be easier in the next two years in advance of the major investment programme in the United Kingdom. The full resource requirements are set out in Appendix 3 and total £3.95 million and 87 new posts.

APPENDICES

1.1. Membership of Medical Manpower Strategy Group
1.2. Clinical involvement
1.3. Resources requirements

APPENDIX 1.1

Membership of Medical Manpower Strategy Group

Mr. R.P. Clifford, Consultant Orthopaedic/Trauma

Dr. J. Harvey, Consultant in Public Health Medicine

Ms. A. Homer, Manager, Surgical Division (formerly Director of Finance and Information) [from September 2000]

Dr. R. Lane, Consultant Anaesthetist

Mr. J. Le Feuvre, Director of General and Acute Services (Chair)

Dr. G. Prince, Consultant Anaesthetist

Dr. M. Richardson, Consultant Physician, Care of the Elderly

Mr. A. Skinner, Director of Community and Social Services

Ms. M. Spencer, Finance and Information [until August 2000]

Mrs. E. Webster, Human Resources Manager.

APPENDIX 1.2

CLINICAL INVOLVEMENT

TWO DAY PRESENTATIONS:

Monday 15th May 2000

Public Health	Dr. R. Grainger Dr. G. Llewellin Dr. S. Foster
Pathology	Dr. I. Muscat
Psychiatry	Dr. Blackwood
Medicine Division	
Elderly Care	Dr. M. Richardson
Medicine	Dr. H. Gibson

Tuesday 16th May 2000

Surgical Division	
Anaesthesia	Dr. G. Prince
Head and Neck	Mr. N. Shah
Ophthalmology	Mr. M. Alwitry
Community Dental/Oral Surgery	Mr. M. Cassidy Mr. M. Belligoi
Orthodontics	Mr. B. Skinner
Orthopaedics/Trauma	Mr. C. Twiston Davies
Accident and Emergency	Dr. C. Clinton
General Surgery	Mr. J. Allardice Mr. N. Ingram
Woman and Children	
Paediatrics	Dr. T. Malpas
Obstetrics/Gynaecology	Mr. N. Maclachlan Mr. J. Day

Friday 16 February 2001

Ophthalmology	Mr. R. Downes
Mental health services	Mr. I. Dyer

March 2001

Radiology	written submission

APPENDIX 1.3

MEDICAL MANPOWER STRATEGY COSTINGS

	WTE	£
Medical Director (part-time)		
Consultant	0.36	39,000
	0.36	39,000
Division of Surgery		
Anaesthetics		
Consultant	1.82	190,000
Secretary	1.00	25,000
Senior House Officer	1.00	61,000
Study Leave		10,000
	3.82	286,000
Gynaecology and Obstetrics		
Consultant	0.91	96,000
Secretary	0.50	13,000
Locum		10,000
Study Leave		5,000
Drugs		20,000
	1.41	144,000
Ophthalmology		
Staff Grade	1.00	65,000
Study Leave		5,000
Drugs		4,000
	1.00	74,000
Surgical Oncologist		
Consultant	0.91	96,000
Secretary	1.00	25,000
Locum		10,000
Study Leave		5,000
Drugs		35,000
	1.91	171,000

	WTE	£
Orthopaedics		
Consultant: Spinal	0.91	96,000
Locum		10,000
Consultant: Upper limb	0.91	96,000
Locum		10,000
Study Leave		10,000
Physiotherapist	2.00	73,000
Secretary	2.00	51,000
Drugs		5,000
	5.82	351,000
General Surgery/Orthopaedics		
Pre-registration House Officer	1.00	42,000
Locum		3,000
Study Leave		2,000
	1.00	47,000
ENT		
Staff Grade	1.00	65,000
Locum		8,000
Study Leave		5,000
Drugs		2,000
	1.00	80,000
Dental		
Community Dental Officer	1.50	84,000
Study Leave		8,000
Dental Supplies		10,000
	1.50	102,000

	WTE	£
Day Surgery Unit: Additional sessions (7)		
Staff Nurses	11.00	277,000
Porter	2.00	41,000
CSSD staff	2.00	41,000
Ward Clerk	1.00	21,000
Theatre supplies		60,000
	16.00	440,000
Theatre: Additional theatre lists		
Staff Nurses	4.00	101,000
Porter	2.00	41,000
CSSD staff	2.00	41,000
Theatre supplies		60,000
Drugs and Anaesthetics		25,000
	8.00	268,000
Surgical Wards		
Staff Nurses	5.00	126,000
Drugs		15,000
	5.00	141,000
Pathology		
MLSO	2.00	73,000
Supplies and Referred tests		10,000
	2.00	83,000
Radiology		
Radiologist	0.91	96,000
Radiographer	1.35	50,000
Secretary	1.00	25,000
Clerk	1.50	31,000
Assistant	1.00	21,000
Supplies		10,000
	5.76	233,000

Outpatients and Administration		
Staff Nurses	4.00	101,000
Medical Records Clerk	2.00	34,000
Stationery and postage		2,000
Clinical purchasing	1.00	32,000
Clinical Audit	1.00	25,000
Business Management	1.00	32,000
	9.00	226,000
	63.22	2,646,000
Division of Medicine		
Medical Staffing		
Consultant Physician	0.91	96,000
SHO Oncology/Haematology	1.00	61,000
Secretary	1.00	25,000
Drugs		100,000
Locum		10,000
Study Leave		5,000
Staff Grade	1.00	65,000
Locum		8,000
Study Leave		5,000
	3.91	375,000
Medical Wards		
Staff Nurses	4.00	101,000
	4.00	101,000
Clinical Investigations		
Technician	1.00	37,000
Supplies		5,000
	1.00	42,000
Pathology		
MLSO	1.00	37,000
Supplies and Referred tests		5,000
	1.00	42,000

Radiology		
Radiographer	0.25	11,000
	0.25	11,000
Pharmacy		
Technician	2.00	50,000
Supplies		5,000
	2.00	55,000
Outpatients		
Staff Nurses	2.00	50,000
Medical Records Clerk	1.00	17,000
Stationery and postage		1,000
Clinical Audit	0.50	13,000
	3.50	81,000
	15.66	707,000
Paediatrics		
Consultant	1.00	105,000
Physiotherapist	2.00	73,000
Sister 2	1.00	45,000
Secretary	0.50	13,000
Paediatric Supplies		20,000
Locum		10,000
Study Leave		5,000
Nuclear Medicine		5,000
	4.50	276,000
Psychiatry		
Staff Grade (Child and Family)	1.00	65,000
Staff Grade (Old Age)	1.00	65,000
Study Leave		5,000
	2.00	135,000
	85.74	3,803,000
Cost/Manpower Summary	**86**	**3,800,000**

APPENDIX 2

GENERAL AND ACUTE SERVICES

IMPLEMENTING A STRATEGY FOR GENERAL AND ACUTE SERVICES

Comparison of five per cent plan and 3.1 per cent offer

			5% plan		3.1% offer	
STRATEGIC GROWTH			**£**	**FTE**	**£**	**FTE**
1	**Medical staff**	Medical Director	39,000	0.36	0	0.00
2		Ophthalmology Staff Grade, Nurses, Sec/Records Clerk	140,000	3.50	70,000	1.00
3		Consultant Physician and Secretary	96,000	1.91	0	0.00
4		Consultant Paediatrician, Nurse, Physio and Secretary	99,000	1.50	0	0.00
5		Consultant Anaesthetist, Secretary and SHO	96,000	1.91	0	0.00
6		Consultant Orthopaedic Surgeon, Physio and Secretary	42,000	0.91	0	0.00
7		Consultant Obstetrician/ Gynaecologist and Secretary	31,000	0.91	0	0.00
8		Consultant General Surgeon and Secretary	0	0.00	0	0.00
9	**DSU Additional sessions (4)**	Staff nurses, theatre porter and CSSD staff	125,000	4.00	0	0.00
10	**Discharge initiative**	Physiotherapist/ Occupational Therapist	50,000	2.00	0	0.00
11	**Pain Clinic**	Nursing support and Physiotherapist	24,000	0.75	0	0.00
12	**Risk Manage-ment**	Support staff	45,000	1.50	0	0.00
			787,000	**19.25**	**70,000**	**1.00**

CURRENT COST PRESSURES

13	**Medical Locums**	Division of Medicine	0	0.00	25,000	0.00
14		Divisions of Surgery and Anaesthesia	0	0.00	40,000	0.00
15	**Theatre Supplies and Staff**	Increased cost/use of clinical supplies	140,000	0.00	140,000	0.00
16		CJD Guidelines Disposable ENT instruments	10,000	0.00	10,000	0.00
17		ODP Trainee and training costs	15,000	0.00	0	0.00
18	**Ward Nursing Staff**	Nursing staff plan 2000 full year effect	100,000	4.00	100,000	4.00
19		Revised staffing based on dependency review	100,000	4.00	50,000	2.00
20	**Outpatients**	Nursing staff	25,000	1.00	25,000	1.00
21	**Drugs and Pharmacy**	Pharmaceutical Developments	320,000	0.00	250,000	0.00
22		Pharmacy staffing re new Chemotherapy agents	25,000	1.00	25,000	1.00
23	**Pathology**	Pathology IT administrator FYE	20,000	1.00	10,000	0.50
24		Workload increase staff and supplies	66,000	1.00	53,000	0.50
25		Donor Screening	33,000	0.00	30,000	0.00
26	**Renal Service**	Nursing staff and clerical post	145,000	6.00	145,000	6.00
27		Clinical Supplies	30,000	0.00	30,000	0.00
28		Drugs	60,000	0.00	60,000	0.00
29	**Diabetes Service**	Provision of supplies to patients in the community	40,000	0.00	40,000	0.00
30	**Oncology Service**	Nursing staff and clerical post	45,000	1.50	45,000	1.50
31		Drugs: New Chemotherapy agents	100,000	0.00	100,000	0.00
32	**Support Services**	Ward Clerks	31,000	1.50	31,000	1.50
33		Medical records	20,000	1.00	20,000	1.00
34		Business Management	32,000	1.00	0	0.00
35		Reception Le Quesne Ward	15,000	0.75	15,000	0.75
36		Clinical Purchasing	32,000	1.00	0	0.00

37	**Overheads**	Medical Defence Insurance	68,000	0.00	68,000	0.00
38	**Major Incident Team**	Major Incident exercise, training and equipment	45,000	0.00	35,000	0.00
		TOTALS FOR GENERAL AND ACUTE SERVICES	**2,304,000**	**44.00**	**1,417,000**	**20.75**

GENERAL AND ACUTE SERVICES

Comparison of five per cent plan and 3.1 per cent offer - Impact Statement

The preliminary plan for the allocation of a five per cent growth in funding enabling the General and Acute Unit to meet existing cost pressures and permit some growth in accordance with the strategic aims of the Committee most obviously in the implementation of the critical elements of the Medical Manpower Plan presented to Committee in late May 2001. The reduction of the budgetary growth to 3.1 per cent is likely to have the following impact on the planned strategic growth and on the ability of the Unit to meet existing cost pressures.

Strategic growth

The plan for 2002 allowed for the introduction of a number of medical posts in line with the medical manpower strategy recently agreed by Committee.

As stated in the Medical Manpower Report there are six main reasons for developing the medical skill mix and expanding the numbers of consultants in particular.

1. Best practice in acute care would require that services such as maternity, paediatrics and trauma are provided as consultant-based services allowing consultant care for emergencies and this level of staffing will be necessary for recognition of our training and consultant posts by the medical Colleges.

2. The requirements of clinical governance have set a standard to minimise the risk of litigation as well as to meet the clinical standards set by the medical colleges and speciality associations. Revalidation of medical posts also requires medical staff to have dedicated time to pursue continual professional education and conduct clinical audit as an aid to monitoring and continually improving clinical quality.

3. There are rising demands on outpatients and inpatient services as a result of increasing specialisation as well as changes in medical technology and increased public expectations.

4. There are some additional services required on the Island in order to meet certain unmet needs. These include community dental services and community paediatrics.

5. Change in conditions of service and standards of training that will affect medical staff numbers. This is as a result of the reduction in the working hours of junior medical staff and new standards for training and specialist registration set by the medical Colleges and other professional bodies. In addition new standards have been set to improve suitable career structures for non-consultant grades.

6. The continuing trend to increasing sub-specialisation with new doctors obtaining specialist registration in a sub-speciality and being less able or equipped to practice across the range of areas.

Under the revised proposals the medical manpower plan will effectively be deferred with the sole exception of the ophthalmology staff grade and even in this area there can be no provision made for support staff to make the necessary enhancements to the ophthalmology service.

More recently there has been no medical staffing plan yet new consultant posts have been created as the demand for services has increased and the expansion in work has led to a sustained rise in costs. There has been a limited increase in funding and the result has been major pressures on current budgets. Having no plan or significantly delaying its possible implementation runs the risk of posts being created outside the agreed budgets in reaction to an unforeseen service pressure. By the end of 2004, the United Kingdom NHS has a target of 10,000 additional hospital doctors (mostly consultants) and 20,000 additional nurses. The recruitment market will be increasingly difficult from the end of 2003. It is important therefore that the committee secures the additional medical and nursing manpower it requires as early in the strategic period as possible.

In addition to the deferment of the medical manpower plan the planned increase in day surgery theatre sessions cannot take place. It is apparent that there is currently surgical activity taking place in main theatre, which could be performed on a day surgery basis. The transfer of this activity to the Day Surgery Unit would have allowed more efficient usage of the main theatre and the inpatient surgical beds permitting the Unit to better manage winter pressures and reduce waiting lists. The withdrawal of the proposed physiotherapy/occupational therapy staffing will impede the discharge of elderly patient from hospital and compound the difficulties in effectively using hospital inpatient beds.

The pain clinic provides significant support to patients suffering long-term chronic pain with the aim of enabling them to better cope with their conditions and lead more productive lives and in some instances remove the need for long-term sickness benefit.

In the changing clinical environment that has developed after certain high profile cases in the United Kingdom it is imperative that effective clinical audit and proactive management of clinical risk are undertaken. To facilitate this process it is necessary for the medical staff to have appropriate support and, with the reduction in funding this cannot be provided.

The Clinical Quality Improvement Group has identifies the management of medical records, and the timely coding of clinical information to be critical to the clinical audit project. The current capacity of ward clerks and records officers is below that needed to maintain these functions when annual or sick leave deplete the numbers of staff available. These posts are essential to the infrastructure of clinical governance.

Current cost pressures

The cost pressures listed are apparent now, or are expected to materialise, based on current trends (e.g. drugs expenditure) and whilst the funding will address those identified it does not allow for any contingencies to meet other developments that may be unavoidable in a dynamic acute hospital.

COMMUNITY AND SOCIAL SERVICES

IMPLEMENTING A STRATEGY FOR COMMUNITY AND SOCIAL SERVICES

Comparison of five per cent plan and 3.1 per cent offer

	Service	Initiative	5% plan		3.1% offer	
			£	FTE	£	FTE
1	**Alcohol and Drugs**	Needle Exchange Scheme/Outreach Worker	75,300	1.00	25,000	0.00
2		Shortfall on Methadone Programme	30,000	0.00	30,000	0.00
3	**Rehab. and Services for**	Community Integrated Care Team	75,000	2.00	0	0.00
4	**Older People**	Funding for Flexible Home Care Support Packages	75,000	0.00	75,000	0.00
5		Community Mental Health Nursing	35,000	1.00	35,000	1.00
6		Home Mental Health Respite 'Sitting Service'	21,000	0.00	0	0.00
7		OT Support for Disabled Clients at Home	65,500	1.00	0	0.00
8		OT Orthopaedic Discharge for Older People	57,000	1.00	57,000	1.00
9		Speech and Language Therapy for Older People with Dementia	23,500	1.00	0	0.00
10		Diversional Therapy for Older People with Mental Health Problems	20,000	0.50	0	0.00
11		Stroke Care and discharge/Outreach Service	57,000	1.00	47,000	1.00
12		Consolidation of Day Centre Services	62,000	1.00	62,000	1.00
13		Social Work Assistant for Mental Health Clients	26,000	1.00	26,000	1.00
14	**Grants**	Les Amis: Shortfall in cost of Respite Service	31,000	0.00	31,000	0.00
15		Grants to Voluntary Organisations	88,800	0.00	50,000	0.00
16		Family Nursing and Home Care Inc.	192,000	0.00	121,000	0.00

17		Special Dietary Pilot Project	30,000	0.00	30,000	0.00
18		Brig-Y-Don Children's Home	110,000	0.00	80,000	0.00
19	**Adult Mental**	Sister 1 in-patient manager/clinical lead	47,800	1.00	0	0.00
20	**Health**	Rehabilitation Hostel within the Community	30,000	0.00	25,000	0.00
21		Occupational Therapy Assistant	26,300	1.00	26,300	1.00
22		Francheville ward to independent residential/ nursing care	50,000	0.00	50,000	0.00
23	**Social Services**	Social Worker Specialising in work with disabled clients	27,000	1.00	0	1.00
24		Hospital Aftercare Scheme: Volunteer Co-ordinator	25,000	0.50	0	0.00
25		Hospital Based Social Worker [Discharge planning]	27,000	1.00	0	1.00
26		To bring Foster Care payments in line with nationally approved levels	115,000	0.00	100,000	0.00
27		Adoption and permanency Specialist	26,000	1.00	0	0.00
28		Funding to meet 1:1 staffing costs for children with challenging behaviour	56,600	3.00	56,600	3.00
29		Funding for specialist United Kingdom placements	10,000	0.00	10,000	0.00
30		Occupational Therapist 1, Community Network Team	45,100	1.00	45,100	0.00
31		Behaviour Advisor for Children	45,800	1.00	45,800	1.00
32		Integration and development of Day services	52,300	1.50	15,000	0.00
33	**Psychology**	To provide Clinical Psychology to EMI service	21,100	0.50	21,100	0.50
TOTALS FOR COMMUNITY AND SOCIAL SERVICES			**1,679,100**	**23.00**	**1,063,900**	**12.50**

COMMUNITY AND SOCIAL SERVICES

Comparison of five per cent plan and 3.1 per cent offer - Impact Statement

Introduction

The five per cent growth plan for Community and Social Services contains 33 individual bids, which together constitute a balanced programme of -

- meeting service demand pressures particularly within the Occupational Therapy, Alcohol and Drugs, Social and Children's Services [adoption, fostering and special needs];
- investing in hospital discharge initiatives;
- delivering a first phase response to the Audit recommendations on the improvement of services to older people with mental illness;
- initiating the first phase of the development plan for the Adult Mental Health Service;
- continuing investment in voluntary partnerships;
- addressing a number of cost pressures.

The programme reflected investments currently being made elsewhere within the United Kingdom to meet a similar profile of service demand, particularly those of responding to the needs of an ageing population and ensuring the effective use of hospital beds.

In order to reduce that programme to meet a 3.1 per cent growth profile a total of 12 bids would have to be deferred indefinitely and the funding substantially reduced in respect of six other bids. The detailed reductions are as follows -

- Bid 1: defer Needle Exchange Post - savings = £50,300
- Bid 3 and 7: although my submission defers the Community Integrated Care Team and Occupation Therapy support for disabled clients at home until 2003 this is for ease of display - what we would actually do is strip out £140,500 from bids 4/8/9 and 12 which are all bids designed to facilitate hospital discharge and support, post-discharge and preventive: savings = £140,500
- Bid 6: defer Respite ' Sitting Service' for carers of older people with mental illness: savings = £21,000
- Bid 9: defer Speech and Language therapy service for Old Age Psychiatry Service: savings = £23,500
- Bid 10: defer diversional therapy hours for Old Age Psychiatry Service: savings = £20,000
- Bid 11; reduced the stroke care initiative by £10,000: savings = £10,000
- Bid 15: reduce grants general budget allocation to £50,000 only: savings = £38,800
- Bid 16: reduce Family Nursing and Home Care grant to 3.1 per cent: savings =£71,000
- Bid 18: further reduce Brig-y-don grant uplift from £130,000 requested to £80,000 only - savings [on original compromise grant allocation of £110,000] = £30,000
- Bid 19: defer sister 1 inpatient manager Adult Mental Health: savings = £47,800
- Bid 20: set savings target of £5,000 for rehabilitation hostel rental [if project goes ahead]: savings = £5,000
- Bid 23: defer appointment of a social worker to specialise in the development of services for disabled clients: savings = £ 27,000

- Bid 24: defer introduction of new Hospital Aftercare Scheme to facilitate prompt discharges: savings = £25,000

- Bid 25: defer appointment of a social worker to improve hospital discharge planning: savings = £27,000

- Bid 26: reduce uplift to foster parent payments until 2003: savings = £15,000

- Bid 27: defer appointment of an Adoption and Fostering Specialist: savings = £ 26,000

- Bid 32: reduce service expansion at Le Geyt Centre to a minimum: savings = £37,300

Total savings achieved = £615,200

Effect of reductions

The major impact of the reduced growth programme would be felt in the following areas -

Hospital discharge initiatives:

Bids 3/7/8/11/24/25 [all of which are either deferred indefinitely or reduced substantially] are all initiatives designed to ensure the effective use of existing hospital beds by facilitating the prompt discharge of patients who require a range of services in order to be safely discharged into the community. The initiatives reflect similar investments currently being made within the NHS to keep pace with the ageing profile of those requiring hospitalisation and the particular discharge and post - discharge needs of older people.

The task of Health and Social Services is to optimise use of existing hospital beds to cater for the changing patient profile. The initiatives we hoped to take are all proven methods of ensuring effective discharge of older patients and of providing effective post-discharge services designed to prevent possible relapse and re-admission. Our inability to keep pace with the rapid development of such services elsewhere in the United Kingdom may not necessarily increase the risk of higher relapse rates among older people but it will inevitably slow down the discharge process among older people with particular discharge needs. The impact of delayed discharge upon effective management of hospital beds, operation waiting lists etc. are already well documented nationally and internationally and do not need to be repeated here.

Services to older people with mental illness:

The Committee has just received the findings of an independent audit carried out by the Treasury Audit Division on services to older people with mental health problems. The Audit, whilst extremely impressed with the quality of service provided by the Old Age Psychiatry Service, nevertheless reported a serious under-investment in resources for this particular client group. The Audit Report recommends additional resources should be made available as soon as possible within certain areas of this Service which are struggling to cope with existing demand and that investment should be made as a matter of priority in new initiatives to mirror the range of services on offer to clients elsewhere within the United Kingdom.

Bids 5/6/9/10/13 are designed to address the areas of investment deemed the most urgent by the Audit findings. In order to meet the 3.1 per cent growth profile it will be necessary to defer bids 6/9/10 thus reducing the investment programme within this Service Area to the absolute minimum required to discharge the basic statutory duties and assessment responsibilities of the Service. No new investment would be made to meet the recommendations of the Audit Report until 2003 at the earliest.

Social Services and Children's Services:

The impact of a 3.1 per cent growth programme is to confine growth within this Service Area solely to meeting existing cost pressures, which are currently unfunded.

The original programme included two new social work posts [bids 23 and 25], each to be established within the second half of the year to avoid full year cost effect: the first was to introduce better discharge planning procedures within the General Hospital for patients requiring residential or nursing home placement and the second was to develop better services for physically disabled clients in the community. The latter in particular is an area in need of urgent investment and the post would have been instrumental in developing new support services for this growing client group. The full year effect of the two appointments would have been met within the 2003 growth programme. Both posts will now have to be indefinitely postponed.

The five per cent growth programme also allowed for the appointment of a dedicated Adoption and Permanency Specialist within the Children's Service [bid 27] but this post will now have to be deferred. The growth in overseas adoptions and the trend toward the adoption of older children place additional demands upon the Children's Service to provide more comprehensive pre- and post-placement support and services to adoptive families. In most other social service departments of this size within the United Kingdom there is at least one dedicated adoption and permanency specialist.

Given the mounting pressures already placed upon the Children's Service to provide additional services for children with severe behavioural difficulties it is not possible to give adoption and post placement services the attention it now requires. The 3.1 per cent growth programme will only allow the Service to keep pace with the demand for services for children with challenging/difficult behaviours and adoption and post-placement services will have to await the required investment.

The Committee received a report from the Children's Service earlier this year, which highlighted the need to address the current allowances paid to foster parents, which have fallen substantially behind the United Kingdom rates. The Committee is keen to address this shortfall as fostering is a vital element of its strategy to keep residential children's home provision to a minimum. Bid 26 sought to partially address the problem but within the 3.1 per cent programme this initiative would have to be reduced and the full uplift postponed indefinitely.

Bid 32 was to have allowed for the deployment of Le Geyt Centre to accommodate a wider range of special needs provision for adults. This scheme will now be modified to consolidate the present initiatives only.

Adult Mental Health Service:

The Committee recently endorsed a bold and imaginative plan for the redesign of Adult Mental Health Service to reflect the very best of modern psychiatric practice and services. The plan requires only a modest interim investment of resources in three areas [bids 19/20/22 refer] plus a small sum to meet the costs of an Occupational Therapist [bid 21] to meet the current needs of hospital inpatients. In order to meet the 3.1 per cent growth profile bid 19 would have to be deferred, preventing the consolidation of a new clinical management structure. The need to move ahead with the development plan to meet capital planning and other development priorities will mean additional savings targets will have to be set in order to proceed with bids 20 and 22, neither of which can be fully financed through the existing growth profile, which in turn may delay the implementation of the development plan.

Alcohol and Drugs Service:

Recent Imperial College research revealed an alarmingly high rate of needle sharing among injecting drug addicts [96 per cent], which has serious implications for the likely future incidence of Hepatitis B and C among not only drug users but also their partners, unaware of the risk of contracting the virus. Although within the restricted growth programme we would defer the appointment of a needle exchange outreach worker [bid 1], seeking initial funding from the DTCF Funds, if the latter were not forthcoming we would be forced to include it within the 2002 growth programme to the exclusion of another bid of that value.

Partnerships with Voluntary Sector Providers:

The Committee provides over five million pounds' worth of annual grants to more than 20 major voluntary sector agencies, which manage services, which would otherwise have to be provided by the State. The Committee receives over £350,000 worth of requests for growth from this sector each year and provides over £150,000 new growth each year on average. In order to meet its other urgent service pressures it will be necessary, within a 3.1 per cent growth programme, for the Committee to substantially reduce the growth funding available to this Sector and inevitably there will be problems stemming from the limited funding provided, which will only become apparent later this year when the Voluntary Sector 2002 grant requests are received.

General:

Many of the bids contained within the five per cent Growth Plan, were concerned with trying to improve investment in Occupational Therapy Services throughout the main Service Areas in order to keep pace with the sharp increase in demand for this provision. This is partially driven by the ageing profile of the population and partly by the growing number of children and young people with physical disabilities. The demand for OT services and special equipment shows no sign of levelling off and we must keep pace with the demand if we are to maintain an effective community care strategy, keeping people within their own homes and communities. Unfortunately, of the six related bids [Bids 3/7/8/10/21/30] originally included within the five per cent growth plan 3 [bids 3/7/10] will have to be deferred indefinitely if we are to remain within a 3.1 growth profile and it will not be possible to meet the full demand for OT services in 2002.

PUBLIC HEALTH SERVICES

IMPLEMENTING A STRATEGY FOR PUBLIC HEALTH SERVICES

Comparison of five per cent plan and 3.1 per cent offer

			5% plan		3.1% offer	
			£	FTE	£	FTE
1	**Public Health Services**	Environmental Health Assistant	26,000	1.00	26,000	1.00
2		Consultant Public Health Secretary	25,000	1.00	25,000	1.00
3		Environmental Health transport	2,500		2,500	
4		Restructure of Public Health	15,000		15,000	
5		Communicable Diseases Control	20,000			
6		Registration Social Worker	19,000	1.00		
			107,500	**3.00**	**68,500**	**2.00**

PUBLIC HEALTH SERVICES

Comparison of five per cent plan and 3.1 per cent offer -
Impact Statement

Public Health Services are planning the development of the Unit in line with the PriceWaterhouseCoopers (PWC) service review and an internal review carried out in 1999 and the Health and Social Services strategy *Improving Health and social care.* The plan identifies the ways in which the department should use existing and new resources to deliver its key functions effectively.

The developments are intended to -

- place greater emphasis on implementing strategies for health improvement;
- enable the unit to undertake multidisciplinary health impact assessment;
- strengthen the needs assessment role, and data provision for planning and monitoring performance;
- extend the role within clinical quality management;
- develop the interface with primary care.

The priorities for growth for 2002 will consolidate existing skills and enable changes in structure to meet the challenges of delivering the above objectives.

1	Environmental Health Assistant (EHA)	The additional demands of monitoring various aspects of the environment require an increase in staffing.
2	Secretary CPHM	The post of consultant in Public Health Medicine was created in 1998 without secretarial support. This post will give consultant and senior managers dedicated secretarial support, and enable a range of administrative responsibilities to be managed more efficiently.
3	Environmental Health transport	Much of the work of the staff requires site visits. This cost covers new charges for use of the four wheel drive vehicles to undertake sampling at low tide, and the need for one additional and one replacement vehicle on a lease basis.
4	Restructure	The plan is to restructure the unit into distinct functional teams, and identify clear leadership roles, in line with the service review.
5	Communicable Disease Control	The arrangements for communicable disease control in the community will be integrated, and will include the team responsible for control of infection in the hospital. The costs cover the extra staff time required to achieve this.
6	Social Worker Inspection of Residential and Nursing Homes	The work involved in the registration and inspection of Residential and Nursing Homes is usually undertaken by a joint (interdisciplinary) unit in the United Kingdom. It is proposed to create a part-time social worker post to support this function. This would also give opportunity to be pro-active in helping homes to achieve the standards required.

The impact of the 3.1 per cent growth would be -

1 Communicable Disease Control - this function would remain patchy and reactive, and as outbreaks are in themselves priorities, medical and nursing staff would have to be diverted from other important tasks to respond

appropriately. Urgent policy reviews (e.g. the tuberculosis control policy) would be delayed.

2 Inspection of Residential and Nursing Homes - there would not be scope to develop a positive pro-active approach to improving the quality of residential homes. Re-allocation of responsibilities with PHS as a whole would be affected.

CORPORATE SERVICES

IMPLEMENTING A STRATEGY FOR CORPORATE SERVICES

Comparison of five per cent plan and 3.1 per cent offer

	CORPORATE SERVICES		5% plan		3.1% offer	
			£	FTE	£	FTE
1	**Estates Manage-ment**	MRI Service Contract	60,000		60,000	
2		Medical Equipment Service Contracts	40,000		40,000	
3		Rolling Plant Maintenance	50,000			
4		Building Maintenance/ Projects	180,000		114,000	
5		Asset Management Officer	27,000	1.00		
6		Training (CPD - Medical Equipment)	20,000			
		Total Estates	377,000	1.00	214,000	
7	**Training**	Development of NVQ programme	20,000	1.00	11,000	0.50
	Information Technology	Implementation of ICT Strategy				
8		(a) Hardware and software maintenance etc.	83,000			
9		(b) Initial manpower requirements	112,000	3.00	112,000	3.00
		Total Information Technology	195,000	3.00	112,000	3.00
		Total Corporate Services	**592,000**	**5.00**	**337,000**	**3.50**

CORPORATE SERVICES

Comparison of five per cent plan and 3.1 per cent offer - Impact Statement

The Corporate services budgets cover many operational areas including estates management, information and computing technology and training services for operational areas. These budgets have received very little growth in the past few years as what little growth that has been received has been allocated to direct patient care. These services are now in danger of not being able to support the direct patient care services in any reasonable manner and it is now felt necessary to address the structure gaps in these services.

At the five per cent level of growth funding it is anticipated that the corporate services will be able to continue to support the direct patient care services in delivering patient care. At the 3.1 per cent level of funding there will obviously be implications which are detailed below.

Implications of 1.9 per cent shortfall

Estates Management

A reduction in the level of funds allocated for rolling plant/building maintenance will result in a probable increase of plant breakdowns, including lifts and air-handling units. Projects will have to be limited and further prioritisation carried out, which will impact negatively on our ability to respond to clinical services.

Asset Management Officer - The HSSC asset base is valued at around £250 million but is not recorded in sufficient detail nor is it as up to date as it should be. At this level of asset base value this requires a full-time post to ensure that it is both comprehensive and up to date. This was the recommendation of a recent audit report and should ensure that all asset registers are suitably maintained. This is a full time job and there is no one available to carry out this task.

Training

The reduction would mean a severe curtailment of our NVQ programme which the Committee have previously approved We currently insist that all our Care Assistants undertake level 2 NVQ and this would be impossible to deliver without this post Secondly, when Job families are implemented we will have even more of a need for this post as NVQ level 3 will need to be provided in greater numbers.

Information Technology

To implement the ICT strategy (which the committee has approved) and to bring online the clinical system required within the next two years it is necessary to increase the level of expertise and resources within the current ICT structure (see PriceWaterhouseCoopers service review). If we are unable to develop and support the clinical systems the overall HSSC strategic objectives will not be achieved.

APPENDIX 3

The States of Jersey Resource Plan 2001

Analysis of HSSC "Growth" figures.

The 2001 Resource Plan shows (Table 4.2, page 8) the following -

	2001 Revenue Expenditure £'000	2002 Revenue Expenditure £'000	Increase %	Real terms increase %
HSSC	91,082	101,452	11.4	7.5

The real terms increase is calculated as the increase above Jersey RPI, currently projected at 3.9 per cent (June 2001).

The actual growth is as follows -

Funding	*Cash value £ million*	*Totals £ million*	*Per cent value*
2001 funding		91.082	
Pay awards*	5.154		5.66
Social Security	0.250		0.27
Inflation	0.855		0.94
Transfers**	(0.184)		(0.20)
RHA***			
2001	1.000		1.10
2002	0.400		0.44
Growth			
2002	2.895		3.17
Cash total	10.370		
2002 Funding		101.452	
Per cent Total			11.38

* The pay awards figure contains pay awards for 2000, 2001 and 2002. Only £1.4 million relates to 2002. The remainder makes good outstanding part-year pay awards from 2000 and 2001.

** The transfers figure relates to transfers of funds from the Health and Social Services Committee to other committees.

*** The £1 million Reciprocal Health Agreement cost has already been set aside in 2001 to pay the United Kingdom the amount owed to it for healthcare treatments for Jersey residents. Only £400,000 has been added for 2002.

[1] Health and Social Services Towards 2000, page 55, paragraph 7.6.

[2] The Government's Expenditure Plans 2001-2002 to 2003-2004, NHS Net Expenditure 1999/00 to 2000/01.

[3] The NHS Plan (paragraph 2.34) Department of Health, London, July 2000.

[4] The NHS Plan (paragraph 5.4).

[5] Investment and Reform for NHS Staff - Taking forward the NHS Plan (paragraph 2.15) Department of Health, London, February 2001.