Education and Home Affairs Scrutiny Panel

The GP Co-Operative Out-of-Hours Service

Presented to the States on 8th March 2007

S.R.6/2007

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1 Terms of Reference

1. To examine whether the proposed GP out-of-hours service would enhance patient care and would meet the requirements of patients and GPs.

2. To consider the implications of a formal service agreement between the Department of Health & Social Services and General Practitioners for GP practices and the services they provide

3. To consider the impact the GP out-of-hours service would have on other services currently provided by the Department of Health & Social Services.

4. To consider the implications of the proposed system for any GP practice which would choose not to form part of the system.

5. To assess whether the proposed arrangements would be the most cost effective way of delivering an out-of-hours service.

2 Panel Membership

Education and Home Affairs Scrutiny Panel

Deputy F.J. Hill BEM, Chairman
Deputy D.W. Mezbourian, Vice-Chairman
Deputy S. Pitman
Deputy J. Gallichan

Work on the GP Out-of-Hours Review began in February 2006 under the auspices of the Social Affairs Scrutiny Panel. Following the establishment of the Health, Social Security and Housing Scrutiny Panel in November 2006, the remit of the Social Affairs Panel was amended. The membership of the Panel remained the same but it was renamed the Education and Home Affairs Scrutiny Panel.

Under normal circumstances, the topic of GP Out-of-Hours Care would now fall within the remit of the Health, Social Security and Housing Panel. However, it was agreed that, for the sake of continuity, the Education and Home Affairs Panel would continue work on the review and present the consequent report to the States.

The membership of the Social Affairs Scrutiny Panel (at the time of the commencement of the GP Out-of-Hours Review) is detailed below. Deputy J.A. Martin resigned from the Panel to join the Health, Social Security and Housing Panel. Deputy A.E. Pryke resigned on 30th January 2007 to become Assistant Minister for Planning and Environment.

Social Affairs Scrutiny Panel

Deputy F.J. Hill BEM, Chairman
Deputy J.A. Martin, Vice-Chairman
Deputy D.W. Mezbourian
Deputy A.E. Pryke
Deputy S. Pitman

3 Chairman's Introduction

When the Panel learnt about the proposed GP co-operative out-of-hours service in January 2006, it seemed to be a highly suitable topic for a Scrutiny Review. Any person living in Jersey might need the services of a GP during the out-of-hours period. The proposal therefore potentially affected the Island's entire population.

The Panel was aware that the development of the co-operative service followed similar moves in England towards a more formalised and accountable system of delivering out-of-hours care. Nevertheless, the Panel wished to ascertain whether a co-operative system was best for *Jersey* and would benefit *Jersey's* patients. To this end, we have examined the evidence provided by the Department of Health and Social Services and GPs and come to the findings that are presented in this report.

The Panel was unable, however, to consider the legal advice given to the Department during the development of the co-operative service. In addition, the Panel was advised that, due to the confidentiality of the document, it could not cite from the one Committee Act that exists in relation to this topic. Whilst this may not have impacted significantly upon the GP Out-of-Hours Report, the Panel is aware that these facts have wider implications for the work of Scrutiny Panels. To the ongoing discussions on these matters, we would like to add that consideration should be given not only of the *access* that Scrutiny Panels have to information but also the *use* they can make of this information when it comes to the presentation of Scrutiny Reports.

On 31st March 2006, the Minister for Health and Social Services wrote to the Panel to advise it of his decision to sign the Service Agreement with Jersey Doctors on Call and thereby establish the co-operative for an introductory period, subject to review. In the letter, the Minister stated that he would take into consideration the Panel's findings when deciding whether his Department would continue to provide funding for the service.

Delays caused by unforeseen circumstances have meant that the Panel's report was not produced until now. However, we hope that he will indeed take account of our findings and use them in working towards our shared aim of ensuring that the public has access to an effective out-of-hours service.

In presenting this report, the Panel would like to thank all those who contributed to the review by making a submission.

Deputy F.J. (Bob) Hill BEM
Chairman
Education and Home Affairs Scrutiny Panel

4 Recommendations

1. The Panel recommends that the annual report should be made public in order to ensure transparency in the use of public funds. If, however, the inclusion of commercially sensitive information precludes this, then a summary of the main parts should be made public. (9.9.9)

2. The Panel recommends that the Department should review its payment arrangement and consider whether the subsidy would be better spent on patient care. (10.1.14)

3. Given that it is not possible for the service to be fully audited at present, the Panel recommends that, at the beginning of 2008, the Minister provides the Health, Social Security and Housing Scrutiny Panel with an update on the co-operative service. (10.2.6)

5 Key Findings

1. The Panel believes that, from the outset, the development of a GP co-operative seemed, to some GPs, to have some merit. The idea had been discussed several times by GPs during the last ten years but this was the second time that the Department had become involved. (7.3.5)

2. The Panel notes the perception that the introduction of JDOC was driven by a minority of GPs. The Panel found no evidence that GPs were coerced to join the co-operative. However, it believes that circumstantial pressures arose once a significant number of GPs had joined. As a result, there were few viable alternatives for practices which chose to remain outside and they were therefore compelled to join. (7.4.17)

3. Bearing in mind that these proposals could potentially affect every islander, the Panel feels that there was a lack of public meetings held by the Joint Working Party. (7.5.14)

4. A belief was expressed that the lack of Public response to the consultation indicated the public was not opposed to the scheme. The Panel can only conclude that a lack of response is evidence that the public did not respond and not evidence of whether the public either supported or opposed the scheme. (7.5.22)

5. The Panel believes it was unsatisfactory for the service to be implemented on the same day as the consultation period ended. The Panel questions whether this left sufficient time for consultation (potentially) to be assessed. (7.5.23)

6. The Panel welcomes the ease with which people can access the co-operative service and agrees that people should only need to make one telephone call. (9.2.9)

7. The Panel acknowledges that the initial telephone call to the service acts as a form of *triage* and therefore recognises that the skills of the receptionist are essential and that relevant training should be provided for this role. (9.3.5)

8. The Panel notes that provision has been made for patients who may not speak English as a first language. (9.4.5)

9. The Panel notes that the appropriate ICT is not yet available to allow the co-operative service to be fully audited. (9.5.12)

10. The Panel notes that, whilst some arrangements have been made, no protocols have been drawn up to address the third Jersey Quality Standard but acknowledges the close working relationship that has been established with Jersey Hospice Care. (9.6.13)

11. The Panel notes that the statements made in October 2006 by the JCRA regarding additions to the co-operative do not refer to the competition clause that was present in its initial decision of 24th August 2006. (9.7.19)

12. The Panel notes that GPs will continue to be able to exercise discretion over fees charged. However, it remains concerned that the level of discretion available to GPs may have been reduced and questions whether the billing process will ultimately be as discretionary as in the past. (9.8.7)

13. As most practices employ their own secretarial and administrative staff which are paid by those practices, the Panel questions whether, in the case of the co-operative, public money should be used to fund these overheads. (9.9.2)

14. The Panel questions whether the process for billing patients that involves the employment of a reconciliation clerk may lead to duplication of work carried out by GP practices' own staff. (9.9.3)

15. The Panel questions why the tax-payer is being asked to subsidise the co-operative scheme. (10.1.4)

16. The Panel notes that the Gwyneth Huelin Wing is being used at a time when otherwise it would be closed. (10.1.6)

17. The Panel questions why, under the JDOC system, it was necessary for a daytime driver to be provided on Saturdays, Sundays and Bank Holidays as GPs would previously have driven themselves when undertaking daytime visits. (10.1.8)

18. The Panel notes that the GP Co-Op Management Board receives £14,400 for payment to Board members which represents approximately 17% of the public investment. The Panel acknowledges the work undertaken by Board members but questions whether the tax-payer should be responsible for paying Board members. (10.1.10)

19. The Panel notes that one of the perceived benefits of the co-operative scheme is the Service Level Agreement made by the Department and JDOC and the possibility that this allows for the introduction of clinical governance. (10.1.13)

20. The Panel found that the introduction of the co-operative service had had no impact on the Accident and Emergency Department. (10.3.9)

21. The Panel believes that ambulance staff expressed reasonable concerns regarding the potential use of the Ambulance Service for JDOC. It agrees that the Service should not be used for this purpose. (10.4.8)

22. The Panel notes the concerns expressed to it that working as part of the co-operative system would not allow GPs to gain the necessary skills and experience required for dealing with people at home. The Panel believes it is the responsibility of individual GPs to ensure that any reduction of out-of-hours duties does not impact negatively on their skills. (11.3.12)

23. The Panel notes the perception that the presence of a GP co-operative would make Jersey a more attractive employment destination for GPs. (11.5.7)

6 Introduction

6.1 The Definition of 'Out-of-Hours'

6.1.1 This report focuses on the delivery of out-of-hours care by General Practitioners (GPs) in Jersey. The term 'out of hours' generally refers to the period outside of the 'normal' working day (and week). In the context of this report, the term is used in specific reference to the following periods:

- 6:00pm to 8:00am on weekdays
- 12:00pm to 8:00am on Saturdays
- All day on Sundays, Bank Holidays and public holidays

6.2 Out-of-Hours Care Prior to April 2006

6.2.1 Out-of-hours care in Jersey was provided by approximately 100 GPs (equivalent to approximately 85 Full Time Equivalent (FTE) GPs). Prior to April 2006, this amounted to approximately ten GP practices (or groups) that provided an out-of-hours service.[1]

6.2.2 Prior to April 2006, GP practices in Jersey made their own arrangements for the delivery of out-of-hours care. For example, some smaller practices joined together to form co-operatives of their own; larger practices were able to organise the care themselves without making such arrangements. However, GPs were not required to provide out-of-hours care. It was therefore possible for GPs to sell their on-call periods to a locum or even to withdraw altogether from providing an out-of-hours service.[2]

6.2.3 Patients accessed out-of-hours care by telephoning their own practice. For many patients, this would lead to a telephone consultation and then (if it were not possible for the GP to deal with the matter over the telephone) either a home visit by the on-call GP or the despatch of an ambulance (depending on the seriousness of the case).[3] The Panel understands that a number of practices opened their surgeries on Saturday mornings and Bank Holidays. The patients of one practice in the Island were also able to access an evening surgery (between 6:00pm and 8:00pm) from Monday to Thursday.[4]

6.3 A New Co-Operative Service

6.3.1 On 3rd April 2006, for many GPs the system of delivering out-of-hours care in Jersey changed with the implementation of a GP co-operative service. The new system involved a partnership between GPs, under the umbrella of Jersey Doctors on Call (JDOC), and the Department of Health and Social Services (hereafter referred to as 'the Department'). The first discussions between GPs and the Department regarding the establishment of the co-operative service had occurred in October 2004. [5]

[1] *Proposed General Practitioners Out of Hours Service*, p. 1
[2] Written Submission from Dr. B. Perchard, 20th April 2006
[3] *Proposed General Practitioners Out of Hours Service*, p. 1
[4] Correspondence (dated 20th January 2006) from Dr. I. Cameron (forming part of the public consultation)
[5] *Proposed General Practitioners Out of Hours Service*, p. 1

6.3.2 A variety of reasons were given (by those behind the scheme) for the introduction of the new system, such as the need to introduce appropriate governance arrangements. It was also believed that the new system would address cost issues as well as the negative impact on GPs of providing out-of-hours care (in terms of their safety and the possibility of becoming fatigued).[6] However, the service was not universally welcomed and alternative views were received and considered by the Panel during its review.

6.3.3 The new service was only available to the patients of those GP practices which chose to join the co-operative. When the co-operative began operating, 61 GPs were involved (representing 71% of the Island's GPs).[7] In October 2006, however, nearly all the remaining practices joined the co-operative. As a result, four GPs remained outside, three of whom comprised the practice that provided services to the Police.[8] Consequently, from October 2006 the majority of people in Jersey were obliged to accept the scheme (without the need to change their GP practice).

6.3.4 Patients accessed the new GP co-operative service by telephoning their own practice. The call would then be diverted and would lead to either a telephone consultation, a home visit by the on-call GP or, during certain hours and by appointment only, a visit to an evening surgery established as part of the co-operative service. The surgery would open from 7:00pm to 10:00pm from Monday to Sunday as well as 10:00am to 12:00pm on Sunday.[9]

6.3.5 To cover the out-of-hours service, JDOC established a rota in which practices (and thus their GPs) were allotted periods when they would be on call and thereby responsible for the delivery of care. There would always be two GPs on call, one to man the surgery and provide telephone advice, the other to undertake home visits.[10]

6.3.6 The nature of the partnership between JDOC and the Department was established in a Service Level Agreement that set out the responsibilities of each party. For example, the Department agreed to provide the facilities for the surgery as well as funding for the employment of certain staff. JDOC (on behalf of the GPs involved) agreed that GPs would be obliged to meet (auditable) standards in the delivery of out-of-hours care. From the GPs' perspective, the co-operative would be overseen by the GP Co-Op Management Board. The Panel will explore the workings of the partnership (including the funding arrangements) in greater detail in later chapters of this report.

6.3.7 The service was implemented on 3rd April 2006 for a trial period of six months to be reviewed at the end of this period. [11] In November 2006, the *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006* was therefore produced: the report outlined how the co-operative had operated during the initial six-month period. The Panel was advised that this report would be included in a final management report that would subsequently be presented to the Minister in order for him to decide whether the Department should continue to fund jointly the service.[12]

[6] *Proposed General Practitioners Out of Hours Service*, p. 1
[7] Notes of Meeting on 7th March 2006 at Ambulance Headquarters
[8] Transcript of Public Hearing 3, 13th November 2006, p. 16
[9] *Proposed General Practitioners Out of Hours Service*, p. 8
[10] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 18
[11] *Service Agreement between the Minister for Health and Social Services, and Jersey Doctors on Call* (MD-HSS-2006-0024), 11th April 2006
[12] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 9

6.4 Developments Elsewhere

6.4.1 The move in Jersey towards a formalised co-operative service for the provision of out-of-hours care reflected developments in out-of-hours care that had occurred in England.

6.4.2 GP co-operatives developed in England from 1995 when GPs were encouraged (by the UK Department of Health) to focus on "*premises-based*" out-of-hours care. [13] By March 2000, however, it became apparent that the system of out-of-hours care was unsustainable and a review was implemented. This review (known as the 'Carson Review') led to the report, *Raising Standards for Patients – New Partnerships in Out-of-Hours Care*, in which it was recommended that Primary Care Trusts (PCTs) take responsibility for providing out-of-hours care. It also ensured that out-of-hours care would be monitored and audited by a set of standards that, in January 2005, were established as the *National Quality Requirements in the Delivery of Out-of-Hours Services*.[14]

6.4.3 The system of provision in England was recently subject to review by the UK government's Comptroller and Auditor-General who assessed whether the UK Department of Health was moving in the right direction in the provision of out-of-hours care.[15] The ensuing report, *The Provision of Out-of-Hours Care in England*, examined the developments that had occurred and provided useful guidance to the Panel when undertaking its own review and gathering evidence.

6.4.4 In addition to England, the Panel is aware that the delivery of out-of-hours care in countries such as Australia, New Zealand, Canada and Ireland has also moved towards greater use of co-operative systems.[16]

6.5 The Scrutiny Review

6.5.1 On 9th January 2006, the Social Affairs Scrutiny Panel met the Minister for Health and Social Services, Senator S. Syvret (hereafter referred to as 'the Minister') to discuss his Department's work programme for the coming year. During the course of this meeting, the Minister outlined the intention that a co-operative GP out-of-hours service would be implemented.[17]

6.5.2 The Panel felt this issue merited attention as the introduction of the system would potentially affect the entire population of the Island (in that any person could potentially require medical care during the out-of-hours period). Consideration was also given to how the system would enhance patient care and, given the Department's involvement, what impact would be had on the Department's (other) services.

6.5.3 The Panel agreed to undertake a review of this topic, established Terms of Reference and began work in February 2006. For the purposes of the review, the Panel agreed that Deputy A.E. Pryke would act as Lead Member (with Deputy D.W. Mezbourian as Assistant Lead Member) to direct the lines of enquiry.

[13] *The Provision of Out-of-Hours Care in England* , p. 9
[14] *The Provision of Out-of-Hours Care in England* , p. 10
[15] *The Provision of Out-of-Hours Care in England*, p. 4
[16] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 26
[17] Minutes of Social Affairs Scrutiny Panel, 9th January 2006

6.6 Methodology

6.6.1 The Panel used the following methods to gather evidence. A full list of the sources considered by the Panel may be found in Appendix 1.

- Research of written sources including relevant legislation, former Committee acts, departmental papers and the JCRA report
- Requests for advice and information from the Department and GP Co-Op Management Board
- Call for Evidence from the public (placed in the *JEP*)
- Written requests for information from potential stakeholders
- Meetings with interested parties
- Public Hearings
- Site visits

6.6.2 One difficulty facing the Panel (and which had also faced the Department and GPs during the development of JDOC and the co-operative service) was the lack of precise quantifiable information relating to previous arrangements. Delivery of out-of-hours care before April 2006 had not been centrally organised nor measured in the same way as the co-operative would be. The co-operative service would therefore enable the collection of information that it had been unable to collect prior to April 2006. This fact could potentially make it difficult to make direct comparisons between previous arrangements and the co-operative system.

6.7 The JCRA Review

6.7.1 On 10th March 2006, the Panel was advised that the Jersey Competition Regulatory Authority (JCRA) would undertake its own review of the proposed GP co-operative service. This had a direct impact on the status of the Panel's own review (although it also allowed the Panel to consider the JCRA's resultant report amongst the evidence it gathered).

6.7.2 The JCRA's review was engendered by an application for JDOC to be granted exemption from Article 8 of *Competition (Jersey) Law 2005*. This article states:

> "*Except as otherwise provided by this Part, an undertaking must not make an arrangement with one or more other undertakings that has the object or effect of hindering to an appreciable extent competition in the supply of goods or services within Jersey or any part of Jersey.*"[18]

6.7.3 The formal application was received by the JCRA on 1st March 2006. However, the Panel understood that a preliminary meeting between the JCRA and representatives of the Department occurred in late 2005.[19]

6.7.4 The JCRA may grant individual exemptions to Article 8 of the Competition Law under Article 9 of the same law. Article 9 indicates four criteria that are used by the JCRA to assess whether an application for exemption shall be granted. During its investigation, the JCRA therefore endeavoured to assess whether the co-operative would:

- improve the distribution of goods or services

[18] *Competition (Jersey) Law* 2005, Article 8(1)
[19] Mr. C. Webb, Transcript of Public Hearing 1, 29th September 2006, p. 3

- allow consumers a fair share of the benefits
- contain no indispensable restrictions to competition
- not lead to the elimination of competition in respect of a substantial part of the goods or services in question[20]

6.7.5 The JCRA is obliged to investigate any application that it receives for an exemption to Article 8. JDOC's application to be granted an exemption was the first to be received by the JCRA and therefore the first opportunity for the JCRA to undertake work of this sort.[21]

6.7.6 Once it had heard about the JCRA's review, the Panel considered the impact it would have on its (the Panel's) own work. The Panel therefore met representatives of the JCRA on 21st March 2006 to consider this issue and to agree upon a mutually convenient way forward.

6.7.7 At the meeting, the Panel was advised that the JCRA hoped to finish its review by the end of April 2006.[22] The Panel consequently agreed that it would await the JCRA's resultant report before completing its own review. The Panel felt it best to wait (before producing its own report) as a decision by the JCRA not to grant JDOC an exemption would have essentially curtailed the co-operative before it began. However, as the JCRA would not be focusing on all the issues which the Panel had addressed in its Terms of Reference, the Panel continued work in those areas.

6.7.8 The Panel had originally intended for its review to last three months (to end by May 2006). The decision to await the results of the JCRA's work meant this would not be feasible.

6.7.9 Due to complexities raised by the analysis of the co-operative under the Competition Law, the JCRA subsequently informed the Panel that it would not be able to complete its review as soon as it had hoped. Subsequent to the meeting on 21st March 2006, therefore, the Panel sought regular updates from the JCRA on the status of its work. At one stage, the Panel believed it would be feasible to hold Public Hearings at the end of May 2006 (on the understanding that the JCRA report would be available for consideration). However, the JCRA's examination needed to extend beyond this time and hence its report was not forthcoming by this time and the Public Hearings were cancelled.

6.7.10 As the Panel had decided to await the JCRA report, its review entered a hibernation period during which work effectively ceased. During this time, the Panel embarked on other reviews. Ultimately, the JCRA completed its review and published its decision on 24th August 2006. In this decision, the JCRA determined that JDOC would be granted an exemption to Article 8 of *Competition (Jersey) Law 2005* and that the co-operative could continue, albeit subject to certain conditions (one of which was that the exemption was granted to last until 31st March 2007).[23]

6.7.11 Once the JCRA had published its report, the Panel recommenced work on its own review.

[20] *Concerning the General Practitioners Out-of-Hours Cooperative Notified under Article 9 of the Competition (Jersey) Law 2005*
[21] Mr. W. Brown, Transcript of Public Hearing 1, 29th September 2006, p. 6
[22] Notes of Meeting with the JCRA, 21st March 2006
[23] *Concerning the General Practitioners Out-of-Hours Cooperative Notified under Article 9 of the Competition (Jersey) Law 2005*, p. 1

6.8 The Purpose and Structure of the Panel's Report

6.8.1 To begin with, the Panel will examine the development of the GP co-operative system. As part of this examination, it will explore the history behind the creation of JDOC and endeavour to assess the preparatory work that was undertaken, both by GPs and the Department.

6.8.2 In the ensuing three chapters, the Panel will explore the workings of the co-operative system in more detail and address those issues which it considered during the review. Primarily, it will do this from the perspective of the patient (in Chapter 9). However, to facilitate the consideration of certain issues, it will also examine the system from the perspective of the Department (Chapter 10) and subsequently from that of GPs (Chapter 11).

7 The Development of the Co-Operative System

7.1 The Genesis of JDOC

7.1.1 JDOC was formed in 2006. Although the idea of a GP co-operative in Jersey was not new, the seed that led to JDOC's formation came in April 2004 at a Primary Care Group meeting. This group was a branch of the Jersey Medical Society (JMS) that focused on GP issues. In a written submission to the Panel, Dr. B. Perchard (a member of the GP Co-Op Management Board) explained what happened:

> "*At this meeting significant interest was expressed in establishing a [co-operative] service in Jersey and I offered to organise a presentation by the Directors of the Isle of Wight GP out of hours service*."[24]

During the development of JDOC, the Isle of Wight was used as a model due to its similar population base to Jersey and as its service was seen to be a successful and popular one.[25]

7.1.2 The presentation, to which all GPs and hospital staff were invited, took place in July 2004. There appeared to be sufficient interest amongst GPs in establishing a co-operative and it was agreed (at a subsequent JMS meeting) to approach the Department about the possibility of a joint venture.[26] The Panel understands that an attempt had previously been made to establish an arrangement between GPs and the Department. However, this had not been successful.

7.1.3 On 18th October 2004, GP representatives met the President of the Health and Social Services Committee (Senator S. Syvret) who was accompanied by the Chief Executive Officer and other senior officers of the Department. This meeting led to the establishment of a Joint Working Party that comprised both GPs and representatives of the Department. Its primary task was stated to be:

> "*To determine the main technical and practical issues to enable this proposal [for a co-operative service] to be implemented (following the necessary assent of the Health and Social Services Committee and the affected GPs and their representatives)*."[27]

7.1.4 The proposal for a joint venture between the Department and GPs was put to the former Health and Social Services (H&SS) Committee at its meeting on 7th October 2005 together with a report from the Joint Working Party. A shortened version of this report became available when plans for the proposed co-operative service were opened to public consultation in January 2006.

7.2 Preparatory Work

7.2.1 The Joint Working Party's report divided the work to be undertaken into three phases, the first of which was to develop the feasibility case for the co-operative. Following approval of the service (by the Committee), 'Phase 2' would involve developing (and

[24] Written Submission from Dr. B. Perchard, 17th March 2006
[25] Written Response from the Department, 25th May 2006, p. 5
[26] Written Submission from Dr. B. Perchard, 17th March 2006
[27] *Proposed General Practitioners Out of Hours Service*, p. 2

communicating) an implementation plan. The final phase would involve actually implementing the service.[28] The report itself (and its consideration by the Committee) marked the end of the first phase identified.

7.2.2 In the report, the following reasons were outlined as justification for changing the arrangements for GP out-of-hours care and therefore introducing the co-operative service:

- "*the complete lack of appropriate governance arrangements, covering such matters as the adequacy of communications with patients/other health service providers, response times, consistency of service, complaints/disciplinary procedures, formal review and audit of activity and practice;*
- *variations in charges for patients depending on practices;*
- *lack of access to less costly out of hours GP services;*
- *the undesirability of having 10 GPs on call per night, carrying out day time duties;*
- *increasing risk and undesirability of lone GPs (in particular female GPs) undertaking night visits*"[29]

7.2.3 The report described how the service would work, indicating the periods during which the service would be accessible and the staffing arrangements that would be necessary.[30] The report also indicated the work which the Joint Working Party had undertaken in preparation for the potential implementation of the service. In this regard, the report indicated that the following would occur (during 'Phase 2' of the project):

- The co-operative would be classed as an association under *Loi (1862) sur les teneures en fidéicommis et l'incorporation d'associations*. This would require an application to the Royal Court.
- The relationship between the co-operative and the Department would be set out in a Service Level Agreement.
- Rules would be established (for GPs) for membership of JDOC.
- GPs would be required to have appropriate insurance.
- Disciplinary and grievance procedures would be developed.
- A clinical governance framework would be established.
- Arrangements would be put in place for the storage of appropriate medicines.[31]

7.2.4 It was recognised in the report that the co-operative service would require ICT (Information and Communication Technology) support. The report set out that the issue of ICT would be addressed in two stages, the first of which would see the provision of a 'basic' computerised system. The second stage would:

> "*see the introduction of a more <u>comprehensive</u> computerised support system that would be compliant with all current UK governance requirements.*"[32]

7.2.5 The report addressed financial matters in relation to the co-operative service and set out the proposed tariffs (from the patients' perspective).[33] The Panel will consider the

[28] *Proposed General Practitioners Out of Hours Service*, p. 3
[29] Ibid, p. 1
[30] Ibid, p. 8
[31] Ibid
[32] Ibid, p. 11
[33] Ibid, p. 12

actual financial arrangements (from the perspectives of patients and the Department) in later chapters of the Panel's report.

7.2.6 The report explained that the service would be monitored and audited in order to assess its efficacy. To this end, a clinical governance framework was set out. Similarly, it was noted that the Joint Working Party had agreed to follow (broadly) the UK *National Quality Requirements in the Delivery of Out-of-Hours Services* with regard to clinical standards. It was also noted that the co-operative service would be subject to annual audits.[34]

7.2.7 Attempts had been made to address the situation (described earlier) in which it was difficult to gather quantifiable data on the out-of-hours arrangements that existed prior to April 2006. In its report, the Joint Working Party therefore used activity data from forty GPs to estimate the anticipated demand on the co-operative service. This data allowed the Joint Working Party to establish whether the proposed tariffs for the co-operative service would have a detrimental effect on the cost to patients. A sensitivity analysis was conducted to test the robustness of the proposed tariffs.[35]

7.2.8 Finally, the report set out the proposed benefits arising from the co-operative service for the patient, for GPs and for the Department. For the patient, the main benefits were stated to be as follows:

- "*the provision of additional 3 hour GP surgeries, Monday through to Sunday with an additional 2 hour surgery on Sunday morning*
- *access to less costly out of hours GP services (i.e. the cost of a visit to the above surgeries is significantly cheaper than a visit by a Visiting GP)*
- *availability of a formal complaints system*
- *the increased likelihood of being seen by a less fatigued GP*
- *increased confidence of a service having good communication facilities adopting appropriate and formal governance and audit procedures*"[36]

7.2.9 The following benefits for GPs were identified:

- "*a reduction in the number of nights on call*
- *the provision of a driver to aid the safety of the GP*
- *the development of closer links with, and greater access to, the services, advice and expertise within Health and Social Services (e.g. support in the development of appropriate governance arrangements)*
- *subject to the agreement of the Health and Social Services Committee, additional support and funding for a comprehensive out of hours information system (to be developed)*"[37]

7.2.10 Finally, it was stated that the Department would benefit in the following way:

- "*the development of closer links with GPs, which in time will allow a greater ability for both parties to co ordinate and reconfigure their services to their mutual benefit and the island as a whole. Such a scenario is in line with the broad strategic objectives of Health and Social Services and the emerging themes from the ongoing New Directions initiative.*"[38]

[34] *Proposed General Practitioners Out of Hours Service*, p. 7
[35] Ibid, p. 14
[36] Ibid, p. 15
[37] Ibid
[38] Ibid

7.3 Other Options

7.3.1 The Panel considered whether the introduction of a co-operative (involving a partnership between GPs and the Department) had been the only option considered for altering out-of-hours services. The Panel was advised that:

> "*The two main options before the Joint Working Party were either to introduce a GP Co-Op type arrangement or if that proved impracticable or difficult to attain, to keep current arrangements.*"[39]

7.3.2 Consideration of other options would seemingly have impacted upon the timetable of development of the co-operative:

> "*Other options would have greatly affected the way GPs operate, funding streams and relationships […]. Such options would have been difficult to achieve within reasonable timescales.*"[40]

7.3.3 On 3rd April 2006, the Panel met the Director of Family Nursing and Home Care (FNHC) from whom a written submission was also subsequently received. The Panel was advised that there had been little involvement of FNHC personnel in the Joint Working Party. FNHC acknowledged the reasons behind the GPs' desire to reshape out-of-hours services but questioned whether the new system would represent the "*most cost-effective use of skill mix.*" It also questioned whether sufficient consideration had been given to other 'step-down' facilities such as rapid response or hospital at home.[41]

7.3.4 Following the receipt of this submission, the Panel asked the Department what consideration had been given to the involvement of FNHC in an out-of-hours service. The Panel was advised that no consideration had been given but that:

> "*It is important to state that the GP Co-Op provides for an out of hours GP service, not an out of hours service that could involve nurses or other professionals for instance. This is not to say that if the GP Co-Op is successful, further developments could not take place e.g. closer liaison and coordination with FNHC and A&E.*"[42]

7.3.5 The Panel believes that, from the outset, the development of a GP co-operative seemed, to some GPs, to have some merit. The idea had been discussed several times by GPs during the last ten years but this was the second time that the Department had become involved.

7.4 Consultation with GPs

7.4.1 Following consideration by the former H&SS Committee on 7th October 2005, 'Phase 2' of the Joint Working Party's work on the development process began. As has been seen from the Joint Working Party's report, this phase would involve developing and communicating an implementation plan.

7.4.2 During its review, the Panel endeavoured to establish the level of support for the co-operative service that had existed amongst the Island's GPs.

[39] Written Response from the Department, 25th May 2006, p. 16
[40] Ibid
[41] Written Submission from Family Nursing and Home Care, 3rd April 2006
[42] Written Response from the Department, 25th May 2006, p. 14

7.4.3 It should be recalled that, prior to the establishment of the co-operative, approximately 100 GPs practised in Jersey although not all worked full time (there was the equivalent of 85 FTE GPs in the Island). The 'significant majority' which the Committee had wished to see was approximately 70%.[43] However, the initial intention when the plans were developed was that all GPs would join the co-operative.[44]

7.4.4 The Panel received information indicating that GPs had been consulted during the earlier stages of development (i.e. during 'Phase 1' prior to presentation of the proposal to the Committee). In a written submission to the Panel, Dr. B. Perchard described the consultation that had occurred with the Island's GPs during 'Phase 1'. For instance, as has already been seen, all GPs were invited to a presentation in July 2004. In the months following the presentation, Dr. Perchard discussed the matter with a number of practices and also undertook three presentations to a total of eight practices.[45]

7.4.5 Following the meeting on 18th October 2004 between GP representatives and the Department, an outline proposal (for the establishment of a co-operative) was taken to a JMS meeting in October 2004. The proposal was approved by forty-five votes to nine. Following this approval, written confirmation from GPs was requested in December 2004 to which sixty-six positive responses were received.[46]

7.4.6 Following the creation of the Joint Working Party, those GPs within that group liaised with all other GPs in the Island. In October 2005, all GPs were sent a copy of the proposed Project Agreement and were requested to confirm whether they would accept or reject the terms of the Agreement. Formal written acceptance was received by a "*significant majority of GPs*".[47]

7.4.7 In January 2006, contracts and rotas were sent to those practices which had showed an interest in joining the co-operative.[48] When the system began operating on 3rd April 2006, 61 GPs had signed up to become part of JDOC.[49]

7.4.8 During its review, the Panel sought information from all GP practices in the Island. The written submissions it received helped to establish why GPs were (or were not) favourable to joining the co-operative service.

7.4.9 One practice supported the scheme as it would mean that patients would be seen by fresher GPs at a cost equivalent to that which was paid previously. This practice also indicated that the introduction of a co-operative service would enable the Island to attract GPs to work here.[50] Two further practices also indicated that the co-operative service would enable patients to benefit from seeing GPs who were not fatigued.[51] The Panel will explore these issues in a later chapter of this report.

7.4.10 The Panel also received submissions from practices which (at that time) had not chosen to join JDOC. Whilst specific reasons were not given in these submissions for remaining outside of the co-operative, it was intimated that the decision had been made with the patients' benefit in mind. During the course of its review, the Panel was

[43] Notes of Meeting on 7th March 2006 at Ambulance Service Headquarters
[44] *Proposed General Practitioners Out of Hours Service*, p. 3
[45] Written Submission from Dr. B. Perchard, 17th March 2006
[46] Ibid
[47] Ibid
[48] Ibid
[49] Notes of Meeting on 7th March 2006 at Ambulance Service Headquarters
[50] Written Submission from Dr. D.I. Balbes (on behalf of Indigo House Medical Practice), 25th March 2006
[51] Written Submissions from Dr. A.P. Vincent (on behalf of Les Saisons Surgery), 29th March 2006, and from Dr. M.J. Bellamy (on behalf of Health+ Surgery), 31st March 2006

advised that opinion on the co-operative service had been divided along generational lines at one practice whilst another practice had chosen not to join due to its belief that the Department should not be involved.[52]

7.4.11 Notwithstanding that the co-operative service provoked mixed reactions amongst GPs, the Panel gave consideration to whether any pressure had been placed on GPs to join JDOC.

7.4.12 Whilst the Panel was aware that some GPs were unhappy with the situation and did not favour the co-operative, it did not receive specific evidence to suggest that pressure had been put on GPs to join the co-operative. However, it was apparent from written submissions made to the Panel that pressure may have been felt by those practices from the change of arrangements that the introduction of the co-operative placed upon them: the development of JDOC led to the ending of 'mini-co-operatives' that had existed beforehand. If one practice in such a 'mini-co-operative' chose to join JDOC, the other practice(s) were forced to find alternative arrangements. However, the presence of the co-operative meant there were fewer alternatives for such practices.

7.4.13 The Panel was certainly aware of the sensitivity of the issue: more than one GP contacted the Panel with a view to commenting upon the co-operative in an anonymous capacity. However, the issue was touched upon in comments made by one GP at a Public Hearing on 29th September 2006:

> "*They [JDOC] had sort of made some sort of punitive measure that if you did not join on the date that they started the co-op that you would be penalised.*"[53]

7.4.14 The Panel understands that the 'measure' in question was the subscription and registration fees that would be required of GPs when joining JDOC. It had originally been proposed that those who joined JDOC immediately (i.e. in time for its implementation on 3rd April 2006) would not be required to pay the subscription fee that would be charged to those who chose to join at a later date (although the annual registration fee would be payable by all). However, ultimately this was not the case.

7.4.15 The issue of pressure was raised when the Panel met Dr. Perchard on 3rd April 2006. When discussing the public consultation that had been undertaken by practices which had chosen to join JDOC, the Panel was advised that participating GP practices had chosen not to advertise their involvement in the co-operative service due to concerns regarding public perception: these practices did not wish to be seen denigrating those who had chosen to remain outside the co-operative.[54]

7.4.16 In addition, the Panel was advised that the Joint Working Party had not wished to give participating practices an unfair advantage over those which did not choose to participate. To this end, for example, it had been agreed that:

> "*GPs in the GP Co-Op will have to purchase drugs, medicines and supplies via distribution routes available to all GP Practices and not access services or support provided by Health and Social Services.*"[55]

[52] Minutes of the Social Affairs Scrutiny Panel, 3rd April 2006
[53] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 12
[54] Minutes of the Social Affairs Scrutiny Panel, 3rd April 2006
[55] Correspondence (dated 7th April 2006) from Mr. M. Littler to the JCRA

7.4.17 The Panel notes the perception that the introduction of JDOC was driven by a minority of GPs. The Panel found no evidence that GPs were coerced to join the co-operative. However, it believes that circumstantial pressures arose once a significant number of GPs had joined. As a result, there were few viable alternatives for practices which chose to remain outside and they were therefore compelled to join.

7.5 Consultation with the Public

7.5.1 In addition to assessing the consultation that occurred with GPs, the Panel also examined the level of consulation that had occurred with the public.

7.5.2 In terms of the consultation undertaken by GPs, the Panel was advised that informal consultation occurred between GPs and their patients. In addition, information was put across in the media. For example, Dr. B. Perchard undertook an interview with BBC Radio Jersey whilst articles also appeared in the *Jersey Evening Post*.[56]

7.5.3 Some written submissions made to the Panel by GP practices (which chose not to join the co-operative) indicated that their patients had been happy for them not to join. For the most part, the Panel was unable to quantify this support offered by patients. However, one practice had chosen to garner the views of its patients by means of a questionnaire. The practice in question sent out 200 copies of the questionnaire that essentially asked the respondents whether they wished the practice to continue to provide its own out-of-hours service or whether they wished the practice to join the GP co-operative. The practice received just under 100 replies of which thirty-five per cent were in favour of it joining the co-operative; fifty-eight per cent of respondents wished the practice to continue its own out-of-hours service; five per cent of people had no opinion (there were some spoilt papers).[57]

7.5.4 On 3rd April 2006, the Panel met Dr. B. Perchard. At this meeting, the matter of public consultation was considered. Dr. Perchard expressed a belief that the lack of Public response to the consultation was surprising but indicated the Public was not opposed to the scheme.[58]

7.5.5 Two months after the former H&SS Committee's meeting in October 2005, Jersey moved to a Ministerial system of government. In anticipation of the new system, guidelines were developed (and presented to the States on 25th October 2005 by the former Policy and Resources Committee) that described the manner in which public consultation would occur under the new system. These guidelines were contained in *Public Consultation* (R.C.82/2005). The development of a co-operative GP service represented one of the first occasions on which these guidelines could be put to use under the Ministerial system. These guidelines applied to the Department (i.e. not the GPs) and provided the following summary of how consultation should occur:

> "*1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage.*
>
> *2. It should be clear who is being consulted, about what questions, in what timescale and for what purpose.*

[56] Minutes of the Social Affairs Scrutiny Panel, 3rd April 2006
[57] Written Submission from Dr. I. Cameron, 20th May 2006
[58] Minutes of the Social Affairs Scutiny Panel, 3rd April 2006

3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.

4. Make documents as widely available as possible, with the fullest use of electronic means (though not to the exclusion of others), and effectively draw consultations to the attention of all interested groups and individuals.

5. Allow sufficient time for considered responses from all groups with an interest. Eight weeks should be the standard minimum period for a consultation.

6. Analyse responses carefully and with an open-mind. Make the results widely available, with an account of the views expressed, and reasons for decisions finally taken.

7. Departments should monitor and evaluate consultations, designating a consultation co-ordinator who will ensure the lessons are disseminated."[59]

7.5.6 The Panel considered whether attention had been given by the Department to the provisions of *Public Consultation* (R.C.82/2005). It was advised that advice had been sought by the Department from the Communications Unit which had, broadly speaking, reiterated the content of the document.[60]

7.5.7 The consultation document for the proposed out-of-hours co-operative appeared in the local press on 10th January 2006 (with further appearances on 20th and 27th January 2006).[61] The document described the current arrangements for out-of-hours care, explained how the new service would work and how much it would cost patients to use the service. It was stated that the consultation period would last from 10th January 2006 until 3rd April 2006.[62] The consultation document was distributed to States Departments through a circular 'cascading' memo to Chief Officers (in that the memo was due to be forwarded for the attention of staff) and was also sent by e-mail to a distribution list of people who had asked to be notified of public consultations. [63]

7.5.8 In addition, the Department directly contacted Age Concern Jersey, Jersey Hospice Care and the Citizen's Advice Bureau and held meetings with the Department of Social Security with a view to establishing the thoughts of these parties.[64]

7.5.9 The Department received eleven written responses as part of the public consultation. These responses came from GPs, individual members of the public and associations and entailed a mixed reaction to the proposed co-operative service: some people explicitly approved of the new service whilst others were evidently not in favour of changing the existing arrangements. Other people merely raised questions relating to the new service without explicitly supporting (or opposing) the creation of the co-operative.

7.5.10 Questions were raised in the submissions in relation to a number of issues. There were concerns regarding the potential cost of using the co-operative service and whether GPs would still be able to use discretion when charging patients. There were a number of comments regarding the driver service that was due to be used by JDOC

[59] *Public Consultation* (R.C.82/2005)
[60] Written Response from the Department, 20th July 2006
[61] Written Response from the Department, 20th July 2006
[62] *New Out of Hours GPs Emergency Service Proposed – Media Release* (9th January 2006)
[63] Written Response from the Department, 20th July 2006
[64] Written Response from the Department, 9th March 2006

whilst at least three individuals raised questions relating to the potential impact on the Accident and Emergency (A&E) Department. Finally, some people were concerned about the lack of continuity from the patients' perspective and whether GPs (aside from a patient's own GP) would have access to patient records.[65] These issues, and others, will be addressed in later sections of this report.

7.5.11 The Department did not produce a summary of the submissions it received.[66] However, each person who made comments or asked questions in relation to the proposed service was sent a response from the Joint Working Party. The responses included a shortened version of the Project Agreement.[67]

7.5.12 During its review, the Panel considered how proactive the public consultation had been. The Panel was advised by the Department that no public meetings were held by them prior to the establishment of JDOC. Although invitations to discuss the draft project agreement were extended by the Joint Working Party in February 2006 to Age Concern, Jersey Hospice Care and the Citizens Advice Bureau, these were not taken up.[68]

7.5.13 The Panel was advised that those GP practices due to join the co-operative did not advertise this fact publicly (i.e. in the press) although the reasons given for this should also be noted (see Item 7.4.15). In addition, the Panel understands that presentations were made by GPs to the Senior Citizens' Association and The Samaritans although at the time of this report's presentation, Dr. B. Perchard had been unable to confirm that these meetings were held prior to the establishment of JDOC.[69]

7.5.14 Bearing in mind that these proposals could potentially affect every islander, the Panel feels that there was a lack of public meetings held by the Joint Working Party.

7.5.15 The first point from *Public Consultation* (cited above) notes that the timing of consultation should be built into the planning process. The period of consultation (as run by the Department) ended on 3rd April 2006; in other words, on the same day as the co-operative service began. The Panel asked the Department why the consultation period had lasted three months. It was advised that this duration had been chosen in order that consultation occurred in accordance with *Public Consultation* (R.C 82/2005).[70]

7.5.16 The implementation date (of 3rd April 2006) was not included in the initial consultation document that appeared in the local press in January 2006. When asked why the start-date had not been indicated in the document, the Panel was advised by the Department:

> "*At the time of the media release dated 10th January 2006, the GP Co-Op Joint Working Party had some doubts as to whether the proposed GP Co-Op could be operational by the proposed implementation target date of 3rd April 2006. As a consequence the media release allowed the consultation process to begin but gave the Co-Op Joint Working Party the opportunity to move the implementation date if it proved necessary.*"[71]

[65] Written Response from the Department, 9th March 2006
[66] *Public Consultation*, Agenda Item A2, Council of Ministers, 25th January 2007
[67] Written Response from the Department, 20th July 2007, p. 2
[68] Written Response from the Department, 18th April 2006
[69] Written Submission from Dr. B. Perchard, 23rd February 2007
[70] Written Response from the Department, 20th July 2006, p. 3
[71] Ibid, p. 3

7.5.17 The Panel also asked whether there had been sufficient time for the Department to monitor the consultation given that, theoretically speaking, responses could have been received days prior to the establishment of the service. This was a concern that had also been raised by one of the respondents to the public consultation document issued by the Department. In response to this concern, the Joint Working Party advised:

> "*in order to meet potential deadlines a number of activities have to be undertaken concurrently rather than sequentially. For instance, the GP Co-Op Working Party is undertaking a public consultation exercise and preparing the GP Co-Op facility. It is doing this as the feedback [i.e. responses to the Public Consultation and informal consultation by GPs] from the Public thus far has been very positive and the facility needs to be refurbished to allow utilisation during the day by Health and Social Services. In the event that the proposed GP Co-Op did not receive support from the Public or sufficient support from GPs the project would be immediately stopped. To date, there is no likelihood of either scenario occurring.*"[72]

7.5.18 This matter was addressed by the Panel at the Public Hearing on 13th November 2006 with the Minister. At the Hearing, the Panel was advised by the Minister:

> "*The bulk of the consultation that had taken place was in and collated by then, and the majority of the Island's GPs wanted the co-op to be launched. There did not seem to be any particularly strong or convincing arguments put forward against it. We were happy that we should press the button and launch it, so we did.*"[73]

7.5.19 The Minister subsequently stated:

> "*Can I also point out that politically you learn that if you try to wait before introducing a new policy or new initiative until everyone is completely happy with it, then you would never introduce anything.*"[74]

7.5.20 At the Public Hearing on 29th September 2006, representatives of the JCRA were asked for their opinion on the consultation undertaken by the Department. In reply, they stated:

> "*I do not know if we have any express views, although I do recall that the period between the close of the consultation and the implementation of the programme was very, very short, if not basically all happening around the same day, which I think was a little curious.*" [75]

7.5.21 The subject of public consultation (as a general issue) came before the Council of Ministers on 25th January 2007. The Council was asked to consider a paper in which the existing system of public consultation was discussed and proposals were outlined for how the system could potentially be improved.[76]

7.5.22 A belief was expressed that the lack of Public response to the consultation indicated the public was not opposed to the scheme. The Panel can only conclude that a lack of response is evidence that the public did not respond and not evidence of whether the public either supported or opposed the scheme.

[72] Correspondence (dated 6th March 2006) from Mr. M. Littler (forming part of the response to public consultation)
[73] Senator S. Syvret, Transcript of Public Hearing 3, 13th November 2006, p. 52
[74] Senator S. Syvret, Transcript of Public Hearing 3, 13th November 2006, p. 52
[75] Mr. C. Webb, Transcript of Public Hearing 1, 29th September 2006, p. 15
[76] *Public Consultation*, Agenda Item A2, Council of Ministers, 25th January 2007

7.5.23 The Panel believes it was unsatisfactory for the service to be implemented on the same day as the consultation period ended. The Panel questions whether this left sufficient time for consultation (potentially) to be assessed.

8 What are the Implications of JDOC?

8.1 On 3rd April 2006, the consultation period ended and JDOC began operating. Development of the co-operative was now in 'Phase 3' (as identified in the Joint Working Party report of October 2005): the implementation of the co-operative service itself.

8.2 From this time, it became feasible, not only for the Panel, but also JDOC and the Department themselves, to assess the actual effectiveness of the co-operative service.

8.3 It has already been noted that the service was to be audited and measured against specific standards. The Panel has noted too that JDOC was implemented on 3rd April 2006 for a six-month trial period (at least, in regard to the partnership between the Department and GPs).

8.4 In terms of measurable standards, the Joint Working Party had proposed to adapt the *National Quality Requirements in the Delivery of Out-of-Hours Services*. As a result, the *Jersey Quality Standards* were established to be used as a means of measuring and assessing the service. The *Jersey Quality Standards* have been reproduced in Appendix 2 of this report.

8.5 At the end of the sixth-month trial period, the co-operative service was subjected to a review and audit against the *Jersey Quality Standards*. The resultant report, *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*, was to be used by the Minister as a means of informing his decision on whether the Department should continue to provide funding.[77]

8.6 The report contained an assessment of the co-operative service against each of the *Jersey Quality Standards*. It also contained copies of questionnaires that had been given to patients (who had used the service) to gauge their opinion on the service. Finally, the report presented the activity data for the first six months (i.e. how many people had visited the surgery, how many had received home visits etc).

8.7 In the following three chapters, the Panel will explore in greater detail the workings of the co-operative service and endeavour to assess it. To this end, the information contained in the six-monthly report proved useful to the Panel.

8.8 When conducting its review, the Panel was primarily concerned with the impact that the creation of JDOC would have on patient care. In the next chapter, the Panel will therefore explore the workings of the system from the patient's perspective. However, as this approach would not allow coverage of all pertinent matters, in the ensuing two chapters, the Panel will examine issues from the perspectives of the Department and then of GPs.

[77] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 9

9 What does JDOC mean for the patient?

9.1 JDOC's Activity

9.1.1 As part of the auditing arrangements for the GP co-operative, it was agreed that activity data would be recorded. Each month, therefore, statistics were collated for the number of people that had used the services provided by JDOC (surgery, visits, and telephone consultations).

9.1.2 The six-monthly report produced by the GP Co-Op Management Board included activity data for the period from 3rd April 2006 to 8th October 2006. During that period, 668 consultations had been undertaken at the co-operative surgery; 1,065 home visits had been undertaken; and 981 telephone consultations had occurred. In total therefore, JDOC had provided a service on 2,714 separate occasions during its first six months of operation.[78] This did not necessarily mean that 2,714 individuals had used the service as repeat consultations or visits could not be accounted for in the data. Nor could the raw data provide a demographic breakdown of those who had accessed the service.

9.1.3 The recorded activity was somewhat different to the projections that had been made during the development of the co-operative. Based on data gathered from 40 GPs, the Joint Working Party had estimated that yearly demand for out-of-hours care would amount to 4,900 evening home visits (between 7:00pm and 11:00pm), 731 night home visits (between 11:00pm and approximately 7:00am) and 2,922 telephone consultations.[79] In total therefore, it was anticipated that out-of-hours care was required on 8,553 separate occasions (equivalent to a figure of 4,276 instances during a period of six months).

9.1.4 The Department anticipated that the demand for consultations at the co-operative surgery would possibly increase. In advice it gave the JCRA, it was noted that experience from co-operatives in the UK suggested this would occur in time.[80]

9.2 Initial Contact

9.2.1 Prior to JDOC's establishment, initial access to one's GP outside of normal working hours would have been by telephone: the specific arrangements differed from practice to practice but, essentially, patients would telephone their practice if they required care during that time. At a Public Hearing on 29th September 2006, one GP advised the Panel of how patients of his practice would reach him if he were on call during the out-of-hours period:

> "*The patient rings up the surgery, a phone message says: "Press 2 if you want the doctor", they press 2 and it comes directly through to my phone.*"[81]

9.2.2 Under JDOC, patients (provided their practice forms part of the co-operative) continue to call the number of their own GP practice in the first instance. During the opening hours of the JDOC surgery, the call is then automatically diverted to the surgery. Once

[78] *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*, p. 11
[79] *Proposed General Practitioners Out of Hours Service*, p. 14
[80] Correspondence (dated 15th June 2006) from Mr. M. Littler to the JCRA
[81] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 30

the surgery has closed, calls are diverted to the Emergency Call Centre (located at the Ambulance Station).[82]

9.2.3 Theoretically, therefore, the system under JDOC would not appear to require any more of an individual than the arrangements in place prior to JDOC (in that patients merely need to telephone their own practice to access the service). However, this system could not be introduced immediately: for a time following JDOC's creation, a person who phoned their GP 'out of hours' was required to dial a second number in order to access JDOC.[83]

9.2.4 To assist its consideration of whether JDOC would improve patient access to GP services during the out-of-hours period, the Panel gave consideration to patients' requirements with regard to contacting a GP practice. In response to a question to this effect, the Department advised that the requirements included:

> "*-timely and reliable access to medical advice*
> *-(where appropriate) reliable access to timely medical treatment consistent with their ailment.*"[84]

9.2.5 The eighth *Jersey Quality Standard* addresses the initial telephone calls that patients make to the co-operative service. This standard establishes the length of time in which calls need to be answered and also sets target limits for the number of engaged and abandoned calls that should occur.

9.2.6 In the six-monthly report, it was stated that the eighth standard could not be fully audited as the ICT system (necessary for it to be measured appropriately) was not in place to allow such auditing to occur.[85] The Department itself was therefore unable to assess fully this standard (due to a lack of appropriate information).

9.2.7 However, the questionnaires distributed by JDOC to gauge patients' views on the care they have received include questions relating to the initial contact:

> "*Did you have difficulty in contacting JDOC?*
> *Was your telephone call answered promptly?*
> *Was you problem dealt with on the first call?*"[86]

9.2.8 From the questionnaires which the Panel was given (and which it was therefore able to consider), it would appear that the majority of those who completed questionnaires were satisfied with the manner in which the service could be accessed.

9.2.9 The Panel welcomes the ease with which people can access the co-operative service and agrees that people should only need to make one telephone call.

9.3 Various Courses of Action

9.3.1 During the opening hours of the surgery, patients' calls are taken by a receptionist employed specifically for that task. When the surgery closes, calls are diverted to the Emergency Call Centre.

9.3.2 Various courses of action may ensue from the initial phone-call:

[82] Written Response from the Department, 25th May 2006, p. 8
[83] Minutes of the Social Affairs Scrutiny Panel, 3rd April 2006
[84] Written Response from the Department, 25th May 2006, p. 8
[85] *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*, p. 5
[86] *Patient Satisfaction Questionnaires*

- If the patient's case is serious, an ambulance will be despatched automatically (these calls would not be forwarded to the on-call GP)
- The on-call GP will undertake a telephone consultation after which no further action may be required (during the out-of-hours period)
- During the opening hours of the surgery, an appointment may be made for the patient to attend the surgery for a consultation
- At any time during the out-of-hours period, the patient may receive a home visit from the on-call GP

In essence, the initial telephone call acts as a form of *triage* (i.e. assessment) in which the patient will embark upon a particular care pathway depending on the magnitude of the case (and, to an extent, the wishes of the patient).

9.3.3 The possibility of telephone consultations (in which a consultation at the surgery or home visit would not be necessary) was stated to the Panel to be an advantage of the co-operative service particularly as no charge is made for these consultations. However, telephone consultations were feasible under the previous system. There were 981 instances of telephone advice being given between the establishment of JDOC (on 3rd April 2006) and October 2006.[87]

9.3.4 The fact that calls may not go directly to the on-call GP was set out (to the Panel) as another advantage of the co-operative service in that ambulances could potentially be despatched quicker than may have been possible under previous systems. The ninth *Jersey Quality Standard* requires the co-operative to be able to react to emergency situations such as these within a given time and to divert calls to the ambulance service within three minutes (if a life-threatening condition has been identified). At the time of the six-month review, this standard could not be audited due to the absence of appropriate ICT support. It was also apparent that members of staff were not yet sufficiently trained, medically-speaking, to address this issue.[88]

9.3.5 The Panel acknowledges that the initial telephone call to the service acts as a form of *triage* and therefore recognises that the skills of the receptionist are essential and that relevant training should be provided for this role.

9.4 EFL Patients

9.4.1 During the review, the Panel considered how the co-operative would cater for patients whose first language was not English. The thirteenth *Jersey Quality Standard* requires the co-operative to provide a service that takes into account EFL (English as a Foreign Language) patients (as well as patients with impaired sight or hearing).

9.4.2 The Panel raised this matter with Dr. B. Perchard at a meeting on 3rd April 2006. At the meeting, the Panel was informed that the GP co-operative would have access to the language service at the General Hospital and that the cost for this use would not be borne by the Department.[89]

9.4.3 In advice received from the Department, the Panel learnt that no specific provision had been made for the receptionist at the co-operative surgery to respond to EFL patients (beyond asking other people for assistance, such as the on-call GP).[90]

[87] *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*
[88] Ibid, p. 6
[89] Minutes of the Social Affairs Scrutiny Panel. 3rd April 2006
[90] Written Response from the Department, 25th May 2006, p. 9

9.4.4 The six-month performance report on the co-operative service indicated that there had been no demand for an interpretation service during that period. However, provision had been made for potential demand in that the interpretation service available to A&E was also accessible by the co-operative.[91]

9.4.5 The Panel notes that provision has been made for patients who may not speak English as a first language.

9.5 The Standard of Medical Care

9.5.1 Notwithstanding the structure of the service provided by JDOC, the Panel gave consideration to the issue of whether the service would mean that patients received a different standard of medical care to that which they had previously.

9.5.2 During its review, the Panel was advised that the establishment of a co-operative surgery (for the provision of medical care during 'out of hours' from 7:00pm to 10:00pm) was a substantial benefit of JDOC as this service had been previously unavailable. Indeed, in the Joint Working Party report this appeared to be a primary benefit of the new service.[92]

9.5.3 However, the patients of one practice were already able to access an evening surgery from Monday to Thursday between 6:00pm and 8:00pm.[93] The Panel understands that, at the time of this report's presentation, these surgeries continued to operate. As such, the patients of this practice had not 'lost' any services as a result of the implementation of the co-operative service.

9.5.4 If a patient is unable to visit the surgery, or if treatment is required once the surgery has closed, the on-call GP may undertake a visit to the patient's home. Once the surgery closes, calls are taken by the Emergency Call Centre which may then transfer it to the on-call GP. From the patient's perspective, this service, in terms of the process, would not appear to differ from the home visits which occurred under previous systems.

9.5.5 One written submission made to the Panel highlighted the issue of patient choice. In this submission, it was suggested:

> "*The patient presently has some choice as to which doctor or practice is called for out-of-hours ('ooh') service. This choice arises from the contract for services which the patient either expressly or impliedly enters into with the practice. The 'Gpooh' [i.e. JDOC] would appear unilaterally to change the conditions of service such that, depending on whole or partial practice adherence to GPooh, the patient is forced out-of-hours to see a doctor either not of their choosing or from a practice not of their choosing.*"[94]

In terms of the standard of medical care, it appeared to the Panel that this statement essentially raised the question of whether the public (i.e. the patients) could have confidence in the medical care given by whichever GP was on call.

9.5.6 It also appeared that, to answer this question comprehensively, it would be necessary to undertake a detailed survey of individual consultations. The Panel is aware that this

[91] *GPCOOP Management Board Performance Report 03.April 2006 – 03 October 2006*, p. 8
[92] *Proposed General Practitioners Out of Hours Service,* p. 15 (The Panel is aware that, in practice, the surgery opens from 6:30pm to 10:30pm)
[93] Correspondence (dated 20th January 2006) from Dr. I. Cameron (forming part of the public consultation)
[94] Written Submission from Dr. M. Young, 26th March 2006

undertaking would prove to be difficult. However, the fourth *Jersey Quality Standard* requires the co-operative to undertake regular audits of a "*random sample of patient contacts*" and would appear to address the issue.[95]

9.5.7 The fourth *Jersey Quality Standard* could not be audited fully after six months due to the lack of appropriate ICT. As a result, manual reviews of 20 sets of notes were undertaken during the initial six months. From this undertaking, the following conclusion was drawn:

> "*All clinical data appeared appropriate with appropriate prescribing and in all cases a plan for follow up had been detailed as necessary.*"[96]

9.5.8 The six-month report explained that it would be difficult to draw further conclusions due to the lack of ICT and that, whilst performance appeared to be satisfactory, the co-operative would be:

> "*dependent on [the] complaints system and [the] patient survey data to highlight areas of concern*."[97]

9.5.9 The need to undertake patient surveys is set out in the fifth *Jersey Quality Standard*. During the initial six months, questionnaires were distributed to every 30th patient who attended the surgery. In total, therefore, 57 questionnaires were handed out, of which 33 were returned. The questionnaires (to be completed anonymously) asked patients to comment on the manner in which their initial calls were handled; the length of waiting-time; the bedside manner of the GP in question; and the facilities at the Gwyneth Huelin Wing. Patients were also asked to rate the service they have received. Of the 33 questionnaires received (which the Panel was able to consider) 32 provided positive feedback on the service and rated it as being 'very satisfactory'. The one exception appeared to come from a person unhappy with the bedside manner of the GP this person had seen.[98]

9.5.10 The Panel was advised of the complaints procedure at the Public Hearing with the Minister on 13th November 2006. The existence of such a procedure is required under the sixth *Jersey Quality Standard*:

> "*A formal complaint is somebody who feels aggrieved and writes a letter to the management board or completes the complaints form, thus triggering the formal complaint system. And patients are aware of that; it is in the information leaflet that is available in the surgeries and at the co-op base. […] But there are informal situations where we hear about someone saying to their GP: "Oh, you know, he was a bit grumpy on Saturday" or: "It was all right but I did not like that aspect."*"[99]

9.5.11 In the six-month performance report, it was noted that no formal complaints had been made but that informal complaints had been received (some of which related to the pricing rates).[100]

9.5.12 The Panel notes that the appropriate ICT is not yet available to allow the co-operative service to be fully audited.

[95] *Jersey Quality Standards*
[96] *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*, p. 3
[97] Ibid, p. 3
[98] Ibid
[99] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 48
[100] *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*, p. 4

9.6 Familiarity and Continuity

9.6.1 It became apparent to the Panel that patients had other requirements regarding the service they received (out of hours) besides the standard of medical care. Certainly in the eyes of some people who made written submissions to the Panel, out-of-hours care should be delivered by the individual patient's own GP. For example, one written submission contained the comment that:

> "*If I need 'out-of-hours' attention, I am comforted by the fact I will see a friendly, understanding face or, if not my own doctor, someone I recognise from his practice.*"[101]

9.6.2 With the introduction of JDOC, a rota was established whereby GPs were allotted slots during which they would be on call. From this, it can be seen that patients would be seen by the GP on call. This would mean they would not automatically see their own GP.

9.6.3 When this question was raised during the Panel's review, it was advised that patients had not been guaranteed to see their own GP under prior arrangements for the delivery of out-of-hours care. The Panel received written submissions from several GP practices on the manner in which they had delivered out-of-hours care before the co-operative service had been established. It is clear that some practices established mini-co-operatives with others and set up a rota. Under this system, it was not certain that patients would be seen by their own GP during a home visit.

9.6.4 However, one GP advised the Panel that, whilst a patient was not guaranteed to see a particular GP, there was a degree of continuity as some patients became known to practices as a whole:

> "*Within our practice, we know them all because we have all seen them lots of times*."[102]

9.6.5 It would appear that some people have not seen any problems arise in this regard since the implementation of JDOC. One written submission (from a member of Jersey Hospice Care) included a comment to this effect:

> "*When a home visit was requested, the Doctor on duty attended promptly and even though the Patient and Family were not known to him, they were treated in a most professional and compassionate manner.*"[103]

9.6.6 In a written submission from another member of Jersey Hospice Care, indications were given to the effect that, whilst a rota had been established for the co-operative service, individual GPs were able to choose to see individual patients even when not on call:

> "*I am told that many General Practitioners continue to make themselves personally available for patients in the in-patient unit in particular, even when they are not on call.*"[104]

9.6.7 The flexibility of the rota in this regard was confirmed at the Public Hearing on 13th November 2006:

[101] Written Submission from Mrs. T. Anderton, 8th March 2006
[102] Dr. I .Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 8
[103] Written Submission from Ms. M. McGovern (Jersey Hospice Care), 20th June 2006
[104] Written Submission from Dr. G. Purcell-Jones (Jersey Hospice Care), 4th July 2006

> "*And you can still do that within the co-op. You can decide…you can give your own phone number to the patient and say: 'Do not call the co-op, call me if you want that individual care.'*"[105]

9.6.8 In relation to this issue, one written submission (from a third member of Jersey Hospice Care) expressed concern that the continuity of care received by a specific group of patients could potentially be compromised (although it was not stated that there had been any actual problems):

> "*My remaining concern is that over a weekend / bank holiday, terminally ill patients whose conditions fluctuate and who require frequent management change could potentially be seen by as many as six different doctors.*"[106]

9.6.9 This concern was put to Dr. B. Perchard at the Public Hearing on 13th November 2006. In response the following comment was made:

> "*In the previous system they [terminally ill patients] could have been seen by a minimum of three different GPs anyway over the course of a weekend because there are very few practices that have the same person on from Friday night through to Monday morning, or over a bank holiday, the Tuesday morning; very few.*"[107]

9.6.10 The third *Jersey Quality Standard* states that the co-operative must have sufficient systems in place to ensure the provision of:

> "*comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).*"[108]

9.6.11 At the time of the six-monthly review, the co-operative had been using the 'Red Folder' system as the appropriate ICT was unavailable. The report emanating from the review explained how this system worked:

> "*The red folder is kept at the JDOC base. Doctors are encouraged to put the details of any vulnerable patients in the folder so that any on call doctor can refer to it in order to optimize (sic) the treatment a patient receives. This way any specific management plans can be continued out of hours.*"[109]

9.6.12 The report also indicated that joint protocols would be drawn up with organisations such as Jersey Hospice Care in order to address the third *Jersey Quality Standard*. This fact was reiterated at the Public Hearing on 13th November 2006 although no protocols had been established by that time.[110]

9.6.13 The Panel notes that, whilst some arrangements have been made, no protocols have been drawn up to address the third Jersey Quality Standard but acknowledges the close working relationship that has been established with Jersey Hospice Care.

9.6.14 The issue of continuity also arose in relation to the period immediately following a consultation. Under the co-operative system, as it is possible that patients may not be

[105] Dr. S. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 39
[106] Written Submission from Sister J. McDonald (Jersey Hospice Care), 20th June 2006
[107] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 21
[108] *Jersey Quality Standards*
[109] *GP COOP Management Board Performance Report 03 April 2006 – 03 October 2006*, p. 1
[110] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 22

seen by their own GP, the question presents itself of how the relevant information (i.e. the results of the consultation) is passed to patients' own practices in order to ensure that continuity of care is maintained.

9.6.15 This matter was highlighted as a potential problem for the co-operative service at a Public Hearing on 29th September 2006. At this Hearing, one GP advised the Panel:

> "*You would hope that the communication systems, you know, are going to work properly and send the information. I mean, clearly that is more complicated with 20 practices than it is within our practice where that sort of thing goes on on a daily basis. I come in in the morning, we put it in the computer now or you stick it on a bit of paper and you pass it on to the relevant doctor. You know: "I went out to see this patient last night and, you know, X, Y and Z; can you do something about it?" You know, that is clearly a really important issue.*"[111]

9.6.16 The Panel highlighted that concerns such as these had been raised when it met with the Minister and members of the GP Co-Op Management Board at a Public Hearing (on 13th November 2006). At this Hearing, the Panel was advised:

> "*It has massively improved communication among the profession and we are all talking to each other about what we are doing and the best way to manage it.*"[112]

9.6.17 The matter of communication (and continuity) is addressed in the second and third *Jersey Quality Standards*. The third standard has already been examined. The second standard states that the co-operative:

> "*must send details of all 'Out of Hours' (OOH) consultations (including clinical information) to the practice where the patient is registered by 10:00 a.m. the next working day.*"[113]

9.6.18 It is apparent that this standard cannot be audited fully until the appropriate ICT system had been implemented. However, the six-month report indicated that the interim system appeared to have been working well and that information had generally been sent to practices the same evening on which consultations had occurred.[114]

9.6.19 When the Panel began its review, it gave consideration to the idea that all GPs (which formed part of the co-operative) would have access to data and information relating to all patients covered by the co-operative.

9.6.20 The issue of access to information was raised in submissions made to the Department as part of its public consultation. For example, one individual, worried at a potential system whereby visiting GPs would not have sufficient knowledge of the patient, raised the issue of privacy of patient data. In response to these concerns, the individual was advised by the Department:

> "*I have discussed this matter with GP representatives on the GP Co-Op Working Party and they have assured me that there are many instances where GPs under current arrangements [i.e. prior to JDOC] have to treat patients on information and symptoms presented to them in the absence of patient records and notes. The GP Co-Op aims to improve on this situation by building up its own*

[111] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 15
[112] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 19
[113] *Jersey Quality Standards*
[114] *GP COOP Management Board Performance Report 03 April 2006 – 03 October 2006*, p. 1

> *confidential patient database that will over time provide the Visiting GP with immediate access to patient information.*"[115]

9.6.21 The Panel was advised that the co-operative's database would be built up each time a patient had contact with an on-call GP (who formed part of the co-operative) whilst GPs would maintain written reports in a cabinet at the surgery base. The electronic database would be accessible by the co-operative's receptionist and reconciliation clerk (employed by the Department) although patient reports would be given to GPs on call when they undertook a consultation or home visit.[116]

9.6.22 The Service Level Agreement between the Department and JDOC included provision for the storage of information:

> "*Both parties acknowledge their respective duties under the Data Protection (Jersey) Law 2005 as applicable and hereby confirm they will comply fully with the said Laws and shall give all reasonable assistance to each other where appropriate or necessary to comply with any obligations arising under the said Laws. The Contractor [JDOC] is for the purposes of the said Laws, the data controller for all personal information processed as a result of this agreement. The Minister is responsible for the technical and organisational security of the data which will be held on the premises and must ensure the data is not used or disclosed for any purpose outside this agreement except on the written instructions from the Contractor.*"[117]

9.6.23 The Panel asked the Department how the liaison between GPs and other medical service providers would be improved by the introduction of the co-operative service. It was advised that:

> "*joint collaboration between H&SS and the GP Co-Op on information technology and information systems, will allow in time greater sharing of patients' information and test results in real time, thereby improving patients care.*"[118]

9.6.24 In July 2006, the Panel was advised that work on introducing a "*comprehensive computerised support system*" would begin when it had been agreed that the co-operative would continue. Until that time, the surgery would be operated as one of the Department's clinics in order that activity data could be collected using existing systems.[119]

9.7 The Cost to Patients

9.7.1 The current costs of JDOC's services are as follows:

- Visit to the surgery (Monday to Sunday 7:00pm to 10:00pm and Sunday 10:00am to 12:00pm): £40.00
- Evening home visit (6:00pm – 11:00pm) £80.16
- Night home visit (11:00pm – 8:00am) £100.72
- Home visit (Saturday 12:00pm – 6:00pm and Sunday, 8:00am – 6:00pm): £80.16
- Telephone consultation: £0.00[120]

[115] Correspondence (Dated 6th March 2006) from Mr. M. Littler (forming part of the response to public consultation)
[116] Written Response from the Department, 25th May 2006, p. 6
[117] *Service Agreement between the Minister for Health and Social Services and Jersey Doctors on Call*, Item 17.1
[118] Written Response from the Department, 25th May 2006, p. 3
[119] Written Response from the Department, 20th July 2006, p. 1
[120] Service Agreement, Schedule 2

For those individuals who do not benefit from Health Insurance Exemption (HIE), these fees exclude the £15.00 subsidy provided by the Department of Social Security.[121]

9.7.2 Under the Service Level Agreement, the prices of services are fixed annually by agreement between the Minister and JDOC.[122] According to advice received from the Department, in practical terms, GPs will be responsible for setting the fees but the Department will take into consideration whether the fees ensure that good value for money is achieved.[123]

9.7.3 However, the JCRA's decision to grant JDOC an exemption from Article 8 of the Competition Law was subject to the following condition:

> "*JDOC […] shall submit for the JCRA's review full details of any proposed increase in fees at least twenty one calendar days prior to such increases taking effect. Any such submission shall explain in detail how the proposed increases are cost justified, and provide sufficient data to the JCRA to examine this justification.*"[124]

9.7.4 Under the previous system, the fees for out-of-hours services differed from practice to practice. For instance, on 1st July 2005, the fees in relation to visits at week-ends (or public holidays) and night visits were as follows:

PUBLIC HOLIDAYS / WEEK-END VISITS

FEE BAND	NUMBER OF PRACTICES
£60.00 - £71.25	3
£71.25 - £82.50	7
£82.50 - £93.75	6
£93.75 – £105.00	4

NIGHT VISITS

FEE BAND	NUMBER OF PRACTICES
£65.00 - £80.00	2
£80.00 - £95.00	10
£95.00 - £110.00	6
£110.00 - £125.00	2

[125]

9.7.5 Notwithstanding the fact that these figures come from 2005, the above tables would appear to suggest that some patients would pay more (whilst others would pay less) for home visits undertaken during the out-of-hours period if their GP practice were to join JDOC.

9.7.6 Work on this issue was undertaken during the development of the co-operative service. It was recognised during development that JDOC's fees would be set at the mean level of fees previously available (as far as possible).[126] Advice to this end was given to those who responded to the Department's public consultation. The argument put forward was that, viewed holistically, the service provided by JDOC would be cheaper for the public of Jersey. The introduction of an evening surgery was also

[121] Advice received from the Department of Social Security, 19th December 2006
[122] Service Agreement, Item 9.1
[123] Written Response from the Department, 25th May 2006, p. 9
[124] *Concerning the General Practitioners Out-of-Hours Cooperative Notified under Article 9 of the Competition (Jersey) Law 2005*, p. 21
[125] *General Medical Practitioners' Fees* (2005)
[126] *Proposed General Practitioners Out of Hours Service*, p. 12

presented as a benefit to the patient (in terms of cost) as access to the surgery would be cheaper than receiving a home visit.[127]

9.7.7 The JCRA focussed on the fee structure of the co-operative service during its own review. This was explained at the Public Hearing with representatives of the JCRA on 29th September 2006:

> "*Probably the most important part of the analysis from our perspective, under the Competition Law lens, was looking at whether this result[ed] in a net increase or decrease in cost to consumers. Competition Law is about protection of competition and ultimately is protection of consumers in terms of price and quality.*"[128]

9.7.8 The JCRA undertook an analysis in which a comparison was made of the overall cost that had been incurred by patients accessing the surgery in the first two months of operation to the overall cost that would have been incurred under prior arrangements. 678 people had used the service in April and May 2006 (roughly 37% visiting the co-operative surgery with the remaining 63% requiring a home visit). The JCRA calculated that these 678 people (between them) paid a total of £45,350. Under previous arrangements, the JCRA calculated these 678 people would have paid a total of £53,000.

9.7.9 The results of the comparison undertaken may be found in the JCRA report. To the JCRA, the results suggested that:

> "*viewed holistically, consumers in Jersey saved over £7,600 in after-hours GP medical care during JDOC's initial two months of operation. These savings result from the significant minority (37.3%) of patients utilizing (sic) the £40 after-hours GP Surgery instead of requiring a GP home visit.*"[129]

9.7.10 At the Public Hearing (on 29th September 2006) with representatives of the JCRA, the Panel asked for clarification of the term 'consumers in Jersey' as it appeared the study may not have made account for those patients not covered by the co-operative service:

> "*There is no set definition given in the law, or in this decision. For the purposes of paragraph 39 [in which the comparison study is laid out] consumers in Jersey I think equals the 678 people who visited the JDOC between April and May 2006.*"[130]

9.7.11 The JCRA ultimately granted JDOC an exemption to Article 8 of *Competition (Jersey) Law 2005*. Essentially, therefore, the JCRA believed the protection of patients (in terms of price and quality) had not been compromised following the implementation of the co-operative service.

9.7.12 The fees for some of JDOC's services were increased to their current level on the day that JDOC began to operate. During the development of the service, it had been foreseen that fees would be £40.00 for a visit to the surgery; £70.00 for an evening home visit; and £95.00 for a night home visit.[131] However, in correspondence dated 7th April 2006, the Panel was advised that the fees for evening and night home visits

[127] *Proposed General Practitioners Out of Hours Service*, p. 15
[128] Mr. C. Webb, Transcript of Public Hearing 1, 29th September 2006, p. 12
[129] *Concerning the General Practitioners Out-of-Hours Cooperative Notified under Article 9 of the Competition (Jersey) Law 2005*, p. 11
[130] Mr. C. Webb, Transcript of Public Hearing 1, 29th September 2006, p. 22
[131] *Proposed General Practitioners Out of Hours Service*, p. 13

had increased to their current level effective from 3rd April 2006. The reason given for this increase was as follows:

> "*The previous fee structure […] was based on 2004 figures. The […] revised rates have been uprated to reflect the average annual percentage.*"[132]

9.7.13 The Panel is aware the States have made a commitment to keep cost increases to a maximum of 2.5% per annum. The changes implemented on 3rd April 2006 represented increases of 14.5% and 6% respectively. Advice given to the Panel indicated that:

> "*It was considered appropriate to maintain a coherent GP CoOp fee structure and hence the decision to use the average annual percentage increase in General Practice fee of 2005 over 2004 as the mechanism to increase the generic fee structure of the GP Co-Op.*"[133]

9.7.14 The JCRA was also interested in this area during its review and was told that increases in GP fees were normally greater than increases in Jersey's RPI.[134]

9.7.15 The JCRA was also advised that the increase had been due in part to the request from GPs for driver support to be covered from 6:00pm to 11:00pm (Monday to Sunday and Bank Holidays) and (for female GPs only) from 11:00pm to 8:00am (Monday to Sunday and Bank Holidays) on a standby basis. It was said that the increase in charges for home visits would just cover the increase in driver support.[135]

9.7.16 The Panel raised the matter of the price increases with the JCRA at a Public Hearing on 29th September 2006. In response to the question of whether the JCRA had been surprised by the increases, the Panel was advised:

> "*I think we were surprised at the lack of consultation on the higher fees but […] at the end of the day, for our analysis, we needed to decide if the fees as implemented were cost justified, which we did.*"[136]

9.7.17 When the JCRA undertook its investigation (and published its decision), JDOC comprised 71% of GPs in the Island. As part of its investigation, the JCRA attempted to assess whether the implementation of JDOC had eliminated competition (from the perspective of the patient). It concluded that:

> "*a significant amount of competition remains in the relevant market after the formation of JDOC. To ensure this remains so, however, as a condition to this exemption the JCRA will require JDOC to receive the JCRA's prior approval written prior before accepting any new members into the cooperative*."[137]

9.7.18 Applications were subsequently received by the JCRA (on 11th September 2006) that, if accepted, would mean that all but four of the Island's GPs formed part of the co-operative. On 16th October 2006, the JCRA published a notice of approval of these applications. The Panel considered whether the additions would effectively create a monopoly (and thus eliminate competition). In the JCRA's press release of 16th October 2006, it was stated:

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[132] Correspondence from Mr. M. Littler to Mr. C. Webb (JCRA), 7th April 2006
[133] Written Response from the Department, 25th May 2006, p. 10
[134] Correspondence (dated 15th June 2006) from Mr. M. Littler to the JCRA
[135] Correspondence (dated 15th June 2006) from Mr. M. Littler to the JCRA
[136] Mr. C. Webb, Transcript of Public Hearing 1, 29th September 2006, p. 16
[137] *Concerning the General Practitioners Out-of-Hours Cooperative Notified under Article 9 of the Competition (Jersey) Law 2005*, p. 20

"*Our [the JCRA's] examination concluded that adding the additional GPs to JDOC would not be contrary to the criteria supporting JDOC's exemption under the competition law, in that they would not place JDOC in a position to harm consumers by increasing prices or reducing quality or service*."[138]

9.7.19 The Panel notes that the statements made in October 2006 by the JCRA regarding additions to the co-operative do not refer to the competition clause that was present in its initial decision of 24th August 2006.

9.8 Discretionary Fees

9.8.1 The Panel understands that, under previous arrangements for the provision of out-of-hours care, GPs were able to exercise discretion in the fees they charged for home visits. Dependent on certain factors (e.g. whether the GP was undertaking a repeat visit or the patient's individual circumstances), the GP could choose to waive part of the fee.

9.8.2 At the Public Hearing on 13th November 2006, it therefore asked whether GPs had lost the opportunity to exercise discretion in relation to charges. The Panel was advised that GPs had not lost the freedom to exercise such discretion. At this Hearing, Dr. B. Perchard was able to cite two occasions on which her own practice had decided to waive fees incurred during the out-of-hours period.[139]

9.8.3 To understand how this would work in practice, it is worth noting the billing arrangements for JDOC. Under the co-operative system, once a patient has been seen by the GP on call, the necessary details are forwarded to that patient's own practice. Under the *Jersey Quality Standards*, this is due to occur by 10:00am the following day.

9.8.4 It then becomes the responsibility of the patient's own practice to bill the patient and collect the fee. At this stage, it is for the patient's own practice to establish whether a fee should be reduced (or waived) in which case discretion will be exercised.

9.8.5 However, payment for the service is due to the practice of the GP who undertook the consultation / visit. In essence, therefore, money needs to be transferred from one practice (to which the patient belongs) to another practice (which provided the service).

9.8.6 At regular intervals, a reconciliation process occurs in JDOC at which point the transfer of funds occurs. To this end, a reconciliation clerk is employed to oversee the operation of the process.

9.8.7 The Panel notes that GPs will continue to be able to exercise discretion over fees charged. However, it remains concerned that the level of discretion available to GPs may have been reduced and questions whether the billing process will ultimately be as discretionary as in the past.

[138] *Approval of Additions to Jersey Doctors on Call*, JCRA Press Release, 16th October 2006
[139] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 41

9.9 The Use of Public Funds

9.9.1 The reconciliation clerk is employed by the Department. From the patients' point of view, therefore, costs are also incurred in their guise as tax-payers as the co-operative service is jointly funded by both GPs (i.e. JDOC) and the Department.

9.9.2 As most practices employ their own secretarial and administrative staff which are paid by those practices, the Panel questions whether, in the case of the co-operative, public money should be used to fund these overheads.

9.9.3 The Panel questions whether the process for billing patients that involves the employment of a reconciliation clerk may lead to duplication of work carried out by GP practices' own staff.

9.9.4 The Panel will explore the Department's funding in greater detail in the following chapter. It is worth noting at this stage, however, that the total cost incurred by the Department amounts to £86,000 per annum.[140]

9.9.5 During its review, the Panel considered whether public funds should be used for a scheme that (potentially) would not be open to all members of the Public. When the service began operation, it incorporated 71% of GPs. The patients of the GPs who chose to remain outside of the project would not be able to access the system and so, theoretically, would not benefit from the injection of public money.

9.9.6 The issue of public funding was raised during the period of public consultation undertaken by the Department. One respondent indicated that the use of public funds could lead to misunderstanding and that it could be suggested that "*public funds were benefiting a private project*." The respondent therefore suggested that "*transparency in the management of costs*" was required. In addition it was suggested that (at least) a summary of the main parts of the annual report should be made public.[141]

9.9.7 The undertaking of an annual review was stipulated in the Service Level Agreement made by the Department and JDOC.[142] The consequent report would:

> "*cover all the main performance issues affecting the GP Co-Op (e.g. finance, operational performance, clinical standards and outcome of audits/complaints etc) over the preceding year*."[143]

9.9.8 In response to the suggestion that part of the annual report be made public, the following advice was given:

> "*The annual report is a confidential report that deals with commercially sensitive information (such as the activity and earnings derived from the GP Co-Op service that will accrue to GPs) and will not be divulged to third parties.*"

It was noted in the response that the question of public disclosure would be addressed at the time of the report's presentation to the Department.[144]

[140] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 31
[141] Correspondence (dated 25th January 2006) forming part of public consultation
[142] *Service Agreement between the Minister for Health and Social Services, and Jersey Doctors on Call* (MD-HSS-2006-0024)
[143] *Proposed General Practitioners Out of Hours Service*, p. 7
[144] Correspondence (dated 3rd March 2006) from Mr. M. Littler (forming part of response to public consultation)

9.9.9 The Panel recommends that the annual report should be made public in order to ensure transparency in the use of public funds. If, however, the inclusion of commercially sensitive information precludes this, then a summary of the main parts should be made public.

9.9.10 The use of public funds was also questioned in submissions received by the Panel. In one written submission, the following comment was made:

> "*I am most concerned about the £86,000 donation of states' funds to support the night visits of GPs.*"[145]

9.9.11 A second written submission acknowledged that it was difficult to provide evidence in relation to this issue and made the following comment:

> "*It is difficult to see how the running of a hospital department, which is in effect what the GPooh (sic) will require can be cheaper than the cost to individuals visiting patients' houses and utilising the minimum of infrastructure to provide a ooh service*."[146]

9.9.12 The matter was also addressed during the Public Hearing with Dr. Cameron, held on 29th September 2006. Dr. Cameron appeared uncertain as to the need to use public funds:

> "*As I understand it, the setting up of the co-op has been subsidised by public money. Why? That money could have been spent on healthcare.*"[147]

9.9.13 At the Public Hearing on 13th November 2006, the Minister advised the Panel that he was satisfied that the use of public funds represented good value for money:

> "*As far as the current spend is concerned I am absolutely satisfied that it represents value for money and a good investment.*"[148]

[145] Written Submission from Mrs. M. Clarke, November 2006
[146] Written Submission from Dr. M. Young, 26th March 2006
[147] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 20
[148] Senator S. Syvret, Transcript of Public Hearing 3, 13th November 2006, p. 27

10 What does JDOC mean for the Department?

10.1 The Department's Involvement

10.1.1 The establishment of a co-operative GP service for out-of-hours care jointly funded by GPs and the Department required a Service Level Agreement to be established in which each party's responsibilities were set out. In this agreement, the Minister was assigned the responsibility of providing the following services:

1. A driver and equipped vehicle (to be provided between 12:00pm and 6:00pm on Saturdays and between 8:00am and 6:00pm on Sundays and Bank Holidays)
2. In addition to the above, an equipped car (to be provided between 6:30pm and 8:00am from Monday to Sunday)
3. The premises of the out-of-hours surgery (Gwyneth Huelin Wing)
4. A receptionist to receive calls, take bookings, meet patients and maintain patient notes
5. An accounts reconciliation clerk to ensure that fees would be directed to the appropriate practice and to compile activity data
6. ICT support systems to be used for collating activity and charging data as well as a voice mail system [149]

10.1.2 The Department was obliged to provide these services under the terms of the Service Level Agreement (provided that JDOC fulfilled its own obligations). This would require a certain level of funding from the Department.

10.1.3 The cost to the Department would total £86,100 per annum. The breakdown of this sum would be as follows:

- Staff costs for a receptionist and reconciliation clerk - £45,000 per annum
- Providing the premises for the surgery - £6,900 per annum
- Providing an equipped vehicle to the co-operative - £1,800 per annum.
- Providing a driver - £18,000 per annum
- Fees for the GP Co-Op Management Board - £14,400 per annum[150]

10.1.4 The Panel questions why the tax-payer is being asked to subsidise the co-operative scheme.

10.1.5 The Panel asked the Department whether other options had been considered for the location of the surgery. It was advised that the Gwyneth Huelin Wing had been chosen for the purpose of neutrality (i.e. that one practice was not favoured above the others) and of closeness to the Department's facilities. The surgery will be used by the Department for other purposes during the day.[151]

10.1.6 The Panel notes that the Gwyneth Huelin Wing is being used at a time when otherwise it would be closed.

10.1.7 According to advice received from the Department, the driver service (i.e. driver and equipped car) would be offered to visiting GPs at the following times:

[149] *Service Agreement between the Minister for Health and Social Services and Jersey Doctors on Call* (MD-HSS-2006-0024), 11th April 2006
[150] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 31
[151] Written Response from the Department, 25th May 2006, p. 16

- 12:00pm to 6:00pm (Saturday)
- 8:00am to 6:00pm (Sunday and Bank Holidays)

In addition, the Department would provide the car for use from 6:30pm to 8:00am from Monday to Sunday. However, the driver service would be paid for by the GPs themselves.[152]

10.1.8 The Panel questions why, under the JDOC system, it was necessary for a daytime driver to be provided on Saturdays, Sundays and Bank Holidays as GPs would previously have driven themselves when undertaking daytime visits.

10.1.9 The final portion of expenditure incurred by the Department would be £14,400 for the fees of the GP Co-Op Management Board. At the Public Hearing on 13th November 2006, the Panel received an explanation as to the work undertaken by the Management Board:

> "*The GP Co-op Management Board come together on a regular basis to look how the GP Co-op is running and they have to do various things like, for instance, audit and overcome any sorts of problems. Basically, that breaks down to 5 GPs at 4 hours per month per person.*"[153]

10.1.10 The Panel notes that the GP Co-Op Management Board receives £14,400 for payment to Board members which represents approximately 17% of the public investment. The Panel acknowledges the work undertaken by Board members but questions whether the tax-payer should be responsible for paying Board members.

10.1.11 In total, therefore, the Department would pay £86,100 per annum towards the cost of the co-operative service. At the Public Hearing on 13th November 2006, the Panel was advised that these costs would be examined in the performance management report that would be produced to inform the Minister when making his decision on whether departmental funding should continue.[154] At the time of the presentation of this Scrutiny Report, the performance management report had not been produced.

10.1.12 The Panel asked the Department whether any other services would receive less funding as a result of the funding given to the co-operative service. The following advice was received:

> "*The financial support provided by H&SS to the GP Co-Op to the value of approximately £86,000/annum will come out of growth monies set aside for service developments. As a consequence, although this would reduce the total amount available for service growth in other areas with H&SS, it will not affect current services.*"[155]

10.1.13 The Panel notes that one of the perceived benefits of the co-operative scheme is the Service Level Agreement made by the Department and JDOC and the possibility that this allows for the introduction of clinical governance.

[152] Service Agreement, Item 4.3.1
[153] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 31
[154] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 36
[155] Written Response from the Department, 25th May 2006, p. 13

10.1.14 The Panel recommends that the Department should review its payment arrangement and consider whether the subsidy would be better spent on patient care.

10.2 Information and Communication Technology

10.2.1 It has already been noted that certain *Jersey Quality Standards* could not be monitored until appropriate ICT systems had been installed. There were five standards that could not be fully audited (in the GP Co-Op Management Board's six-month report) due to this fact. These were Quality Standards 2, 8, 9, 10, and 12. In addition, it was difficult to monitor comprehensively Standard 4.[156]

10.2.2 The Panel considered this issue with the Minister and members of the GP Co-op Management Board at the Public Hearing on 13th November 2006. It was advised that the Adastra system (used in the UK) would be implemented in the event that the co-operative service was given the go ahead after consideration of the six-month review.[157]

10.2.3 The Adastra system (developed by Adastra Software Ltd) provides "*a specialist call management, data distribution and clinical recording system*." The system is used by more than 95% of UK unscheduled primary care operational hubs as well as by corresponding services in Holland and the Republic of Ireland.[158]

10.2.4 The Panel was also advised at the Hearing that the implementation of ICT systems for use by JDOC would form part of larger scale development in ICT systems in the Department. The Minister advised the Panel:

> "*On a general point, we are going to be investing very substantially in IT in Health and Social Services in the coming 3 years of £500,000 out of the States.*"[159]

10.2.5 At the Hearing, it was indicated that the cost of developing these ICT systems would amount to a figure of between £12.5 million and £15 million. These systems would be used by the Department and would not merely be for the GP co-operative.[160]

10.2.6 Given that it is not possible for the service to be fully audited at present, the Panel recommends that, at the beginning of 2008, the Minister provides the Health, Social Security and Housing Scrutiny Panel with an update on the co-operative service.

10.3 The Impact on Other Services – Accident and Emergency

10.3.1 During the course of its review, as part of its third Term of Reference, the Panel considered what impact involvement in the co-operative service might have on other departmental services.

10.3.2 As has been seen, the Joint Working Party also considered this issue during its preliminary work. In the report considered by the Committee in October 2005, it was stated that the full financial impact on the Department would be addressed in a separate business case. In addition, the following was stated:

[156] *GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006*
[157] Transcript of Public Hearing 3, 13th November 2006, p. 11
[158] www.adastra.co.uk
[159] Senator S. Syvret, Transcript of Public Hearing 3, 13th November 2006, p. 11
[160] Mr. M. Pollard, Transcript of Public Hearing 3, 13th November 2006, p. 13

> "*Although the impact of implementing a GP Co-Op on the Accident and Emergency (A&E) Department cannot be accurately determined until after the proposed GP Co-Op is implemented, experience in the UK and discussions with the consultants in A&E suggest that the impact will be manageable*."[161]

10.3.3 Prior to the establishment of the co-operative, the Panel considered whether the situation would arise whereby patients at A&E would be directed towards the co-operative out-of-hours surgery (situated a short walk away from the Gwyneth Huelin Wing). If such a situation were to occur, patients would therefore be directed from a free service (A&E) to one for which a charge would be incurred.

10.3.4 It would appear this would only be an issue during the opening hours of the co-operative surgery. The Panel understood that this situation would not arise and that patients would not be directed from one service to the other. It also understood that access to the co-operative surgery was by appointment only: it would be necessary for patients to telephone the out-of-hours service to arrange a consultation (or, indeed, a home visit). Patients would not therefore be able to turn up unannounced at the surgery.

10.3.5 It was a stated hope of the Department, however, that the introduction of the co-operative surgery would lead to reduced demand on A&E's services. In May 2006, the Panel was advised that:

> "*As time goes on and the GP Co-Op becomes more established, it is hoped that the public (under their own free will) will use the A&E Department as an accident and emergency department rather than (at times) as an extended medical service*."[162]

10.3.6 During its review, some three months after the implementation of the service, the Panel was supplied with official confirmation that the Consultant in A&E believed there had been little effect on the service provided by A&E:

> "*It remains my opinion and that of other members of the Emergency Department staff that there has been no significant impact attributable to the opening of the GP Co-op.*"[163]

10.3.7 The Panel also raised this issue at the Public Hearing on 13th November 2006. It asked whether there had been any incidences of patients being directed from A&E to the co-operative surgery. In response, it was advised:

> "*It happened twice but we are not quite sure who sent them and never really got to the bottom of that. But we think it may have been someone in reception saying: "Well, if you think it is busy you could go round the corner" but it has not happened again and it is certainly not A&E policy or our policy, and we have got an agreement that stipulates that should not happen.*"[164]

10.3.8 The Panel was advised that the Department collates (daily) activity data on the number of attendees at the A&E Department. As such, the Department would be able to monitor whether the co-operative had an impact on the service provided by A&E.[165]

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[161] *Proposed General Practitioners Out of Hours Service*, p. 15
[162] Written Response from the Department, 25th May 2006, p. 15
[163] Written Submission from Dr. A. Brett, 20th July 2006 (received as part of Written Response from the Department, 20th July 2006)
[164] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 37
[165] Written Response from the Department, 25th May 2006, p. 15

10.3.9 The Panel found that the introduction of the co-operative service had had no impact on the Accident and Emergency Department.

10.4 The Impact on Other Services – The Ambulance Service

10.4.1 The co-operative service implemented on 3rd April 2006 differed in some ways to the format that had been envisaged for the service at various stages of its development. For example, in relation to the driver service, it had been intended at one time that use would be made of the Ambulance Service. Whilst this issue has been resolved, the Panel feels that note should be made of the arrangements.

10.4.2 The funding of the driver service is split between the Department and the GPs themselves. The Department provides the car and pays for the driver on Saturdays from 12:00pm to 6:00pm and on Sundays and Bank Holidays from 8:00am to 6:00pm. At all other times, the services of the driver are paid for by JDOC.

10.4.3 Details on the driver service were provided at the Public Hearing on 13th November 2006. The car is a Ford Focus and is equipped with medical equipment, such as a defibrillator.[166]

10.4.4 On 7th March 2006, the Panel's Lead and Assistant Lead Members attended a meeting at Ambulance Headquarters and were advised on this issue. Initially, it had been intended for part-time drivers to be employed to offer the service for GPs. However, there had been concerns regarding the cost of this system and it was consequently suggested that the Ambulance Service could instead provide transport.[167]

10.4.5 Two ambulance crews are on call at night. Under the system proposed, the second of these crews would have provided the driver service for the GP co-operative. However, concerns had been expressed regarding the unpredictability of demand for the Ambulance Service. It had therefore been suggested that a trial period be implemented to gauge the impact (during which a third crew would have been introduced to provide appropriate cover). However, ambulance staff had subsequently rejected the call for them to provide <u>any</u> transportation service as they felt it would compromise delivery of the Ambulance Service.[168]

10.4.6 On 3rd April 2006, the Panel met representatives of the Association of Professional Ambulance and Paramedic Staff (APAPS). It was also provided with documentation by APAPS that showed the concerns that its members had expressed regarding the potential use of ambulance staff in providing a transportation service to the GP co-operative. For instance, members of staff were concerned that crews would not be available to provide the service; that response times would be increased; or that it would be unclear what role ambulance staff would play once the GP had arrived at the patient's home.[169]

10.4.7 At the meeting on 3rd April 2006, the Panel was informed that a meeting of approximately 20 ambulance staff had occurred on 6th March 2006 to consider the possibility of using ambulance crews to provide a driver service for on-call GPs.

[166] Transcript of Public Hearing 3, 13th November 2006, p. 35
[167] Notes of Meeting on 7th March 2006 at Ambulance Headquarters
[168] Notes of Meeting on 7th March 2007 at Ambulance Headquarters
[169] Written Submission from APAPS, 7th March 2006

Following discussions, staff ultimately chose to have no involvement in providing a driver service.[170]

10.4.8 The Panel believes that ambulance staff expressed reasonable concerns regarding the potential use of the Ambulance Service for JDOC. It agrees that the Service should not be used for this purpose.

[170] Minutes of the Social Affairs Scrutiny Panel, 3rd April 2006

11 What does JDOC mean for GPs?

11.1 Introduction

11.1.1 Membership of JDOC is not compulsory for GPs. The Panel was aware of this fact when it began its review. It therefore set out to ascertain not only what the co-operative service would mean for GPs who joined JDOC (hence its second Term of Reference) but also those who chose to remain outside the co-operative (in its fourth Term of Reference).

11.1.2 One condition applied by the JCRA to the continuation of JDOC was that JDOC would not accept any additions without prior approval from the JCRA. On 18th September 2006, the JCRA indicated that an application for such approval had been made. The JCRA approved these additions to JDOC (effective from 13th October 2006).[171] Subsequently, JDOC comprised all but three of the Island's GPs.[172]

11.1.3 During the initial stages of its review, the Panel gave due consideration to its fourth Term of Reference. As a result of the additions, however, it would potentially be difficult for the Panel to assess fully the implications for GPs of remaining outside the co-operative and thereby fulfil its fourth Term of Reference.

11.1.4 It can be seen from previous chapters that the introduction of a co-operative system would have various effects on the working arrangements for on-call GPs. For example, under the previous system, it was possible that GPs would receive calls directly from patients during the out-of-hours period; under JDOC, calls would come to the GP either via the receptionist at the surgery (during the surgery's opening hours) or via the Emergency Call Centre. It was feasible therefore that GPs might not take calls (that they would have received previously) as these would be dealt with by the receptionist / Emergency Call Centre.

11.1.5 In this chapter, the Panel will address issues that may not have become apparent in earlier sections of the report.

11.2 Clinical Governance and Standards

11.2.1 Perhaps the most significant aspect of JDOC from the perspective of GPs (and, indeed, the Department) was the need to adhere to standards that would be audited and reviewed on a regular basis. The establishment of (some form of) clinical governance was identified as a benefit of the co-operative service in the Joint Working Party report of October 2005. The Service Level Agreement signed by JDOC and the Department stipulated that JDOC was required to:

> "*ensure that it has in place a Clinical Governance Framework to endeavour to continuously improve the quality of its services and safeguard high standards of care*."[173]

[171] *Approval of Additions to Jersey Doctors on Call*
[172] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 16
[173] *Service Agreement between the Minister for Health and Social Services and Jersey Doctors on Call* (MD-HSS-2006-0024), 11th April 2006

This would only apply to the provision of out-of-hours care by GPs. The care provided by GPs during 'normal' working hours was unaffected by the Service Level Agreement.

11.2.2 The Service Level Agreement stipulated that JDOC would also endeavour to adhere to standards issued by the National Institute of Clinical Excellence and, indeed, any other relevant professional body (as well as recommendations arising from any audit and any Patient Adverse Incident or Serious Untoward Incident).[174]

11.2.3 This marked a change to the previous system in which GPs had not been contractually obliged to follow given standards and where it was somewhat difficult to address any potential failure to meet such standards. As the Minister indicated at the Public Hearing on 13th November 2006, there would appear to have been little recourse (prior to the establishment of JDOC) in the event that a GP was seen to be 'failing':

> "*And there is no kind of intervention or mechanism that you can use at the moment to kind of require improvements in standards in people's performance or behaviour. I mean, we have the kind of nuclear option of going to court and getting somebody deregistered so they are struck off the register in the Royal Court. I think there might be some more minor powers available to the Employment and Social Security Department in terms of patient subsidy and prescription subsidy, but there is not actually any kind of statutory hierarchy in Jersey at the moment that can actually call GPs in, say, you know: "You are failing for XYZ reasons and this is the programme of improvement we want you to meet" and this kind of thing.*"[175]

11.2.4 The Panel understands that the implication of wishing to implement these procedures was not because GPs in Jersey were considered to be performing unsatisfactorily. It appeared to be good practice.

11.2.5 The issue of clinical governance was addressed in submissions made to the Panel by other parties. One written submission, for example, implied that the introduction of the co-operative service would amount to 'overregulation'.[176] The Panel also received an oral submission from one GP who wished to give evidence in an anonymous capacity. At this meeting, the GP expressed concern that the principles underlying general practice had altered and that the emphasis had moved from 'general practice' to 'primary care'. The GP expressed further concern that services were now run more as a business than they had been previously and that more responsibility was placed in the hands of administrators rather than health professionals. The GP suggested the establishment of the Co-Operative was symptomatic of this situation.[177]

11.2.6 The Panel understands that the environment in which GPs work has changed in recent years and that a need has been identified for greater and clearer governance. This fact was acknowledged by Dr. B. Perchard in written advice she gave to the Panel:

> "*This drive for service development has come from the Doctors themselves, we feel it is the only way to secure the long term viability of a GP out of hours service. It is a simple choice between developing an auditable, accountable open and professional service- which the General Medical Council will insist on us delivering in order to maintain our professional registration, or a service which delivers none of these benefits and cannot deliver the huge benefit of a reduction in cost.*"[178]

[174] Ibid
[175] Senator S. Syvret, Transcript of Public Hearing 3, 13th November 2006, p. 45
[176] Written Submission from Mr. M. Husbands, 24th March 2006
[177] Notes of Meeting with Dr A, 10th May 2006
[178] Written Submission from Dr. B. Perchard, 19th April 2006

It would appear that the results of the 'Shipman Enquiry' have been significant in the general move towards greater accountability.

11.2.7 The need for governance was acknowledged by Dr. I. Cameron when he met the Panel at a Public Hearing on 29th September 2006:

> "*It is part of normal practice nowadays, is it not, to have some sort of governance over what you are doing and some level of supervision and standard setting.*"[179]

However, Dr. Cameron felt that the current arrangements allowed for sufficient supervision and accountability.

11.2.8 However, the necessity for JDOC to meet standards only applied to out-of-hours GP services. The Panel asked the Department whether there were any implications of this move for the daytime service offered by GPs. It was advised that:

> "*discussions are taking place in another forum, between GPs and Health and Social Services to set up a Governance framework that will in time cover all the activities of GPs*"[180]

11.2.9 The issue was also addressed at the Public Hearing on 13th November 2006 with the Minister and members of the GP Co-Op Management Board. At the Hearing, the Department's Chief Executive Office advised the Panel on moves:

> "*The GP community is sitting down with us and discussing the establishment of a special board called a GP Governance Board. And fundamental to that [are] two documents which are very important. One is a complaints procedure that does meet all of the requirements of patient care, does not allow it to fall between three -- complaints ultimately to fall between three schools. And, secondly, is to devise a poorly performing doctor procedure; in other words, what do we do, what does the GP and Health and Social Services Department do if a GP's performance dips and needs to be corrected? And those two things are missing at the moment and GPs are very keen, with no prompting, of their own volition, are very keen to try and correct that. And we are looking to help them establish that by the middle of next year*."[181]

11.3 Working Arrangements

11.3.1 All GPs of practices who joined JDOC were placed on a rota that established when each GP is on-call (i.e. to man the surgery and undertake home visits). The Panel was advised by Dr. Perchard how the rota had been established:

> "*The rota was very complex but surgeries have been allocated slots on an equal basis, they then sort out which doctors are around to cover the shifts themselves, each individual surgery may have a different way of doing this. The Co-op is then sent the shifts and we fill in the master copy. […] Basically every doctor has an equal share of the rota, if they are unable to work those shifts they must organise swaps themselves.*"[182]

[179] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 25
[180] Written Response from the Department, 25th May 2006, p. 12
[181] Mr. M. Pollard, Transcript of Public Hearing 3, 13th November 2006, p. 45
[182] Written Submission from Dr. B. Perchard, 7th June 2006

11.3.2 Given that the rota was divided up equally, the out-of-hours demand on GPs within JDOC would be somewhat less than it had been prior to the creation of the co-operative. Certain practices advised the Panel to this effect in written submissions made to the Panel. For example, one practice indicated its GPs would move from a rota of one in seven to a rota of one in fourteen.[183] This statement was made before the additions to JDOC in October 2006; the demands on GPs would be less, subsequent to these additions.

11.3.3 Fundamentally, therefore, the creation of JDOC meant that those GPs who joined would undertake less work during the out-of-hours period (notwithstanding the discretion that could be exercised on a case-by-case basis to see individual patients).

11.3.4 This situation would appear to address one of the stated needs for changing the system: that it was undesirable to have so many GPs on call during one night when they would also be expected to undertake day time duties. In other words, the previous system could lead to GPs becoming fatigued and thereby compromising patient care. Indeed, this was presented as a benefit (for GPs) of the system in the Joint Working Party's report.[184]

11.3.5 Under the JDOC system, it would appear that there would be less reason for GPs becoming fatigued in that they would not be required to undertake as much work outside of daytime working hours. However, whilst the frequency of out-of-hours shifts would diminish, the fact remained that GPs would still be on-call during nights and week-ends. It appeared that GPs could still be in a position of having to be on call and then work during the subsequent day. Indeed, in the written submission of one practice to the Panel, it was acknowledged that work undertaken for the co-operative would possibly be fatiguing:

> "*We expect an increased throughput of patients whilst working for the Co-Operative and to work a full shift, with probably little opportunity for sleep, when we work at night. This will represent a significant change as, at present, we can often sleep through the night or only be disturbed once or twice*."[185]

It should be noted that this statement was based on the anticipated impact of working as part of JDOC rather than the actual impact.

11.3.6 The Panel raised this issue at the Public Hearing on 13th November 2006. The Panel asked how GPs were dealing with this matter and whether GPs were arranging their shifts to be followed by a day off. The Panel was subsequently advised:

> "*Our experience is that many of the shifts do enable doctors to get 5 hours of rest, meaning that should they choose to work the next day they would probably be able to do so. Having said that, a large number of GPs have chosen to re-organise and re-structure their working hours such that they do not have to work the next day or if they do it is a half day, to counteract the effect of tiredness.*"[186]

However, the Panel was also advised that, whilst reorganisation was occurring, different practices were responding differently to the situation and that the GP Co-Op Management Board did not oblige them to take any particular action.[187]

[183] Written Submission from Dr. N. Minihane (on behalf of The Laurel Medical Practice), 27th March 2006
[184] *Proposed General Practitioners Out of Hours Service*, p. 15
[185] Written Submission from Dr. N. Minihane (on behalf of The Laurel Medical Practice), 27th March 2006
[186] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 17
[187] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 17

11.3.7 At the same Hearing, the Panel received further advice in relation to this issue. By this time, the service had been running for some seven months and it was therefore feasible for comments to be made on the actual impact:

> "*Also we are not talking about a lone GP anymore. We are talking about, in parallel, the GP Co-op surgery manned by one GP alongside another ready for home visits. So a lot of the extra workload, certainly during the peak time, is covered by the GP Co-op surgery. Also, I think there are two GPs on this that split the night as well, so it is not from, say, 5 o'clock right the way through to 8.00 a.m. as on previous. We have got two GPs covering that and we have got the GP Co-op surgery open.*"[188]

11.3.8 It would appear that, whilst the rota was divided up equally, the flexibility referred to by Dr. Perchard could potentially lead to GPs choosing to undertake more out-of-hours work if such GPs desired (for whatever reason) to do so. This would appear to suggest that GPs could theoretically find themselves in a position whereby they could become fatigued. However, the Panel has seen no evidence to suggest that this has, in fact, occurred.

11.3.9 During the course of its review, it was suggested to the Panel that it would be undesirable for GPs to undertake less out-of-hours work as they would lose the skills required for such work. Dr Cameron suggested as much at a Public Hearing on 29th September 2006:

> "*You cannot get the mileage under your belt that you need to do unless you go out and do it. How are you going to have experience with dealing with people at home if you do not go? How do you keep up your skills of visiting people at night? Well, if you are not doing them, you do not.*"[189]

11.3.10 Dr. Cameron's comments would appear to raise the issue of continuity that the Panel addressed in section 9.6, however, this time from the perspective of the GP. From the GP's perspective, Dr. Cameron advised the Panel on the benefits of undertaking home visits:

> "*I am talking about when families have crises or people have crises, often it is at night time. To understand their crises, you may need to visit them at home. You know, if they come into surgery, it is difficult to gauge somebody's crisis when they are sitting next to you because they present a completely different face to what is going on at home. Crises often occur at night, in the dark, in the small hours of the morning.*"[190]

11.3.11 The implication of Dr. Cameron's statements would appear to be that working as part of the co-operative system would not allow GPs to gain the necessary experience in relation to their patients.

11.3.12 The Panel notes the concerns expressed to it that working as part of the co-operative system would not allow GPs to gain the necessary skills and experience required for dealing with people at home. The Panel believes it is the responsibility of individual GPs to ensure that any reduction of out-of-hours duties does not impact negatively on their skills.

[188] Mr. M. Littler, Transcript of Public Hearing 3, 13th November 2006, p. 18
[189] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 4
[190] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 7

11.3.13 The introduction of the co-operative service engendered a change in which GPs would travel to their patients' homes. It has already been seen that a jointly-funded driver service became available to the on-call GP.

11.3.14 The Panel understood that the driver service was optional. However, it was advised at the Public Hearing on 13th November 2006 that there had been 100% take-up of the service between 6:00pm and 11:00pm. Dr. B. Perchard explained the benefit that GPs had felt:

> "*It is invaluable and means that our ability to manage our workload and achieve good target times for getting to patients to avoid undue delay has been enabled.*"[191]

When the Panel met Dr. Perchard on 3rd April 2006, it was advised that the driver service would also help with finding the location of home visits.[192]

11.3.15 The need for a driver service had been explained in the Joint Working Party's report. One of the identified 'needs for change' was the increasing risk to GPs (particularly female GPs) of carrying out night visits.[193]

11.3.16 This need for change was questioned by one respondent to the Department's public consultation who suggested that women should not be used as an excuse. In reply, the respondent was advised that:

> "*This issue of the desirability or otherwise of lone GPs carrying out night visits was raised by GP representatives on the GP Co-Op Working Party. The potential risk to the GP (of whatever sex) undertaking a night visit to patient homes is recognised*."[194]

11.3.17 At the Public Hearing on 13th November 2006, the Panel learnt that an optional driver service was available after 11:00pm and that female GPs were using the optional service (on safety grounds).[195]

11.3.18 On 29th September 2006, the Panel met another GP at a Public Hearing. It took the opportunity to ask the GP about the issue of safety and was advised that:

> "*I have never been threatened, felt threatened, within Jersey when visiting. I have been to see a few patients wielding large knives and I never felt threatened by them and, if I had done, I would have called the police. So, is that real or perceived? We live in a very fearful society. Our children are not allowed to cycle to school on their bikes because it is too dangerous, you know, they cannot walk in the streets at night because it is too dangerous, they cannot play outside because it is too dangerous, and now general practitioners cannot drive to their patients' houses because it is too dangerous. How many general practitioners have been threatened or injured in any way?*"[196]

[191] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 32
[192] Minutes of Social Affairs Scrutiny Panel, 3rd April 2006
[193] *Proposed General Practitioners Out of Hours Service*, p. 1
[194] Correspondence (dated 6th March 2006) from Mr. M. Littler (forming part of response to public consultation)
[195] Dr. B. Perchard, Transcript of Public Hearing 3, 13th November 2006, p. 33
[196] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 28

11.4 Financial Implications

11.4.1 The Panel has already explored the financial issues from the perspectives of the patient and of the Department. Different questions arise, however, when considering these issues from the perspective of the GPs.

11.4.2 It should be noted that only a relatively small part of GPs' income would appear to come from the out-of-hours care they provide. In a written submission to the panel, one practice indicated that out-of-hours work accounted for 2% of the practice's income.[197] The implication of this information was that the desire to alter the system of delivering out-of-hours care (and for that practice to join the co-operative) was not driven by financial concerns.

11.4.3 The Service Level Agreement did not require JDOC to provide services in the same way that it stipulated the Department would provide services (for example, the receptionist). However, during the course of its review, the Panel was advised that GPs would contribute in excess of £38,000 towards the scheme. £38,000 would come from GPs to pay for the driver to work between 6:00pm and 8:00am from Monday to Sunday (the manner in which the Department's funds are used for the driver service were described in Item 10.1.7). The GPs were also responsible for funding the drugs and medicines available in the co-operative surgery as well as the stationery and telephone bills.[198]

11.4.4 The initial financial implication of JDOC for GPs (as individuals) was a registration fee. At the time of this report's presentation, the registration fee stood at £600.[199]

11.4.5 In addition to the services listed in Item 11.4.3, the Panel was advised that the registration fee was used towards payment for services provided on Bank Holidays. Normally, on call GPs would not be paid for the sessions they worked: the fees incurred would be transferred to the relevant practice (and not to the individual GP). However, on Bank Holidays, it would appear that GPs would be paid per session.[200]

11.5 Recruitment

11.5.1 During its review, it was suggested to the Panel that the introduction of a GP co-operative for the provision of out-of-hours care would make Jersey a more attractive place to work as a GP.

11.5.2 This issue was raised at the Public Hearing on 13th November 2006 at which it was noted that GPs in the UK are no longer obliged to undertake out-of-hours work. In the UK, there exist similar systems to that which had been set up in Jersey. As such, the creation of the co-operative was seen as positive for recruitment.[201]

11.5.3 The matter of recruitment was also addressed in written submissions received from GP practices. In one submission, for example, it was stated that:

> "*In order to attract high quality doctors to general practice in Jersey we have to make it attractive to them. In the UK most GPs are not contracted to perform any*

[197] Written Submission from Dr. A.P. Vincent (Les Saisons Surgery), 29th March 2006
[198] Written Response from the Department , 25th May 2006
[199] Written Submission from Dr. B. Perchard, 16th January 2007
[200] Ibid
[201] Senator S. Syvret, Transcript of Public Hearing 3, 13th November 2006, p. 54

out of hours service and if we cannot offer an attractive out of hours package to them they simply will not come and this will ultimately be to the detriment of general practice and the community as a whole."[202]

11.5.4 Another GP commented on this issue at a Public Hearing on 29th September 2006, indicating that the co-operative service could well assist in recruiting GPs to Jersey:

"*There is a problem with recruitment of general practitioners nationwide and that affects Jersey. I think it is perceived that the absence of a co-op is a negative feature in attracting new doctors to come to the practice, or to come to Jersey, full stop.*"[203]

11.5.5 The same GP was asked for his opinion on how the co-operative service would impact upon recruitment. In response, he stated:

"*I do not know; it is a difficult thing. I think it is perceived as being very important. It is perceived to be very important.*"[204]

11.5.6 It is worth noting that the proportion of GPs in Jersey per capita of the population would appear to be higher than in the UK. With 85 FTE GPs in the Island and an estimated resident population of 87,700[205], that was the equivalent of 0.97 GPs for every 1,000 people. This compares to a similar figure of 0.6 GPs for every 1,000 people in the UK.[206]

11.5.7 The Panel notes the perception that the presence of a GP co-operative would make Jersey a more attractive employment destination for GPs.

[202] Written Submission from Dr D.I. Balbes (on behalf of Indigo House Medical Practice), 25th March 2006
[203] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 12
[204] Dr. I. Cameron, Transcript of Public Hearing 2, 29th September 2006, p. 25
[205] *Jersey in Figures 2005*, p. 28
[206] Information garnered from www.rcgp.org.uk

Appendix 1 – Sources Considered

BACKGROUND PAPERS:

The Panel undertook research of the background documentation to this issue. Some documents were presented to the Panel by the Department (at times on behalf of the GP Co-Op Management Board) whilst other documents arose from the Panel's independent research.

Legislation:

Medical Practitioners (Registration) (Jersey) Law 1960

Competition (Jersey) Law 2005

Minutes of the States Assembly:

Questions without notice to the Minister for Health and Social Services, 31st January 2006 (Items 3.2.3, 3.2.8 and 3.2.9 of the Official Record of the States Assembly)

Other States Documents:

*Public Consultation (*R.C.82/2005)

General Medical Practitioners' Fees (an annual survey undertaken by the Department of Social Security)

Jersey in Figures 2005, States of Jersey Statistics Unit

Committee Acts/Papers:

Act B4 of the former Health and Social Services Committee – 7th October 2005

Public Consultation, Agenda Item A2, Council of Ministers, 25th January 2007

Ministerial Decisions:

Service Agreement between the Minister for Health and Social Services, and Jersey Doctors on Call (MD-HSS-2006-0024), 11th April 2006

Papers provided by the Department of Health and Social Services:

Proposed General Practitioners Out of Hours Service (4th October 2005) [Received in confidence]

GPCOOP Management Board Performance Report 03 April 2006 – 03 October 2006 (November 2006)

Patient Satisfaction Questionnaires

Detailed GP Co-Op Activity Data for April, May and June 2006

Written responses to written questions posed by the Panel (18th April 2006, 25th May 2006 and 20th July 2006)

Correspondence (dated 7th April 2006 and 15th June 2006) from Mr. M. Littler to Mr. C. Webb (JCRA)

Information relating to the public consultation undertaken by the Department of Health and Social Services (including the responses received)

Advice from the GP Co-Op Management Board:

During the review, the Panel requested information that was subsequently provided by Dr. B. Perchard, representing the GP Co-Op Management Board. Information was provided on the following dates:

- 17th March 2006
- 19th April 2006
- 16th May 2006
- 31st May 2006
- 7th June 2006
- 16th January 2007
- 23rd February 2007

Papers provided by the JCRA:

Concerning the General Practitioners Out-of-Hours Cooperative Notified under Article 9 of the Competition (Jersey) Law 2005 (JCRA Decision C 015/06), 8th August 2006

JCRA Consultation on Proposed Additions to the Cooperative for After-Hours General Practitioner Services (18th September 2006)

Approval of Additions to Jersey Doctors on Call (16th October 2006)

Other Documents and Information:

Raising Standards for Patients – New Partnerships in Out-of-Hours Care (October 2000), an Independent Review of GP Out-of-Hours Services in England commissioned by the Department of Health

The Provision of Out-of-Hours Care in England (5th May 2006), report by the Comptroller and Auditor General (HC 1041 Session 2005 – 2006)

Advice was received from the Department of Social Security on 19th December 2006 in response to a request from the Panel

Websites:

Adastra Software - www.adastra.co.uk

Royal College of General Practitioners - www.rcgp.org.uk

WRITTEN SUBMISSIONS:

The Panel placed a call for evidence in the JEP on 6th and 7th March 2006 asking for members of the Public to make written submissions. The following submissions were received:

1.	Ms. T. Anderton	8th March 2006
		13th March 2006
2.	Mr. M. Husbands	24th March 2006
3.	Dr. M. Young	26th March 2006
4.	Dr. R. Thacker	30th March 2006
5.	Mrs. M. Clarke	November 2006

In addition, the Panel wrote to potential stakeholders to request information and views. In response, it received the following written submissions:

1.	Family Nursing and Home Care	3rd April 2006
		21st June 2006
		23rd June 2006
2.	Mrs. M. McGovern (Jersey Hospice Care)	20th June 2006
3.	Mrs. J. McDonald (Jersey Hospice Care)	20th June 2006
4.	Dr. G. Purcell-Jones (Jersey Hospice Care)	4th July 2006
5.	Association of Professional Ambulance and Paramedic Staff	7th March 2006

The Panel wrote to all GP practices registered in the Island and received the following responses:

1.	Dr. W.H. Franklin (on behalf of White Lodge Medical Centre)	23rd March 2006
2.	Dr. A. Balmer (on behalf of Drs. Stevens, Balmer and Webster)	23rd March 2006
		2nd May 2006

3.	Dr. M. Johnson (on behalf of Drs. Holmes, Johnson and Thompson)	25th March 2006 30th May 2006
4.	Dr. D.I. Balbes (on behalf of Indigo House Medical Practice)	25th March 2006
5.	Dr. N. Minihane (on behalf of The Laurels Medical Practice)	27th March 2006
6.	Dr. A.P. Vincent (on behalf of Les Saisons Surgery)	29th March 2006
7.	Dr. G. Callander (on behalf of Cleveland Clinic)	28th March 2006 3rd May 2006
	Dr. I. Cameron (on behalf of Cleveland Clinic)	20th May 2006
8.	Drs. G. Hughes and G. Wildy (on behalf of Ivy House Surgery)	24th March 2006
9.	Dr. L. Mirvis (on behalf of Clifden House Surgery)	4th April 2006
10.	Dr. M.J. Bellamy (on behalf of Health+)	31st March 2006

11. Dr. I. Cameron made two written submissions in his own name on 12th and 16th October 2006.

12. The Panel received one written response from a GP who wished to remain anonymous.

13. A second GP, who made two written submissions (on 10th and 20th May 2006), also wished to remain anonymous.

MEETINGS WITH INTERESTED PARTIES:

1.	21st March 2006	Mr. W. Brown and Mr. C. Webb, Jersey Competition Regulatory Authority
2.	3rd April 2006	Mrs. D. Minihane MBE, Age Concern Jersey, and Mr. R. Le Brocq, Senior Citizens Association
3.	3rd April 2006	Mrs. K. Huchet, Family Nursing and Home Care
4.	3rd April 2006	Mrs. Z. Bisson, Parents' Action Group
5.	3rd April 2006	Dr. B. Perchard, General Practitioner
6.	3rd April 2006	Mr. M. Judge and Mr. G. O'Rourke, Association of Professional Ambulance and Paramedic Staff
7.	10th May 2006	Dr. A. (Deputies D.W. Mezbourian and A.E. Pryke met one GP who wished to remain anonymous)
8.	30th May 2006	Mrs. R. Higgins

In addition to the above, on 7th March 2006, Deputies D.W. Mezbourian and A.E. Pryke undertook a visit to Ambulance Headquarters where they met Officers of the Department and had an opportunity to gather evidence pertinent to the review.

SITE VISITS:

The Panel undertook two site visits to the Gwyneth Huelin Wing, location of the co-operative surgery. It first visited the surgery on 17th March 2006. It subsequently visited on 11th May 2006 (in the evening).

PUBLIC HEARINGS:

29th September 2006:

Public Hearing 1 Mr. W. Brown (Chief Executive, Jersey Competition Regulatory Authority)
Mr. C. Webb (Legal Advisor, Jersey Competition Regulatory Authority)

Public Hearing 2 Dr. I. Cameron (General Practitioner)

13th November 2006:

Public Hearing 3	Senator S. Syvret (Minister for Health and Social Services) Mr. M. Pollard (Chief Executive, Health and Social Services) Mr. M. Littler (Directorate Manager of Medicine) Dr. B. Perchard (General Practitioner) Dr. S. Perchard (General Practitioner)

Appendix 2 – Jersey Quality Standards

1. **The GP COOP will report regularly to the GP COOP Management Board and HSS on compliance with the Quality Standards.**

2. **The GP COOP must send details of all 'Out of Hours' (OOH) consultations (including appropriate clinical information) to the practice where the patient is registered by 10.00 a.m. the next working day.**

3. **The GP COOP must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).**

4. **The GP COOP must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting GP COOP Management Board and HSSD.**

5. **The GP COOP must regularly audit a random sample of patients' experiences of the service and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the Governance Board and HSSD.**

6. **The GP COOP must operate a complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting Governance Board and HSSD. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.**

7. **The GP COOP must demonstrate its ability to match their capacity to meet predictable fluctuations in demand for their service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.**

8. **Initial Telephone Call:**

Engaged and abandoned calls:
- No more than 0.1% of calls engaged
- No more than 5% calls abandoned.

Time taken for the call to be answered by a person:
- All calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long.
- Where there is no introductory message, all calls must be answered within 30 seconds.

9. **Telephone Clinical Assessment**

Identification of immediate life threatening conditions

The GP COOP must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment

The GP COOP to demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

10. Face to Face Clinical Assessment

Identification of immediate life threatening conditions

The GP COOP must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Definitive Clinical Assessment

The GP COOP to demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

11. The GP COOP must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence

12. Face-to-face consultations (whether in the surgery or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour.
- Urgent: Within 2 hours.
- Less urgent: Within 6 hours.

13. Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. The GP COOP must also make appropriate provision for patients with impaired hearing or impaired sight.

Appendix 3 - Timeline

April 2004	The idea of a GP co-operative is raised at a Primary Care Group meeting of the JMS (this is not the first occasion on which the idea is mooted; consideration was given on occasion to the idea during the previous decade)
July 2004	A presentation on the Isle of Wight's system of out-of-hours care is given to GPs and hospital staff
18th October 2004	GP representatives meet the President of the H&SS Committee to consider a joint venture for the creation of a co-operative service.
October 2004	The JMS agrees (by 45 votes to 9) to an outline proposal for a GP co-operative
December 2004	Approximately 78% of the Island's GPs confirm their interest in joining a co-operative
7th October 2005	The H&SS Committee considers the proposed GP co-operative service.
October 2005	All GPs in Jersey are sent a copy of the proposed Project Agreement and are asked to accept or decline the conditions
10th January 2006	Public notice appears in the *Jersey Evening Post* marking the beginning of public consultation (the advert also appeared on 20th and 27th January 2006)
January 2006	Contracts and rotas are sent to those practices which expressed an interest in joining the co-operative
1st March 2006	JDOC applies to the JCRA for an exemption from Article 8 of the Competition Law

3rd April 2006	Public consultation on the proposed co-operative ends. JDOC begins operation.
8th August 2006	The JCRA decides that JDOC will be granted an exemption to Article 8(1) of *Competition (Jersey) Law 2005*
11th September 2006	JDOC applies to the JCRA for additions to be made to the co-operative
13th October 2006	The JCRA decides that additions may be made to JDOC thereby signifying that all but three of the Island's GPs form part of the co-operative.