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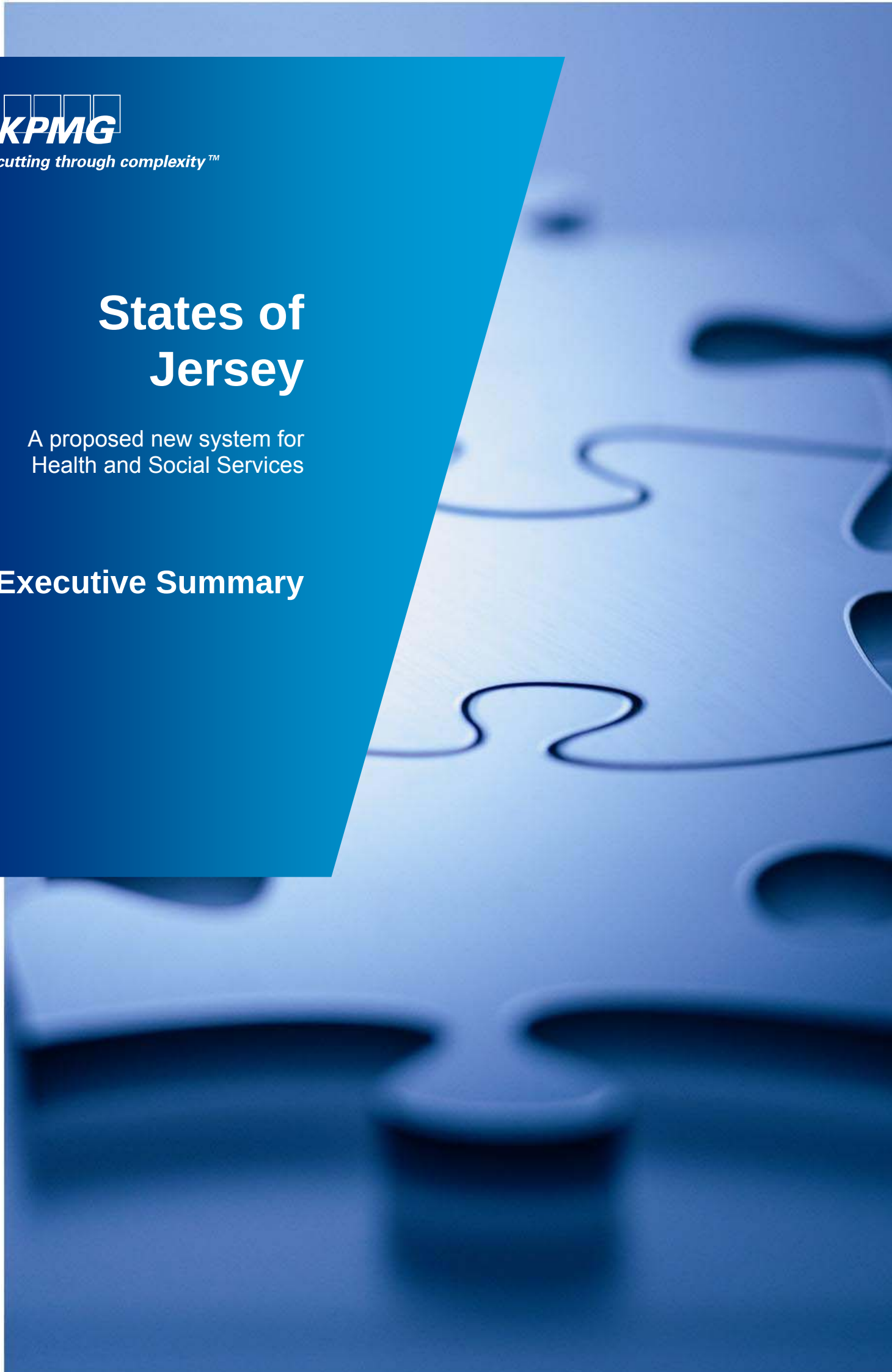
States of Jersey

A proposed new system for Health and Social Services

Executive Summary



Important Notice and Disclaimer

Status: This executive summary is in final format, as at 25 May 2011. The concepts and service models herein have been discussed with, and agreed by key stakeholders. Detailed comments received from Steering Group and Ministerial Oversight Group members have been incorporated into this document.

1 Executive Summary

1.1 Overview

Health and social care services in Jersey are at a crossroads. Existing capacity is due to be exceeded in some services as early as December 2011, the elderly population is rising disproportionately and almost 50% of the medical workforce is due to retire in the next 10 years. Decisions on which path to take are needed now, and those decisions will have a major bearing on how health and social care is provided, organised, and funded for the population of Jersey for the next several decades.

KPMG has, over 5 months, worked with Ministers and officers of the States of Jersey, and particularly of the Health and Social Services Department, with staff, stakeholders and other interested parties across health and social care and in related areas and services. A robust approach has been adopted, with the work developed by a joint KPMG / States of Jersey team, as outlined in Appendix 1. Our brief has been to assess current and future needs and identify a model of health and social care services for Jersey. This report is the output of that work. We have, with colleagues from Weber Shandwick, developed a Green Paper the purpose of which is to enable and support public consultation on these important issues.

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. These challenges are substantial today. Without immediate action they will become more acute in future years; therefore 'do nothing' is not an option if the people of Jersey are to receive care in the future that is safe, sustainable and affordable.

Demographic change is dramatically increasing demand on all health and social care systems. Technological advances are allowing efficiency and quality improvements but also creating major new costs. Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals. Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically. And service ethos is shifting from treatment to prevention and promoting independence. Health, social care and third sector teams need to work closely with one another and with patients, service users and carers to provide tools and evidence-based services, managing demand, promoting health and wellbeing, ensuring equality of access, protecting / safeguarding vulnerable people and enabling people to be cared for in the most appropriate place, living as productive and independent lives as possible.

Jersey is experiencing many of the same challenges as all other health and social care systems internationally. But it also has some unique challenges, for example in the atypical mix of its medical workforce, the low intensity support provided in the community and the need for both a range of health and social care services to support operational viability, and bespoke care packages, which may be more challenging to provide cost effectively on island due to low volumes. All systems are reforming and changing to meet the challenges of demand, cost and quality. And all systems are spending increasing amounts year on year, both in real terms and as a proportion of GDP/GNI, on health and social care.

Changes are being planned and introduced already to address some of the quality and funding challenges, for example the Primary Care Development Plan, a Long Term Care fund, the children

and young peoples framework and a number of productivity changes in hospital. However, the scale of challenges which Jersey faces in the next 10 years requires additional strategic service development. If the States acts now it can:

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

Any change in sevice will, by necessity, be evolutionary. The timing of changes will need to be carefully considered in order to ensure that they are achievable, whilst also supporting the required pace. The balance between different elements of the health and social care system will need to be carefully considered in order to support the ongoing service viability, and to support staff in continuing to provide safe, accessible, high quality services. The 'enablers' for strategic change must also be fully considered in order for benefits to be realised – including IT support and management capacity to implement change. It is clear that these changes, along with the opportunities identified in this report, will be required in order for future services in Jersey to be safe, sustainable and affordable.

1.2 The Challenge in Jersey

The challenges facing Jersey can be summarised as the issues and implications of isolation and demography.

Isolation

Jersey is a small island. In normal circumstances it's population would be considered too small to support comprehensive acute hospital services and very specialist social care services. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of acute and emergency services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

Jersey is therefore, of necessity, providing a model of hospital services for a population of 94,000 which would, in most modern health systems, be provided only for a population of over 250,000. Jersey's geographic isolation and low total population inevitably creates issues of diseconomy of scale.

This diseconomy has two principal effects. Firstly, the unit cost of delivering hospital and social care services in Jersey is higher compared with systems serving larger populations. This difference occurs because the fixed costs of key services such as Accident and Emergency, intensive care, and secure residential accommodation are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to a "premium", estimated to be in the region of 15 – 20%, which increases unit costs. Secondly, it leads to vulnerable services due to workforce models, particularly in the medical workforce, which are relatively light, highly reliant on very small numbers of individuals and where the achievement and maintenance of specialist skills is difficult given relatively low patient numbers.

The States must address these two factors if it is to provide health and social care services that are safe, sustainable and affordable.

Demography

The population of Jersey is rising only slowly, but it is ageing rapidly. Over the 30 years from 2010 to 2040 the numbers of residents over 65 will rise by 95%; in the period to 2020 the increase is projected to be 35%. This demographic change will create a huge surge in demand for health and social care services which will overwhelm the current capacity of the existing services.

The current numbers of hospital beds, operating theatres, residential and nursing care beds and other key community services will be inadequate to meet demand. The current capacity will be exceeded in most of these service areas within the next 5 years. These services therefore need to be expanded, supplemented and/or changed urgently to ensure that services can be safely and sustainably provided for the growing elderly population.

In addition, the working age adult: older adult ratio reduces from 3.9:1 in 2010 to 1.8:1 in 2040. This change will create a dual challenge which can be summarised in the questions 'who will provide the hands on care required?' and 'who will pay for the costs of care required?'

We should remember that older people make an important contribution, and supportive ways of helping them make an even more important contribution need to be developed. If properly managed the forthcoming population change could present opportunities, and the benefit of the greater wisdom and experience which comes with older age can be invested back into Jersey to enrich and sustain the community.

1.3 The Current Services in Jersey

Health and social care services in Jersey are, with some exceptions, relatively comprehensive. Key performance indicators suggest they are performing well compared with similar international jurisdictions. Generally, staff are highly motivated, committed, with good levels of experience and high levels of goodwill, and outcomes are good.

However, services are poorly integrated across States departments and with external agencies. There is a high dependence on institutional base care.

Health services are relatively medically dominated, with relatively low levels of team based practice. Performance management in terms of outcome measurement, audit and regulation has been largely absent, although this is improving.

The island's model of privately delivered primary care alongside other State provided services has benefits but also creates perverse incentives which skew natural patterns of service usage. There is a high number of GPs (relative to the size of the population) but very low levels of supporting nursing and allied health professional staff in primary and community care settings, and limited integration with social care and third sector provision. As a result the skills of GPs are deployed on tasks that, elsewhere, would be delegated safely to other professionals.

In acute services the hospital consultants are relatively "generalist" with relatively low levels of subspecialisation. Advanced practitioners in nursing and allied health professions are rare and

consultants tend to work as individuals rather than within peer or multidisciplinary teams. Middle and junior grade medical staff levels are low and contact between hospital consultants, GPs and tertiary consultants is limited. Capacity in hospital services is under increasing strain with key elements, particularly beds and operating theatres, rapidly approaching capacity. There are persistent problems encountered in recruiting, and subsequently retaining, nurses in what is becoming a very competitive global employment market. Nearly 60% of the hospital consultants will be eligible to retire during this decade and very few of them will be replaced on a like for like basis. With relatively low levels of audit and peer review, appropriateness of practice and quality of outcome cannot be routinely assured.

In social care high use is made of institutional models of care and lower numbers of Older Adults are living independently in the community. This is driven by the lack of availability of 24-hour nursing and home care services, respite and palliative care, and is compounded by the high cost of living, which the number of unpaid carers. Children's services are under pressure because of very high referral rates and the difficulty of securing a good supply of foster carers. However, they have succeeded in providing some innovative community based packages of care for children and young adults with special needs, and given the challenges of a small island they have enjoyed some success in placing children into adoption.

Jersey has a vibrant third sector and Parish system, providing information, support and services for particular groups of patients, service users and carers. However, there is limited integration between third sector providers, and between third sector and States-provided health and social care. This may lead to duplication or gaps in services, and opportunities to work jointly with care designed and delivered for individuals may be lost. There is also a lack of performance information with which to assess value for money and service development requirements.

1.4 Towards a New Model of Care

Three guiding principles were identified by stakeholders in Jersey:

- 'Safe' – While many health interventions involve an inherent levels of risk, that patients and service users should not be exposed to an undue level of risk
- 'Sustainable' – that services should be organised in a way that is not vulnerable to change in the short term
- 'Affordable' – that the model of services represents value for money relative to other potential; models

These were distilled into the principles by which the strategic vision was to be developed:

1. Create a sustainable service model – efficient, effective, engaging the public in self-management and with consistent access and thresholds
2. Ensure clinical/service viability – overcome the challenges of low patient volumes, delivering high quality care and minimising risk
3. Ensure financial viability – reduce the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
4. How should we fund health and social care? – establishing a charging model that incentivises care and cooperation
5. Optimising estate utilisation – ensuring the estate is fit for purpose and utilised to maximum efficiency

6. Workforce utilisation and development – supporting and utilising the workforce to the best of their abilities
7. Clinical governance – sustaining a culture of safety, learning and transparency
8. Use of business intelligence - with robust data to support decision making based on fact, and including patients and the public in service design and decision making

1.5 Overview of Future Scenarios

As a result of our work we have identified three strategic scenarios which encompass the options of the future of health and social care in Jersey: In collating work through stakeholder engagement, modelling, benchmarking and economic analysis, three overarching strategic scenarios have been identified:

Table 1: Outline of future scenarios

		Outline	Implications
1	'Business as Usual'	■ Services are delivered in the same way as in 2010. ■ At 2010 prices, the cost of scenario 1 would be: – £171m in 2010 – £211m in 2020 – £320m in 2040.	■ Cost pressure of almost £150m by 2040 ■ Service model unviable as impossible to recruit the number of staff needed – compounded by returement and generalist / specialist staff ■ Pressure on workforce – increased sickness (therefore cost) and possible safety issues ■ Institutionalised and medicalsed model continues
2	'Live within our current means'	■ Funding remains the same with inflation uplift of 2% p.a. for three years, then inflation only for the remaining period. ■ Some services changes are implemented, but only where this is possible within funding constraints. ■ At 2010 prices, the cost of scenario 2 would be: – £171m in 2010 – £178m in 2020 – £178m in 2040.	■ Only £7m additional funding by 2020 ■ Services close – possibly only emergency services available, which undermines hospital viability ■ Most service's capacity exceeded within 2 years ■ Beds (including surgical) blocked ■ Waiting lists increase significantly; backlog for assessments increases ■ No increase in community support – pressure on carers, culture of dependence ■ Increased clinical and professional risk, including infection ■ Increased means testing, increased inequality
3	A new model of care	■ A revised service model is developed and implemented, building on all elements of this programme of work, including benchmarking, stakeholder engagement, economic analysis and international best practice. ■ At 2010 prices, the cost of scenario 3 would be: – £171m in 2010 – £207m in 2020 – £290m in 2040.	■ Costs £4m less than scenario 1 in 2020 and £30m less than scenario 1 in 2040. This is due to the impact of demography, particularly the older adult population. This population increases by 35% in the period to 2020 but by 95% in the period to 2040 ■ Increased integration ■ Enhanced roles, more attractive career paths for a wider range of professionals ■ Increased independence for service users, support for carers and enablement to live at home ■ Less children in residential care, better outcomes

This report outlines strategic scenarios. The scenarios have not been considered at an operational level of detail. Any staffing and costings herein are, by necessity, indicative and high level.

Further information is anticipated for capital costs, associated with:

- Increasing capacity to meet demand. The required increase will vary depending on the scenario
- Improving the estate to meet legislative requirements e.g. for mentally disordered offenders and in residential homes
- Improving the estate in accordance with best practice, e.g. single sex wards
- Addressing any backlog maintenance
- Complete new build of Jersey General Hospital, which will be required some point in the future

Costs to implement change, and operational costs such as management capacity, office space and consumables have not been incorporated, as this level of detail, along with further detail on staffing and full costs, is required after public consultation has enabled the identification of an agreed way forward. This would be produced in partnership with clinical and professional staff as business cases and operational implementation plans are produced for any service changes that result from the public consultation.

1.6 Scenario one – "Business as usual"

Scenario one is both **unaffordable** and **unsustainable**. Due to demographic pressure caused by the elderly population, capacity starts to be exceeded within the next year, but there are severe limitations on increasing capacity due to staffing availability and the pressure on buildings as activity increases.

Projecting the 2010 expenditure forwards (with the current service model) indicates that the service would cost £211m in 2020 and £320m in 2040, compared to £171m in 2010.

Figure 1: Projection of health and social care spend in Jersey

Total Spend		2010		2020		2030		2040
Department of Health and Social Services Net Expenditure	£	170,507	£	211,115	£	261,700	£	318,195
Total contributions from other parties	£	15,944	£	18,550	£	22,072	£	24,912
Department of Health and Social Services Gross Expenditure	£	186,451	£	229,664	£	283,772	£	343,107
Third sector	£	1,756	£	4,640	£	8,698	£	12,212
User Pays (excluding private and insurance)	£	14,172	£	18,403	£	18,916	£	19,069
Total social security payments	£	36,322	£	43,477	£	50,860	£	54,405
Total Spend	**£**	**238,701**	**£**	**296,184**	**£**	**362,246**	**£**	**428,793**

In the period to 2020, pressure on staff increases significantly as caseloads and workloads increase. This is compounded by the retirement profile, which leads to increased stress and sickness absence and a further exacerbation of the current vacancy and locum situation – which further increases costs and clinical risk, and impacts quality and safety.

Older adult services quickly reach capacity in a scenario where services are delivered under the current model. This would require significant additional funding and facilities (more than £6m additional by 2020, taking the total cost to more than £16m) or would to lead to overspill into other (more intensive) care settings, with medical outliers in surgical beds and/or delayed discharges causing operations to be cancelled and waiting lists to grow. Increased spot purchasing of independent sector capacity would be required, which (if it were available) would continue to be provided in varying levels of value for money. The current 'institutionalised' model would continue,

which impacts people's ability to live productive and independent lives in the community, supported by a range of care professionals. Capacity constraints will start to be exceeded in the next year, with most services reaching capacity within 2 years.

Maintaining the current medicalised, model of care and managing demand reactively in **hospital** with a 'bedded' solution would drive cost exponentially and require a large capital and revenue investment. An additional 20 medical beds would be required by 2015 to cope with activity and a further 40 beds would be needed to cope with the activity projected in 2040.

On current service usage, main theatre utilisation exceeds 98% (the Audit Commission best practice guidance is 90% utilisation). By 2020, 349 main theatre procedures plus 827 day cases p.a. would either not be able to be undertaken or would require an additional funding of £5m capital to increase theatre capacity. The cost of of-Island treatment would also increase by almost £1m p.a to more than £9m p.a.

Waiting lists would increase and service quality reduce, and by 2020, major investment in the hospital estate would be required for an upgrade or complete new build in order to make the environment fit for purpose.

Whilst **GPs** and **Pharmacists** currently have excess capacity, increased demand caused by the elderly population would soon utilise this as consultations increase from almost 343,000 to almost 358,000 by 2020, or to almost 365,000 if 85 and over increased consultation rates are included. The Quality Framework is designed to help to improve outcomes and reduce inequality. Based on experience in the UK it may also increase demand.If demand increases at the same rate as experienced in the UK after the introduction of the Quality Outcomes Framework, there could be almost 539,000 consultations per annum by 2020. It should be noted, however, that, due to different payment systems and remuneration levels in Jersey, this increase in demand may be lower than that experienced in the UK. We have included a high estimate of the demand impacts from the introduction of the Quality Framework within this document; this will need to be further tested with key stakeholders and modelled through as part of the detailed business case following the consultation period.

If primary care continues to be delivered by a GP-led model, the opportunity to enhance and expand the primary care team would be lost, with co-payments continuing to deter some patients from accessing primary care, increasing health inequalities as patients remain undiagnosed/untreated, or increasing the pressure on unscheduled care as they continue to present at A&E.

Significant opportunities for improving the health and wellbeing of the population are also lost as **self care** remains underdeveloped, leading to increased demand and cost in later years. Conflicting information and duplication in resources would continue to exist. Pockets of good practice would continue, but third sector and other organisations would soon become swamped by the increasing elderly population with long term conditions and at least £1.5m additional funding would be required for district nursing and home care (in addition to the £3.4m capital expenditure required to improve the condition to meet inspection requirements).

Public health intelligence would continue to remain a challenge, and undertaking robust health needs assessment of the population would be severely limited. As a result, the health and social care needs

of the population may not be accurately assessed, and the most effective and appropriate care provided.

Demand for the mental health and social care services for **younger adults** and **children** are projected to reduce slightly. However, challenges would remain with limited Tier 1 and 2 mental health services and a high proportion of Looked After Children in institutionalised settings, both of which impact outcomes.

Critical limitation – even if funding were available, the above increases in capacity would be severely limited by staff availability. This is compounded by the retirement profile, need for generalist competency in a specialist training environment, onerous on call rotas, increased pressure of caseloads and workload, a relatively unattractive career path for professions other than doctors, high cost of living and immigration constraints.

1.7 Scenario two – "Live within our current means"

Scenario two is potentially **unsafe**.

The projected funding envelope at 2020, using assumptions of inflation + 2% increases for the first three years, then inflation only thereafter, would be c£178m, compared with c£171m in 2010. The cost of continuing the current service model in scenario 1 was shown to be £211m in 2020 and £320m in 2040. Therefore, the funding envelope from scenario 2 would create a gap of £33m by 2020 and £142m by 2040, or lead to radical reductions in the range and availability of services or the imposition of new and increased charges that would potentially exclude a significant proportion of the population from accessing proper care. However, the critical constraint is capacity – both of staff and estates (hospital beds, residential care places etc).

This would lead to:

- **Closure** of services
- **Prioritisation** of younger patients with greater life expectancy as competition for resources becomes more severe
- Eventually, an **emergency only** service in hospital, with limited or no States-funded elective care being provided in Jersey. This would undermine the clinical viability of the hospital
- A significant **backlog** in assessments, with increased risk whilst assessments are being progressed – this would particularly impact the increasing number of older people with dementia
- Extremely **long waiting times**, and/or increased thresholds, so that illness is only treated when it has advanced to a more acute stage (and therefore is more costly and has worse outcomes)
- **Occupancy rates** of 100%, with pressure to discharge quickly but limited services for follow-up and ongoing care
- **Bed blocking** in acute care, with consequential impacts on bed capacity, and medical patients outlying into any remaining surgical beds
- A significant reduction in the number of people supported in the community to lead productive and independent lives, creating a culture of **dependence** and further increasing costs

- Prioritisation of health funding, with a reduction in social care and Tier 1 and 2 mental health funding or the introduction of increased **means testing** and eligibility criteria. This would lead to service users paying for their own equipment, adaptations and aids and would reduce social care and mental health teams so that only individuals in crisis would be supported
- Many patients/service users being treated in inappropriate settings, by the wrong staff groups, with **institutionalised** settings of care, particularly for children and older adults
- As capacity in hospital, residential care and other settings becomes exceeded, more people would need to be cared for at home. However, there would be no opportunity to develop a range of 24-hour care, including night sitting, home care and district nursing. Without this support, the **risk of service user injury or incident** would increase
- **Reduction in grants** to third sector organisations, and a reduction in the number of community groups due to a reduction in physically and mentally able volunteers due to the ageing population
- This would significantly increase the **burden on unpaid carers**, but there would be no opportunity to develop support for carers, and as unpaid carers on the island remain largely unsupported, there would also be a risk of pushing the cost of care onto the next generation
- Increased **infection rates** as limited time for full cleaning is available between episodes
- Very **limited palliative care**, with all people dying in institutionalised settings, reducing their privacy and dignity at the end of life
- Increased eligibility criteria, which increases **inequality** and creates a two tier system, with people on lower incomes receiving limited care as they are unable to pay. Individuals/employers funding of healthcare (insurance, co-payment, direct payment) would need to increase by 574% from £32m to £215m
- **Increased 'fee-for-service'**, where individuals fund their own care e.g. payment for non-urgent attendances at A&E and for prescriptions would need to be introduced, and/or an insurance system that covers ambulance journeys, attendances at A&E and potentially some non-elective procedures as well as all elective work
- **Increased primary care co-payment** per consultation, co-payments for a wider range of primary care services being introduced or (through reducing GP income) or a redistribution of income in primary care which may deter GPs from continuing to practice as income is reduced
- As capacity is exceeded and demand continues to rise, there is also a risk that **suppliers increase prices** and create a supplier driven market
- The balance of funding required from the States and **individuals/employers** would need to shift from 87%/13% to 50%/50%
- A lack of coordinated information would continue to lead to **incorrect targeting** of health promotion and service development, and potentially wasteful efforts.
- **No funding for new drugs, treatments or technology**

Funding pressures can drive positive changes, for example:

- Robust procurement and contracting for spot purchased beds, with strategic market management which could improve value for money by up to 10%, based on experience in other health and social care economies

- Co-location of A&E and the Out of Hours service could improve senior decision making and help to avoid admission to hospital
- Changing primary care payments and the balance of staffing in primary care so that professions other than GPs undertake basic care at no (or minimal) cost to the patient
- Effective telephone triage and an enhanced paramedic role could be introduced, to stabilise and treat patients in their own home without admission
- A bank of volunteers in each of the 12 Parishes to support those with complex needs or those who require additional support to live independently
- A review of staffing models and a use of annualised hours to reduce staffing and spend

However, as previously noted, even employing all of these mechanisms will not reduce costs sufficiently to accommodate the increase in demand and maintain quality or standards of care.

1.8 Scenario three – A new model for Health and Social Care

This scenario is **safe, sustainable** and **affordable**. It involves implementing a new approach to health and social care delivery. The principal features are:

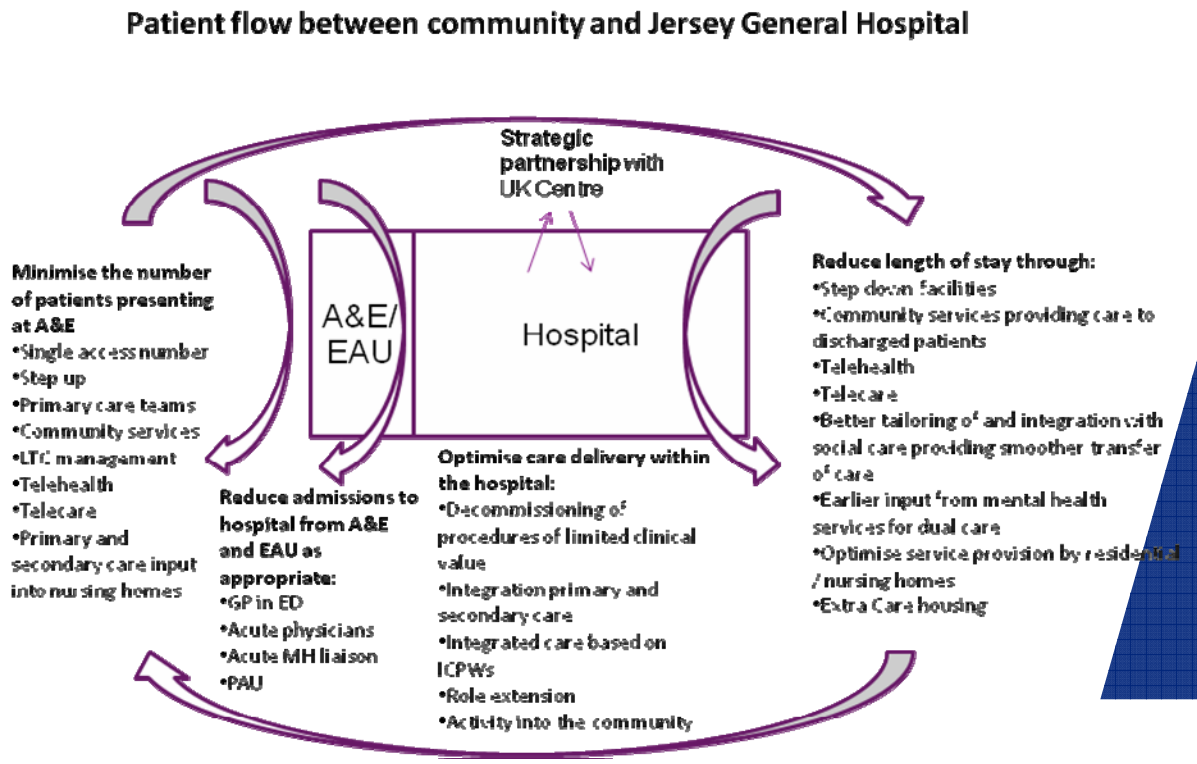
- greater **integration** between all services
- greater **standardisation** of processes, with those processes being mirrored by health and social care e.g. common assessment, consistently applied thresholds
- greater **team-style working**
- greater use of **enhanced role** nursing and allied health professionals
- closer **joint working** between GPs, hospital consultants and tertiary sector consultants
- increased **independence** for patients, service users and carers, with greater delivery of health and social care services in home, community and primary care settings in particular through the use of telehealth and telecare technologies
- the development of intermediate care services and new community based staffing models which will help stop or at least **delay the onset of residential care**
- greater use of non-institutional **social care** models including fostering for children, and supported home-based care for older adults
- greater diversification, for example with people having more **choice** about the services they receive, and a wider range of providers delivering those services

This scenario involves substantial change to existing service models, staff roles and organisational structures. It would however reduce, but not remove, the requirement for capital and other investment in hospital and other institutional care.

Under this scenario we assess that, over the period 2010 to 2020 total health and social care costs to Jersey would rise from £171m to £207m in 2020 and £290m in 2040. Whilst this is higher than scenario 2 (£178m at 2010 prices), it is less than the cost for scenario 1 in both 2020 and 2040 – it is £4m less than scenario 1 in 2020 and £30m less in 2040. The increase in cost is driven by the impact of demography, particularly the older adult population. This population increases by 35% in the period to 2020 but by 95% in the period to 2040. It is also due to the fact that the productivity and cost savings from some of the service changes associated with scenario 3 would increase in future years.

Patients and service users would be seen in the most appropriate place, by the most appropriate care professional working in a multidisciplinary team, utilising scarce resources (staffing, estate and funding) effectively, and with ongoing care that is personalised, coordinated and provided in an integrated and seamless manner. Care coordinators would undertake integrated health and social care assessments, and care processes would be streamlined and standardised. This would particularly benefit **older adults**, who have complex multiple health and social care needs and require a range of services, therapies, adaptations and equipment, available 24 hours, to support them in living independently in their own homes. Care would be enabled by a citizen's portal which provides information and acts as a single point of access for care professionals and patients/service users alike, and the dignity of the individual will be maintained at all times, including at the **end of life**, where the individual will have choice.

Figure 3:



Individuals would be able/willing to make informed choices about their lifestyles and **self care**, when provided with the right information, support and incentives to do so. This would improve the efficiency and productivity of services as people access only the services that they really need, plus reduce demand in the longer term as people slow down the progression of their condition through improved management and monitoring. Patients / service users and their carers would feel more in control of their condition and would be more confident, which impacts positively on their quality of life.

The provision of services would be driven by a clinical strategy, supported by health needs assessment undertaken by an enhanced **primary care** team, including non-medical staff and practice nurses.

The role of health and social care professionals and the **third sector** would develop, to identify those patients and service users in greatest need both now and in the future, and in to help those patients to

navigate the system, access care and equip themselves to take control of their condition. Risk stratification and case finding, would proactively target patients most in need or at risk, in order to reduce admissions and slow disease progression and therefore cost in the future. Expert Patient groups and the third sector would have a significant role, and equipment, home care and telecare would be available to support people at home, improving their ability to undertake activities of daily living and enabling a longer and more productive life within their own homes.

Scenario three, in addition to providing co-ordinated, personalised, high quality care for patients and service users would also provide interesting roles for all care professionals, which would assist with the current recruitment and retention challenge by making roles more attractive. This would include, for example, Emergency Care Practitioners, Care Navigators and Nurse Consultants, with an expanded role for Pharmacists and Practice Nurses supporting GPs.

Multidisciplinary teams, including medical, nursing, AHP, social care, mental health and third sector staff would deliver coordinated, effective care in all settings, including **acute care**. Teams would work across care settings (specifically some GPs working in acute settings), co-located where possible (for example, A&E and GP out of hours services; community teams) and specialist staff and teams would develop to support, for example, COPD patients in the community. A strategic partnership would develop with hospitals in the UK, with clinicians providing consultations through video links, and providing additional support, training and clinical leadership to enhance that already provided in Jersey.

The range of services available in non-acute settings would also develop, including step up and step down care, Tier 1 and 2 mental health services and a flexible Adult **Mental Health** facility at Overdale.

Fostering would be professionalised, to reduced the number of Looked After **Children** in institutionalised settings, with co-ordinated services 'wrapped around the child', building on the children and young people's framework plan which is currently in development.

Some treatment would continue to be received off-island, however, advances in technology and the use of telemedicine for remote consultations would support repatriation of activity, retaining income on island. Strategic partnerships would be developed with a small number of UK centres of excellence for specialist care, either to support remote consultations or to provide sub-specialist interventions in Jersey using visiting consultants. In addition, all contracting would be strengthened, with robust SLAs, active market management and rigorous performance monitoring to improve standards and value for money.

Incentives would be devised to drive professional and patient/service user behaviour, for example introducing a single point of access in A&E.

1.9 Conclusion and recommendation

Jersey's health and social care services are at a crossroads. The future challenges are unavoidable and the case for change is clear Doing nothing is not an option if Jersey is to continue to enjoy health and social care services that are safe, sustainable and affordable into the future. And timing is critical. Because capacity starts to be exceeded in the next 12 months, decisions need to be made now.

Our recommendation is that Jersey resolves to change its model of health and social care services towards the 'Scenario 3' new model of health and social care services as described in this report. We

assess that making this change will reduce the additional costs of health and social care delivery in Jersey associated with the increase in older adults, by £30m over 30 years compared with the current service model (at 2010 prices).

The full implementation of this model of service will take considerable time, at least 5 years in our view, and longer for capital solutions such as a rebuild of the hospital. There are immediate challenges to ensure capacity continues to be available, particularly for older adults and in theatres, but other elements of the model can be developed and implemented over time to a planned programme in the context of the States' future fiscal strategy.

There is considerable appetite for change to the new model among staff and stakeholders with whom we have worked, and a recognition and acknowledgement of the immediacy of the challenge and the need for change. The change process will, however, be complex and inherently risky. We advise the States of Jersey to ensure that it has or obtains the necessary capacity and capabilities to successfully manage the required detailed planning, transition and implementation processes and realise the benefits of the new model.

Next steps

To proceed with this process we advise that States of Jersey should:

1. Proceed to public consultation to allow the public of Jersey to be informed of the challenges facing health and social care services and to comment on the proposed way forward
2. Subject to the outcome of public consultation, a summary of which will be compiled and published, develop a White Paper that will be submitted to the States, outlining more detailed phased and costed plans, in order to secure approval for the implementation of a strategic change programme
3. Secure the required change management capacity (leadership, governance and resources) to plan and effect the implementation of the new model of services
4. With key stakeholders, including clinicians, social care professionals and the third sector, produce detailed business cases for each proposed change, which link with individual service strategies e.g. the Primary Care Development Programme, the Long Term Care funding model, hospital productivity programme, Children and young people's framework and an Older Adults strategy

- Undertake further work to consider options for the future funding of care, including the relative balance between States funding, tax, insurance and individual contributions.