STATES OF JERSEY

THE REDESIGN OF HEALTH AND SOCIAL SERVICES (S.R.10/2014): JOINT RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES AND THE MINISTER FOR TREASURY AND RESOURCES

Presented to the States on 29th September 2014
by the Minister for Health and Social Services

STATES GREFFE

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THE REDESIGN OF HEALTH AND SOCIAL SERVICES (S.R.10/2014): JOINT RESPONSE OF THE MINISTER FOR HEALTH AND SOCIAL SERVICES AND THE MINISTER FOR TREASURY AND RESOURCES

Ministerial Response to: S.R.10/2014

Ministerial Response required by: 20th October 2014

Review title: The Redesign of Health and Social Services

Scrutiny Panel: Health, Social Security and Housing

INTRODUCTION

The Ministers for Health and Social Services and Treasury and Resources welcome the Panel's constructive review of the redesign of Health and Social Services. The Ministers would like to extend their thanks to the Scrutiny Panel, and Scrutiny Officers, for all their work. It is recognised that their approach has been thorough and wide-ranging in the period since the States' approval of P.82/2012 (Health and Social Services: A New Way Forward) on 23rd October 2012.

FINDINGS

	Findings	**Comments**
1	The Peer Review commissioned by the Ministerial Oversight Group made 11 Recommendations in total, many of which mirror the Scrutiny Panel's Findings and Recommendations contained in its "Health White Paper" report (S.R.7/2012).	S.R.7/2012 made 33 Findings. Of the 21 Recommendations, 12 were accepted, 8 were noted, and one was rejected. In producing S.R.10/2014, the Scrutiny Panel requested a briefing from the Ministerial Oversight Group (MOG) Expert Panel, but did not request a briefing from the Departments regarding their response. The Departments accepted most of the MOG Expert Panel's findings and recommendations, but rejected or questioned other findings: the Departments would have valued the opportunity to discuss this with the Panel prior to S.R.10/2014 being produced. Four recommendation themes are similar in S.R.7/2012 and the MOG Expert Panel report – • Data to monitor the impact of P.82/2012 investments (S.R.7/2012, Finding 4, Recommendations 1, 5, 16 and 17; MOG Expert Panel, Recommendation 4). The MOG Expert Panel report recognised that: ***"this is being addressed especially around the performance of the health and social care system and the health profiling of the population"***

	Findings	Comments
		• Prioritising a sustainable funding mechanism (S.R.7/2012, Recommendations 2 and 18; MOG Expert Panel, Recommendation 8). This is being progressed by the Treasury and Resources Department. • Involvement of G.P.s in planning for primary care and community services (S.R.7/2012, Recommendation 8; MOG Expert Panel, Recommendation 3). The MOG Expert Panel specifically commended the stakeholder engagement and noted that the ***"consultation process was inclusive and thorough".*** • Understanding the impact of any proposed charges in A&E on patients (S.R.7/2012, Recommendation 6; MOG Expert Panel, Recommendation 11). It should be noted that, at present, there are no proposed charges in A&E. Many of the findings from the MOG Expert Panel Report and S.R.7/2012 are also consistent – • The MOG Expert Panel recommendations strongly supported the health and social care transformation programme, as outlined in P.82/2012. ***"The Panel was clear that the case for change was made and the selection of a new model for health and social care was the right one."*** Recommendation 1 states: ***"That the States continue with a new model of health and social care. The original KPMG analysis that produced these options was robust and the consultation taken since has confirmed that there is widespread support for pursuing this new model".*** This is consistent with S.R.7/2012, Finding 3. • The 2 reports agree on the size of funding required: S.R.7/2012, Finding 1 notes that: ***"The proposals contained in the Report and Proposition: "Health and Social Services: A New Way Forward" require significant additional funding.";*** the MOG Expert Panel note that: "***The scale of the increase in resources required is difficult to forecast accurately, but the Panel was clear that it would be substantial from whichever perspective it was viewed".*** • S.R.7/2012 also noted challenges regarding I.T., which the MOG Expert Panel report identified. In a number of notable areas, the MOG Expert Panel reported positively on themes that had been

	Findings	Comments
		identified in the findings or recommendations from S.R.7/2012 – • The MOG Expert panel report specifically commended the stakeholder engagement (S.R.7/2012, Finding 2, Recommendations 10 and 15) and noted that the ***"consultation process was inclusive and thorough".*** They also recognised that: ***"Consultation is not about ensuring everyone gets what they want but the process served to engage stakeholders and help build alignment, establish consensus and mitigate potential problems in the future".*** • In relation to primary care system changes (S.R.7/2012, Findings 5 and 31, and Recommendation 19), the MOG Expert Panel findings noted that: ***"the mixed economy model of provision is the best building block for system reform. The perverse incentives currently operating must be tackled as they present real barriers to system reform".*** The MOG Expert Panel identified a number of strengths and positive aspects of the health and social care transformation programme, including its focus on system change and progression towards a single-patient record. It stated strong support for a new hospital, on dual sites, and noted that the future hospital programme must be delivered more quickly. ***"This scheme and the associated system reforms make a major statement to the people in Jersey and those outside about the nature and importance of the health agenda in this jurisdiction's future. This should not be underestimated"*** The MOG Expert Panel report strongly supported the transformational change programme, but noted the size of the challenge and the capacity for change management. The report concluded that: ***"We believe system integration is the right approach and applaud the efforts to build support amongst all stakeholders"***, and Recommendation 2 states: "***That the management capacity driving system reform should be considered and supplemented where necessary by encouraging greater involvement from clinicians, interim or external support. Resourcing this work properly must be a priority".***

	Findings	Comments
2	The Peer Review commissioned by the Ministerial Oversight Group, were not provided with W.S. Atkins' full report, its addendum or the additional studies undertaken by W.S. Atkins. The review seemed to focus on earlier work undertaken by KPMG in 2011.	The MOG Expert Panel was provided with a significant amount of information, both written and through presentations and discussion. The original KPMG report was just one document in a suite of almost 30 documents that were provided to the Panel. Given the nature of the review and the time available, the Department considered that a detailed briefing on the future hospital project and outcome of the Strategic Outline Case was more appropriate than provision of these detailed reports. The MOG Expert Panel received a detailed briefing, with questioning and challenge which lasted for a full afternoon. The Panel were given the opportunity to request additional documentation but did not do so.
3	The original intention was to provide mental health facilities at the Overdale Hospital site. The dual site hospital proposal has impacted on this vision, and an alternative facility will need to be identified as part of the Mental Health Review.	No decisions have yet been taken regarding the future location of mental health services. There may be advantages to co-location of mental health services with ambulatory care services, and therefore discussions have taken place with the future hospital technical advisers regarding reviewing whether co-location of urgently required mental health services at Overdale is advisable.
4	The Council of Ministers agreed that proposals for the new model of primary care should be delivered by the end of September 2014 in order to align them with the related proposals for sustainable funding of health and social services. However, the Panel has found that the new model of primary care will not be delivered by the end of September 2014 and a new date for completion has been proposed for April 2015.	Sustainable primary care is critical to the delivery of health and social care. Identifying the right model, with key stakeholders, is critically important and must not be rushed. During 2013, an expert partner was sought to assist in this. However, through ongoing discussions, a number of stakeholders felt that this was not the right solution. The procurement process was then stopped, and the project was re-focused with leadership from within the Health and Social Services Department. The project has therefore been delayed; however, key stakeholders are fully involved and committed, and are working enthusiastically and very positively with the Department to design and develop options for sustainable primary care into the future. A public consultation on a White Paper is planned for June 2015.
5	The development of the primary care service model has experienced some significant difficulties, and yet the configuration and delivery of	The configuration and delivery of hospital services has a significant dependency on a range of health and social care services, not just primary care. This has been clearly identified in the future hospital planning work, and the team leading that work

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	hospital services has a significant dependency on the nature and implementation of that model.	continues to work with colleagues in the primary care project and P.82/2012 service developments, to understand and to work through the impacts. The health and social care reform programme, of which sustainable primary care is just one part, aims to ensure Islanders are cared for in their own homes wherever possible. The benefits and impacts of this will continue to be modelled and monitored. The 'out-of-hospital' system development has one of the most significant impacts on the future hospital. The Out of Hospital system is not fully dependent on a new model of primary care, and has already been introduced as a pilot project, with further development this year. The model for sustainable primary care is also being developed this year; key leaders from the future hospital project are involved in this, and *vice versa*, to ensure the model developments progress iteratively and with a good understanding of the respective plans and cross-project impacts.
6	Achieving the Health White Paper's objectives requires an integrated approach to planning and developing services across the whole system of health and social care. The Panel has found little evidence that a whole system approach has been undertaken. This is concerning to the Panel because if one work-stream is developed without cognisance of the other, the successful delivery of the redesign programme is put at risk.	The health and social care reform programme has taken a system-wide, integrated approach to planning and developing services from its inception. This is important because challenges and developments in one part of the system impact significantly on all other parts of the system. As presented in the Green Paper: '*Caring for each other, Caring for ourselves'* in 2011, the health and social care system faces a number of significant challenges, including the demands placed on the hospital. The analysis demonstrated that, if no changes were made, the hospital would quickly run out of beds. It also identified some gaps in community services. For these 2 reasons the investment in community services was prioritised, whilst the future hospital planning work was being progressed. But it was also important to ensure that the programme of service changes is manageable and realistic; changing every part of the system simultaneously is not possible. In terms of encouraging the whole system to work together, and planning across the whole system – A system-wide 'U:collaborate' event was held at the programme's inception, where stakeholders shared thoughts and ideas and these were integrated to consider the system impact. Each of the Outline Business Cases and each of the detailed plans have been developed with a range of stakeholders from across the system (including

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		community staff, G.P.s, voluntary sector, hospital). This helps to ensure that each part of the system 'has its say', and is able to challenge each of the plans on the impact that it will have on their profession, team or organisation and on their part of the system. The Transition Plan Steering Group has met monthly since December 2010. It comprises representatives from across the health and social care system, including G.P.s and voluntary sector, whose role is to challenge the emerging plans from a system-wide perspective. The investment priorities, the Green Paper, White Paper and P.82/2012 were agreed by the Steering Group. The Health and Social Services Ministerial Advisory Panel (HASSMAP) challenged each of the plans. This group comprises independent experts from social care, children's services, mental health, hospital and primary care. Each of the major projects has its own steering group or development board; these report into the Transition Plan Steering Group or directly into the Ministerial Oversight Group. Key individuals from the System Redesign and Delivery Team participate fully in these groups to ensure cross-fertilisation and integration between the different work programmes.
7	The Panel's previous review of the Health White Paper found in 2012 that the current I.T. system was not integrated between primary and secondary care and was a problem which required urgent resolution. The Panel has found that this issue is still outstanding.	The Health and Social Services Department has made good progress on the I.T. issues identified in S.R.7/2012. The Department considered a wide range of issues and produced an Informatics Strategy, which was provided to the Panel as part of their review. The draft Informatics Strategy was agreed in January 2013 and is now being delivered. Ongoing delivery is subject to ongoing funding. The Panel's reports make specific comment on integration between primary and secondary care systems. It is important to recognise the achievements to date and to note that the right progress must be made against realistic timescales in order to maximise value for money. For example, the new primary care I.T. system (G.P. Central Server) is currently being implemented; it would not be sensible or feasible to attempt to integrate or establish links with a system that is not yet in place. Whilst the primary care system has been developed and the implementation planned, HSSD has completed the implementation of an electronic ordering and delivery system for pathology and radiology tests.

	Findings	Comments
		Initial discussions have taken place regarding how the primary care and hospital systems may be linked, and work has commenced on a business case for this. The Department is also establishing a system-wide health and social care informatics group to further progress I.T. integration.
8	Informatics and technology are essential to deliver and monitor the service changes and transformation described in the Health White Paper. The Minister for Health and Social Services acknowledged the lack of historical data, and made a commitment in 2012 that work would be undertaken to address this issue. The Panel has found that little progress has been made in this area, which is disappointing particularly when the need for improved information systems was identified as far back as the 1990s.	The Department has made significant improvements and advances in information technology and management over the past 3 years. In particular, the implementation of the ICR project delivered – • A replacement hospital administration system (Trakcare), ranked as one of the best in the world. • A new child health system, enabling Jersey to excel in protecting our children against infectious diseases. • Modern radiology systems across the hospital introducing electronic storage and retrieval of X-rays and scans. • Integration between Trakcare and other hospital systems. • A foundation, based on a world leading system, that is key to enabling the further developments and improvements to be delivered. In addition to, and following, the main project, other significant achievements in this area include – • The Informatics Strategy was agreed in January 2013, and is now being delivered. • Implementation of electronic ordering of pathology and radiology tests throughout the hospital. • Introduction of SMS text messaging reminders for appointments. • Implementation of case management system for mental health services. • Implementation of long-term care assessment system to enable the introduction of Long-Term Care Benefit. • Supporting and enabling the CAB to develop and implement the Jersey Online Directory. • Implementation of bowel-screening system. • Implementation of endoscopy reporting system.

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		• Agreed arrangements with Hospice to fund the implementation of a Hospice-based system to integrate with the hospital and other systems. • Supporting FNHC to implement a donor management system. • Implementation of traceability system in dental services. • Implementation of environmental health system. • Upgrade of ambulance and patient transport systems, including the addition of tetra location services. • Upgrade and integration of the clinical investigation system. In addition, a number of information-based projects are currently underway; these include – • The development of an Island-wide health and social care informatics group. • The establishment of a Standard Data Set across HSSD, enabling benchmarking internally and against UK hospitals. • The development of business cases to support the next major systems developments – o E-prescribing o Community Information System o Primary care/secondary care integration and interfacing o Hospital Electronic Patient Record. • The replacement and update of radiology system hardware and software. • The implementation of a 'medical desktop' solution across the Department, supporting the use of mobile devices. • A Post-Implementation Review of Trakcare and Order Communications. • Implementation of a system to support the Jersey Talking Therapies service. This demonstrates a significant improvement and advancement in information systems over recent years, and illustrates a significant current and ongoing programme of work. It is important to recognise that, as with healthcare itself, there is an almost infinite demand for information and information systems. These demands have to be prioritised and managed to deliver the best possible

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		value for money within the Department's overall capacity to deliver the organisational change that necessarily comes with new systems.
9	One of the overall conclusions contained in the Comptroller and Auditor General's report: "Use of Management Information in the Health and Social Services Department – Operating Theatres" was that improvements to management information should be seen as a priority. The Panel wholeheartedly agrees and expects the Minister for Health and Social Services will take heed of the C&AG's report and its recommendations and conclusions.	The thoroughness and depth of the Report has been welcomed by the Minister. Work had commenced on theatres prior to the Comptroller and Auditor General's review. An action plan was developed on receipt of the report, with work underway to address the relevant recommendations. A formal response will be submitted to the Public Accounts Committee by 1st October 2014. Data is routinely collected on all the key aspects of theatre usage and can be accessed for audit or operational use. However, the Department accepts that the methods of data capture could be improved and that greater operational use could be made of the data currently collected.
10	The Commissioning team acknowledged that there is a limited pool of health staff available on the Island, which will have an impact on service development and delivery.	The Green Paper '*Caring for each other, Caring for ourselves'* stated that the increasing demand for health and social care in the future will pose workforce challenges. Most staff want to work in a supportive, modern and innovative care setting where their contribution and their full potential can be realised. P.82/2012 offers the opportunity to redesign the workforce and introduce expanded roles with greater responsibility; this can both attract and retain staff. In addition to securing the right number of staff, motivation and retention is important. This includes – • Clear roles and scope • Control over job performance • Interesting career opportunities • Good educational opportunities • Trust and collaboration • Recognition • Effective communication. The Department's workforce strategy includes – • increasing the number of nurses employed, for example through pre-registration nurse education on the Island • expanding nursing roles to ensure nursing careers are more attractive; for example, through non-medical prescribing

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		• training health and social care staff, such the BTech qualification in partnership with Highlands College • delivering more education and training on-Island; for example, the degree and Masters courses delivered in partnership with the University of Chester. Jersey is no different from other jurisdictions in facing a recruitment and retention challenge; a proactive workforce strategy with a combination of 'growing our own' and recruiting off-Island, along with a good working environment and opportunities, will help to address these challenges. Since 2010, 100 additional nurse posts have been created in HSSD. Because of the strategic approach to recruitment campaigns and local professional training and succession planning, as outlined above, vacancies have reduced – in July 2012 there were 41.5 posts vacant out of 708; in July 2014 this has fallen to 34.2 posts vacant out of 766.
11	Since 2012, there has been an improvement in the level of communication between the Health Department and members of the Voluntary and Community Sector.	The voluntary and community sector is a key partner in developing and delivering health and social care services, and is also a very valuable and respected 'voice of the patient'. We are pleased that the Panel has recognised the significant improvement in relationships between the Department and voluntary sector partners. This has come about through willingness and openness on both sides, and through the active involvement of the sector in whole system planning and delivery. Through the P.82/2012 investments, we have been able to support the voluntary sector partners with additional funding; for example, to support the expansion of Hospice services. We have also been delighted to see strong delivery partnerships building, so that now organisations are working together to deliver services. We look forward to seeing relationships further improve and to working even more closely with our partners across the system into the future, delivering a choice of excellent health and social care to Islanders.
12	Recent mediation in 2014 has improved the relationship between the Health Department and G.P.s However, poor communication during 2012/2013 has caused a delay in the development of a new model of primary care.	The relationship between the Health and Social Services Department and G.P.s has been developing over the past years. As with any relationship, there have been some challenges, but these have not been with every G.P. or in every area of work. The Primary Care Governance Team came into being in 2011; they have developed positive

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		relationships with G.P.s, with regular communication – for example, monthly G.P. meetings and monthly meetings with the primary care body, in addition to meetings with individual G.P.s and practices. We have worked together on a number of positive developments, including the G.P. Central Server and the Performers List, which was approved by the States earlier this year. The challenges regarding the new model of primary care arose from ongoing discussions and involvement of primary care representatives in the selection of an expert partner. As a result of the concerns raised by G.P.s, the procurement was halted and an alternative way forward was identified through facilitated discussions with the G.P.s. These facilitated discussions were open, honest and positive; they were not adversarial mediations as the Panel implies. The relationship with the primary care body has improved significantly, and a primary care hub has been set up, where G.P.s work jointly with officers from the Health and Social Services Department and Social Security Department. This is further improving relationships and understanding, and the participants have demonstrated their commitment and enthusiasm to working together in an open and trusted way.
13	One of the priorities given to W.S. Atkins was to identify an appropriate site on which acute healthcare services could be delivered. However, their evidence to the Panel stated that they found it frustrating that they were not afforded the opportunity to participate in meaningful clinical team engagement.	Initially, the site selection was largely driven by size and site development matters, and therefore the Strategic Outline Case (SOC) could not have been meaningfully influenced by clinicians. The Design Champion co-ordinated clinical engagement to test whether a dual site option was clinically safe and feasible. W.S. Atkins produced the SOC Addendum, which reflected the dual site design developed by the Design Champion in consultation with clinicians.
14	The timeline for completion of the Full Business Cases to introduce more community services, originally due to commence in January 2013, was ambitious and, due to a number of factors, the timeline changed considerably.	Phase 1 of the Transition Plan was scheduled for implementation in 2013–2015. This is still the case, and, halfway through this period, the vast majority of additional services have now been introduced and are delivering real benefits for Islanders. This includes intermediate care, children's respite care, pulmonary rehabilitation, expanded services at Hospice, Jersey Online Directory, rapid access for heart failure, oxygen therapy and Community Midwifery. The new services are offering greater choice for Islanders, with reduced waiting lists,

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		accessible information to support carers and individualised care. There has been excellent feedback from those using the services and their carers; and the services are continuing to develop and improve. As the Panel notes, the original timetable was very ambitious, and the timeline has changed through ongoing discussions with stakeholders and as a result of challenge from the Scrutiny Panel. The work to develop the detailed specifications, implementation and delivery plans started in October 2012, following the States approval of P.82/2012. In January 2013 we undertook a 'listening exercise', as some stakeholders had raised concerns regarding their involvement. Working with stakeholders, we then rescheduled the work plan to ensure that we were responding to their concerns, developing plans together and ensuring the workload and pace of change was manageable.
15	The impact of delaying the implementation of community-based care strategies will have a significant effect on determining the size of the hospital.	The initial investment into community-based investments was not delayed; it started immediately after P.82/2012 was approved. Intermediate Care, end-of-life care and respite for dementia were all enhanced from late 2012, and have been developing and improving since that time. Priority investments in long-term conditions were made in mid-2013, and rapid response was piloted from May 2014. A 'winter pressures' project ran during 2013, bringing together services from across health and social care to improve discharge. The health and social care reform programme has taken a system-wide, integrated approach to planning and developing services from its inception. This is important because challenges and developments in one part of the system impact significantly on all other parts of the system. As presented in the Green Paper '*Caring for each other, Caring for ourselves'* in 2011, the health and social care system faces a number of significant challenges, including the demands placed on the hospital. The analysis demonstrated that, if no changes were made, the hospital would quickly run out of beds. It also identified some gaps in community services. For these 2 reasons the investment in community services was prioritised, whilst the future hospital planning work was being progressed. But it was also important to ensure that the programme of service changes is manageable and realistic; changing every part of the system

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		simultaneously is not possible. The 'out-of-hospital' system development has the most impact on determining the size of the future hospital. The aim is to enable Islanders to be cared for at home for as long as possible, reducing the demand on the hospital and on care homes. The services comprise rehabilitation and step-up step-down (previously called 'intermediate care'), rapid response, long-term conditions care, end-of-life care, a single point of access, and older adults' mental health care. These strategies have already had a noticeable effect on the hospital: in winter 2012, up to 60 beds were closed due to an outbreak of Norovirus, but the hospital coped with this because the additional community services had started to be available. The services and the system remain under review, to ensure that investments are made in those services that can have the greatest impact and benefit. In May and November 2013 a 'snapshot' audit was undertaken of hospital bed use. This identified some process improvements, and confirmed that the further investment and enhancement of community services (planned for 2014) was required. A formal evaluation of the Intermediate Care pilot was reported in February 2014, and plans for the future service have been developed since that time. In terms of planning further forward, the future hospital and 'out-of-hospital' projects both include very detailed demand and capacity modelling. Activity modelling suggests that the new hospital requires 300 beds, rather than 400 beds, which would be the requirement if there were no investments in community services. The hospital is being designed and 'sized' for 2040 capacity. It will be completed in 2024, but will have the right capacity for 2040 – so some of the capacity should not be needed at that point, which allows some degree of mitigation in the short term to the risk created by any delays in the delivery of community initiatives.
16	Following the implementation of the Community Midwife Service, most views from G.P. surgeries were positive about the new system of providing an Island-wide ante-natal care service in accessible non-hospital settings.	The P.82/2012 investments are intended to improve choice for Islanders, as well as offering quality and value for money. Very positive feedback has also been received from individuals who have used the Intermediate Care service and Children's respite care.

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17	Even though the Specialist Fostering service was brought forward to 2013, no specialist foster carers have been appointed to date.	As at September 2014, 3 new foster carers and one new connected person carer have been approved, as well as 3 sets of level 2 specialist foster carers (where a 'set' is an individual or family unit). A further 5 x level 2 carers will be approved in the near future. The new specialist foster carers are completing their training; children will be matched to the specialist foster carers according to needs. Due to this increase in local foster carers, no more children have been placed in off-Island fostering placements this year.
18	There is a lack of available health visitors on the Island to undertake training for the Sustained Home Visiting Programme, and therefore it has been necessary to recruit from the UK. Family Nursing & Homecare are still in the process of recruiting, and they are therefore unable to implement fully the Sustained Home Visiting Programme.	The Sustained Home Visiting Programme has already started delivering services. The implementation commenced in December 2013, and the service was planned to be fully available from October 2014. Two Health Visitors commenced in September. A further Health Visitor will start in October and the final staff member in November. The operational planning has progressed well whilst the recruitment was taking place; the Licence has been obtained, resources ordered and delivered, and a Co-ordinator/Champion appointed. Programme model training has been delivered to 50% of the current Health Visitors, and they have taken a small number of clients each to embed this training. E-learning modules have been completed, and Supervision training to support the programme has been delivered.
19	It is unclear to what extent the White Paper development in out-of-hospital care has been taken forward successfully. The one review undertaken by the Health Department – of the intermediate care pilot – is highly critical in that it indicates a lack of readiness to initiate the service, as well as a failure to put in place systems to monitor adequately the use of these resources.	The Scrutiny Panel has received a number of private briefings and held public hearing regarding the White Paper. The Panel has also been provided with a significant volume of information. Pilot projects are designed to identify challenges and issues, and to provide the opportunity to address these before the full service goes live. Intermediate Care is critical to the success of the White Paper, and therefore needed to be piloted. The pilot commenced in late 2012, and has been monitored and evaluated since, with service developments being made along the way. In terms of the development of the 'out-of-hospital' system: from November 2013 – January 2014, 'commissioning intentions' were developed. These identify what services are needed into the future, and were based on discussions with key stakeholders, an

	Findings	Comments
		understanding of service gaps and needs, and the emerging learning from the Community Intermediate Care (CICS) pilot. A formal evaluation of the Intermediate Care pilot was reported in February 2014. Also in February, the Minister approved the commissioning intentions, and agreed that a whole system approach to 'out-of-hospital' care would be developed, integrating the Intermediate Care and Long-Term Conditions developments into one co-ordinated system. Since that time, FNHC have commenced a Rapid Response pilot, Community and Social Services have progressed their Single Point of Referral (SPOR) and discussions have commenced regarding the integration of Older Adults Mental Health into the system-wide approach. The previously overspending CICS budget has been brought back under control and resources are being effectively managed. As agreed by the Transition Plan Steering Group in late January 2014, the system development will be led through a multi-agency group, with an integrated project approach. A Development Board has been set up, and a Project Brief have been produced which outlines the key elements of this, along with the governance, deliverables and timelines. The Development Board comprises leaders from the key organisations (FNHC, HSSD, primary care); their role is to develop and oversee the delivery of the 'out-of-hospital' system, and to address the issues of readiness to initiate the service and the systems to monitor adequately the outcomes and use of resources.
20	Proposition P.82/2012: "Health and Social Services: A New Way Forward" required the Council of Ministers to bring forward proposals for investment in hospital services and detailed plans for a new hospital (either on a new site or rebuild on the current site) by the end of 2014. This included full details of all manpower and resource implications necessary to implement such plans.	The Council of Ministers intends to report back to the Assembly with the outcome of the future hospital feasibility study, as set out in P.82/2012. This was originally intended for the end of 2014; however, S.R.10/2014 acknowledged that there was a significant change to the proposed approach to delivery of the future hospital during 2013, resulting in the development of the dual site pre-feasibility concept in October 2013. The Ministerial Oversight Group has therefore approved a revised timescale for delivery of the feasibility study for the future hospital, which will now report to the States during 2015.

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21	The Ministerial Oversight Group considered a Communication Plan for public consultation. Its aim was to confirm the preferred site through a States decision to enable detailed feasibility work to follow, and design for a new hospital to be developed and procured. However, the Panel has concluded that no States decision has been taken on this issue, despite being the original intention of the Ministerial Oversight Group.	S.R.10/2014 acknowledges that within Budget 2014 (P.122/2013), the Minister for Treasury and Resources set out for the Assembly, details of the proposed Dual Site approach proposed within the Strategic Outline Business Case, and indicated clearly that this would form the working assumption adopted within the feasibility study – funding for which was supported by the Assembly in approving Budget 2014.
22	Although the Department has undertaken some form of consultation on the future hospital, the Panel would have expected to have seen greater and more meaningful public consultation, together with a more detailed analysis of the results.	A public communication rather than a formal public consultation was considered appropriate, given that no decision relating to the requirements of P.82/2012 was proposed. The Health and Social Services Department and Jersey Property Holdings held an extensive public communication exercise during the period between lodging and debate of Budget 2014 (P.122/2013), including – • Four public, key stakeholder and staff focus groups to gauge likely public response to future hospital proposals • Five public events open to all Islanders • Extensive promotion via social media of a future hospital website: www.gov.je/futurehospital • The development and launch of video promotions and animations of the Dual Site concept – these were widely publicised by written, audio and visual media • Placing advertisements in the Jersey Evening Post, on Jersey Insight and other electronic media, promoting the information available • A comprehensive social media campaign that resulted in over 7,250 people being made aware of the future hospital video, with over 1,100 viewings of the video on YouTube. Formal consultation will be undertaken as part of the feasibility study in advance of seeking outline planning applications and as part of the Environmental and Health Impact Assessments.

	Findings	Comments
23	Concerns have been highlighted by the general public and States of Jersey employees about the dual site proposal in relation to: operating from 2 sites, efficiency and transport. The Panel has seen no evidence that these concerns have been addressed.	The communication exercise clearly demonstrated that the public response to the future hospital proposals was overwhelmingly in favour of the proposed changes. In terms of responding to concerns raised, the Acute Service Planning process has actively involved clinicians and other staff. Over 80 engagement meetings having been held to inform the design process already. Concerns raised are being addressed through the planning process: The refined concept pre-feasibility design includes almost 300 staff and public car parking spaces at Overdale. During the feasibility study phase, detailed transport plans for both Overdale and General Hospital sites will be used to inform a Transport Impact Assessment that will be part of the Outline Planning Application for the development. Underground parking is being considered for the site, together with further parking for the Crematorium. The refined concept pre-feasibility design also includes costs for a frequent shuttle bus service between the General Hospital and Overdale sites. This proposal will be tested and quantified further, following the development of transport plans as part of the current feasibility study.
24	One of the reasons for rejecting the Zephyrus site (Waterfront) was the separation of the sites by the main road, which would present significant obstruction to providing the necessary clinical and operational links between the sites. This is inconsistent with the later proposal by the Ministerial Oversight Group to operate a dual site hospital from the current hospital site and Overdale, which involves a substantially greater degree of physical separation.	The 2 matters are separate, but the responses given by Ministers are consistent. As part of the pre-feasibility development of the Strategic Outline Case, several combined sites were considered for development of a wholly new hospital. These included a combined Waterfront site where the current Waterfront Car Park and part of the Waterfront site south of Victoria Avenue were considered together, to see whether a viable single hospital could be developed over the 2 combined sites. The clinical adjacency possible for this site configuration was very poor, and therefore it was not progressed to shortlisting in this configuration. This is very different from the dual site proposal within the Addendum to the Strategic Outline Case which required consideration of a partially new-built and part-refurbished hospital. Here, the dual site proposal separates ambulatory care at Overdale and acute inpatient care at the General Hospital. UK NHS examples have proved that these 2 functions can be operated on different locations very successfully.

	Findings	Comments
		Therefore the 2 approaches are not comparable in the way suggested in S.R.10/2014. The first approach attempted to fit a large wholly new-built hospital onto a site with insufficient ground floor footprint, necessitating a bridge over Victoria Avenue. The second separates ambulatory care from inpatient care in a manner proven by exemplars elsewhere. The point being made by the Minister for Treasury and Resources and the Treasurer giving evidence, was that combinations of sites had been considered prior to the Design Champion proposing a dual site in response to the clarification of the budget available for the project, as was evident from the Strategic Outline Case provided in evidence.
25	At a Ministerial Oversight Group Sub-Group meeting in February 2013, the Chief Executive of the States expressed a view that unless the cost of the scheme could be reduced down to the levels identified in R.125/2012 (between £389 million – £431 million), it would be necessary for the project to consider what clinical compromises were necessary to achieve a total project cost of below £400 million.	This is correct; however, the Chief Executive was careful to refrain from proposing a suggested budget in the Ministerial Oversight Group Sub-Group meeting in February 2013. The subsequent approach to identify a sufficient budget involved an extensive review of other facilities, a cost challenge and the clinical engagement work, which collectively confirmed that, in principle, a budget of £297 million should be sufficient to enable the priorities for improvement identified by the Health and Social Services Department to be met. This information has been provided in evidence to the Panel.
26	Although the Waterfront options had attractions in terms of potential benefits, costs and ease of construction, the Ministerial Oversight Group Sub-Group agreed that any Waterfront option would be out of keeping with the existing Esplanade Quarter Masterplan, and would require considerable lost opportunity costs to replace or compensate for the loss of existing uses. Furthermore, the options developed were considered likely to have a detrimental impact on the development of the Jersey International Finance Centre which would form an income-stream considered essential for the development of the new hospital.	This is correct.

	Findings	Comments
27	A wide range of sites were considered by W.S. Atkins between May 2012 and June 2013, including greenfield sites, and many of these were worked up into relatively detailed costings. The preferred option that emerged was to rebuild on the existing General Hospital site. However, the introduction of a reduced budget envelope necessitated a reconsideration of this choice.	This is correct.
28	Although the preferred site option developed by W.S. Atkins identified a total new construction and land cost of approximately £462 million, the Ministerial Oversight Group subsequently determined a maximum sustainable total capital funding package of £250 million (excluding contingency).	In June 2013, the Pre-Feasibility Project Board recommended that a more detailed concept for a £250 million first phase of a new hospital be presented within a revised Strategic Outline Case to the Ministerial Oversight Group, together with a package of proposals for transitional capacity and essential maintenance and upgrades and the Ministerial Oversight Group agreed. In practice it proved difficult to achieve the outcomes needed by the Health and Social Service Department within a £250 million envelope; and a higher budget of £297 million was subsequently proposed by the Project Board and accepted by the Ministerial Oversight Group, as has been provided in evidence to the Panel.
29	The design champion identified that a single investment in the General Hospital site would not maximise the benefit of the available investment and would result in a more lengthy and complicated construction programme, causing significant disruption and inconvenience to patients. The Panel has found no evidence of his analysis on public record to enable an assessment of the factors taken into account or the robustness of judgements derived from it.	In the Minister for Treasury and Resources' evidence to the Panel, the Treasury and Resources Department confirmed that there was a public record of the Design Champion's iterative development of the future hospital concept. W.S. Atkins confirmed that the Design Champion's proposals were sensible, given the brief. Therefore an independent professional assessment has been provided.
30	W.S. Atkins felt that at times they were set unrealistically short timescales for the delivery of information or reports. They also felt that they were not able to engage fully with key members of	This may be a correct reporting of W.S. Atkins International's view; however, W.S. Atkins accepted the brief provided to them and confirmed they could achieve the timescale set. It is true that the Project Board did robustly challenge W.S. Atkins' assumptions on occasion, as

	Findings	Comments
	the Project Board, and as a consequence it was difficult to ensure that they fully understood the challenges of proceeding down a particular route or direction of travel.	might be expected on a project of such significance to the States, and this may be the reason for the view given.
31	It was not until May 2013 that W.S. Atkins were informed of the available budget for the future hospital project. While it may be appropriate that in the initial stages the contractor is not limited by budget, it should become clear very early on what the budget envelope is likely to be, so that appropriate value is obtained from consultant time and expertise.	It is true that W.S. Atkins were informed of the available budget for the future hospital project in May 2013. However, W.S. Atkins, who were employed as consultants, not contractors, also confirmed in their evidence that it was not unusual for a budget not to be confirmed until a public authority had determined what could be afforded. Ministers took time to challenge all elements of the Strategic Outline Case to establish that the budget for a wholly new hospital was fully robust. As soon as it became clear that the cost of a whole new hospital would be unaffordable, the Project Board reviewed the available alternatives in relation to the spatial standards, cost assumptions and re-use of some hospital buildings.
32	A greenfield site for a new hospital would have been the best option in terms of less risk, more benefits, and a lower overall cost.	This is agreed; however, no suitable greenfield site was identified that would be capable of development for a whole new hospital.
33	The process followed to appoint the design champion was flawed. Others were not given the opportunity to apply for the post and W.S. Atkins were unaware that an appointment was being made to conduct work of direct relevance to their own pre-existing and continuing appointment.	Financial Directions allow for appointment of consultants where time does not allow for a full procurement and a suitably experienced and qualified candidate is available, as in this case. W.S. Atkins were made aware of the appointment; their own appointment had concluded at that point, and it was an extension of their work that followed under a new brief to produce the supporting Addendum to the Strategic Outline Case.
34	Although the dual site offers a potential solution for a reduced budget, the current proposal means that 44% of the existing hospital will be new build, 30% will be refurbishment and the remainder will be existing use. This will inevitably result in a need for further capital investment in the future.	It is inevitable that further capital investment will be required at some point in the future for the hospital. However, Ministers accepted collectively and in principle that the dual site concept set out in the Addendum to the Strategic Outline Case represented good value for money and an affordable investment, as well as a safe and sustainable hospital provision.

	Findings	Comments
35	The result of W.S. Atkins pre-feasibility study dated May 2013 was that a phased development of the existing hospital site offered the best location for key investment in future hospital capacity, following which a draft Report and Proposition was prepared detailing the outcome of the pre-feasibility study. The Panel note that this did not mention Overdale Hospital or the dual site concept.	The draft Report and Proposition was policy in development and was never progressed. Instead, the Ministerial Oversight Group accepted the Pre-Feasibility Project Board recommendation to develop a more detailed concept to an indicative £250 million budget. The dual site option emerged after this decision.
36	There are conflicting views on who identified the dual site solution. On the balance of the evidence, it seems most likely that the dual site solution had not been identified as an option until it was introduced by the design champion in July/August 2013.	This finding is based upon a mis-communication during the Public Hearing, as is explained in response to Finding 24.
37	During the development of the future hospital, options have been continually developing. As assumptions change, the basis for comparisons also change, and it is therefore necessary to present clearly what is included in the various options. This has not always been apparent in the documentation provided to the Panel, and it is therefore questionable whether all options have been compared on a like-for-like basis.	In each case where an option was under serious consideration, a full feasibility cost estimate was produced in line with a consistent best practice protocol (the UK NHS Health premises Cost Guides) by a local qualified quantity surveyor. As the brief changed, so did the assumptions within the cost estimates.
38	The proposed dual site option is not included in previous options produced by W.S. Atkins and which reflected the original brief, which in turn reflected the intention of P.82/2012. The impact on patient care of this decision to go with a lesser mix of new and refurbishment has not been made clear and is not in the spirit of the decision to provide new modern hospital facilities in Jersey.	Proposition P.82/2012 "*Health and Social Services: A New Way Forward*" requires the Council of Ministers to bring forward proposals for investment in hospital services and detailed plans for a new hospital (either on a new site or rebuild on the current site). The dual site refined concept proposal is consistent with this proposition. Whilst a wholly new hospital has been confirmed as unaffordable, the dual site proposal includes proposals for a new hospital (the ambulatory care centre at Overdale), and new build and refurbished hospital on the current site. All published communication regarding the dual site is consistent with this approach.

	Findings	Comments
39	Although estimated revenue figures will be refined alongside the detailed feasibility work, the additional cost of operating on a dual site is estimated by the Treasury Department to be an annual recurrent cost of £1.7 million in 2019 when the Overdale site is planned to be opened. The Panel has found that as the dual site concept was identified at a late stage, a high level analysis of the estimated revenue consequences had not been undertaken when all other options were being considered.	The Appendices in both the original Strategic Outline Case and the Addendum include estimated revenue consequences. A significant number of sites were evaluated and subsequently discounted, and it would not have been cost-effective to develop revenue costs for all of these options. All shortlisted options were analysed for revenue implications. This information was provided to the Scrutiny Panel during their review.
40	There is a lack of clarity around the decision-making process in determining the size of the budget and why a 100% new build hospital was unaffordable.	The decision-making process and the record of it have been made available in evidence to the Panel. The process followed to arrive at an acceptable budget was iterative and the result of a combination of cost challenge, challenge to spatial assumptions, benchmarking and re-analysis of planning assumptions.
41	The Panel conclude that although mention was made of the dual site proposal in the 2014 Budget report, no formal decision has been taken on this issue as it was not included in the proposition.	Whilst the final decision on the approval of the feasibility study will be a matter for the States Assembly, the dual site concept informed the funding strategy approved by the States in approving Budget 2014 (P.122/2013) and awarding £10.2 million feasibility study funding. As such, Ministers consider that a decision of intent to adopt a dual site solution as suitable for consideration in the feasibility study has been made by the Council of Ministers, and that the States Assembly was fully aware of this intent in approving P.122/2013.
42	The purchase of the 2 hotels in Kensington Place would make a sensible strategic investment for the States of Jersey, as well as providing space to facilitate the development of the existing site.	Strategic investments will be considered against affordability and space requirements. As the feasibility study develops the potential for this site will be considered robustly, and Jersey Property Holdings have been instructed to establish the price for which the site might be secured to inform the feasibility study.
43	Due to the limited budget proposed by the Ministerial Oversight Group, W.S. Atkins explained that a target figure of a 15% reduction of room sizes below the UK NHS spatial guidance has been adopted.	This is the assumption within the Addendum to the Strategic Outline Case, and is a working assumption within the feasibility study. Analysis of spatial standards provided to the Panel indicated that very few UK NHS hospitals were constructed in accordance with the NHS Design Guidance and that many international hospitals, including in the USA

	Findings	Comments
		and Australia, had reduced spatial standards in many rooms. Patient safety will be a primary aim of the feasibility design, and space will be assessed on this basis. If space and cost can be reduced safely, this will be proposed within the response to P.82/2012.
44	The 1960s building situated at the current hospital site has been excluded from the planning as it is not fit for clinical use. Therefore, at the end of the hospital project, the 1960s building will still stand, but it is not clear what purpose it will serve in the future, or whether optimum value from the current site is being achieved.	The 1960s building has not been excluded from planning, but is not considered suitable for clinical use in the long term. The feasibility study is investigating whether the building can be used for non-clinical support and administrative functions as part of the overall site development.
45	Although the plan is for the Overdale site to be completed by 2019, the overall hospital project will be completed by December 2024. The cost of the project so far totals £574,534.	There are significant risks in undertaking too much refurbishment at one time in the Island's only hospital whilst it has to remain operational. The feasibility study will consider ways to reduce the construction timescale to the minimum possible.
46	There appears to be a lack of progress in strategic planning for acute services and services provided on-Island/off-Island since 2012. The acute services strategy is not complete, and as with the absence of a primary care strategy, has created major difficulties for the Panel in reaching a conclusion about the robustness of the plans for the role, range and scale of future hospital services.	The concepts underpinning the Acute Services Strategy have been in development for some time, and have been produced with Clinical Directors and Senior Nurses. The dual site option in late 2013 changed the emerging Acute Services Strategy. The future hospital project director was recruited in December 2013; as a clinician, his role was to engage with clinical colleagues to develop an Acute Services Strategy and plan based on a dual site concept. Developing a strategy, in partnership with a wide range of stakeholders, is a time-consuming but necessary process. The Acute Services Strategy is currently being consulted on to test the degree to which the strategic principles, strategic objectives and clinical model it describes reflect the contributions made by stakeholders.
47	One of the reasons for the dual site concept was because of the potential disruption redevelopment of the current hospital site would cause for staff and patients. The Panel accepts that construction by its very nature does cause disturbance, but there are ways to	The dual site option is an option that meets the HSSD Departments needs within the budget identified. As part of the planned feasibility study development, a comparable single site option will be prepared to demonstrate the performance of a single site option compared to a dual site alternative. The cost comparison work will be made available as a

	Findings	Comments
	minimise this both for patients and staff. Lessons and experience from other hospital redevelopments which have managed their levels of disturbance well could have been explored further, rather than opting for redevelopment and new build over 2 sites.	Report, with cost information provided to the Panel under commercially confidentiality protocols.
48	The Minister for Treasury and Resources stated that the central assumption for growth in the Strategic Reserve is based upon investment returns averaging 5% over the next 10 years. The Minister also stated that with such an investment return, the hospital funding of £297 million can be fully met, and the Strategic Reserve would rise to a value of £810 million. It is unclear what the plan will be if the Fund does not return the anticipated sum of money when it comes to funding the capital projects.	The Minister for Treasury and Resources made clear in evidence that in the unlikely event that investment returns from the Strategic Reserve were not sufficient to fund the hospital investment, then adjustments would need to be made according to the prevailing economic conditions. In 2013, returns on the Strategic Reserve were such that, after taking account of inflation, £79.4 million had already been secured by 31st December 2013. The Strategic Reserve continues to make strong returns in 2014.
49	The Minister for Treasury and Resources made a commitment within the Budgets 2014 and 2015 that the hospital project will be fully paid for by the time it is completed, and there will be no cost to the taxpayer and no debt for future generations.	This is correct, but was caveated by the assumptions stated within Budget 2014 (P.122/2013).
50	The Long-Term Revenue Plan is being developed by the Treasury and Resources Department. This aims to provide a higher level of funding certainty and will enable long-term sustainable financial planning by the Health Department. It is understood that the sustainable funding mechanism for health and social care will be achieved via the Long-Term Revenue Plan by the end of September 2014, as agreed in P.82/2012.	The States has embraced longer-term financial planning. The Treasury and Resources Department continues to develop a working document that helps to identify issues and potential measures that must be considered when reviewing the next MTFP period. All funding pressures and growth requests from Departments feed into this document, alongside future income projections and economic assumptions. This includes funding requests identified by H&SS. How those and other pressures are funded is a policy decision that has not yet been made. That policy decision will be guided by the professional advice already received, the advice of the Expert Panel, as well as current thinking in the UK and elsewhere in the world, for example the

	Findings	Comments
		very recent report of a Commission of the Kings Fund, chaired by Dame Kate Barker , who is also a member of the FPP.
51	The Long-Term Revenue Plan will confirm the level of investment in health and social services into the future. The Panel was informed that it will not propose a separate health fund in addition to the existing Health Investment Fund and Long-Term Care Plan. The Treasury Department explained health services are a public good, and as such must be rationed to prevent an unsustainable impact on the wider Jersey economy.	The Long-Term Revenue Planning Review includes the level of growth required by H&SS for the next MTFP period. These pressures must be considered alongside all other requirements across the States. No decision has been made as to how costs will be funded.
52	The Minister for Health and Social Services recognised the requirement that the funding mechanisms for primary care link with the sustainable funding streams for the whole of health and social care, and that parts (b)(ii) and (b)(iii) of P.82/2012 link together. It is therefore unclear what impact the delay in completing the new model of primary care will have on the sustainable funding mechanism for health and social care.	Each of the elements of P.82/2012 link together. The Ministerial Oversight Group retains an overview of the entire programme, and officers work closely together to consider the interactions. The sustainable funding work-stream continues to be developed, and it is not envisaged that any delay in completing the primary care model will affect the solution to identifying a sustainable funding mechanism for health and social care in principle.
53	The work being undertaken to develop a new model of primary care and sustainable funding mechanism for health and social care is likely to impact on the Health Insurance Fund held within the Social Security Department. It is expected that an increase in contributions will be required from individuals in the future.	Until that work has been finalised, it is not possible to say what effect that solution will have on any existing contributions to existing Funds, as it cannot be presumed that the current funding structure of the HIF will be maintained. What is clear is that the ageing population will place rising pressures on primary care as well as on secondary and community services, and will require an increased funding alternative, however delivered.
54	The Long-Term Capital Plan, published as an Appendix to the Medium Term Financial Plan 2013 – 2015 and developed by the Treasury and Resources Department, estimates that £332 million would be required in 2016 for the hospital, but this	The £332 million MTFP estimate comprised £300 million for the new hospital. This was an indicative figure provided by KPMG, based upon a UK assumption that new hospitals cost approximately £1 million per bed and £32 million for transitional capacity – and was at 2010 prices. Subsequent work in pre-feasibility has established a more detailed cost estimate.

	Findings	Comments
	figure did not reflect additional costs of construction in Jersey compared to the UK. The budget figure was to be developed once there was greater certainty arising from the feasibility work.	
55	Within the 2015 Budget it is proposed that contributions to the Long-Term Care Fund in 2014 and 2015 are deferred in order to balance the Consolidated Fund.	As the scheme only commenced on 1st July, at this stage it is difficult to know whether the payments out of the scheme are likely to differ significantly from the long-term forecast which was developed from the OXERA model and was the subject of an Internal Audit Review. Given the above, assuming the modelling is accurate, it was agreed that up to £5 million in each year of 2014 and 2015 could be taken from the previously agreed transfers and returned to the Consolidated Fund. This matter will be kept under constant review.

RECOMMENDATIONS

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
1	The Peer Review Panel's report on the reform of health and social services should be published by the Ministerial Oversight Group along with a formal response to its 11 recommendations before the Budget 2015 debate.		Accept	The Ministerial Oversight Group will publish the Expert Panel Report and response before the Budget 2015 debate.	September 2014
2	Detailed proposals to develop and fund a fully integrated I.T. system should be included in the Medium Term Financial Plan 2016 – 2019.		Accept	The Health and Social Services Department has made good progress on the I.T. issues identified in S.R.7/2012. The Department considered a wide range of issues and produced an Informatics Strategy, which was provided to the Panel as part of their review. The Panel's reports make specific comment on integration between primary and secondary care systems. It is important to recognise the achievements to date, and to note that the right progress must be made against realistic timescales in order to maximise value for money. For example, the new primary care I.T. system (G.P. Central Server) is only now being implemented; it would not be sensible or feasible to attempt to integrate or establish links with a system that is not yet in place. Whilst the primary care system has been developed and the implementation planned, HSSD has completed the implementation of an electronic ordering and delivery system for pathology and radiology tests. Initial discussions have taken place regarding how the primary care and hospital systems may be linked, and work has commenced on a business case for this.	Q3 2015

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
				The Department is also establishing a system-wide health and social care informatics group to further progress I.T. integration. As the Panel have noted, the Department's initial submissions to the Long-Term Revenue Plan reflect funding for further development of information systems. Nowhere in the world has successfully implemented a fully integrated I.T. system across all areas of health and social care. Therefore, whilst this recommendation is accepted in principle, in common with other health and social care economies the Department does not envisage implementing a complete, comprehensive and fully integrated I.T. system across all aspects of health and social care across the Island by 2019.	
3	The Ministers for Treasury and Resources and Health and Social Services should respond to the specific aspects of the C&AG report: "Use of Management Information in the Health and Social Services Department – Operating Theatres" within the next 3 months and publish their conclusions about the implications of its findings for the work conducted to date on the planning and development of hospital and 'out-of-hospital' services.		Accept	The thoroughness and depth of the Report has been welcomed by the Minster. An action plan was developed on receipt of the report, with work underway to address the relevant recommendations. A formal response will be submitted to the Public Accounts Committee by 1st October 2014. Data is routinely collected on all the key aspects of theatre usage and can be accessed for audit or operational use. However, the Department accepts that the methods of data capture could be improved and that greater operational use could be made of the data currently collected.	1st October 2014
4	Together with the Council of Ministers, the Minster for Health and Social Services		Noted	The Future Hospital planning assumptions are consistent with the current States of Jersey	Q4 2015

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
	must ensure that the new population policy to be agreed by the States in 2015 is taken into consideration when determining the size and scale of the future hospital.			population policy. Should this policy change in 2015 before the Feasibility Study is complete, the model used for hospital planning purposes will be updated and the revised population policy planning assumptions incorporated.	
5	The financial and other consequences of the dual site option for the delivery of mental health services and associated facilities must be identified and understood prior to any decision involving the future of acute hospital services and where they are located.		Accept	The Mental Health Strategy is currently being developed and is anticipated to report in March 2015. This will identify the proposed mental health services for the future and any resulting estate needs. The financial and service consequences of the Future Hospital Feasibility design solution upon other Health and Social Services will be set out within the Feasibility Study.	Q4 2015
6	Regardless of any future decision to use the Overdale site for hospital services, an appropriate site for mental health services should be identified as part of the Department's review of mental health which will be produced in March 2015.		Accept	No decisions have yet been taken regarding the future location of mental health services. This is the subject of estate planning work being undertaken in tandem with the development of the Mental Health Strategy. There may be advantages to co-location of some mental health services with ambulatory care services, and therefore the Future Hospital Technical Advisers will be briefed to review whether co-location of urgently required mental health services at Overdale is advisable.	Q4 2015
7	An action plan to ensure the delivery of all 8 key enablers should be produced along with appropriate timescales and presented to the States within the next 12 months.		Reject	The Scrutiny Panel has received a number of briefings related to the strategic and policy matters of P.82/2012, and has been provided with a large volume of information to assist in their review. Strategies are already in place to address the 8 key enablers. These are overseen by the Health and Social Services Corporate	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
				Directors and reported to the Minister for information – • The development of the workforce strategy and action plan will be linked to the States-wide Reform programme • The Estates strategy/action plan is incorporated within the Long-Term Capital Plan • The Department has an approved I.T. strategy, which incorporates informatics (data) as well as I.T. systems • The Primary Care work-stream is being developed through the Sustainable Primary Care project • The Commissioning work-stream has made good progress, through the appointment of the 3 Deputy Directors of Commissioning in 2013 • The Department has a programme of legal and regulatory developments • The funding work-stream is encapsulated within the State's financial planning requirements, including the Medium Term Financial Plan, Long-Term Revenue Plan and Long-Term Capital Plan. The financing elements are incorporated into the Sustainable Funding work-stream, which is being led by the Treasury and Resources Department.	

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
8	Proposals for the new model of primary care should be finalised and agreed by the States at least 2 months before the Medium Term Financial Plan 2016 – 2019 is debated.		Accept	The Sustainable Primary care project is due to deliver a White Paper for public consultation in June 2015. By May 2015, work will have been completed regarding the potential quantum of revenue cost implications. This will be incorporated in the MTFP, which will be lodged in July 2015. The Medium Term Financial Plan debate is scheduled for September 2015.	June 2015
9	Work undertaken by the design champion should be independently reviewed by a fully qualified cost adviser to ensure that the overall cost of the dual site option can be compared with other options considered by W.S. Atkins on a level playing-field basis. The result of this work should be published and reported to the States within a 6 month period.		Accept	The cost assessments within the Strategic Outline Case and Addendum were drawn up by a qualified cost adviser (Currie and Brown Plc. sub-contracted to W.S. Atkins International) with both local and international hospital cost estimate expertise. This includes work undertaken by the Design Champion. Several core assumptions changed between the development of the Strategic Outline Case (wholly new build) and its Addendum (the Dual Site concept) which means these are not comparable on a level playing-field basis. As part of the planned Feasibility Study development, a comparable single site option will be prepared to demonstrate the performance of a single site option compared to a dual site alternative. The cost comparison work will be made available as a Report, with cost information provided to the Panel under commercial confidentiality protocols.	March 2015

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
10	Further work should be undertaken to determine what impact the proposed dual site option based on budget of £297 million will have on patient care in both the medium and longer term, and a detailed explanation should be provided to the States on why a 100% new build hospital is unaffordable. This should be completed before seeking a formal decision on the site of the future hospital.		Accept	This is the purpose of the Feasibility Study already underway.	Q4 2015
11	The Minister for Treasury and Resources should provide a detailed plan setting out what actions would be taken if the Strategic Reserve does not return the anticipated return expected from investments within the next 6 months.		Accept	A proposal will be included within the Outline and Full Business Case undertaken within the current Feasibility Study for sensitivity around such an eventuality.	Q4 2015
12	The Council of Ministers should lodge a proposition prior to the lodging of the Medium Term Financial Plan 2016 – 2019 to ask the States Assembly to decide on the site for the future hospital in order for a formal decision to be made on this issue.		Accept	Ministers consider that in view of the scale of the project, a standalone Proposition and Report on the future hospital is in the best interests of transparent and open Government.	Q2 2015
13	A 10 year timeframe to develop a new hospital is unacceptable, and the Council of Ministers should review both the timescale and the overall budget envelope to ensure that any new hospital will meet the future needs of the Island. This should be completed within the next 12 months.		Accept	This is the instruction by the Ministerial Oversight Group to the Feasibility Study Project Board.	Q4 2015

	Recommendations	To	Accept/ Reject	Comments	Target date of action/ completion
14	The Panel recommends that percentage for art (based on 0.75%) for the total construction cost of a development should not be allocated for the future hospital project.		Noted	The Feasibility Study will include a review of the benefits of including public art in developing a healing environment, and will report back in response to P.82/2012. The review will include what the appropriate level of investment in public art within the Future Hospital should be. The final decision as to whether the proposed investment is appropriate will be a matter for the Planning Authority.	
15	In parallel with the work being undertaken to develop a new model of primary care and a sustainable funding mechanism for health and Social care, the Minister for Social Security should present to the States the long-term contribution proposals to support the existing Health Insurance and Social Security Funds.		Reject	The long-term funding requirements of the Social Security and Health Insurance Funds are both the subject of independent expert Actuarial reports recently published. The strategy for the future funding of the Social Security Scheme will be undertaken during 2015, with publication of proposals expected to be considered once the next Actuarial Review has been undertaken. The Panel's report presupposes that the future funding mechanism will be built upon the existing model, but this work is yet to be completed. The Panel can be assured that the sustainable funding mechanism work-stream will be developed in conjunction with both the Ministers for Health and Social Services and Social Security, and their Officers. If the outcome of that work leads to the need for the existing contributions to existing Funds to be changed, the Minister for Social Security would of course present those proposals to the States.	

CONCLUSION

The Ministerial Oversight Group accepts the majority of the Scrutiny Panel's recommendations and noted the Panel's findings. The actions noted in this response were already underway, and the Ministerial Oversight Group will continue to monitor the reform of Health and Social Care and to hold Officers to account.

APPENDIX 1

States of Jersey

Peer Review of Reform of Health and Social Services

Final Report

July 2014

Introduction

The Panel (membership detailed at appendix 1) was asked by the States of Jersey to consider and comment on proposals to deliver aspects of the reform programme for the provision of health and social care services in Jersey by 2021.

This has been a short and sharp review based on written material supplied by the States of Jersey, presentations and discussions over three days with key senior departmental members from Health and Social Services, Treasury, Property and Social Security. We did not have discussions with carers, users or health professionals other than those who presented to us. That said it has been a comprehensive exercise looking at future health and social care in Jersey at a strategic level.

During the preparatory work and the evidence taking many issues were raised and a considerable level of challenge laid down by the Panel to the presenting team. Our conclusions inevitably are at a high level, but we have indicated in a number of areas where we believe more detailed consideration is needed.

The panel would like to record its appreciation to the Health and Social Services Department and other States colleagues for all the preparatory material and the time taken in presenting evidence and answering questions. The work was of high quality and the whole atmosphere of the review was very open and constructive.

The views expressed in this report are the personal opinions of the Panel members and are not the views of any organisations that they are associated with.

The Case for Reform

As a starting point, the Panel revisited the original KPMG review (States of Jersey – A proposed new system for Health and Social Services KPMG 2011) and supporting documentation and discussed its contents with States staff in some depth during the evidence taking. This comprehensive piece of work from KPMG examined three potential future scenarios:

- ✓ Business as usual
- ✓ Live within our current means
- ✓ A new model for health and social care

The Panel was clear that the case for change was made and the selection of a new model for health and social care was the right one. Put simply, given the forecasted increased demand for health and social services based on changed demographics, business as usual and living within current means were simply not viable options as resources would have to increase significantly and major changes would be required around ways of working and configuration of services. The 2011 KPMG technical report which was commissioned to outline the funding options for the proposed reforms supports these assumptions. The scale of the increase in resources required

is difficult to forecast accurately but the Panel was clear that it would be **substantial** from whichever perspective it was viewed. Where those resources would come from and how they could be utilised is discussed later in this report.

The process of consultation (in the Green and White papers proposals) conducted by the States of Jersey following the KPMG report, confirmed broad acceptance from stakeholders of the KPMG analysis.

The process of consultation which sought to gain the widespread involvement of all stakeholders including the third sector, GPs, the public and patients, and all those in government is to be commended. There were and indeed there continue to be differences in views, but the consultation process was inclusive and thorough. Consultation is not about ensuring everyone gets what they want but the process served to engage stakeholders and help build alignment, establish consensus and mitigate potential problems in the future.

We are aware that as the KPMG report reflects, there is an absence of robust data and information in a number of areas and that this is being addressed especially around the performance of the health and social care system and the health profiling of the population. The absence of this material has prevented a deep understanding of the delivery and quality of the present service and the future health needs of the population. We are aware of the commitment to ensure this 'data lite' position is rectified. We should emphasise this is not about any reference to targets or similar arrangements but rather about understanding what is required to be delivered, how it is being delivered, and the quality of what is being provided.

System Reform: An integrated service with users at its heart

For the purpose of this report, integrated care is taken to mean shared working between different parts of the health and social care system that goes beyond the simple exchange of letters, and places the patient at the centre of care.

In conducting our work, we were acutely conscious that the programme of reform had already started and is still at an early stage. The Panel spent some time establishing and clarifying the different dimensions of the current system and quickly identified in discussions a very pivotal dimension to the service. It was clear that in previous work (and still mentioned in discussion) the language used was about the performance and function of different health service areas. The Panel was immensely relieved to note that in all the reform proposals the language moved away from discreet service areas and focused on system change. The importance of changing the way services interact with each other has been one of the most significant things learned across the world in recent years when the reform of health systems has been considered. Put simply, whilst it is important to know how different elements of health and social care services perform, ultimately it is how they work together and organise around the patient which is crucial and must be the main focus.

The current system

Jersey operates a mixed economy model with private, voluntary and state provision present and funded through a mix of (predominantly) public and private sources not untypical to most health and social care systems around the world. The panel found enormous strengths in the current system and could understand why it had developed in the Jersey context. We did consider whether a wholesale restructuring of this model would have been more appropriate to reform the system, but quickly concluded that the strengths of the current mix far outweighed its weaknesses and indeed provided a firm foundation for a reformed system. That said it was clear that there are some perverse incentives operating currently which must be tackled if real system reform is to be achieved. In particular, we noted the out-of-pocket payments for GP consultations and the out-of-hours home visits contrasted sharply with free access to the hospital accident and emergency services which lead to inefficient incentives to patients and providers alike.

A strong, sustainable and effective system of General Practice care is crucial in any service. Jersey has a record of considerable success in this area but for the future there needs to be a widespread acceptance that GPs have to move away from seeing themselves as the central figure in providing care for their patients to a position where they are also leaders of *teams* providing care for their patients. This is a change that emphasises the important position we see for this professional group for the future in delivering an accessible and value-for-money health service for Jersey. We can see the scale and extent of work that has been undertaken to bring GPs into the heart of the decision-making about system reform and feel that this must continue. In addition we feel strongly that that the hospital clinical leaders and consultants must also be brought into this 'conversation'. There appears to be some evidence that - for understandable reasons - they are currently not as engaged as they should be. System reform is about organising around the patient and hospital services in hospital and at home or in the community setting are an essential part of that reforming activity.

The role of the third or voluntary sector in the Jersey context is also crucial. As services have developed in Jersey the voluntary sector contribution has been a major building block. In a future mixed health economy, the sector has a strong role to play but it has to become part of a reformed system and be integrated into a leadership framework that enables it to fit into the whole picture. The sector will need to adapt and change and become part of continuity of care, including help to support 24/7 care that is organised around the patient and the communities in which they live.

The panel has concluded that the mixed health economy model is the most appropriate way forward to enable successful system reform. In taking forward the work, focus must be on integrating to achieve truly patient-centred services and, in particular, to challenge and change a range of perverse system incentives and behaviour which may provide barriers to change.

We have not had the opportunity to fully review the governance arrangements around system reform. What we have heard and read has been encouraging – although questions have been raised in our discussions which suggest that the current model – where the Department is leading change and seeking to bring all stakeholders into the debate – has many good points but may fall short of creating a forum with real power and clarity where all areas of the system are represented enabling issues to be resolved more easily. We believe this challenge merits further consideration. Good governance must be at the heart of system reform.

Information and I.T.

We have previously referred to the absence of important data – a 'data lite' situation. We should say again that this is not an observation or a concern about the absence of targets, comparative performance tables and so on. Our concern is that in any health system reform, there needs to be clarity about current and future objectives and agreed outcome metrics so that there is transparency about what has been achieved (and against what starting point), what needs to be done and what changes in policy direction may be necessary. Though we understand that this is being addressed, we think there needs to be a clearly articulated and understood information technology and data strategy which sets out future goals and milestones in the collection and provision of essential management and performance data.

Grabbing this agenda in terms of data information technology will be a major strategic gain for system reform. It will undoubtedly help in securing the right funding algorithm and, especially in the current funding context, will help towards fundamentally understanding the health needs of the population and give the means to demonstrate good value for money. It will help inform standards and quality and provide increased accountability in the reform system.

We are aware of some strengths in the Jersey system in particular the movement towards shared electronic records. We however feel that there is a way to go for example with the use of tele care in supporting self-care and addressing access.

Management capacity

Over the period of its work the Panel developed some concern about the level of management capacity to deliver the system reform in Jersey. This will also be referred to when we consider the new hospital project. There is a widely held perception that more managers in the health system is always bad – and certainly there is evidence from around the world of managerial overcapacity stifling system reform. However, the change agenda Jersey is facing in the health and social care system is considerable, and if it is to be successful it needs to be resourced properly. Getting clinicians involved managerially and in leadership roles can often be a major source of support.

A new model of Primary care

As referred to previously, the Panel supports the case for a new model of health provision. System reform – particularly starting from the Jersey position – will mean a fundamentally different model of primary care. We referred to the notion of GPs as leaders in providing a variety of services to patients and this model will mean considerable change is required. Incentives and system behaviours will have to be implemented. The GP's current position puts them in a strong role to help lead the orchestration of service provision for patients in the future.

GPs are best placed managing long term complexity and supporting multidisciplinary working as well as using their skills in dealing with acute, self-limiting illness and managing risk and uncertainty.

The Jersey context in its scale, current distribution of physical assets and resources means that the hospital will have a crucial role to play as part of the primary care model as well as in its acute services roles. How this element of the service is led and integrated is an important issue.

Other community-based services such as dentistry, pharmacy and optometry - which (like General Practice) currently operate in a free market context with the State bearing a degree of funding responsibility but with little or no effective management, financial or policy control will have to change. This is not a proposal for state provision, but rather a plea for consideration to be given to more state regulation from a cost control perspective.

Pharmacists are an important resource and though we did not have time to explore this service area and how it integrates, we advise Jersey to address the transformation of pharmacy alongside primary care. We understand the project scope deals with this issue.

Hospital Services

The Panel reviewed extensive background information provided and received comprehensive presentations followed by an opportunity for detailed questioning. We concluded that a new hospital is indeed needed in Jersey. The current infrastructure has a limited life and ever-increasing maintenance requirements. But this is a complicated issue – especially in any island jurisdiction where there is inevitably a cost premium involved. It is a challenge given Jersey's population to provide all the services (at high quality) that might be expected of a typical district general hospital. It would probably be better referred to as a district general hospital supported by a range of off island specialist services together with the necessary arrangements for transferring patients. There may be other options as the new hospital is developed – perhaps the potential to partner with UK NHS Trusts enabling information exchange, visiting consultants, research/development and training to complement in Jersey provision. This could alleviate the need to some extent for transferring patients but this will always be a requirement.

Building or refurbishing a new hospital is always a major cross generational opportunity and, whilst we can increasingly forecast in sophisticated terms likely population demand, it is increasingly difficult to forecast changes in the *type* of clinical services that will be provided in the future given the developments in health care technologies and advances in medical research.

All of this points to a need to build in flexibility in whatever is constructed. 'Future proofing' by building in flexibility in design is crucial.

We have looked in some detail at the current project and how it has been put together. It is clear that it has been a very difficult decision to find the right site and while we understand the selection of the two-site option and a phased development programme over 10 years, we do have concerns which we feel must be addressed as the project is fully developed.

In summary these concerns are as follows:

1. A new build on a single site which is unencumbered as far as possible is always the preference. This would enable a quick build, consistency in current service and a much easier move from existing buildings. While we understand this option has not been possible to pursue, it is important to understand the implications that follow this decision.

2. The ten-year phased programme over two sites is too long. Every effort must be made to see whether it is possible to reduce this time line. The potential disruption for current services should not be understated and must be addressed as a major risk – and mitigated. This can be addressed in the procurement process as the technical issues are addressed. Movement or decanting space will be critical so any opportunity to acquire adjacent properties to enable this would be, we suggest, crucially important and should be seized. Indeed such acquisitions will also be helpful in for example ensuring adequate provision of future facilities including step-down which will ease pressures on beds.

3. The size of the hospital is another critical issue. It has been impossible to construct a rigorous re-evaluation of the future demand requirements identified in earlier reports given time available and the impact on beds provided etc. These may also be second order issues given the point we make about the once in a generation opportunity and the key issue of building in flexibility in space use and future proofing as far as possible.

4. We are aware of the considerable debate on the capital monies available to fund the scheme. We would only say that this is probably the one big opportunity to resource health services in Jersey in one critical aspect and the gains by getting it right and future proofing are highly significant. There are too many examples of health projects which have failed to realise their full potential. The cost of getting it wrong is huge.

This scheme and the associated system reforms make a major statement to the people in Jersey and those outside about the nature and importance of the health agenda in this jurisdiction's future. This should not be underestimated.

5. A further concern is on the timeline and potential cost overruns. We have already suggested that a decade is too long and it is vitally important that the highest quality technical support is employed as early as possible to seek to address this issue. We believe the same approach should be taken to provide a procurement route which mitigates risk as far as possible.

A final more general point is that given the overarching goal of strengthening integration across all health and social care services, we would strongly recommend that as the project develops it is crucial to recognise that it is part of the system reform approach which has been developed. To this end it is vitally important as the project moves forward that its leaders look to the wider system and bring other stakeholders into the process. A fundamental part of the system reform will be to ensure the hospital looks outward to community and primary care services as well as third sector providers and of course patients and the public and behaves in a way which supports that approach. Our earlier reflections on the leadership of the whole system reform are relevant here.

Sustainable funding mechanisms

As with all health and social care systems around the world, Jersey is likely to face increasing pressure in future to spend more on care. The drivers of this pressure – as in the past – will be a combination of amongst other things increased demand as populations grow and age, increased income (with the general preference being to spend extra income on health and social care) and supply induced demand arising from new medical technologies (new drugs, new surgical interventions and so on). Given this, a key question addressed by the 2011 KPMG report (*Financing options for health and social care in Jersey*) was the sustainability of current funding mechanisms over the next thirty years. In particular, will projected future levels of funding meet future funding needs.

KPMG estimate that there is likely to be a growing shortfall between actual and needed funding, growing to around £75 million by 2040 and accumulating at around £3 to £4 million per year[1]. As KPMG acknowledge, such projections are inherently subject to a high degree of uncertainty. Even a small change in assumptions about revenue growth (assumed to be 0.5% pa in KPMG's modelling) or slight over/underestimates of need (e.g. there appears to be no allowance for morbidity

[1] On this, we would note that page 25 of the KPMG report states that projected health care costs by 2040 will be £294 million and revenues £241 million – a gap of £53 million. However, the second bullet on page 25 states the gap at £75 million by 2040. It is not clear why these estimates differ. Moreover, revenue of £205 million in 2012 growing at 0.5% a year equals £236 million by 2040, not, as stated on page 25, £241 million.

compression and it is unclear what uncertainty surrounds population forecasts used) can significantly affect the size of the 'need gap'.

We would suggest that unless already produced, the estimate for the funding gap should be subject to some sensitivity testing with respect to assumptions made on the cost or 'need' side (as well as some clarification regarding the report's figures – as noted in the footnote below) as it has on the revenue side of the equation (page 41 of the KPMG report).

Accepting that a gap between funding and costs will exist, the KPMG report sets out four options for meeting the shortfall –

1. Improve existing collection mechanisms
2. Change/incorporate elements of different collection mechanisms
3. Limit/cap health/social care benefits package
4. Improve productivity and efficiency.

KPMG rule out options 1 and 4 (the latter as it was considered to be outside the scope of their analysis) and focus on options 2 and 3.

While option 4 is ruled out in the KPMG analysis, the projections and estimates they calculate could vary significantly given even modest assumptions about improvements in productivity over time. For example, productivity improvements amounting to around 0.75% p.a. (on top of the assumed 0.5% growth in revenues) would virtually eliminate the funding shortfall by 2040. In many projections of health spending, assumptions about productivity are nearly always very important (cf. Office for Budget Responsibility (OBR) Fiscal Sustainability Report, 2013 and Derek Wanless's 2002 UK health care projections for example). We would suggest therefore that productivity assumptions be included in KPMG's sensitivity analyses. The 0.75% p.a. gap could be interpreted as a productivity challenge for the service.

Following our consideration, and the production of this report, we have been advised that the further recent modelling work by W.S. Atkins has considered productivity. We have not had sight of this report but remain of the view that productivity is an important strategic issue.

KPMG conclude that, given the unlikelihood of political agreement to increase current income and other taxes, the preferred option would be to close the gap through a combination of higher/extended patient charges and a new revenue source which expands on and modifies the existing Health Insurance Fund (HIF). This would require a compulsory levy on personal income below £150,000 (including pension income) starting at 0.8% and growing up to 2040 to around 3.5%. The new HIF together with all other funding sources (including current tax revenue) would be rolled up into a '2040 Fund'. We comment on the arrangements for this below.

The impact on the balance of funding between 2014 and 2040 is shown in figures 1 and 2 (data taken from page 39 of the KPMG report).

Figure 1: Revenue composition in 2014

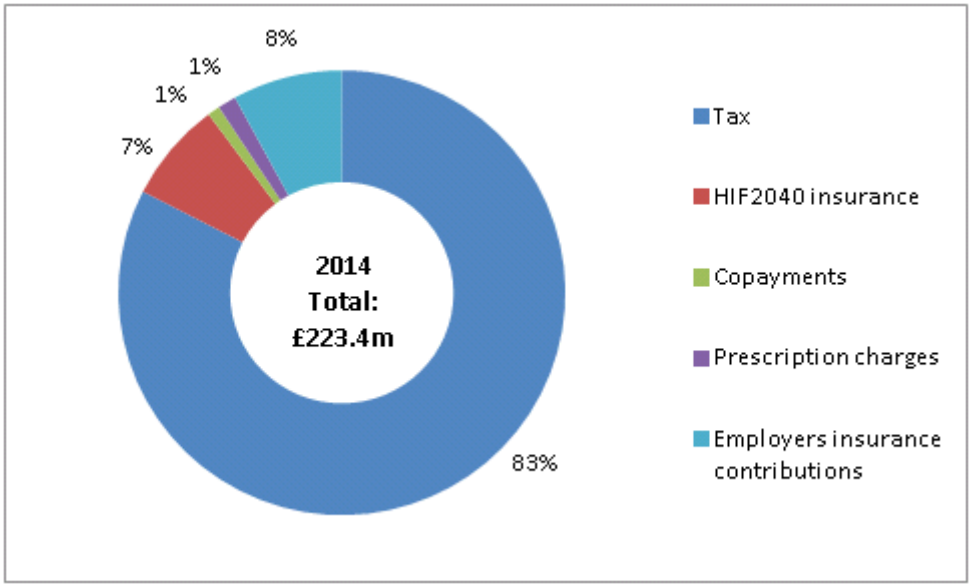
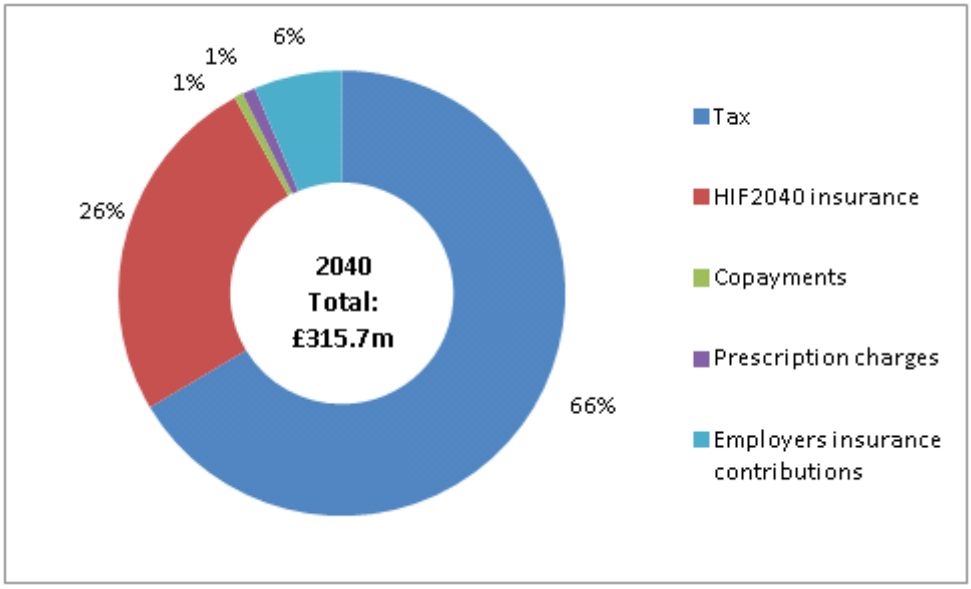


Figure 2: Revenue composition in 2040.



Although proposing extra patient charges – such as the payment for use of A&E – overall, such changes make a limited difference in either total funding or in the balance of funding over time. We do however recognise that the recent pilot on maternity services has suggested there is a significant potential gain in exploring a capitation model as an element of co-funding where the patient pays for unlimited access to consultation with the GP and state provided maternity services by a block payment. This could be rolled up into a capitation payment by the patient for other services such as care for long term health conditions. We would recommend that this capitation model as part of co-payment be examined further.

While employer insurance contributions rise in real terms, they shrink as a proportion of funding given the growth in overall funding provided via the existing tax system and the new 2040 Fund (which incorporates the existing Health Insurance Fund (HIF)). The introduction of the insurance fund reduces the proportion of tax revenue funding from 83% to 66%.

On the proposal for increased charges – the reintroduction of charges for prescriptions and the new charge for A&E services – we would suggest that that if these proceed, then provision is made to monitor their impact – in particular their impact on prescribing and GP visits in total and across demographic groups. This would help test the assertion that up to 50% of all A&E attendances were a result of patients choosing to avoid a GP visit due to the cost of an attendance.

On the proposed new social insurance fund, we think this is an imaginative suggestion. In terms of its public acceptability, while we have not seen any public polling in Jersey regarding people's attitudes to health spending, other surveys in the UK (cf. the British Social Attitudes Survey) have consistently indicated that health spending is the top priority for a significant majority of the public; it is unlikely that Jersey differs significantly in this respect. Therefore, while the insurance fund would represent a minority of funding by 2040 (see figure 2, above), the explicit link between this source of funding and health/social care spending would, we think, appeal to the public.

The crucial questions concern the implementation and administration of the 2040 Fund – which KPMG suggest would incorporate all sources of revenue. The suggestion that all revenues for health and social care be administered (i.e. spent plus overseeing investment of the 2040 Fund and setting rates) by an independent board is a significant political and organisational step. There needs to be careful consideration of the governance of such an arrangement – particularly as public money is involved.

Apart from powers to set contribution rates and oversee investments, it is unclear what powers and authority the 2040 Fund board would have to determine the details of spending across health and social care or its relationship with ministers and the determination of health policy. (We would note in passing that the recent reforms to the English NHS have attempted to set up a more arm's length relationship between the NHS and ministers/Department of Health with accountability of the former to the latter (and hence Parliament) embodied in a form of contract known as the Mandate which sets out broad goals for the NHS to achieve – leaving NHS England and the provider side regulators to ensure objectives are met. The extent to which this relationship is/will be successful remains to be seen). We would suggest therefore that if the social insurance fund idea is pursued that considerable thought be given to its governance arrangements (including independent audit arrangements) and its accountability to those who contribute to the fund through their taxes and levies and to all who use the health and social care services the 2040 Fund pays for.

Conclusion and recommendations

The building of a plan for a new model of health and social care in Jersey has taken some time. We believe system integration is the right approach and applaud the efforts to build support amongst all stakeholders. There are major challenges to face in delivering the changes and close attention must be given to de-risking as much as possible in the approach. This is a significant moment for Jersey. Getting this system reform right makes a big statement to the people of Jersey and those outside the jurisdiction.

Recommendations

We recommend:

1. That the States continue with a new model of health and social care. The original KPMG analysis that produced these options was robust and the consultation taken since has confirmed that there is widespread support for pursuing this new model.

2. That the programme for improving the quantity and quality of relevant data and information is pursued as vigorously as possible. Knowing what is being delivered and its quality and outcomes will be of enormous help in delivering the reforms.

3. That the mixed economy model of provision is the best building block for system reform. The perverse incentives currently operating must be tackled as they present real barriers to system reform.

4. That the management capacity driving system reform should be considered and supplemented where necessary by encouraging greater involvement from clinicians, interim or external support. Resourcing this work properly must be a priority.

5. That the focus on integration and system reform be continued and deepened using GPs as a mainstay in the system. We also urge consideration of how other aspects of primary care e.g. pharmacy should be integrated in the new approach. We understand the project scope addresses this issue.

6. That the provision of a new hospital is pursued as quickly as possible and the implications of the two site approach be assessed in terms of risk and mitigations identified and applied.

7. That the governance arrangements for the integrated system be re-examined. We believe the current work is being well led, but there will be a requirement in the future for the leadership of the system to be more inclusive of clinicians in primary and secondary care and other representatives from within the system. This has to be a group which is accountable and has the authority and power to resolve problems for the

benefit of patients. We are not recommending building any sort of replica of the system in the UK but rather ensuring accountability for those that are leading the system.

8. That work on building a sustainable set of funding mechanisms be accelerated and in particular that, unless already produced, the estimate for the funding gap should be subject to some sensitivity testing with respect to assumptions made on the cost or 'need' side.

9. That the productivity assumptions be included in KPMG's sensitivity analyses. Any mitigation of rising costs must include a review of potential productivity in the system. We understand that productivity has been addressed in the latest piece of work by W S Atkins but have not had sight of this report. We believe that productivity is a critical issue.

10. That if the proposal for increased charges – the reintroduction of charges for prescriptions and the new charge for A&E services proceed then provision is made to monitor their impact. In particular, their impact on prescribing and GP visits in total and across demographic groups.

11. That if the social insurance fund idea is pursued, then thought needs to be given to its governance arrangements (including independent audit arrangements) and its accountability to those who contribute to the fund through their taxes and levies and to all who use the health and social care services the 2040 Fund pays for.

Appendix 1

Terms of Reference – Peer Review of Reform of Health and Social Services

1) To receive a full briefing on the background and context to Report and Proposition P.82/2012 including the underpinning technical report by KPMG, utilising the Bailiwick Model.

2) To receive and review progress reports on the 4 parts of the proposition:

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

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

     (i) proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), by the end of 2014. (to be led by the Treasury & Resources Minister and the Minister for Health and Social Services)

     (ii) proposals to develop a new model of Primary Care (including General Medical Practitioners, Dentists, high street Optometrists and Pharmacists), by the end of 2014 (to be led by the Minister for Health and Social Services and the Social Security Minister);

     (iii) proposals for a sustainable funding mechanism for health and social care, by the end of 2014 (to be led by the Treasury & Resources Minister).

3) To consider and offer comment on progress to date across all aspects of the programme of reform for health and social services as set out in P.82/2012 and, in particular, in the context of the overall States of Jersey Reform programme and latest strategic and system thinking emerging from expert organisations such as the King's Fund and the Nuffield Trust.

4) To consider and offer comment on the short term and longer term approach and options for sustainable funding of Health and social services, taking into account work undertaken by KPMG.

Panel Members

Sir David Henshaw – Expert Adviser to Reform POG (Local Government and Hospital)

Dr. Patrick Geoghegan – Expert Adviser to Health and Social Services Minister (Mental Health and Community Services)

Mr. Andrew Williamson – Expert Adviser to Health and Social Services Minister (Social Services and Health Commissioning)

Dr. Clare Gerada, MBE MOM FRCPsych FRCP FRCGP – Chair of Primary care transformation board, NHS London Region and former Chair of Council of the Royal College of General Practitioners.

Prof John Appleby – Chief Economist, The King's Fund

APPENDIX 2

HEALTH AND SOCIAL SERVICES TRANSFORMATION PROGRAMME
MINISTERIAL OVERSIGHT GROUP

Review title: States of Jersey Peer Review of Reform of Health and Social Services

Report by: Ministerial Oversight Group Expert Panel

RESPONSE

The Ministerial Oversight Group welcomes the Panel's constructive review of the Health and Social Services transformation programme. The Ministers would like to extend their thanks to the Expert Panel for all their work.

The Ministerial Oversight Group recognise, as indeed did the Panel in the report, that the time for the review was very limited and the brief to be covered extremely broad, and that, as the Panel stated, that '*the reform is still at an early stage*'.

RECOMMENDATIONS

Recommendation	**Response**
1. That the States continue with a new model of health and social care. The original KPMG analysis that produced these options was robust and the consultation taken since has confirmed that there is widespread support for pursuing this new model.	Agreed. We also welcome the Panel's finding that the KPMG report and the reform programme has been devised from a system-wide perspective from its inception.
2. That the programme for improving the quantity and quality of relevant data and information is pursued as vigorously as possible. Knowing what is being delivered and its quality and outcomes will be of enormous help in delivering the reforms.	Agreed. We are pleased that the Panel noted that '*this is being addressed'*; and in particular, Ministers understand that – • The health and social care data set work is well underway, and will lead to agreement of a minimum data set across health and social care, which will be reported to Corporate Directors and used to further develop and improve services. • Each of the service specifications from the transformation programme, and each of the Agreements for Service with non-HSSD providers contains a suite of metrics (including demand, output, outcome and quality). These are regularly collected as part of the performance management approach. Officers would have been very happy to share the detailed transition plans, service specifications and

Recommendation	Response
	monitoring arrangements with the Panel. • The pilot projects were evaluated, using a suite of metrics and through discussions; this has been used to inform the ongoing service development and the agreed, adjusted service provision – particularly for the 'out-of-hospital' system. • Work is also well underway to review these metrics, and to identify a set of system-wide metrics that will help to confirm the system-wide impact of the transformation programme, in particular the impact on the hospital. • The introduction of the Jersey Quality Improvement Framework (JQIF) for Primary Care in 2015 will establish a series of clinical databases for the Island. An anonymised feed of this data to HSSD will support significantly better planning. In addition to the work on metrics, Ministers are pleased that the Department has made significant improvements and advances in information technology and management over the past 3 years. The implementation of the ICR project delivered – • A replacement hospital administration system (Trakcare), ranked as one of the best in the world. • A new child health system, enabling Jersey to excel in protecting our children against infectious diseases. • Modern radiology systems across the hospital introducing electronic storage and retrieval of X-rays and scans. • Integration between Trakcare and other hospital systems. • A foundation, based on a world leading system, that is key to enabling the further developments and improvements to be delivered. In addition to, and following, the main project other significant achievements in this area include – • The Informatics Strategy was agreed in January 2013, and is now being delivered. • Implementation of the electronic ordering of pathology and radiology tests throughout the hospital. • Introduction of SMS text messaging reminders for appointments. • Implementation of a case management system for mental health services. • Implementation of a long-term care assessment system to enable the introduction of Long-Term Care Benefit.

Recommendation	Response
	• Supporting and enabling the CAB to develop and implement the Jersey Online Directory. • Implementation of a bowel-screening system. • Implementation of an endoscopy reporting system. • Agreed arrangements with Hospice to fund the implementation of a hospice based system to integrate with hospital and other systems. • Supporting FNHC to implement a donor management system. • Implementation of a traceability system in dental services. • Implementation of and environmental health system. • Upgrade of ambulance and patient transport systems including the additional of tetra location services. • Upgrade and integration of the clinical investigation system. In addition, a number of information-based projects are currently underway; these include – • The development of an Island-wide health and social care informatics group. • The establishment of a Standard Data Set across HSSD, enabling benchmarking internally and against UK hospitals. • The development of business cases to support the next major systems developments – o E-prescribing o Community Information System o Primary Care/Secondary Care Integration and Interfacing o Hospital Electronic Patient Record. • The replacement and update of radiology system hardware and software. • The implementation of a 'medical desktop' solution across the department, supporting the use of mobile devices. • A Post-Implementation Review of Trakcare and Order Communications. • Implementation of a system to support the Jersey Talking Therapies service. This demonstrates a significant improvement and advancement in information systems over recent years, and illustrates a significant current and ongoing programme of work. It is important to recognise that, as with healthcare

Recommendation	Response
	itself, there is an almost infinite demand for information and information systems. These demands have to be prioritised and managed to deliver the best possible value for money within the Department's overall capacity to deliver the organisational change that necessarily comes with new systems.
3. That the mixed economy model of provision is the best building-block for system reform. The perverse incentives currently operating must be tackled as they present real barriers to system reform.	Agreed. The Sustainable Primary Care project has identified a number of alternative models internationally, and stakeholders are working together to consider the relative merits and application for Jersey, including the impact of these models on incentives and behaviours, and the possible unintended consequences.
4. That the management capacity driving system reform should be considered and supplemented where necessary, by encouraging greater involvement from clinicians, interim or external support. Resourcing this work properly must be a priority.	Agreed. The Panel commended the current management capability and approach, and noted the transition programme's ambition. We agree that the current workload is significant, and is led and overseen by a small team. HSSD Corporate Directors are committed to the transformation programme and continue to work together to secure additional skilled and experienced resources, and to progress the required actions, including culture change, within their areas of responsibility. In order to address the capacity issues, we – • Regularly review priorities in order to focus effort. • Have secured an additional post within the System Redesign and Delivery team. • Reconfigured the roles and responsibilities of the System Redesign and Delivery team, refocusing one post on the 'out-of-hospital' system development. • Secured an external partner to progress the mental health service review with us. • Designed the Sustainable Primary Care project with a view to sharing the work-stream leadership across the Board. • Appointed a Project Manager for the Sustainable Primary care project. • Recognised that additional, expert input will be required for the Sustainable Primary Care project, for example in health economics, and have made available a project budget. • Have identified programme budget to fund input from Primary Care professionals to the transformation programme. • Appointed experienced resources to lead the Future

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	Hospital project, including 2 Project Directors plus project management. • Appointed technical, financial and legal advisers for the future hospital project. • Are progressing the selection of partners to deliver acute services, who will also assist with service review and redesign. • Secured external service review resource from the Royal College of Physicians and the Royal College of Paediatrics and Child Health to review current staffing and ways of working, and then to advise HSSD on the capacity and capability of these services to meet the challenges presented by future service demands. • Recognised that peaks in workload relating to the future hospital will require additional resources for bespoke pieces of work more generally (e.g. to support the development of services plans' need to inform the design brief), and more specifically if particular services as a result of their relative professional and geographical isolation are finding it difficult to envision a future service that needs to look very different from the present. • Have clarified roles and responsibilities for service providers charged with leading the service implementation and delivery. • Have developed a (funded) Primary Care Hub to encourage G.P. leadership, to build relationships and to develop jointly the transformation programme. • Continue to actively involve the voluntary and community sector, hospital, Community and Social Services, and other service providers. • Are holding active discussions regarding leadership capacity, accountability and delivery. • Are progressing a clinical leadership development programme. • Have started a Clinical Forum, bringing together clinicians from the hospital and Primary Care. Notwithstanding this, the System Redesign and Delivery Team is a very small team.
5. That the focus on integration and system reform be continued and deepened, using G.P.s as a mainstay in the system. We also urge consideration of how other aspects of primary care, e.g. pharmacy, should be	We are heartened that the Expert panel report specifically commended the stakeholder engagement and noted that the ***"consultation process was inclusive and thorough".*** It also recognised that ***"Consultation is not about ensuring everyone gets what they want but the process served to engage stakeholders and help build alignment, establish consensus and mitigate potential problems in the future".***

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integrated in the new approach. We understand the project scope addresses this issue.	The health and social care reform programme has taken a system-wide, integrated approach to planning and developing services from its inception. This is important because challenges and developments in one part of the system impact significantly on all other parts of the system. As presented in the Green Paper: '*Caring for each other, Caring for ourselves'* in 2011, the health and social care system faces a number of significant challenges, including the demands placed on the hospital. The analysis demonstrated that, if no changes were made, the hospital would quickly run out of beds. It also identified some gaps in community services. For these 2 reasons the investment in community services was prioritised, whilst the future hospital planning work was being progressed. But it was also important to ensure that the programme of service changes is manageable and realistic; changing every part of the system simultaneously is not possible. In terms of encouraging the whole system to work together and planning across the whole system – • A system-wide 'U:collaborate' event was held at the programme's inception, where stakeholders shared thoughts and ideas and these were integrated to consider the system impact. • Each of the Outline Business Cases and each of the detailed plans have been developed with a range of stakeholders from across the system (including community staff, G.P.s, voluntary sector, hospital). This helps to ensure that each part of the system 'has its say', and is able to challenge each of the plans on the impact that it will have on their profession, team or organisation and on their part of the system. • The Transition Plan Steering Group has met monthly since December 2010. It comprises representatives from across the health and social care system, including G.P.s and voluntary sector, whose role is to challenge the emerging plans from a system-wide perspective. The investment priorities, the Green Paper, White Paper and P.82/2012, were agreed by the Steering Group. • The Health and Social Services Ministerial Advisory Panel (HASSMAP) challenged each of the plans. This group comprises independent experts from social care, children's services, mental health, hospital and Primary Care. • Each of the major projects has its own steering group or development board; these report into the Transition Plan Steering Group or directly into the Ministerial Oversight Group. Key individuals from the System Redesign and Delivery Team participate fully in these

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	groups to ensure cross-fertilisation and integration between the different work programmes.
6. That the provision of a new hospital is pursued as quickly as possible, and the implications of the 2 site approach be assessed in terms of risk and mitigations identified and applied.	Agreed.
7. That the governance arrangements for the integrated system be re-examined. We believe the current work is being well led, but there will be a requirement in the future for the leadership of the system to be more inclusive of clinicians in primary and secondary care and other representatives from within the system. This has to be a group which is accountable and has the authority and power to resolve problems for the benefit of patients. We are not recommending building any sort of replica of the system in the UK, but rather ensuring accountability for those that are leading the system.	We acknowledge that, whilst the Panel received documentation outlining the governance of the programme, this was not discussed with the Panel because the Panel's scope did not extend to this level of detail, and that time was limited. The Ministerial Oversight Group would like to note that clinicians have been heavily involved in the transition programme since its inception in November 2010 – • The Transition Steering Group includes a number of clinicians (the Medical Director of the Hospital, the Deputy Medical Director for Community and Social Services, a representative from the Primary Care Body (often 2), the Medical Officer of Health, the Chief Nurse) as well as management representatives and a Voluntary and Community Sector representative. • Clinicians were involved in agreeing the strategic principles in early 2011, and led the allocation of the service developments into 'red, amber, green' in early 2013 – this then formed the basis of the programme plan. • All service design workshops had a wide range of clinical members; this approach will continue as effective service change must be co-produced. • The Medical Staff Committee and Clinical Directors Groups have been briefed and involved throughout, as were G.P.s via the regular G.P. Forum sponsored by HSSD. • The Sustainable Primary Care project was designed with a view to sharing the work-stream leadership across the Board (which predominantly comprises clinicians). • The mental health services review is based on action learning sets, with participants from the clinical community across the health and social care system. • The Project lead for the mental health service review has a background as a mental health nurse. • One of the Future Hospital Project Directors is a clinician.

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	• Clinicians are heavily involved in the design and decision-making regarding the acute services strategy, acute services plan and future hospital (over 80 meetings have been held to date). • The (funded) Primary Care Hub has been set up to encourage G.P. leadership, to build relationships, and to develop jointly the transformation programme. • A clinical leadership development programme is being progressed. • The Clinical Forum brings together clinicians from the hospital and Primary Care.
8. That work on building a sustainable set of funding mechanisms be accelerated and, in particular, that unless already produced, the estimate for the funding gap should be subject to some sensitivity testing with respect to assumptions made on the cost or 'need' side.	Agreed. The 'Bailiwick model', produced by KPMG, enables us to perform sensitivity analysis on the 'cost or need' elements.
9. That the productivity assumptions be included in KPMG's sensitivity analyses. Any mitigation of rising costs must include a review of potential productivity in the system. We understand that productivity has been addressed in the latest piece of work by W.S. Atkins, but have not had sight of this report. We believe that productivity is a critical issue.	We note and agree with the Panel's comment that: '*the scale of the increase in resources required is difficult to forecast accurately but the Panel was clear that it would be substantial from whichever perspective it was viewed*'. The most recent modelling (W.S. Atkins) was based on actual usage, sensitised for various elements, including productivity. Detailed modelling work underpins the Acute Services Strategy, planning for the Future Hospital and the 'out-of-hospital' demand; this will improve our understanding and also support sensitivity analysis of projections. We are concerned by the Panel's comments regarding productivity opportunities and the impact on future funding. In particular, we requested further information from the Panel regarding the assertion that productivity gains of 0.75% p.a. would '*virtually eliminate the funding shortfall by 2040*', but have not received any further information from the Panel. The Panel received information regarding the historic and current funding position and the work completed to date regarding cost savings, along with our lean programme and continued focus on improvement. Productivity is an important element of our plans, and we have incorporated assumptions about improved productivity and achievement of efficiencies in our 2014/15 plan and beyond into the LTRP planning period (2016 – 2020). Cash-releasing efficiency savings targets over the 2013 – 2015 period are

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	averaging in the region of £2 million p.a. (approximately 1% of budget), and our LTRP submission was based on being able to continue to deliver at least ½% p.a. cash-releasing savings, as well as non-cash-releasing efficiencies /productivity gains. Indications suggest that the cash-releasing target may increase significantly once the next MTFP is finalised.
10. That if the proposal for increased charges – the reintroduction of charges for prescriptions and the new charge for A&E services proceed, then provision is made to monitor their impact. In particular, their impact on prescribing and G.P. visits in total and across demographic groups.	Agreed. The implementation of any charges would inevitably be linked to means-testing and would incur an administrative cost, but could generate reasonably significant levels of income. Any charging policy would require political approval and careful planning to consider the impact on clinical and patient behaviour and to avoid introducing perverse incentives.
11. That if the Social Insurance Fund idea is pursued, then thought needs to be given to its governance arrangements (including independent audit arrangements), and its accountability to those who contribute to the Fund through their taxes and levies, and to all who use the health and social care services the 2040 Fund pays for.	Agreed.

CONCLUSION

We thank the Panel for their acknowledgement of our philosophy and the principles underpinning our reform programme, and for their recognition of the role of the voluntary sector; the sector has developed significantly over the past 3 years and we have embraced the reform programme and the consequential changes to the system, services and the ways of working for individual organisations. In particular, we are pleased with the Panel's recognition of the Department's leadership and relationship building in this regard, and the way that Officers have engaged a range of stakeholders who are now working in partnership to progress the system reform.

We would also like to express our thanks to the Panel for their verbal feedback, and the Panel's suggestion that this work demonstrates to politicians the critical importance of the health agenda.