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# States of Jersey

A proposed new system for  
Health and Social Services

## Important Notice and Disclaimer

Status: This document 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.

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# 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 service 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.

These challenges are discussed further in Chapter 3 of this report

## **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.

Service performance is discussed further in Chapter 4 of this report

## 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	<p><b>'Business as Usual'</b></p> <ul style="list-style-type: none"> <li>■ Services are delivered in the same way as in 2010.</li> <li>■ At 2010 prices, the cost of scenario 1 would be:               <ul style="list-style-type: none"> <li>– £171m in 2010</li> <li>– £211m in 2020</li> <li>– £320m in 2040.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Cost pressure of almost £150m by 2040</li> <li>■ Service model unviable as impossible to recruit the number of staff needed – compounded by retirement and generalist / specialist staff</li> <li>■ Pressure on workforce – increased sickness (therefore cost) and possible safety issues</li> <li>■ Institutionalised and medicalised model continues</li> </ul>
2	<p><b>'Live within our current means'</b></p> <ul style="list-style-type: none"> <li>■ Funding remains the same with inflation uplift of 2% p.a. for three years, then inflation only for the remaining period.</li> <li>■ Some services changes are implemented, but only where this is possible within funding constraints.</li> <li>■ At 2010 prices, the cost of scenario 2 would be:               <ul style="list-style-type: none"> <li>– £171m in 2010</li> <li>– £178m in 2020</li> <li>– £178m in 2040.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Only £7m additional funding by 2020</li> <li>■ Services close – possibly only emergency services available, which undermines hospital viability</li> <li>■ Most service's capacity exceeded within 2 years</li> <li>■ Beds (including surgical) blocked</li> <li>■ Waiting lists increase significantly; backlog for assessments increases</li> <li>■ No increase in community support – pressure on carers, culture of dependence</li> <li>■ Increased clinical and professional risk, including infection</li> <li>■ Increased means testing, increased inequality</li> </ul>
3	<p><b>A new model of care</b></p> <ul style="list-style-type: none"> <li>■ 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.</li> <li>■ At 2010 prices, the cost of scenario 3</li> </ul>	<ul style="list-style-type: none"> <li>■ 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</li> <li>■ Increased integration</li> </ul>

would be:	<ul style="list-style-type: none"> <li>– £171m in 2010</li> <li>– £207m in 2020</li> <li>– £290m in 2040.</li> </ul>	<ul style="list-style-type: none"> <li>■ Enhanced roles, more attractive career paths for a wider range of professionals</li> <li>■ Increased independence for service users, support for carers and enablement to live at home</li> <li>■ Less children in residential care, better outcomes</li> </ul>
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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.

The detailed service scenarios are discussed further in Chapters 6, 7 and 8 of this report

## 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
<b>Total Spend</b>	<b>£ 238,701</b>	<b>£ 296,184</b>	<b>£ 362,246</b>	<b>£ 428,793</b>

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 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

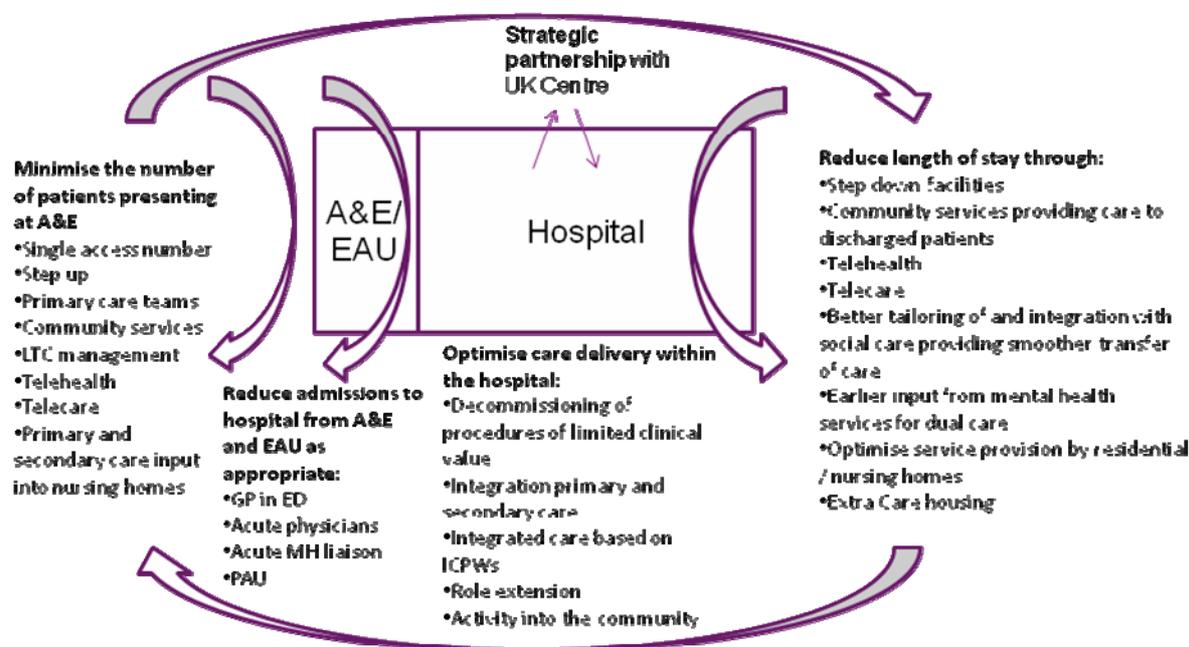
This scenario involves substantial change to existing service models, staff roles and organisational structures. It would however reduce, but not remove, the requirement for capital and other investment in hospital and other institutional care.

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:

### Patient flow between community and Jersey General Hospital



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

## 2 This document

### 2.1 Purpose of this document

This document outlines the strategic vision for health and social services in Jersey, which has been developed with stakeholders. It builds upon the work outlined above, including benchmarking, modelling, economic analysis, engagement and the consideration of international models of best practice. It has been devised to address the identified challenges and constraints facing Jersey currently and for the period 2012-2020.

The three deliverables from KPMG's work with HSSD are:

1. This technical document which has been written principally for an audience including Ministers, Members, officials and staff of the States of Jersey, including members of Scrutiny. It is expected, however, that this document will be circulated more widely
2. A "green paper" which is a much briefer summary of the key issues and recommendations containing of necessity much less detail and written in a style intended to be accessible by all. The green paper is primarily intended to support public consultation
6. The activity, resource and cost model. This is a live, updatable model which we will transfer to SoJ. We will also train appropriate SoJ staff in it's use

### 2.2 Notes on this document, and document structure

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. Costs to implement change, and operational costs such as management capacity, office space and consumables and overheads have not been incorporated, as this level of detail, along with further detail on staffing and full costs, is required after public consultation. This level of detail 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.

All costings in this document are high level and indicative only. Costs have been presented to the nearest £'m or £'000, as applicable. Some rounding adjustments have been made. All costs are presented as at 2010 prices, to ensure comparability between years by removing the effect of RPI. The exceptions to this are salary, medical supplies and drug cost inflation. Because these costs increase above the rate of RPI, the net increase for these two cost types have been included. This, therefore, reflects a net inflationary increase of 1.9% p.a for salaries and medical supplies and 7.9% p.a for drugs.

This document builds the case for change for Jersey by presenting the analysis and benchmarking undertaken. This outlines the pressures and challenges that Jersey will face in the period to 2020, and demonstrates clearly that decisions must be made now in order to design and deliver health and social care services that are safe, sustainable and affordable for the future. It should be noted that analysis has only been undertaken on data provided for publicly-funded activity. Any demand which is currently not met by publicly funded care has not been incorporated.

Each scenario presents, at a strategic level:

- An outline of services
- Activity implications
- Staffing implications
- Funding implications
- Benefits
- Risks
- Implementation timetable
- Fit with strategic imperatives

Finally, the key enablers which would need to be in place in order to develop, design and implement change are outlined. Change management is complex, and the capacity and capability required should not be underestimated. Any change programme needs to be undertaken in partnership with clinical and professional staff, and in full consideration of the views of the public, patients, service users, carers and other partners, including other States departments and the third sector.

The Green Paper and public consultation is the first stage in this change programme, and we would strongly recommend that the principles and change management structures that have been implemented during our work (e.g. Ministerial Oversight Group, Steering Group and programme office) are continued during the consultation process in order to ensure a smooth transition into detailed business case production and implementation planning.

## 3 Introduction

Jersey residents are today living longer than ever before. New medicines, better ways of diagnosing and treating illnesses such as cancer, and other advances have improved life expectancy but mean that many residents of Jersey need to visit the doctor or hospital more often. Chronic conditions such as arthritis and diabetes are rising and patients require treatment and care throughout their lives.

New medicines and new surgical techniques cost money, and so the States (like all other health and social care economies) is spending an increasing amount each year on treating illnesses and providing operations. As Jersey's elderly population grows there are also, naturally, more people who need help with day-to-day living. The result is ever-increasing demands on health and social care services.

Last year, the States' Comprehensive Spending Review found that it would not be possible to continue to provide services in the same way over the next 3 years without a significant increase in cost or a reduction in some essential services. Services in Jersey need to be 're-designed' or provided in a different way, in order to meet the needs of the island in future years in an effective and affordable way.

As a relatively prosperous community the residents of Jersey are entitled to expect to be well cared for. However, the research conducted in the course of preparing this document suggests that there are important issues to address. Discussions with the island's charities, and with Jersey's doctors, nurses, therapists and social workers, suggests that there is still more that could be done to help people with physical or mental illnesses, vulnerable older people and children.

Jersey also needs to consider what is affordable to spend, and how to make money go as far as possible.

### 3.1 Context

The Health and Social Services Department (HSSD) of the States of Jersey is responsible for the planning and provision of a wide array of hospital, community, mental health, and adult and children's social care services. This includes providing services for people recovering from ill health, improving the quality of life for the rising number of people living with long term conditions, and preventing premature deaths. Islanders should expect a positive experience of care, delivered in a safe environment which protects them from avoidable harm.

HSSD monitors and oversees improvements in the quality of all services in response to changing needs, expectations and medical advances. The Department is also responsible for the education and development of the island's medical professionals to ensure that their skills match the needs of their patients.

The General Practitioner (GP) should be the first port of call for a patient, apart from in an emergency or in the event of a serious accident. Whilst there are 77 GPs in Jersey, there are only 4.5 practice nurses. Patients can choose which GP they would like to see, and have to pay a charge for seeing them.

Some services are provided in the community, predominantly by Family Nursing and Home Care (FNHC), however, these services are not available 24 hours. Social care and mental health services are provided for all age groups in a combination of residential settings e.g. St Saviour, and Sandybrook, and (especially for working age adults) within the community. It is estimated that c1,000 older people are cared for in residential settings currently, although this includes private sector as well as States-provided and funded care. As with all countries, it is difficult to estimate the number of unpaid carers in Jersey.

Jersey General Hospital provides a full range of elective and emergency services, including a full A&E. Some specialist treatments are provided in UK hospitals, where there is insufficient volume in Jersey. The island has more Looked After Children than the UK,; 20% more are cared for in residential settings rather than by foster carers.

Jersey's health and social care system benefits from a vibrant and committed third sector<sup>1</sup>. Organisations such as Jersey Alzheimer's Society, Autism Jersey, Age Concern, Autism Jersey, FNHC and Jersey Hospice provide a range of information, services and support directly to the public, to help them live active lives. Some health promotion activities exist, undertaken by a combination of the third sector organisations and the Health Promotion Department.

This review covers all areas of publicly-funded health and social care, whether they are delivered in the hospital, in the community or in people's homes. To provide focus to the scope of the review, however, we have not included optical and dental services which, while important in primary care, will be dealt with separately.

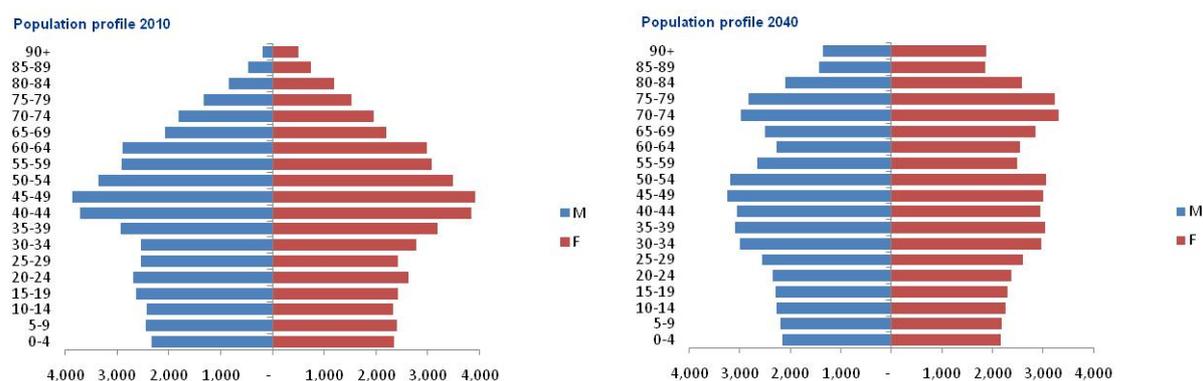
## **3.2 Service pressures**

### **3.2.1 Outline of service pressures**

In 30 years time, the make-up of the island is likely to be different to the Jersey we know today, as demonstrated in figure 1 below. The ageing population will more than double by 2040, meaning the cost of caring for the elderly will triple, as older people are more frequent users of health and social care services. There will also be fewer people of working age to support the increasing number of older people (the working age adult: older adult ratio reduces from 3.9:1 in 2010 to 1.8:1 in 2040).

<sup>1</sup> "Third sector" organisations are generally defined as charities, the voluntary sector, the community sector, not for profit organisations & NGOs (Non-Governmental Organisations)

Figure 4: Jersey faces an ageing population



Jersey faces the same challenges as other countries, and needs to continue to deliver high quality, cost effective health and social care which meets the needs of its residents. Jersey's health and social care services are, in most areas, performing on a par with Guernsey and the UK at present. There are plans to develop services e.g. the Primary Care Development Plan, Long Term Care funding and the children and young people's framework plan. However, health and social care services in Jersey are configured in such a way that will increase pressures on the service in the future, and factors in addition to the ageing population will impact demand. These challenges are outlined in more detail in section 4: the case for change, and include:

#### *Small islands are unique*

The structure and design of the health and social care system is a result, in part, of Jersey's island status. Services on small islands such as Jersey have evolved over time to fit the population's requirements.

But, because Jersey has a small population (less than 100,000 residents), it costs more to provide some health services than it would for a larger population. Where a large population shares local services, the cost per person reduces. For example, a district general hospital in England typically needs to serve a population of 250-300,000 people to be affordable. With a population significantly less than this, it therefore costs more per person to provide treatment at Jersey's hospital.

#### *Use of hospital services*

A relatively high proportion of residents use Accident and Emergency departments (A&E) within hospitals as the first port of call when they seek medical help. A&E is free, whereas patients have to pay to be seen by their GP. This encourages patients to use hospital, when in many instances they could be cared for more appropriately by their GP.

The service within hospital is very 'medicalised', and consultants have lower numbers of middle and junior grade doctors supporting them than in comparator geographies. In addition, nursing and AHP roles have not developed at the same rate as in the UK. Whilst there are some role developments in some specialties, these could be further enhanced and applied across the hospital.

#### *Looked After Children*

Jersey has 20% more Looked After Children than its UK comparators. This may be due in part to the assertion that, because the cost of living is high in Jersey, many people have to undertake paid work, many more women work, and people often have more than one job. This reduces the number of people who are available to become foster carers.

### *Use of residential care*

Similarly, the cost of living may reduce the number of unpaid carers available to look after elderly relatives. This, along with the lack of 24-hour community support, has led to a high proportion of older adults being placed into residential care. Whilst a placement assessment was introduced in 2008, this has not been applied retrospectively.

### *Primary care*

Jersey has a high proportion of GPs per population, but only 4.5 practice nurses for the island. This increases the workload pressure on GPs, who undertake procedures such as ear syringing and blood pressure monitoring, which could safely be undertaken by other professions.

### *Workforce*

The workforce is central to any health system, but Jersey experiences challenges with attracting and retaining health and social care staff:

- Many health and social care staff are approaching retirement age – almost 50% will be eligible for retirement in the next decade.
- Many of these retiring professionals are generalists who can treat a range of conditions. However, new health professionals across the UK are now trained to be specialists, focusing on more narrow, specific areas of care. This means that every retiring hospital doctor may well need to be replaced by a number of specialist doctors. This makes replacing the retiring doctors more expensive.
- The high cost of living in Jersey, competitive pay packages in the UK and some rules for entry and residency in Jersey mean we that Jersey must consider how to attract the next generation of health and social care staff to live and work on the island.

In any health system, the majority of spending is on the workforce – therefore increasing the cost of employing the workforce increase will place further financial pressure on the current system of providing services.

### *Estate*

There are challenges with the current estate. Jersey is not subject to UK requirements in terms of the functionality of buildings, for example in terms of single rooms and single sex wards. Within residential care, a General Hospital has very few single rooms and States owned care homes will be required to comply with the Inspection and Registration of Homes Care Standards from April 2012.

### *Payment systems*

Where people are treated, as well as by whom, matters. Current funding arrangements do not always encourage people to seek the right help in the right place from the right healthcare professional. As

noted above, some Jersey residents present at A&E rather than at their GP practice, and it is asserted that the co-payment for GP services is a contributory factor to this access pattern.

### 3.2.2 Addressing the service pressures

Only by acting now can Jersey make preparations for a safe, sustainable and affordable health and social care system in the coming years. Countries facing the same challenges as Jersey, including Guernsey, have already begun to consider this.

One way of responding to rising demand (and to increasing costs) is to cut back services, for example, by only providing 'essential' services for the most urgent needs. This could mean stopping certain services completely. However, services would need to be cut to such a level that care becomes unsafe, or the viability of services is undermined, in order to deliver care within budget. A more acceptable approach would be to address the forthcoming challenges through considered, positive change.

Preventative measures can be taken to look after the general health and well-being of the island's population. For example, providing better information and community services would encourage residents to live healthier lifestyles and manage their long term conditions more effectively. This would help to avoid unnecessary admissions to hospitals and long terms care and improve the quality of life, enabling and supporting people to live independently in their own homes for as long as possible. Payments for carers and foster carers should also be considered, to attract more people into these roles, providing more personalised care which improves outcomes at a lower cost.

Jersey will need to consider how to pay for health and social care in the future. Some ailments, for example, could be managed better by the individual patient in their own home with the help of new technology. This would also reduce the cost of overnight hospital stays and release time for frontline doctors and nurses.

Many minor injuries and illnesses could easily be dealt with by qualified nurses rather than a hospital doctor or a GP, and GPs themselves could help relieve some strain by working in the hospital.

In cases of less common illness and injury, it may make sense to transfer patients to the UK, or indeed, doctors from the UK to Jersey.

Increased integration between States, voluntary and private providers and, where appropriate, sharing of information, would enable health and social care professionals to intervene early to avoid mental or physical problems escalating and to provide the best possible solutions to meet health and social care needs.

**The challenge in the coming years is clear. With more demand on services from an ageing population, it is no longer possible to continue treating people using the same system we do today. A new system for health and social care is needed now to ensure Jersey can continue to care for it's population and provide service that are safe, sustainable and affordable for the future.**

## 4 The case for change

This chapter outlines the reasons why change in Jersey health and social care services is necessary. It considers issues of demography, economics and workforce and assesses the financial implications of responding to these issues. We also outline the current health and social care service and how demand and need for these services will change as a result of known future changes, particularly those driven by demography.

### The case for change in summary

The population of Jersey is growing relatively slowly but it is ageing rapidly. Between 2010 and 2040 there will be a 95% increase in the over 65 population, with a 35% increase by 2020. This growth in the older adult population will create a **huge increase in demand** for health and social care services.

Current services are performing generally well but they are close to capacity and could not accommodate this increase in demand. The island will **run out of capacity** in key service areas over the next 5 years, but within 2 years in many areas – and **within a year** in some areas. The services therefore need significant expansion and/or change to ensure that the needs of the people of Jersey can be met into the future.

Current services are also vulnerable due to workforce pressures with many staff approaching retirement age. Almost 50% of the hospital consultants are due to retire in the next 10 years and, due to changes in medical training and education, these consultants cannot be replaced on a like for like basis. Competition for skilled staff is increasingly hard given, in particular, high costs of living in Jersey and increasingly competitive remuneration packages for similar staff in the UK. Some services have high vacancy rates currently and, unless services change, there will be **insufficient staff to deliver services** for people with health and social care needs.

Jersey therefore needs a model of health and social services which can respond to the huge increase in demand while doing so in a way which enables the skills of local staff to be used to the maximum and new roles created which will attract new staff to work on the island.

Timing is critical, as **these pressures will impact as early as 2012. Decisive action is needed now**, in order to secure service changes that meet the island's needs in the short term, and ensure services are safe, sustainable and affordable for the future.

### *A significant increase in demand, driven by twice the number of older people*

Jersey's ageing population is more pronounced than in comparable European countries, with the over 65 population forecast to increase by 95% between 2010 and 2040. Older people are more frequent users of health and social care services. Already, Jersey has a much higher proportion of older people living in residential and nursing care than in comparable regions in England.

### *A workforce under immense pressure, as recruitment and retention reduce and 50% of staff retire*

- many consultants, GPs and nurses are approaching retirement age (almost 50% of consultants are due for retirement by 2017)

- an increasing trend towards sub-specialisation in medical training, whereby doctors working in secondary care focus more on a particular area, increases the number of staff need to replace those leaving or retiring
- a middle grade and junior doctor workforce that is significantly less than all other benchmarked peers, which increases the strain on the senior workforce
- high cost of living in Jersey, and competitive remuneration packages in the UK reduce the number of available staff
- rules for entry and residency in Jersey further reduce the number of available staff
- Doctors need to see a sufficient number of patients to ensure that they are ‘fit to practise’ (maintaining key skills and ensuring patient safety)
- the number of junior doctors in training is proportionately low

#### *No more capacity*

- On the current service configuration the capacity of the existing services will be exceeded within two years in key older adults services
- In the hospital, capacity is already exceeded in theatres and more medical beds will soon be required
- Staff in the community already have very high caseloads and are only able to provide limited support in many cases, due to workload pressure

#### *“Coping strategies” will not resolve the issue*

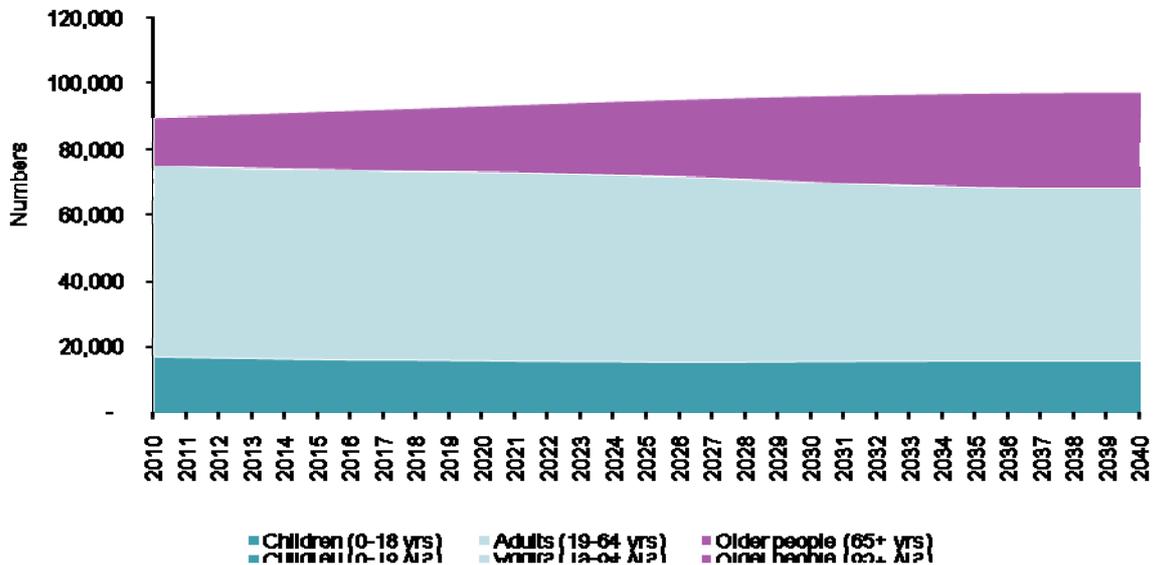
If services are not developed in response to the forthcoming challenges, coping strategies will be employed. This would be a suboptimal strategy as it would only delay the inevitable need to redesign services, and could lead to:

- Only emergency services being available – i.e. elective care is reduced to a point where waiting lists increase significantly
- Increased vacancies as staff seek alternative employment due to unsustainable pressure of workload and concerns over patient and service user safety
- Increased means testing and eligibility criteria so that more people on lower incomes have to pay for their own care. This increases inequality, reduces access, people pay privately or go without
- Increases in thresholds, so that people have to be much more unwell before they get treatment – or have to wait much longer for their operations

## **4.1 Demographic changes**

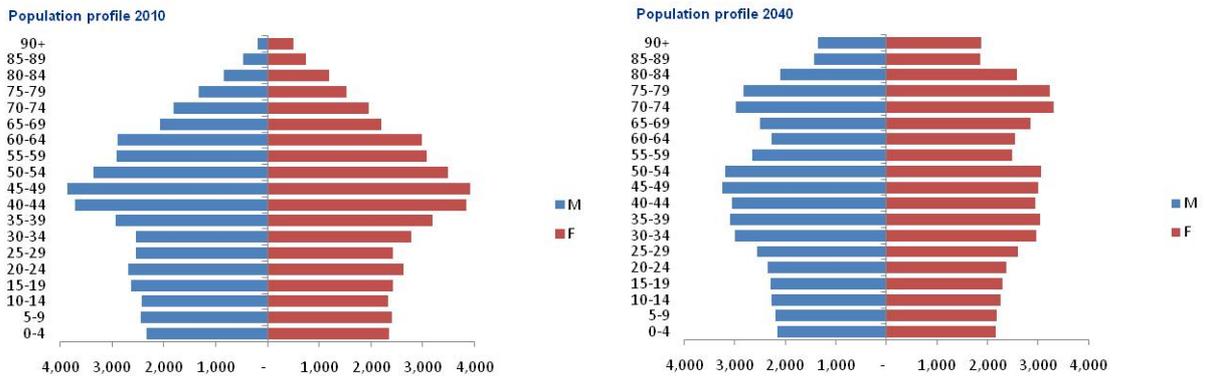
Using the population forecasts from the Statistics Unit, with 150 households per year of net immigration, the population of Jersey is projected to increase by 8% over the next 30 years.

Figure5: Population forecast



Source: Jersey modelling tool outputs, 2011.

However, the profile of the population will change dramatically as the population ages:



Source: Jersey modelling tool outputs, 2011.

The population of people aged over 65 will almost double (projected to increase by 95% between 2010 and 2040), and the population aged over 80 will more than triple (projected to increase by 245%). At the same time, the population of working age adults will decline by 9%. In the period to 2020 the population over 65 is projected to increase by 35%.

This means that the support ratio of adults of working age for every older person will change from the current 3.9 working age adults for every older adult, to only 1.8 by 2040. This will have significant impacts on the use of health and social care services, as older people use more health care services than working age adults. It will also have significant impacts on the tax revenue received by the States of Jersey.

The summary population trends are shown below.

Figure 6: Summary population trends

Population projection	2010	2020	2030	2040
Children (0-18 yrs)	17,260	16,131	15,839	15,999
Adults (19-64 yrs)	57,762	56,941	54,243	52,263
Older people (65+ yrs)	14,797	19,982	25,943	28,882
<b>Total</b>	<b>89,819</b>	<b>93,053</b>	<b>96,025</b>	<b>97,144</b>
Support ratio	3.90	2.85	2.09	1.81
Dependency ratio	3.35	3.53	3.42	3.27

Source: Jersey modelling tool outputs, 2011.

## 4.2 Activity Impact

The unavoidable demographic change outlined above will drive an extensive and rapid increase in activity in health and social care. If the current services were to respond as they do currently, activity levels would need to rise.

### 4.2.1 Self Care

#### 4.2.1.1 Current services

At present, Jersey does not have a specific model or approach to self care. However, a multiplicity of services and resources are currently available separately to support basic self care within HSSD, primary care, education and the third sector. This includes some information and advice on prevention, with some support to individuals in managing their condition. 'Pockets' of good practice exist, particularly within the third sector, with numerous charities providing different elements of community based support aimed at assisting individuals and families in improving/managing their health and social care needs.

#### *Health and wellbeing of the people of Jersey*

According to the Jersey Annual Social Survey in 2009, when asked to self rate their health, over 85% of adults in Jersey rated their health as good or better. There were differences across age groups with 91% of individuals aged between 16 to 34 rating their health as 'good' or better, compared with 70% of those aged 65 and over.

Whilst this suggests that the public in general have a positive perception of their health and well-being, the survey also highlights that the public may be unaware of how their lifestyle choices impact on their health and well-being. For instance, survey results concluded that approximately half of men (46%) and more than a third of women (35%) exceeded recommended daily levels of alcohol consumption (3 to 4 units of alcohol per day). Also, 15% of the adult population scored themselves with high levels of depression and anxiety - this equates to more than 10,000 people in 2010 rising to more than 11,000 people in 2020.

#### *Jersey key facts*

##### Obesity

- 1 in 8 adults are obese and 1 in 3 are overweight.
- 1 in 10 5 year olds are obese and 1 in 4 are obese or overweight.

- Obesity costs the States of Jersey and other employers an estimated figure of almost £4m each year including health-care costs and sickness absence.

#### Smoking

- An estimated 170 each year die of smoking related disease.
- Of approximately 17,000 smokers, 12,000 want to quit.
- Approximately 400 babies leave maternity to a home where at least one person smokes.

#### Physical activity

- Just over half of the adult population do not achieve the recommended amount of physical activity each week for health benefits.
- Older adults are less likely to be participating in physical activity on a regular basis.
- Young people are less likely to walk or cycle to school than in the past.

#### Mental health and well being

- Levels of suicide are higher than England and Wales. Suicide is the biggest cause of premature death
- Higher levels of anxiety and depression are experienced by adults in Jersey than the UK
- 40% of repeat visits to GPs are by people diagnosed with depression and/or anxiety

Source - 'Health for life', HSSD, States of Jersey HSSD

Numerous studies such as the World Health Organisation's Global Status Report on Alcohol (2004) have concluded that excessive alcohol consumption, in addition to smoking and/or a poor diet/exercise regime can lead to a higher prevalence of long term conditions such as diabetes, COPD (Chronic Obstructive Pulmonary Disease) and Coronary Heart Disease (CHD), in addition to mental health conditions such as anxiety and depression.

Jersey currently has 3,369 patients registered as diabetic and a further 1,563 patients estimated to be unregistered or undiagnosed with the condition (Jersey Diabetes Centre, 2011). Their projections indicate that by 2020 12,000 people (more than 13% of the total population) will have Diabetes. The rate of new cases of Diabetes is projected to have increased five-fold, to 1500 cases per year, which is the equivalent of 4 new cases every day.

The prevalence of COPD in Jersey is currently estimated at 3.3% (Jersey Public Health Intelligence, 2011) of the population aged 16+, which equates to 2,361 individuals. According to the World Health Organisation, approximately 15% of smokers will develop COPD, and that by 2020, COPD will be the third leading cause of death and the fifth leading cause of disability. This substantial increase in the global burden of COPD projected over the next ten years partly reflects the worldwide use of tobacco.

#### *Availability of Information*

Significant amounts of information/material are available to support informed lifestyle choices. Duplication exists in some areas by the multiple organisations producing various self care material. There is no central point where people can access all health promotion information in the first instance, although some third sector facilities exist to provide information and support to specific

groups such as families and child care. Furthermore, no quality assurance standards exist to control/approve the information which is available.

Health promotion is delivered by the Health Improvement team within the Public Health Directorate. Supported by the Healthcare Programmes team (also within the Public Health Department), they focus on the priorities drawn from results of the Jersey Annual Social Survey, together with disease and mortality rates from secondary care information systems. They adopt a programme approach in addressing the health needs of the island, based on identified priorities which include mental health, alcohol/substance misuse, obesity and smoking, using a range of activities such as smoking cessation clinics. The 'Help to Quit' programme provides smoking cessation clinics. An annual budget of more than £400k exists to support this scheme which includes 3 fte nurses. Jersey has achieved a reduction in smoking prevalence which reached 29% of the adult population in 2000 falling to 23% in 2010. However based on the numbers of people which express an interest in smoking cessation this could be reduced to 10% by 2020.

In addition to the Health Promotion team, over 75 third sector organisations have an active role in providing information to support various groups with specific needs and conditions, and are often key in navigating some vulnerable groups around their care. Whilst this provides a broad range of support available for people with different needs, it may lead to conflicting messages, duplication of services, and confusion for individuals attempting to improve their health and well-being.

Primary care information systems are variably developed compared to other countries such as the UK, with a mixture of systems for recording, monitoring and sharing information. The ability to register with more than one practice also increases the risk of data duplication and creates governance concerns, along with 'doctor-shopping' linked drug misuse. Consequently, public health intelligence is limited to the results from the Jersey Annual Social Survey and disease/mortality rates from a range of sources. This impacts the ability to adopt a targeted approach to identifying the population's health needs, such as using prevalence rates of long term conditions gathered from primary care systems. Monitoring the improvement or decline in health and social care outcomes in order to target interventions is also difficult to determine.

### *Third sector*

There are 263 registered charities in total in Jersey. 75 organisations focus on different aspects of health and social care, providing information, guidance and support to patients, service users and carers. Examples include:

- The Bridge – Family/Child support
- Brighter Futures – Parental support
- Brook - Sexual health
- Condition specific support groups e.g. Jersey Alzheimer's Society
- Cancer services e.g. Jersey Hospice

Community support groups exist in some Parishes. These comprise registered volunteers, and provide support to enable individuals to live more independently. Despite offering a quality service for a proportion of the population, other parts of the island population are unable to access this support or equivalent creating an inequity across Jersey.

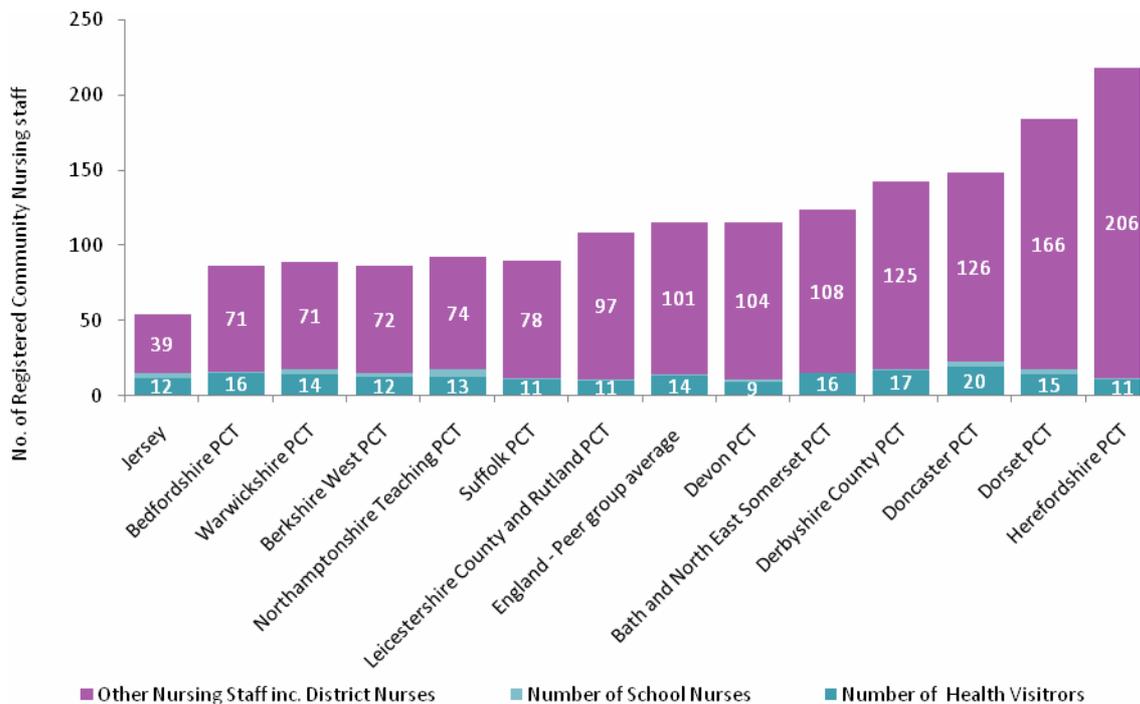
### Support to independent living

Help at home is currently available to support independent living. This includes home care to support basic needs such as shopping, laundry and meal preparation through to more clinical needs provided by district nursing. This service provides support from morning to night, however, it does not provide 24 hour support.

Benchmarking indicates that Jersey has a relatively low number of registered community nursing staff (including registered health visitors, district nurses and other community nursing staff) - 52 per 100,000 population, compared to an English peer group average of 115 per 100,000 population.

It should be noted that for English comparators, NHS Primary Care Trusts (PCTs) have been used as comparator organisations for community nursing staff. Currently, under the 'Transforming Community Services' agenda, PCT provider arms have or are in the process of, transferring community services to acute and/or mental health organisations. Hence, the number of community nursing staff indicated for some comparator organisations in this report may be lower than in practice.

Figure 1: Number of registered community nurses per 100,000 population



Source: NHS Information Centre; Jersey H&SSD data; KPMG Analysis.

The comparator peer organisations have moved towards a more community care based model than in Jersey, in addition to utilising a broader skill mix to Jersey. The capacity of the current community nursing workforce should be considered along with the potential skill-set of this staff group, should Jersey decide to follow a more community based model of care. Based on future projections of demographics and ageing population, current levels of district nursing and home care staff would need to increase from 39 fte and 57.5 fte respectively to more than 50 fte and more than 90 fte by 2020 to meet the increased demand in activity.

## Community Pharmacists

The population of Jersey use pharmacies for receiving medication and other medicines for general ill health, including dressings.

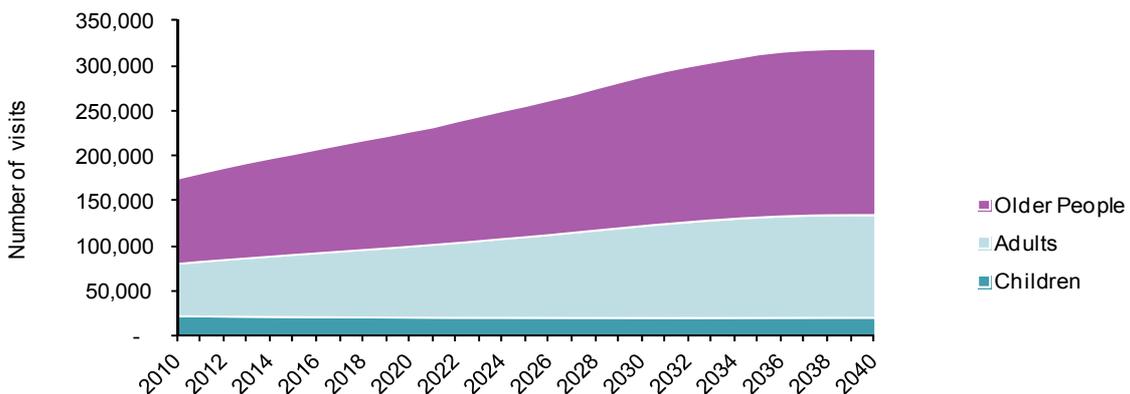
There are currently 30 community pharmacies in Jersey, staffed by approximately 80 registered Pharmacists resident in Jersey, with an additional 20 registered to work within Jersey on an interim basis if required.

Approximately 12 community pharmacies provide basic health checks such as blood pressure, cholesterol and diabetic screening. However, feedback suggests that not all the public are fully aware or make maximum use of the services available, which may partly be due to the public perception of pharmacists being limited to 'dispensers of medication', or the public's unawareness of the true capability and skills of the pharmacist profession.

### 4.2.1.2 Future need

Driven by demographic changes, the demand for community nursing increases significantly. It should be noted, however, that this demand projection is based on the current model of service delivery, which is not available 24 hours per day:

Figure 2: Community nursing visits



Source: Jersey modelling tool outputs, 2011.

## 4.2.2 Primary Care

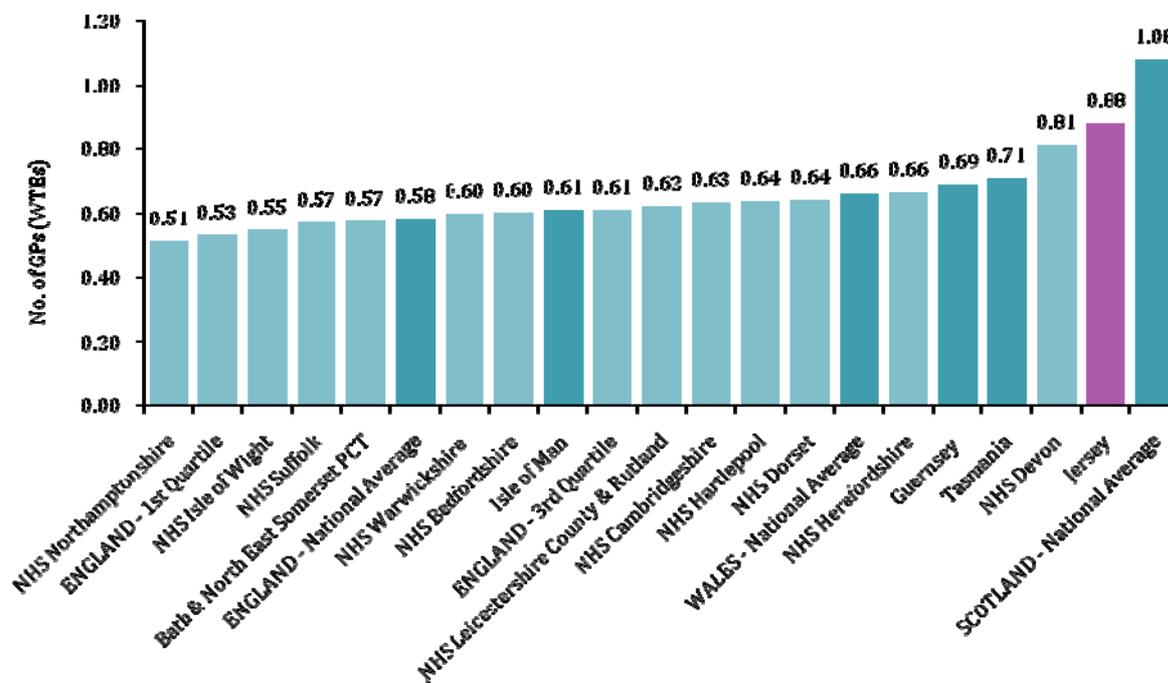
### 4.2.2.1 Current services

At present, primary care is predominantly provided through privately funded general practice - 94 GPs (77 fte), and 4.5 fte Practice Nurses.

GPs provide generalist primary care medical services. Most patients make a co-payment for all consultations and pay for issuing of repeat prescriptions, although GPs can and do waive or reduce fees where they feel patients cannot afford them. The States pay a benefit from a contributing Health Insurance Fund (HIF) for each consultation and referral. Some patients eligible for income support receive subsidised consultations.

The number of General Practitioners in Jersey per 1,000 population is significantly higher than in other comparator jurisdictions - 0.88 GPs per 1,000 population in Jersey compared to England (0.58), the Isle of Man (0.61), Guernsey (0.69) and Tasmania (0.71).

Figure 3: Number of GPs per 1,000 population



Source: NHS Information Centre; ISD Scotland; Health Stats Wales; OECD; Australian government health data; Jersey H&SSD data; KPMG Analysis.

This suggests that there may be opportunities to utilise and build upon the existing capacity and capability within general practice to provide other areas of healthcare. An alternative course of action would be to progressively reduce the number of GPs through substitution by other healthcare (or social care) professionals.

In December 2010 it was forecast that there would be almost 343,000 GP consultations per annum (i.e. an average of 4 consultations per person p.a). At a public subsidy of £19 per session, the total cost is calculated to be more than £6.5m p.a in 2010. This figure excludes the patient's co-payment and the 'Other Services' category of payments made by Social Security to GPs (referrals etc), which is currently worth more than £2m p.a. Prescribing costs almost £12m p.a.

Currently, the barrier to accessing GP care by those who can not or are unwilling to pay leads to increased demand on hospital services as these are 'free at the point of delivery'. This increases demand on A&E services and outpatient clinics. This impacts on waiting lists and in time it may lead to patients presenting with more advanced disease.

Due to the funding mechanism, the current model of care is dominated by doctors, with limited care offered by other professionals.

There are no registered lists of patients – patients are free to consult with any GP they wish and with as many GPs at any one time as they wish. This, plus the co-payment / income support system

encourages GPs to provide good customer service, but is complicated by clinical governance and 'doctor-shopping concerns'.

There is currently limited interaction between primary and community services, specifically between GP-led services and FNHC. There is little incentive for GPs to host midwives undertaking clinics in primary care as these do not attract payment for the GPs. The community clinic at The Bridge cares for low risk pregnancies, but the care is not shared. There are less than 10 health visitors in Jersey, who tend to act independently of GP practices. They are locality-based rather than attached to a practice.

### Out of Hours (OOH)

GP surgeries are typically open during the day on weekdays, and on Saturday mornings. The out of hours service is operated on behalf of all GPs by a GP out of hours co-operative (except those who are on-call as Forensic Medical Examiners), with the co-operative billing practices for services delivered to patients.

In 2010 there were:

■ basebase surgery visits	3,100
■ night visits ( after 11pm)	550
■ evening and weekend visits	2,600
■ telephone advice	2,500

Base visit from the out of hours service costs patients £42.68, home visit after 6pm £80, and £110 after 11pm. These costs exclude the rebate / medical benefit subsidy of £19 per consultation.

The out of hours service is based within the hospital, but is not co-located with A&E.

#### 4.2.2.2 Future need

The 2010 primary care activity of almost 343,000 consultations is projected to increase to almost 365,000 in 2020, taking into account the increased consultation rates for the elderly population, particularly those aged 85 and over. If the consultation rate increases following the Quality Framework introduction at the same rate as was experienced in the UK, the annual consultation rate would be almost 539,000. This increase is driven by:

- Consultation rates - older adults are high users of primary care services. UK figures indicate that, in particular, people aged 85-89 attend 14.0 times per annum for a male and 13.5 times a year for a female<sup>2</sup>
- Increased disease incidence, which is driven by age and lifestyle. For example, the growing numbers of patients with obesity would have a consequent impact on health needs (including raised blood pressure, diabetes, coronary heart disease, stroke, muscular skeletal problems and kidney failure)

<sup>2</sup> QResearch Final Report to NHS Information Centre and Department of Health. Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database. NHS Information Centre

- Increased expectations through the development of innovation in care, including technology

### 4.2.3 Acute Care

#### 4.2.3.1 Current services

The majority of care is provided free of charge at the point of delivery by the States to the population of Jersey. Almost 50% of the population currently have private health insurance. The coverage of the various insurance policies vary, and many people still opt for State provided care.

Jersey General Hospital provides a comprehensive range of acute services, including emergency care and EAU, medical and surgical specialties, anaesthetics, ITU and therapies. It has:

- 245 beds in total – 217 public and 28 private
- 4 main theatres (one is a ring-fenced emergency theatre)
- 2 day case theatres
- 2 endoscopy theatres
- 1 maternity theatre

Expenditure in 2010 was £77 million. By 2020 this is projected to increase by 27% to almost £98m, the majority of which is due to salary and healthcare inflation on pharmaceuticals and supplies.

Figure 10: Projected hospital spend

Hospital Spend	2010	2020	2030	2040
Salary costs	£ 56,929	£ 69,275	£ 83,982	£ 99,584
Supplies and Services	£ 16,185	£ 23,321	£ 33,637	£ 46,649
Commissioning	£ 8,595	£ 10,560	£ 12,786	£ 14,178
Other	£ 2,722	£ 2,820	£ 2,918	£ 3,017
<b>Gross Cost</b>	<b>£ 84,430</b>	<b>£ 105,977</b>	<b>£ 133,323</b>	<b>£ 163,427</b>
Income	-£ 7,417	-£ 8,081	-£ 8,800	-£ 9,266
<b>Net Hospital Spend</b>	<b>£ 77,013</b>	<b>£ 97,896</b>	<b>£ 124,523</b>	<b>£ 154,161</b>

Patients with emergency or urgent care need currently present to the A&E Department or GP Out of Hours (OOH) service within the hospital, or to GPs through appointments or home visits in non-hospital settings.

#### Accident and Emergency

In 2010, there were almost 37,500 attendances at A&E, of which the majority were categorised as minor or non-urgent. The cost was more than £3m, which equates to approximately £85 per attendance.

The table below categorises the 2010 A&E attendances<sup>3</sup>. Although 20% of the attendances were uncoded, 75% of the coded attendances were classed as standard, seen by a nurse only or non-

<sup>3</sup> Data provided by HSSD PAS system January to December 2010

urgent. This suggests that several attendances could have been seen in primary care or with some advice, avoided an attendance.

Figure 11: A&E attendances, by time

Triage category	Count of Patient's Number
IMMEDIATE - RED	117
NON URGENT - BLUE	48
SEEN BY NURSE ONLY	396
STANDARD - GREEN	22529
URGENT - YELLOW	6534
VERY URGENT - ORANGE	807
(blank)	7037
<b>Grand Total</b>	<b>37468</b>

If a child presents, he/she is seen in A&E and sent to Robin Ward. Alternatively, Robin Ward currently offers a 'drop in' service. In 2010, children and adolescents aged 18 years or under accounted for more than 9,000 A&E attendances (24% of total A&E attendances). This resulted in just less than 800 non-elective admissions, with an average length of stay of 2.4 days. In common with Adult and Elderly A&E activity, this may result from the co-payment required for a GP appointment, compared with A&E appointments which are free of charge.

Patients presenting with a potential mental health issues are assessed by the Acute Liaison Team which, although based in the hospital only offer an off-site, on-call out of hours service.

#### *Emergency Ambulance Service*

More than 6,000 emergency ambulance journeys were undertaken in 2010, of which more than 2,500 (42%) were for patients aged over 65. There are currently 3 ambulances in Jersey.

#### *Non elective spells*

70% of patients present at A&E and then are admitted for a short stay to the Emergency Admissions Unit (EAU), a 16 bedded ward, and from there to a general medical ward or home. The remainder are either discharged directly from A&E or admitted to a ward.

Analysis indicates that non-elective admissions are driven by general medical patients, of which 53% are over 65 years old. In 2010 there were almost 7,000 non elective spells. The average length of stay for non-elective patients was 7 days, which is high compared to the average length of stay for a General Medicine patient in Guernsey but approximately average for UK length of stay at 6.7 days.

Figure 12: Non elective admissions by Specialty

In patients <sup>4</sup>	NEL
Cardiology	1
Dental	0

<sup>4</sup> HSSD PAS data

In patients <sup>4</sup>	NEL
Dermatology	0
Diabetes/Endocrinology	0
ENT	121
Gastroenterology	0
General Medicine	3,641
General Surgery	1,151
Neurology/Neurosurgery	0
Obstetrics and Gynaecology	335
Oncology	14
Ophthalmology	15
Trauma and Orthopaedic	976
Paediatrics	558
Renal	8
Urology	32
Cardio-thoracic surgery	0
Other	0
<b>Total</b>	<b>6,852</b>

Two medical practices currently exist for the care of non-elective patients 'post-take':

- the admitting consultant retains the patient's care throughout their stay
- the care of the patient is transferred to the relevant specialist as soon as possible i.e. diabetes patient to the diabetologist.

Currently, other than the Samares Rehabilitation Ward, there are no step up/step down facilities for patients who may be demonstrating exacerbation of long term conditions and who could be managed outside of a hospital environment if services were available.

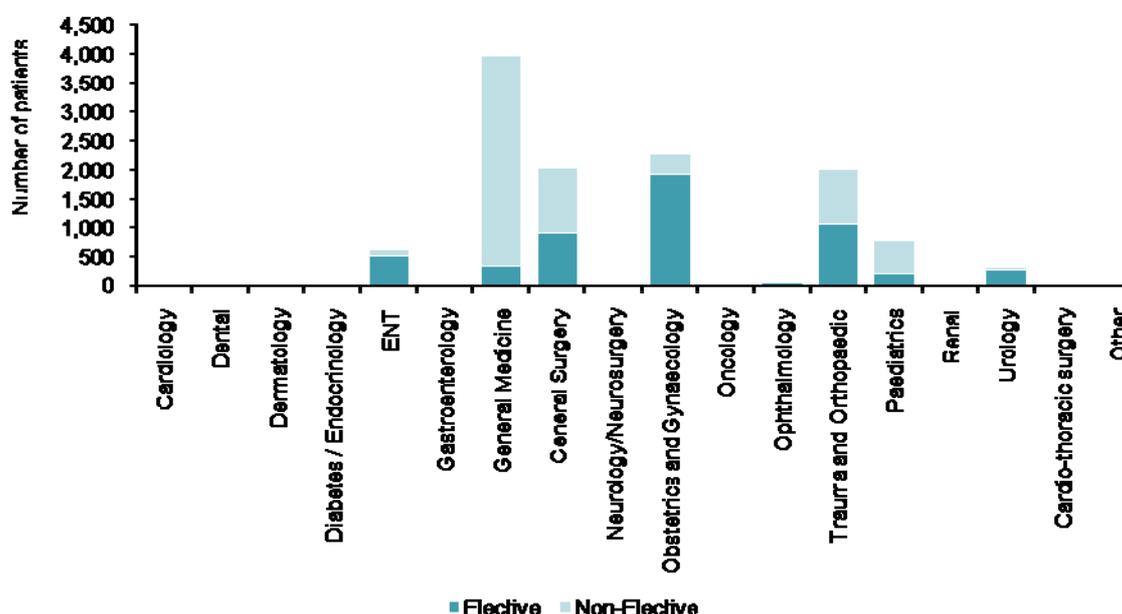
During 2009-10 Jersey General Hospital treated more than 12,000 surgical cases:

Figure 13: Surgical cases, 2009/10

In patients	Elective	NEL
General Surgery	884	1,151
Ophthalmology	49	15
Trauma and Orthopaedic	1,040	976
Urology	264	32

Total	5,230	6,852
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Figure 144: Inpatients by Specialty



Certain procedures are not undertaken in Jersey either due to their complex nature or equipment requirements. The size of the population and the incidence of medical and surgical conditions on the island limit the number of certain procedures that Consultants are required to perform and therefore it is difficult to uphold their required level of competency. Arrangements are in place with NHS providers in the UK for patients to be treated off island. 90% of UK based activity is carried out by 9 providers, with 45% provided by Southampton University Hospital Trust.

Specialist care is provided in Jersey hospital for the Jersey population, with some care provided at Overdale (diabetes, rehabilitation, outpatient clinics etc).

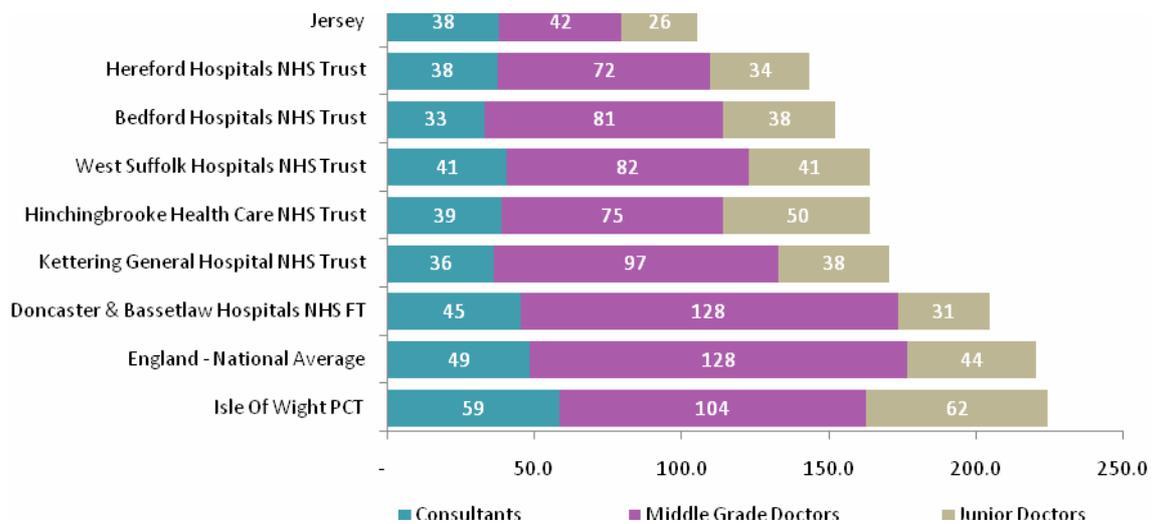
#### Workforce – Medical staff

There are 38 fte consultants per 100,000 population in Jersey, compared with an English average of 49. The proportion of middle grade doctors to consultant staff is particularly low. This could at least in part be explained by:

- Sub-specialisation in hospitals in England, whilst consultants in Jersey deal with a relatively generalist caseload
- Some activity, particularly complex cases, are treated off island
- Visiting consultants undertaking specialist work, which has not been taken into account.

It should also be noted that the European Working Time Directive is not applicable in Jersey as the comparator organisations which also accounts for some of the difference.

Figure 5: Medical staff by grade per 100,000 population



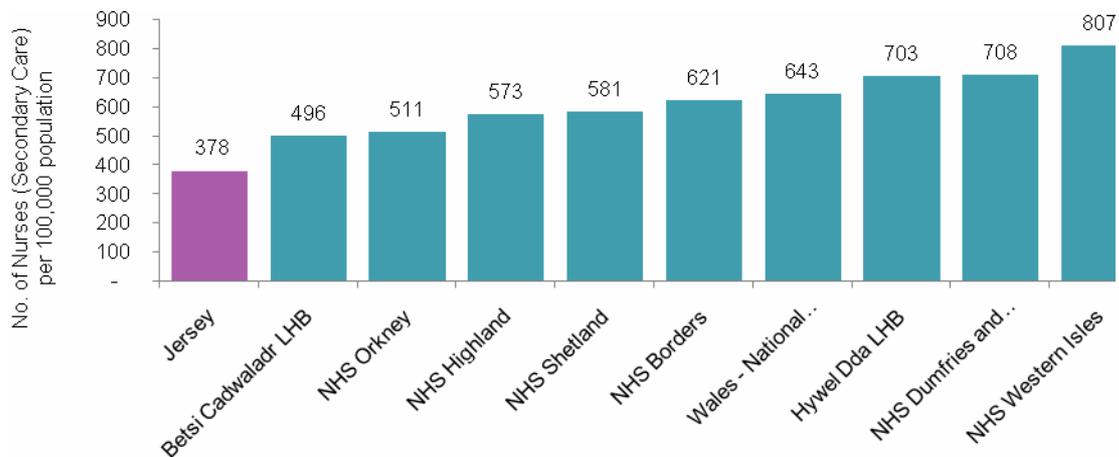
Source: NHS Information Centre; Jersey H&SSD Data; KPMG analysis

### Workforce – Registered Nursing & Midwifery Staff

Jersey appears significantly low when comparing the number of nursing staff (all grades) against Scottish and Welsh comparators. When the number of registered nursing and midwifery staff in Jersey is benchmarked against English comparators, Jersey also appears lower than the national average.

The current model is primarily medicalised and has not developed roles such as Nurse Practitioners (New Zealand and UK); Clinical Associates (Canada) or Extended Scope Practitioners (England), all of whom have prescribing rights. Jersey currently employs 340 fte nursing staff within secondary care. This equates 378 fte per 100,000 population and includes adult/paediatric nursing and midwifery staff.

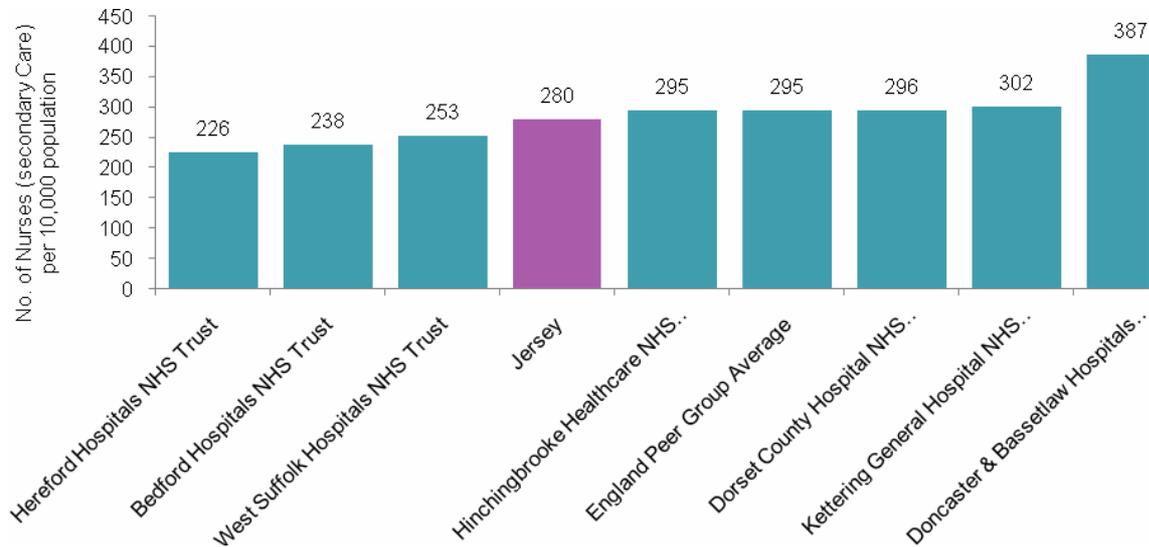
Figure 16: Nursing and Midwifery staff (all grades) per 100,000 population



Source: ISD Scotland; Health Stats Wales; Jersey H&SSD data; KPMG analysis.

Within this, 252 fte (or 280 per 100,000 population) are professionally registered.

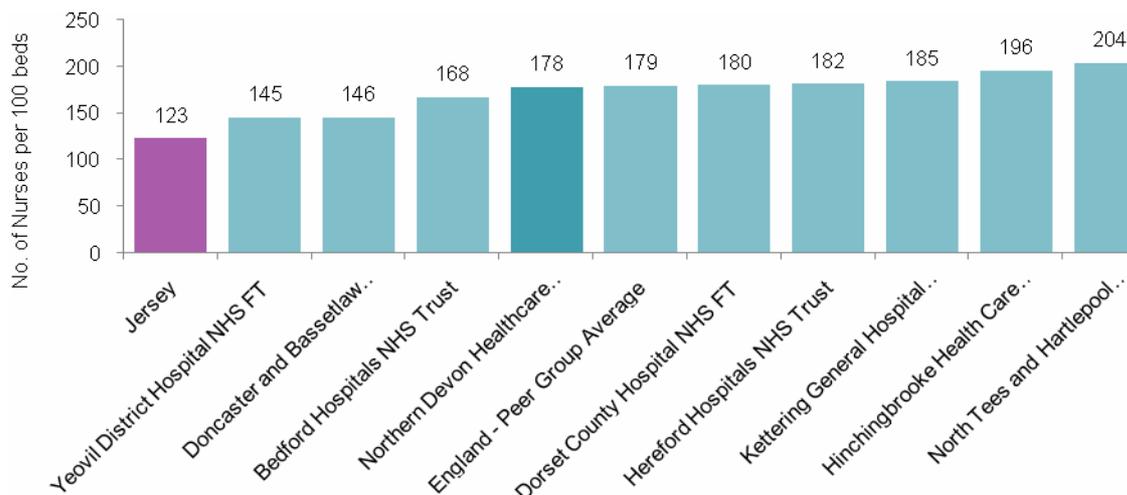
Figure 17: Registered Nursing Staff per 100,000 population



Source: NHS Information Centre; Jersey H&SSD Data; KPMG analysis.

The nurse to bed ratio is also lower in Jersey when compared against English peers (which includes all nursing staff grades) which suggests that the overall number of nursing staff is lower in Jersey. This may be due to an adoption of a more medicalised model of care in Jersey compared to comparator organisations which offer more nursing led services. This could also be explained by the challenge which exists of attracting lower grade nursing staff due to the cost of living within the island.

Figure 18: Number of Nurses (all grades) per 100 Beds

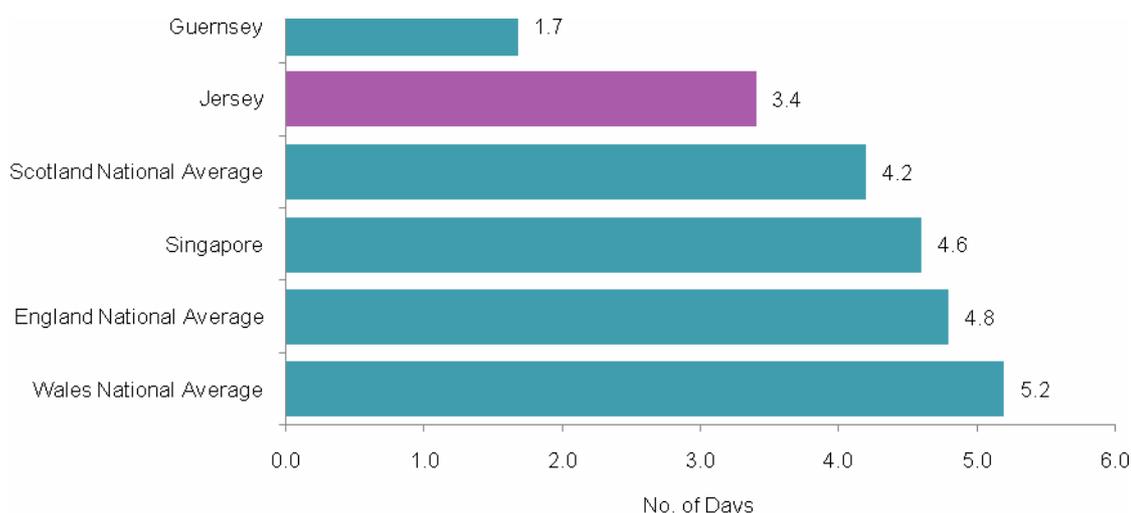


Source: Dr Foster Intelligence; Jersey H&SSD data; KPMG analysis

### Length of stay, general surgery

The length of stay for general surgery appears shorter in Jersey at 3.4 days compared to its peer comparators. In England, the national average is 4.8 days. Similarly, the national averages for Scotland and Wales are also higher than Jersey with an average of 4.2 days in Scotland and average of 5.2 days in Wales.

Figure 196: Length of Stay, General Surgery



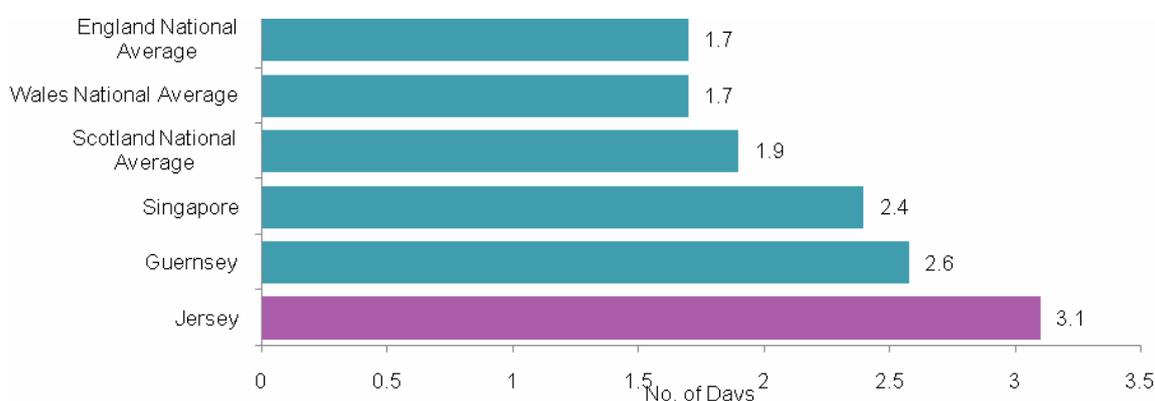
Source: Dr Foster Intelligence, ISD Scotland; Health Stats Wales; Guernsey HSS Intelligence; Singapore Ministry of Health; Jersey H&SSD data; KPMG analysis.

Whilst the length of stay for general surgery is shorter in Jersey, this may reflect the casemix of procedures carried out in comparison to UK peers. One reason why the casemix may differ is because the more complex and by implication, longer stay cases are transferred off island. In addition, in England there has been an increase in minor procedures carried out in the community, which in Jersey may still be performed in hospital.

### Length of stay – Obstetrics

The length of stay for obstetrics appears particularly higher in Jersey at 3.1 days compared to each of its peer groups.

Figure 20: Length of Stay, Obstetrics



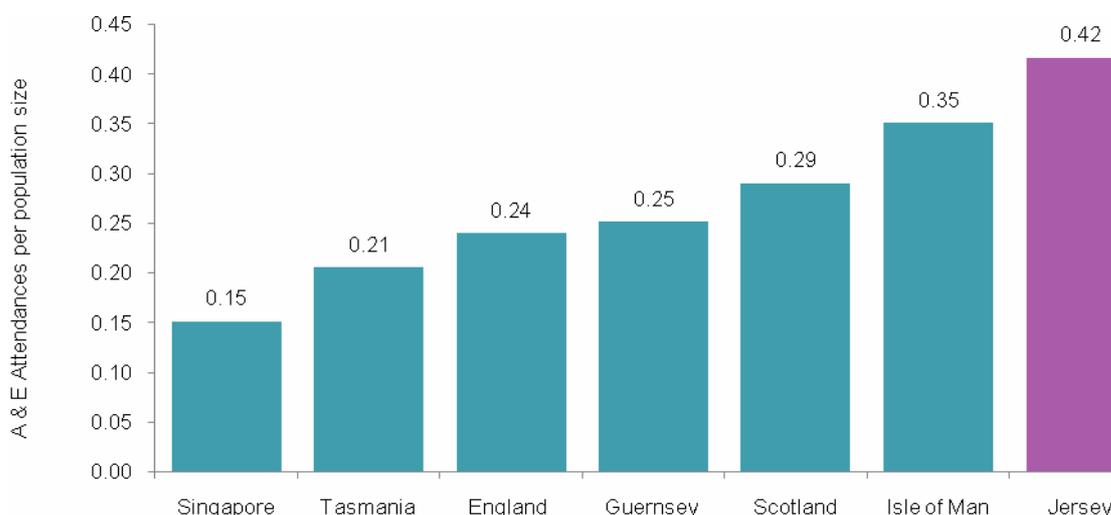
Source: Dr Foster Intelligence, ISD Scotland; Health Stats Wales; Guernsey HSS Intelligence; Singapore Ministry of Health; Jersey H&SSD data; KPMG analysis.

The current provision of maternity services in Jersey is delivered on a hospital based service model as opposed to a community led service, which also explains the higher length of stay compared to its peers. Offering choice of place of birth, including more care in the home and increased access to midwifery led care, may lead to a reduction in lengths of stay and number of beds required as low risk women are seen more at home.

### Use of Accident and Emergency Service

A&E usage in Jersey is relatively high at 0.42 attendances per annum per population, in comparison to its peers where national averages for both England and Scotland is estimated at 0.24 and 0.29 respectively.

Figure 21: Use of Accident and Emergency Service



Source: Guernsey HSS Business Intelligence; Tasmania Health & Human Services; Isle of Man (Noble Hospital data 2009); Jersey H&SSD data; KPMG analysis.

The high number of A&E attendances is likely to be driven by the primary care co-payment model, compared to the UK model which provides free (at the point of delivery) primary and secondary care. It may also be explained by the minor injuries units which exist in England and Scotland to reduce the number of A&E attendances. Cultural patterns may also impact, for example the Portuguese and Polish population are more used to going directly to hospital than using primary care.

### Theatres

In 2010 elective theatre utilisation was 90% (utilisation is defined as full usage of time available, ie after cancellations and any time wastage between sessions, or due to short sessions etc). If booked time were measured then the figure runs at 98%. The Audit Commission recommends maximum theatre utilisation to be 90%<sup>5</sup>, taking account of cancellations and required downtime. Under this assumption, and using projected demand, theatre capacity at Jersey General Hospital is already being exceeded.

<sup>5</sup> Audit Commission, Acute Hospital Portfolio, Operating Theatres

#### 4.2.3.2 Future need

Despite the population increasing by 9%, inpatient spells are projected to increase by 33%:

Figure 22: Acute activity projections

Activity over time	2010	2020	2030	2040
In patient spells	29,577	33,415	37,400	39,576
Outpatient appointments	136,720	145,852	155,060	159,156
A&E attendances	37,468	39,234	41,109	42,565
<b>Total</b>	<b>203,765</b>	<b>218,502</b>	<b>233,569</b>	<b>241,297</b>

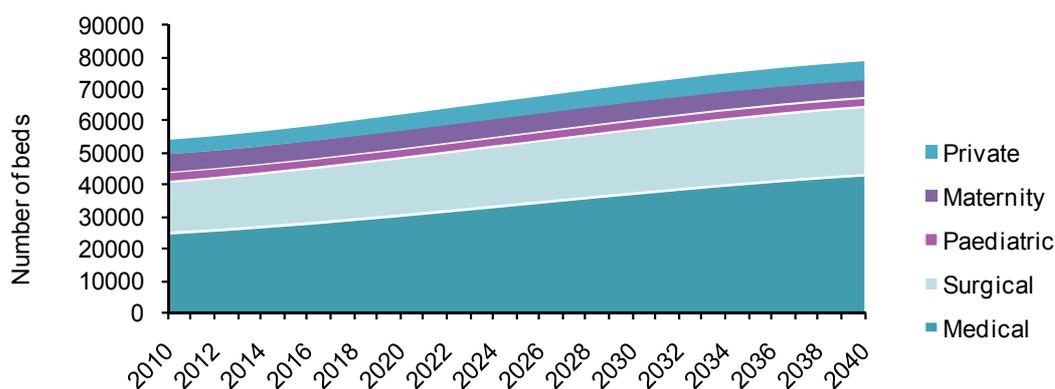
Source: Jersey modelling tool outputs, 2011

This increase in activity leads to a more significant increase in the requirement for hospital beds. The most significant requirement is an increase in medical beds (25% by 2020 and 72% by 2040) and although this is offset by flat or slightly falling demand in paediatrics and maternity, the overall impact still approaches 50% by 2040.

Figure 23: Acute activity projections

Number of bed days by type	2010	2020	2030	2040
Medical	25,201	30,681	37,429	43,221
Surgical	15,874	17,902	19,942	21,309
Paediatric	3,110	2,876	2,903	2,872
Maternity	5,524	5,624	5,712	5,551
Private	4,522	5,063	5,635	6,026
<b>Total</b>	<b>54,231</b>	<b>62,146</b>	<b>71,621</b>	<b>78,979</b>

Figure24: Number of bed days by type



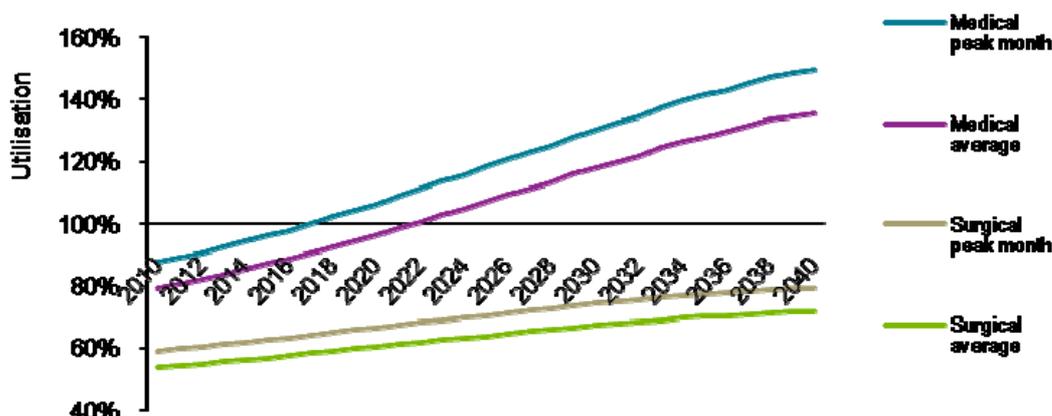
Source: Jersey modelling tool outputs, 2011.

Current capacity is inadequate to meet this demand. Under this model, utilisation in the busiest month would exceed 100% by 2017 and in an average month by 2022. This would suggest significant

numbers of untreated acute patients from the 2020s, and in practice to significantly extended waiting times.

In reality problems would be seen much sooner, due to fluctuations in requirements and the inefficiencies of operating with near 100% utilisation. Surgical bed capacity remains reasonably static, but would not be sufficient to accommodate increases in medical demand.

Figure 25: Acute bed utilisation if no bed investment



Source: Jersey modelling tool outputs, 2011.

## 4.2.4 Older Adults

### 4.2.4.1 Current services

As at 31 Dec 2010:

- the Island's population of Older Adults was 14,797
- HSSD expenditure on Older Adults was more than £10m

Services to older adults include home care, district nursing, respite care, various day services, residential and nursing home care, assistance for those with sensory impairments, and mental health (particularly dementia)

#### *Support to independent living*

Help at home is currently available to support independent living. This includes home care to support basic needs such as shopping, laundry and meal preparation through to more clinical needs provided by district nursing.

Benchmarking indicates that Jersey has a relatively low number of registered community nursing staff (including registered health visitors, district nurses and other community nursing staff) - 52 per 100,000 population compared with an English peer group average of 115.

In general the level of support to people in their own homes is low in Jersey.

#### *Family Nursing and Home Care*

FNHC provides services in the community for family health, chronic disease management, and long term care provision. It aims to support as many people as possible within the home but has no access

to enabling technologies such as telehealth or to adaptations to modify the home. It has an income of just over £7 million, some 85% of which is derived from a States grant, and the remainder from charitable organisations and a membership subscription service.

Overall the States provide almost £8m in grants to the third sector, although this sum covers children, younger adults and older adults.

### Nursing and Residential Care

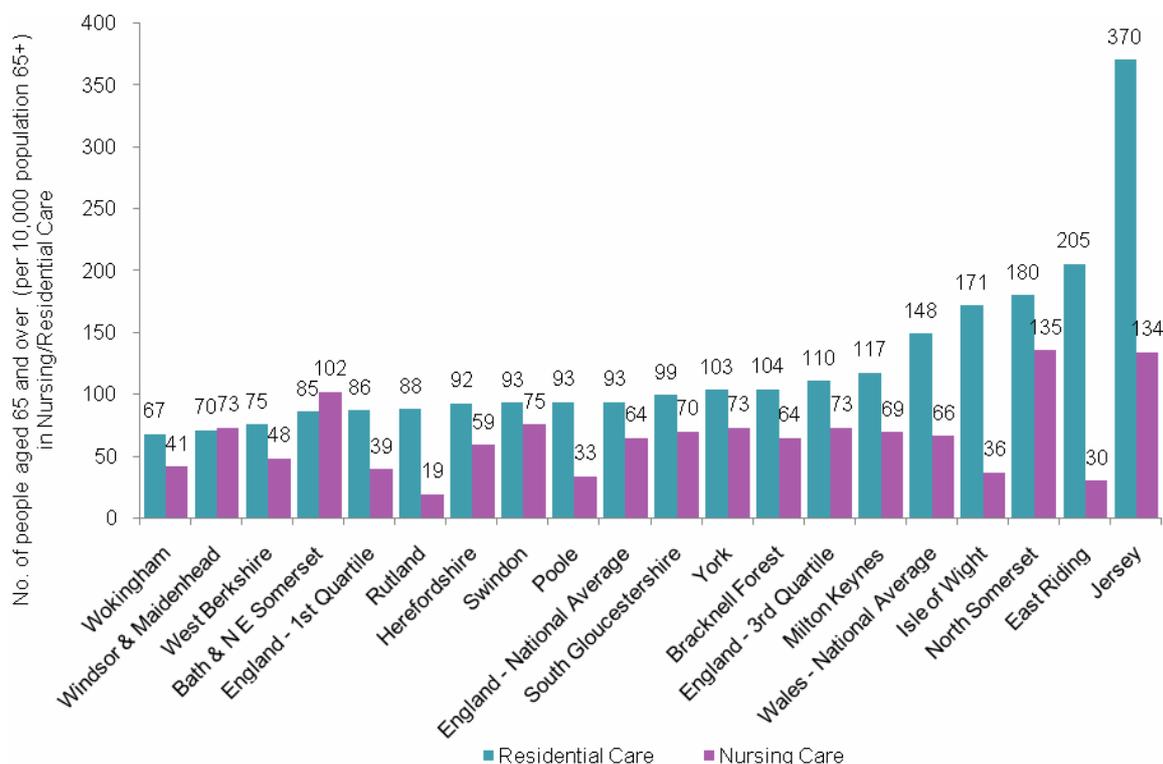
Jersey has a relatively high proportion of older adults in care homes, more than double the rate of UK comparators. This high rate reflects anecdotal evidence from interviews with staff, which indicated that a combination of relatively low levels of dependency at the point at which self funding people access residential care, and the lack of available intermediate care services and 24 hour support when people are discharged from hospital, contribute to high care home usage. In addition, since 2008 a 'placement tool' has been applied, which assesses eligibility for States funded residential care. However, current residents are not reassessed for continued eligibility

Having a large percentage of people in facility based care increases both dependence on care services and the speed of deterioration.

Currently on the island there are:

- 646 residential care beds for older people (increases to 859 when include physical, learning or mental disability for under 65)
- 240 nursing home beds

Figure 76: Number of people 65 and over in Residential and Nursing care (per 10,000 population)



Source: NHS Information Centre; Jersey H&SSD data; KPMG Analysis.

As at December 2010<sup>6</sup> the States accessed approximately 40% of the available nursing beds on the island:

Figure 27: Nursing bed utilisation

States Homes	Beds
Limes	36
Sandybrook	28
<b>Total</b>	<b>64</b>

Nursing Beds (2010)	Available	States funded (contracted)	States funded (spot purchased) Updated
Palm Springs	25	4	12
Guardian	29		6 Now closed
Little Grove	33		1 No longer routinely purchased
Clifton	34		11 Arrangement changed
Lakeside	39	5	9
Silver Springs	37	30	
L'Hermitage	25	5	7
La Haule	5		1
<b>Total</b>	<b>227<sup>7</sup></b>	<b>44</b>	<b>47</b>

There is currently a waiting list for States- funded access to nursing home and mental health inpatient beds. In 2010, 180 patients were entered onto the long term nursing bed waiting list. Of these, 28 went to residential care, 10 were removed from the list, and 6 went to the elderly mentally infirm ward (EMI) and 98 to a nursing bed. Of this number 38 patients died whilst awaiting a bed.

The average waiting time for a nursing home bed was 45 days<sup>8</sup> for residential care and 26 days for a mental health assessment/ continuing care bed. The majority of patients / service users wait in the hospital<sup>9</sup> and therefore, delays or reduction in capacity for speedy access to nursing beds has an impact on the remainder of the health system.

Managing this situation may be compounded by the disparate IT infrastructure, whereby information is currently maintained in silo environments and access to management information is limited. The initial phase of the ICR programme did not include social care and still remain outside of this system. This situation creates challenges in service coordination and provision.

The States is making increasing use of private and third sector provision, and a high proportion of these spaces are spot purchased rather than being based on longer term contractual arrangements.

<sup>6</sup> Guardian has since closed reducing capacity by 29 beds. Does not include St Ewolds with 5 Nursing Home beds or Jeanne Jugan with 10 beds – total as at February 2011, 219 beds

<sup>7</sup> See note re the impact of the Guardian closure

<sup>8</sup> 2010 referrals for Long Stay Nursing Beds; spreadsheet supplied by H&SSD

<sup>9</sup> 2010 referrals for Long Stay Nursing Beds; spreadsheet supplied by H&SSD

### *End of life care*

In their end of life phase older adults often have several admissions to hospital and/or a long spell in an acute setting. The Hospital Medical Director's professional judgement is that around 70% of older adults who are admitted to hospital, and who then die more than two weeks later, could have benefitted from an end of life care pathway.

### *Third sector*

263 charities are registered in Jersey. 75 organisations focus on different aspects of health and social care, providing information, guidance and support to patients, service users and carers. There are varying levels of grant provided to the third sector such as £14k for Jersey Alzheimer's Society, £677k for Shelter and almost £6m<sup>10</sup> for Family Nursing and Home Care.

Dementia affects one in 14 people over the age of 65 and one in six over the age of 80. Currently in Jersey, this equates to almost 1,800 people. By 2020, this rises to almost 2,500. The Jersey Alzheimer's Association would continue to provide a range of services to support to those affected with dementia. 20 people per week use this service due to capacity constraints.

Community support groups exist in some Parishes. These comprise registered volunteers, and provide support to enable individuals to live more independently. Despite offering a quality service for a proportion of the population, other parts of the island population are unable to access this support or equivalent creating an inequity across Jersey.

### *Information technology*

One challenge facing the States is that personal data relating to health and wellbeing is held in separate places - PAS for acute, Softbox for Social Care and FACE for Mental Health – with the result that it inhibits the co-ordination of services

Managing this situation may be compounded by the disparate IT infrastructure, whereby information is currently maintained in silo environments and access to management information is limited. This situation creates challenges in service coordination and provision.

#### **4.2.4.2 Future need**

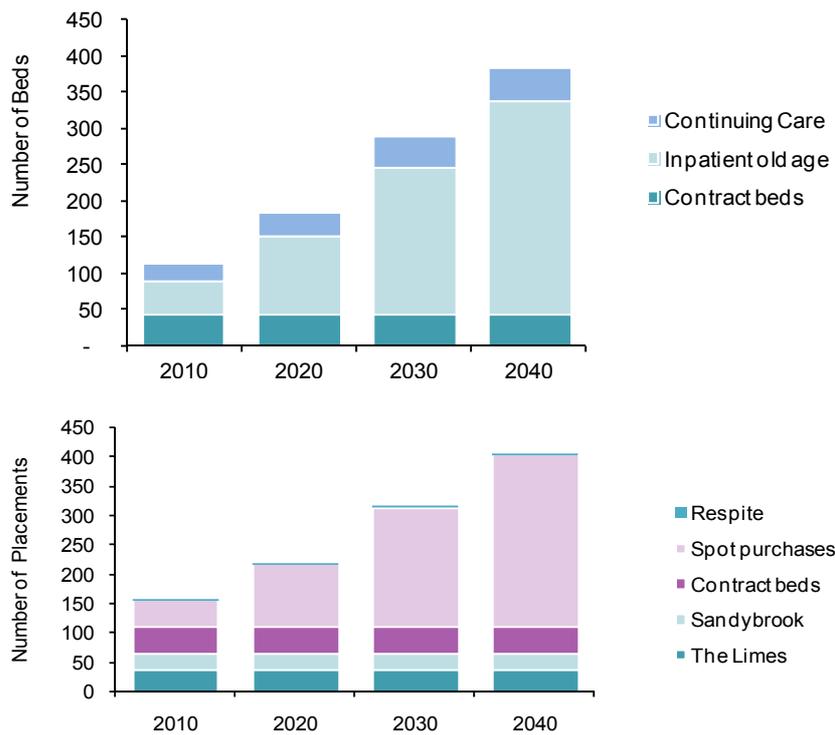
As of 2020:

- the population growth for Older Adults is projected to increase by 35% to almost 20,000
- the HSSD annual resource cost for Older Adults is projected to be more than £16m

The requirement for older people's social care beds is projected to increase from 114 beds in 2010 to more than 180 beds in 2020, and more than 380 beds in 2040.

<sup>10</sup> HSSD General Ledger December 2010

Figure 28: Number of beds required for older people



Source: Jersey modelling tool outputs, 2011

## 4.2.5 Younger Adults Social Care and Mental Health

### 4.2.5.1 Current services

The current model of care for Younger Adults (aged 18 to 64 years) both within social services and mental health is predominantly States provided, with service provision determined by the professional involved with each service user's care. Although third sector and private provision is available, this is focused on cases of low complexity and need, and therefore a wide range of choices are not available for many service users.

In England, mental health care accounts for approximately 11% of a PCT budget<sup>11</sup>. In Jersey mental health care accounts for 8% of HSSD's net expenditure (£14.2m of £170.5m in 2010)<sup>12</sup>. The 2009 Jersey Annual Social Survey reported that 15% of Jersey adults suffered from depression or anxiety<sup>13</sup>. This is consistent with the prevalence in Great Britain, where the World Health Organisation reported that 1 in 6 of the population suffered from depression or anxiety in 2000.<sup>14</sup>

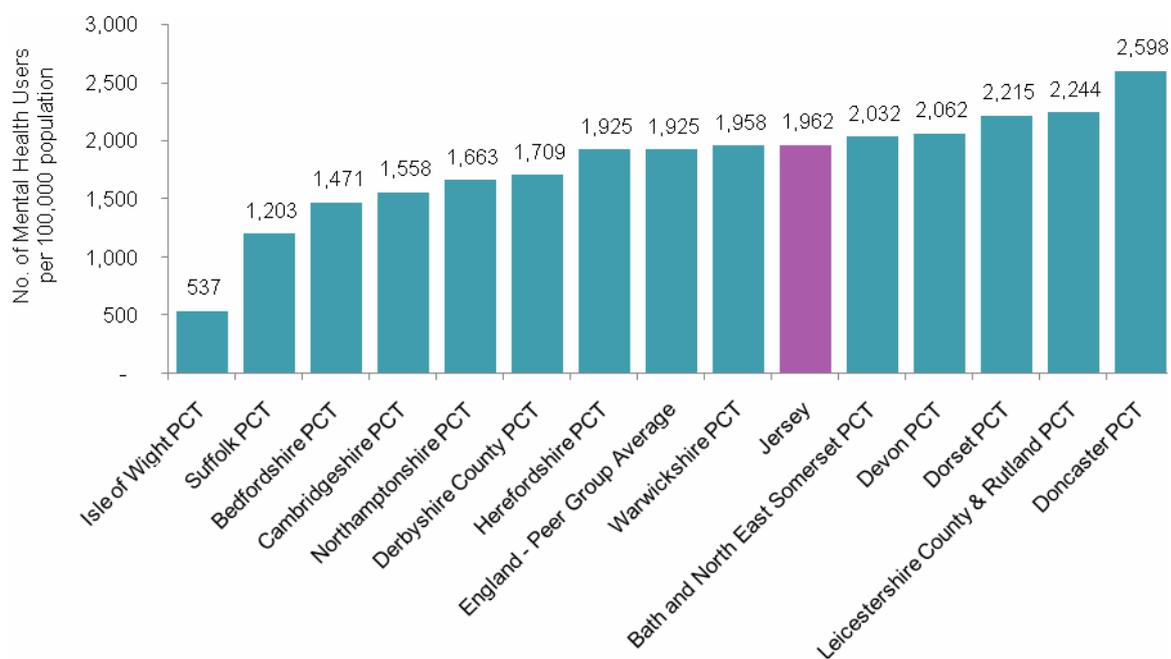
<sup>11</sup> Department of Health Programme Budgets, 2009/10

<sup>12</sup> Health and Social Services Department General Ledger 2010

<sup>13</sup> Health and Social Services, Jersey Annual Social Survey, States of Jersey Statistics Unit, 2009

<sup>14</sup> World Health Organisation; 2000

Figure 89: Number of Mental Health Users per 100,000 population



Source: NHS Information centre 09/10; Jersey H&SSD data; KPMG analysis.

Service provisions in 2010 were:

- *Acute Liaison Team* – based in the hospital, assesses patients presenting at A&E – 415 referrals p.a
- *Active Recovery Team* – has a caseload of patients in the community as well as in the inpatient unit – caseload of c370 people
- *Orchard House* – an inpatient unit of 17 beds
- *Clairvale Road* – a step down unit of 10 beds which is staffed as residential unit
- *Maison du Lac* – residential care of 10 beds for long term patients
- *Drug and Alcohol Service* – community based service currently with a referral rate of approximately 650 per year
- *Psychological Therapy service* – outpatient at Overdale with a referral rate of approximately 750 per year

Due to 2010 being an anomaly year for inpatient activity with very low occupancy rates (43% average), it was agreed with the Community and Social Services Management Team that 2009 data would be used.

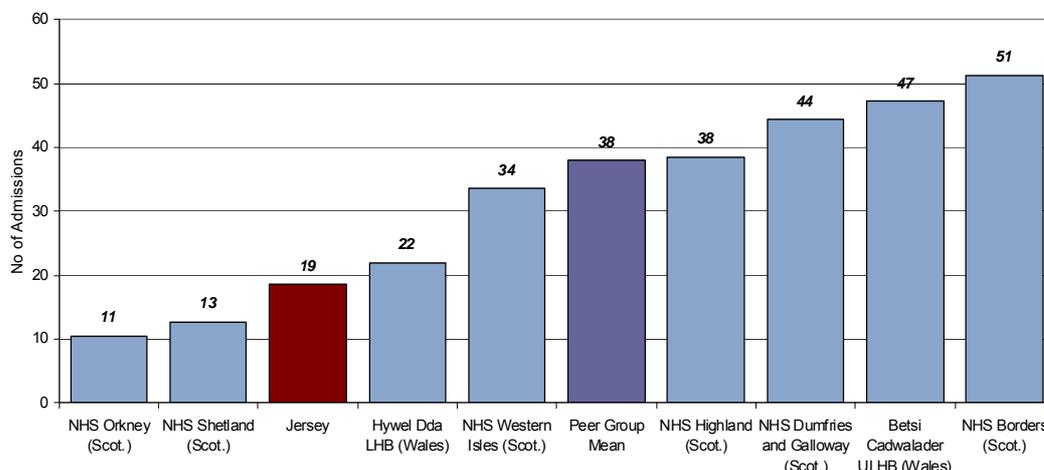
In 2009 the average occupancy rate was almost 60%. This indicates that the average number of beds required in 2009 was as follows:

- Orchard House – 10 (capacity 17 beds)
- Clairvale Road – 8 (capacity 10 beds)
- Maison du Lac – 9 (capacity 10 beds)

However, it should be noted that fluctuations in occupancy rate mean that at times occupancy is over 100%.

The number of adult and older adults inpatient admissions in Jersey were 30 per 100,000 population. This is high for the peer group (who have an average of 21 admissions per 100,000).

Figure 30: All (adult and old age) Inpatient Admissions per 10,000 population



Source: StatsWales; ISD Scotland; Jersey H&SSD data; KPMG Analysis.

The admissions per 100,000 above include both adult and older adult. Older adults have a more inpatient based model and a higher proportion of continuing care beds, with a greater demand placed on the service.

In 2009, 40 younger adult patients were detained under the Mental Health Act in Jersey (rising to 41 in 2010).<sup>15</sup> Most were detained on the mental health inpatient ward of Orchard House, which is a refurbished, rather than a purpose built unit. Orchard House is subject to fluctuations in occupancy which are challenging to predict.

Implementing legislative changes regarding mentally disordered offenders from 2012 would currently be challenging on Jersey as there is currently no designated secure facility available.

Mental health services have progressed moving care into the community. This presents associated challenges in terms of the level of risk borne in the community. Although services for mental health are fairly well provided once a service user become unwell, the level of service provision available for mild to moderate conditions appears to be fairly low as services are mainly provided within primary care and are not universally accessed.

Mental health services are delivered in a 'tiered model'. The prevalence of Tier 3 mental ill health, at 15% of the population,<sup>16</sup> is lower than that of mild to moderate symptoms (Tiers 1 and 2). However, at present the majority of Jersey's current service provision is secondary care, Tier 3 services for patients with severe and enduring mental illness. GPs provide care but there is a high level of

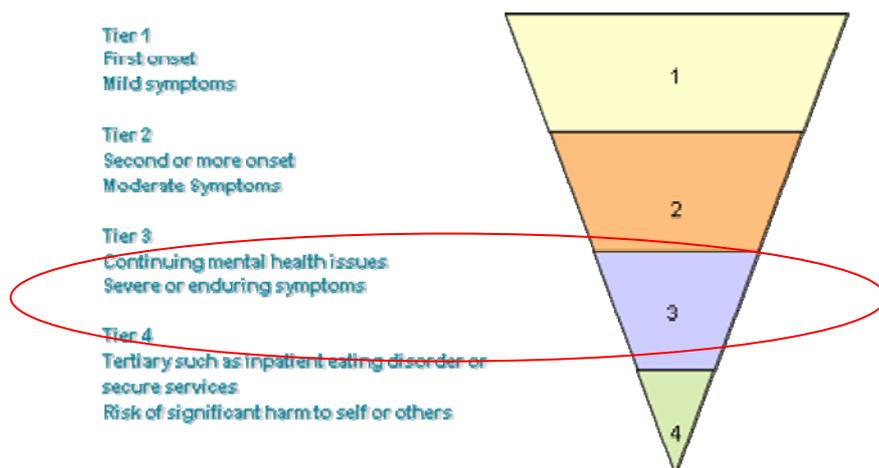
<sup>15</sup> Jersey Mental Health Data supplied from HSSD

<sup>16</sup> Jersey Annual Social Survey, States of Jersey 2009, HSSD

prescribing particularly for benzodiazepines, hypnotics and antidepressants which generated a cost of £450,000 to the States in 2009.<sup>17</sup>

Tier 4, for patients requiring secure mental health care (particularly those detained under an Article of the Mental Health Act) is mostly provided off island, or on occasion in the acute inpatient unit determined on a case by case basis.

Figure 31: Tiers of mental health need



#### Adult social care

Jersey has by far the largest number of adult referrals from the source of secondary care. Jersey receives 35% from secondary care a whole 5% more than the next nearest outlier.

Figure 32: Adult Referrals (aged 18+) by Source



<sup>17</sup> Jersey Annual Social Survey, States of Jersey 2009, HSSD quoted in *Strategic Plan 2009-2014*. States of Jersey.

## Special Needs

The Special Needs service delivers care through a range of services including day centres, residential, respite and community based.

The current service includes tailored care packages for individuals in the community, day centre, respite and residential care:

Figure 33: Special Needs service users

Special Needs Service	Service users in 2010 <sup>18</sup>
Day service	80
Residential service	128
Supported in the community	60
<b>Total</b>	<b>268</b>

The principle for the service has been to enable service users to live in the community as far as possible and provide the right level of service support to the individuals.

### 4.2.5.2 Future need

As the population ages, the demand for younger adult mental health beds is projected to reduce by 2020, However, it is noted that fluctuations in demand are hard to predict and that there can sometimes be up to 19 patients (including weekend leave) in the current 17-bedded inpatient unit.

Figure 34: Younger adult mental health future need

Number of beds required for Adults	2010	2020	2030	2040
Acute inpatients service	10	10	9	9
Maison du lac	9	9	8	8
Clairvale Road	8	8	8	7
<b>Total</b>	<b>27</b>	<b>27</b>	<b>25</b>	<b>24</b>

Social work referrals are projected to reduce from almost 888 p.a in 2010 to just over 800 p.a in 2020, and the number of Special Needs service users is projected to reduce from 268 in 2010 to almost 250 in 2020.

## 4.2.6 The Child

### 4.2.6.1 Current services

Children and families health and wellbeing on the island is provided through a multitude of agencies and organisations; health, social care, GPs, third sector, education, housing and the police.

<sup>18</sup> HSSD Special Needs data provided from Mental Health and Social Care service

The children's department offers a range of services<sup>19</sup> in a multi-disciplinary environment including:

- Assessment and child protection team
- Child care team
- Home finding team including fostering and adoption
- Residential services
- Family centre and family support services

The ethos of the children's department is to *"aim to promote safeguarding and improve the wellbeing of all children and their families in Jersey.... a multi-disciplinary approach that utilises the expertise of a range of individuals and agencies is used to achieve these aims."*<sup>20</sup>

In addition to service provided by the children's department, services for children are provided within the acute hospital:

- Midwifery
- Paediatrics
- Maternity
- Assessment and Child Protection
- Community and Support Teams
- Complex Needs and Disabilities
- Leaving Care
- Fostering and Adoption
- Respite
- Secure Provision
- Intensive Support Services

As of 2010:

- The population of children on the island was more than 19,000<sup>21</sup>
- The current resource for Children social care was almost £11m p.a

The rate of referral per 10,000 children (0 to 17 year olds) in Jersey in 2010 was 651 per annum. Jersey referral rates appear low when compared to Welsh comparator authorities who's average is 707. However, the referral rates appear significantly higher when compared to England, exceeded by only one of the comparative authorities and 70% higher than the average for the 15 English authorities.

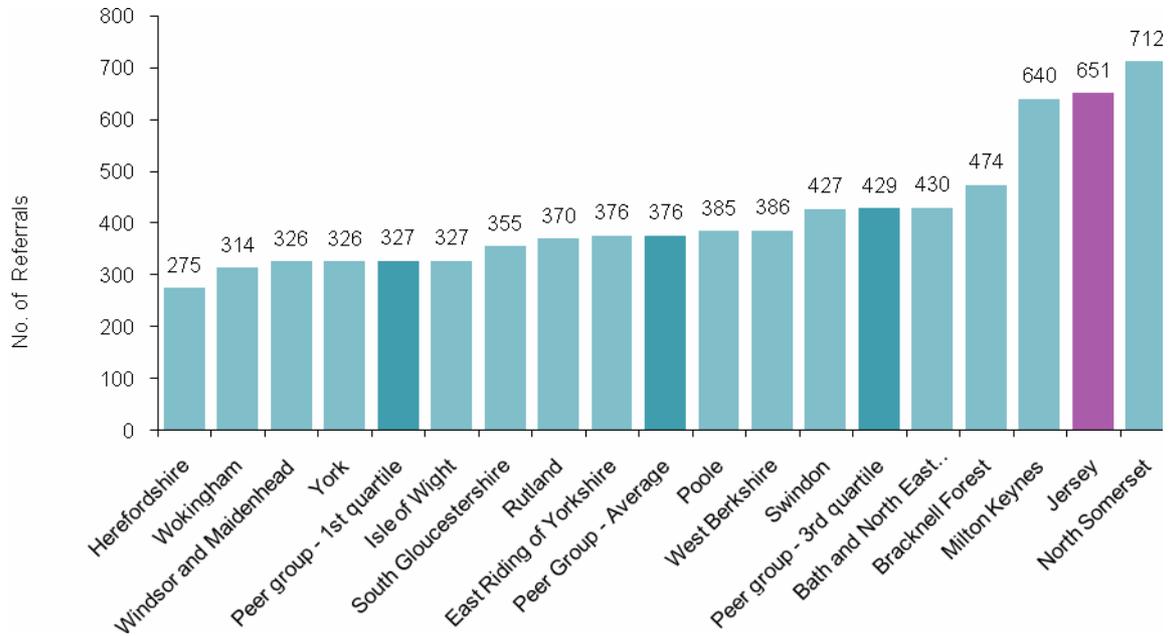
<sup>19</sup> Reference taken from States of Jersey website, Children and Childcare - <http://www.gov.je/Caring/Children/Pages/default.aspx> accessed 21 April 2011

<sup>20</sup> Reference taken from States of Jersey website, Children and Childcare - <http://www.gov.je/Caring/Children/Pages/default.aspx> accessed 21 April 2011

<sup>21</sup> Based on the Jersey Roadmap Model

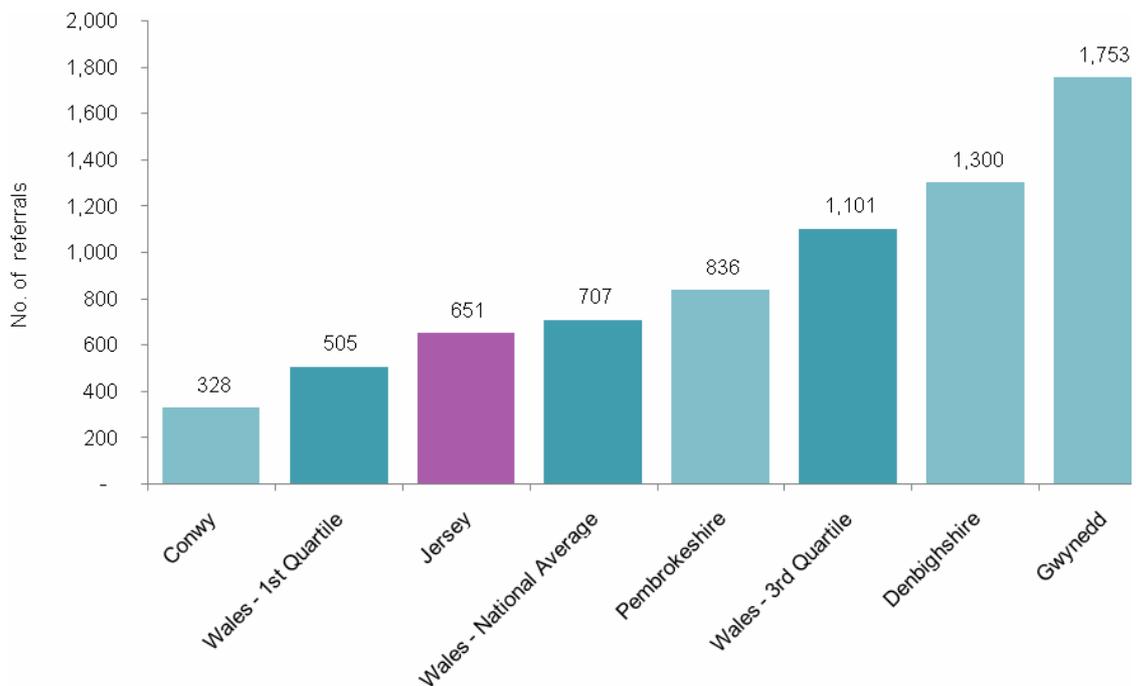
Anecdotal evidence from the Referral and Thresholds project indicates that such high referral rates (inflated by risk mitigating behaviour of partner organisations such as the police) combined with lower thresholds has led to a larger than necessary 'children in need' number.

Figure 35: Children's Referral Rates per 10,000 (0 to 17yr olds) - England



Source: DCSF; Jersey H&SSD data; KPMG Analysis.

Figure 36: Children's Referral Rates per 10,000 (0 to 17yr olds) - Wales



Source: Stats Wales; Jersey H&SSD data; KPMG Analysis.

Referral rates are driven by two overriding factors; demographic need and partner awareness. The impact of investment in training with partner authorities may have resulted in Jersey Social Services becoming overly aware of situations involving children and hence, very risk averse. Typically in Jersey, any police incident which involves a child is automatically referred to Children' Services, via an informal unstructured referral from the police.

### *Children looked after*

A disproportionately large number of children are placed in facility based care as opposed to foster care (almost 20% more than UK comparators)<sup>22</sup>.

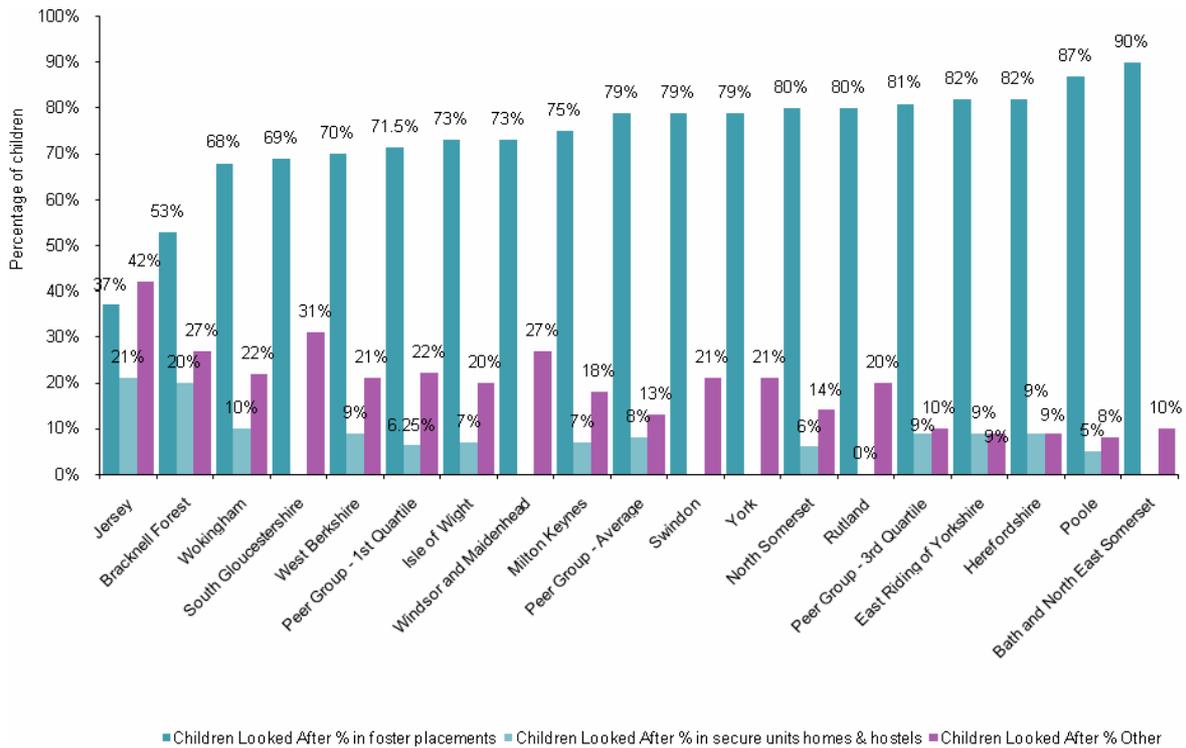
Only 37% of Children looked after in Jersey are in foster placements compared with typically 80% in England and Wales, although this is substituted by a large number of special guardianships and kinship placements. Factoring in this number this takes the comparison figure to 70% which is still 10% below the UK average.

It is acknowledged that an island presents limitations to the supply pool of internal fostering and adoption families and the high cost of living puts more pressure on this pool. Also, Jersey has 20% of it's Looked After Children in secure homes or hostels, 17% higher than Welsh national average of 3% and more than twice the English average of 8%.

It is also acknowledged that many of the children who could and should be cared for by fosterers and adopters are in residential care due to an inability to grow the fostering and adoption pool further. This may partly be caused by the fact that many potential foster carers are in full time employment.

<sup>22</sup> Jersey Benchmarking Study

Figure 37: Placements of Looked After Children



Source: DCSF; Jersey H&SSD data; KPMG Analysis

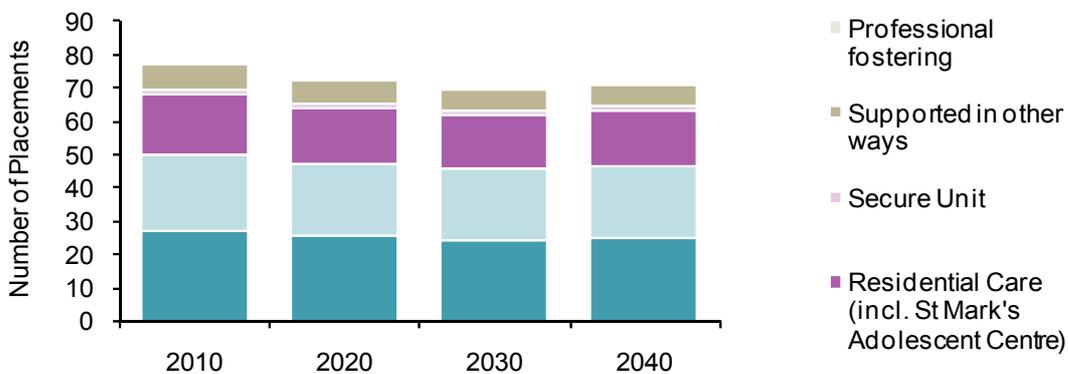
A Children’s Plan is currently being created. The Child working group (comprising representation from health, social care, the third sector and mental health) noted the development as very positive. However, their view was that the plan would be “as-is”, rather than a progressive strategy to integrate services at a strategic level across partners and coordinate the delivery of health and wellbeing to the child and family.

4.2.6.2 Future need

As at 2020:

- The population of children on the island is projected to decrease to just over 18,000
- Accordingly, the resource cost for Children’s social care is projected to decrease to just over £600k

Figure 38: Looked after children



Source: Jersey modelling tool outputs, 2011

### 4.3 Financial Impact

Undertaking these levels of activity within the current service model would lead to a major increase in health and social care costs. The States of Jersey health and social security budget is projected to require an increase of 76% between 2010 and 2040.

Figure 39: Projected total expenditure, 2010 - 2040

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
<b>Total Spend</b>	<b>£ 238,701</b>	<b>£ 296,184</b>	<b>£ 362,246</b>	<b>£ 428,793</b>

Figure 40: Projected total expenditure

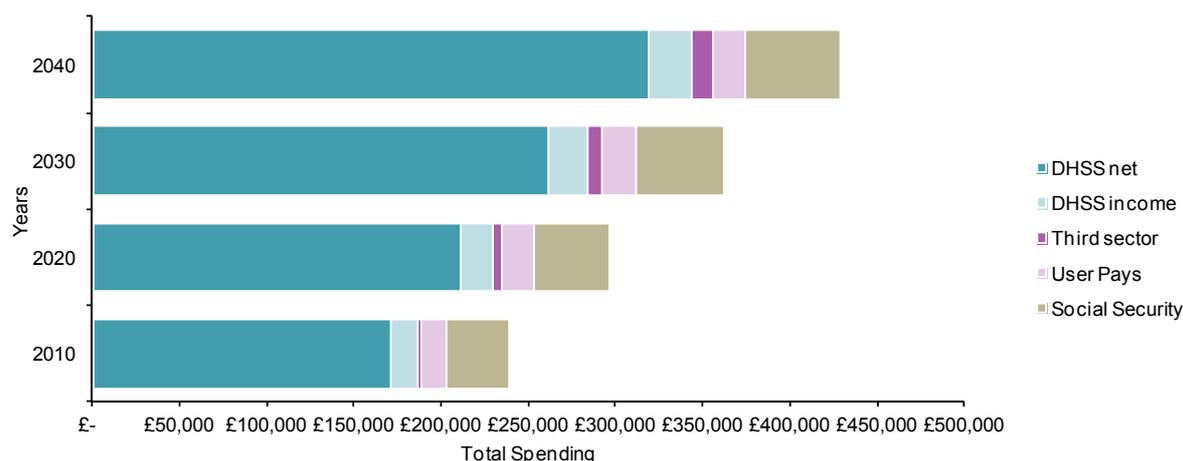
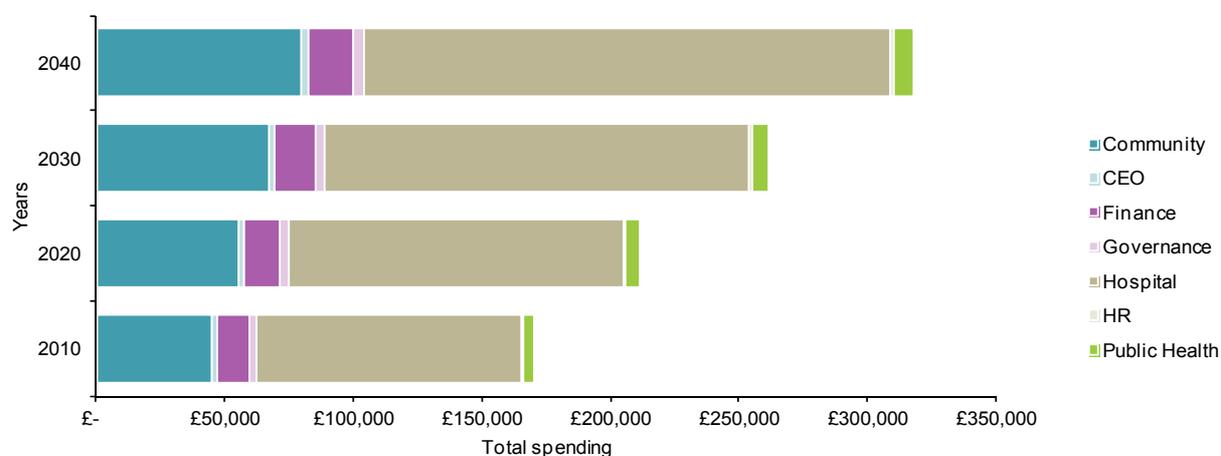


Figure 41: HSSD spend

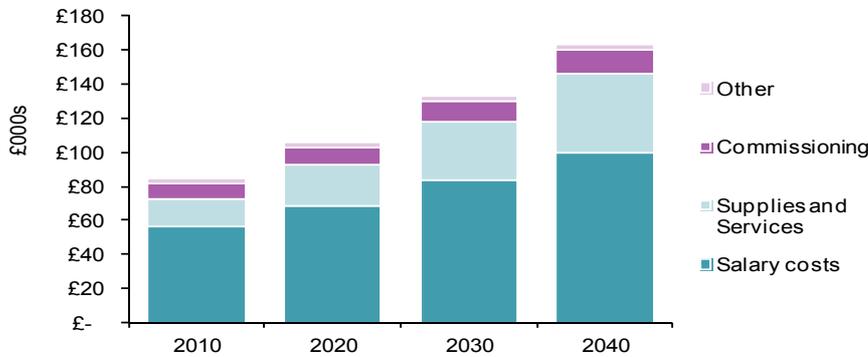


Source: Jersey modelling tool outputs, 2011.

### Acute spend

The overall projected increase in acute costs is driven by increases in salary costs, commissioning costs for off island care and supplies and services costs.

Figure 42: Projected acute spend

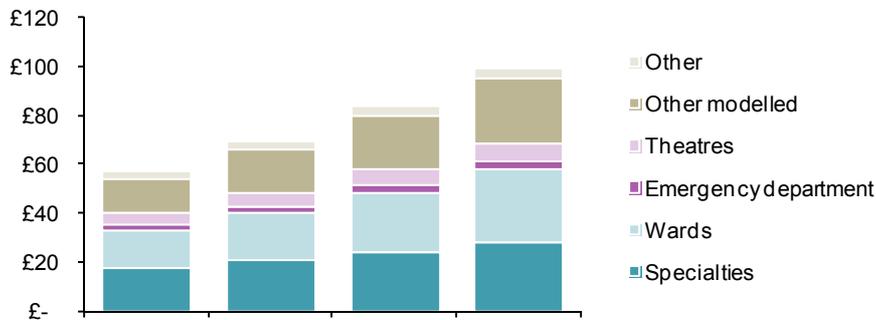


Source: Jersey modelling tool outputs, 2011.

### Salary costs

Salary costs are projected to increase significantly, driven both by above inflation salary cost pressures and changes in activity levels, particularly for those services which cater for the over 65s, which lead to requirements for substantially larger staff numbers. The biggest change is projected in ward costs and specifically in medical wards, which increase to about two and a half times their current cost.

Figure 43: Projected staff cost increases (£'m)

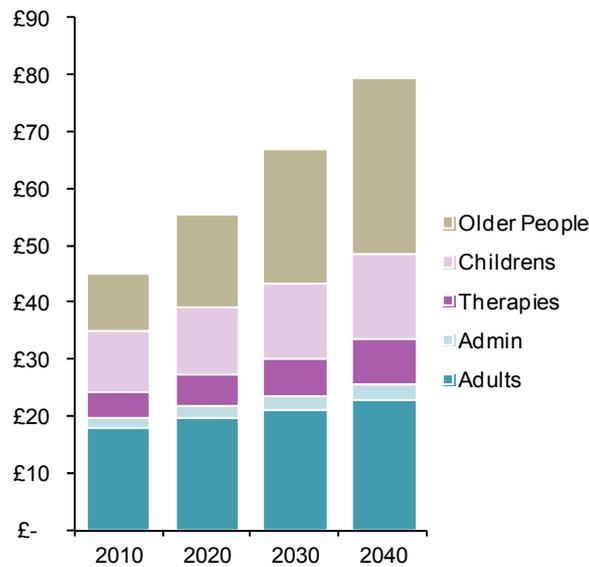


Increases in specialty costs are projected to vary by specialty, with the highest percentage increases in specialties associated with elderly medicine, such as general medicine (94%) and urology (112%); oncology also sees a significant increase (84%).

### Community and social care

Community and social care spend is projected to increase by 76% by 2040. This increase is led by the costs of caring for older people, which is set to rise by 206%.

Figure 44: Projected staff cost increases (£'m)



Source: Jersey modelling tool outputs, 2011

## 4.4 Views from stakeholder interviews

The views identified from the interviews are not unique to Jersey. Most health and social care economies struggle with similar challenges. However, the more remote the population, the more exacerbated such challenges become as there is limited scope for accessing resources in neighbouring economies.

Themes from stakeholder interviews are:

- The development of an overall strategic plan as an overarching context for the development of the above is essential. This should address any changes required in the structure of services and relationships between them, as well as future funding mechanism to ensure the changes in service provision required will be delivered
- There is a groundswell of appetite for change
- Considerable scope exists for improvement in the coordination, collaboration and communication between different services and service providers
- Some gaps in service provision exist
- Elements of the operational infrastructure would benefit from strengthening. This includes improved mechanisms for data collection and distribution, recruitment and retention of key staff, and improvement and better use of estate

A full summary of the interviews undertaken and the information collated is in Appendix 2.

## 5 Towards a new model of care

This chapter describes the considerations which have guided our work to assess the appropriateness of various options for the future model of health and social care for Jersey. The “strategic imperatives” and “strategic vision principles” were agreed with key stakeholders in Jersey:

### 5.1 Strategic imperatives

Above all, Jersey’s health and social care system must be safe, sustainable and affordable:

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

### 5.2 Strategic Vision Principles

These principles reflect the essential criteria for any future service model, as viewed by staff and stakeholders. In addition, they help in articulating the challenge HSSD faces and act as a reference point for decision making purposes. The eight strategic vision principles are:

2. Create a sustainable service model:
  - Efficiency across health, community, social care and third sector
  - Create an effective service configuration and workforce profile
  - Clarity of access, with consistent assessment thresholds to ensure equality
  - Engage the public in healthy lifestyles and self-management
7. Ensure clinical/service viability – overcome the challenges of low patient volumes, so that:
  - Clinical risk is mitigated
  - High quality care is delivered
8. Ensure financial viability – reduce the impact of diseconomies of scale:
  - Understand the ‘island’ premium and the costs of off-island delivery
  - Robust procurement and contract performance management to drive improved value from suppliers
  - Availability of data to assess value for money
9. How should we fund health and social care?
  - Establish a funding and charging model that meets economic requirements
  - Incentivise care in the right place at the right time
  - Remove political/funding structures that discourage co-operation

## 10. Optimising estate utilisation

- Ensure estate resources are utilised to maximum efficiency
- Ensure the estate is fit for purpose

## 11. Workforce utilisation and development

- Create a consistent organisational infrastructure
- Utilise the workforce to the extent of their abilities
- Support staff in developing and achieving their full potential

## 12. Clinical governance

- Sustain a culture of safety, learning and transparency

## 13. Use of business intelligence

- Collate and analyse robust data to support decision making based on fact
- Include patients and the public in service design and decision making

## 5.3 Service principles and assertions

A series of principles and assertions have been developed through discussions with stakeholders, underpinned by analysis and modelling:

### 5.3.1 Self care

- Self care is a way of promoting healthier lifestyles and behaviours and creating an environment which makes healthy lifestyles easier; supported by a strengthened personal responsibility, it can ultimately support delays in the progression of health and social care needs and improve the individual's health, wellbeing, independence and quality of life
- A 2008 US study, Prevention for a Healthier America<sup>(a)</sup>, concluded that for every US\$1 invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels), the return on investment over and above the cost of the program would be US\$5.60 within five years
- People with long term conditions live better lives when they are supported to take care of their conditions themselves. This can lead to improved quality of life, wellbeing, confidence and self esteem
- Self care is not just about a change in service provision, but about a cultural change, allowing patients to be partners in their care, letting them decide what support they need, when they need it and how – giving people more control and choice and enabling them to live independent and productive lives

### 5.3.2 Primary care

- The definition of primary care in the public's mind needs to be developed beyond simply those services provided by a GP, to encompass all care professionals working on the front line of service

<sup>(a)</sup> Trust for America's Health, Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities. 2008, Trust for America's Health (<http://healthyamericans.org/reports/prevention08/>).

delivery in the community. This incorporates both the prevention and treatment of disease and the promotion of wellbeing and independence

- Effective, enhanced primary care services are dependent on all professionals being willing to accept new models of collaborative working, with clearly defined and safe care pathways and a distribution of responsibilities between primary, secondary, mental health, social care and third sector services – and the patient, service user and carer
- Existing financial incentives and funding mechanisms can be flexed and used imaginatively to accommodate new patient flows and the roles of different care professionals. This would support equality of access and encourage patients / service users and professionals to seek and provide effective care, provided in the most appropriate place by the most appropriate professional

### *Acute care*

- The use of the current assets and resources needs to be optimised as far as possible to deliver high quality care to the population of Jersey
- Expanded roles can to be developed to enhance the service delivery model, as demonstrated elsewhere in the world such as New Zealand (Nurse Practitioners), England (Extended Scope Practitioners) and Guernsey (GP cover in A&E) and to include prescribing roles for non-medical staff through legislative change
- A range of options along a continuum can be explored, from supporting a strategy of decommissioning procedures deemed to be of limited clinical value through to expanding the use of the hospital to optimise the quality of service provision delivered on island
- Specialist and complex activity should continue to be delivered off island where clinically and economically justified

### *Social Care and Mental Health*

- Social care and health should be integrated as seamlessly as possible on a service user's life journey, with teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff working together, working with the third sector and private sector providers
- Integration would be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and ensures that needs drive services and not the reverse, to improve social and health wellbeing
- Single, integrated care pathways, single assessment and a move towards personalisation and needs driven individual budgets would provide choice and empowerment. This would address the needs of the family, especially those “complex” families which place a disproportionate burden on State services and finances
- Clarity and consistency for service eligibility should be developed
- Service plans and changes should be evidence based e.g. joint social care and health strategic needs assessments, provider performance data, outcome (or proxy outcome) measures. This would drive a range of service developments, including expanding less intensive social care services to reduce overall costs by reducing people's level of dependency whilst safeguarding vulnerable adults
- Early intervention for adults who are displaying early signs of anxiety and depression has been shown to reduce the need for inpatient beds in the future. The development of Tier 1 and 2 services with early intervention techniques including Improving Access to Psychological Therapies

and an extended GP role could reduce the number of people requiring acute intervention later in the care pathway

- Service provision should move away from residential care and institutionalisation within social care towards an increase in community provision to allow service users to integrate and to lead independent and productive lives
- A range of service provision, delivered with and through partner organisations (where appropriate), and more robust supplier management, would be underpinned by an ethos of partnership working and non adversarial relationships. This would include third and private sector providers, thereby moving monopoly provision away from the States
- Closer working with partners such as Criminal Justice, Education, Housing, etc is required, to build an understanding of how to make appropriate referrals and further support the management of complex service users.

## 5.4 Strategic scenarios

In collating work through stakeholder engagement, modelling, benchmarking and economic analysis, three overarching strategic scenarios have been identified:

1	'Business as Usual'	<ul style="list-style-type: none"> <li>■ Services are delivered in the same way as in 2010. The demographic changes place pressure on capacity and costs, leading to a significant cost pressure by 2020.</li> </ul>
2	'Live within our current means'	<ul style="list-style-type: none"> <li>■ Funding remains the same as in 2010, with an uplift of inflation + 2% p.a. for three years, then inflation only for the remaining period.</li> <li>■ Some services changes are implemented, but only where this is possible within funding constraints. Significant restrictions are introduced to enable resources to be prioritised on the most essential services.</li> </ul>
3	A new model of care	<ul style="list-style-type: none"> <li>■ A revised strategic service model, building on international best practice, benchmarking, stakeholder engagement and economic analysis.</li> </ul>

The following chapters present overview of each strategic scenario, followed by a detailed explanation of the elements of that strategic scenario, for:

- Self care
- Primary Care
- Acute Care
- Social Care and Mental Health:
  - Older Adults
  - Younger Adults
  - The Child.

It should be noted that these elements of service are mutually supportive within the models described, however, each relevant concept or model is presented only once and then referenced where appropriate – so, for example, the principles within Self Care underpin the service models in Social Care and Mental Health, but have not been re-presented within that section. Readers are therefore requested to consider all elements of each scenario, to develop a complete view of the proposed strategic service model.

## 6 Scenario one – “Business as usual”

### 6.1 Scenario ‘at a glance’

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.

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
<b>Total Spend</b>	<b>£ 238,701</b>	<b>£ 296,184</b>	<b>£ 362,246</b>	<b>£ 428,793</b>

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 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. Whilst the Quality Framework could help to improve outcomes and reduce inequality it may also increase demand, and 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.

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.

## 6.2 Self Care

### 6.2.1 Outline of service

#### 6.2.1.1 Availability of Information

Conflicting information in self care material would continue to exist, as would instances of duplication in resources. The Health Promotion team's budget is currently £20k p.a for producing

information/material, and there are approximately 75 third sector organisations in Jersey, who also produce material providing advice and support for health and social care needs.

If an average of £5k was spent by each organisation per annum on producing information, with an estimated 5% spent on material which is duplicated, this would suggest that nearly £20k (i.e. the same budget as for the entire Health Promotion team) is spent on unnecessary duplication of information. Whilst this does not impact directly on service capacity, a lack of coordinated information, multiple access points, and self care that is only basic and therefore does not encourage proactive management will result in higher inappropriate access to services by the increased elderly population in particular, as they may be confused regarding what to access, when and how. This could impact their ability to live independently in the community and lead to a continued high rate of residential care and unplanned access to acute care. The additional costs and resource implications of this are identified within the 'Older Adults' and 'Acute' sections of this scenario.

#### 6.2.1.2 Third Sector

'Pockets' of best practice would continue to exist in supporting individuals in self care, particularly within the third sector. For example 'Brighter Futures' provides opportunities for children, families and young people in Jersey to be safe, healthy and happy, helping to build stronger families and communities. This includes a variety of programmes including structured groups where both adults and children undertake activities which are nurturing, challenging, engaging and playful, promoting a child's self-esteem, sense of belonging and empathy for others.

The different third sector groups would initially continue to provide excellent community based support for individuals with specific needs and conditions. However, an increase in people with long term conditions and long term care needs would significantly increase the demand for community support groups who, if additional funding is not available, will soon be unable to meet the increased demand.

Third sector organisations would continue to compete for funding. As limited information would exist to help determine the health and social care needs of the population, support groups who successfully manage to attract funding/donations might not meet the real needs/conditions of the population. Similarly, various health improvement activities and campaigns might not be targeted and might consequently not address the population's priority needs.

#### 6.2.1.3 Public Health/Health Promotion

Health Promotion would continue to deliver programmes to address the public health needs based on the Jersey Annual Social Survey results. For smoking cessation, approximately 7% of the adult population who smoke (c.1,000 adults), contact the smoking cessation service each year. Demand for the service remains high with waiting lists during busy parts of the year. On average 20 "Help to Quit" clinics are run each week with between 12 – 16 people seen in each clinic. The current annual budget for smoking cessation service is £400k, funding 3 fte smoking cessation nurses. Based on the existing service model, an increase of £400k per annum would be required to support an increase in smoking cessation clinics in order to achieve a reduced smoking prevalence of 10%, as identified in the HSSD Business Plan 2011.

Additional resource would also be required to address some of the highest public health priorities for Jersey. This includes £175k to support a child weight management programme to reduce the levels of

child obesity, and £460k for 'Improving Access to Psychological Therapies' (IAPT) programme, as outlined in the 'Younger Adults' section of this scenario.

#### 6.2.1.4 Support to independent living

Community nursing and home care would continue to be provided in the same nurse: patient ratio at present and with the same breadth of services, i.e. high volumes of home care but low intensity of support, with care not available 24 hours. The current budgets for district nursing and home care services are £2.2m and £2.18m respectively.

Analysis indicates that, as of 2012, available capacity will be exceeded. On the current service model, in order to meet the projected increase in the elderly population, increased funding of c£1.5m p.a. would be required. This would fund a total of 53 fte district nurses and more than 90 fte home care staff. By 2020, this would require an increase in the annual budget for district nursing and home care services to almost £3m each for both district nursing and home care.

## 6.2.2 Activity Implications

Service	Projected change to 2020
<b>Family nursing and home care</b>	35% increase in district nursing and home visits - increasing to almost 79,000 and more than 127,000 visits respectively by 2020
<b>Health Promotion Department</b>	With the current service provision, smoking prevalence would reduce from 23% to 16% by 2020. In order to achieve the target in the 2011 HSSD Business Plan (reduce smoking prevalence to 10% of adult population) there would need to be an increase of approximately 800 service users accessing the smoking cessation clinics
<b>Third sector</b>	Modest numbers continue to access support groups such as Saturday outings provided by Jersey Alzheimer's (c20 people) due to limited capacity. This leads to an inequity of support for others within Jersey, in particular 'hard to reach' and vulnerable groups

## 6.2.3 Staffing Implications

Staff group	Number of staff	Cost in 2020 (£)
<b>Family nursing and home care</b>	District nursing - increase from 39 fte to 52.7 fte Home care – increase from 57.5 fte to 91.2 fte	District nursing almost £3m p.a (increased from £2m p.a in 2010) Home care almost £3m p.a (increased from £2.1 p.a in 2010)
<b>Health Promotion Department</b>	Smoking cessation clinic staff would need to double from 3 fte to 6 fte	£400k per annum
<b>Third sector</b>	A significant increase in third sector staff would be required in order to meet the increasing demand caused by an increased elderly population. As information regarding current staffing / volunteer numbers is not available, it is not possible to quantify this increase – however, as the older adult population is increasing by 35%, staffing / volunteer numbers would need to increase proportionately	Almost £11m p.a would be required (an increase of 35% of the 2010 £8m grant funding)

## 6.2.4 Revenue and capital implications

Description	Impact	Set up costs	Additional annual running costs in 2020
<b>District nursing and home care</b>	<ul style="list-style-type: none"> <li>■ An ageing population leads to a 35% increase in district nursing and home care visits</li> <li>■ District nursing - an increase of 22,550 visits per annum by 2020, delivered by a total of 53 fte district nurses (an additional 14 fte from current capacity)</li> <li>■ Home care - an increase of approximately 33,000 visits per annum by 2020, delivered by a total of 91 fte home care staff (an additional 34 ftes from current capacity)</li> </ul>	N/A	<ul style="list-style-type: none"> <li>■ District nursing – increase of almost £1m p.a plus “other costs”<sup>23</sup> of an additional £50k (increased from £150k in 2010 to £200k in 2020)</li> <li>■ Home care – increase of c£700k p.a plus “other costs” of an additional £40k (from £115k in 2010 to £155k in 2020)</li> </ul>

<sup>23</sup> Taken from FNHC budget and category not split out further

<b>Health Promotion Department</b>	<ul style="list-style-type: none"> <li>At current levels, smoking prevalence would reach 16% by 2020. Smoking cessation clinics would need to double, requiring a further 3 fte nurses plus associated non pay costs</li> </ul>	N/A	<ul style="list-style-type: none"> <li>Increase of c£400k p.a.</li> </ul>
<b>Third sector</b>	<ul style="list-style-type: none"> <li>An ageing population leads to at least a 35% increase in the demand for third sector support</li> </ul>		<ul style="list-style-type: none"> <li>If third sector funding increases proportionately, an additional c£3m p.a would be required (an increase of 35% of the 2010 £8m grant funding)</li> </ul>

## 6.2.5 Benefits

### 6.2.5.1 Service user/carer

- Information and services would continue to be available to support individuals in living healthy lifestyles, living independently and managing their condition. However, duplication of information and conflicting messages would continue to impact the quality of some information provided
- Limited programmes would be available to support self care and self management of conditions. However, not all communities are aware of services, which could create inequality and impact particularly on 'hard to reach' groups and vulnerable people

### 6.2.5.2 Workforce

- Additional staff available to meet demand. However, as activity continues to increase and needs become more complex, this becomes more difficult to manage and clinical risk increases

### 6.2.5.3 Business

- A small reduction in health and social care costs associated with lifestyles choices such as smoking and the subsequent reduction in the prevalence of COPD

## 6.2.6 Risks

- Costs of visiting a GP may deter individuals from attending, particularly for people with long term conditions and long term social care needs, who may be unable to afford the care they need to maintain their health and wellbeing – unless these visits are paid for by The States through income support. Those individuals would then access A&E and other unscheduled care services, placing further pressures on those parts of the system
- Limited coordinated public health intelligence leads to less effective targeting of health and social care campaigns
- Duplication of resources/services as no single approach to self care exists
- Information becomes quickly out of date, with conflicting messages due to the volume of information and lack of quality assurance on the content of material produced
- Quality of care is compromised as staff struggle to cope with increasing demand
- Lack of 24 hour community care to support individuals to live independently leads to increased emergency and unscheduled care, higher rates of hospital admissions and/or demand for nursing and residential care
- Long term implications of reactive care and condition management, through increased demand later in life.

## 6.2.7 Implementation timetable

Initiative	Timescale	Action
<b>Family nursing and home care</b>	October 2011	Recruit additional district nurses and home care staff, as the service is currently at maximum capacity
<b>Health Promotion Department</b>	October 2011	Recruit additional staff to meet the HSSD targets for smoking
<b>Third sector community support groups</b>	October 2011	Recruit additional staff / volunteers to meet the current and projected demand

## 6.2.8 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Partly met	Whilst activities exist to promote a proactive culture of self care and better management of LTCs, the challenge of an increasing population overwhelms the marginal benefits delivered by the existing approach and capacity
<b>Ensure Clinical/service viability</b>	Unmet	Additional support is provided in community nursing and home care. However, this relies on continued investment which is eventually unsustainable as demand exceeds both resources available to fund the service, and staff available to deliver the service
<b>Ensure financial viability</b>	Unmet	Additional financial resources are provided to meet demand, however, a lack of self care and a lack of 24 hour community services create both an immediate impact on secondary care and a longer term impact on the health and social care system (including residential care), which is financially unsustainable without significant increases in funding
<b>Optimising estate utilisation</b>	Partly met	Hospital admissions/readmissions, and residential care admissions, continue to rise as individuals are unable to manage their long term conditions and long term care needs in the community
<b>Workforce utilisation and development</b>	Partly met	As currently, services are not provided 24-hours and there are limited opportunities for role enhancements e.g. Community Matrons. Staff continue to work in individual teams rather than in integrated community teams, providing a reactive service
<b>Clinical governance</b>	Unmet	The lack of a system/quality standard to produce self care information leads to a risk of producing conflicting messages
<b>Use of business intelligence</b>	Unmet	The lack of robust primary care system hinders any targeted social marketing or health promotion initiatives. Health needs assessment is not achievable, so future services are not planned or targeted to the real needs of the population.

## 6.3 Primary Care

### 6.3.1 Outline of service

#### 6.3.1.1 General Practice

The same level and type of services would be provided, i.e. predominantly GP-provided services, with limited interaction across community and social care provision and very limited non-medical provision in primary care settings.

The 2010 primary care activity of almost 343,000 consultations is projected to increase to almost 365,000 in 2020, taking into account the increased consultation rates for the elderly population, particularly those aged 85 and over. If the consultation rate increases following the Quality Framework introduction at the same rate as was experienced in the UK, the annual consultation rate would be 538,934 – however, as scenario 1 is predicated on 2010 service delivery, this has not been factored in to this section.

The projected 6.4% increase in consultations would require the number of GPs to increase from 77 fte in 2010 to more than 80 fte GPs in 2020. This increase is driven by:

- Consultation rates - older adults are high users of primary care services. UK figures indicate that, in particular, people aged 85-89 attend 14.0 times per annum for a male and 13.5 times a year for a female<sup>24</sup>
- Increased disease incidence, which is driven by age and lifestyle. For example, the growing numbers of patients with obesity would have a consequent impact on health needs (including raised blood pressure, diabetes, coronary heart disease, stroke, muscular skeletal problems and kidney failure)
- Increased expectations through the development of innovation in care, including technology.

The total cost in 2010 (almost £7m in rebate plus theoretical maximum of almost £11m in co-payment plus £1.5m for quality giving a total of £19.5m) is projected to increase to almost £21m in 2020.

However, demand for primary care services may not increase in line with increased need, due to the system of co-payments, which is unlikely to change in the foreseeable future. Patients may decide to limit their attendances in an effort to reduce the financial cost to themselves, or to present at ('free') non-primary care services as an alternative. This would increase the pressure on non-primary care services or, if untreated, the patient's condition may worsen, with more serious consequences and further increased demand on hospital and social care.

#### 6.3.1.2 Out of Hours

The Out of Hours co-operative would continue to be based in the hospital, and would continue to provide clinic access and a visiting facility, funded by charging the patient's practice.

A 57% increase in activity driven by demographic trends would lead to costs increasing by more than c£230k.

#### 6.3.1.3 Community Pharmacist

Community pharmacies would continue to provide the same service, i.e. predominantly dispensing, with some pharmacies providing health advice and other generic health checks such as blood glucose and blood pressure.

<sup>24</sup> QResearch Final Report to NHS Information Centre and Department of Health. Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database. NHS Information Centre

### 6.3.2 Activity Implications

A steady growth in demand is predicted, based on the increasing elderly population, with their associated increased prevalence of disease and increased needs. As previously noted, the 2010 primary care activity of almost 343,000 consultations is projected to increase to 364,800 per annum in 2020.

The number of prescription items dispensed is projected to increase from more than 1.6m in 2010 to almost 2m in 2020 given demographics alone. This does not take into account the likely increase in prescribing as a consequence of the introduction of the quality framework. It also does not include the effects of any medicines management interventions to reduce waste. Further, there is likely to be an additional cost for dosette type packaging for medicines for the elderly to aid with compliance with medicines taking.

### 6.3.3 Staffing Implications

Staff group	Number of staff	Cost in 2020 (£)
<b>GP</b>	Increase from 77 fte to more than 80 fte	£21m p.a (States costs almost £7m) (increased from £19.5 p.a total in 2010)
<b>Practice Nurse</b>	Increase from 4.5 fte to 4.8 fte nurses	negligible
<b>Out of Hours</b>	Capacity grows to accommodate 57% growth	c£230k p.a
<b>Community Pharmacist</b>	Increase from 60 fte permanent	Prescribing costs increased from almost £12m in 2010 to almost £19m p.a – an increase of almost £7m)

Achieving the required increases in staffing would be challenging due to the current difficulties in attracting and retaining staff in Jersey. Should the services continue to be delivered in accordance with the 2010 model, increases in demand without increased capacity is likely to have a detrimental effect on the willingness, and possibly the ability, of staff to work in the system.

It should be noted that plans are in place to develop primary care. Whilst the impact of these has not been taken into account within scenario 1, these plans may place further pressure on the system – although they are likely to also address some of the current challenges in terms of governance, outcomes and quality. Within the Primary Care Development Programme PID, the issues of Governance within primary care are being addressed. There are plans to establish a performers' list with the supporting systems to demonstrate, identify and address quality issues.

This PID also supports the development of the quality framework, the establishment of effective coding and recording of data and audit of clinical activity. This is being funded by the additional temporary £4 addition to the £15 rebate and is fixed at a maximum of £1.5m (index linked).

### 6.3.4 Revenue and capital implications

Description	Impact	Set up costs	Additional annual running costs at 2020
<b>Growth in demand for primary care services</b>	More than 6% increase in consultations, as the population increases by 4%, but the older adult population increases by 35%		<ul style="list-style-type: none"> <li>■ General practice – increase of c£2.5m p.a (however, this doesn't include any increase in consultations from the Quality Framework)</li> <li>■ Out of hours – increase of c£230k p.a</li> </ul>

### 6.3.5 Funding implications

Payments from patients will increase as consultations increase. This may act as a barrier to access, particularly for low income and vulnerable individuals, or those whose condition required frequent appointments, particularly as the income support system funds 16 appointments per annum (although patients can apply for additional funding on a needs basis).

### 6.3.6 Benefits

#### 6.3.6.1 Service user/carer

- Freedom to choose doctor and/or register with multiple doctors simultaneously
- Ease of getting appointment
- Personalised service, with the GP having a good relationship with, and knowledge of the patient
- Many premises are new and purpose built

#### 6.3.6.2 Workforce

- Continuation of current system, therefore no challenges caused by change
- Job satisfaction - ability to demonstrate impact on patients and to develop a relationship with a patient and their family

#### 6.3.6.3 Quality

- Quality of care is delivered as in 2010

#### 6.3.6.4 Business

- Customer retention drives service provision
- Increased demand in the future provides a secure income base
- Joint working/ownership of pharmacies

### 6.3.7 Risks

- The funding model continues to provide a perverse incentive to patients, to attend (free) non-primary care services, thereby placing pressure on those elements of the system
- Continued unmet need and patients whose long term conditions are not fully managed and monitored, due to the expense of multiple GP consultations and gaps in community provision
- Increase in health inequalities and in a lack of co-ordination with social care
- Failure to retain GPs as capacity is exceeded and pressure increases, if more GPs are not recruited

- Limited career and development opportunities for a range of professionals
- Increased costs to the hospital, social care and carers
- GPs continue to deliver basic care, including ear syringing and phlebotomy, thereby not optimising their skills and time
- Continued lack of information with which to measure, benchmark and assure quality, and limited information regarding quality and service provision which may impact patients expectations
- The lack of registered list continues to inflate practice lists and hinders health needs assessment
- Patients continue to have to purchase their own dressings e.g. hydrocolloid
- Contraceptive preparations are not included in the formulary
- Continued limited availability of diagnostics in primary care, with limited direct access referrals to diagnostics. This increases referrals to first outpatient appointments which could have been avoided
- Increasing challenges in recruiting pharmacists as the services offered are much more limited than those in the UK

### 6.3.8 Implementation timetable

Initiative	Timescale	Action
<b>Increase staffing in general practice</b>	2013	Recruit additional GPs, practice nurses and administration / reception staff
<b>Increase out of hours staffing</b>	2013	Recruit additional out of hours staff
<b>Increase community pharmacists</b>	2013	Recruit additional pharmacists

### 6.3.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Unmet	<ul style="list-style-type: none"> <li>■ Growth in demand is not met by the capacity in the system, due to challenges in funding and recruiting additional staff (particularly GPs)</li> <li>■ Payment systems for primary care increase pressure and costs in A&amp;E</li> <li>■ Risk of failure to address long term conditions and long term care needs appropriately</li> </ul>
<b>Ensure Clinical/service viability</b>	Unmet	<ul style="list-style-type: none"> <li>■ Primary care remains a viable service is payment systems are retained, however, this does not drive optimal care of value for money for the whole system</li> </ul>
<b>Ensure financial viability</b>	Unmet	<ul style="list-style-type: none"> <li>■ A lack of controls on expenditure or claims by GPs could lead to supplier-induced demand and therefore increased rebate and copayment claims by those professionals who are paid on a fee-for-service basis</li> </ul>
<b>Optimising estate utilisation</b>	Unmet	<ul style="list-style-type: none"> <li>■ Failure to provide a full range of potential services means that estates are not utilised to full capacity</li> </ul>
<b>Workforce utilisation and development</b>	Unmet	<ul style="list-style-type: none"> <li>■ The current model, in which Jersey has a high number of GPs per population and a very low number of practice nurses per population, would continue</li> <li>■ Any excess capacity (and therefore under-utilisation) would continue</li> <li>■ GPs would continue to provide services which could be provided by other care professionals in a more cost effective manner</li> <li>■ Traditional models of service delivery limit the opportunities for workforce development in non-medical professions, including nursing and home care</li> <li>■ In particular, clinical leadership skills would not be further developed</li> </ul>
<b>Clinical governance</b>	Partially met	<ul style="list-style-type: none"> <li>■ The limited clinical governance at present would continue into the future</li> </ul>
<b>Use of business intelligence</b>	Unmet	<ul style="list-style-type: none"> <li>■ Limited information is available at present, both to assess the quality of services delivered and outcomes, and to support closer working between professional groups</li> </ul>

## 6.4 Acute Care

### 6.4.1 Outline of service

Demand for hospital services is predicted to continue to increase in line with demographic change. Emergency medical admissions are the key driver for demand for medical beds. If services continue to be provided in the same way as in 2010, the current capacity of the hospital is projected to be exceeded in almost all elements of care by 2020. In order to meet these increased demands, additional capacity (including staff) would be needed. If additional capacity was not provided, waiting lists would increase further from their 2010 levels:

#### *Waiting list*

The table below outlines the waiting list at at 1 December 2010. This demonstrates that although there is a backlog of 1,641 patients, approximately 83% are waiting 6 months or less for treatment. Of these numbers the greatest pressure is in orthopaedic surgery with 467 patients waiting 6 months or less and 4 waiting over 6 months.

Figure 45: Waiting list as at December 2010

Count of Date on this list List Sub-spec	Months waiting					Grand Total	TCI's
	0-1 (0-30 days)	1-2 (31-60 days)	2-3 (61-90 days)	3-6 (91-180 days)	6+ (181+days)		
COMMUNITY HS DENTAL	15	4	0	2	0	21	17
ENT	65	45	25	23	1	159	35
ENDOSCOPY	94	31	5	1	2	133	72
GENERAL SURGERY	76	57	27	28	1	189	61
GYNAECOLOGY	56	33	16	5	0	110	47
OPHTHALMOLOGY	47	38	54	54	0	193	64
ORAL SURGERY	25	36	46	35	1	143	19
PAIN	32	14	9	0	0	55	12
PLASTIC SURGERY	4	0	3	0	0	7	5
TRAU AND ORTHOPAEDIC SURGERY	132	120	105	110	4	471	63
UROLOGY	41	12	6	1	0	60	15
<b>Grand Total</b>	<b>587</b>	<b>390</b>	<b>296</b>	<b>259</b>	<b>9</b>	<b>1541</b>	<b>410</b>
<b>% of Grand Total</b>	<b>38%</b>	<b>25%</b>	<b>19%</b>	<b>17%</b>	<b>1%</b>	<b>100%</b>	

Providing care in the same way as 2010 (including a waiting list as above), the costs in acute care are projected to increase by more than 20% to almost £98m p.a, the majority of which is due to salary and healthcare inflation on pharmaceuticals and supplies.

Figure 46: Projected hospital spend

Hospital Spend	2010	2020	2030	2040
Salary costs	£ 56,929	£ 69,275	£ 83,982	£ 99,584
Supplies and Services	£ 16,185	£ 23,321	£ 33,637	£ 46,649
Commissioning	£ 8,595	£ 10,560	£ 12,786	£ 14,178
Other	£ 2,722	£ 2,820	£ 2,918	£ 3,017
<b>Gross Cost</b>	<b>£ 84,430</b>	<b>£ 105,977</b>	<b>£ 133,323</b>	<b>£ 163,427</b>
Income	-£ 7,417	-£ 8,081	-£ 8,800	-£ 9,266
<b>Net Hospital Spend</b>	<b>£ 77,013</b>	<b>£ 97,896</b>	<b>£ 124,523</b>	<b>£ 154,161</b>

#### 6.4.1.1 Accident and Emergency

Due to the ageing population, demand in 2020 is projected to have increased by 5%, to more than 39,000 attendances p.a. Based on projected demand, and with a continued model, the cost of A&E in 2020 is projected to increase from almost £3m to c£3.3m p.a by 2020.

On the assumption that the staffing capacity currently within the A&E department is able to meet the current level of activity, demand is projected to exceed the current A&E staffing capacity by 2017 (after a 3% increase in demand to almost 39,000), which the staff are able to flex to meet, however after which point, additional staff would be required to meet demand for 2020.

#### 6.4.1.2 Emergency Ambulance Service

It is assumed that demand for ambulance services will increase with the ageing population, resulting in 16% more journeys by 2020 (more than 7,000 total journeys).

Additional investment in an extra ambulance would be required. Fischer et al 2000 calculates that in 1999 the marginal cost of running an additional ambulance was £250k<sup>25</sup> per ambulance including staffing, maintenance and leasing. Assuming an annual 2% inflation this could be up to £320k p.a in

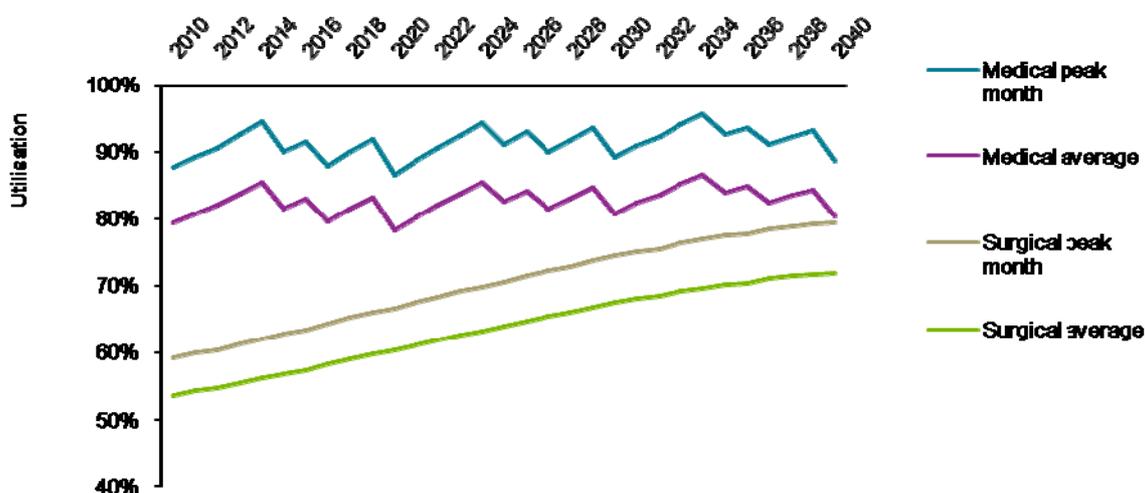
<sup>25</sup> Fischer et al; Ambulance Economics; Journal of Public Health Medicine Vol 22 No 3 p413 – 421; 2000

2011, however purchase of a new bariatric ambulance is estimated to be £90k plus the predicted growth in staffing from 55 to 64 from 2010 to 2020 at an estimated cost of c£1m including salary inflation.

### 6.4.1.3 Non elective beds (including General Medicine)

The number of elderly patients has a direct impact on the rise in demand for general medicine non-elective beds. This is projected to increase by 22% from 3,641 spells in 2010 to almost 4,500 spells in 2020 for general medicine alone, and by 15% across all non-elective activity from 6,852 to almost 8,000 spells in total.

Figure 47: Acute bed utilisation if no bed investment



Source: HSSD Financial model version 1.0

This projected increase in demand would mean that capacity is exceeded in 2017, and an additional 20 general medical beds would be required by 2020, and 60 general medical beds by 2040. It is estimated that a minimum capital investment of £5m would be required per theatre based on recent modular build costs such as at Bradford Teaching Hospital NHS Foundation Trust<sup>26</sup>. There would be a revenue implication of £1m supplies and c£2m salary.<sup>27</sup>

### 6.4.1.4 Surgical beds

Elective surgical demand is projected to increase by 9% in the period to 2020. As indicated in the graph above, surgical bed capacity is sufficient to meet this projected demand. The demand for surgical beds peaks during the months June and July, however, even in these months they do not reach the target utilisation level of 85%. Modelling has projected that, even by 2040 the utilisation rate for surgical beds will not be higher than 79% in the peak months. Data has not been available to

<sup>26</sup> Based on Bradford modular build of 4,950 sqm facility accommodates three new state-of-the-art 28-bed wards and six general operating theatres, with a full height glazed link to the main hospital and three ambulance bays cost of £9m. Requirement for Jersey would be 20 bedded ward. New build costs would be significantly higher. <http://www.yorkon.co.uk/bradford-hospital.html>

<sup>27</sup> As per the KPMG model

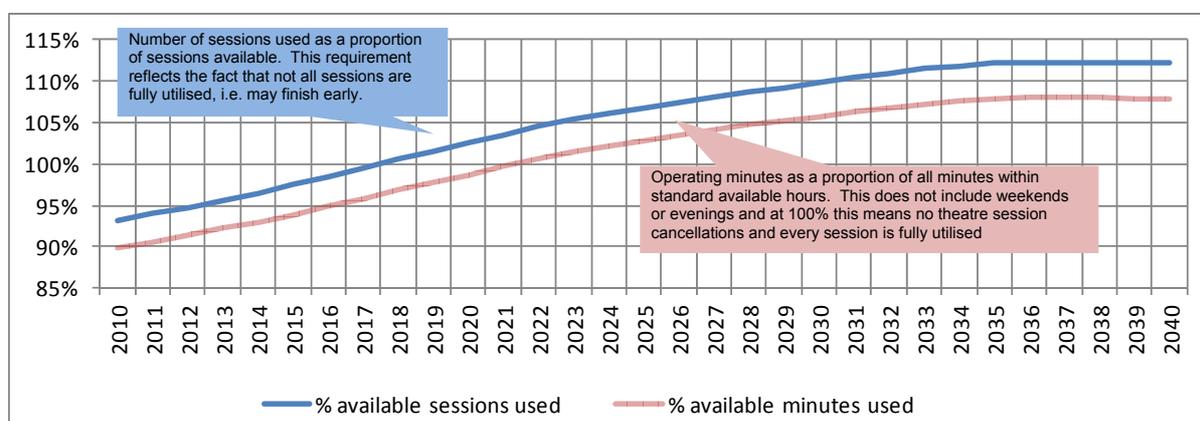
measure medical outliers in surgical beds. Scenario 1 outlines the services as delivered at 2010. Therefore there would continue to be a waiting list for surgery, as identified in section 6.4.1 above.

### 6.4.1.5 Theatres

There are 3 main theatres for elective procedures and one main theatre ringfenced for emergency surgery. One third of one of the 3 elective theatres is also used for emergency surgery, leaving sessions equivalent to 2.69 theatres for elective procedures.

In 2010 elective theatre utilisation was 90% (utilisation is defined as full usage of time available, ie after cancellations and any time wastage between sessions, or due to short sessions etc). If booked time were measured then the figure runs at 98%. The Audit Commission recommends maximum theatre utilisation to be 90%<sup>28</sup>, taking account of cancellations and required downtime. Under this assumption, and using projected demand, theatre capacity at Jersey General Hospital is already being exceeded.

Figure 48: Demand for main theatres



Source: HSSD Financial model version 1.0

In 2010, 5230 procedures were undertaken in main theatres, and the list of patients who had been waiting for more than 3 months decreased by 163 procedures from 1704 on 3 October 2010 to 1541 1 December 2010<sup>29</sup>.

Demand for surgery is projected to increase by 9%. If the current model of service (and therefore current utilisation rates) continue and no more theatre capacity were created by 2020, 433 procedures p.a. would not be able to be undertaken, or waiting lists would increase further.

Upon current usage and utilisation patterns, the hospital needs an additional 8% of capacity in each elective theatre. Therefore, this would represent sessions equivalent to (8% x 3 theatres) = 24% of a new theatre.

<sup>28</sup> Audit Commission, Acute Hospital Portfolio, Operating Theatres

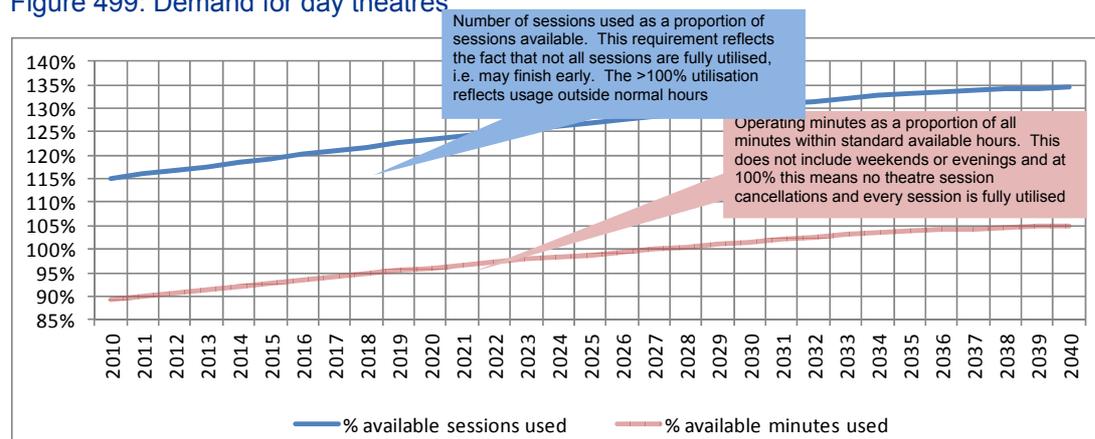
<sup>29</sup> Waiting List Project Board Project 01 December 2010 supplied by Angela Body 20 April 2011

Unless theatre sessions are flexed to find additional capacity within the existing footprint, additional funding of £5m capital<sup>30</sup> would be required for a new theatre now. Staffing costs would be almost £200k p.a.<sup>31</sup>

#### 6.4.1.6 Day case surgery

Day case surgery is already at capacity, at 8,622 cases p.a in 2010. The list of patients who had been waiting for more than 3 months also increased. The projected demand at 2020 is almost 9,500 cases p.a. (an increase of almost 10%). With no service changes more than 800 procedures will not be able to be undertaken in 2020, or waiting lists would increase further.

Figure 499: Demand for day theatres



Source: HSSD Financial model version 1.0

In 2010 there were 2 day case theatres. Booked day case surgery capacity was 2.11 theatres in 2010, and would need to be c2.25 in 2020, with the utilised capacity at 1.79 in 2010 increasing to just more than 1.9 in 2020. Utilisation is at 90% is already at the best practice rate of 90% in 2011. Therefore if no changes were made to the service then additional day theatre capacity of sessions equivalent to a quarter of a day theatre would be required by 2020. Capital costs would be approximately £5m<sup>32</sup> and staffing costs would c £120k p.a.<sup>33</sup>

#### 6.4.1.7 Critical care

At present the hospital has 9 critical care beds, which include both high dependency and intensive care beds. A business case has been submitted for a tenth bed and a reconfiguration of the critical care beds into a separate intensive care and high dependency beds (including Coronary Care). The data available on spell length of stay in the hospital does not distinguish between ward bed days and critical care bed days, and so it has not been possible to model future demand for critical care beds. Surgery and Trauma are the main drivers for the critical care bed capacity and as these are not projected to significantly increase by 2020, it is predicted that demand for critical care beds would rise in correlation.

<sup>30</sup> Bradford Royal Infirmary [www.yorkon.co.uk/bradford-hospital.html](http://www.yorkon.co.uk/bradford-hospital.html)

<sup>31</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre

<sup>32</sup> Estimates based on £2k per sqm + 30% equipment costs; requires specialist advice

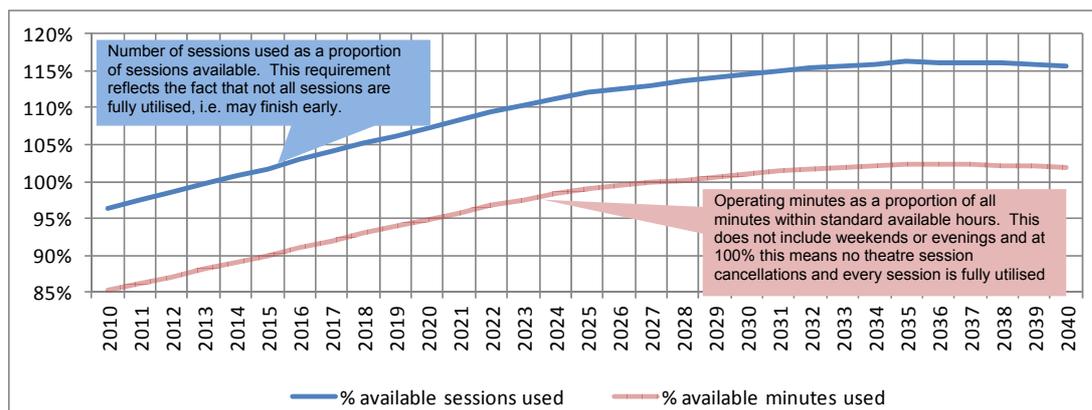
<sup>33</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

### 6.4.1.8 Endoscopy

In 2010, 2,568 gastroenterology endoscopy procedures were undertaken and the list of patients who had been waiting for more than 3 months increased by 7 (from 145 on 3 October 2010 to 152 on 1 December 2010)<sup>34</sup>.

96% of available endoscopy sessions are used, with overall endoscopy theatre utilisation at 85%. Utilisation is projected to reach 90% in 2015 and 96% in 2020.

Figure 50: Endoscopy theatres



Source: HSSD Financial model version 1.0

In 2010 there were 2.0 endoscopy theatres. At current utilisation rates, the requirement in 2020 would be c.2.25 endoscopy theatres. If the current model of service (and therefore current utilisation rates) continue, an additional 0.25 of an endoscopy theatre would be required by 2020. New build would cost £1m<sup>35</sup> in capital and staffing could be phased, but would c £130k p.a.<sup>36</sup>

The waiting list for endoscopy was 140 in December 2009, and 156 in December 2010. This means there was a 10% increase over one year. This increased demand should also be taken into consideration in determining future capacity.

### 6.4.1.9 Off island care

Patients currently travel to the UK for specific conditions, procedures and interventions:

Figure 51: Inpatient spells

Specialty Group	Activity (Spells)	Percentage
Clinical Oncology	196	17
Cardiac and Thoracic Surgery	174	15
Paediatrics	149	13

<sup>34</sup> Waiting List Project Board Project 01 December 2010 supplied by Angela Body 20 April 2011

<sup>35</sup> Based on Lister Hospital £1m, and Brecon Hospital £2m estimated costs; requires specialist advice

<sup>36</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

Specialty Group	Activity (Spells)	Percentage
General Surgery	146	13
Urology	93	8
Neurology/Neurosurgery	59	5
Trauma and Orthopaedics/Spinal	58	5
Ophthalmology	40	4
General Medicine	13	1
Other	223	19
<b>Total</b>	<b>1151</b>	<b>100</b>

Source: Trevor Myers Associates, UK Mainland Health Activities Report, October 2010

Patients return to Jersey for their follow up care. This has proven to be challenging at times when discharge information has not been sent through in time, especially when complications arise.

The table below outlines the projected cost<sup>37</sup> for off-island treatment for the top 5 specialties:

Figure 52: Off island activity – top 5 Specialities

Specialty	Activity off island 2010	Activity off island 2020	Costs off island 2010	Costs off island 2020
Neurology and neurosurgery	59	66	£663k	c£750k
Cardiothoracic	174	196	£1.7m	c£2.0m
General surgery	351	392	£2.1m	c£2.5m
T&O	55	65	£571k	c£650k
Oncology	196	227	£1.1m	c£1.2m

Source: HSSD Financial model version 1.0

If all off-Island activity (including mental health) were to increase in line with demographic change, then by 2020 costs would increase by almost £1m (2010 prices) from just over £8m to more than £9m p.a.

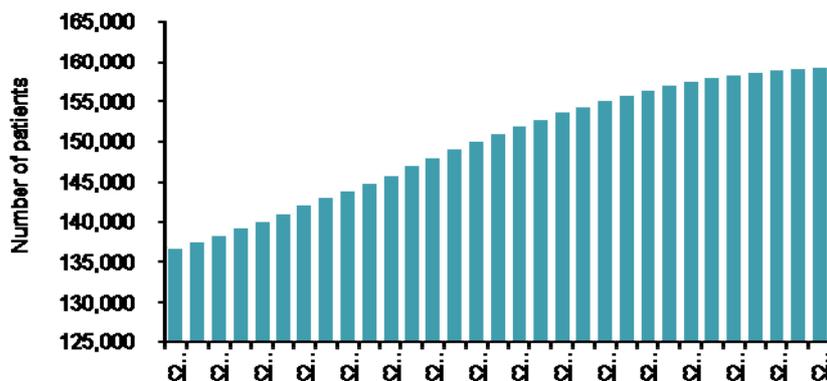
#### 6.4.1.10 Outpatients

By 2020 the demand for outpatients appointments is projected to increase by more than 9,000 outpatient appointments p.a, from 136,720 in 2010 to almost 150,000 in 2020. As at 1 December 2010, 191 patients had been waiting for longer than 6 months for a first outpatient appointment<sup>38</sup>. Under scenario 1, these waiting times would continue.

<sup>37</sup> Excluding transport, escort and accommodation costs which currently estimated to be £1.5m of which approximately £800,000 is variable and this is projected to increase to £1m by 2020

<sup>38</sup> Waiting List Project Board Project 01 December 2010 supplied by Angela Body 20 April 2011

Figure 53: Outpatients



Source: HSSD Financial model version 1.0

Therefore, between now and 2020, almost 7% additional capacity would be required. At current new to follow up rates this equates to 913 clinics at 10 patients per clinic, i.e. an additional 22 clinics per week (based on single handed clinic and 42 weeks per year as per the consultant contract). Capital costs of this would depend on where the additional capacity could be created. If a neighbouring room or a room in an offsite building eg Overdale can be converted then capital costs would be limited (£50k-£100k<sup>39</sup>). Staffing of a clinic would require one nurse band 4-6 for 2 consultants (estimated costs £55k p.a per nurse)

#### 6.4.1.11 Support Services

##### *Clinical Support Services*

The costs are projected to increase from more than £18.4m in 2010 (>£14m salary and £4m supplies) to almost £24m in 2020 (almost £18m salary and £6m supplies), based on projected demand.

##### *Non-clinical support services*

Portering, catering, cleaning and laundry (together) would require an increase in spend from £19.5m in 2010 to almost £23m in 2020 (including staff and supplies), based on predicted demand.

<sup>39</sup> Estimate, requires specialist advice

## 6.4.2 Activity Implications

Service	Projected change to 2020
<b>Emergency Ambulance service</b>	Increase from 6,039 in 2010 to c7,000 in 2020 (16% increase)
<b>A&amp;E</b>	Increased from 37,468 in 2010 to almost 39,250 appointments in 2020 (5% increase)
<b>Elective Surgical beds</b>	Nil change required
<b>Non-elective Medical beds</b>	General Medical non-elective spells are projected to increase from 6,852 in 2010 to c7,900 spells or almost 46,000 bed days in 2020
<b>Theatres</b>	An additional 8% in each theatre, requiring 24% of a new theatre in 2020 at a capital cost of £5m <sup>40</sup>
<b>Day case theatres</b>	Increase from 8,622 cases p.a. in 2010 to c9,500 cases p.a. in 2020 (almost 10% increase)
<b>Critical care</b>	As per business case
<b>Endoscopy</b>	Increase from 2,702 cases p.a. in 2010 to >3,000 cases p.a. in 2020 (11% increase)
<b>Off island treatment</b>	Increase from 1,151 to c1,300 spells, with costs increasing by almost £1m from £8.2million to >£9 million p.a. (including mental health)
<b>Outpatients</b>	Increase from 136,720 in 2010 to almost 146,000 appointments in 2020 (c7% increase)
<b>Clinical Support Services</b>	Pro rata increase in line with demand, from £18.4m in 2010 to >£23m in 2020 (c26% increase) for therapies, pharmacy, pathology, radiology etc
<b>Non clinical support services</b>	Pro rata increase in line with demand, from £19.5m in 2010 to almost £23m in 2020 (18% increase) for portering, cleaning, catering, estates and facilities etc

<sup>40</sup> Bradford Royal Infirmary [www.yorkon.co.uk/bradford-hospital.html](http://www.yorkon.co.uk/bradford-hospital.html)

### 6.4.3 Staffing Implications

Staff group	Number of staff	Cost in 2020 (£)
<b>Emergency Ambulance service</b>	<ul style="list-style-type: none"> <li>■ c64 ambulance staff (increase from 55 in 2010)</li> <li>■ c13 patient transport staff (increased from 12 in 2010)</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£1m p.a</li> <li>■ Increase of c£100k p.a</li> </ul>
<b>A&amp;E</b>	<ul style="list-style-type: none"> <li>■ Consultant – 3 (as at 2010)</li> <li>■ Middle Grade – 5 (as at 2010)</li> <li>■ Junior Doctor – 6 (as at 2010)</li> <li>■ Nurses (band 4 – 6) – c24 (increased from 23 in 2010)</li> <li>■ Nurses (band 1 -3) – 2 (as at 2010)</li> <li>■ Other – c6 (increase from 5 in 2010)</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£300k p.a (no increase)</li> </ul>
<b>Surgical beds</b>	<ul style="list-style-type: none"> <li>■ No additional capacity needed</li> </ul>	<ul style="list-style-type: none"> <li>■ N/A</li> </ul>
<b>Medical beds</b>	<ul style="list-style-type: none"> <li>■ c140 nurses (band 4-6) (increase from 112 in 2010)</li> <li>■ c55 nurses (band 1-3) increased from 43 in 2010</li> <li>■ 10 other staff (increased from 8 in 2010)</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£2m p.a</li> </ul>
<b>Theatres</b>	<ul style="list-style-type: none"> <li>■ ODP x1 band 4-6</li> <li>■ Nurses x3 band 4-6</li> <li>■ HCA x1 band 1-3</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£200k p.a<sup>41</sup></li> </ul>
<b>Day case theatres</b>	<ul style="list-style-type: none"> <li>■ ODP x1 band 4-6</li> <li>■ Nurses x3 band 4-6 (including for recovery)</li> <li>■ HCA x1 band 1-3</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£120k p.a<sup>42</sup></li> </ul>
<b>Critical care</b>	<ul style="list-style-type: none"> <li>■ As per business case</li> </ul>	<ul style="list-style-type: none"> <li>■ As per business case</li> </ul>
<b>Endoscopy</b>	<ul style="list-style-type: none"> <li>■ Nurse x1 band 4-6</li> <li>■ HCA x1 band 1-3</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£130k p.a<sup>43</sup></li> </ul>
<b>Off island treatment</b>	<ul style="list-style-type: none"> <li>■ No additional staffing required</li> </ul>	<ul style="list-style-type: none"> <li>■ Minimal cost increase for staffing</li> </ul>
<b>Outpatients</b>	<ul style="list-style-type: none"> <li>■ Nurse x1 band 4-6 for 2 consultants</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£700k p.a</li> </ul>
<b>Clinical Support Services</b>	<ul style="list-style-type: none"> <li>■ 28 staff across all clinical support services</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of &gt;£4.5 m p.a (includes supplies)</li> </ul>
<b>Non clinical support services</b>	<ul style="list-style-type: none"> <li>■ No staff data available</li> </ul>	<ul style="list-style-type: none"> <li>■ Increase of c£3.5m p.a</li> </ul>

Recruiting and retaining staff would present a significant challenge, if the service model does not change:

- 46% of consultant staff (16 staff) will have become due for retirement by 2020

<sup>41</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre

<sup>42</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

<sup>43</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

- It would become increasingly difficult to recruit medical staff. The number of clinical presentations in a relatively small population means that consultants are required to deal with a wider variation of conditions. This requires generalist skills and expertise. However, medical training and consultant posts in UK hospitals have become increasingly specialised
- 6 Specialties are currently provided by a single handed consultant, which is not sustainable, due in part to the onerous on call arrangements
- Both recruitment and retention of middle grade doctors and other professional staff would be increasingly difficult due to terms and conditions, housing policy, and cost of living, especially childcare. There would continue to be a significant use of locum doctors in these posts, adding to costs and clinical risk
- The development of nursing and AHP roles has not kept pace with the mainland. This would compound in the period to 2020, making posts less attractive
- Pressure will continue on the existing community nursing, home care and hospice staff providing palliative care in the community

## 6.4.4 Revenue and capital implications

Description	Impact	Set up costs	Additional Annual running costs at 2020
<b>Ambulance costs</b>	Purchase of additional ambulance (Bariatric equipped)		£90k <sup>44</sup> p.a plus additional staffing costs of £1m
<b>A&amp;E staff</b>	Increase staff to meet 5% increase in demand		Staffing c£170k p.a
<b>Surgical beds</b>	N/A – no additional surgical wards required	N/A	N/A
<b>Medical beds</b>	1 additional ward of 20 beds with a phased opening of beds to manage the non-elective demand	£5m capital <sup>45</sup>	Staff c£2m p.a Supplies c£1m p.a
<b>Theatres</b>	1 additional main theatre to manage the additional demand for surgery	£5m	c£200k p.a <sup>46</sup>
<b>Day surgery theatre</b>	Provide additional day surgery capacity	£2-5m	c£120k p.a <sup>47</sup>
<b>Critical care</b>	As per business case		
<b>Endoscopy theatre</b>	Provide additional endoscopy capacity	£1m	c£130k p.a <sup>48</sup>
<b>Increase provision of off Island provision</b>	Accommodate increased demand	N/A	c£1m p.a
<b>Outpatients</b>	Accommodate additional 9,132 appointments at current new to follow up rates	£50-100k for converting existing room	c£700k
<b>Clinical Support Services</b>	Increase required in line with increasing demand	N/A	>£4.5m p.a
<b>Non clinical support services</b>	Increase required in line with increasing demand	N/A	c£3.5m p.a

In the period to 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. If newly built this is likely to cost £1m per bed<sup>49</sup> i.e. if the hospital required 237 beds as predicted based on demographic changes by 2020, then this would cost £237m.

<sup>44</sup> Nick Trigg article on BBC news 3 February 2011 <http://www.bbc.co.uk/news/health-12287880>

<sup>45</sup> Based on Bradford modular build of 4,950 sqm facility accommodates three new state-of-the-art 28-bed wards and six general operating theatres, with a full height glazed link to the main hospital and three ambulance bays cost of £9m. Requirement for Jersey would be 20 bedded ward. New build costs would be significantly higher. <http://www.yorkon.co.uk/bradford-hospital.html>

<sup>46</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre

<sup>47</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

<sup>48</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

<sup>49</sup> Industry rule of thumb, specialist advice would be required

## 6.4.5 Benefits

The following benefits pertain to the scenario whereby increased demand is able to be treated and cared for through increased capacity being made available (within the same service provision model):

### 6.4.5.1 Service user/carer

- Patients would experience the same service
- Fit for purpose facilities when the hospital is upgraded
- Free and speedy access to A&E and prescriptions
- Free ambulance journeys and non-elective care
- Senior model of care delivered by consultants
- Off-island care provided in the same way and for the same range of procedures as in 2010

### 6.4.5.2 Workforce

- Staffing levels are maintained
- Surgeons, anaesthetists and theatre staff would experience better working conditions as hospital estate is upgraded
- As currently, hospital consultants would continue to earn revenue from private practice, and clinical autonomy would continue
- Consultants would continue to have professional autonomy

### 6.4.5.3 Quality

- The current quality of service would be maintained
- Reduced risk of hospital acquired infections from a new build hospital
- Care delivered by consultants in the majority of cases

### 6.4.5.4 Business

- Ongoing income from private practice for the hospital. However, there may be pressure on private or public practice at times of high demand, when capacity is limited
- Provides an equitable service to the population including access for those who are less affluent and may not be able to afford private care

## 6.4.6 Risks

If capacity is not increased, services quickly become overloaded, with negative impacts on quality, safety, waiting lists and pressure on staff. Resources may be prioritised into emergency care only, which would undermine the clinical viability of elective care and therefore the hospital

- Recruitment challenges for all staff, especially due to the need for generalist and specialist skills and expertise in a specialist training environment, onerous on call rotas and single handed practices. This is compounded by Jersey immigration constraints and the pressure caused by the retirement of current consultant staff
- Nursing staff, AHPs and other professions would continue to practise as before, with no additional training or change in practice

- Clinicians in hospital as well as in the community would experience increasing pressure through increased demand
- Significant cost increase
- Funding for increased activity off island would need to increase
- The hospital building is not fit for purpose, and unless action is taken the quality of the estate will reduce further in the future, with possible impacts on hospital acquired infections and quality of service provided
- The service would become increasingly pressurised as capacity pressures continue
- Governance and GMC revalidation requirements may not be achieved which means that affected medical staff could no longer practice in Jersey
- Specialties provided by single handed consultants will become increasingly unsustainable
- The waiting lists for some specialties are currently over 3 months and growing
- Elderly cases are becoming more complex. This will require additional skills and expertise from clinical staff at all levels
- The risk of suboptimal arrangements with UK providers, especially poor communication regarding discharges will increase in line with activity sent off island and increasing complexity
- Increased costs and risks associated with heavy use of locum staff

## 6.4.7 Implementation timetable

Initiative	Timescale	Action
<b>Ambulance leasing</b>	2011	Business case for leasing cost for new ambulance
	2012	Recruitment for new ambulance staff for additional ambulance
	2012	Lease new ambulance and staff part time to cover peak demand periods
	2013	Review of demand to determine staffing levels and increase if required
<b>Open new medical ward</b>	2013	Planning and business case submission for 20 additional beds planned to be opened in 2015
	2014	Building commences
	2015	Open ward – staffing six beds
	2017	Staff additional six beds (12 beds on ward)
	2020	Open and staff final eight beds (total 20 beds)
<b>Build new theatre</b>	2011	Plans and business case
	2011	Secure funding
	2011	Tendering process
	2011-12	Build theatre
	2012	Recruit staff
<b>Expand day surgery theatre</b>	2012	Plans and business case; secure funding
	2012	Tendering process
	2012	Build theatre; recruit staff
<b>Expand endoscopy capacity</b>	2014	Plan for additional capacity
	2015	Building
<b>Outpatients</b>	2012	Identify rooms; building work
<b>Enhance support services</b>	2011-2013	Assess and address shortfall in clinical support services (radiology, pathology, pharmacy)
	2011-2013	Assess and address shortfall in non-clinical support services (catering, laundry, cleaning)

## 6.4.8 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Unmet	As demand increases, services risk becoming unsustainable due to funding and resource requirements or a not fit for purpose estate It is highly unlikely that the number of additional staff required would be available, due to immigration constraints. Therefore, the service would not be able to meet demand As pressure increases, emergency services would be prioritised. This would eventually undermine the clinical viability of elective care and, in time, the viability of the hospital
<b>Ensure Clinical/service viability</b>	Unmet	As demand increases, services risk becoming clinically unsafe due to funding and resource requirements or a not fit for purpose estate As noted above, prioritisation of emergency care would eventually undermine the clinical viability of the hospital
<b>Ensure financial viability</b>	Unmet	The hospital estate needs to be upgraded to ensure it is fit for purpose, at a capital cost of £237m <sup>50</sup> for a new build based on projected demand of beds by 2020 Opportunities for productivity improvements would not be progressed
<b>Optimising estate utilisation</b>	Unmet	The estate footprint is limited. Additional physical estate would need to be sourced for the additional capacity required Opportunities for optimising estate utilisation, e.g. optimising theatre capacity, would not be progressed The hospital estate needs to be upgraded to make it fit for purpose
<b>Workforce utilisation and development</b>	Unmet	Recruitment and retention of nurses under the current model and terms and conditions is increasingly challenging. The additional activity may make this even more difficult which would discourage development of the staff as the focus would be on constant delivery of service provision
<b>Clinical governance</b>	Unmet	This is potentially a risk if services are not invested in. Strong clinical audit and informatics are required to support good governance
<b>Use of business intelligence</b>	Unmet	The current investment in business intelligence is not adequate to meet clinical governance requirements and to make well informed management decisions

## 6.5 Older Adults

### 6.5.1 Outline of service

Under scenario 1 the same service continues to be delivered in exactly the same way as it in 2010. However, demand is projected to increase, driven by a 35% increase in the number of older adults in Jersey and the increased care needs associated with this population.

The current service has recently changed moving from an adult service to one for older adults specifically. This service works closely with other agencies such as housing and the third sector to support the older adult population.

Of particular note, dementia affects one in 14 people over the age of 65 and one in six over the age of 80. Currently in Jersey, this equates to 1,757 people. By 2020, this rises to almost 2,400.

<sup>50</sup> Industry rule of thumb, requires specialist advice

In addition, people are living longer and are therefore requiring additional assistance to continue living healthy, independent and productive lives within their own homes and within their community. This places further pressure on services and budgets – both for staffing and for aids, adaptations and equipment.

A public census was undertaken in September 2010 which demonstrated that there were approximately 1,000 people aged over 65 in care homes on Jersey<sup>51</sup>. This figure includes those people who pay for their care privately, which is outwith the remit of this report.

Due to demographic change the current system would be unable to cope within months, and our model suggests that capacity will be reached for all services before 2020. By December 2020, the older adults service within Community and Social Services is projected to require £6.2m p.a more than 2010 funding levels (an increase from £10.1m to almost £16.5m p.a).

HSSD currently has a spend of £8m<sup>52</sup> with the third sector, which to meet the demand, would need to increase to almost £11m by 2020. The impact could be:

- Family Nursing would continue to provide district nursing to people in their own homes. The service would not be available 24 hours per day. Demand would increase from 58,000 p.a in 2010 to c79,000 p.a in 2020)
- Home care would continue to support basic needs such as shopping, laundry and meal preparation. Demand would increase from 94,000 in 2010 to c127,000 in 2020
- 60 additional nursing home and residential care beds would be required by 2020. Sandybrook and The Limes are already at capacity, so all of the additional capacity required would need to be spot purchased.
- An additional 608 people are projected to have dementia in Jersey by 2020. The number of Dementia Assessment beds is projected to increase from 24 in 2010 to 32 in 2020.
- In addition, the number of Mental Health Continuing Care beds is projected to increase from 61 to c82
- Psychology is projected to remain the same at approximately 750 referrals per annum
- Community support groups would continue to exist in some Parishes. These comprise registered volunteers, and provide support to enable individuals to live more independently. Despite offering a quality service for a proportion of the population, other parts of the island population would still be unable to access this support or equivalent creating an inequity across Jersey
- The Jersey Alzheimer's Association would continue to provide a range of services to support to those affected with dementia. 20 people per week used this service in 2010 with a funding grant of £14k<sup>53</sup>. However, it is likely that demand would increase but current capacity constraints have limited the number of people who can be supported
- Jersey Hospice plays an important role in caring for those patients in end stage cancer, however this does not receive a grant or any States funding. It has capacity to treat 6 patients at one time.

<sup>51</sup> Public Health Census of Nursing Homes, undertaken by Mark Richardson, Social Security Department, September 2010

<sup>52</sup> HSSD Ledger 2010

<sup>53</sup> HSSD ledger 2010

- Meals on Wheels run an entirely voluntary service with running costs of approximately £8k p.a.<sup>54</sup>. This is supported by user payment and although the majority of the customers are older adults, there are some younger adults. There are currently 120 customers on the register with almost 90 regular users however this number has declined over the past five years. This service could see a growth as the older population increases however is challenged due to the continued reliance on volunteers.
- Equipment and adaptations budget
- Patient transport is currently run by Jersey Ambulance service and is manned by 12 staff with a budget of £420k projected to increase to c£520k by 2020 with an increase of one staff member. This is a capacity limited service and feedback re the day care service has been that often the reduction in the numbers has been connected to the lack of patient transport rather than demand<sup>55</sup>

Further funding will be required to ensure the States owned care homes comply with the Inspection and Registration of Homes Care Standards due to be introduced in April 2012. This will require modifications such as the widening of corridors, removing double occupancy rooms and installing bed friendly lifts. This is estimated to cost in the region of £1.7m each for Sandybrook and The Limes plus additional revenue costs of c£500k p.a. per home<sup>56</sup>. It is anticipated that these changes will be phased in over time. The same report noted that most of the independent regulated sector are either already compliant with the standards or are in the process of planning refurbishment/replacement of premises to meet the standards.

In April 2013, the Long Term Care Benefit is scheduled to be introduced, however as it was not in place in 2010 this has been excluded from scenario 1.

The current waiting lists for States- funded access to nursing home and mental health inpatient beds would continue. In 2010, 180 patients were entered onto the long term nursing bed waiting list. Using demand projections, this would increase to 243 p.a. by 2020.

Services such as respite care, 24 hours community care, reablement, night sitting, extra care housing, supported living, rehabilitation and additional support for carers would not be developed, thereby missing the opportunity to develop an Older Persons Strategy which supports older people to live active, independent lives for longer in the community.

Managing the system would continue to be compounded by the disparate IT infrastructure, with information maintained in silo environments and limited access to management information.

### 6.5.2 Activity Implications

The activity projections are based on services being delivered in the same service model, with the same coverage, caseloads and intensity of support as in 2010.

<sup>54</sup> Interview with meals on wheels held 13 December 2010

<sup>55</sup> Rachel McBride Day Services Manager, 18 April 2011

<sup>56</sup> Report produced by Jersey Regulation and Inspection Manager, Public Health Services, 2010

Although the psychology service and occupational therapy service are outlined in the 'staffing implications' section, psychology referrals are identified in the younger adults section and occupational therapy stand alone data is not available.

Service	Projected change to 2020
<b>Family Nursing and Home Care</b>	Home care – increase from 94,149 visits in 2010 to c 127,000 visits p.a in 2020 (more than 33,000 additional visits p.a) District nursing – increase from 58,425 visits in 2010 to c 79,000 visits p.a. in 20 (almost 21,000 additional visits p.a)
<b>Nursing Care</b>	Additional bed capacity would need to be spot purchased, as it is assumed that The Limes, Sandybrook, and the current level of States purchased contract beds with the independent sector remains the same during this period Increase from 46 beds spot purchased in 2010 to c106 beds in 2020
<b>Older Adults Mental Health Community</b>	Increase from 8,776 visits in 2010 to c12,000 visits p.a by 2020 (more than 3200 additional visits p.a)
<b>Day Care</b>	These services are currently not always full to capacity but mostly due to patient transport challenges rather than need <sup>57</sup> . It is anticipated that demand for each of these services will grow by 35% in line with the population growth by 2020 <b>Supported Social Day Care</b> Hollies Day centre - 30 places per day Monday to Friday, 20 places per day Saturday, 25 lunch club places on a Sunday <b>Sandybrook Day Centre</b> 20 places per day Monday to Friday (under review - may be increased to 25 due to staffing considerations) <b>Mental Health Day Services</b> Poplars Day Centre - 30 places per day Monday to Friday Poplars Assessment Unit - 12 places per day Monday to Friday <b>Good Companions Club</b> for simple social day care 80 places per week <b>Willows Day Centre</b> is a volunteer run day centre providing simple social day care
<b>Adult Social Care</b>	Adult Social Work referrals <ul style="list-style-type: none"> <li>■ 888 referrals in 2010 across adults and older adults could increase to 1,200 referrals by 2020 based on the older adult demographic change<sup>58</sup></li> <li>■ A recent audit<sup>59</sup> demonstrated that there are currently approximately 1,000 people aged over 65 in care homes on Jersey. From April 2013, all of these individuals including self funders, will require an assessment for them to be able to access Long Term Care Benefit Fund. Currently 40% of residents have been assessed by the social work and nursing team and therefore this would potentially increase the workload by over double.</li> </ul>
<b>Psychology</b>	Referrals projected to stay broadly the same from 2010 to 2020 at 750 per annum, due to this service supporting both adults and older adults but under 65s in the main
<b>Mental Health Inpatient Old Age</b>	Inpatient Mental Health assessment <ul style="list-style-type: none"> <li>■ 24 beds in 2010, increasing to c32 beds by 2020 (additional 8 beds)</li> </ul> Continuing Care <ul style="list-style-type: none"> <li>■ 61 beds in 2010, increasing to c82 beds by 2020 (additional 21 beds)</li> </ul>

### 6.5.3 Staffing Implications

<sup>57</sup> Rachel McBride Day Services Manager, 18 April 2011

<sup>58</sup> This represents the number of social workers across both adults and older adults but the total is shown here for completeness

<sup>59</sup> Public Health Census of Nursing Homes, undertaken by Mark Richardson, Social Security Department, September 2010

Traditionally Jersey has found the recruitment of health and social care staff to be challenging due to a number of factors including the cost of living, staffing terms and conditions and immigration controls. In order to attract the additional staff required for the service in the future, the staffing benefits packages offered may need to be revised upwards – and this will increase the overall cost of care packages still further. However, notwithstanding the increased cost, service risks and pressure on staff will increase significantly if posts are unfilled.

Service	Number of staff in 2020	Cost in 2020 (£)
<b>Family Nursing and Home Care</b>	<ul style="list-style-type: none"> <li>■ District nurses - increase from 39 fte in 2010 to 53 fte in 2020</li> <li>■ Home Care staff projected to increase from 67.5 fte in 2010 to &gt;90 fte in 2020</li> </ul> Total c145 staff (projected increase from 106.5 in 2010)	(as already noted in the 'Self Care' section of this scenario: <ul style="list-style-type: none"> <li>■ District nursing – increase of almost £1m p.a plus “other costs”<sup>60</sup> of an additional £50k (increased from £150k in 2010 to £200k in 2020)</li> <li>■ Home care – increase of c£700k p.a plus “other costs” of an additional £40k (from £115k in 2010 to £155k in 2020)</li> </ul>
<b>Nursing Home Care (Sandybrook and the Limes)</b>	<ul style="list-style-type: none"> <li>■ Nursing homw staff numbers are anticipated to remain the same as in 2010</li> <li>■ Additional 2 fte for assessment and administration of additional referrals</li> </ul> Total 81 staff (projected to remain the same as capacity constrained)	<ul style="list-style-type: none"> <li>■ c£4.2m p.a in 2020 (increased from £3.6m in 2010)</li> </ul>
<b>Older Adults Mental Health Community Team</b>	<ul style="list-style-type: none"> <li>■ 2 social workers (as at 2010)</li> <li>■ 1 consultant (as at 2010)</li> <li>■ 3 middle grade doctors increased from 2 in 2010</li> <li>■ 12 fte band 4-7 nurses increased from 9 in 2010</li> <li>■ 7 fte band 1-3 nurses increased from 5 in 2010</li> <li>■ 3 others increased from 2 in 2010</li> </ul> Total 28 staff (projected to increase from 21 in 2010)	<ul style="list-style-type: none"> <li>■ c£2m p.a in 2020 (increased from £1.2m in 2010)</li> </ul>
<b>Social Care</b> <sup>61</sup>	Due to demand growing against younger adults the current staffing profile across social care remains as at 2010. It is noted that if demand were to grow in line with older adults and if the Long Term Care Benefit were introduced this staffing would likely double by 2020, due to the increased need for assessments	<ul style="list-style-type: none"> <li>■ c£1.3m p.a. in 2020</li> </ul>
<b>Occupational Therapy</b> <sup>62</sup>	<ul style="list-style-type: none"> <li>■ Increase from 44 fte in 2010 to c47 fte in 2020</li> <li>■ 3 others</li> </ul>	<ul style="list-style-type: none"> <li>■ c£3m p.a in 2020 (increased from £2.3m in 2010)</li> </ul>
<b>Psychology</b> <sup>63</sup>	Other therapy staff (including psychologists, counsellors and family therapists) - increase from 20 fte in 2010 to c21 fte in 2020 1 nurse band 4-7 as at 2010	<ul style="list-style-type: none"> <li>■ c£1.3m p.a (increased from £1m in 2010 – an increase of £300k)</li> </ul>
<b>Mental Health Inpatient Old Age</b>	Total c122 staff (projected to increase from 81 in 2010)	<ul style="list-style-type: none"> <li>■ c£7m p.a (increased from c£4m in 2010)</li> </ul>

<sup>60</sup> Taken from FNHC budget and category not split out further

<sup>61</sup> This represents the number of social workers across both adults and older adults but the total is shown here for completeness

<sup>62</sup> The numbers are for the occupational therapist department and therefore is not specific to children but is noted here for completeness

<sup>63</sup> The numbers are for the psychology department and therefore is not specific to children but is noted here for completeness

The costs required to operationalise the future operating model will need to be modelled as part of the detailed business planning stage. Office space constraints may require a different operating models to be employed such as hot desking or working remotely for the frontline staff working in the community. The associated IT costs that this may incur such as additional laptops, VPN network and secure log ins would need to be determined but this will be driven from the agreement of a new operating model.

#### 6.5.4 Revenue and capital implications

Description	Impact	Set up costs	Additional annual running costs at 2020
<b>Introduction of the Registration and Inspection of Homes Care Standards in 2012</b>	Requirement to ensure Sandybrook and The Limes meet the required standards	c£3.5m capital costs for estate upgrade	c£1m p.a
<b>Family Nursing and Home Care</b>	Additional FNHC visits requires 37 district nursing and home care fte	Recruitment and onboarding costs	c£1.7 m p.a
<b>Nursing Care</b>	Additional assessment and administration for 312 placements Additional 60 beds Registration and Inspection	Minimal	c£600k p.a for increases in assessments <sup>64</sup>
<b>Older Adults Mental Health Community</b>	Additional staff for increase in activity of c3,200+ visits p.a		c£800k p.a
<b>Day Care</b>			
<b>Social Care</b>	More than 300 additional service users		
<b>Occupational Therapy</b>			c£3m p.a
<b>Psychology</b>			c£1.3m p.a
<b>Mental Health Inpatient Old Age</b>	29 staffed inpatient beds and	Modular development i.e. 1 ward equivalent – c £5 million	Inpatient facilities – additional staffing cost - c£3 m p.a

#### 6.5.5 Benefits

- The same level and type of care continues to be provided
- Services would increase to meet the projected demand
- Existing levels of quality are maintained
- Funding is made available to meet the new Inspection and Registration of Homes Care Standards required of State-run care homes

## 6.5.6 Risks

- Traditional models of care are retained
- Reduced independence for older people as a disproportionate number of adults are cared for in residential and nursing care homes rather than being supported in their own homes
- More places in institutionalised care will be required over time and unless this process is managed effectively from a commissioning and procurement perspective, it may result in unnecessary costs being incurred
- Challenges in staff recruitment and retention would continue

## 6.5.7 Implementation timetable

Initiative	Timescale	Action
<b>Increase capacity</b>	June 2011	Business case for funding for additional older adult nursing and continuing care beds
	June 2011	Work with care homes to gain dual registration where possible
	July 2011	Tendering for additional capacity for dementia assessment beds
	November 2011	Additional capacity commissioned
	November 2011 – January 2012	Subject to agreement of preferred approach, recruitment of professionals to undertake initial assessments (either tender or additional staffing)
	ongoing	Baseline assessments undertaken

## 6.5.8 Strategic imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Unmet	<ul style="list-style-type: none"> <li>■ The current service model is unsustainable, and capacity is exceeded in the next 12 months</li> <li>■ Significant additional funding to increase capacity would not resolve the issue, due to challenges in staff recruitment and retention</li> <li>■ Additional capacity would need to be built for States-run nursing and residential care, which would have a long lead-time. The alternative is to spot purchase beds from the private sector – but there may be limitations on capacity (and viability)</li> </ul>
<b>Ensure Clinical/service viability</b>	Unmet	<ul style="list-style-type: none"> <li>■ The current service model does not ensure clinical or service viability due to the capacity constraints of residential and nursing beds on the island and of social care and community staff</li> <li>■ Services such as respite care, 24 hours community care, reablement, night sitting and additional support for carers would not be developed</li> </ul>
<b>Ensure financial viability</b>	Unmet	<ul style="list-style-type: none"> <li>■ The projected cost increase is 60% by 2020 - from £10m to £16m – and is therefore potentially financially unsustainable without significant additional funding</li> <li>■ Additional private sector capacity would be required, which would be spot purchased – which often is worse value for money than block purchasing or States-provided care</li> </ul>
<b>Optimising estate utilisation</b>	Unmet	<ul style="list-style-type: none"> <li>■ The bed capacity in the current model is insufficient to meet the projected demand. The shortfall in nursing beds presents an immediate challenge</li> </ul>
<b>Workforce utilisation and development</b>	Unmet	<ul style="list-style-type: none"> <li>■ Terms and conditions have made recruitment increasingly difficult and retaining the number of additional staff required for the projected level of demand may not be achievable</li> </ul>
<b>Clinical governance</b>	Unmet	<ul style="list-style-type: none"> <li>■ Although clinical governance may be met in the current service model, the projected demand and forecast capacity requirements may mean this becomes unmet before 2020 due to a lack of dual registered homes on the island which does not keep pace with demand</li> </ul>
<b>Use of business intelligence</b>	Unmet	<ul style="list-style-type: none"> <li>■ Additional Information requirements are needed to support all the patients in the future, including the potential investment in ICR or other IT systems for social care</li> </ul>

## 6.6 Younger Adults Social Care and Mental Health

### 6.6.1 Outline of service

#### 6.6.1.1 Mental Health

Currently mental health services are delivered through either the Acute Liaison Team, Active Recovery Team; Drug and Alcohol service or the inpatient unit at Orchard House. There are also third sector providers such as Silkwood Lodge for detoxification services or Focus On Mental Health which is a mental health charity

The service also has links with other agencies such as criminal justice and housing.

Demand for services is projected to reduce slightly from the 2010 level of 57,762, as the demographic for the age group 19 – 64 years decreases by 1.4% by 2020 as the table outlines below:

Figure 54: Demographic change

Population Projection	2010	2020	2030	2040
Children (0-18 yrs)	17,260	16,131	15,839	15,999
Adults (19-64 yrs)	57,762	56,941	54,243	52,263
Older people (65+ yrs)	14,797	19,982	25,943	28,882
<b>Total</b>	<b>89,819</b>	<b>93,053</b>	<b>96,025</b>	<b>97,144</b>
Support ratio	3.90	2.85	2.09	1.81
Dependency ratio	3.35	3.53	3.42	3.27

Source: HSSD Financial Model v1.0

Mental health delivery supports service users in the community as far as possible. In this regard, Jersey have progressed further than the UK, however the increases the amount of risk that is managed in the community and this is currently under review.

The main challenge is the lack of critical mass of patients to be able to sustain full services across the Tiers of mental health needs. This mainly affects Tier 4 tertiary/ specialist service including secure and forensic provision.

The proposed legislative change for the detainment of mentally disordered offenders will create a challenge. The financial impact of this is yet to be assessed, but may result in the need to use estate differently, such as the investment in a different type of inpatient provision that could be flexed to include the necessary secure provision. This would need to be funded within the current capital, which may involve the sale of current assets to fund a change in the service provision.

#### 6.6.1.2 Special Needs

The current model is person-centric, with care delivered in the community to enable service users to live as productive and independent lives as possible, and be as integrated into the community as possible. This is supported with individual 'wrap around' packages for ten individuals as well as day centres and respite.

Some capacity constraints exist within the Special Needs service, for example residential care is already at capacity with a recent placement off island, and respite care and day centres are also becoming over subscribed. This means that there are some short-term challenges for the service to continue to deliver the current model of care.

## 6.6.2 Activity Implications

Staff group	Projected activity to 2020
<b>Mental Health inpatient</b>	<ul style="list-style-type: none"> <li>■ Orchard House – occupancy is projected to remain the same as 2010 with a requirement for an average of 10 beds (although the variation in demand means that the current 17 bedded unit may be fully occupied at peak times)</li> <li>■ Clairvale Road – step down unit - occupancy is projected to remain the same as 2010 at an average of 8 beds</li> <li>■ Maison du Lac – residential care for long term patients – occupancy is projected to remain the same as 2010 at an average of 9 beds<sup>65</sup></li> </ul>
<b>Mental Health Community</b>	<ul style="list-style-type: none"> <li>■ Activity is projected to remain broadly the same or reduce slightly from 2010 to 2020:               <ul style="list-style-type: none"> <li>– Acute Liaison Team – reduction in referrals from 415 in 2010 to &lt;410 p.a in 2020</li> <li>– Active Recovery Team – reduction in caseload from 369 in 2010 to &lt;365 p.a in 2020</li> <li>– Drug and Alcohol Service – reduction in referrals from 650 in 2010 to &lt;640 p.a in 2020</li> <li>– Psychological Therapy service – reduction in referrals from 758 in 2010 to &lt;750 p.a in 2020</li> </ul> </li> </ul>
<b>Special Needs Day Service</b>	<ul style="list-style-type: none"> <li>■ Projected to reduce by 1 every 5 years</li> </ul>
<b>Special Needs Residential Care</b>	<ul style="list-style-type: none"> <li>■ Projected to reduce from 128 in 2010 to c125 in 2020</li> </ul>
<b>Special Needs Community support</b>	<ul style="list-style-type: none"> <li>■ Projected to reduce from 60 in 2010 to marginally &lt;60 in 2020</li> </ul>

Note: This is based on incidence within the current age group 19- 64 years and not driven through pathways i.e. does not follow from children through to adults and older adults

## 6.6.3 Staffing Implications

Due to the declining demographic of younger adults the service has the potential to be able to continue to meet demand within its current model, however the management of risk within the community is a consideration for the staffing model.

There is a short term challenge for the service model, which is at capacity for some services such as Special Needs residential care and respite services.

There have been considerable challenges regarding recruiting and retaining the right level of workforce, particularly nursing, due to the terms and conditions and this has affected morale.

## 6.6.4 Revenue and capital implications

As the younger adult population is projected to reduce by 1.4% in the period to 2020, services should be able to continue being provided in the same configuration as 2010 at an increase of c£1.8m (due to salary inflation).

However, this increase does not include capital investment, which may be required to ensure the inpatient facilities are to the right standard<sup>66</sup>.

<sup>65</sup> It is noted that this service provision model is currently under review

It also does not include increases in service provision for Special Needs continuing care, day centres and respite care.

## 6.6.5 Benefits

### 6.6.5.1 Service user / carer

- Adults with special needs and mental health issues would continue to be cared for in the community as much as possible
- Individuals within the special needs services would continue to receive a tailored, wrap around service within the community to ensure they can lead a full and independent life

### 6.6.5.2 Workforce

- The special needs team would continue to deliver 'wrap around' services for the individual service users
- The ethos of supporting service users within the community as much as possible is retained

### 6.6.5.3 Quality

- The current community-focus and personalised service delivery would continue. This provides more personalised, appropriate services which enable service users to lead independent and productive lives, rather than being treated in institutionalised care settings

### 6.6.5.4 Business

- Demand reductions through demographic change would ease the pressure on services

## 6.6.6 Risks

- Potential future legislative changes to mental health law could increase costs
- Recruitment and retention of the right staff is critical to the continuation of the community-focused service. This is a continuing challenge in Jersey due to the cost of living, staff terms and conditions and immigration constraints
- Estate condition deteriorates in the future if no additional funding is available, requiring increased maintenance or new build

## 6.6.7 Implementation timetable

N/A – the current social care and mental health service model is sustainable within the context of declining demand. The special needs service is taking steps to address its short term capacity issue. This is an operational detail and hence is not outlined in this strategic scenario.

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<sup>66</sup> This is not currently estimated as the change in the legislation is due in 2012 and the impact has not been assessed here

## 6.6.8 Strategic Imperatives met / unmet

Service design principle	Met / Unmet	Justification
<b>Create a sustainable service model</b>	Met	The current service model would be maintained with a declining population
<b>Ensure Clinical/service viability</b>	Met	The current service model is clinically viable
<b>Ensure financial viability</b>	Met	The current service model is financially viable with a declining population – other than if mental health legislation requires capital expenditure, or if estates maintenance is discontinued and a backlog of essential maintenance impacts the estate condition
<b>Optimising estate utilisation</b>	Unmet	Additional capital investment may be required to meet legislative requirements
<b>Workforce utilisation and development</b>	Unmet	Staff recruitment and retention would continue to be a challenge
<b>Clinical governance</b>	Met	Risk is managed in the community by the community teams. This would need to be monitored
<b>Use of business intelligence</b>	Unmet	Opportunities for integration and the further support of personalised care may be reduced if investment is not undertaken in informatics

## 6.7 The Child

### 6.7.1 Outline of service

Demographic projections indicate that the number of children on the island will decrease up until 2028. Although the last two years has seen an increase in births the States Statistics Department is confident this does not reflect the long term trend for the birth rate, which also takes into account factors such as migration and infant mortality. The States Statistics Department currently supports the projection and will not be in a position to review this until the results of the 2012 census are available. The current projections indicate that the overall population of children may reduce by more than 1,000 - from 19,327 in 2010 to just over 18,000 in 2020, a reduction of c6.4%.

Although the overall child population is projected to reduce, the Statistics Department is projecting an increase in the proportion of children from migrant families. In other economies such as the UK, there is a view that there is a positive correlation between the proportion of non-indigenous children and the levels of social care activity. Therefore, it is possible that similar activity increases might be experienced in Jersey if this proportion increases from current level of c22.5%.

Under scenario 1 the service would continue to be delivered in exactly the same way as in 2010. Therefore, if the requirement for social care is directly proportional to the number of children then activity can also be assumed to reduce by c6.4%. There has been significant investment in children's services following the Williamson report in 2009,<sup>67</sup> including the implementation of the new Intensive Support Team and additional psychology and therapy services. These initiatives have the potential to strengthen children's services considerably. Under scenario 1 it is assumed these services would continue to be funded

<sup>67</sup> Williamson report, 2008

In terms of service provision:

- A disproportionately large number of children would continue to be placed in facility based care as opposed to foster care (almost 20% more than UK comparators). This is more likely to lead to worse outcomes for the child
- Tier 1 and 2 mental health services for children would continue to be less well developed than in the UK. Embedding services into schools and into basic health assessments would continue to be a challenge. The benefits of early identification and treatment of conditions such as eating disorders and depression would not be achieved
- Priority would continue to be given to providing services on-island where practical, accepting that some intensive care packages for children with the most complex issues, including very challenging behaviour, would always need to be provided off-island. However, it may not be possible to replicate or expand some of the more innovative community based packages currently provided to children and young adults with very special needs
- Grant funding of the third sector would continue. Children's services currently account for 20-30% of the third sector's £8.3 million total funding, delivered through organisations such as Brook and FNHC
- Pressure on the hospital would continue as children and families present to A&E rather than their GP because of the difference in charging. Of more concern would be that children do not access either primary or acute care
- Some of the CYPP plan and Williamson recommendations would not be implemented. Examples might include a shift away from facility based care (see above), an improved out of hours service, and fully integrated multi-agency working

## 6.7.2 Activity Implications

Service	Projected change to 2020
<b>Children's Safeguarding and Community Support (excluding CAMHS)</b>	<ul style="list-style-type: none"> <li>■ Safeguarding - projected reduction from 1,390 referrals in 2010 to just over 1,300 p.a in 2020</li> <li>■ FNHC - projected reduction from 22,484 referrals in 2010 to over 21,000 referrals p.a in 2020</li> </ul>
<b>Looked After Children</b>	<ul style="list-style-type: none"> <li>■ Projected reduction from 77 children in 2010 to c72 children in 2020 (reduction of approximately 5 children)</li> <li>■ Foster care – a reduction from 27 to c25 fte</li> <li>■ Family/ friends – a reduction from 23 to c22 fte</li> <li>■ Residential 18 to c17 fte</li> <li>■ Supported in other ways – demand would remain approximately the same at c7 children p.a</li> </ul>
<b>Secure</b>	<ul style="list-style-type: none"> <li>■ The same demand, with an average of 1 (this is sometimes empty and sometimes has several children residing in the unit)</li> </ul>
<b>CAMHS (including Psychology)</b>	<ul style="list-style-type: none"> <li>■ Projected reduction from 330 referrals in 2010 to c310 referrals p.a. in 2020</li> </ul>

Please note that all these activity projections are driven principally by the reducing the number of children, but variations in the make-up of the children population, economic circumstances and other social trends could all affect the actual number.

### 6.7.3 Staffing Implications<sup>68</sup>

Staff costs are projected to increase due to a salary inflation of 1.3%

	Number of staff 2020	Cost in 2020 (£)
<b>Children's Safeguarding and Community Support (excluding CAMHS)</b>	<ul style="list-style-type: none"> <li>■ Social workers - decrease slightly from 16 fte in 2010</li> <li>■ RCCO care workers – remain broadly the same (there were 2 fte in 2010)</li> <li>■ FSW care workers decrease slightly from 7 fte in 2010</li> <li>■ 2 others</li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from c£1.4m p.a in 2010, due to salary inflation</li> </ul>
<b>Looked After Children</b>	<ul style="list-style-type: none"> <li>■ Social workers - decrease slightly from 18 fte in 2010</li> <li>■ The remaining staffing establishment would remain broadly the same as in 2010, which was:               <ul style="list-style-type: none"> <li>– RCCO care workers - 6 fte</li> <li>– FSW care workers – 3 fte</li> <li>– Social work assistant – 1 fte</li> <li>– 1 other</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from c£1.7m, due to salary inflation</li> </ul>
<b>Secure</b>	<ul style="list-style-type: none"> <li>■ RCCO care workers would remain broadly the same as at 2010 - 13 fte</li> <li>■ 3 others</li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from £600k p.a in 2010, due to salary inflation</li> </ul>
<b>Residential</b>	<ul style="list-style-type: none"> <li>■ RCCO care workers and other staff would remain broadly the same as at 2010 - 41 fte</li> <li>■ 2 others</li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from £2.1m p.a in 2010, due to salary inflation</li> </ul>
<b>Respite Care</b>	<ul style="list-style-type: none"> <li>■ Slight decrease from the 2010 levels of 21 fte in 2010</li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from c£1m p.a in 2010, due to salary inflation</li> </ul>
<b>CAMHS</b>	<ul style="list-style-type: none"> <li>■ Staffing establishment would remain broadly the same as at 2010</li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from c£600k p.a in 2010, due to salary inflation</li> </ul>
<b>Speech and Language Therapy</b>	<ul style="list-style-type: none"> <li>■ Staffing establishment would remain broadly the same as at 2010</li> </ul>	<ul style="list-style-type: none"> <li>■ Slight increase from c£700k p.a in 2010, due to salary inflation</li> </ul>
<b>Occupational Therapy<sup>69</sup></b>	<ul style="list-style-type: none"> <li>■ Occupational therapists and other staff c50 fte in 2020, increased from 47 fte in 2010</li> </ul>	<ul style="list-style-type: none"> <li>■ c£3m in 2020</li> </ul>

Although only three professional groups are represented above, it is acknowledged that a full range of staff from other departments and teams work with children and young people on the island including within both HSSD such as education and the third sector.

Small reductions in staff and associated cost could be achieved through natural wastage as demand reduces. Alternatively, the small amount of time released could be re-directed into other roles.

<sup>68</sup> All staffing figures from HR and HSSD General Ledger at January 2011 (full year effect for 2010)

<sup>69</sup> The numbers are for the occupational therapist department and therefore is not specific to children but is noted here for completeness

#### 6.7.4 Revenue and capital implications

There are no revenue implications under scenario 1 other than the implications for staff pay already outlined. This would increase the revenue cost from £11m in 2010 to c£12m p.a in 2020.

#### 6.7.5 Funding implications

No changes to funding mechanisms would be required.

#### 6.7.6 Benefits

- The same traditional service model would be retained
- There would be limited change in social care practice management although the impact of funding resulting from the Williamson Report recommendations would be expected to take effect on the quality of safeguarding
- The settings in which Looked After Children are cared for would remain the same

#### 6.7.7 Risks

- Children would continue to be looked after in residential settings, leading to worse outcomes than foster care
- A lack of investment is likely to hinder a move towards more integrated working
- Social work practice may not develop
- The development of community based services may be limited, with children remaining in care for longer than necessary
- Pressure continues on acute settings, especially A&E
- A lack of integrated information hinders the assessment of need and the coordination of care, creating delays and potentially increasing risk

#### 6.7.8 Implementation

Services would continue to be provided in the same way as at 2010. As demand for services is projected to reduce, there would be no implementation plan.

## 6.7.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Partially Met	Despite a reduction in activity, with no investment in enhancing services, this leads to an underdeveloped workforce and eventually impacts the quality and access to services delivered
<b>Ensure Clinical/service viability</b>	Unmet	Provision of children's services for areas such as mental health continues to be a challenge due limited resources/ capacity with no investment to further develop the skills and expertise of the workforce. Also, pressure on hospital services would continue as children and families present to A&E rather than primary care.
<b>Ensure financial viability</b>	Partly Met	Financial gain from reduced activity is offset by inflation and additional resources required to maintain the service in a steady state. No resources are available to enhance services
<b>Optimising estate utilisation</b>	Partly met (with negative outcome implications)	Utilisation of the estate would be maximised by placing a larger number of children in residential care. However, this would lead to worse outcomes for the child
<b>Workforce utilisation and development</b>	Unmet	There would be no change in working practices or investment in training and development, leading work practices becoming outdated
<b>Clinical governance</b>	Partly Met	The lack of investment to develop staff / services would impact on the ability to follow best practice guidelines and further develop the skills and expertise of the workforce
<b>Use of business intelligence</b>	Unmet	With no investment in business intelligence, the current challenges in the quality of information would continue. This leads to difficulties in assessing children's health and social care needs in Jersey

# 7 Scenario 2 – “Live within our current means”

## 7.1 Scenario two ‘at a glance’

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 10%
- 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.

## **7.2 Self Care**

### **7.2.1 Outline of services**

Support for patients and service users to take responsibility and control of their own health, to proactively increase health, wellbeing and independence, and to access prevention services has a critical impact on the sustainability of the health and social care system. With limited funding and capacity for staff to educate people on the importance of self care and how they can improve their lifestyle, the opportunity to create a culture of self care is lost. This would lead to an increase in demand from long term conditions (as the condition is not managed effectively), with increased costs. This would then compound the pressure on the system, and as the funding envelope is exceeded, services to support people in the community would reduce, eligibility criteria would increase, thresholds would increase, which would then further reduce independence and the ability to live for people to live in their own homes and community settings with support from health and social care. This would therefore produce a societal cost, in addition to a financial and economic cost.

#### **7.2.1.1 Availability of Information**

By 2020, an ageing population leads to higher incidence of long term conditions, particularly for those which have not been proactively identified and targeted. Due to funding constraints, information would be distributed to only those individuals who have presented with certain condition, and would be limited to basic material such as pamphlets to inform lifestyle choices, rather than a coordinated use of media and other communication channels.

A directory of information would be created, which would go some way to reducing the current duplication of information, improving resource use and highlighting areas where information is less available.

Whilst there would be an improvement in the coordination of information produced, in the absence of a robust information system, there would be a limited understanding of the population's total health and social care needs. This might lead to incorrect targeting of health promotion efforts.

The opportunity to create a culture of self care would be lost due to the limited funding and capacity for staff to educate people on the importance of self care and how they can improve their lifestyle. This would lead to an increase in demand from long term conditions, with increased costs. This would then compound the pressure on the system, increasing the speed at which funding constraints increase, and the speed at which services to support people in the community would reduce, eligibility criteria would increase, thresholds would increase and services would reduce, which would then further reduce independence and the ability to live for people to live in their own homes and community settings with support from health and social care.

#### **7.2.1.2 Third Sector**

Community support groups would continue, and the 12 Parishes would develop their own bank of volunteers to support those with complex needs or those who require additional support to live independently. Volunteers would have been screened and would provide basic support including

completion of application forms and befriending services, emulating the current initiative provided by the St. Clement's Parish Community support team.

For example, dementia affects one in 14 people over the age of 65 and one in six over the age of 80 (Alzheimer's Association). Currently in Jersey, this equates to 1,757 people. By 2020, this rises to almost 2,500. The Jersey Alzheimer's Association would continue to provide a range of services to support to those affected with dementia. However, only 20 people per week use this service currently, due to capacity constraints.

#### 7.2.1.3 Primary Care

Individuals visiting their GP would be provided with targeted health promotion materials (self management information packs), to encourage an improvement in lifestyle choices through diet, exercise and smoking cessation, or targeted at individuals with a genetic or lifestyle predisposition. The packs would also contain advice how to better manage their condition and signposting to community support groups or other services available. This leads to a better understanding of their condition and how to monitor symptoms, reducing exacerbations and improving quality of life. However, due to funding constraints, the availability of self management information packs would be limited and therefore opportunity for making a significant impact through self care would be lost.

#### 7.2.1.4 Public Health/Health Promotion

There would be a gradual improvement in some health outcomes associated with lifestyle choices such liver disease through the alcohol strategy, or early diagnosis of Alzheimer's through awareness campaigns and social marketing.

However, by 2020 the impact of the health promotion activities would not achieve a significant reduction in the prevalence of long term conditions, partly due to the limited information systems available to support planning and understanding of the health and social care needs of the population.

#### 7.2.1.5 Support to independent living

District nursing and home care services already operate at maximum capacity. 39 fte district nurses provide 58,425 visits for approximately 3,465 patients. By 2020, the demand for district nursing is projected to increase by 35% to almost 79,000 visits p.a based on the current service model (i.e. not 24-hour support). The new funding envelope would only pay for 62,000 visits for 3,680 patients, leaving an unmet demand of c17,000 visits for 1,000 patients in 2020. Whilst additional activity could be met through increasing district nursing caseloads, services may become unsafe as district nurses currently operate at a caseload of c89 patients per district nurse (examples in the UK range from 50 to 60 patients per fte) – and therefore only limited support would continue to be available. Using different skill mix, such as developing the role of health care assistants in the community may support and ease district nursing caseloads.

For home care, 67.5 fte staff provide 94,149 visits to approximately 684 service users. By 2020, the demand for home care increases by 35% to just more than 127,000 visits p.a. The new funding envelope would only pay for 100,000 home care visits for 725 service users. More than 27,000 home care visits would be required to meet actual demand by 2020. Additional activity may be achieved through increasing the caseloads of home care staff supported by the use of Parish based community volunteers. Training and sharing of best practice may also enable district nurses and home care staff in increasing their caseload and managing workflow effectively.

## 7.2.2 Activity Implications

Self care demand is driven by:

- The individual's lifestyle choices e.g. diet, exercise, alcohol consumption
- The individual's behaviour e.g. visiting their GP for health checks, particularly those with long term conditions
- Awareness of the services available
- Need for dispensing medicines and other general pharmaceuticals
- Demography and disease incidence.

Service	Projected change to 2020
<b>GP</b>	<ul style="list-style-type: none"> <li>■ A 4% increase in GP appointments is projected by 2020. Funding streams would continue to create a financial disincentive for individuals, especially those with high needs, to access primary care, and equality of access and care would reduce, leading to increased exacerbations (and therefore pressure on unscheduled acute care), or an increase in the acuity of conditions (and therefore costs of treatment). Community pharmacists could provide an alternative for basic health checks and some proactive self care activities e.g. health promotion, however, this would also need to be on a fee-for-service basis</li> </ul>
<b>Family Nursing and Home Care</b>	<p>District nursing</p> <ul style="list-style-type: none"> <li>■ Currently at maximum capacity providing 58,425 visits for 3,465 patients. By 2020, capacity would increase to c62,000 visits for 3,680 patients (from an additional 2% funding). A further 17,000 visits for an additional 1,000 patients is required to meet demand for current services by 2020. Demand for 24-hour services has not been assessed</li> </ul> <p>Home care</p> <ul style="list-style-type: none"> <li>■ Currently at maximum capacity providing 94,149 visits for approximately 684 service users. By 2020, capacity would increase to 100,000 visits for 725 service users. More than 27,000 visits for an additional 200 patients is required to meet demand for current services by 2020. Demand for 24-hour services has not been assessed</li> </ul>
<b>Health Promotion Department</b>	<ul style="list-style-type: none"> <li>■ The 'help to quit' programme would continue to provide smoking cessation clinics based on existing funding. From the 12,000 of adults who wish to cease smoking ('Health for Life', HSSD States of Jersey), 7% contact the programme for support. However, reductions in funding would reduce the number of people able to access this service, and may result in increased need for, and therefore cost for, treatment and care for long term conditions such as COPD and CHD</li> <li>■ Other health promotion programmes targeted at improving the population's health and wellbeing would continue. As funding reduces these programmes would need to target only those in highest need, however, the absence of robust public health intelligence makes it difficult to conduct an accurate assessment of population's health and social care needs</li> </ul>
<b>Third Sector &amp; Volunteers</b>	<ul style="list-style-type: none"> <li>■ The current volunteering model based on St. Clements' community based support programme comprises c20 registered volunteers. 240 registered volunteers (c20 per Parish) would be required to provide support to help people live independently at home. However, the availability of volunteers may reduce as the burden on unpaid carers increases</li> </ul>

## 7.2.3 Staffing Implications

Staffing would increase to meet the increased demand from an older population. This would only be partly funded, and a shortfall in capacity would exist:

Service	Projected change to 2020
<b>GP</b>	See Primary Care section of this scenario
<b>Family Nursing and Home Care</b>	<p>District nursing</p> <ul style="list-style-type: none"> <li>2010 – At maximum capacity; 39 fte district nurses provide services to almost 3,465 patients</li> <li>2020 - Funding for an additional 2 fte district nurses would be available. However, a 35% increase in activity would require an additional £600k (c11 fte) to provide the current service coverage, and this would not meet demand for 24 hour care</li> </ul> <p>Home Care</p> <ul style="list-style-type: none"> <li>2010 – At maximum capacity, with 67.5 fte providing home care support to 684 service users</li> <li>2020 – Funding for an additional 4 fte home care staff would be available. However, a 35% increase in activity would require more than £615k p.a. to provide the current service coverage, and this would not meet demand for 24 hour care</li> </ul>
<b>Health Promotion Department</b>	<ul style="list-style-type: none"> <li>2010 - The 'Help to quit' programme comprises 3 fte nurses to deliver smoking cessation clinics.</li> <li>2020 – Funding for an additional 0.3 fte smoking cessation nurses (band 5)</li> </ul>
<b>Third Sector &amp; Volunteers</b>	<ul style="list-style-type: none"> <li>2010 – The current volunteering model includes c20 registered volunteers in the St. Clements' Parish. Third sector groups also provide support for specific needs/conditions, however, this is restricted due to limited resources</li> <li>2020 - c240 registered volunteers would be required across 12 Parishes. However, the numbers of physically and mentally able volunteers begins to decline due to the ageing population and the increased burden on unpaid carers. Similarly, there is a reduction in support provided by third sector organisations due to competition for funding</li> </ul>

## 7.2.4 Revenue and capital implications

Description	Impact	Set up costs	Additional annual running costs in 2020 (£)
<b>GP</b>	See Primary Care section of this scenario		
<b>Family Nursing and Home Care</b>	<p>District nursing</p> <ul style="list-style-type: none"> <li>Funding increase would provide capacity for 62,000 visits for 3,680 patients. Approximately 17,000 further visits would be required for an additional 1,000 patients to meet demand by 2020</li> </ul> <p>Home Care</p> <ul style="list-style-type: none"> <li>Funding increase would provide capacity for 100,000 visits for 725 service users. More than 27,000 visits for an additional 200 patients would be required to meet demand by 2020</li> </ul>	Recruitment costs of c £20k for advertisement, travel & accommodation expenses of non Jersey candidates and c£8k relocation fees per position (for district nursing positions)	<ul style="list-style-type: none"> <li>District nursing – increase from £2.2m in 2010 to c£2.35m p.a in 2020</li> <li>Home care – increase from £2.19m in 2010 to c£2.3m p.a in 2020</li> <li>Almost £650k p.a more funding for district nursing and £500k p.a for home care would be required to meet projected demand (based on current service model – i.e. not including demands for 24 hour care)</li> </ul>
<b>Health Promotion: 'Help to Quit' (Smoking Cessation)</b>	By 2020, the prevalence of smoking in adult population reduces from 23% (approximately 16,500) to 16% (approximately 12,400)	N/A	Funding at 2020 projected to be £439k p.a, which would include the funding for an additional 0.3 fte smoking cessation nurse

Description	Impact	Set up costs	Additional annual running costs in 2020 (£)
			plus associated non pay costs
<b>Third Sector &amp; Volunteers</b>	<ul style="list-style-type: none"> <li>■ Parish volunteers provide support to enable individuals to live more independently. Estimated at approximately 20 volunteers per Parish</li> <li>■ Third sector community groups support those with specific needs/conditions</li> </ul>	N/A	Small increase in travel and subsistence costs – e.g. cost of the weekly ‘Saturday Club’ delivered by the Jersey Alzheimer’s Association are more than £25k p.a. which includes 10 staff, transport costs and catering

### 7.2.5 Funding implications

Current funding streams create a financial disincentive for individuals, especially those with high needs, to access primary care. Changing the way practices are paid for activity can provide more flexibility to use a wider skill mix to deliver services. This is outlined in the Primary Care section of this scenario.

Increased demand pressure on services may lead to increased competition between third sector organisations to attract donations.

As insufficient funding would be available for the required increases in capacity, especially in district nursing and home care, thresholds and eligibility criteria would be required, and individuals would be required to fund, or part-fund the support they receive within their own homes – including paying for aids, adaptations and equipment to assist with activities of daily living. Alternatively, patients and service users may be admitted to long term residential or nursing care at an earlier stage due to the unavailability of 24-hour support in the home, which would impact their independence. Within a year the capacity in residential and nursing care becomes exceeded, and service users and patients would be required to fund this care, or remain in their own homes with limited community support.

This could create a two tier system, or could lead to care only being provided for those in greatest need, increasing the burden on unpaid carers and reducing their ability to lead productive and independent lives.

### 7.2.6 Benefits

#### 7.2.6.1 Service user/carer

- Improved quality of life for those who meet the eligibility criteria for, or are able to self-fund home care and/or district nursing support
- Increased control, confidence and empowerment for those accessing self care
- A gradual increase in cultural awareness of how people’s own actions can improve their health and wellbeing

#### 7.2.6.2 Quality

- Some information and services available to support individuals in living healthy lifestyles and managing their condition
- Good quality of care for those meeting eligibility criteria or able to self-fund

## 7.2.7 Risks

- Costs of visiting a GP may continue to deter individuals from attending, particularly those with long term conditions and long term care needs, as access to care becomes increasingly based on ability to pay. This would lead to a reduction in proactive case management and ability to slow the progression of need for long term care, impacting demand and costs downstream and placing further burden on budgets, capacity and unpaid carers. This could be partly addressed by increasing the role of community pharmacies and increasing the skill mix in primary care (if this was States funded rather than fee-for-service)
- Significant increased pressure on district nursing and home care, leading to unmet demand and increased admission to hospital / residential homes as patients cannot be supported in the community
- No support available for patients and service users over a 24-hour period. This would increase demand on institutionalised settings and increase the burden on unpaid carers
- Limited increases in budgets for aids, adaptations and equipment, reducing the ability of service users to perform activities of daily living in their own homes, and increasing their dependence and need for long term residential care
- Residential and nursing homes exceed capacity, leading to a need for spot purchasing (at higher cost and potentially reducing outcomes)
- A two tier system would develop, based on ability to pay for care
- Limited public health intelligence would be available to support targeted health and social care campaigns
- Information becomes quickly out of date, with conflicting messages due to the volume of information and lack of quality assurance on the content of material produced
- Identifying hard to reach groups and creating an inequitable services would be limited due to information availability
- Patients and service users may be resistant to self care, if they do not take responsibility for their own health and wellbeing

## 7.2.8 Implementation timetable

Initiative	Timescale	Action
<b>Family Nursing and Home Care</b>	June 2011	Recruitment of additional district nurses and home care staff
<b>Health Promotion</b>	December 2011	Develop coordinated directory of self care information/services
<b>Third Sector &amp; Volunteers</b>	December 2011 and ongoing	Increase number of Parishes providing community groups

## 7.2.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Unmet	Initiatives in place to support self care do not achieve the impact required due to limited funding to drive full coordination and enhance self care services
<b>Ensure Clinical/service viability</b>	Unmet	District nursing and home care have insufficient funding to meet demand based on current service provision – and no funding to increase service provision to 24 hours  Some utilisation of other professional groups e.g. community pharmacists provide additional capacity to deliver access for some services
<b>Ensure financial viability</b>	Unmet	Limited resources to support patients in the community leads to increased care in expensive estate-based services e.g. hospital and residential homes  Capacity is exceeded in residential and nursing homes, and spot purchasing is necessary (at higher cost)  Care becomes increasingly based on ability to pay  Limited resources to support self care leads to greater prevalence of long term conditions and social care needs. Consequently, demand continues to increase in future years
<b>Optimising estate utilisation</b>	Partially met	Facilities such as community pharmacies and third sector community groups are utilised to provide services to support self care. However, implications of limited resources to support self care lead to avoidable admissions/readmissions to hospital in addition to nursing and residential homes
<b>Workforce utilisation and development</b>	Partially met	Increased demand to support individuals living independently places significant pressure on district nursing and home care staff  Pressure to meet immediate demands reduces the opportunity for role review and enhancement; nursing roles in particular continue to be delivered in traditional service models
<b>Clinical governance</b>	Unmet	District nursing and home care services become unsafe as staff are challenged with meeting increased demand within limited resources
<b>Use of business intelligence</b>	Unmet	Public health intelligence continues 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.

## 7.3 Primary Care

### 7.3.1 Outline of services

In 2010, the States funding of General Practice totalled £8.7m – (£20.4m including prescribing). Caring for a total of 89,819 patients, this equates to £96.71 (£228 with prescribing) per patient per annum.

Within a scenario of public funding at inflation +2% for three years, then inflation thereafter, a total funding envelope of £9.13m (including the Quality Payment, which is capped at £1.5m) would be available for primary care in 2020. This funding envelope would need to care for 93,053 patients, equating to £96.03 per patient per annum.

However, this reduced 'allocation' per patient per annum would need to fund increased activity, as the ageing population has higher health and social care needs. The 2010 primary care activity of almost 343,000 consultations is projected to increase to almost 539,000 in 2020, reflecting both the increased need from the elderly population plus an increased demand driven by the new Quality Framework. As previously noted, this demand increase is based on the experience following the introduction of the Quality Outcomes Framework in the UK, and may in reality be lower in Jersey due to the difference in funding and payment mechanisms and the detail which will be contained within the Quality Contract. This would reduce the total rebate from the States per consultation from >£19 in 2010 (when 'other services' payments are included) to c£16 per consultation in 2020. Removing the 'other services' element of this rebate would produce a copayment per patient for the consultation element only of c£13.

Prescribing would increase to £12.5m if uplifted by 2% and there were no changes in prescribing behaviours; however, it is highly likely that the incidence of long term conditions and the demographic changes would increase this still further.

#### 7.3.1.1 General Practice

This scenario includes the work being introduced by the Primary Care Development Programme<sup>70</sup>:

- the introduction of General Practitioner regulation (performers list)
- performance monitoring and quality information
- the rebate (£15) and quality payment (currently £4), capped at £1.5m in total (plus inflation)) may be applied to practice staff other than GPs
- non-medical prescribing, allowing nurses, pharmacists and other appropriately trained clinicians to prescribe, both as part of an agreed plan (dependent prescribing) and as an individual taking on the clinical responsibility (independent prescribing)

The introduction of a Quality Framework can have significant benefits for patients. However, lessons should be learned from the experience of the UK Quality and Outcomes Framework (QOF). As the plans for the Quality Framework in Jersey are developed, the lessons learned from the UK should be fully considered and incorporated, and the systems developed to enhance current services and build upon the incentives for both patients and staff which are inherent in Jersey's future funding of primary care. A recent report by the Kings Fund<sup>71</sup> concluded that QOF:

- has incentivised general practices to have a more organised approach to chronic disease management, and provided a strong incentive to engage in secondary prevention

<sup>70</sup> Proposition 36 (Health Insurance (Medical Benefit) (Amendment No. 3) (Jersey) Regulations 201 May s2010

<sup>71</sup> Impact of Quality and Outcomes Framework on health inequalities. Kings Fund, April 2011

- has entrenched a medicalised and mechanistic approach to managing chronic disease that does not support holistic care or promote self-care and self-management
- has gradually reduced differences in performance on QOF between the least and most deprived practices, which have all but disappeared in recent years
- provided an incentive for deprived practices that were not well organised and lacked resources to adopt a more systematised approach
- however, QOF has not incentivised primary prevention, self-care and self-management

It also concluded that, for the future:

- QOF indicators and the weighting of points need to be aligned to the objective of reducing health inequalities. Other pay-for-performance frameworks may need to be developed to reward deprived practices for delivering care that meets the needs of vulnerable and hard-to-reach populations
- Pay-for-performance schemes should be linked to improvements in performance above an established baseline rather than achievement of absolute thresholds in order to ensure that inequalities in practice resources are not worsened. They should also reward population outcomes such as reduced emergency admissions
- Thresholds within the QOF need to be set so that there are sufficient incentives for proactive case finding, particularly in deprived areas where prevalence is higher. Practices also need to reach out to individuals and find ways of providing services to those patients who are less likely to attend the practice

In Jersey, some practices have reported that only a proportion of chargeable income is actually received. This information has not been verified or validated, and it should be noted that not all stakeholders in Jersey agree with this assertion.

The Quality Outcomes Framework in the UK rapidly increased the consultation rate from just below 4 consultations per patient p.a to c5.5 consultations per patient p.a shortly after its introduction. This, along with the increased consultation rate for older people, particularly those over 85, indicates that, by 2020, almost 539,000 primary care consultations p.a would be required. This is an increase of almost 60%. In order to fund this additional activity, two options exist:

**Option 1:** funding systems remain the same (rebate and co-payment)

**Option 2:** co-payment for GP services, with subsidised service provision from other primary care professionals

#### 7.3.1.2 Option 1: funding systems remain the same (rebate and co-payment)

If the **availability of GPs was unlimited** (so therefore all increases in demand could be met by GPs), the rebate/ State funding for primary care would need to reduce from the current £19 per consultation to c £13 per consultation in order to remain within the publicly funded cost envelope for the rebate of c£9.2m (including quality payment) in 2020 – or an average of c£16 per consultation when ‘other services’ are included.

In order for GPs to receive the same total funding per consultation, the co-payment element would therefore need to increase from £35 per consultation to >£40, if all chargeable payments were made and received.

GPs would continue to undertake an average of c10 consultations per session.

The co-payment total would be >£21m, with an overall total of >£29m. This compares to the 2010 totals of £12m for co-payments and >£18.5m overall total, and reflects the increase in demand as previously noted.

Assuming 9 sessions per GP, 46 weeks per year, the current consultation rate is c10 consultations per session per fte GP. In order to meet the additional demand, at the same rate of consultations per session, c100 fte GPs would be required by 2020.

In an environment where the **availability of GPs was limited**, increased productivity would be required in order to care for the increased demand. This increased productivity (and therefore increased activity) would still incur the same rebate and co-payment as outlined above. This would require the current 77 fte GPs to undertake 7,000 consultations p.a, equivalent to 16 consultations per session.

### 7.3.1.3 Option 2: co-payment for GP services, subsidised service provision from other primary care professionals

As demonstrated above, demand for primary care services, driven by the ageing population and quality framework, would increase by almost 196,000 additional consultations per annum.

Internationally, primary care services have moved towards a more multidisciplinary model. For example, in the UK<sup>72</sup> 34% of primary care consultations are undertaken by nurses, with 'other' staff undertaking 4% of consultations (i.e. 62% of primary care consultations are undertaken by GPs).

Within a flat funding scenario, however, the patient may need to pay for the services of the multidisciplinary team within primary care.

Using the UK rate of primary care consultations, primary care demand would be met by:

Figure 55: Primary care consultations

Profession	Proportion of care	Number of cases (projected at 2020)	Cost per consultation (rebate and co-payment at 2010 rates)	Total cost (total)	Total cost (rebate @£19 per consultation)
GPs	62%	c334,000	£54 (incl quality payment capped at £1.5m)	c£18m p.a	c£6.5m p.a
Practice nurses	34%	c183,250			c£500k p.a
Other	4%	c21,500			
<b>Total</b>	<b>100%</b>	<b>c539,000</b>		<b>£18m p.a</b>	<b>c£7 m p.a</b>

<sup>72</sup> Research Final Report to NHS Information Centre and Department of Health. Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the Research database. NHS Information Centre

The table above indicates that the total cost for GP consultations in 2020 would be just over £18m. At the same rebate rate of £19 per consultation (including quality payment), the cost to the States would be c£6.5m. Of the projected c£9m States rebate funding envelope, c£3.5m p.a would therefore remain. However, this rebate would also need to fund 'other services', so the actual consultation rebate remaining would be c£1m p.a. This would be required to fund more than 200,000 consultations that would be provided by a nurse or other professional in primary care – i.e. c£5 per consultation.

An average cost per consultation for a Band 6 nurse is c£7.50 (at a total salary cost of £50k p.a). The States would need to negotiate a sessional rebate / funding for practice nurses and other staff in order to cover the costs of running their premises and other services e.g. receptionists and administrative staff.

Therefore, co-payments would need to be introduced for other primary care staff – however, these would be minimal. As part of the detailed business case, the levels of Primary Care payments will need to be further considered, particularly with regards to the need to support and maintain the ongoing financial viability of Primary Care services in Jersey.

#### 7.3.1.4 Out of Hours Service

It is assumed that demand for the out of hours service would increase at the same rate as the demand for primary care, i.e. almost 60% over the period:

Figure 56: Out of hours projections

Activity type	2010 volume	2020 volume	2010 total rate	2020 cost (c60% increase in activity)		2010 States cost £	2010 co-payment £	2020 States cost £ (inc quality payment)		2020 co-payment £
				2010 cost £	2020 cost £			2020 States cost £	2020 quality payment £	
Base surgery visits	3,100	c4,870	c£61	£190k	c£300	£60k	c£130k	c£90k	c£205k	
Night visits	550	c865	£129	£70k	c£110k	£10k	c£60k	c£15k	c£95k	
Evening and weekend visits	2,600	c4,080	£99	£405k	c£405k	£50k	c£210k	c£80k	c£325k	
Telephone advice	2,500	3,925								
<b>Total</b>	<b>8,750</b>			<b>c£520k</b>	<b>c£815k</b>	<b>c£120k</b>	<b>c£400k</b>	<b>c£185k</b>	<b>c£630k</b>	
Increase					c£300k			c£70k	c£130k	

#### 7.3.1.5 Community Pharmacist

The drug budget is currently almost £12m. An increase of c 60% would result in a drugs budget of £18.5m i.e. an increase of c£6.5m p.a.

### 7.3.1.6 Enhanced governance

The Primary Care Development Programme introduces new governance arrangements for GPs. This is due to be implemented, and is essential to the continued employment of GPs in Jersey. It is understood that funding for this has already been agreed, and as such we have not modelled the impact of this.

### 7.3.2 Staffing Implications

Staff group	Number of staff	Cost in 2020 (£)
<b>GP</b>	<p>Option 1</p> <ul style="list-style-type: none"> <li>■ GPs increase from 77 fte in 2010 to c100 fte in 2020</li> <li>■ If productivity increases from c10 consultations per session to 16 consultations per session, almost 90 fte GPs are required</li> </ul> <p>Option 2</p> <ul style="list-style-type: none"> <li>■ GPs reduce from 77 fte in 2010 to c55 GPs in 2020 (at 16 consultations per session)</li> </ul>	The cost is incorporated in the rebate and co-payment – see ‘Revenue and Capital implications’ section
<b>Practice Nurse</b>	<p>Option 1</p> <ul style="list-style-type: none"> <li>■ Practice nurses and other staff do not increase from 2010 levels of 4.5 fte</li> </ul> <p>Option 2</p> <ul style="list-style-type: none"> <li>■ &gt;30 fte practice nurses and other staff</li> </ul>	c£1.5m p.a
<b>Out of Hours</b>	Possible increase to cover weekend visits	c£200k
<b>Community Pharmacists</b>	Visits/consultations increase from 6,240 in 2010 to c9,750 by 2020	This would be a co-payment cost to the patient

Jersey born doctors can enter into practice on the Island without restriction, however, in the future, recruitment of GPs may be hindered by:

- Reduced financial attractiveness of working on the island relative to the UK (where GP remuneration (including a pension) is increasing)
- The need to buy ‘goodwill’ (estimated at £270k per GP)
- The possible need to pay rent on accommodation or buy into practice property
- The need to provide for private pensions
- Costs of living in the Island (particularly education and university costs for children)
- The erosion of chargeable income from patients (as personal incomes fall)

Nurses have also been traditionally difficult to recruit to the island as they do not attract housing rights and have hitherto experienced a more limited career path than in the UK.

### 7.3.3 Revenue and capital implications

Description	Impact	Set up costs	Additional annual running costs in 2020 (£)
<b>Growth in demand for primary care services and in particular long term conditions</b>	Increased demand by almost 60%	Education and recruitment costs for more than 30 fte additional nursing staff - £150,000	<p>Option 1:</p> <ul style="list-style-type: none"> <li>■ Total cost increases from c£18.5m in 2010 to &gt;£29m p.a in 2020</li> <li>■ The funding envelope for States funding increases from c£8.7m in 2010 to &gt;£9m p.a in 2020</li> <li>■ Co-payments therefore need to increase from £12m in 2010 to &gt;£21m p.a in 2020</li> </ul> <p>Option 2:</p> <ul style="list-style-type: none"> <li>■ The rebate remains at £19 per consultation.</li> <li>■ GPs undertake 62% of consultations, at a cost to the States of c£6.5m</li> <li>■ £3.5m p.a remains for a rebate for other primary care staff and 'other services'</li> </ul>
<b>Enhanced Governance</b>	Improved governance to meet revalidation standards of GMC-UK	<p>Establishment of performers list - c£25k</p> <p>Additional equipment costs e.g. spirometers c£50k</p>	<p>Governance costs c£200k p.a (0.4 fte Responsible Officer and supporting staff)</p> <p>Remedial costs for clinical staff c£50k p.a</p>
<b>Community Pharmacists</b>			Cost to patient

### 7.3.4 Funding implications

As outlined above, there are two options for funding primary care services within scenario 2:

**Option 1:** funding systems remain the same (rebate and co-payment)

The funding system would remain as is, but the amount and proportion of States rebate and copayment would change to reflect the new funding envelope and demand.

**Option 2:** co-payment for GP services, subsidised service provision from other primary care professionals

Primary care services would develop so that patients had access to an increased range of professionals. Funding for GP services would remain as is, and The States would provide a rebate for non-GP primary care services.

### 7.3.5 Benefits

The potential benefits from this scenario will depend on the funding option that is progressed.

#### 7.3.5.1 Service user/carer

- For those who can afford it, earlier more effective risk assessment, detection, diagnosis and treatment. For option 2 this benefit is less dependent on ability to pay, as non-GP primary care services are available at a very low cost to the patient
- (option 2) Ability to see nurse or other healthcare professional, as appropriate
- (option 2) Improved treatment of long term conditions
- (option 2) Less dependence on hospital

#### 7.3.5.2 Workforce

- (option 2) Nurses and other care professionals would develop skills and capability in primary care to deliver a wide range of services including disease management. Nurses could become non-medical prescribers

#### 7.3.5.3 Quality

- (option 2) Ability to provide a holistic care focus as opposed to an illness based approach
- (option 2) Services are provided by right staff member with lots of experience e.g. phlebotomy

#### 7.3.6 Risks

- Risks are inherently the same as for scenario 1; although, depending on the funding option, greater capacity from a range of primary care professionals may be available
- Recruitment and training (including prescribing training) will continue to be challenging

#### 7.3.7 Implementation timetable

This is being in part implemented through the Primary Care Development Programme, for example developing systems to support the quality initiative (e.g. Proposition 36 (Health Insurance (Medical Benefit) (Amendment no. 3) (Jersey) Regulations 2011, which comes into effect in May 2011).

When the Quality Framework is introduced, there is likely to be an increase in demand. This could reach the 5.5 consultations per patient year depending on whether the costs of attending the GP act as a barrier to care.

Skill-mix changes are unlikely to be introduced rapidly due to recruitment challenges. Recruitment and training of nurses is likely to be problematical for the first 3 - 5 years until existing nurses on the island are trained and in post.

### 7.3.8 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Partially met	The Primary Care Development Programme goes some way to addressing the challenge of sustainable quality, through introducing the quality contract  The public's ability / willingness to pay will impact sustainability for option 1; recruitment of primary care nurses and other primary care professionals will impact sustainability for option 2
<b>Ensure Clinical/service viability</b>	Partially met	Broadening the range of professionals working in primary care would increase the service viability through a larger and more interchangeable team
<b>Ensure financial viability</b>	Unmet	A lack of controls on expenditure or claims by GPs could lead to supplier-induced demand and therefore increased rebate and copayment claims by those professionals who are paid on a fee-for-service basis
<b>Optimising estate utilisation</b>	Partially met	Improved use of resources would be achieved by extending the primary care team, with more patients presenting in primary care relieving some of the estates pressures in acute settings
<b>Workforce utilisation and development</b>	met	Broadening the primary care team would improve appropriate focusing and use of skills, and would support role enhancements and multidisciplinary team working
<b>Clinical governance</b>	Partially met	This should be achieved through the Quality Framework and governance structure
<b>Use of business intelligence</b>	Unmet	Comprehensive systems and records need to be in place with skills to extract and analyse data. The Quality Framework hopes to begin to address this

## 7.4 Acute Care

### 7.4.1 Outline of Services

The emergency and unscheduled care budget forms part of the main hospital budget. Due to the nature of the ward configuration it is not possible to separate ward costs.

Scenario 1 demonstrated the impact on services from the pressure of projected demographic change. In a scenario with limited funding, this would produce a significant budget shortfall:

Figure 57: Projected budget shortfall, acute care

	£m (2010 prices)
2010 funding for the hospital	£103m
Projected 2020 funding for the hospital	£113m <sup>73</sup>
Projected 2020 cost for the hospital (based on salary inflation and demographic change)	£130m
Projected gap between funding and cost at 2020	<b>(c£17m)</b>

Demand would increase to levels that are not treatable within the current capacity. This would lead to either a number of patients not being treated, or significant increases in waiting lists:

<sup>73</sup> Modelled 2013 financials

Figure 58: Projected activity shortfall, acute care

Activity not treated over time	2010	2020	2030	2040
Elective inpatient spells	-	433	820	950
Non-elective inpatient spells	-	1,030	2,330	3,390
Outpatient first appointments	-	2,210	4,350	5,290
Outpatient follow up appointments	-	6,920	13,990	17,150
Day case spells	-	2,370	4,670	5,660
Emergency attendances	-	1,770	3,640	5,100

A cost reduction programme could typically be expected to reduce costs by c10% - reducing the funding gap to just above £7m p.a. However, due to the isolated nature of Jersey and the lack of alternatives for treatment in the community, a prudent target would be 5%. If this were achieved, this would therefore reduce the funding gap to more than £12m p.a.

As previously noted, this also does not take into account additional funding required for advances in technology and drugs. Therefore, savings achieved through productivity / efficiency would still not be sufficient to meet the funding gap identified above, and therefore services would either need to close, need to be funded from non-public sources, or eligibility criteria and thresholds would have to rise so that patients would be treated at a more advanced stage of their condition.

#### 7.4.1.1 Decommissioning procedures of limited clinical value

In the context of financial and capacity pressure, a decision would be made regarding which procedures would be funded publicly.

Procedures of limited clinical value<sup>74</sup>, for example certain cosmetic surgery, would not be funded by the States.

Provision of other surgical procedures would be subject to thresholds and protocols to ensure these are conservatively managed as clinically appropriate until surgery is the most appropriate intervention.

In order to provide an assessment of the level of savings that could potentially be achieved as a result of decommissioning of procedures of limited clinical value, we have mapped the 34 procedures from the list from the London Health Observatory<sup>75</sup> and taken a proxy of 10% of general surgery. This would save around one bed p.a.<sup>76</sup>

The above initiatives would have the following impact on different parts of the hospital:

<sup>74</sup> London Health Observatory, Save to Invest

<sup>75</sup> London Health Observatory, Save to Invest, 2003

<sup>76</sup> HSSD Financial model version 1.0

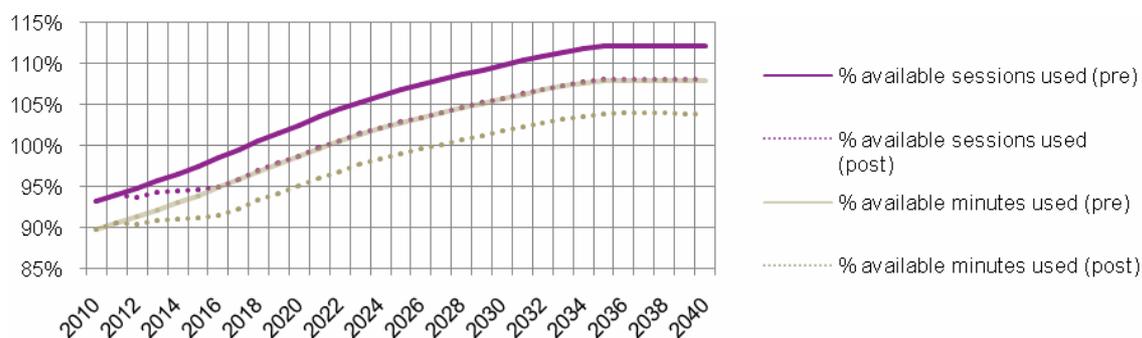
### 7.4.1.2 Surgical beds

As outlined in section 8.2.1.7 'Strategic Partnership with UK Centre', Jersey General Hospital should be able to achieve upper quartile day case rates (71.6% in England). This would reduce the need for surgical beds by 4<sup>77</sup>.

### 7.4.1.3 Theatres

As outlined in scenario 1, by 2020 the hospital is projected to need an extra 8% of capacity in each elective theatre. Therefore, this would represent sessions equivalent to (8% $\times$ 3 theatres) = 24% of a new theatre required.

Figure 58: Projected theatre demand



Source: HSSD Financial model version 1.0

Scenario 1 also indicated that unless theatre sessions are flexed to find additional capacity within the existing footprint, additional funding of £5m capital<sup>78</sup> would be required for a new theatre now. Full staffing of a theatre would cost £1.3million, but this could be implemented in a phased manner reflecting the additional workload. By 2020 the staffing costs would be c£200k<sup>79</sup> p.a. for one quarter usage of additional capacity.

Theatre use is likely to be impacted (see graph above) by decommissioning of procedures of limited clinical value. A proxy figure of 10% in general surgery would mean that additional capacity would be available in main theatres for another 4 years. Savings would also be made of more than £500k p.a.

As outlined under section 8.2.1.7 'Strategic Partnership with UK Centre', Jersey should be able to achieve upper quartile day case rates (71.6% in England). This would decrease the need for main theatre capacity by 19%. According to the information provided and our model<sup>80</sup>, this would mean that the need for day theatre capacity will become even more acute, but the need for main theatre capacity would be reduced to a level at which no additional capacity would have to be built (ie no need for an extra main theatre).

<sup>77</sup> HSSD Financial model version 1.0

<sup>78</sup> Bradford Royal Infirmary [www.yorkon.co.uk/bradford-hospital.html](http://www.yorkon.co.uk/bradford-hospital.html)

<sup>79</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre by 2020

<sup>80</sup> HSSD Financial model version 1.0

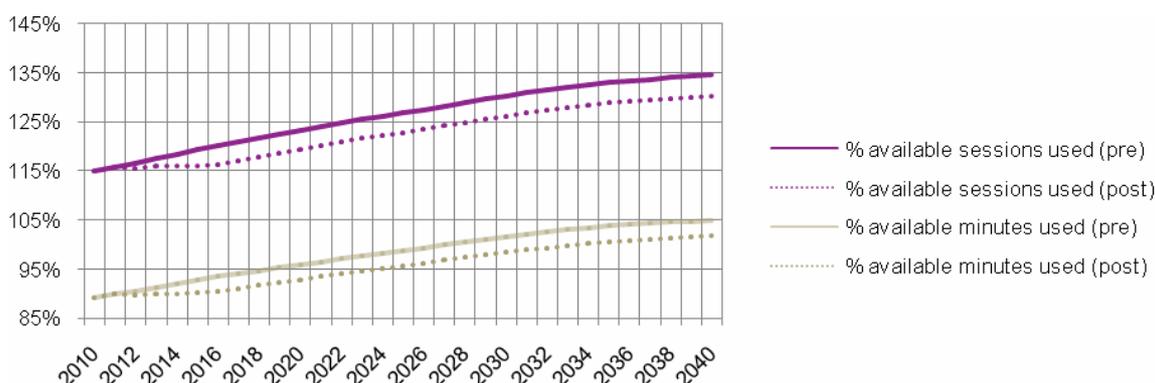
Waiting lists should also be taken into consideration. The net change in the waiting list for all surgery increased between December 2009 and December 2010 was an increase of 5 procedures. As the waiting list as at December 2010 comprises 1,591 procedures, this would suggest a legacy waiting list. The waiting list is equivalent to 47% of the annual surgical activity. Of these, 268 waited longer than 3 months, which represents 8% of annual surgical activity. The largest increases were for oral surgery (54 cases), and ENT (29 cases). Other specialties reduced their waiting list during the period.

#### 7.4.1.4 Day case theatres

As outlined in scenario 1, day case surgery is already at capacity, at 8,622 cases per annum. The projected demand at 2020 is almost 9,500 cases per annum. Therefore, with no service changes 827 procedures will not be able to be undertaken in 2020, and the waiting list would increase significantly.

Scenario 1 also indicates that booked day case surgery capacity is 2.11 theatres in 2010, and would be 2.24 in 2020, with the utilised capacity at 1.79 in 2010 increasing to 1.92 in 2020. Utilisation is at 90% in 2011, and would reach 95% in 2018. Therefore if no changes were made to the service additional day theatre capacity of sessions equivalent to a quarter of a day theatre would be required by 2020. Capital costs would be £5m<sup>81</sup> and staffing costs would be c£120k p.a.<sup>82</sup> for additional theatre capacity by 2020.

Figure 59: Projected day care theatre demand



Source: HSSD Financial model version 1.0

Use of day theatres is likely to be impacted by decommissioning procedures of limited clinical value. A proxy figure of 10% in general surgery would mean that additional capacity would be available in day theatres for another 5 years. Savings would also be made of almost £210k p.a.

The impact of integration between primary and secondary care, and care provided based on integrated care pathways, is expected to be minimal, as this would not result in a reduction of procedures. However, it may mean that the procedures in day theatres could also be carried out by GPs with additional training, possibly within a primary care setting. This would require detailed analysis of clinical safety and appropriateness given the close proximity of the hospital to most GP surgeries.

<sup>81</sup> Estimates based on £2k per sqm + 30% equipment costs; requires specialist advice

<sup>82</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

As outlined above under section 8.1.2.7 'Strategic Partnership with UK Centre', Jersey should be able to achieve upper quartile day case rates for day surgery (71.6% in England). This would require an increase in day theatre capacity of 25% by 2020.

#### 7.4.1.5 Accident and Emergency

Demographic projections indicate that demand would increase by 5%, or 1,800 attendances p.a. (from 37,468 to almost 39,250). With no changes to access and productivity, A&E activity is modelled to exceed staffing capacity in 2017 prior to this it is assumed that the increase of 3% could be absorbed with the current staffing level.

##### *Reduce minor injury attendances*

Social marketing, self care and the provision of information and education would encourage people to attend A&E for the appropriate reasons. The impact of this could reduce A&E attendances by up to 5% or up to 2,000 attendances by 2020, thereby enabling demand to be treated within the current capacity. However, given the funding pressures and impact on health and wellbeing promotion and self care outlined in the 'Self Care' section of this scenario, and the significant increase in demand and potential increase in co-payments outlined in the 'Primary Care' section of this scenario, it is likely that demand for A&E would increase rather than reduce. It is therefore likely that A&E capacity would become very quickly exceeded, leading to significantly increased waiting times and pressure on staff, with a consequential impact on sickness absence, retention and safety.

##### *Co-location*

Currently A&E has 3 consultants and a junior doctor (F2), with a GP out of hours centre located on the opposite side of the hospital. Avoiding admission is proven to be supported through early senior decision making. Co-location could improve this decision making through access to a GP out of hours to support the F2 in A&E, and improve speed of throughput and reduction in admission to A&E. It is anticipated that this would support the effective discharge of patients and the appropriate use of the EAU beds.

##### *Payment for non-urgent attendances at A&E*

This strategy may have to be employed, to ensure that perverse incentives driven by the current co-payment system are removed from the system.

In 2010, 75% of attendances at A&E were categorised as non-urgent. 24% of A&E attendances (9,036) were from children and adolescents aged 18 years or under. This does not include attendances on Robin Ward, where parents are able to 'drop in' for assessment. Only 788 non-elective admissions resulted from more than 9,000 presentations. The average length of stay was 2.4 days. This profile suggests that many attendances are either by the 'worried well' or for checks.

It is estimated that 40% of A&E attendances<sup>83</sup> could incur a co-payment charge of approximately £30. This would raise revenue of £360k p.a but, more importantly, would encourage patients to present at the most appropriate place and/or engage in increased self care activities.

<sup>83</sup> Based on professional opinion from Jersey U:collaborate Emergency Group and GP opinion and the Cooke et al; Towards Faster Treatment: Reducing attendances and waits at A&E departments; DH; Service Delivery Organisation; October 2005;

### *Payment for prescriptions*

Prescriptions are currently free from A&E. In addition, some drugs on the formulary can only be commenced by a consultant, although they can be continued by the GP. This puts additional pressure on the hospital and increases attendances at both A&E and Outpatient clinics. The introduction of a prescription payment in the hospital could reduce this demand. Detailed analysis of the pricing would be required to determine the potential revenue stream.

### *Expanded insurance payments*

A system similar to that of Guernsey could be introduced - an insurance system that covers ambulance journeys, attendances at A&E and potentially some non-elective procedures, as well as all elective work.

This would have the effect of reducing the amount of activity that is States-funded, as the majority of the island would be insured. The implications of this would require a full detailed review as part of a further business case stage of work.

#### **7.4.1.6 Emergency Ambulance Service**

The ambulance service is currently at capacity, with demand predicted to increase by 16% by 2020. An additional ambulance is required, unless demand can be reduced. . The cost of the purchase of a new bariatric ambulance is approximately £90k p.a.<sup>84</sup> plus staffing. Within a flat funding scenario, investment would not be available to fund an additional ambulance, or a call handling / telephone triage centre which could assist with managing demand.

#### **7.4.1.7 Medical and surgical wards**

##### *Reducing length of stay*

Length of stay for elective care is currently comparable to the UK average. For non-elective care it is slightly higher, at 7 days. If reduced to 6 days, through the introduction of measures such as additional weekend or nurse led discharge this could save the equivalent of 3,500 bed days in 2010, rising to almost 4,500 by 2020 (equivalent to 11 beds based on 85% occupancy level). This has the potential to delay the crisis of the bed utilisation exceeding current capacity from 2015 to 2021.

However, savings could only be realised if beds were actually closed and staffing levels adjusted.<sup>85</sup> Moreover, this would require a full range of community care available 24 hours, including intermediate care for 'step down' from hospital – and with a limited funding envelope, it is unlikely that this would be available (see the 'Older Adults' section of this scenario).

Length of stay could be improved through measures such as:

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<http://www.sdo.nihr.ac.uk/files/adhoc/29-briefing-paper.pdf> and Primary Care and Emergency Departments; Report from the Primary Care Foundation March 2010 p5

<sup>84</sup> Nick Trigg report 3 February 2011 <http://www.bbc.co.uk/news/health-12287880>

<sup>85</sup> This would not be possible without the prerequisite community services and beds becoming available

- Admit on day of surgery – for patients with transport problems, list them for afternoon session
- Hold pre-assessment clinics at first outpatient appointment and list for surgery at that time
- Reduce waiting and reporting times for investigations
- Access to weekend diagnostics
- Discharge patients otherwise fit but awaiting an investigation/ report
- Introduce ‘assertive in-reach’ from community teams
- Agree full care pathways including community and primary care, with protocols for length of stay and discharge
- Introduce ‘consultant of the day’ to undertake ward round on all patients (not just their own)
- Introduce an investigations ward with trolleys/chairs rather than beds, to ensure investigations are undertaken as day cases
- Implement a pooled referral scheme to ensure consultant-to-consultant referrals are progressed quickly and appropriately
- Reduce outliers (who often have longer lengths of stay and less clinically appropriate treatment)
- Expand the Enhanced Recovery Programme<sup>86</sup>, a dedicated programme improving patient outcomes and speeding up a patient’s recovery after surgery. Case studies<sup>87</sup> show that for total hip or knee replacements, the mean length of stay could be reduced from 8 days to 5 days. Based on an average cost per bed day of £233<sup>1</sup>, this equates to an efficiency saving of c£700 per patient for those procedures.
- Medical needs addressed during in-patient time for surgery
- Review staffing and skill mix to ensure optimum use of staff’s competencies
- Weekend discharges
- Discharge planning upon admission
- Closer working with social services and FNHC to reduce the number of delayed discharges (average of 20 delayed transfer of care each day<sup>88</sup>)
- Consultants attached to wards
- Nurse-led discharge

### *Reducing non elective admissions*

- Undertake a full review of the acute medical pathway, including the thresholds for admittance
- Reprofile the workforce and utilise available resources, such as the newly appointed Night Nurses, to ensure the staffing are in the right place to support speedy discharge of patients from EAU
- Agree the ‘take’ protocols and ensure one approach is undertaken

<sup>86</sup> Clinical evidence for enhanced recovery in surgery - MSK’, NHS Enhanced Recovery Programme 2010

<sup>87</sup>

[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/enhanced\\_recovery\\_programme.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html)

<sup>88</sup> Statistics from Madeline Simpson and Andrew McLaughlin Wednesday 23 March 2011

#### 7.4.1.8 Theatres

- Co-ordinate start times of relevant staff groups to reduce delays to start times
- Increase number of cases per session – identify and address limiting factors
- Implement robust pre-assessment to reduce last minute cancellations caused by patient fitness, patient education
- Increase day surgery rate to that of the England upper quartile
- Medicines Management in theatres: the provision of a pharmacy led drug stock management system<sup>89</sup> and a clinical pharmacist presence in theatres and recovery reduces drug loss and wastage from expiration, better management of drug stocks in theatres and recovery; reduction on theatre and recovery staff time spent on drug stock management.

#### 7.4.1.9 Outpatients

- Reduce DNAs:
  - Phone/text reminder
  - Agree date for follow-up when discharged
  - Robust policy for non-attenders
  - Provide a notice for GP surgeries re: DNAs and cost wastage

Such initiatives<sup>90</sup> can help reduce DNA rates by 10% - 15%. Based on the number of Outpatient Follow Up appointments in Jersey (2010), this equates to approximately 14,000 – 20,000 appointments p.a

- Provide clinics at accessible times
- Reduce follow-up outpatient appointments
- Introduce a rapid access clinic with clear criteria

#### 7.4.1.10 Clinical Support Services

- Reduce requests for inappropriate investigations
- Reduce unnecessary duplication/repeat of investigations
- Reduce turnaround time
- Stagger request times for investigations and medication/TTOs to reduce peaks and troughs in demand
- Standardise forms and process for requesting investigations

#### 7.4.1.11 Non clinical support services

- Review cleaning, catering, laundry and estate management arrangements
- Renegotiate contracts for supplies
- Monitor compliance

<sup>89</sup> Branch et al, 1993

<sup>90</sup> The effect of reminder calls in reducing non-attendance rates at care of the elderly clinics' (F. Dockerty et al, 2000)

## 7.4.2 Activity Implications

Service	Projected change to 2020
<b>Emergency Ambulance service</b>	<ul style="list-style-type: none"> <li>■ Projected to increase from 6,039 journeys in 2010 to more than 7,000 journeys p.a in 2020</li> </ul>
<b>A&amp;E</b>	<ul style="list-style-type: none"> <li>■ Projected to increased from 37,468 attendances in 2010 to more than 39,250 attendances p.a in 2020. Measures such as introducing self care measures could reduce this by the predicted 5% or 2,000 attendances. Other measures such as charging may develop an income stream and in time reduce activity, predicted to be up to 10%</li> </ul>
<b>Surgical beds</b>	<ul style="list-style-type: none"> <li>■ An increase in day case rate for surgery to upper quartile (England) would save 4 beds</li> </ul>
<b>Medical beds</b>	<ul style="list-style-type: none"> <li>■ Projected to increase from 6,852 spells in 2010 to almost 8,000 spells or almost 46,000 bed days in 2020</li> <li>■ Reducing the average length of stay from 7 days to 6 days would save the equivalent of 3,500 bed days in 2010, rising to almost 4,500 by 2020 (equivalent to 11 beds). This has the potential to delay the crisis of the bed utilisation exceeding current capacity from 2015 to 2021</li> </ul>
<b>Theatres</b>	<ul style="list-style-type: none"> <li>■ Increased scheduling in day theatre and endoscopy may provide additional capacity to accommodate the need for 0.25 additional day and endoscopy theatres by 2020; for main theatres additional capacity will still be required based on information available</li> </ul>
<b>Outpatients</b>	<ul style="list-style-type: none"> <li>■ Reducing DNA rates would provide additional capacity for 14,000 to 20,000 additional appointments</li> </ul>
<b>Clinical Support Services</b>	<ul style="list-style-type: none"> <li>■ Reduction in inappropriate or unnecessarily repeated investigations could reduce activity by 10%</li> </ul>
<b>Non clinical support services</b>	<ul style="list-style-type: none"> <li>■ Lean methodology could reduce waste through streamlining of processes</li> </ul>

## 7.4.3 Staffing Implications

Staffing may change as a result of cost improvement measures, both in terms of number and skill mix.

Staff group	Number of staff	Cost in 2020 (£)
<b>Emergency Ambulance service</b>	Staffing for 1 additional ambulance	Increased by c£320k for leasing of ambulance, including staffing.
<b>A&amp;E</b>	1 additional Nurse band 4-6 and middle grade doctor	Increased by c£200k p.a. <sup>91,92</sup>
<b>Surgical beds</b>	Reduced due to 4 bed reduction Major investment in the hospital estate would be required to make it fit for purpose. If a new build were required, the cost would be c £1 million per bed <sup>93</sup> . Without changes in practice the projected bed requirement for 2020 will be 237 beds. That means that the cost of a new build hospital would be c £235m	Reduced by c£160k p.a
<b>Medical beds</b>	Staffing for 20 additional beds (required from 2021) <sup>94</sup>	Increased by £1.9m p.a in 2021
<b>Theatres</b>	Staff for additional theatre capacity	Increased by c£200k p.a. <sup>95</sup>
<b>Day case theatres</b>	Staff for additional theatre capacity may still be required to provide for additional sessions even if scheduling enhanced	Increased by c£120k p.a. <sup>96</sup>
<b>Endoscopy</b>	Staff for additional endoscopy capacity may still be required to provide for additional sessions even if scheduling enhanced	Increased by c£130k p.a. <sup>97</sup>
<b>Off island treatment</b>	Not affected	Of the £1.5m costs associated with off island treatment, c£800k are variable costs which may be associated with travel. It is anticipated that this could increase by c£200k p.a by 2020 <sup>98</sup>
<b>Outpatients</b>	Reduction in staff for clinics for 14,000-20,000 appointments which would equate to 1,400-2,000 clinics <sup>99</sup>	31 – 44 PAs saved to be redirected to other work such as additional ward rounds to assist discharge
<b>Clinical Support Services</b>	Requires Lean assessment	Requires Lean assessment
<b>Non clinical support services</b>	Requires Lean assessment	Requires Lean assessment

<sup>91</sup> Based on salary of A&E nurse band 4-6 in 2010

<sup>92</sup> Based on salary for middle grade in 2010

<sup>93</sup> Industry rule of thumb, specific advice needs to be sought

<sup>94</sup> Assumed funding, staffing and capital requirements would have been identified before 2020

<sup>95</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre

<sup>96</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

<sup>97</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

<sup>98</sup> HSSD ledger 2010 and HSSD Financial Model v1.0

<sup>99</sup> Based on assumed number of patients per clinic of 10

As with scenario 1, challenges will exist regarding the recruitment and retention of staff for all professions. This will be compounded by the retirement profile of consultant and nursing staff, of whom almost 50% will be due for retirement during the period to 2020.

Pressure will increase on community staff and primary care teams, as the efficiency measures outlined above reduce length of stay and patients return to the community earlier.

Sub-specialisation increases the difficulty of recruiting generalist doctors. As such, particularly in A&E but also within the medical specialty, it may be necessary that as consultants leave or retire, Acute Physicians who have been specifically trained in A&E and non-elective care are recruited to replace them. This could go some way to support the demand driven by elderly, non-elective general medical patients.

Challenges exist around support within A&E, particularly junior doctor cover at night. The co-location of the GP OOH service into A&E would offer the opportunity to improve the service within the same cost envelope.

Additionally, the extended roles that the Non-Medical Prescribing legislation offers, such as nurse prescribing, could support expanded roles for nurses and pharmacists in both A&E and also in caring for non-elective patients. The Scottish Governments review of nurse prescribing in 2004 concluded that “Nurse prescribing led to better use of GPs’ and Nurses’ time as nurses dealt with minor problems leaving GPs free to deal with more serious cases”.<sup>100</sup> The recent review in February 2011 regarding nurse prescribing in acute care by Jones, Edwards and While concluded that “Nurse prescribing was seen as a positive development: there were benefits for patients through better use of staff skills and improved service delivery and both the prescribers and their colleagues were positive about the changes and their impact. Patients were more likely to be satisfied with the medication information they had received if they had seen a nurse rather than a doctor. Patients from different ethnic groups appeared to have similar views about their experience and medication. The prescribing practice of the doctors and nurses were found to be similar. Shared vision, local championship, action learning and team, peer and buddy support were all identified as factors that actively enabled implementation.”<sup>101</sup>

However, as previously stated, the significant increases in demand, challenges in staffing capacity and lack of funding available for investment in all parts of the health and social care system – but most notably in community health and social care – will lead to an increase in demand on the hospital as patients present at more advanced stages of disease, or present in A&E to avoid the primary care co-payment. This will increase waiting times and, if significant changes are not implemented, will cause resources to be prioritised towards unscheduled care, which could impact the safety and sustainability of elective care.

#### 7.4.4 Revenue and capital implications

Typically 10% savings can be achieved from a comprehensive cost improvement programme. However, given the isolated nature of Jersey a more prudent target would be 5%. For Jersey General

<sup>100</sup> Research Literature Review on Nurse Prescribing; Scottish Government, 2004;

<http://www.scotland.gov.uk/Publications/2004/08/19843/42006>

<sup>101</sup> Edwards, Jones and While; Evaluating nurse prescribing in acute care: a case study; 3 February 2011; Journal of the Association of Nurse Prescribing: <http://anp.org.uk/category/journals/>

Hospital, this would equate to >£5m (based on £103m budget for estates and facility management, hospital management and administration, and hospital operations).

However, even with the productivity measures outlined in this section, major investment in the hospital estate would be required to make it fit for purpose. If a new build were required, the cost would be c £1 million per bed<sup>102</sup>. Without changes in practice the projected bed requirement for 2020 will be 237 beds. That means that the cost of a new build hospital would be c£235m.

<sup>102</sup> Industry rule of thumb, specific advice needs to be sought

Description	Impact	Set up costs	Additional annual running costs at 2020 (£)
<b>A&amp;E staff</b>	Increase staff to meet 5% increase in demand		Increased by c£200kp.a <sup>103104</sup>
<b>Ambulance costs</b>	Lease or purchase of 1 additional ambulance		Increased by c£320k p.a, including staffing costs  If ambulance is purchased this equates to £90k capital cost <sup>105</sup> plus staffing (estimated salary cost of c£500k) <sup>106</sup>
<b>1 additional ward of 20 beds with a phased opening of beds</b>	Manage the non-elective demand based on the general medical patients	£5m capital <sup>107</sup>	Staff and supplies c£3m p.a
<b>Surgical beds</b>	Reduction of length of stay resulting in 11.5 beds closing by 2020		Saving of £2.25m p.a
<b>1 additional main theatre</b>	Manage the additional demand for surgery	£5m	Increased by c£200k p.a <sup>108</sup>
<b>Day surgery theatre</b>	Provide additional day surgery capacity	£5m	Increased by c£120k p.a <sup>109</sup>
<b>Endoscopy theatre</b>	Provide additional endoscopy capacity	£1m	Increased by c£130k p.a <sup>110</sup>
<b>Increase off Island provision</b>	Accommodate variable costs of escort and accommodation	N/A	Increased by c£1m
<b>Clinical Support Services</b>	Increase required in line with increasing demand	N/A	Increased by £4.5m p.a as per scenario one – unless full productivity measures are introduced which would reduce this accordingly (however by 2021 additional medical beds are required which could mean the cost is still incurred)
<b>Non clinical</b>	Increase required in line with	N/A	Increased by £3.5m p.a as with

<sup>103</sup> Based on salary of A&E nurse band 4-6 in 2010

<sup>104</sup> Based on salary for middle grade in 2010

<sup>105</sup> Purchase of bariatric ambulance Nick Trigg report 3 February 2011 <http://www.bbc.co.uk/news/health-12287880>

<sup>106</sup> HSSD ledger emergency ambulance staff £3.5m across 55 staff - £63,000 per staff member and assumed 6 drivers required to man an ambulance 24/7 including covering holidays and sickness

<sup>107</sup> Based on Bradford modular build of 4,950 sqm facility accommodates three new state-of-the-art 28-bed wards and six general operating theatres, with a full height glazed link to the main hospital and three ambulance bays cost of £9m. Requirement for Jersey would be 20 bedded ward. New build costs would be significantly higher. <http://www.yorkon.co.uk/bradford-hospital.html>

<sup>108</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre

<sup>109</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

<sup>110</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

Description	Impact	Set up costs	Additional annual running costs at 2020 (£)
<b>support services</b>	increasing demand		clinical support services
<b>Dedicated programme manager</b>	To ensure cost improvement programme is implemented	Recruitment costs	If interim post may cost c£130k p.a
<b>Clinical engagement</b>	To ensure clinical staff buy in for implementation and compliance	N/A	2 days p.w of consultant time plus 5 days p.w. of nursing time = c£200k p.a

#### 7.4.5 Funding implications

A number of funding options would be considered, in order to reduce the cost to The States and provide sufficient total funding to increase capacity. Funding options should be carefully considered, to ensure they incentivise the desired clinical and patient / service user behaviours, and to ensure they do not restrict access and equality, particularly for vulnerable and hard to reach groups:

- Co-payments for A&E presentations
- Payment for prescriptions
- Increased thresholds and eligibility criteria for treatment, which may lead to patients paying for treatments privately, or not being treated until their need has increase significantly
- Closure of services. This would lead to patients paying privately (either on or off island)
- Expanded insurance schemes, which pay for ambulance journeys
- Expanded insurance schemes, which pay for all non-elective care except for a road traffic accident or certain exemption categories

Enhanced community and primary care services need to be in place so that patients can be discharged to the community. In order for this to be acceptable to the patient, costs of hospital care and care in the community should be equitable, to avoid perverse incentives. This should include care provided by practitioners, as well as clinical products such as wound dressings.

#### 7.4.6 Benefits

##### 7.4.6.1 Service user/carer

- Productivity improvements would reduce waste and duplication and result in more streamlined processes which should improve the patient experience
- Patients would continue to be referred by their GP, with diagnosis, intervention and ongoing care provided at the hospital – providing they meet the thresholds / eligibility criteria
- Retention of an accessible emergency service, available 24/7 – although co-payments may be required to meet the funding gap

##### 7.4.6.2 Workforce

- Hospital consultants would continue to earn revenue from private practice
- Streamlined processes would improve the working lives of all clinical staff groups

- The expansion of the role of the nurses and other care professionals through the implementation of the non-medical prescribing legislation could support the recruitment and retention of professionals
- Staff engagement in the development of initiatives to improve patient pathways

#### 7.4.6.3 Quality

- More streamlined services with less waste and duplication, through lean processes, lead to better patient experience and reduced risk
- Co-location of the GP out of hours within A&E has the potential to improve quality of initial triage and diagnosis and support the F2 doctor at night without increasing the cost

#### 7.4.6.4 Business

- A potential income stream is available to the hospital through charging for non-urgent attendances at A&E and prescriptions
- Income from private practice for the hospital might increase as more patients choose to be treated privately

#### 7.4.7 Risks

- The service would become increasingly pressurised as capacity becomes increasingly limited if productivity improvements are not implemented. This may result in reduced patient safety
- Whole-hearted and unanimous senior clinical buy-in is required for cost improvement measures to succeed. Staff may be resistant to changing ways of working and current practice
- Recruitment and retention challenges would continue, compounded by pay and conditions as cost pressures increase
- The hospital estate condition would deteriorate if funding is not made available for maintenance and/or rebuild
- Patients with minor ailments may redirected away from A&E
- As pressure increases, prioritisation decisions would be required. This may lead to increases in thresholds, meaning that patients who would expect to be treated in 2010 would not be eligible for treatment in 2020
- Due to capacity issues, the system may only be able to treat more acutely unwell patients
- A full emergency service may not be able to be deliverable in the future due to funding constraints – the service may downgrade to the equivalent of an urgent care centre in England and real emergencies such as RTAs may be stabilised and treated off- island
- As funding reduces in real terms and demand from older adults increases, prioritisation decisions may lead to funding being targeted at emergency services, thereby reducing the interventions available as elective care. Eventually this could lead to issues with clinical viability for elective care
- Lack of public engagement due to the potential increase in co-payments

## 7.4.8 Implementation timetable

Initiative	Timescale	Action
<b>Cost improvement programme</b>	3 months	Recruit programme manager
	3-6 months	Clinical engagement for agreement of initiatives and development of plan
	6-24 months	Implementation of initiatives
<b>A&amp;E</b>	September 2011	Co-location of GP Out of Hours service into A&E
	April 2012	Social marketing campaign focusing on reducing minor injury and primary care attendances at A&E
	April 2013	Introduction of co-payments in A&E and prescription charges
<b>Non-elective activity</b>	September 2011	Review and reduction in length of stay for general medical patients
	December 2011	Introduction of measures such as weekend discharge
	April 2013	Introduction of non-medical prescribing and nurse-led discharge
<b>Ambulances</b>	January 2012	Business case developed for enhanced role for ambulance staff and additional ambulance
	April 2012	Training in new role
	July 2012	Roll out of new role
<b>Funding system</b>	April 2012	Review of current funding system, analysis of insurance based funding system such as the Guernsey model

## 7.4.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service</b>	Unmet	<p>As funding decreases, salary and healthcare inflation will mean that either:</p> <ul style="list-style-type: none"> <li>■ services will reduce to meet the funding envelope</li> <li>■ capacity remains at 2010 levels and demand increases significantly, leading to increases in waiting times and pressure on service delivery</li> <li>■ productivity and efficiency improvements are required</li> </ul> <p>The latter option, using lean / systems thinking methodologies, can help to engender a culture of continuous improvement, thereby improving the future sustainability of services – however, it would not be sufficient to meet the funding gap</p> <p>In addition, a lack of funding and investment in community services would limit the options for speedy discharge and/or management of demand in non-acute settings, placing further pressure on sustainability of health and social care</p>
<b>Ensure Clinical/service viability</b>	Unmet	<p>As demand and waiting times increase, clinical risk increases</p> <p>The estate would further degrade without funding for upgrading</p> <p>As prioritisation decisions become increasingly difficult, funding may be targeted on emergency care, which could undermine the clinical viability of elective care</p>

Service design principle	Met/Unmet	Justification
<b>Ensure financial viability</b>	Partially met	Cost reduction measures typically save c10% of costs, once successfully implemented – however, this is unlikely to be achieved in Jersey  Reductions in States funding would mean that difficult prioritisation decisions are required, and more people may have to pay for private treatment. Whilst this could result in income for the hospital, it does not support the financial viability of publicly-provided care
<b>Optimising estate utilisation</b>	Unmet	No change in estate utilisation is anticipated – however, pressure on services would lead to an increased need for a new, fit for purpose hospital  The estate footprint is limited and in order to accommodate the additional ward by 2020, additional physical estate would be required  Further, without capital expenditure the hospital estate would degrade, backlog maintenance would increase and significant capital expenditure would be needed to rectify this
<b>Workforce utilisation and development</b>	Unmet	Some changes to roles of clinical staff may result from the cost improvement programme. This would include changes to competencies and ways of working  Recruitment and retention of all staff under the current model and terms and conditions becomes increasingly difficult as all staff are subject to increased pressure and clinical risk. This is compounded by the retirement profile in the period to 2020
<b>Clinical governance</b>	Unmet	Without investment the clinical risk would increase. Strong clinical audit and informatics is required to support good governance  Measurement of outcome data, audit and implementation of continuous improvement would still be required
<b>Use of business intelligence</b>	Unmet	Tools and mechanisms for measuring key data sets including outcome data to measure quality and safety of service would still be required  The current investment in business intelligence is not adequate to meet clinical governance requirements

## 7.5 Older Adults

Assuming funding increases by inflation +2% for three years up to 2013, and remains static thereafter, by 2020 the budget for older adults would increase from £10.5m in 2010 to £12m p.a in 2020. This compares with the funding required to care for the projected increase in population during the same time period (from scenario one) of almost £16.5 million.

Third sector spend is currently £8m which by 2020 will increase to almost £10.5m

Under the current service model, therefore, there would be a shortfall of almost £4.5 million.

By 2013 most services - nursing care, residential care and community services - will not be able to provide the same quality or quantity of service as capacity is exceeded due to significant increases in demand and dependence, particularly for long term conditions and long term care.

The new Long Term Care scheme in 2013 has the potential to further increase the demand for States funding, although within the White Paper of November 2010, it was assumed that in addition to the proposed 1.5% individual contribution rate, the States contribution of £30m a year<sup>111</sup> towards the cost of long term care would continue<sup>112</sup>. Moreover, this change will increase the workload pressure on the referral and assessment team.

The new long-term care benefit will be a ring fenced fund *“established based on compulsory contributions from employees, the self employed and pensioners. There will be no earnings ceiling for the contributions.... The benefit will be funded on a ‘pay as you go’ basis (today’s contributions paying for those claiming the benefit today) with a small buffer built up to protect against temporary variations.*

*The benefit will be available to all eligible claimants from day one of the scheme, including those already in care on that day. To achieve this there will need to be some transitional funding... The scheme will be administered by the Social Security Department.”*<sup>113</sup> Long-term care funding white paper p16

The challenge posed to the current community and social services team regarding the introduction of the long term care benefit is the care assessment that is proposed to be undertaken through a ‘placement tool’ which requires *“involvement and judgement of appropriately quality and experienced professionals such as dosial workers, nurses and, when appropriate, doctors, occupational therapists, physiotherapists, psychiatrists and specialist nurses. Where the individual’s needs are extremely complex then a full case conference may be required (and, as described above, ultimately the nature of their care needs may require additional funding for a tailored care package from Health and Social Services)”*<sup>114</sup>. Long-term care funding white paper p20

The recent census<sup>115</sup> of over 65s currently resident in care homes demonstrated that there were over 1,000 people of which approximately 40% are funded by the States. The remaining 60% are self-funding and therefore do not currently have an intervention from the C&SS team. The introduction of the assessment for the LTCB will impact on the team as every individual within a care home will require an initial assessment, which could increase the workload by over double. The current process is to have annual reviews with each individual in a care home receiving a States funded package, if this extends to all individuals, again this would double the current workload of the team.

This assessment also applies to care in the home and the white paper predicts that *“demand for such domiciliary care (i.e. care in your own home) is likely to increase in the future and there will need to be an expansion of the services available to meet this demand.”*<sup>116</sup> Long-term care funding white paper p23. This has the potential to impact on the third sector and organisations such as Family Nursing and Home Care. At this stage this has not been further quantified.

<sup>111</sup> HSSD £16m and Social Security £14m Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p9

<sup>112</sup> Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p6

<sup>113</sup> Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p16

<sup>114</sup> Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p20

<sup>115</sup> Public Health Census of Nursing Homes, undertaken by Mark Richardson, Social Security Department, September 2010

<sup>116</sup> Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p23

This scheme is based on the Guernsey Long-term Care Insurance Scheme (LTCI) which in 2009 had almost £17m paid into the fund from contributors. With the benefit administration expenditure of £14m in the year the fund had an operating surplus of almost £3m.<sup>117</sup>

It is not currently clear in the white paper, if additional monies will be made available to support the additional workload of the C&SS team.

As stated in scenario 1 for older adults, within the next 12 months the demand for some facilities and services is projected to exceed current capacity. Without increases in capacity or improvements in productivity to alleviate this pressure the needs of the population will not be met. This may lead to:

- A significant reduction in the number of older adults able to lead productive and independent lives, which is compounded by pressure on funding to support activities of daily living
- Bed blocking in hospital because of delayed transfers of care, with an adverse impact on both medical and surgical bed capacity
- Service users being in care settings that are inappropriate for their needs, or not receiving the care to which they might be entitled now
- Increased backlogs in care assessments and/or reduced service user/professional contact time, potentially increasing risk
- A reduction in privacy and dignity as there are no choices for palliative care
- Increased pressure on unpaid carers, as residential and nursing home placements are unavailable, eligibility or thresholds increase, and 24-hour care and respite care is not available to support service users in community settings. This also increases risk – not only to the service user (e.g. from falls), but also to the carer

Managing this situation may be compounded by the disparate IT infrastructure, whereby information is currently maintained in silo environments and access to management information is limited. This situation creates challenges in service coordination and provision.

The three options available are:

- Improve productivity and efficiency
- Tighten eligibility criteria such that access to services is restricted and/or fewer people qualify to receive services
- Change funding mechanisms to reduce public spend

Some examples are provided in the following text. This is not an exhaustive list as this document is strategic and hence a cost improvement diagnostic has not been undertaken.

It should be noted that, as stated above, the funding gap is likely to be almost £4.5m p.a by 2020. Therefore, employing all of the options below would still be insufficient.

<sup>117</sup> Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p33

#### 7.5.1.1 Improve productivity and efficiency

- Increase (where feasible) the size distribution of care homes used, thus taking advantage of economies of scale in terms of staffing cover and other overheads
- Introduce robust procurement and contracting, for example through competitive tendering (where there is sufficient supply on the island). For example, action which reduces the proportion of spot purchased care beds, as opposed to be called off a contractual framework, could improve value for money by as much as 10%. This level of saving is synonymous with underdeveloped Local Government commissioning and procurement functions.<sup>118</sup> However, as noted in scenario 1, as capacity is exceeded, private sector suppliers are likely to increase their prices, therefore this quantum of saving may not be achievable in a small community, and overall costs would increase further
- Increase caseloads for all staff. However, caseloads are already high, with only low intensity support provided in the community, so this is likely to either reduce the input available for each service user and/or increase pressure on existing staff – thereby impacting sickness levels and retention

#### 7.5.1.2 Increase thresholds and change eligibility criteria

- Tighten thresholds for publicly-funded care, in order to reduce expenditure by providing care only to those assessed as having high levels of need. This would apply both the staff-provided care and to equipment, aids and adaptation to support people with activities of daily living
- Increase the number of older people patients looked after at home by unpaid carers. Due to the high cost of living on the island many households face financial constraints and a large proportion of people who would be carers are working full time. Therefore this may only be available to a small proportion of islanders. This situation would be compounded as limited additional funding would be available to develop and provide the full range of community services, including respite care, night sitting and day care.
- Operate more residential care homes under dual registration, which in turn may lead to slightly but not significantly higher occupancy levels
- Introduce more stringent means testing, with higher eligibility levels, to reduce the proportion of service users who are eligible for States funded care. This would lead to a two tier system, based on ability to pay. It would also impact particularly on vulnerable people and hard to reach groups

#### 7.5.1.3 Change funding mechanisms to reduce public spend

- Introduce charges for services such as domiciliary care, aids and adaptations, and occupational therapy
- Increase the membership base of Family Nursing and Home Care, and increase annual membership charges
- Combine the funding from Social Security and Social Services for residential and nursing care. The Long Term Care scheme is likely to increase the levels of States funding to support the longer

<sup>118</sup> Previous KPMG experience across a range of local authorities

term care of older adults, although it has been identified as remaining at £30m for the first five years of which HSSD contribution is £16m<sup>119</sup>.

## 7.5.2 Activity Implications<sup>120</sup>

The activity implications are based on no change to the current service model, because it is assessed that there are limited opportunities to manage the level of demand from older adults without some initial investment to change service coverage or configuration.

However, States-funded activity could potentially reduce if eligibility criteria or service charges were increased in response to the funding shortfall, as more older people would then be required to pay privately for their care needs, or have unmet need. This would require careful consideration as it would create a two tier system and may be ethically unacceptable.

All activity implications are based on the funding agreement of +2% being incurred until 2013. From this point onwards it is assumed that funding does not increase and therefore the shortfall is from the 2013 activity. Please note FNHC is also included in self care but this is for completeness this should not be double counted.

Service	Projected change to 2020
<b>Family Nursing and Home Care</b>	Home care – a shortfall of c22,000 visits p.a District nursing – a shortfall of c13,000 visits p.a
<b>Nursing Care</b>	<i>Spot purchase beds – a shortfall of &gt;45 beds p.a</i>  Note that the The Limes, Sandybrook, and the current level of States purchased contract beds with the independent sector remains the same during this period
<b>Day Care</b>	These services are currently not always full to capacity but mostly due to patient transport challenges rather than need <sup>121</sup> . It is anticipated that demand for each of these services will grow by 35% in line with the population growth by 2020. It is anticipated that by 2020 there will be an overall shortfall <sup>122</sup>
<b>Social Care</b>	It is noted that the impact of the Long Term Care Benefit policy and subsequent assessments will increase the workload of the social work team. A recent audit <sup>123</sup> predicted this to double based on current activity levels. Adult Social Work referrals – a shortfall of 200 referrals p.a
<b>Mental Health</b>	Older Adults Community Team – a shortfall of c2,000 visits p.a

<sup>119</sup> HSSD £16m and Social Security £14m Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p9

<sup>120</sup> Although the psychology service and occupational therapy service are outlined in the staffing section, psychology referrals are outlined in the younger adults section and occupational therapy stand alone data is not available

<sup>121</sup> Rachel McBride Day Services Manager, 18 April 2011

<sup>122</sup> Due to the booking being on a week by week basis and demand changing, a specific prediction would require further detailed analysis so could comprise part of the development of a business case if agreed in principle

<sup>123</sup> Public Health Census of Nursing Homes, undertaken by Mark Richardson, Social Security Department, September 2010

Service	Projected change to 2020
	Inpatient MH assessment – a shortfall of c 5 beds p.a
	Continuing Care – a shortfall of c 14 beds p.a

### 7.5.3 Staffing Implications

The staffing changes outlined below could be made only if the States were able to bridge the funding gap by increasing charges to eliminate the £4.3 million shortfall referred to above. The major staffing challenge remains around the potential impact of the Long Term Care scheme assessments that will be required from 2012 which C&SS management have suggested may double the caseload of the current social work team<sup>124</sup>. As the funding stabilises in 2013, the number of staff in 2020 are assumed to be the same as at 2013 and as outlined in the activity section, this has a risk that service users will either receive a level of provision that has a lower intensity or they are ‘untreated’ by the States.

Whilst it is assumed that funding for physical office space would also be required, this is an operational requirement and therefore would be included in the development of a detailed business case (and is therefore out of scope for this strategic document).

<sup>124</sup> Stuart Brook meeting held 14<sup>th</sup> April 2011

Service	Number of staff in 2020 (based on 2013 figures)	Cost in 2020 (£) (based on 2013 figures)
<b>Family Nursing and Home Care</b>	Funding increases could support 43 fte district nurses – a shortfall of c10 against projected demand Funding increases could support 76 fte home care staff – a shortfall of c15 against projected demand	District nurses - c£500k p.a shortfall against the projected requirement for 2020 Home care – c£500k shortfall against the projected requirement for 2020
<b>Nursing Care</b>	Additional c30 staff required to meet projected demand	A shortfall of c£500k against the projected requirements for 2020
<b>Older Adults Mental Health Community</b>	Projected shortfall of 5 against 2020 projections	A shortfall of c£500k against the projected requirements for 2020
<b>Adult Social Care</b> <sup>125</sup>	This staffing is currently projected against the adult rather than older adult population, as the staffing establishment is not divisible into age groups	A shortfall of c£100k against the projected requirements for 2020 This does not take into account the predicted increase in the workload of this team for the LTBC assessments
<b>Occupational Therapy</b> <sup>126</sup>	Projecting a shortfall of 2 fte staff by 2020	A shortfall of c£400k against the projected requirements for 2020
<b>Psychology</b> <sup>127</sup>	A small increase (1 staff member) is required	Costs increase marginally 2010
<b>Mental Health Inpatient Old Age</b>	A projected shortfall of 23 fte staff by 2020)	A shortfall of c£1.7m against the projected requirements for 2020

#### 7.5.4 Revenue and capital implications

As outlined above, there is a projected revenue deficit of c£4.5m for older adults by 2020.

In addition, capital expenditure of c£3.5m, plus £500k p.a would be required to ensure the States owned care homes comply with the Inspection and Registration of Homes Care Standards due to be introduced in April 2012. This will require modifications such as the widening of corridors, removing double occupancy rooms and installing bed friendly lifts.<sup>128</sup>

#### 7.5.5 Funding implications

As stated above improving productivity and efficiency and raising eligibility criteria could help reduce the projected c£4.5 million funding gap at 2020. However, without significant service reductions these measures would not fully bridge the gap, and therefore more radical funding options would need to be considered. This would incorporate increasing charges for services and introducing charges for services which are currently States-funded. This would increase the financial and care burden on individuals and would lead to a two-tier system, impacting particularly those on low incomes.

<sup>125</sup> Activity and staffing are across both adults and older adults

<sup>126</sup> The numbers are for the occupational therapist department and therefore is not specific to children but is noted here for completeness

<sup>127</sup> The numbers are for the psychology department and therefore is not specific to children but is noted here for completeness

<sup>128</sup> Report produced by Jersey Regulation and Inspection Manager, Public Health Services, 2010

### 7.5.6 Benefits

- The same model of care would be retained but it may be available to fewer people and/or at increased cost as the funding position is not sustainable. This situation may be partially offset if it is possible to make productivity gains and/or reduce third party spend by implementing and performance managing more robust contracts with the independent and third sectors
- Limited change to working practice and roles, which may be attractive to some elements of the workforce (but see risks below)
- Limited benefits due to significantly increased pressure and risk, and potentially reduced access to services – other than for those who are able to pay for their care and health needs to be provide privately

### 7.5.7 Risks

- Increased institutionalisation of care, driven by the need to achieve greater economies of scale and care for increased demand. This would lead to an outdated mode of care provision which is suboptimal in terms of quality, risk and cost
- Significant reductions in face to face interactions as staff increase caseloads to unsustainable levels
- Increased staff sickness absence and reduced morale
- Limited assurance and risk management of services and providers with the potential for increases in legal claims
- Service users or patients eventually cannot access some services due to prioritisation of resource
- Unrealistic demands on carers and increased breakdown of family support

### 7.5.8 Implementation timetable

Due to the critical timescale for Older Adults, action would need to commence immediately:

Initiative	Timescale	Action
<b>Improve productivity and efficiency</b>	June 2011	Review of current service model to identify areas of potential efficiency
	September 2011	Review of all the current residential and nursing placements
	October 2011	Implement productivity measures with a focus on increasing capacity

<b>Increase thresholds and change eligibility criteria</b>	September 2011	Review current residential and nursing placements to determine the level of threshold currently in place
	December 2011	Short term threshold change
	September 2012	Introduce assessments for the Long Term Care scheme – determine the impact of the threshold changes in relation to the new policy
<b>Change funding mechanisms to reduce public spend</b>	April 2013	Introduce new Jersey fiscal policy and funding mechanism for older adults nursing care – Long Term Care scheme

### 7.5.9 Strategic imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Unmet	The current model is unsustainable, with a significant gap between projected demand and funding. Implementing productivity measures would be insufficient to reduce this gap to manageable levels. Without a significant increase in funding, access to services will need to be limited and substantial needs may not be met As demand from older adults increases after 2020 the service becomes increasingly unsustainable
<b>Ensure Clinical/service viability</b>	Unmet	In addition to the funding pressure noted above, capacity constraints exist for residential and nursing beds As service pressure increases, caseloads and service user: staff ratios will increase, possibly to unsafe levels
<b>Ensure financial viability</b>	Unmet	Significant cost reductions, productivity improvements and changes to funding, including thresholds and eligibility, would be required in order to meet demand within the funding envelope
<b>Optimising estate utilisation</b>	Unmet	Bed capacity (in acute, residential and care homes) in the current model is insufficient to meet the projected demand Increased care in institutionalised settings would compound this
<b>Workforce utilisation and development</b>	Unmet	Significant increases in pressure, caseloads and service user: staff ratio increases reduce the attractiveness of the caring professions as a career path. This is compounded by the retirement profile in the period to 2020 and the cost of living on Jersey
<b>Clinical governance</b>	Unmet	Although clinical governance may be met in the current service model, the projected demand and forecast capacity requirements may render the service unsustainable by 2020, and clinical risk increases
<b>Use of business intelligence</b>	Unmet	With no investment, limited information would be available for decision making and monitoring service provision

## 7.6 Younger Adults Social Care and Mental Health

Scenario 2 for Younger Adults Social Care and Mental Health is the same as scenario 1, due to the impact of a declining demographic. For ease of reading, the entire scenario has not been replicated here.

Figure 60: Projected budget shortfall, mental health

	£m (2010 prices)
2010 funding for Younger Adults Social Care and Mental Health	£17.9
Projected 2020 funding for Younger Adults Social Care and Mental Health	c£18.4m
Projected 2020 cost for Younger Adults Social Care and Mental Health (based on salary inflation and demographic change)	c£19.7m
	<b>(c£1.3m)</b>

In order to further improve value for money, a number of opportunities would be required, including:

#### *Improve productivity and efficiency*

Orchard House has 17 beds, with the average utilisation just below 60% equating to an average of 10 occupied beds in 2010. The staffing establishment is 24 fte, at a cost of c£1.25m p.a. A review of the staffing model would enable staffing to match demand, for example using annualised hours as at peak occupancy there have been up to 19 patients in the unit including weekend leave beds.

#### *Increase thresholds and change eligibility criteria*

Funding grants to third sector services may need to be reviewed and eligibility criteria raised to ensure the neediest service users are cared for as a priority.

#### *Change funding mechanisms to reduce public spend*

Introduce means testing for younger adults in line with the older adults strategy and charge for certain elements of the service such as residential placements, day centre care or respite care.

### 7.6.1 Funding implications

Despite a declining demographic, the Special Needs service is currently at capacity for services such as continuing care, day centres and respite care. In the short to medium term additional revenue may need to be raised through charging for these services.

## 7.6.2 Strategic Imperatives met / unmet

Service design principle	Met / Unmet	Justification
<b>Create a sustainable service model</b>	Unmet	Despite a declining population, current demand and capacity issues mean that, unless service changes are implemented, some services such as special need respite care may not be sustainable
<b>Ensure Clinical/service viability</b>	Unmet	Mental health inpatient care and residential care would continue to be clinically viable, but some elements of the service may become unviable and service levels decline as demand reduces
<b>Ensure financial viability</b>	Unmet	Elements of service would need to discontinue or means testing/ payment introduced for services such as day centres in order to maintain their financial viability in the short to medium term
<b>Optimising estate utilisation</b>	Unmet	Additional capital investment may be required to meet legislative requirements
<b>Workforce utilisation and development</b>	Unmet	Challenges would continue regarding staff recruitment and retention
<b>Clinical governance</b>	Met	Clinical governance could continue to be met if unsustainable/ unviable services are discontinued
<b>Use of business intelligence</b>	Unmet	Investment in informatics and analysis is required in order to provide information for future service development

## 7.7 The Child

### 7.7.1 Outline of the service

Assuming funding increases by inflation +2% for 3 years and at inflation only thereafter, the budget for children's services in 2020 would be just above £11m p.a. Even though demand is declining this uplift creates very limited headroom for investment in children's social care, and under the modelling assumptions equates to only £166k by 2020, due to the impact of salary inflation exceeding RPI.

Potentially, the available sum for investment could be increased through measures to improve efficiency and productivity, for example by competitive tendering of services, or process/efficiency improvements.

Subject to there being no unexpected surge in demand, this limited headroom could begin to address some of the challenges of the current service model, particularly those which require low initial investment. For example, more cohesive partnership working e.g. between CAMHS and children's social care, a refocusing of services on early intervention work, and diversifying provision by capitalising on services provided by private and third sector. These service enhancements, for which there is a strong case for change, are explored more fully under scenario 3.

An alternative strategy to this limited service enhancement would be to use "released" staff to improve service quality, for example by increasing face to face time with the child and family, or improving further the timeliness of assessments.

With the injection of additional funding following the Williamson Report<sup>129</sup> and the potential “benefit” of reduced demand based on demographic projections it could be tempting in a financially challenged environment to make economies. However, there is an opportunity to put in place excellent practice in safeguarding, place Looked After Children into more permanent care settings, and develop preventative strategies e.g. early intervention, to offset longer term issues.

Moreover, with the children’s service now subject to external inspection – from the Scottish Social Work Inspection Agency – it is imperative that the States can demonstrate continuous improvement and respond constructively to those inspections. The headroom for investment of £166k would enable Social Services to start to address these challenges to a limited extent.

The service enhancements that could be implemented as part of the continuous improvement are considered briefly below and the C&SS department could prioritise which initiatives would be the most beneficial and start to implement.

#### 7.7.1.1 Early intervention

An early intervention strategy would require investment in preventative services on the premise that this would lead to improved outcomes for children and reduce the need for reactive services from social care and other agencies later in life. It would be possible to fund an early intervention pilot with new posts, which is estimated to be £80k<sup>130</sup>.

#### 7.7.1.2 Wrap around the child

Each child supported by the care system would be allocated a lead professional e.g. social worker or nurse, who would be responsible for ensuring that a child (and his/her family) has a single multi-professional assessment, and then has a co-ordinated set of services designed to improve outcomes. The implementation of the ‘wrap around the child’ concept is dependent upon an integrated service model that, as far as it is feasible to, vires funding between existing budget lines.

#### 7.7.1.3 Managing and diversifying provision

The States would adopt a more robust approach to commissioning, procurement and the performance management of service providers. It would work with existing and potentially new providers to consider reshaping services to increase choice.

#### 7.7.1.4 Professional fostering

To help move “appropriate” Looked After Children out of residential-based care the States would professionalise it’s fostering service by offering substantially more attractive payments to potential foster carers. This carries with it some challenge regarding the culture on the island of a high number of working mothers and smaller houses due to the cost of living, however it is an option that should be further explored.

This could be fully supported by two additional care co-ordinators (social workers or other professionals) working intensively with a caseload of 4-5 each. These staff could be redeployed from

<sup>129</sup> Williamson Report 2008

<sup>130</sup> Based on the 2010 salary of a social work assistant of £40,000

other existing services, as outlined in the Staffing Implications section. Where appropriate this professional will seek to support the needs of the family as well as the child.

### 7.7.1.5 Integrated services

It is imperative that there is a States department approach to the delivery of children’s services ensuring that the relevant agencies are included and involved. All relevant States departments and external agencies would establish an approach that results in meaningful integration at a strategic, managerial and operational level. This would be most effective if budgets and roles could be pooled to ensure seamless working across departments such as education and health.

### 7.7.2 Activity Implications

The activity projections are driven principally by demographics. However, but variations in the make-up of the children population, economic circumstances and other social trends could all affect the actual number. The service changes would not particularly impact on specific areas – for example Looked After Children has both fostering and residential care within its portfolio of care and therefore although a child may change setting, the activity figures in that area would not seem to change. Therefore, the activity figures below are demonstrated by team rather than initiative.

Service	Projected change to 2020
<b>Children’s Safeguarding and Community Support (excluding CAMHS)</b>	Safeguarding - projected reduction from 1390 referrals in 2010 to just over 1300 p.a in 2020 FNHC - projected reduction from 22,484 referrals in 2010 to just over 21,000 referrals p.a in 2020
<b>Looked After Children</b>	<ul style="list-style-type: none"> <li>■ Projected reduction from 77 children in 2010 to c72 children in 2020</li> <li>■ Foster care – a reduction from 27 to c25</li> <li>■ Family/ friends – a reduction from 23 to c22</li> <li>■ Residential 18 to c17</li> <li>■ Supported in other ways – demand would remain approximately the same at c7 children p.a</li> </ul>
<b>Secure</b>	The same demand, with an average of 1 (this is sometimes empty and sometimes has several children residing in the unit)
<b>CAMHS</b>	Projected reduction from 330 referrals in 2010 to just under 310 referrals p.a. in 2020

### 7.7.3 Staffing Implications

Staffing projections have been maintained for Scenario 2 and per Scenario 1 due to the impact of the funding/ demand remaining relatively the same. The staff costs increase due to inflation of 1.3% real terms.

	Number of staff 2020	Cost (£) 2020
<b>Children's Safeguarding and Community Support (excluding CAMHS)</b>	A small decrease (2 fte staff, who would be redeployed)	Increased by c£100k by 2020 for salary inflation
<b>Looked After Children</b>	A small decrease (1 fte staff, who would be redeployed)	Increased by c£100k by 2020 for salary inflation
<b>Secure</b>	Staffing is projected to remain as at 2010	Increased by c£100k by 2020 for salary inflation
<b>Residential</b>	Staffing is projected to remain as at 2010	Increased by c£200k by 2020 for salary inflation
<b>Respite Care</b>	A small decrease (1 fte staff, who would be redeployed)	Increased by c£50k by 2020 for salary inflation
<b>CAMHS</b>	Staffing is projected to remain as at 2010	Increased by c£100k by 2020 for salary inflation
<b>Speech and Language Therapy</b>	Staffing is projected to remain as at 2010	Increased by c£100k by 2020 for salary inflation
<b>Occupational Therapy<sup>131</sup></b>	Occupational therapists increased by c3 fte	Increased by c£500k by 2020
<b>Psychology<sup>132</sup></b>	Other staff roles (including psychologists, counsellors and family therapists) increased by c1fte in 2010	Increased by c£300k by 2020

#### 7.7.4 Revenue and capital implications

Given the limited headroom for investment under scenario 2, The States would need to make choices about which service enhancements to pursue, and to what extent.

In scenario 3 we consider the implications for these various options in more detail.

#### 7.7.5 Funding implications

Funding sources, mechanisms and levels would remain unchanged.

#### 7.7.6 Benefits

- Some limited investment would be available, which might be focused on initiatives such as effecting more integrated working across States departments and external agencies, piloting new approaches e.g. early intervention, professional fostering, diversifying provision with the third sector, and improving value for money through more robust commissioning/procurement
- It may also enable increased face-to-face time between care professionals and children (and their families) as caseloads decrease due to the demographic shift

<sup>131</sup> The numbers are for the occupational therapist department and therefore is not specific to children but is noted here for completeness

<sup>132</sup> The numbers are for the psychology department and therefore is not specific to children but is noted here for completeness

- Staff could be reallocated within the service, maintaining consistency and continuity and enhancing the service in those prioritised areas
- Professional staff may feel under less pressure

#### 7.7.7 Risks

- A lack of immediate pressure on capacity or funding leads to opportunities for service improvement and productivity improvements being lost
- Looked After Children may be retained within residential settings, reducing outcomes

#### 7.7.8 Implementation timetable

Implementation would be in accordance with the timeline shown at in scenario 3.

## 7.7.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Partly met	As demand for children's services declines, the inflationary uplift creates a marginal but limited scope for investment. By 2020, efficiencies are required to provide the same level of services which may impact on access, quality and eventually outcomes of children's health and social care
<b>Ensure Clinical/service viability</b>	Partly met	The funding available from the inflationary uplift enables some of the challenges to be met, e.g. greater partnership working between children's health and social care services. However, efficiencies may be required to continue the same level of service provision
<b>Ensure financial viability</b>	Partly met	The limited funding available for the first 3 years provides some scope to invest in services. However, from 2013 onwards, financial efficiencies may be required to maintain the level of service provision as in 2010
<b>Optimising estate utilisation</b>	Partly Met	Looked After Children would be re-placed into more permanent care settings. Whilst this would result in positive outcomes for the child's social care, this could lead to partly underutilised facilities within children's care homes. However, the Williamson Implementation Plan is predicated on the sale of any vacated homes <sup>133</sup>
<b>Workforce utilisation and development</b>	Partly met	Developments in partnership working between health and social care services e.g. CAMHS, contribute to developing the workforce. However, further investment would be required beyond 2013 to ensure that staff are equipped to maintain and further develop their skills and expertise to deliver the quality of services
<b>Clinical governance</b>	Partly met	Limited investment would be available for children's health and social care. However, the funding constraints would hinder any real enhancements of services and the ability to further develop the workforce. This may impact on the staff's ability to manage workload effectively and ultimately the quality of service provided
<b>Use of business intelligence</b>	Unmet	As with scenario 1, with no investment in business intelligence, the current challenges in the quality of information would continue. This leads to difficulties in assessing children's health and social care needs within Jersey.

<sup>133</sup> Williamson Implementation Plan, January 2009

# 8 Scenario 3 – A new system of health and social care

## 8.1 Scenario three ‘at a glance’

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

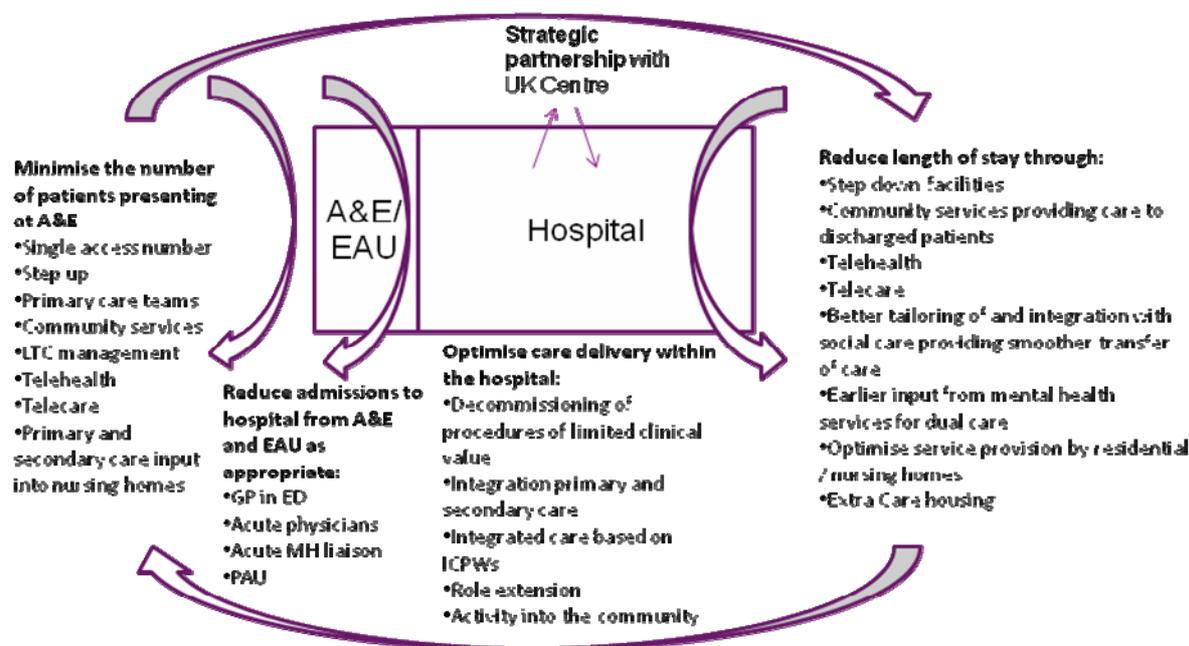
This scenario involves substantial change to existing service models, staff roles and organisational structures. It would however reduce, but not remove, the requirement for capital and other investment in hospital and other institutional care.

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.

### Patient flow between community and Jersey General Hospital



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.

## 8.2 Self Care

Self care is a key aspect of health promotion and can be undertaken with or without the direct oversight of care professionals. It is one of the essential building blocks of long term condition management and policy in the UK and internationally, including in neighbouring Guernsey.

The engagement of the public in their own care is a resource that Jersey can develop to reduce pressure and cost for health and social care – and help move the overall system from a 'sickness' to a 'wellbeing' model. It is a key building block to support individuals in leading productive and independent lives in the community, taking control of their own health and care needs, making informed choices and accessing a range of support systems appropriately.

Figure 61: Self Care model

The model for self care would be based on 5 elements:



*Model of Self Care developed at U-Collaborate event*

Key enablers to support this model include:

- Improved information systems to enable a targeted approach to identifying the population's health and social care needs
- Public acceptance and cultural change, including the individual's social responsibility for taking a proactive approach to managing their health and wellbeing
- Incentives which influence public behaviour on how and where people access services and how to manage their own health and wellbeing
- Training, education and acceptance of both the public and professionals to engage and support the different approaches and access points for self care

### 8.2.1.1 Informed Lifestyle Choices

Patients and service users would be able/willing to make informed choices about their lifestyles, 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, and it would reduce demand in the longer term as people slow the progression of their condition through improved management and monitoring.

An additional benefit would be secured as patients and their carers feel more in control of their condition and are more confident, which impacts positively on their quality of life. This would impact both their health and social care needs, by keeping well and active and by improving both their physical and psycho-social condition.

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 to help those patients to navigate the system, access care and equip themselves to take control of their condition.

In order to make informed lifestyle choices, the following would need to be available:

- Information and education material, provided through a variety of communication channels and formats on areas such as fitness, exercise, hygiene, life skills, nutrition and stress management. This would be delivered through a citizen's portal, which would provide a single point for information for all those involved in care – including health, social care and the third sector, patients, service users and carers
- The citizen's portal would support person-centred, individualised care, to enable all agencies and individuals to share assessments and care planning, and to communicate securely. Functionality for individuals would include, for example, links to their diary of activities e.g. community fitness classes, personal bookmarks to preferred information sources and optional forums to engage with other people with similar conditions
- Parishes acting as key access points to ensure that all individuals have the ability to use the portal and provide support to those less able to use technology. This support would be delivered by a trained, registered volunteer, who would help the individual to navigate the system and make informed choices. Support and quality assurance would be required, to ensure the volunteers receive sufficient guidance
- A multi-agency approach, coordinated through the citizen's portal, to reduce duplication of effort between health, social care and the third sector
- Social Marketing, which would be used to drive behaviours and incentivise positive lifestyle changes and maintenance (such as promoting smoking cessation, nutritional advice and breast feeding)
- Robust public health intelligence (e.g. through primary care risk stratification tools), to identify specific areas where targeted campaigns could be beneficial e.g. smoking cessation campaigns based on high COPD prevalence rates. Targeted social marketing campaigns would then be devised, using a variety of media channels including posters in public places such as libraries and supermarkets, radio advertisements, Facebook and the citizen's portal
- Care navigators, enhancing the support provided by the Parishes, to help patients and service users navigate services and information, and to make informed lifestyle choices. They would signpost the individual to services and information as appropriate, to help support their condition and/or promote health and wellbeing
- Early education, building upon existing relationships to develop more health and social care education programmes in schools such as smoking prevention, sex education and targeted food education.

#### 8.2.1.2 Help At Home

Forthcoming demographic changes will place a significant capacity pressure on both staff and estate as the over 65 population increases by 35% to 2020.

On current projections, the general medical bed capacity will be exceeded in 2015.

The long term, nursing and residential care needs of the older population would need to be considered. By 2012, capacity is already projected to have been exceeded for residential and nursing care beds, and in addition, there is an assertion that people would prefer to be cared for in their own homes for as long as possible, rather than being transferred to long term residential care.

Help at home is aimed at providing the support functions to enable patients and service users to be cared for in their own homes, thereby reducing the need for admission to an (often expensive) care home and providing a longer independent life. This comprises:

- Equipment, aids and adaptations to help individuals, family and carers maintain independent living, such as walking aids, stair lifts etc. Telecare would also be provided, for example smoke alarms, falls sensors and enuresis sensors. These passive alarm systems alert a monitoring centre when triggered, and an appropriate response is coordinated. These systems are designed to enable service users to live in their own homes rather than being admitted to long term residential care – they offer choice, independence and increased confidence and can have a significant impact on the lives of service users and their carers
- Home care support to assist individuals with activities of daily living such as laundry, meals, shopping, etc. A range of home care provision enables service users to be supported in their own home and can help reduce the burden on unpaid carers. Services could be provided through social care or by the third sector, and can also include psycho-social support such as befriending schemes
- Telehealth to assist individuals in the management of long term conditions without relying on intensive support from care professionals. Individuals would monitor vital signs at home using telehealth technology (e.g. blood pressure cuffs and peak flow meters). The patient’s vital signs are monitored against their individual parameters, and the monitoring nurse determines the most appropriate response – whether this is a telephone call, visit by a community professional, or referral to primary or acute care. This helps all care professionals to target their time towards those most in need, and supports an increase in caseloads. Community based professionals would then be able to provide 24-hour response services without significant increases in establishment.
- Telehealth would be targeted at patient groups with moderate to severe long term conditions who are able to use the technology. For Jersey, this is estimated at 20% of patients with COPD (c 470 patients), and 75% of those with moderate to severe coronary heart disease (c120 patients). The number of patients is based on estimated prevalence of COPD (3.3% of population aged 16+) and PAS data for condition related hospital admissions including CHD.
- Based on other UK and International case studies<sup>134</sup>, it is estimated that, for a similar sized patient group receiving telehealth, benefits include a 40% - 50% reduction in hospital admissions and a 50% - 60% reduction in A&E attendances. Studies also indicate a reduction in GP visits, however, these have not been incorporated due to the significant difference in the funding mechanisms for primary care in Jersey:

Figure 62: Projected benefits from telehealth

	COPD	CHD	TOTAL
Reduction in A & E attendances	c650 (60%)	c110 (50%)	c760
Reduction in ambulance journeys	c105	c20	c125

<sup>134</sup> Switch On: The Case for Telehealth, KPMG 2010

Reduction in hospital admissions	c420 (50%)	c90 (40%)	c505
Reduction in bed days	c4,000	c800	c4500
Estimated financial efficiencies	c£1.1m	c£180k	c£1.25

## 8.2.2 Financial efficiencies are based on the following assumptions

- c£85 per A & E attendance (2010 cost £3.2m for 37,468 attendances)
- c£235 per bed day (2010 cost £1.7m for a 20 bed ward)
- c£625 per ambulance journey (2010 cost £4.3m for 6,039 journeys, of which 88% were emergencies)

Indicative implementation costs comprise c£530k equipment costs (£900 per patient), and annual running costs of c£800k (equipment running costs plus £500,000 for 10 fte nurses.)

In addition to telehealth, the benefits associated with other 'help at home' activities include an improved quality of life, independence and empowerment. For the elderly group in particular, the emotional stress of moving to a new place and new routine would also be avoided, which has a further consequential impact on physical wellbeing.

Telehealth and telecare can also slow the progression of need (due to improved disease management and increased confidence in being supported, including undertaking activities of daily living in the home), thereby delaying the point at which long term residential or nursing care is required. Increased home care and the availability of equipment, aids and adaptations will also delay the point at which a service user requires long terms residential or nursing care. However, due to the longer payback period, these savings have not been incorporated into the projections.

### 8.2.2.1 Community Based Support

The primary care multidisciplinary team, individuals and families would work together to provide mutual support and enhance self care for the individual – both in terms of the support they receive and the support they provide to others. This approach can improve psycho-social outcomes such as fear for the future and regaining control over their emotional wellbeing, in addition to having a positive consequential impact on physical health. Community based support brings together:

- Self care management training and support networks; with
- Expert Patient Programme

**Self Care management training/support** - Community provided support groups and networks delivered by health, social services, third sector groups and volunteers, providing guidance and support for people with long term conditions or social care needs. Examples include 'Breathe Easy' groups for people with lung disease, and Computerised Cognitive Behavioural Therapy for individuals with anxiety and depression.

This approach would also be used for social care needs, facilitated by the Jersey Brighter Futures programme, and would include confidence building, effective thinking skills, self-awareness and life skills such as cooking, lifestyle coaching and preparation for employment, to support individuals as they build the ability to manage their long term care needs more positively.

**‘Expert Patient Programmes’** and peer networks to develop self-help or to be called upon to support patients individually. This approach is used effectively to support patients with long term conditions in the UK and internationally e.g. the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) and DAFNE (Dose Adjustment For Normal Eating) programmes for those with diabetes. The Expert Patient Programme (EPP) comprises several weekly sessions led by volunteer lay tutors with experience of the same condition. Following this, strong befriending support networks are developed, providing telephone or face-to-face support, advice and guidance.

Expert Patient Programmes have reported benefits including improved activities of daily living and a better knowledge and understanding of the patient’s condition, which leads to a 16% reduction in A&E attendances and 10% reduction in outpatients appointments (*‘The Expert Patients Programme’*, UK Department of Health, 2007):

Figure 63: Projected benefits from Expert Patient programme

	COPD	CHD	Diabetes	TOTAL
Reduction in A & E attendances (16% reduction)	c695	c10		c705
Reduction in ambulance journeys	c110	-	-	c110
Reduction in outpatient appointments (10% of follow up appointments)	c570	c130	c320	c1020
Estimated financial efficiencies	<b>c£155k</b>	<b>c£10k</b>	<b>c£15k</b>	<b>c£180k</b>

In addition to the assumptions set out within the telehealth initiative, efficiencies are based on estimated cost per outpatient appointment of £44 per appointment. These are based on staff costs of £235k (1 fte consultant and 1 specialist nurse), 45 sessions per week, and 12 appointments per session.

Initial set up costs for establishing the programme are estimated at c£60k p.a for 1 fte Programme Manager, plus associated on costs.

#### 8.2.2.2 Community Based Professionals

A collaborative alliance of community-based professionals from the public, third and independent sectors would be supported by the citizen’s portal. The community based professionals would both coordinate and deliver care (including supporting self care):

**Professionals to support independent living** - Multidisciplinary community teams, enhanced and with a specific role in supporting self care and independent living. These teams would be supported by inter-operable IT infrastructure, supporting the safe sharing of patient and service user notes, care plans and results.

As more individuals are supported to live independently, demand for home care and district nursing visits are projected to increase from 94,149 and 58,425 respectively in 2010 to c127,000 and c79,000 by 2020. This would require an increase in staff costs of c£730k p.a for home care and c£720k p.a for district nursing. Supporting these staff with telehealth technology to enable appropriate prioritisation and targeting of support would enable staff to increase caseloads and provide 24-hour response

services. Other community roles including Parish based volunteers (mentioned below) would also provide support which may, in time, reduce the demand for home care staff.

Community pharmacies would provide advice and consultation for minor and self-limiting conditions e.g. eczema clinics and hypertension monitoring, smoking cessation clinics and medicines review. Community pharmacies would become regarded by the public as an alternative to primary care for basic health needs and support extending to hard to reach groups. People would become more proactive in managing their health and well-being seeking advice to promote healthier living and/or managing their condition.

There are currently 30 community pharmacies in Jersey, staffed by approximately 80 professional registered pharmacists. Of the 30 community pharmacies, only 12 currently offer basic health checks. Approximately 10 people per week currently access community pharmacies for such services – i.e. 6,240 visits per annum.

Capacity exists to extend the provision of such services from 12 community pharmacies to 20. Through raising public awareness including signposting of community pharmacies as a provider of services, by 2020 activity would increase by 50% from 6,240 to c9,400 visits p.a. Services provided by community pharmacies would be charged a nominal fee, paid by the service user. It is anticipated that service users would be incentivised by the difference in fee for accessing community pharmacies for basic health checks compared to the fee charged by their general practice.

**Other independent/voluntary groups to promote health and wellbeing** - third sector groups would encourage people to lead healthier lifestyles and bring communities together. For example, the Walking for Health (WfH) programme encourages more people to become physically active in their local communities.

Gyms and leisure centres would provide health checks and to help identify aspects of people's lifestyle that may put them at risk of future health problems.

Organisations across all sectors would introduce a variety of interventions to encourage health and wellbeing, from policies for reducing smoking rates and preventing smoking on work premises through to enabling interventions such as:

- Offering healthy food options in cafeterias, vending machines and at company-sponsored events
- Introducing point-of-decision signs encouraging stairway use
- Providing facilities with showers
- Allowing flexible work schedules to accommodate physical activity during the work day
- Providing reimbursement/subsidies for use of community fitness centres
- Opening facilities and areas for physical activity and exercise, such as on-site fitness centres, walking paths, and bike trails

Parishes volunteers would support those requiring additional support to live independently. Based on existing examples of similar volunteering schemes within Jersey Parishes, a pool of approximately 20 registered volunteers would be required per Parish to support this scheme. The cost for this would be limited as no staff costs would be required.

### 8.2.2.3 Support and Guidance from Care Professionals

**Information Prescriptions and pathways to support self care** - health and/or care professional would work together with the patient / service user, informed by the citizen's portal which contains information on service availability, to produce personalised instructions/content, including specific information for an individual based on their age, lifestyle and health needs. Information prescriptions would enhance the basic self care packs described in scenario 2, and would ensure that an individual's holistic needs are considered and appropriate care packages devised with the aim of improving outcomes.

Standardised pathways would include explicit trigger points, with clear access channels to help ensure that individuals, families and carers seek professional help in a timely and appropriate manner.

### 8.2.3 Activity Implications

Service	Projected change to 2020
<b>Informed lifestyle changes</b>	<ul style="list-style-type: none"> <li>■ Mortality rates from heart disease, stroke and related diseases for people under 75 would be maintained below 85 per 100,000</li> <li>■ Reduced prevalence of smoking in adults to 10% and to 5% for under 16 year olds</li> <li>■ Reduced incidence of overweight and obesity to below 20% in children and below 35% in adults</li> <li>■ Reduced per capita consumption of pure alcohol per year to 10 litres</li> <li>■ Reduced proportion of the population self reporting anxiety and depression to below 10%</li> </ul>
<b>Help at home, community based support and community based professionals</b>	<ul style="list-style-type: none"> <li>■ A 35% increase in both home care and district nursing, from 94,149 and 58,425 respectively in 2010 to c127,000 and c79,000 by 2020</li> <li>■ The use of telehealth and Parish based volunteers would enable community caseloads to increase and would provide capacity for 24 hour response service</li> <li>■ The number of state funded beds required reduces from 154 to 124 as more people are supported to live independently (see Older Adults section of this scenario)</li> <li>■ Increased use of Information Prescriptions would support individuals with long term conditions or social care needs. For people with conditions such as COPD, this would amount to c2,350 information prescriptions, based on 3.3% prevalence (aged 16+) and c1,500 for those affected by dementia (particularly for carers).</li> </ul>
<b>Care professionals / volunteers</b>	<ul style="list-style-type: none"> <li>■ Initiatives to support healthier lifestyles such as 'health walks' lead to a 40% to 50% increase in the population receiving the recommended amount of exercise. This contributes to a reduced incidence of obesity mentioned above.</li> </ul>

### 8.2.4 Staffing Implications

Service	Projected change to 2020
<b>Informed lifestyle changes</b>	<ul style="list-style-type: none"> <li>■ Additional 1 fte Programme Manager fixed term for 1 year to establish Expert Patient Programme</li> <li>■ Utilise existing capacity to deliver targeted education programmes, social marketing and other health promotion/improvement initiatives to support self care/public health</li> </ul>
<b>Help at home</b>	<ul style="list-style-type: none"> <li>■ Additional 10 fte district nurses for telehealth monitoring, based on caseload of 50 - 60 patients</li> </ul>
<b>Community based support and care professionals / volunteers</b>	<ul style="list-style-type: none"> <li>■ 240+ registered volunteers (at least 20 per Parish) to provide care navigation and other support to help people live independently at home</li> <li>■ Strong leadership, support and guidance</li> <li>■ Pool of up to 24 lead walkers to support healthy walking groups</li> </ul>

**Community based professionals**

- Increase in district nurses from to c55 fte in 2020
- Increase in home care to >90 fte in 2020

## 8.2.5 Revenue and capital implications

Description	Impact	Set up costs	Additional annual running costs in 2020 (£)
<b>Informed lifestyle changes</b>	<p>Smoking cessation</p> <ul style="list-style-type: none"> <li>Reduction in smoking prevalence from 23% (17,000) in 2010 to 10% in 2020</li> <li>This is based on a success rate of smoking cessation clinics of 50% with 10% of smokers accessing clinics increasing to 25% by 2020</li> </ul> <p>Early education</p> <ul style="list-style-type: none"> <li>Reduce the incidence of obese and overweight children to below 20%. The Children's Weight Programme would work closely with primary schools to bring about behaviour change for children and their families</li> </ul>		<p>Smoking cessation</p> <ul style="list-style-type: none"> <li>10 sessions per service user equates to £153 (£93 for non pay costs and £60 pay costs)</li> <li>Payment is made based on outcomes</li> <li>Based on 1,690 service users accessing the service in 2010 and a 50% success rate, cost would be c£230k in the first year rising to c£270k p.a by 2020</li> </ul> <p>Early education</p> <ul style="list-style-type: none"> <li>£175k p.a per annum – staff costs of c£120k (3 fte) and c£60k non pay including venue hire, training, equipment and materials</li> </ul>
	<p>Availability of information</p> <ul style="list-style-type: none"> <li>Information available to promote benefits of improved lifestyle choices and support people with specific needs/conditions includes information prescriptions</li> </ul>	<p>Availability of information</p> <ul style="list-style-type: none"> <li>Cost of producing material estimated at £2 to 4 per booklet. For information prescriptions such as COPD, this amounts to c£7k for 2,350 printed booklets. Use of online tools would support managing the volume of printed material distributed</li> </ul>	<p>Availability of information</p> <ul style="list-style-type: none"> <li>Cost of monitoring updating information portal would be includes 1 fte I.T. support at c£25k p.a</li> </ul>
<b>Help at home (telehealth)</b>	<ul style="list-style-type: none"> <li>50% - 60% reduction in A&amp;E attendances (760 attendances)</li> <li>2% reduction in emergency ambulance journeys (c125 journeys)</li> <li>40% - 50% reduction in hospital admissions (c4,500 bed days)</li> </ul>	<p>Initial capital costs £531k (£900 per patient)</p>	<ul style="list-style-type: none"> <li>Annual equipment running costs c£350k p.a (£600 per patient for 470 patients)</li> <li>10 fte monitoring nurses - c£500k p.a</li> </ul>
<b>Community based support (Expert Patient Programme)</b>	<ul style="list-style-type: none"> <li>16% reduction in A&amp;E admissions (c700 attendances)</li> <li>10% reduction in follow up appointments for COPD, Cardiology and Diabetes patients (1020 follow up appointments)</li> </ul>	<ul style="list-style-type: none"> <li>Cost of 1 fte Programme Manager for 1 year to establish Programme - c£50k</li> <li>Equipment costs c£10k</li> </ul>	<ul style="list-style-type: none"> <li>Once established, delivered by lay volunteers</li> </ul>

Description	Impact	Set up costs	Additional annual running costs in 2020 (£)
	<ul style="list-style-type: none"> <li>Cost reduction of up to c£180k per annum</li> </ul>		
<b>Community based professionals</b>	<ul style="list-style-type: none"> <li>Support individuals to live independently at home</li> <li>By 2020, demand increases to c920 service users for home care and c4,700 for district nursing</li> </ul>	<ul style="list-style-type: none"> <li>Equipment costs c£300 per patient - total c£280k</li> <li>Assumed that this equipment may be recycled</li> </ul>	<ul style="list-style-type: none"> <li>Additional staffing costs c£1.5m p.a.</li> </ul>
<b>Community Based volunteers to support Care coaches/ Citizen's portal/ Health walks</b>	<ul style="list-style-type: none"> <li>Support individuals through helping people to live at home</li> <li>Provide assistance in navigating those requiring additional support in using the citizen's portal</li> </ul>	<ul style="list-style-type: none"> <li>Costs associated with training (citizen's portal, care navigators and 'health walks' facilitators)</li> <li>Anticipated that this would be provided by existing health promotion staff post of c.£50k</li> </ul>	<ul style="list-style-type: none"> <li>Costs neutral with the exception of reimbursement of expenses e.g. travel</li> </ul>

## 8.2.6 Funding Implications

- The current funding model would increase the demand for community pharmacists as an alternative to primary care for basic health checks/screening. The funding of this service may need to be on a fee-for-service from the individual patient, however, it is anticipated that this would be lower than the GP consultation fee
- Commercial models may be adopted for telehealth, where suppliers share the risk on benefits being achieved through a gainsharing model, thereby reducing the funding requirement from Jersey HSSD
- Eligibility criteria and thresholds would need to be rigorously applied, to manage demand and cost
- Incentivised payments would be made to community pharmacies for smoking cessation clinics, dependent on success rates

## 8.2.7 Benefits

### 8.2.7.1 Service user/carer

- Improved patient experience - increased service user and carer confidence through a better understanding of their condition and an improvement in their health, independence and quality of life
- More equitable access to health and social care services through identifying hard to reach groups and ensuring that the public are made aware of the services available
- Improved risk stratification and case finding to identify those most at risk / most in potential need, through working with primary care. This would help to reduce inequalities and proactively prioritise and plan care, and would help to engage with hard to reach and vulnerable groups
- Greater patient voice as volunteers are represented on the collaborative alliance for self care
- Improved culture of self care and lifestyle choices through early education and targeted social marketing campaigns

- Improved health outcomes as individuals and patients adopt a more proactive approach to managing their health and wellbeing
- Further reduction in hospital admissions/ readmissions as patients are less likely to suffer acute episodes
- Home adaptations and equipment are more readily available, further supporting individuals to live productive and independent lives, and relieving some of the burden on carers
- Community support, including home care, available 24 hours, which would support people in living at home for a longer period, delaying the point at which long terms residential or nursing care is required
- Reduced confusion as information is not duplicated, is easily accessible and understood, and is targeted appropriately
- Initial support and guidance from care navigators to support service users in accessing the citizen's portal. Care navigators also work with service users to ensure informed choices are made, providing further control over the care delivered to them

#### 8.2.7.2 Workforce

- Reduced pressure on staff as resources are increased to meet demand, and as demand begins to reduce as a result of self care, health promotion and increased alternatives to unscheduled and reactive acute admissions
- Increased staff satisfaction as roles are enhanced to maximise professionals' skills and expertise. This may lead to reduction in sickness rates and improved recruitment and retention
- Better utilisation of staff as patients are seen by the most appropriate staff, only when this is required
- Community multidisciplinary team working engenders mutual professional support and improved job satisfaction through a reduction in silo working

#### 8.2.7.3 Quality

- Reduced non elective admissions and A&E attendances through improved condition management, enabling service users to remain independently in their own homes
- Service users are confident and empowered to manage their own condition
- Increased access and support for individuals to proactively manage their health and wellbeing
- Reduced burden on carers through the increased availability of 24 hour community support, including home care, aids and adaptations, telehealth and telecare

#### 8.2.7.4 Business

- Reduced cost of treating patients with long term conditions
- Reduced inappropriate admissions as more individuals take an active role in managing their own health and wellbeing
- As a single model for self care is established, staff become more aware of information and services, making signposting easier. Similarly, the public become more aware of actions to help manage their own condition or live a healthier lifestyle
- Duplication in resources are reduced as organisations which support self care become more integrated

### 8.2.8 Risks

- Funding mechanisms may create financial disincentives to access primary care or community pharmacists
- Cultural shift required to encourage the population to adopt a self-care approach
- Lack of primary care data /information system to provide robust public health intelligence for risk stratification and service development
- May experience some resistance from community staff as care becomes available 24-hours (requiring changes to working patterns)
- Increased costs for home adaptations and equipment
- Requires willing public volunteers
- As people live healthier and longer lives, this leads to additional social care costs

## 8.2.9 Implementation timetable

Initiative	Timescale	Action
<b>Improved lifestyle choices</b>	November 2011	Establish alliance of organisations and individuals
	December 2011	Build a directory of information/activities for self care to provide guidance to individuals on self care and management of long term conditions
	November 2011	Build upon existing work/initiatives for education programmes and social marketing
	January 2012	Identify community pharmacists interested in providing additional services Raise awareness with the public regarding breadth of services available from community pharmacies
<b>Home care</b>	October 2011	Identify service users in need of home care support
	January 2012	Recruit staff to meet demand of district nursing and home care
	January 2012 to January 2013	Introduce integrated community MDTs, including changes to working practices (telehealth monitoring nurses and 24 hour response services)
<b>Telehealth and telecare</b>	January to December 2012	Identify patient groups; initial rollout to 50% of patient group
	March 2012	Train staff on monitoring equipment
<b>Expert Patient Programme</b>	January 2013	Implement remaining 50% of patients targeted at receiving telehealth and telecare
	January 2012	Recruit Programme Manager to develop and roll out the Expert Patient Programme (Programme to initially focus on one LTC e.g. COPD before roll out on other conditions)
	March 2012	Identify patients living with COPD willing to participate in the Expert Patient Programme
	April 2012	Identify patients who may benefit from the Expert Patient Programme
	May 2012	Commence Expert Patient Programme
	July 2012	Gradual Roll out of Programme to other conditions
	January 2013	Continue roll out of Expert Patient Programme
	March 2013 and ongoing	Ongoing recruitment and training of patients able to facilitate the EPP. Anticipated that Patients trained in year 1 will train other patients.
<b>Community based support</b>	January 2012 and ongoing programme of recruiting volunteers	Engage with St. Clements Parish to understand their model Identify community based volunteers in other Parishes
	February 2012 and ongoing	Security (CRB) screening checks carried out for volunteers
<b>All</b>	January 2013 onwards	Ongoing roll out of self care activities and support to increase public awareness and change culture to a proactive approach to managing individual's health and wellbeing.

## 8.2.10 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Met	<ul style="list-style-type: none"> <li>■ Introducing community MDTs, supported by telehealth and telecare, targeting proactive interventions to those patients most in need and providing regular monitoring and a tailored response reduces exacerbations, unscheduled care and non elective admissions</li> <li>■ The resulting reduction in demand helps to improve productivity and reduce costs, and produces a more sustainable service model which reduces the need for costly unplanned care in estates-based facilities</li> <li>■ Engaging the population to be proactive in their health and lifestyle choices reduces demand on health and social services in the future as disease incidence and need reduces</li> <li>■ It also provides the population with more tools to manage their ongoing condition, thereby reducing demand on services immediately as choices are made which do not necessarily involve presentation at A&amp;E</li> </ul>
<b>Ensure Clinical/service viability</b>	Met	<ul style="list-style-type: none"> <li>■ Better utilisation of skills and resources through enhanced roles, providing additional capacity to support improved access and increased available capacity to provide care for those most in need</li> </ul>
<b>Ensure financial viability</b>	Met	<ul style="list-style-type: none"> <li>■ Cost of care reduces as people are supported in their own homes rather than costly estates-based facilities. As intervention is targeted and prioritised, improved value for money from clinical and professional staff is achieved</li> <li>■ Self care leads to reduced demand in the future, which improves financial viability</li> <li>■ An immediate cost benefit is achieved from telehealth through a reduction in A&amp;E, ambulance and non-elective admission costs</li> </ul>
<b>Optimising estate utilisation</b>	Met	<ul style="list-style-type: none"> <li>■ Greater use of other facilities such as community pharmacies to provide health checks and advice</li> <li>■ Improved utilisation of beds through reducing admissions/readmissions as condition management improves</li> </ul>
<b>Workforce utilisation and development</b>	Met at cost	<ul style="list-style-type: none"> <li>■ Staff roles are enhanced to maximise the use of professionals' skills and expertise. Staff resources are increased, reducing pressure</li> <li>■ Multidisciplinary team working also encourages the sharing of skills and approaches</li> </ul>
<b>Clinical governance</b>	Met	<ul style="list-style-type: none"> <li>■ A coordinated approach to providing information and advice ensures that self care material meets a consistent standard of quality</li> </ul>
<b>Use of business intelligence</b>	Met at cost	<ul style="list-style-type: none"> <li>■ Improved public health intelligence enables targeted prioritisation of the population's health and social care needs through risk stratification</li> <li>■ Information on outcomes also supports value for money assessments and future planning of service delivery</li> </ul>

## 8.3 Primary Care

There are two strategic aims:

- Maintain the health of the population, with a health service that actively promotes this; and

- Align the objectives of all of the healthcare providers to work to the same goal, through establishing a service where all components are incentivised to continuously review and improve services. This produces a dynamic, self-improving service in which care professionals are empowered to work together, to innovate and provide the best possible service to optimise the health and wellbeing of the population.

Jersey is currently developing a Quality Contract / Quality Framework for primary care. The detailed business case will need to clearly incorporate this, as the plans develop and the elements of the framework and it's intended operation become increasingly clear.

It is also noted that, along with all other elements of scenario three, the potential changes to primary care are significant. It is imperative that, in developing the business case, the detail of the future model and the implementation / transition plans are fully considered, to ensure the ongoing viability of the service and to ensure stakeholders are fully supported through the change.

#### 8.3.1.1 A population based approach to health and wellbeing

##### *Registration with a doctor*

Each patient would register with a primary care provider of their choice. There would be freedom to change doctors, but patients can only be registered with a single primary care provider at any one time. Patients could choose to access other GPs, but in such cases, would not receive any HIF subsidy.

Single registration would build on the close relationship that GPs currently have with their patients, and enable an accurate assessment of demand through developing knowledge of the numbers and clinical needs of patients. It also allows closer checks on eligibility for care through a central registration process and enables more accurate health needs assessment and planning through the provision of improved information.

Following the introduction of the Quality Contract, accurate metrics would be needed for monitoring performance against quality targets.

##### *Needs Based Assessment*

Understanding the population is essential to ensuring that their needs are identified, understood and addressed, and that the health and social care services of Jersey have the capacity to meet those needs.

A needs based assessment would incorporate both health and social care. It would be completed, for individual patients, by a key worker – in primary, community or social care – and shared across all parts of the system to support effective care coordination.

Maintaining central records of the needs based assessment for the population would identify and reduce health inequalities through risk stratification, case finding and proactive interventions, targeting care for those populations who might benefit the most, for example, targeting self care to patients with early COPD to provide improved condition management, slow the progression of disease and delay the timescale at which needs increase, thereby reducing suffering for the patient and reducing costs to the States.

### *Comprehensive integrated clinical information system*

An effective clinical information system would allow a common care record and the transfer of information between providers. This would support the integration of services, would reduce time taken inputting patient details numerous times, ensure that all staff had timely access to the patient's records and could easily review their care package, and reduce wastage of time awaiting results of tests, investigations and other consultations.

Emergency and out of hours care would be enhanced by having access to all relevant information, case histories, medication details etc. This would also help to reduce clinical risk.

Accurate recording and coding of clinical activity would support health needs assessment through the targeting of health care resources and a more accurate assessment of impact, and clinical audit would be facilitated and made more robust by accurate data.

Such a system should be robust and secure, facilitating interchange and access to information as and when appropriate. Electronic access to a variety of services, including making payments through a mobile phone, are becoming common place. People would be able to order repeat medications, arrange appointments, receive test results and copies of clinical reports from their healthcare professional through the use of such technology.

### *Determining priorities*

Increasing demand in terms of quantity and also from advances in care increases the importance of clinical decision making and prioritisation.

This will increasingly need democratic accountability, with the public being involved in the decisions about their care and the priorities. Insurers may also have to specify priorities for care.

Health needs assessment and the subsequent priority setting process would determine the content and focus of a clinical strategy.

### *Contracting for quality*

Systems and metrics to monitor and assess the performance against the contract would be established and implemented. The use of resources by primary care including prescribing, tests and investigations, hospital resources (including patient A&E attendance), social care resources and nursing care would be assessed for appropriateness, effect and value for money.

A clinical strategy would need to include explicit statements regarding quality thresholds. The States would establish a suitable clinical forum along with membership from the general public to define standards.

Systems would be introduced to provide assurance to the population that the health and social care services are fit for purpose, produce the desired outcomes and represent value for money.

Success would be measured by outcomes determined in the clinical strategy and through robust management of contracts.

The States are in the process of establishing governance processes for general medical practitioners, as outlined in scenario 2. Providers of healthcare would ensure that their governance procedures are robust and satisfactory and that reports providing assurance are made available publicly on at least an annual basis.

The States would have systems in place to ensure that any unexpected variations of care are identified and handled appropriately and rapidly.

This would require funding, to ensure optimal use of resources and it also has to be able to demonstrate that the monitoring system adds value and pays for itself through efficiencies. It would also require staffing and an IT infrastructure.

### 8.3.1.2 Expanded primary care teams

As outlined in scenario 2, demand for primary care services, driven by the ageing population and quality framework, would increase demand for primary care from almost 343,000 to almost 539,000 consultations per annum in 2020, if the demand for primary care services increases to the same extent as that experienced following the introduction of the Quality Outcomes Framework in the UK.

At present, the majority of services in primary care are provided by GPs, and the development of primary care teams has been slow due to the public subsidy from the HIF which only pays when the patient is seen by a doctor.

In the future, the primary care team would be an integrated team of GPs and other care professionals, providing personalised, local care for their registered population. Such teams would provide a comprehensive range of services, including improving the ability of people to maintain their autonomy in living in their own home and mental health as well as medical issues. Such teams may also have a more inclusive approach to education, police and the judiciary to further extend their influence on the ability of individuals to optimise their health and wellbeing.

Internationally, primary care services have moved towards a more multidisciplinary model. As outlined in scenario 2, in the UK<sup>1</sup> 34% of primary care consultations are undertaken by nurses, with 'other' staff undertaking 4% of consultations (i.e. 62% of primary care consultations are undertaken by GPs). This would reduce the requirement for GPs in primary care settings to between 50 and 60 fte, thereby releasing time to enable GPs to work closely with secondary care colleagues, as outlined in the 'Acute Care' section of this scenario. Practices would be enhanced by more than 30 additional practice nurses, in order to meet the demand for primary care services.

Practices would develop extended skills to cope with long term conditions and the standards that would be required, providing care in any health or social care setting including schools. Services offered in primary care could expand, for example to include specialty clinics for Asthma, COPD and Diabetes.

In addition, specialist teams would be developed in primary care for priority conditions (those which have a high prevalence and which can be effectively monitored and managed out of hospital, proactively, to reduce the risk of a non elective admission). Specialist teams would be located in a practice or based within the hospital, and shared between local practices – or they could be mobile, working in different practices on different days of the week. The locations for this would be developed as part of the detailed business case, to ensure this supports Jersey's preferred structure and focus

for services. Examples of specialist care which could be provided in primary care include long-term conditions, end of life care, mental health, speech and language therapy, physiotherapy, podiatry, dietetics, LD, stoma care, antenatal care. Providers would enter into contracts with each other or the States to provide services. Accountable Care Organisations (ACOs) could develop. These organisations provide prime contracting (with subcontracting to other providers), to deliver a range of care for a particular condition. Alternatively, providers may wish to employ clinicians throughout an Integrated Care Organisation (ICO).

The exact detail of the specialist team model would be developed further as part of business case planning. There are a number of detailed contractual considerations:

- Provide each practice with a contract explicitly stating requirements with defined quality standards
- Provide each practice with a defined budget for primary care services
- Help practices to understand the consequences of their care on patients and upon the healthcare system e.g. the importance of early detection and diagnosis of diabetes and its subsequent care upon the patient, carers and healthcare system in reducing costs from premature morbidity caused by organ damage and the associated costs of trying to rectify problems that present late
- Provide each practice with a budget for secondary care and other health and social care services
- Introduce a system of attributing costs to particular patients and therefore practice (including 'personal budgets' for individual patients to take over control of the purchase of their own health care)
- Charge primary care for the use of secondary and other health and social care services e.g. patients attending A&E
- Incentivise clinicians to work to a common goal by allowing them benefit from savings. In this way clinicians can identify and eradicate wasteful practice. An example would be the establishment of a 'mutual organisation' where clinicians and professionals across care settings work to meet the required outcomes in as efficient a manner as possible, sharing any savings. If the system does not deliver or is not efficient then this 'dividend' is lost
- Allow clinicians and professionals to work across boundaries

### 8.3.1.3 Pharmacy

Pharmacists train to Masters level and the drug budget is one of the largest and most volatile of the healthcare spends. Significant costs can be saved through effective use and compliance with medication and by reducing waste through unnecessary ordering of medicines.

Pharmacists would develop services, understanding medicines, their use, abuse and interactions and working more closely with GPs.

Systems to reduce unnecessary bureaucracy and repeat prescribing would be established through repeat dispensing protocols, and economies of scale in procurement considered in order to reduce costs.

A strategy for the role of community pharmacists would be developed, with strategic principles agreed based on the above. This would also consider the contractual, funding and incentive structures for pharmacists, as part of a multidisciplinary primary care team.

#### 8.3.1.4 Closer working across health and social care

Multi-disciplinary teams would develop, focused on ensuring that the care provided to groups of patients is appropriate and properly targeted. These teams could build upon the current Parish system, be co-located and be responsible for a cohort of patients and service users in a geographical area or locality – this would be agreed in the detailed business case, through consultation with a range of stakeholders.

Aligning these teams with a practice, or set of practices, would further support the multidisciplinary team working approach and enable truly holistic care to be planned and provided. These teams could also take responsibility for coordinating the needs and support for complex families, working with education, criminal justice and other States Departments, and responsibility for coordinating the needs of older adults, working with Housing.

Example models are outlined further in the 'Acute' and 'Older Adult' sections of this scenario.

As outlined in 'Self Care', the citizens' portal would provide a single point of information for clinicians, patients, service users and carers. Information on self care, and information on the care and support available from all agencies (including the third sector) would be held in one place online, accessible by all. Care navigators would be available to assist those who are unable to understand or access this information, and to support people in making choices. Technology will support individual's constant, fast and easy access to this information, and (with appropriate data protection measures) their own care records would be available through this route – further supporting people in taking responsibility for their own health and social care needs, self care, and increased control.

#### 8.3.1.5 Closer working across health locations

Closer working across health and social care and needs based approach to planning and providing care would help ensure the care workload is shared across professions. As outlined above, this should release capacity for GPs to provide support to hospital colleagues working in clinical areas, in order to release consultants from providing care that could be appropriately provided by general practitioners, and therefore enabling specialists to concentrate on their areas of expertise.

GPs would have the opportunity to 'skill up' in particular medical speciality fields. As professionals in their own right in the integrated health system they would have admitting rights. GPs would work with consultant teams to provide extra capacity in A&E and outpatients departments and providing interventional services (as outlined in the 'Acute' section of this scenario).

Over time a model of a GP who has trained as a hospital 'generalist' would be developed, similar to that in other remote areas such as Scotland. A single point of accountability through a shared contract would encourage GPs and consultants to work together to maximise efficiency and effectiveness.

This model would need to develop over time, as working practises develop. A phased approach would be likely, as GPs develop skills and competency to support their secondary care colleagues. This evolutionary approach will be developed as part of the detailed business case.

### 8.3.2 Activity Implications

- Demand for primary care is projected to increase by 57% to approx 538,934 consultations (including an additional 46,000 consultations for over 85s alone due to their higher consulting rate).

GPs would meet 62% of this demand, with practice nurses and other primary care professionals meeting the remaining 38%, as outlined in scenario 2

- Risk stratification should reduce the need for acute care and may benefit social care by keeping people healthier, thereby reducing the need for unscheduled care and emergency admissions. Identifying the top 250 patients at highest risk of admission could save £95,000 in prevented admissions alone<sup>135</sup>
- Practices would work more closely together, sharing specialist resources,, with integrated working with all health and social care providers utilising resources and skills to enhance care whilst reducing waste and therefore cost. Improved joint working and more proactive and consistent primary care would reduce the demand for unscheduled care
- Visits to community pharmacies for health checks and screening would increase from 6,240 in 2010 to 9,400 at 2020 as more people use access facilities as an alternative to general practice

### 8.3.3 Staffing Implications

Staff group	Number of staff at 2020	Cost (£) Additional at 2020	Impact
<b>GP</b>	c60 GPs	Will depend on the copayment	The current excess GP capacity (approx 10 fte) would be deployed elsewhere in the system (e.g. hospital services) or removed over time through retirement or leaving general practice
<b>Practice Nurse</b>	>30	c£1.5m p.a	Undertakes up to 38% of activity which, in 2010, is undertaken by a GP
<b>Other primary care</b>	Prescribing pharmacists		Some pharmacists could become salaried, and focus on medicines management. The effective control of prescribing costs should reduce waste and inappropriate prescribing balancing the additional costs of managing long term conditions (i.e. increased costs of prescribing medicines for raised blood pressure, diabetes etc.) and numbers of patients being treated

- Challenges may be experienced regarding changing organisational culture and introducing unfamiliar working practices. Aligning incentives should help overcome the majority of these, for example delivering care as a mutual society, which pays a bonus or dividend in the event of successful completion of a contract
- Recruitment challenges may continue, particularly for practice nurses. This would be addressed through the development of relevant training programmes
- Services have historically been developed on a fee charging basis. Changes to the funding of primary care would lead to changes in skill mix structures, which are necessary to deliver a population based approach to optimising health for all
- Clinical leadership would need to be enhanced, and GPs unskilled in care provision across a spectrum of locations (including A&E and outpatients)

<sup>135</sup> Combined Predictive Model Final Report & Technical Documentation; December 2006 Kings Fund and Department of Health, UK

- Additional skills would also be required to support GPs in risk stratification, case finding and the development of the clinical strategy. Additional support may also be required for developing and monitoring outcomes measure, performance management and multidisciplinary working
- Robust contracting mechanisms would be required to clarify the roles, inputs and expectations for all professional groups

The costs of transition, specifically the financial aspects of reducing the number of GPs in Jersey (upon retirement or leaving the profession or the island). At present, these costs can be significant. The detailed business case needs to ensure the transition costs (including retirement costs) are fully incorporated, and should consider how and when these costs are met.

### 8.3.4 Revenue and capital implications

Description	Impact	Set up costs	Annual running costs (New)
<b>Growth in demand for primary care services and in particular long term conditions</b>	Population increases by c4%; consultation rate increases to 5.5 as a consequence of increased demand and the quality initiative – demand in primary care increases by almost 60% in total by 2020	Education and recruitment costs for additional nurses - c£50k	c60 fte GPs - c£20m p.a Practice nurses c£1.5m p.a. Education £5k p.a
<b>Enhanced community teams</b>	Improved community-based working, with multi-disciplinary teams working together and supporting localities / geographies of patients and service users		Costs are incorporated into the Older Adults section of this scenario
<b>Enhanced Governance</b>	Improved governance to meet revalidation standards of GMC-UK	Establishment of performers list - £25k Additional equipment costs	Maintenance of performers list c£1k p.a.
<b>Development of clinical strategy and contract for primary care</b>	Health Needs Assessment, priority setting process and development and implementation of strategy Management of the system should cost between 5-6%	IT infrastructure costs to collect health data or extract from GP clinical systems as part of quality framework would be dependent on suitability of existing GP systems	HNA £250k p.a Prioritisation and development of strategy c£50k Contracting mechanism c£250k
<b>Risk Stratification</b>	Identifies those most at risk of utilising healthcare resources, supported by a database of population for accounting and health needs purposes	IT system and integration of IT could cost up to £1m	c£100k p.a for licences Admin c£30k p.a
<b>Non-medical prescribers</b>	Staff developed professionally to make best use of resources		Training and education c£5k p.a

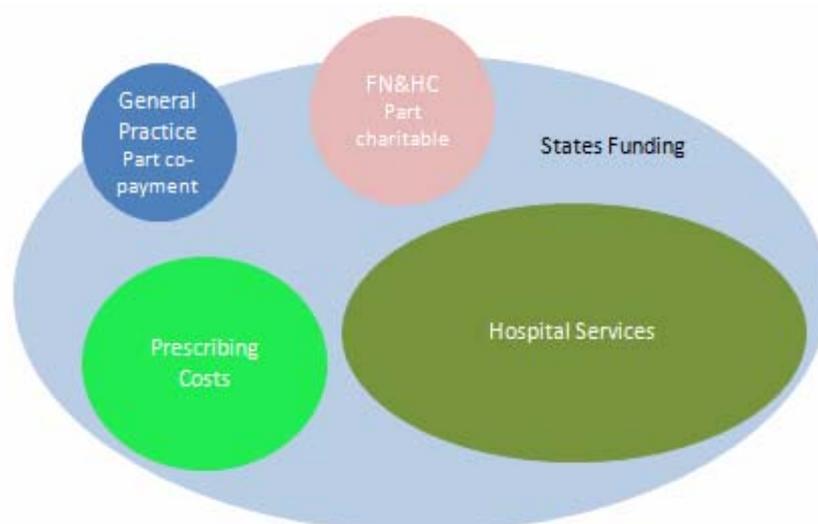
- All operational costs (including accommodation, estates, management and IT costs) will need to be determined as the business case progresses.
- The transition costs will also need to be incorporated into the detailed business case.

### 8.3.5 Funding implications

- The funding model needs to remove perverse incentives in seeking and delivering health and social care. Aligning the objectives of the clinicians and professionals throughout the pathway should reduce waste and inefficiencies

- The current rebate system encourages activity increases but with no challenge and no controls on quality and value. These monies could be pooled and allocated to practices to provide particular services against a contract. The £1.5m (index linked) quality payment would be targeted to fund additional consultations and services needed to address long term conditions and care needs and the problems associated with the very elderly
- The method of distribution would be through weighted capitation to set equitable budgets based upon the predicted health care needs. This system can also be used to measure the impact and effectiveness of providers
- Budgets for practices would take into account all primary, community and secondary healthcare needs, with success being measured against impact care has had on the use of resources, and savings being shared between providers
- The funding and budget aspects of this scenario will need to be developed to ensure the continued financial viability of the service. In particular, consideration needs to be given to the financial and funding flows around the system, and the quantum of funding for primary care, to support non-patient facing activities such as clinical leadership and continuing professional development
- The transition from current arrangements to any new funding and contractual mechanisms will also require careful planning and engagement

Figure 64: Budget allocations to practices



## 8.3.6 Benefits

### 8.3.6.1 Service user/carer

- Patients are still able to choose their own GP
- Patients are able to choose most appropriate health care professional in primary care
- More health and social care delivered in non-hospital settings, including web based services
- Quality of services assured and demonstrated
- Care designed and delivered according to the results of health needs assessment and risk stratification, to meet the needs of the population
- Seamless, integrated delivery of care, with individualised care packages that are designed and delivered to meet holistic care needs and support independence in the community

- A range of community services available, including 24-hour support, to reduce the need for long terms residential care and to reduce the burden on carers
- Proactive approach to maintaining health, with technology used to support individuals in taking control of their own health and understanding the care and support they are receiving
- [if funding issues resolved] removal of barriers to accessing most appropriate level of care
- Shorter waiting times to see specialists

#### 8.3.6.2 Workforce

- Increased opportunities for non medical staff, with expanded roles and a more attractive career paths
- Multidisciplinary team working, which would improve relationships between care providers, providing a demonstrably enhanced service and improving job satisfaction

#### 8.3.6.3 Quality

- Standards determined and demonstrated
- Access to tests and investigations as clinically necessary
- Publicly available quality accounts

#### 8.3.6.4 Business

- Moving to a registered list of patients with a defined contract would bring enhanced security to GPs who are currently private businesses carrying most of their own business risk
- Provides enhanced business resilience

### 8.3.7 Risks

- Failure to take bold action that introduces meaningful and lasting change
- Culture and behaviours of clinicians and patients / service users impedes progress
- Business risk (carried now)
- Need to determine skill sets, then match or educate individuals – some challenges with recruiting and retaining staff in Jersey would continue
- Prescribing by pharmacists will represent a challenge both to pharmacists and GPs. However, non-medical prescribing has been well accepted in the UK
- Increased workload for primary care teams and the community as more care is delivered out of hospital
- Need to break down the barriers between the professional groups to ensure efficient and effective working
- Incentives need to drive the desired behaviours and unite care providers in having the same objectives which benefits the patient / service user whilst maintaining a safe sustainable and affordable service
- Need to ensure that remuneration is appropriate to recruit and retain all grades of staff
- Need to ensure the Jersey remains a desirable place to work
- Need to ensure that gaps in professionalism between UK and Jersey do not grow to the detriment of the Jersey service

- Information systems need to mature quickly in order to help drive the necessary behaviours and decision making
- Information needs to flow freely between partners in health and social care whilst maintaining appropriate information governance

### 8.3.8 Implementation timetable

The implementation timetable for enhanced community teams is presented in the 'Older Adults' section of this scenario

Initiative	Timescale	Action
<b>Enhanced primary care teams</b>	2012	Recruit additional practice nurses and administration / reception staff
<b>Funding and commissioning</b>	2012	Review funding of health and social care to explore options for future funding scenarios and flexibility within the existing system
	2012	Establish process to develop clinical strategy
	2013	Develop and agree clinical strategy
	2014	Implement clinical strategy
	2014	Establish and implement performance management processes
	2015	Review progress and effectiveness of clinical strategy
<b>Population based approach to care</b>	2012	Define and implement registration process for patients
	2012	Establish IT system
	2012	Agree information governance requirements and compliance
	2013	Health Needs Assessment to be completed and agreed
	2013	Stakeholder engagement and market research to support the health needs assessment
	2013	Benchmarking against public health measures to support the development commissioning strategy and priority setting
	2013	Gap analysis against current services
	2013	Prioritisation of needs to be addressed
	2013	Gain clinical ownership of clinical strategy, standards of care, outcomes and measures of success
	2013	Establish process for effective clinical governance
	2013	Develop plan for integration of services (including governance, education and supervision)
	2014	Implement transformation plan
	2015	Review impact on health and wellbeing

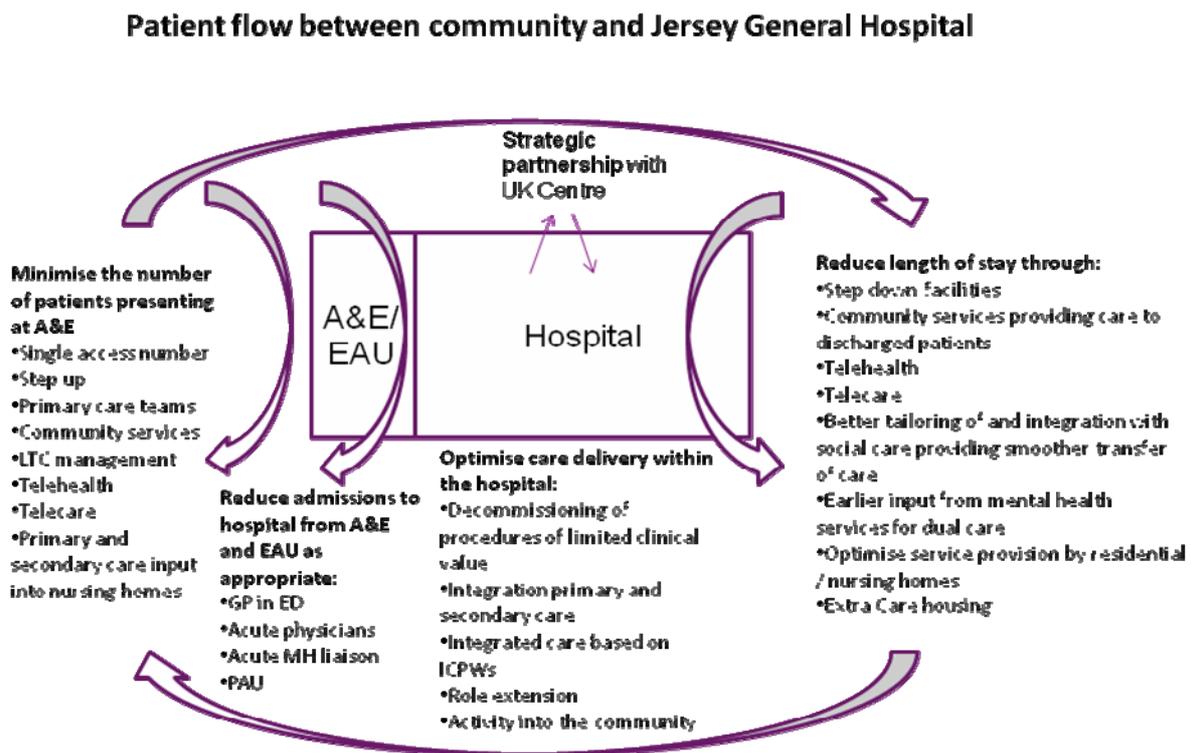
### 8.3.9 Strategic Imperatives met/unmet

Service design principle	Met/unmet	Justification
<b>Create a sustainable service model</b>	Met	<ul style="list-style-type: none"> <li>■ Supported by self care, the clinical strategy is developed with input from all sectors of health and social care, based on needs assessment. The system then continually reviews and amends its provision to ensure demand is understood and needs are prioritised, to provide targeted, personalised holistic care which is delivered by a multidisciplinary team from primary care, and which reduces the demand on costly estates-based care</li> <li>■ The system begins to self modify to maximise effectiveness and efficiencies, supported by the removal of perverse incentives. This also reduces inequalities and improves access, particularly to primary care</li> <li>■ Primary care uses its resources more effectively, particularly in prescribing, and provides more preventative care, reducing the need for unscheduled hospital care</li> <li>■ Increased capacity in primary care (provided by non medical staff) reduces the demand on hospital</li> </ul>
<b>Ensure Clinical/service viability</b>	Met	<ul style="list-style-type: none"> <li>■ Clear standards and outcomes measures ensure that the most appropriate service is being delivered in the most effective and efficient manner</li> <li>■ Increased capacity in primary and community care reduces demands on acute care, thereby supporting the system's clinical and service viability</li> </ul>
<b>Ensure financial viability</b>	Met	<ul style="list-style-type: none"> <li>■ Information on expenditure, value for money and outcomes is available from the health needs assessment / information system</li> <li>■ Perverse incentives are removed from the system, and changes in skill mix reduce the cost of care</li> <li>■ Increased capacity and care within primary and community care settings, with proactive care targeted to those most at risk of hospital admission and greatest need, helps to reduce demand on acute care and hence support the system's financial and capacity viability</li> <li>■ A lack of controls on expenditure or claims by GPs could lead to supplier-induced demand and therefore increased rebate and copayment claims by those professionals who are paid on a fee-for-service basis</li> </ul>
<b>Optimising estate utilisation</b>	Met	<ul style="list-style-type: none"> <li>■ Full use of the expanded primary care team utilises practice premises as well as other health care locations and peripatetic services to maximise estate use and deliver efficiencies</li> <li>■ Increased care in primary and community settings reduces the need for costly acute care and releases capacity in acute and long term residential settings</li> </ul>
<b>Workforce utilisation and development</b>	Met	<ul style="list-style-type: none"> <li>■ Expanded workforce focusing on their key skills to optimal effect</li> <li>■ Improved career path for nurses and other non medical staff</li> <li>■ Increased skills and coordination between primary and secondary care, which supports the sharing of skills and approaches</li> </ul>
<b>Clinical governance</b>	Met	<ul style="list-style-type: none"> <li>■ Improved governance and increasing numbers of non-medical staff in primary care further improve clinical supervision and quality</li> <li>■ Monitoring process utilises clinical information from IT system for audit of adherence to pathways and standards of care</li> </ul>
<b>Use of business intelligence</b>	Met	<ul style="list-style-type: none"> <li>■ Information collected systematically extracted and analysed to determine health needs, identify at risk individuals and provider performance.</li> </ul>

## 8.4 Acute Care

The future model for acute medical care would be part of a wholly integrated system, designed to provide the most appropriate care by the most appropriate practitioner in the most appropriate setting. It would be based on the premise that as much care as possible should be provided on island, to consolidate existing services both clinically and financially, to minimise the need for travel by patients and relatives, and to reduce the unit cost by making best use of fixed costs of providing care.

Figure 6510: Patient flow between community and Jersey General Hospital



Services would be provided as part of fully integrated care pathways (ICPWs) which are designed to ensure inpatient spells are minimised both in number and in duration to relieve the pressures on the bed base and hospital facilities. The ICPWs would be supported by multi-disciplinary teams (MDTs) spanning primary and secondary care (as noted in the 'Primary Care' section of this scenario), as well as care provided off island, social care, mental health, the third sector and Parishes.

Efficiency measures as outlined in scenario 2 to reduce length of stay, optimise the efficient use of existing resources and improve the discharge process would be implemented.

Close co-operation and liaison with, and earlier input from mental health services, community services, social care, third sector and Parishes would be achieved through a common assessment process, supported by the citizen's portal and care navigators. Close working between acute and community multidisciplinary teams would support speedy discharge following an acute episode through proactive planning and management. Increased care provision and alternatives to acute care provided in the community, for example step down units and supported discharge with telehealth in 'virtual wards', to reduce non-elective admissions following presentation to A&E, and to reduce length of stay following an acute episode. Protocols for admissions and discharges, including for off island care, would be agreed and implemented.

The demand for acute-based emergency and unscheduled care would be managed through risk stratification and proactive case finding and management in a range of non-acute settings. Care in all settings would be delivered by multidisciplinary teams, with clear pathways.

Incentives would be devised to drive behaviours for patients/service users and staff, encouraging the appropriate use of emergency services including A&E. This would include, for example, a proactive approach to patients entering the system, through a single point of access such as a three digit number, and thereafter a co-ordinated approach to their care.

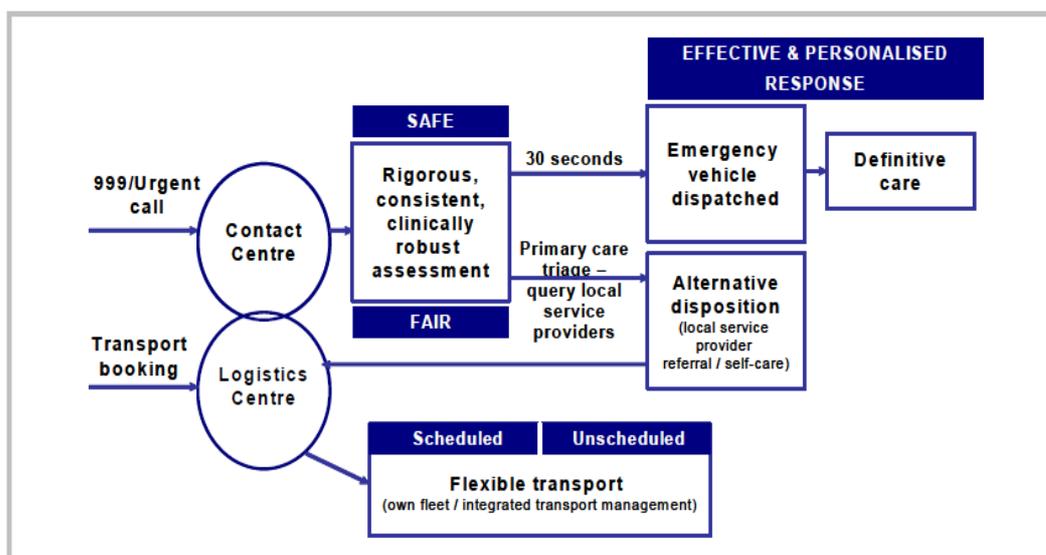
Diagnosis, stabilisation and treatment in A&E would be provided by a multidisciplinary team, with enhanced roles for nurses and AHPs and with clinical staffing by consultants and GPs and a specific Paediatric Assessment service.

Certain trauma cases would continue to be stabilised on the island and treated off island, where Jersey does not have in-house sub-specialists, and telemedicine would support remote treatment of an increasing number of emergency cases and of outpatient appointments with off-island specialist, where appropriate.

#### 8.4.1.1 Single point of access- triple digit number

75% of A&E attendances in 2010 were classed as 'standard', seen by a nurse only or non-urgent. Similar to the triple digit number managed by the ambulance trusts in the UK<sup>136</sup> a more robust triage would be introduced. All patients would call a single number to be pre-triaged, provided with an access number if their condition was deemed to be appropriate for A&E, and only then would that patient be allowed to access A&E. The triage system would be managed through either a GP service or through the ambulance service. This would determine whether an emergency ambulance or primary care attendance is required and ensure that the correct pathway is adhered to. The North East Ambulance Service model<sup>137</sup> is outlined below.

Figure 66: Single Point of Access Model



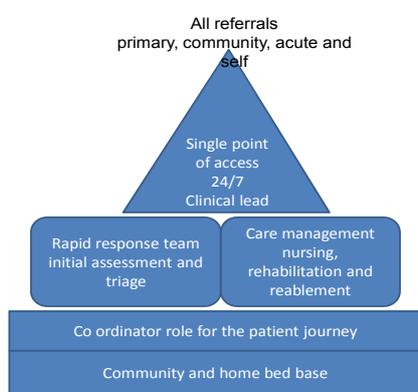
<sup>136</sup> A vision for emergency and urgent care, NHS Confederation and the Ambulance Network p10 -12, 2008

<sup>137</sup> North East Ambulance Service: Next Stage of Our Vision; May 2008

Evidence from UK Ambulance Trusts<sup>138</sup> demonstrated that the introduction of the triple digit number reduced the number of patients seen by 10% per month – 5% to self care and no attendance and 5% redirected to primary care. Applied to Jersey this could result in 4,200 fewer appointments against the projected increase per annum by 2020.

Patients who were deemed to have not met the access criteria would be routed to appropriate diagnosis, treatment and care - for example, in primary care or an outpatient referral. The three digit number therefore acts as a single point of access, and would be supported by the citizen's portal, which provides information on service availability for patients and staff.

Figure 67: A vision for urgent and emergency care



Source: NHS Manchester intermediate care model 2010<sup>139</sup>

Co-locating the GP Out of Hours service with A&E would drive economies of scale and the current JDoc telephone number could be expanded to become a triple digit number. It is estimated that expanding the capacity of the line would require additional costs of £50,000.

Co-payments could be introduced for those patients who do not ring the triple digit number and attend A&E with a primary care presentation; this would incentivise patients to seek care in the most appropriate location.

#### 8.4.1.2 Enhanced teams in A&E

A 2003 BMJ article *Discharge from Triage*<sup>140</sup> demonstrated that almost 30% of patients were discharged after clinical assessment without a diagnostic or intervention, and only 3.5% had already accessed primary care, suggesting that almost 30% of attendances could have potentially been treated in primary care.

<sup>138</sup> A vision for emergency and urgent care, NHS Confederation and the Ambulance Network p10 -12, 2008

<sup>139</sup> NHS Manchester model for intermediate care, March 2010

<sup>140</sup> Cooke et al; Discharge from triage: modelling the potential in different types of emergency department 2003; 20; 131-133; <http://emj.bmj.com/content/20/2/131.abstract?>

In 2005 the Service Delivery Organisation, Department of Health, published findings<sup>141</sup> that improvements in primary care and primary care gatekeeping reduced Emergency Department attendances. In 2010 the Primary Care Foundation<sup>142</sup> identified that the proportion of cases that could be classified as primary care (i.e. regularly seen in primary care) was up to 30%. A Primary Care Foundation report in March 2010<sup>143</sup> demonstrated a 30% reduction in A&E activity in English systems as a result of GP triage in A&E. This is based on redirecting patients who inappropriately presented. When this data was tested with a group of Jersey consultants, nurses and GPs, this was estimated to have the potential to be up to 40% for Jersey<sup>144</sup>, once the system was fully operational. The impact of this would not translate into a direct reduction of activity, as in the NHS system, due to the payment system being different (tariff versus block payments), however, it is anticipated that a primary care co-payment could be levied and treatment undertaken swiftly by a GP.

Triage is undertaken by nursing staff currently. This would be strengthened through the creation of an Emergency Care Practitioner<sup>145</sup> role, which supports decision making. The role would incorporate autonomous working and would be able to prescribe once the non-medical prescribing legislative changes are in place.

Once patients have presented at A&E, the introduction of a GP triage system would further reduce the pressure on the hospital. The GP out of hours service (currently managed by J-Doc) would be co-located with A&E, and senior decision making would be enhanced with 24/7 GP triage, provided by GPs with a special interest (including for mental health, where service users would be transferred to the relevant Acute Liaison Team following initial triage).

Senior decision making within A&E would be further enhanced through the future appointment of Acute Medical Physicians to replace the current A&E Consultants as they retire/leave, with a view to prioritising complex elderly patients. A recent study by the Royal College of Physicians<sup>146</sup> in December 2010 recommended that all hospitals have Acute Medical Units (Jersey has an Emergency Assessment Unit which was recently extended to 16 beds) and a lead consultant within these units. East of England<sup>147</sup> have been at the forefront of this development, with the aim of managing patients for up to 24 hours, stabilising critically unwell patients, and working in liaison with specialty physicians and primary care.

The Royal College has envisaged that Acute Medical Physicians in the future will take on the role of general physicians, running short stay units, giving general medical opinions throughout the hospital and operating admission avoidance clinics. This model, when combined with the GP in A&E, supports

<sup>141</sup> Cooke et al; Towards Faster Treatment: Reducing attendances and waits at A&E departments; DH; Service Delivery Organisation; October 2005; <http://www.sdo.nihr.ac.uk/files/adhoc/29-briefing-paper.pdf>

<sup>142</sup> Primary Care and Emergency Departments; Report from the Primary Care Foundation March 2010 p5

<sup>143</sup> Cooke et al; Towards Faster Treatment: Reducing attendances and waits at A&E departments; DH; Service Delivery Organisation; October 2005; <http://www.sdo.nihr.ac.uk/files/adhoc/29-briefing-paper.pdf>

<sup>143</sup> Cooke et al; Discharge from triage: modelling the potential in different types of emergency department 2003; 20; 131-133; <http://emj.bmj.com/content/20/2/131.abstract?>

<sup>143</sup> Primary Care and Emergency Departments; Report from the Primary Care Foundation March 2010 p5

<sup>144</sup> Post U:Collaborate Emergency Care working group session held 23 March 2011

<sup>145</sup> South Australian Emergency Care Practitioner model

<sup>146</sup> <http://www.rcplondon.ac.uk/specialty/acute-medicine>

<sup>147</sup> [http://www.eoedeanery.nhs.uk/medical/page.php?page\\_id=846](http://www.eoedeanery.nhs.uk/medical/page.php?page_id=846) - cohort comprises of Norfolk and Norwich University NHS Foundation Trust Hospital and Cambridge University Hospitals NHS Foundation Trust and several unnamed DGHs

the acute physicians to spend more time supporting the Emergency Admissions Unit, increasing the number of patients discharged directly from the unit rather than admitted to a ward for further care. This would also support a Hospital at Night model, with nursing staff providing a greater level of support to the F2 doctor on duty at night in A&E.

The legislation for non-medical prescribing has the opportunity to enhance the roles of nursing staff, Pharmacists and other Allied Health Professionals such as the Emergency Care Practitioner and/or Paramedics, providing a greater degree of care in the patient's home and subsequently in A&E.

Opportunity also exists to improve access to diagnostics such as MRI scans overnight through the development of Extended Scope Practitioner roles, able to support the basic reading of x-rays etc to release specialist capacity to undertake more complex diagnostics. However, costs have not been modelled as the reduction in demand as a result of the introduction of the options may mean this is not required into the future.

#### 8.4.1.3 Paediatric Assessment

In 2010, 75% of attendances at A&E were categorised as non-urgent. 24% of A&E attendances (9,036) were from children and adolescents aged 18 years or under. This does not include attendances on Robin Ward, where parents are able to 'drop in' for assessment. Only 788 non-elective admissions resulted from more than 9,000 presentations. The average length of stay was 2.4 days. This profile suggests that many attendances are either by the 'worried well' or for checks. The introduction of co-payment in A&E would encourage parents to attend the GP with their children in the future.

The proposed model for Adult A&E would be extended to children and adolescents, with a Paediatric Assessment Unit providing specialist support. Initial triage would be undertaken by a GP, with onward referral to the Paediatric Assessment Unit, which would be staffed by a specialist Nurse Practitioner over the period of greatest demand (8am until 8pm).<sup>148</sup>

It is estimated that 40% of A&E attendances<sup>149</sup> could incur a co-payment charge of approximately £30. This would raise revenue of £360,000<sup>150</sup> but, more importantly, would encourage patients to present at the most appropriate place and/or engage in increased self care activities.

#### 8.4.1.4 Trauma and subspecialist emergency care

The Royal College of Surgeons (2009) acknowledged that "*major trauma admissions to hospital are estimated to be 27 – 33 patients per 100,000 population per year. (About 40% of trauma deaths occur at the scene of the incident).*"<sup>151</sup>

<sup>148</sup> Model supported by Central Manchester to reduce Paediatric A&E attendance in 2010 – Central PBC Commissioning Brief for Clinical Board Urgent care for Children Paediatric A&E September 2010

<sup>149</sup> Based on professional opinion from Jersey U:collaborate Emergency Group and GP opinion and the Cooke et al; Towards Faster Treatment: Reducing attendances and waits at A&E departments; DH; Service Delivery Organisation; October 2005; <http://www.sdo.nihr.ac.uk/files/adhoc/29-briefing-paper.pdf> and Primary Care and Emergency Departments; Report from the Primary Care Foundation March 2010 p5

<sup>150</sup> Based on benchmarking of GP and A&E attendances against the UK and the presumed impact that GP appointment co-payments contributes an additional 10% of attendances in A&E

<sup>151</sup> Royal College of Surgeons: Guidance to Trauma for commissioners: November 2009

It is envisaged that emergency cases requiring complex treatment would still need to be stabilised and treated in specialist units outside of Jersey. An emergency system based on the current model should be in place to ensure that this is initiated quickly and effectively. This could be coupled with specialist input from tertiary centres supporting the emergency work (see section 8.2.1.7 “Strategic Partnership with UK centre”).

#### 8.4.1.5 Integration of primary and secondary care within the hospital

Increased integration would be developed, with GPs, hospital consultants and other clinical staff working together. As outlined in the ‘Primary Care’ section of this scenario, enhancing primary care teams could release up to 20% of GP capacity, equivalent to c10 fte GPs p.a.

GPs would undertake a clinical associate role within the hospital, and would increase capacity within existing hospital services. It is estimated that through shared clinics some 60% of follow up outpatient appointments could be discharged from the hospital. This would equate to 64,144 outpatient appointments per annum against 2010 activity. Based on 12 patients per clinic<sup>152</sup>, this would save c5,350 clinics in 2010 (almost 5,700 in 2020). GP clinical associates would also transfer skills and knowledge between primary and community care, acting as a source of information and advice to the primary care/community/GP teams.

GPs would:

- see and treat patients with primary care presentations in A&E
- provide shared outpatient clinics with consultants and nurse practitioners, increasing clinical capacity
- carry out specific procedures in the secondary care setting (as is already happening in endoscopy, where one GP is currently performing endoscopy in the hospital)
- perform minor surgery in the secondary care setting with appropriate training. This could include procedures such as ‘lumps and bumps’ requiring general anaesthetic, vasectomies
- undertake shared ward rounds with consultants to support speedier discharges

In addition, acute clinicians would work in and/or with primary care:

- hospital medical staff and nurse practitioners would provide clinical leadership, outreach and expert advice on a condition specific basis particularly for long term condition management. This would support primary care teams, GPs and community practitioners, including social care and the third sector, to case manage within the community. This would include extended roles for nurses and AHPs, working in primary and community care settings to support long term condition management and care navigation, and in secondary care to take parts of the junior doctors’ role
- enhanced direct access to support services such as pathology, radiology, pharmacy from community and primary care services may result in a reduction of 15% outpatient appointments for patients who are referred for such investigations. For new outpatient appointments in surgery, this may mean a reduction of c3,650 appointments in 2010, rising to more than 4,000 in 2020. Based on 6 new appointments per clinic, this equates to 13.5 PAs in 2010, rising to almost 15 PAs in 2020<sup>153</sup>.

<sup>152</sup> Estimated as 4 follow up appointments per hour

<sup>153</sup> Based on 45 weeks of clinics per annum

- hospital pharmacy linking with community pharmacy and primary care teams to support self care post discharge. This would improve communication and may reduce wastage.
- more intermediate care and expanded community services and closer cooperation with social care and residential and nursing homes to reduce delayed discharges

#### 8.4.1.6 Integrated community care based on agreed care pathways

##### *Introduction*

All services and frontline functions involved in the delivery of health and social care would be based on the General Hospital site.

Parish-based, integrated multidisciplinary teams would be developed across health and social care, primary care and the third sector to ensure that the patient is cared for in a coordinated manner in the community. This could provide a cost effective and clinically appropriate alternative to an acute episode, relieving the capacity pressures on acute care by providing an alternative to admission, or by supporting early discharge for patients who do not need the acuity of care provided by a hospital.

The co-location of multidisciplinary teams (the location of which would need further work up but could be based in parish locations) would enable the design of more integrated processes to ensure that “step-up” and “step-down” from hospital works effectively and that patients/clients are in the most appropriate setting for their care needs. It could also facilitate more streamlined processes, for example quick and early diagnosis, as well as arranging care packages in the community. This option does not mean that all services are delivered at the hospital, but that as a minimum they are managed and organised from that base, where appropriate.

##### *Case finding*

Risk stratification would be undertaken to identify those patients who are at risk of presentation at A&E either through an exacerbation of a chronic disease or high risk of developing the first signs of one. In 2010, there were 4,000 acute spells for patients with a primary diagnosis of COPD, CHD or diabetes. Many of these patients could be cared for by community multidisciplinary teams, supported by telehealth and Telecare, as outlined in the ‘Self Care’ section of this scenario.

##### *Staffing*

These teams would have access to a geriatrician, nurse practitioner or consultant specialising in elderly care, who would also undertake outreach into nursing homes to help prevent easily avoided admissions caused by dehydration or UTI<sup>154</sup>. Evidence from Gwent<sup>155</sup> and Southampton<sup>156</sup> demonstrates that the provision of acute consultants in the community reduces acute admissions. There are also currently approximately 1,000 people aged over 65 in care homes in Jersey<sup>157</sup> who could be supported through such an integrated community team.

<sup>154</sup> High Impact Actions for Nursing and Midwifery, NHS Institute for Innovation and Improvement

<sup>155</sup> Frailty Concept/Hospital without Walls, Professor Pradeep Khanna, Aneurin Bevan Health Board

<sup>156</sup> Previous stakeholder interview with Patricia Ritchie, Consultant Geriatrician, Pennine Acute Trust

<sup>157</sup> Public Health Census of Nursing Homes, September 2010

The Gwent Frailty model<sup>158</sup> below demonstrates how a new type of worker with generic skills that span health and social care could be developed to support the needs for the ageing population:



This new model of care acknowledges the changing role of the specialist to the generalist and the increased potential to have a team across GPs, geriatricians, community nursing, occupational therapists, social workers, pharmacists etc to support the patients with long term conditions in the community.

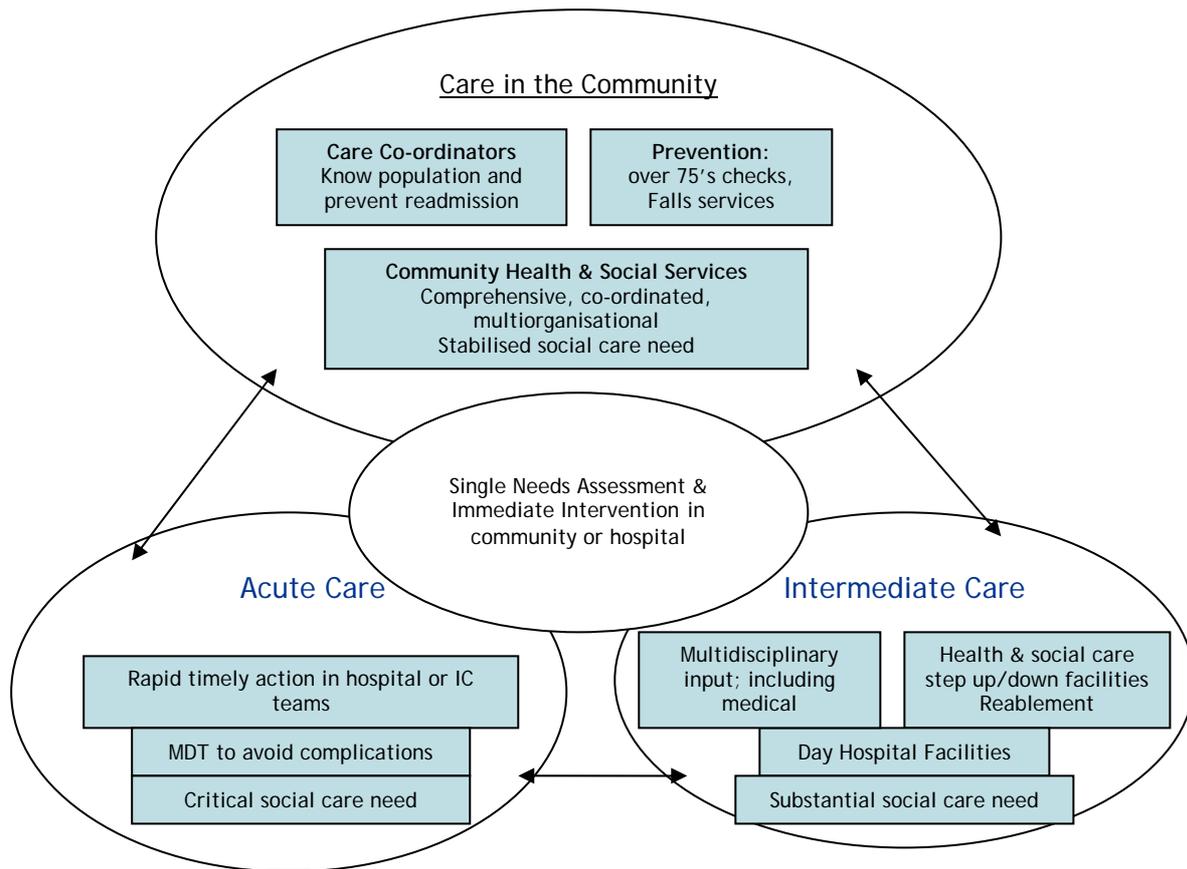
There are two elements to the model – crisis management and reablement. Crisis management is outlined here whereas reablement is considered within the 'Older Adults' section of this scenario.

Figure 68: Gwent Frailty Pathway<sup>159</sup> - the "Hospital without walls"

(Adapted from the National Institute of Innovation & Improvement)

<sup>158</sup> Gwent Hospital without walls presentation 2009

<sup>159</sup> Gwent 'Happily Independent'; Strategic Vision for Gwent Frailty Programme, 2009



#### Aims

- Better management at home or in a community setting
- Engagement with care homes and the independent sector
- Management of patients in A&E
- Patients handed over to district nursing teams on discharge from service

#### Main Functions<sup>160</sup>

- Assessment of 200 new patients per month for acute exacerbations of chronic conditions and associated disorders
- Follow-up of 200 patients per month
- 7-day presence in A&E and MAU to assess patients and prevent admissions
- Daily "Hot Clinics" for each Borough for the provision of advice for GPs
- Formal links with other specialties, including General Medicine, Falls, Trauma & Orthopaedics
- Ongoing management of patients at home for a 5 – 7 day length of stay (care package)
- The Gwent-wide combined team of ACAT, Rapid Response and PATH to provide around 70 virtual beds across Gwent

<sup>160</sup> Gwent Happily Independent: Strategic Vision for Gwent Frailty Programme, 2009

### Step up / step down unit

The model would also deliver 70 “virtual beds” plus 20 step up/step down beds<sup>161</sup> which could maintain the level of non-elective admissions within the current bed base of the hospital and negate the need for additional general medical beds on the hospital site. This overall saving is the projected 60 beds by 2040.

The virtual beds would be managed across a network of residential care, nursing homes and patients own homes providing outreach services into these areas to care for patients. The step up / step down facility could be developed on the Overdale site as part of the social care relocation of the St Saviours site. This is further outlined in the ‘Younger Adults’ section of this scenario. It is anticipated that post surgical patients will continue to go to the Samares Ward, with appropriate patients moved from Samares to the step up/step down unit or back to the community.

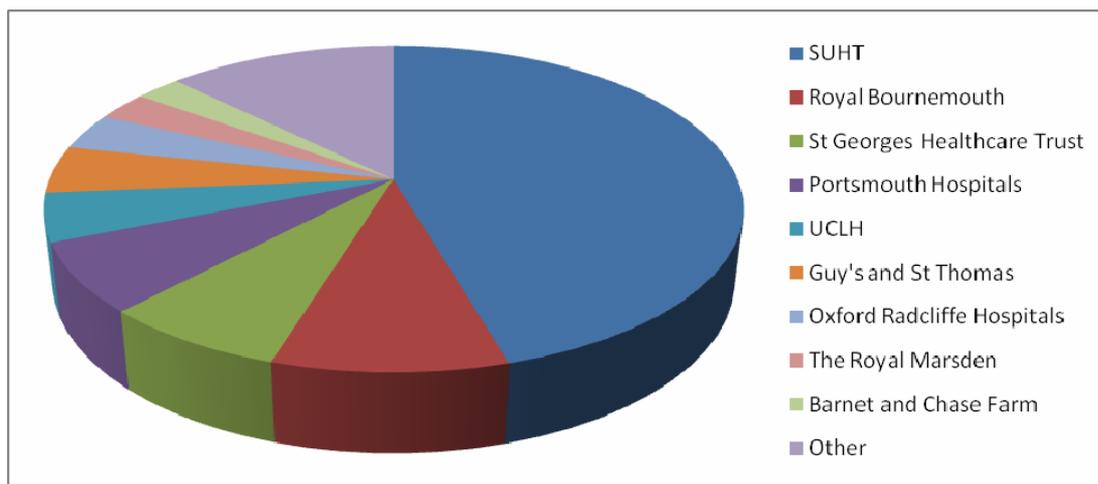
The step up / step down unit is envisaged to be nurse-led with access thresholds for step up from the community for patients exhibiting early signs of exacerbated conditions, referred into from any team member within the community including GPs. It would also act as a medical step down unit for those patients currently within the hospital considered medically fit for discharge but requiring a few extra days support to be able to return to their own home or residential care. It is envisaged that this would operate as a short stay unit with length of stay between 24 and 72 hours to prevent blockages.

The above measures have been implemented in various degrees by the Integrated Care Pilot Programme<sup>162</sup>, which concluded in March 2011. Unfortunately the economic evaluation of these pilots has not yet been completed.

#### 8.4.1.7 Strategic partnership with UK centre(s)

The 2010 off island activity was provided by a multitude of UK providers<sup>163</sup>:

Figure 69: Activity provided in the UK

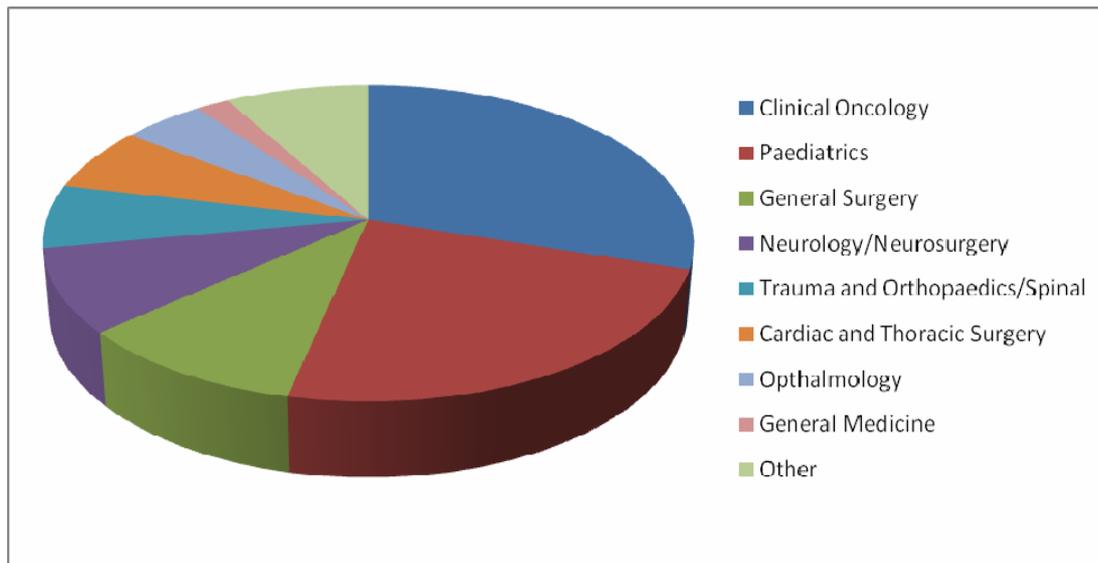


Source: Myers Report 2010 based on 2009-10 data

<sup>161</sup> Based on Gwent Frailty Model, outlined on following pages

<sup>162</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089338](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089338)

<sup>163</sup> These costs exclude transport, escort, accommodation costs etc



Source: Myers Report 2010 based on 2009-10 data

Secondary care would have a strategic partnership with one or a limited number of UK providers, subject to robust contract arrangements and clinical governance stipulations. This would support joint decisions on where a certain procedure is best carried out, and effective, integrated and co-ordinated care would be provided in the most appropriate place.

This would mean that Jersey consultants and other clinical staff would be supported in their practice whilst keeping as much as possible of the medical and surgical care on the island. This would enhance recruitment and retention of both medical and other clinical staff due to the variety of practice on offer. It would also enhance and support the quality of emergency care provided on the island due to experience of clinicians regarding a wide range of conditions and treatments.

A strategic partnership would mean:

- weekly or monthly (depending on demand) visits from mainland consultants with joint operating lists, supporting patients being treated on island where possible
- attendance by Jersey consultants and consultants from partner organisation(s) at MDT meetings either in Jersey, by telemedicine (remote video link) or in the UK. This could allow the repatriation of current off island activity
- close collaboration on follow ups within agreed integrated care pathways (ICPW) for early discharge and return to Jersey
- Jersey consultants to spend a certain number of days a year visiting the UK centre, for training, case reviews, MDTs, audit and other governance and CPD/revalidation requirements
- rotation of junior medical and other clinical staff between jersey and mainland partner organisation

The exact arrangements and costs would depend on the contract negotiated with the UK provider. This will in turn depend on the competency and expertise of the Jersey consultants in each specialty and what can be provided by the UK partner organisation.

Purely from a procurement perspective<sup>164</sup>, consolidating the off island arrangements into one contract is expected to provide savings of c10%, or c£800k p.a.

This would provide:

- clinical integration of on and off island providers
- increased access to specialisation
- increased use of technology, including telemedicine
- support for and development of on island expertise
- sustainable provision of healthcare to the Jersey population
- improved governance, patient safety and clinical outcomes
- increased on island provision with reduced need for patients to travel to the UK
- care provided off island subject to ICPWs and MDT working, with clear protocols for discharge and follow up joint decision making

Any costs involved would depend on the decision taken by HSSD on which specialties and procedures to provide on and off the island. This would also depend on the expertise of on island consultants (which may change with newly recruited consultants), and the UK partner organisation.

The impact of a strategic partnership between Jersey General Hospital and a UK centre on the use of day theatres, as with main theatres mentioned above, would depend on the decisions made by HSSD on the degree to which services will remain on the island and which can be transferred to the UK. This will depend in turn on the competency and expertise of the consultant staff in Jersey and the contract negotiated. If as many services as possible are to remain on the island, or even repatriated to Jersey with the support from the UK partner organisation with consultants flying onto Jersey, then theatre usage will go up, and the need for additional theatre capacity will become even more urgent.

It is likely that with ongoing transfer of leading edge knowledge and skills through the closer working between Jersey consultants and consultants from the UK centre as outlined above would result in moving Jersey to upper quartile day case rates (71.6% in England) from its current level of almost 65%. This would require an increase in day theatre capacity of 25% by 2020, and a decrease in main theatre capacity of 19%. In addition, this would equate to a reduction in bed use of 4 beds. This would mean that the need for day theatre capacity becomes even more acute, but the need for main theatre capacity would be reduced to a level at which no additional capacity would have to be built (ie no need for an extra main theatre)

#### 8.4.1.8 Decommissioning procedures of limited clinical value

In the context of financial and capacity pressure, a decision would be made regarding which procedures would be funded publicly.

Procedures of limited clinical value<sup>165</sup>, for example certain cosmetic surgery, would not be funded by the States.

<sup>164</sup> Views from procurement experts

<sup>165</sup> London Health Observatory, Save to Invest

Provision of other surgical procedures would be subject to thresholds and protocols to ensure these are conservatively managed as clinically appropriate until surgery is the most appropriate intervention.

In order to provide an assessment of the level of savings that could potentially be achieved as a result of decommissioning of procedures of limited clinical value, we have mapped the 34 procedures from the list from the London Health Observatory<sup>166</sup> and taken a proxy of 10% of general surgery. This would save around one bed p.a.<sup>167</sup>

The above initiatives would have the following impact on different parts of the hospital:

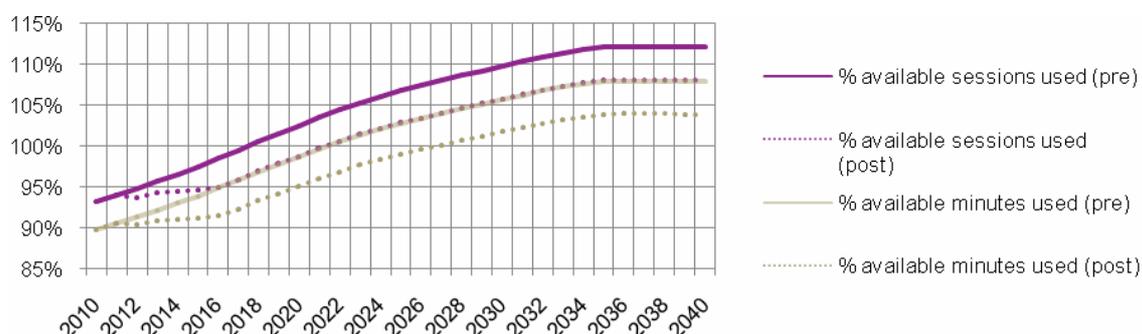
#### 8.4.1.9 Surgical beds

As outlined in section 8.2.1.7 'Strategic Partnership with UK Centre', Jersey General Hospital should be able to achieve upper quartile day case rates (71.6% in England). This would reduce the need for surgical beds by 4<sup>168</sup>.

#### 8.4.1.10 Theatres

As outlined in scenario 1, by 2020 the hospital is projected to need an extra 8% of capacity in each elective theatre. Therefore, this would represent sessions equivalent to (8%x3 theatres) = 24% of a new theatre required.

Figure 70: Projected demand for theatres



Source: HSSD Financial model version 1.0

Scenario 1 also indicated that unless theatre sessions are flexed to find additional capacity within the existing footprint, additional funding of £5m capital<sup>169</sup> would be required for a new theatre now. Full staffing of a theatre would cost £1.3million, but this could be implemented in a phased manner reflecting the additional workload. By 2020 the staffing costs would be c£200k<sup>170</sup> p.a. for one quarter usage of additional capacity.

<sup>166</sup> London Health Observatory, Save to Invest, 2003

<sup>167</sup> HSSD Financial model version 1.0

<sup>168</sup> HSSD Financial model version 1.0

<sup>169</sup> Bradford Royal Infirmary [www.yorkon.co.uk/bradford-hospital.html](http://www.yorkon.co.uk/bradford-hospital.html)

<sup>170</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre by 2020

Theatre use is likely to be impacted (see graph above) by decommissioning of procedures of limited clinical value. A proxy figure of 10% in general surgery would mean that additional capacity would be available in main theatres for another 4 years. Savings would also be made of more than £500k p.a.

As outlined under section 8.2.1.7 'Strategic Partnership with UK Centre', Jersey should be able to achieve upper quartile day case rates (71.6% in England). This would decrease the need for main theatre capacity by c19%. According to the information provided and our model<sup>171</sup>, this would mean that the need for day theatre capacity will become even more acute, but the need for main theatre capacity would be reduced to a level at which no additional capacity would have to be built (ie no need for an extra main theatre).

Waiting lists should also be taken into consideration. The net change in the waiting list for all surgery increased between December 2009 and December 2010 was an increase of 5 procedures. As the waiting list as at December 2010 comprises 1,591 procedures, this would suggest a legacy waiting list. The waiting list is equivalent to 47% of the annual surgical activity. Of these, 268 waited longer than 3 months, which represents c8% of annual surgical activity. The largest increases were for oral surgery (54 cases), and ENT (29 cases). Other specialties reduced their waiting list during the period.

#### 8.4.1.11 Day case theatres

As outlined in scenario 1, day case surgery is already at capacity, at 8,622 cases per annum. The projected demand at 2020 is almost 9,500 cases per annum. Therefore, with no service changes more than 800 procedures will not be able to be undertaken in 2020, and the waiting list would increase significantly.

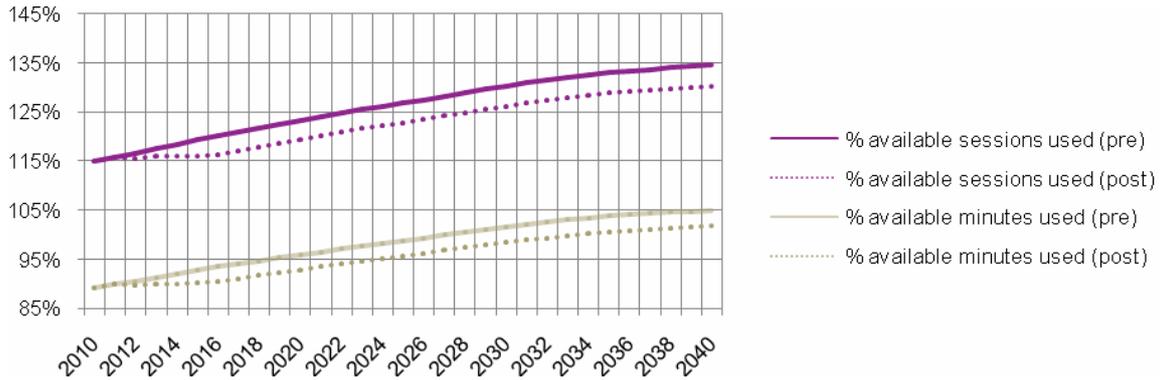
Scenario 1 also indicates that booked day case surgery capacity is 2.11 theatres in 2010, and would be 2.24 in 2020, with the utilised capacity at 1.79 in 2010 increasing to 1.92 in 2020. Utilisation is at 90% in 2011, and would reach 95% in 2018. Therefore if no changes were made to the service additional day theatre capacity of sessions equivalent to a quarter of a day theatre would be required by 2020. Capital costs would be £5m<sup>172</sup> and staffing costs would be c£120k p.a<sup>173</sup> for additional theatre capacity by 2020.

#### Figure 71: Projected demand for day theatres

<sup>171</sup> HSSD Financial model version 1.0

<sup>172</sup> Estimates based on £2k per sqm + 30% equipment costs; requires specialist advice

<sup>173</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020



Source: HSSD Financial model version 1.0

Use of day theatres is likely to be impacted by decommissioning procedures of limited clinical value. A proxy figure of 10% in general surgery would mean that additional capacity would be available in day theatres for another 5 years. Savings would also be made of more than £200k p.a.

The impact of integration between primary and secondary care, and care provided based on integrated care pathways, is expected to be minimal, as this would not result in a reduction of procedures. However, it may mean that the procedures in day theatres could also be carried out by GPs with additional training, possibly within a primary care setting. This would require detailed analysis of clinical safety and appropriateness given the close proximity of the hospital to most GP surgeries.

As outlined above under section 8.1.2.7 'Strategic Partnership with UK Centre', Jersey should be able to achieve upper quartile day case rates for day surgery (71.6% in England). This would require an increase in day theatre capacity of 25% by 2020.

#### 8.4.1.12 Endoscopy

In 2010, 2,568 endoscopy procedures were undertaken. The projected demand at 2020 is more than 2,850 cases per annum. Therefore, with no service changes 286 procedures will not be able to be undertaken in 2020, and the waiting list would increase significantly.

The required endoscopy capacity was 2.0 endoscopy theatres in 2010, and would be 2.23 in 2020, with the utilised capacity at 1.78 in 2010 increasing to 1.98 in 2020. Utilisation would reach 90% in 2015 and 95% in 2020.

If the current model of service (and therefore current utilisation rates) continue, additional capacity would be required: a quarter of an endoscopy theatre would be required by 2020. New build would cost £1m<sup>174</sup> in capital and staffing could be phased, but would be c£130k p.a.<sup>175</sup> for additional staffing by 2020.

<sup>174</sup> Based on Lister Hospital £1m, and Brecon Hospital £2m estimated costs; requires specialist advice

<sup>175</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

The waiting list for endoscopy was 140 in December 2009, and 156 in December 2010. This means there was a 10% increase over one year. This increased demand should also be taken into consideration in determining future capacity.

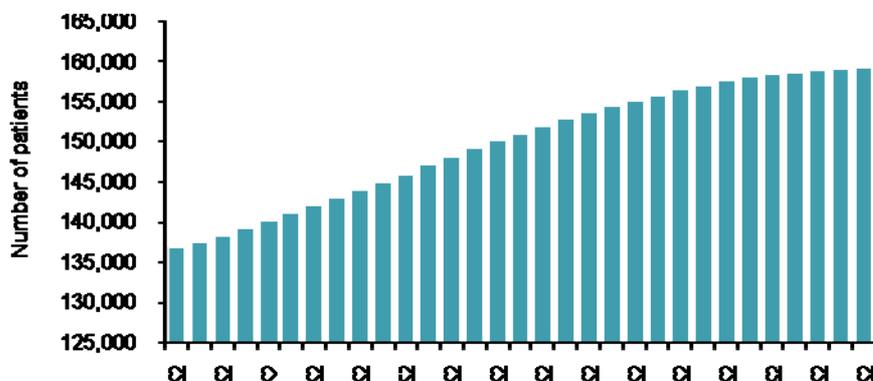
#### 8.4.1.13 Critical care

At present the hospital has 9 critical care beds, which include both high dependency and intensive care beds. A business case has been submitted for a tenth bed and a reconfiguration of the critical care beds into separate intensive care and high dependency units (including coronary care). The data available on spell length of stay in the hospital does not distinguish between ward bed days and critical care bed days, and so it has not been possible to model future demand for critical care beds. Surgery and Trauma are the main drivers for the critical care bed capacity and as these are not projected to significantly increase by 2020, it is predicted that demand for critical care beds would rise in correlation.

#### 8.4.1.14 Outpatients

By 2020 demand for outpatients appointments is projected to increase from 136,720 to almost 146,000 (more than 9,000 additional outpatient appointments p.a.) Therefore, 6.7% additional capacity would have to be found to accommodate additional clinics, including staffing. Capital costs of this would depend on where the additional capacity could be created. If a neighbouring room or a room in an off-site building eg Overdale could be converted then costs would be limited (£50k-£100k)<sup>176</sup>. Staffing of a clinic would require one nurse band 4-6 for 2 consultants.

Figure 7211: Outpatients



Source: HSSD Financial model version 1.0

A 60% reduction in follow up outpatient appointments as outlined above equates to more than 40,300 outpatient appointments per annum in 2010, and based on an assumed number of 12 patients per clinic<sup>177</sup>, this would save c3,360 clinics.

#### 8.4.1.15 Clinical support services

The costs are projected to increase from c£18.5m in 2010 to more than £23m in 2020, based on predicted demand. This is an increase of c25%, presumed across all specialties rather than one

<sup>176</sup> This is an estimate and requires specialist advice

<sup>177</sup> Estimated as 4 follow up appointments per hour

particular specialty driving the cost increase. It has not been possible to separate out surgical specialties and outpatients only.

#### 8.4.1.16 Non clinical support services

Porter service, catering, cleaning and laundry (together) would require an increase in spend from c£19.5m in 2010 to almost £23m in 2020, based on predicted demand. This is an increase of c17% of cost. The increase is driven by an increase in activity across all specialties. It has not been possible to separate out surgical specialties and outpatients only.

## 8.4.2 Activity Implications

Service	Projected change in 2020
<b>Ambulance journeys</b>	<ul style="list-style-type: none"> <li>■ Projected to increase from 6,039 journeys in 2010 to more than 7,000 journeys p.a in 2020</li> <li>■ Although the measures outlined should reduce emergency ambulance journeys, capacity would be reached by 2012 and therefore an additional ambulance would be required at cost of £90k for a new bariatric ambulance<sup>178</sup> plus staffing or c£320k to lease including staffing<sup>179</sup></li> </ul>
<b>Single point of access – triple digit number (A&amp;E Attendances)</b>	<ul style="list-style-type: none"> <li>■ Projected to reduce from 39,200 attendances in 2010 to c35,000 attendances p.a. in 2020</li> </ul>
<b>Enhanced teams in A&amp;E</b>	<ul style="list-style-type: none"> <li>■ GPs within A&amp;E are projected to reduce attendance by 40% through effective triage (reduction of 17,000 attendances p.a. past the point of triage)</li> <li>■ Acute medical physicians would discharge patients from A&amp;E quickly and move patients through EAU reducing follow-on admissions to the medical wards to protect the beds as much as possible</li> </ul>
<b>Paediatric Assessment</b>	<ul style="list-style-type: none"> <li>■ Specialist nurse practitioner would treat appropriate paediatric patients once they have been triaged by a GP, which would reduce the number of inappropriate attendances</li> <li>■ This role would also support the ward attenders on Robin Ward and the non-elective admissions(788 in 2010) to ensure the speedy treatment of children in the Jersey General Hospital</li> </ul>
<b>Integrated Multidisciplinary Teams/ Step up/step down care</b>	<ul style="list-style-type: none"> <li>■ 50% reduction in general medicine non-elective admissions into the hospital through a virtual ward - with up to 2,400 p.a. patients cared for in the community by 2020 which reduces the need for the additional medical beds (20 in 2020 and up to the 60 in 2040). This model prevents admissions of patients with esacerbations.</li> </ul>
<b>Surgical beds</b>	<ul style="list-style-type: none"> <li>■ Decommissioning of procedures of low clinical value would reduce the bed base requirement by 1 bed by 2020</li> <li>■ Reduction in need for surgical beds by 4 due to increase in day surgery rate to upper quartile England rate</li> </ul>
<b>Medical beds</b>	<ul style="list-style-type: none"> <li>■ Bed use is driven by emergency medical activity, which is profiled to increase by 22% by 2020 (15% overall for non-elective activity)</li> <li>■ Increase from 6,852 spells in 2010 to almost 7,900 spells p.a in 2020 – equivalent to almost 46,000 bed days p.a. This would have required an additional 20 beds by 2020 and 60 beds by 2040. However, the measures outlined above would enable the increase in activity to be treated within current capacity using a 'virtual ward'<sup>180</sup> model to support 2,400 patients in the community</li> </ul>
<b>Theatres</b>	<ul style="list-style-type: none"> <li>■ Reduction in general surgery by 10% as proxy for decommissioning of procedures of limited clinical value. This would equate to 130 fewer procedures in main theatres and additional capacity would be available in main theatres for another 4 years. Savings would also be made of some £500k p.a.</li> </ul>

<sup>178</sup> Nick Triggle report 3 February 2011 <http://www.bbc.co.uk/news/health-12287880>

<sup>179</sup> Ambulance Economies; Fischer et al; Journal of Public Health Medicine; 2000; 22 p413-21

<sup>180</sup> Gwent Frailty Model

<b>Day case theatres</b>	<ul style="list-style-type: none"> <li>■ Reduction in general surgery by 10% as proxy for decommissioning of procedures of limited clinical value. This would equate to 203 fewer procedures in day theatres and additional capacity would be available in day theatres for another 5 years. Savings would also be made of c£200k p.a</li> </ul>
<b>Endoscopy</b>	<ul style="list-style-type: none"> <li>■ Increase from 2,568 in 2010 to almost 3,000 in 2020</li> </ul>
<b>Off island care</b>	<ul style="list-style-type: none"> <li>■ Activity and cost would depend on contract agreed with a UK Strategic partner(s)</li> </ul>
<b>Outpatients</b>	<ul style="list-style-type: none"> <li>■ New outpatient appointments are projected to reduce by 15%, resulting in c670 fewer clinics p.a by 2020</li> <li>■ Follow-up outpatient appointments are projected to reduce by 60% resulting in c5,700 fewer clinics p.a by 2020</li> </ul>
<b>Clinical support services</b>	<ul style="list-style-type: none"> <li>■ Minimal impact (savings of £30,000 by 2020)</li> <li>■ The number of community tests would increase, however the introduction of the virtual ward rather than new acute hospital wards should reduce the projected impact on the hospital</li> </ul>
<b>Non clinical support services (e.g. porter service, catering, cleaning etc)</b>	<ul style="list-style-type: none"> <li>■ Minimal impact (no costs available)</li> <li>■ A 20 bedded step up/step down facility at Overdale would require catering, cleaning etc</li> </ul>

### 8.4.3 Staffing Implications

The new model would deliver a change in traditional roles, moving to an increasingly nurse-led and community based model. The exact staffing model, skill mix and grade mix would be agreed at the business case stage. The job titles may differ from those outlined below, but the key consideration is the skill sets required e.g. staff who are empowered to make decisions, work autonomously and prescribe once the legislation allows this.

Staff group	Number of staff	Cost at 2020 (£)
<b>Surgical beds</b>		Unless a ward were closed it would not be possible to realise the potential savings
<b>Theatres</b>	Decommissioning of procedures of low clinical value would reduce staff requirement by 2 fte in main theatres and 0.5 fte in day theatres <sup>181</sup> Additional staffing would be required <sup>182</sup> for additional theatre capacity, but delayed by 4 years due to decommissioning of procedures of limited clinical value	Saving c£500k p.a due to decommissioning of procedures of limited clinical value Additional costs £200k p.a <sup>183</sup> in 2020 for one quarter usage of additional capacity Net c£300k saving
<b>Day case theatres</b>	Additional staffing requirement would be delayed by 5 years due to decommissioning procedures of limited clinical value Decommissioning of procedures of low clinical value would reduce staff requirement by 0.5 fte in day theatres <sup>184</sup>	Saving c£200k p.a savings (staff, supplies) due to decommissioning of procedures of limited clinical value Additional cost c£120k p.a <sup>185</sup> for additional theatre capacity by 2020 Above figures do not take into account the savings made from 0.5 fte due to decommissioning Net c£180k saving
<b>Endoscopy</b>	Additional capacity required to meet demand	Additional cost c£130k p.a <sup>186</sup> for additional capacity by 2020
<b>Off island treatment</b>	Depends on contract negotiated	Depends on contract negotiated
<b>Outpatients</b>	15% reduction in new outpatient appointments due to direct access by GPs to diagnostics. This would equate to almost 3,900 new outpatient appointments, releasing c9 PAs 60% reduction in follow-up outpatient appointments in surgery would equate to 40,312 fewer appointments in 2020, equating to more than 4,000 clinics <sup>187</sup> releasing c90 PAs	9 PAs would equate to 1 consultant post C90 PAs would release the equivalent of 9 consultant posts It is anticipated that these sessions would be utilised for additional ward rounds for speedier discharge
<b>Single Point of Access</b>	c6 additional nurses	c£330k p.a
<b>Enhanced teams in A&amp;E</b>	GPs as clinical associates – 6 x 4 hour sessions per day, plus 7 additional medical and nursing staff	c£1m p.a for GP sessions during the day
<b>Community care teams (as per Gwent model)</b>	c25 medical, nursing and therapy staff Access to a network of approximately 50 Generic Health & Social Care Support Workers, and/or rapid access to immediate	c£1.5m p.a

<sup>181</sup> Based on proxy modelling of 10% of general surgery (see above)

<sup>182</sup> Based on typical DGH in England

<sup>183</sup> Based on total staff costs for main theatres divided by 4 theatres, for 24% of usage of additional theatre

<sup>184</sup> Based on proxy modelling of 10% of general surgery (see above)

<sup>185</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 24% usage of additional theatre by 2020

<sup>186</sup> Based on total staff costs for day theatres and endoscopy, divided by 4 theatres, for 25% usage of additional capacity by 2020

<sup>187</sup> Based on assumed average of 10 patients

Staff group	Number of staff	Cost at 2020 (£)
	home care (recommended that this is reviewed in line with the current staffing arrangement) Additional administrative and secretarial staff	
<b>20 bedded step up/ step down unit</b>	c9 staff (predominantly nursing and therapies)	c£500k p.a Assumed would be developed through a network with the community team, FNHC, the Parishes and nursing homes
<b>Clinical Support Services</b>	By 2020 increase of up to 30 staff across all clinical support services	c£4.5m (includes supplies)
<b>Non clinical support services</b>	No staff data available	c£3.5m p.a (includes supplies)

- A more attractive career path would be developed for nurses, Allied Health Professionals and other non medical staff
- Social care, mental health and third sector staff would all need the skills and competencies to work within the agreed integrated care pathways, with improved communication and sharing of roles in order to avoid duplication and gaps in service
- Roles would be developed for generic care workers as care navigators and care coaches, assisted by telehealth and Telecare, as outlined in the 'Self Care' section of this scenario
- Medical staff would continue to need a balance of generalist and specialist skills and expertise, working closely with GPs in the hospital and in the community
- Recruitment would need to continue in order to fill wider spectrum of nursing and other clinical posts
- Competency based training would be introduced for new extended roles, including GPs taking on clinical associate roles

## 8.4.4 Revenue and capital implications

Description	Impact and savings	Set up costs	Additional annual running costs in 2020 (£)
<b>Single point of access – triple digit number</b>	Reduction of 10% A&E attendances (4,200 by 2020 approximately) c£350k p.a. <sup>188</sup>	Hardware/software c£50k <sup>189</sup> Staff set up and training costs based on 1 month salary c£30k	Staffing x 6 nurses <sup>190</sup> c£330k p.a
<b>Ambulance journeys</b>	Emergency journeys increased by 16% by 2020 (based on demographics)		Estimated annual lease cost of additional ambulance c£320k p.a (incl staff) or additional cost of £90k for a purchase of a bariatric ambulance and c£500k for 6 additional staff to man 24/7
<b>Enhanced teams in A&amp;E</b>	GPs in A&E to provide primary care to 40% of patients attending A&E (reduction of 17,000 seen by A&E staff) Savings of 5 fewer middle grades c£360k p.a Acute medical physicians and Emergency Care Practitioners in A&E	Recruit as part of succession plan for current consultants £20k training costs	c£1m p.a. <sup>191</sup> for GP sessions during the day
<b>Paediatric Assessment</b>	Specialist Nurse Practitioner to see triaged paediatric patients – initial reduction contained with GP clinical associate		c £130k p.a (to be shared with Robin Ward)
<b>Integrated Multidisciplinary Teams/ Step up/step down care Step up/step down unit</b>	Based on the Gwent Fragility model	Capital investment required to open 'hub and spoke model' as part of Overdale redevelopment (20 beds) £5m <sup>192</sup> Equipment to set up - £500k	c£2m p.a staffing <sup>193</sup> Supplies £1m p.a
<b>Decommissioning of procedures of low clinical value</b>	Reduction in bed base by 1 bed p.a. Delay in need for main	Develop assessment tool and threshold criteria Assume 2 days of	0.5 day per consultant p.a. – a total of 2.5 days (5 specialties) £4k p.a

<sup>188</sup> Based on £85 per attendance 2010 costs

<sup>189</sup> Based on the expansion of JDoc line already in place

<sup>190</sup> Assuming shift patterns of 2 staff members on duty between 8am and 4pm each day, then 4pm until midnight and 1 from midnight until 8am – to be located in A&E department (potential to have some resource reallocated from current staffing level of 23 band 4-6 nurses (2010 figures)

<sup>191</sup> This assumes that the current 12 hour out of hours J-Doc arrangement will continue and there would be 12 hours in the daytime on a sessional basis

<sup>192</sup> Based on Bradford modular build of 4,950 sqm facility accommodates three new state-of-the-art 28-bed wards and six general operating theatres, with a full height glazed link to the main hospital and three ambulance bays cost of £9m. Requirement for Jersey would be 20 bedded ward. New build costs would be significantly higher.

<http://www.yorkon.co.uk/bradford-hospital.html>

<sup>193</sup> Based on the staffing costs in section on staffing implications

Description	Impact and savings	Set up costs	Additional annual running costs in 2020 (£)
	<p>theatre (4 years) and day theatre (5 years) capacity</p> <p>Savings of:            £517k<sup>194</sup> p.a for procedures done in main theatres            £209k<sup>195</sup> p.a for procedures done in day theatres</p>	<p>consultant time per relevant surgical specialty</p> <p>10 days (5 specialties)            £15k</p>	
<b>Integration of primary and secondary care</b>	<p>60% reduction in follow up outpatient appointments: savings of 119 PAs pa= £1.26m p.a in 2020</p> <p>Direct access to investigations, assumed reduction in new outpatient appointments of 15%: savings of 13.5 PAs =£148k p.a in 2020</p>	<p>Training for GPs to become clinical associates</p> <p>45 days training over 1-2 years with assessment costs (and trainer costs)</p> <p>42 @ £500 = £21k based on 1 day sessional fee per GP</p> <p>Assessment and training costs estimated to be £10k p.a.</p>	<p>Costs of GPs in shared clinics within acute settings based on sessional fee c £260k p.a</p>
<b>Integrated care based on agreed Integrated Care Pathways</b>	<p>Reduction in LoS</p> <p>Enhanced efficiency, improved patient experience</p>		<p>Estimated salary for member of staff £50k p.a for facilitation of care pathway development</p> <p>0.5 day training with annual updates costs £10k</p> <p>Staff time to take part in process 2 days each</p> <p>Consultants c£70k p.a</p>
<b>Strategic partnership UK centre</b>	<p>Improved sustainability</p> <p>Reduction in off island procedures</p> <p>Improved clinical governance</p> <p>Savings through consolidation of current arrangements</p> <p>Savings released from consolidation of arrangements 10%-35%<sup>196</sup></p> <p>This would equate to</p>	<p>Costs of tendering process</p>	<p>Travel to UK of 2 days every 6 months c £350k p.a</p>

<sup>194</sup> Based on proxy of 10% of general surgery activity

<sup>195</sup> Ibid

<sup>196</sup> Estimated by procurement experts

Description	Impact and savings	Set up costs	Additional annual running costs in 2020 (£)
	between £800k and £2.8m potential savings		
<b>Costs of new main theatre, day theatre, endoscopy as outlined in scenario 1</b>	To accommodate additional demand	£5m main theatre £2-5m day theatre £1m endoscopy	£200k p.a (staff and supplies) £120k p.a (staff and supplies) £130k p.a (staff and supplies)

Major investment in the hospital estate would be required to make it fit for purpose. If a new build were required, the cost would be c £1 million per bed<sup>197</sup>. Without changes in practice the projected bed requirement for 2020 will be 237 beds. That means that the cost of a new build hospital would be more than £235m. With the changes in practice outlined above, the bed requirement in 2020 would be as currently.

#### 8.4.5 Funding implications

- The funding model needs to be adapted to incentivise care delivery by the most appropriate clinician in the most appropriate setting. It would also need to be devised in such a way that it does not reduce access and equality for vulnerable groups
- The future funding mechanism would need to recognise the interaction between public and private care. Private healthcare provides individual clinicians with additional income, but also represents an income stream for the hospital. Information systems should be strengthened to ensure this income stream and its potential are captured
- A compulsory private health insurance covering primary, community and secondary care as well as off island care could incentivise the active monitoring and management of long term conditions so that acute exacerbations and complications requiring elective interventions (e.g. vascular disease in diabetes) are prevented where possible (premiums could be lower as a result of good preventative care and life style changes)
- As the number of elective procedures increases, the private/public funding split should be considered. At peak times there may be pressure to prioritise private patients, both for bed usage and for theatre capacity
- A legislative change could offer the opportunity for the hospital to charge for attendance at A&E for conditions that are considered to be a primary care presentation
- Charges for prescriptions could also be levied by the hospital
- There are additional funding requirements from a workforce perspective, although the majority of this relates to caring for elderly patients within the community which could be funded through the Long Term Care scheme once this is available from 2012
- Capital investment for the step up/step down unit should be considered as part of the development of the Overdale site to relocate mental health services based on the capital receipt from the St Saviour site

<sup>197</sup> Industry rule of thumb, specific advice needs to be sought

## 8.4.6 Benefits

### 8.4.6.1 Service user/carer

- Care is provided by a wider range of clinicians and care professionals, working together in integrated teams across the health and social care spectrum with the patient / service user at the centre. This should produce appropriate, targeted, evidence based care pathways which meet the holistic needs of the patient / service user
- Reduced travel off island for care as UK consultants provide more care on Jersey
- Improved access to the latest technologies for those procedures provided in the UK. Shorter waiting times and better monitoring of long term conditions, would lead to fewer acute exacerbations, elective interventions and fewer and shorter hospital stays
- Triage is undertaken quickly and effectively on the telephone to ensure that the patient is either reassured that they do not require an emergency attendance and has a GP appointment made or they have the correct level of service provided quickly
- Senior decision making in A&E ensures that assessments are quickly made and treatment/care delivered
- Step up/down care available within the community reduces the need for hospital admission
- Patients supported through an integrated approach to health and social care and in their own home or nursing home rather than in the hospital

### 8.4.6.2 Workforce

- Expansion of nursing and allied health professional roles would provide a more attractive career path and improve recruitment and retention. This would include the expansion of roles e.g. nurse practitioners, nurse consultants, physiotherapy consultants
- Staff would work in safer conditions, both in terms of physical environment, and with support from a UK provider and care delivered according to integrated care pathways
- A triage service ensures that patients receive the right level of clinical care quickly and that clinical resources are targeted appropriately
- Job satisfaction for staff providing a good standard of care, supporting patients to manage their conditions and remain well for longer in the community
- GPs have an increased role in the care of patients within the hospital as well as out in the community including nursing homes

### 8.4.6.3 Quality

- Safe (through improved governance arrangements, outcome data collection and continuous sharing of clinical practice), sustainable (of service and clinically as a wider variety of clinicians with varied skills are involved in the care delivery within established multi-disciplinary teams and working within integrated care pathways), and viable (through containing costs)
- Improved communication between UK centre and Jersey consultants regarding interventions the patient has received in the UK, which will improve patient safety
- Quality improves through the proactive approach to risk stratification, case finding and management of patients to prevent exacerbations
- The opportunity to speak to a nurse on a triple digit number and be triaged by a GP upon arrival at A&E for speedy treatment and discharge or further referral

#### 8.4.6.4 Business

- Better use of existing resources, and increased cost effectiveness
- Reduction in locum costs as multidisciplinary teams expand and increased capacity is available from non-medical staff
- Contract management facilitated through consolidation of existing multiple arrangements with UK providers
- More cost effective care is provided through improved use of existing resources and role extensions
- Savings made through decommissioning of procedures of limited clinical value
- Efficiency savings through consolidation of off island arrangements
- Opportunity to charge for minor injuries may be more viable if patients are seen quickly and effectively with different rates for different staff i.e. medical v nursing

#### 8.4.7 Risks

- Capital investment is required to update the hospital estate and expand theatre capacity
- Ongoing challenges may be experienced with recruitment
- Acceptability to staff, particularly those who would need to work across current settings of care
- Revision of funding model may be required to ensure changes in service structure and behaviour are incentivised appropriately
- Need to invest time in strengthening the partner relationship with a UK provider, to develop trust and a high quality relationship
- Single point of access and pre-triage may not be culturally acceptable, especially for those redirected to primary care and therefore subject to an out of pocket expense
- Cost implications to having more senior decision making in A&E and potentially creating additional roles such as nurse practitioners

## 8.4.8 Implementation timetable

Initiative	Timescale	Action
<b>Decommission procedures of limited clinical value</b>	3 months	Decision made to proceed – legal implications to be considered which may influence timescale
		Engage clinicians
		Agree which procedures in scope
		Develop Jersey assessment and threshold criteria
<b>Integration of primary and secondary care</b>	6-24 months	Extension of nursing and AHP roles
<b>Integrated care based on agreed care pathways</b>	6-18 months	Training of GPs to act as clinical associates
		Enhance multi-disciplinary teams
<b>Theatres<sup>198</sup></b>	2011	Plans and business case; secure funding
	2011	Tendering process
	2012	Building work
<b>Day case theatres<sup>199</sup></b>	2012	Plans and business case; secure funding
	2012	Tendering process
	2013	Building work, recruitment of staff
<b>Endoscopy<sup>200</sup> additional capacity</b>	2012	Plans and business case; secure funding
	2012	Tendering process
	2013	Building work, recruitment of staff
<b>Strategic partnership with UK centre(s)</b>	6-24 months	Agree activity and procedures to be included in arrangements
	6-12 months	Run tendering process; on site visits
	6-12 months	Develop protocols and care pathways
<b>Single point of access</b>	April 2012	Installation of the telephone triage line
	May 2012	Training of A&E staff – 6 dedicated nurses
	June 2012	Marketing campaign to advertise new service
	July 2012	Go live
<b>Enhanced teams in A&amp;E</b>	April 2012	Co-location of GP Out of Hours service in A&E
	July 2012	Development of business case to fund GPs on 3 session days
	April 2012	Additional GP sessions commence in A&E

<sup>198</sup> Included here as identified in option 1 for completeness

<sup>199</sup> Ibid

<sup>200</sup> Ibid

Initiative	Timescale	Action
	May 2012	Recruitment of Paediatric Nurse Specialist x 2
	May 2012	Recruitment of Emergency Care Practitioner (or Emergency Nurse Specialist)
	September 2012	Set up Paediatric Assessment Unit in A&E (access post triage)
	September 2012	Establishment of the Emergency Care Practitioner role within A&E
<b>Integrated multi-disciplinary team</b>	June 2011	Business planning to develop the community team
	October 2011	Workforce plan to develop and fund new roles
	January 2012	Funding agreement for new model
	March 2012	Advertisement for community team roles - phased
	September 2012	Establishment of initial community team (nursing team at Overdale to be recruited post build)
<b>Step up: step down unit</b>	June 2011	Business planning for development of the Overdale site for the movement of services from the St Saviour site
	January 2012	Capital investment funding agreed
	April 2012	Building of new unit
	September 2012	Recruitment of additional nursing team for step up/step down unit
	February 2013	Training of new staff
	April 2013	New unit opened – fully staffed

## 8.4.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Met	<ul style="list-style-type: none"> <li>■ Demand within the system is more appropriately managed by using existing capacity in primary care and integration with secondary care, improving flexibility of nursing and AHP staff through role extension, and by containing the need for additional beds</li> <li>■ Patients are proactively identified and treated / cared for in the most appropriate place</li> <li>■ Care is delivered in the community utilising the network of nursing homes, patients own homes and community staff. This reduces the pressure on the hospital bed based</li> <li>■ Risk stratification and targeting provides more patient centred proactive care, which helps to maintain people for longer in their own homes and reduce exacerbations, A&amp;E attendances and unplanned admissions, thereby further improving the resource utilisation of the hospital</li> </ul>
<b>Ensure Clinical/service viability</b>	Met	<ul style="list-style-type: none"> <li>■ Strengthening the clinical staffing model through close collaboration with a UK provider, which would provide staff on rotation, and increased regular on island presence of senior medical staff</li> <li>■ Additional opportunities for nursing and AHP staff for rotation and for role expansion which improves recruitment and retention</li> <li>■ Patients are cared for in the community through the expansion in the nursing and primary care workforce</li> <li>■ This relieved pressure on the acute bed base and ensure that proactive care can be delivered to optimise service quality and appropriateness</li> </ul>
<b>Ensure financial viability</b>	Met	<ul style="list-style-type: none"> <li>■ Cost containment would be achieved through reduction in length of stay</li> <li>■ More patients would be treated on island by visiting specialists which reduces the cost of off island treatment</li> <li>■ Capital investment is potentially reduced through the 'virtual ward' rather than a major reinvestment in hospital beds</li> </ul>
<b>Optimising estate utilisation</b>	Met	<ul style="list-style-type: none"> <li>■ Use of hospital facilities would be reduced: capacity would be released in the outpatient department when 60% of follow up appointments are carried out in the community</li> <li>■ Fewer beds would be required than the predicted future need due to reduction in length of stay and increased appropriateness of admissions</li> <li>■ Some reduction in need for theatre use as a result of decommissioning of procedures of limited clinical value</li> <li>■ The development of the Overdale site for both a replacement for St Saviour and a step down for the hospital and step up for the community would integrate health and social care provision</li> <li>■ Reductions in unscheduled acute care would improve hospital utilisation as beds would be utilised by those most in need, with patients cared for in community settings where appropriate</li> </ul>
<b>Workforce utilisation and development</b>	Met at cost	<ul style="list-style-type: none"> <li>■ Extended roles of non-medical staff would provide more opportunities for development and career progression</li> <li>■ Closer working and integration between primary and community care would further strengthen relationships and assist with skills transfer and delivering patient-centred care</li> <li>■ However, this requires investment particularly in the nursing and primary care workforce</li> </ul>
<b>Clinical governance</b>	Met	<ul style="list-style-type: none"> <li>■ The strategic relationship with a UK centre would require Jersey hospital to take part in collective audits</li> <li>■ Clinicians in MDT meetings would share clinical practice and attend the UK</li> </ul>

Service design principle	Met/Unmet	Justification
		<p>centre for a designated period each year for training purposes</p> <ul style="list-style-type: none"> <li>■ Improved clinical governance through the addition of GPs in A&amp;E, the support from the acute physicians and a greater role for nursing both in the hospital and community</li> </ul>
<b>Use of business intelligence</b>	Met at cost	<ul style="list-style-type: none"> <li>■ Systematic data collection will have to be undertaken to measure more detailed activity and outcome data and assess the quality and safety of service, for comparison with partner organisation and for contract management</li> <li>■ An investment in an IT system that spans across health and social care is required to support the care for patients in the community. A review of a single system is required</li> </ul>

## 8.5 Older Adults

The aim of the older adults service would be to support and enable service users and their carers to live productive and independent lives in their own homes for as long as possible. In order to achieve this, older adults would receive a personalised, coordinated range of physical and mental health services, driven by single assessment and active case management and taking into account the wishes, needs and choices of the service user and their carer.

Multi-professional care co-ordinators would work together to assess the needs of the individual and agree a care package consistent with following the principles of the single care pathway. Their task would be supported and enabled by information available on the citizens' portal. Service users and their carers would continue to be supported by volunteer care navigators, who would assist them in understanding the citizens portal and accessing the care that is most appropriate for their needs and wants, as outlined in the 'Self Care' section of this scenario.

Access to a full range of health, community, social, housing and social security services would be facilitated based on single point of access and linkage models well established in the UK. This would include supported living and extra care housing, as appropriate.

Older adults would be cared for in their own homes for as long as possible, supported by the community team. The community team would comprise social care, medical, nursing, therapy and support staff. It would be supported and enhanced by 24-hour district nursing, home care, night sitting and aids, equipment and adaptations, telecare and telehealth (for both physical frailty and organic mental health needs), as outlined in the 'Self Care' section of this scenario.

Vulnerable older adults and hard to reach groups would be engaged through active case finding, and safeguarding would be supported to ensure that, where possible, risk is minimised and service users are protected from harm.

Intermediate care (step up and step down), and 'virtual wards' would provide more intensive support where needed, but without the need for an acute hospital stay, as outlined in the 'Acute' section of this scenario. Services such as reablement and/or intensive support would be available in the period immediately following hospital discharge, with the aim of maximising the older adult's functioning and independence, to delay or stop deterioration, increase confidence and regain the physical ability to undertake activities of daily living, rather than addressing health needs.

The needs of carers would be met through respite care and carers' support groups/networks, along with Expert Patient programmes. These would all be supported by extended Parish networks, as outlined in the 'Self Care' section of this scenario.

The dignity of the individual will be maintained at all times, including at the end of life, where the individual will have choice in terms of their place of death.

Improved value for money would be driven through contracting for quality. This incorporates market stimulation, agreeing more rigorous quality contracts with a multitude of providers and rigorous assessment and monitoring to ensure quality standards are achieved.

In addition, at time of writing this document, the White Paper for Long Term Care scheme is being considered. This is due to be implemented in full from 2013. The provisions of the White Paper will have significant implications for the future of long term care, including:

- The States will be the key commissioner of social care services on the island. As such, the States will be looking to assess all older adults, including those who self fund. This will lead to an increase in assessments and a consequential impact on resources
- It is suggested an additional 1.5% contribution from taxpayers is ring-fenced into long term care funding such that it can be accessed later in life. This may lead to a stronger sense of entitlement for long term care

Please note that because the detailed mechanism is still being drafted at the moment, the Long Term Care scheme is considered in the narrative of this report but not in the calculations. The White Paper assumes that the States contribution for long-term care will remain at £30m per annum for five years.<sup>201</sup>

## 8.5.1 Outline of service

### 8.5.1.1 Personalisation

At present complex services are provided by a multiplicity of providers, teams and professions. Services and professions often have different referral and access points, assessment frameworks, eligibility criteria, pathways and ways of working. The risk of miscommunication, duplication or unmet need increases with complexity and the number of care professionals involved.

Traditional mechanisms of referral to residential based care can also lead to higher costs and levels of dependence. Jersey currently has twice the amount of older adults in residential based care as comparator UK Local Authorities and PCTs. This difference may be accounted for by the lack of intermediate care facilities and/or by cultural "norms" which suggest when it is appropriate for a person to enter residential based care. However, many older adults would prefer to maintain their independence by being supported in their own homes, providing the range of services is available to enable this. In addition, options exist for more intensive support within community settings, such as

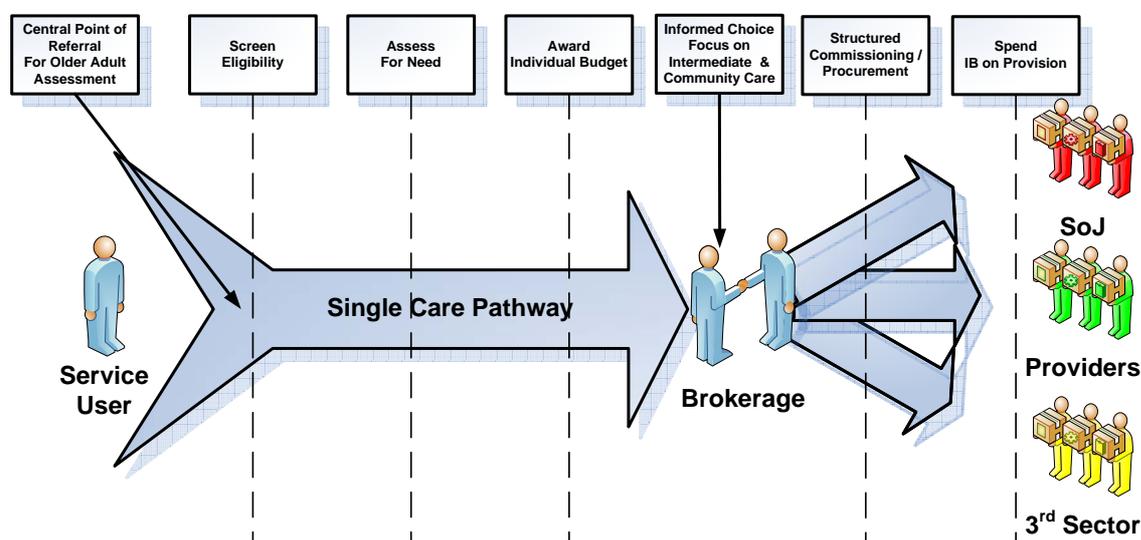
<sup>201</sup> HSSD £16m and Social Security £14m Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p9

supported living and extra care housing, which provide additional care input without the need for admission to a long term residential care setting.

Simplifying and standardising the current range of approaches would improve coordination, providing a holistic, streamlined service which improves quality and outcomes – which provides support, enablement and choice of care setting for older people and support for their carers.

Personalisation changes the relationship between citizens and public services in order to empower the individual.<sup>202</sup> Evidence published in 2009 by the Social Care Institute for Excellence demonstrated that “people using self-directed support instead of traditional support are generally more likely to report improved outcomes and satisfaction”<sup>203</sup>

Figure 72: Example pathway for older adults



Personalisation can also empower the older adult population (or their representatives), enabling them to choose the care they receive, who provides it, where and how:

- The service user would enter through the central point of referral (which could be a centralised team) and travel through a single care pathway, as far as possible dependent on need
- The service user would be guided by a care coordinator (who could be a social worker, nurse or therapist) through the majority of their journey, either in a face to face interaction or via the citizens' portal (with the exception of the assessment, which would need to remain as a face to face interaction)
- Screening for eligibility to services would be undertaken using a common assessment framework, which would also include eligibility to the ring fenced money for the Long Term Care scheme

<sup>202</sup> New Horizons, HM Government, UK , December 2009 p28

<sup>203</sup> Paths to Personalisation in Mental Health, National Mental Health Development Unit, March 2010, p11 quoting SCIE report March 2009

- The service user is then assessed by their allocated care co-ordinator (who also accesses advice from other professionals as necessary), using a standard assessment process and based on levels of need and outcomes to be achieved or met. Standardising this approach reduces the time wasted duplicating basic patient details on multiple assessment forms
- The level of need is interpreted by a Resource Allocation System, which equates need to a scoring system which can then be used to purchase services either internally or externally. This is sometimes described as a 'points means pounds' system
- Robust, integrated real time management information would support the entire process (by enhancing or replacing existing systems)

At this point, the service user is provided with a choice of an enhanced single care pathway or a personal budget.

#### 8.5.1.2 Enhanced single care pathway

- The care coordinator devises a care package and pathway for the service user, based on their assessed needs and the services available (accessed through the citizens' portal)

#### 8.5.1.3 Personal budget

- The service user would be allocated either a virtual budget (which will be managed on his behalf by the States) or a direct payment to purchase services. This decision must be agreed between the care coordinator and the service user, taking into account factors such as risk and availability of services (e.g. a dual diagnosis mental health patient would be unlikely to receive a direct payment; a physically frail older adult whose neighbour acts as a personal assistant would be likely to receive a direct payment)
- The service user could then either choose services themselves via the citizen portal or be supported by either a care navigator, a care coordinator or by brokerage. This places the service user as the key commissioner of their own care pathway, further increasing their choice and empowerment
- After the service user has received the service they could leave feedback for the service (essentially like an Amazon or an eBay model) which would add transparency to the delivery of services and drive performance between suppliers
- The reassessment period will be set by the risk profile of the service user, which would send the service user back to the start of the journey

In Jersey, we understand that the implementation of personal budgets would require a legislative change to allow service users to have access to States funding. However, we have not been provided with written legal advice on this issue.

A recent review by Carr (2011) of personal budget outcomes both in the UK and internationally concluded that, "*personal budgets need to be seen as just one part of the wider adult social care transformation agenda. The provision of personal budgets needs to be consistent with the principles and values of personalisation. Personal budgets should maximise choice and control for people using services, and their carers and families, wherever possible. The international literature shows that, to achieve this, independent advice and support services, and confident, well-informed and trained staff*

are vital. The evidence demonstrates the importance of organisational change when developing personal schemes, particularly when considering risk management and safeguarding issues.”<sup>204</sup>

Personalisation as a philosophy has the ability to be adopted quickly and easily. Personal budgets require further consideration and planning. Once established, the single care pathway approach would immediately be transferable to younger adults, and also with some modifications in time to certain cohorts of children.

#### 8.5.1.4 Care outside of a residential setting

##### *Enhanced community support for prevention and promoting independence*

The Parishes and other community based organisations have the opportunity to support the delivery of better services and support older adults to remain independent for longer and actively encourage reablement as an alternative to residential care. Reablement can apply both in the step up process to delay admission to residential care and also to re-equip people with life skills post hospital discharge. A reablement intervention usually lasts between six and 12 weeks and, according to the Department of Health circular from 2010, should not be charged for in the first six weeks.<sup>205</sup> There is no definitive model for reablement and the emerging practice messages from the Social Care Institute for Excellence (SCIE) indicate that reablement is rapidly evolving. A key point is that *“reablement is significantly associated with better health-related quality of life and social care-related outcomes compared with conventional home care”*.<sup>206</sup>

The support already available within the community would be enhanced and structured through resourcing support networks. . In addition, the Parishes would support establish physical services such as Assisted Living Facilities. Examples of where HSSD are already working in this direction are Health and Social Care Preventative Services; elsewhere examples such as LinkAge Plus drop in centres such as in Tower Hamlets<sup>207</sup>, which are open to all over 50 years old and offer support with both drop in and outreach across a range of health and social care related activities including health promotion and welfare advice.

All such community support would need to be locked into a contractual framework where the States as commissioner agrees levels of activity related to costs, as well as expected outcomes, and robustly performance manages the contracts.

##### *Community multidisciplinary teams (MDT)*

The Community MDTs would comprise physical and mental health and social care professionals, with input from the third sector. They could be based in a variety of locations but it is assumed that this model would work best if co-located into the Parishes. An illustrative example of how an integrated multi-disciplinary community team is the Gwent Frailty model<sup>208</sup> as outlined in the ‘Acute’ section of

<sup>204</sup> Carr S: Personal budgets and international contexts: lessons from Home and abroad: Journal of Care Services Management 5 (1), January 2011, p 9 -22

<sup>205</sup> Francis, J; Fisher M; Rutter D; Reablement: a cost effective route to better outcomes: Social Care Institute for Excellence: Research Briefing 36; April 2011 p1

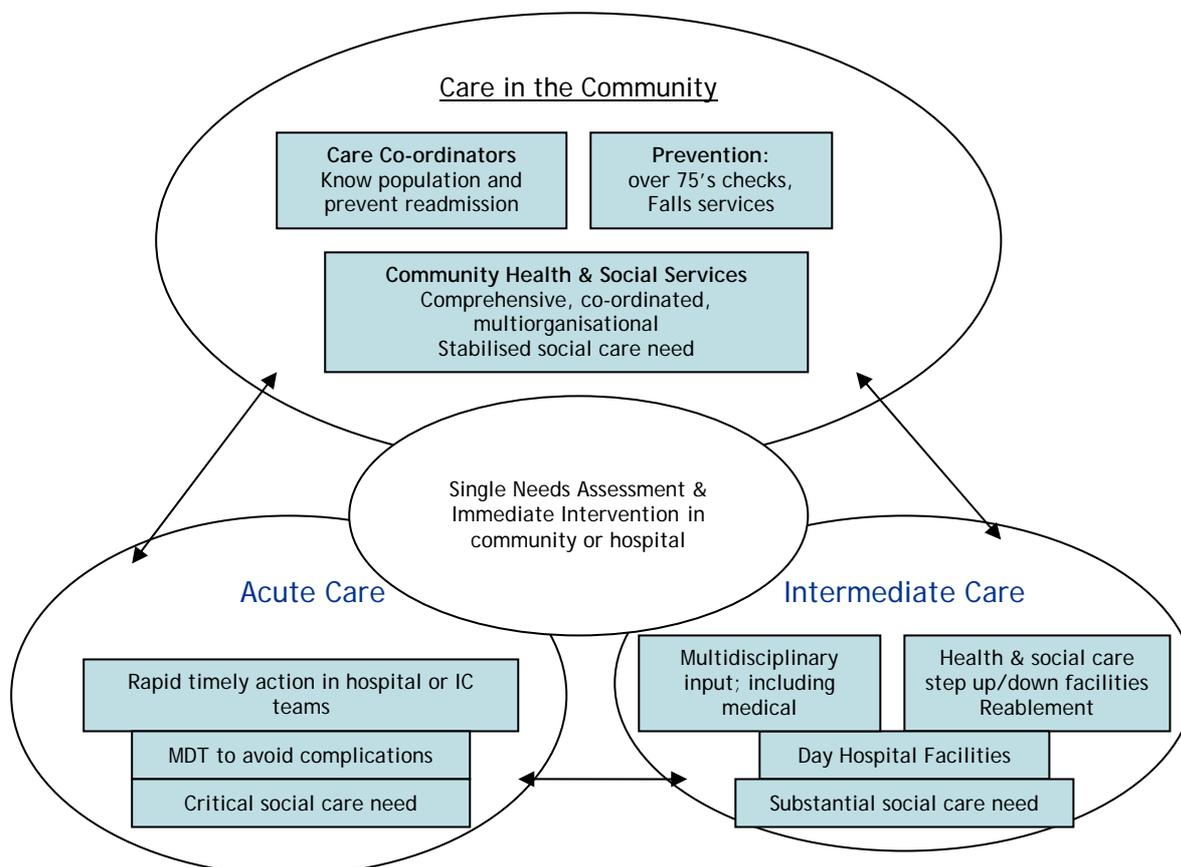
<sup>206</sup> Francis, J; Fisher M; Rutter D; Reablement: a cost effective route to better outcomes: Social Care Institute for Excellence: Research Briefing 36; April 2011 p3

<sup>207</sup> [http://www.towerhamlets.gov.uk/lgsi/601-650/640\\_activities\\_for\\_older\\_peopl.aspx](http://www.towerhamlets.gov.uk/lgsi/601-650/640_activities_for_older_peopl.aspx)

<sup>208</sup> Gwent ‘Happily Independent’; Strategic Vision for Gwent Frailty Programme, 2009

this scenario. This brings together social workers, OTs, nurses, reablement officers and GPs to provide care to 2,400 people with long term conditions in a 70-bedded 'virtual ward' in the community. The model is outlined in brief below, and is presented in more detail in the 'Acute Care' section:

Figure 73: Gwent Frailty model



### Gwent Frailty Programme

The Gwent Frailty Programme is based on tailoring support to their five local and distinct boroughs and aims to "provide equitable access to the range of services along the continuum of care, whilst retaining the local 'flavour'"<sup>209</sup>.

This model could be adapted by Jersey on a Parish level. It comprises of all the health and social care professionals such as social workers, district nurses, therapy staff, clinicians working together to one approach across three responses:

- crisis
- reablement
- longer term care

<sup>209</sup> Gwent 'Happily Independent'; Strategic Vision for Gwent Frailty Programme, 2009

which individuals can choose to retain their independent living and builds up local knowledge about who receives care and who may need to.

The model is based on an integrated approach and assumes the team will work in a co-ordinated and multi-disciplinary way to provide the best care for the individuals.

It is envisaged that as part of the community multi-disciplinary team (of which the model outlined above is only one example), care coordinators would support a caseload, being responsible for supporting the individual and their carer(s). They would ensure needs assessments are completed and individual care plans produced, and then help to navigate the spectrum of physical and mental health care, including third sector provision, and secure the most appropriate ongoing support. This would be supported by the citizens portal, which would contain real time information on service availability.

Using the citizens' portal and, in the future, android phone technology, service users and their carers would be encouraged and supported to take control of their condition, linking with self care and with primary care teams – for the immediate future, volunteer care navigators would be available to assist service users and carers with this.

### *Telecare*

Advanced assistive technologies would enable service users to be cared for in their own homes for longer, thereby reducing the need for long term residential care. Telecare can support a range of physical health, mental health and social care needs, as outlined in the 'Self Care' section of this scenario:

- Predictive telecare – Technologies which monitor the habits and behaviour of a service user (such as how many times a glass of water is filled up)
- Reactive telecare – Such as pendant alarms to flag up distress or inactivity which may indicate a medical emergency such as a fall, shortness of breath or chest pain
- Preventative telecare – Such as a door alarms to prevent wandering, or flood alarms to alert that a tap has been left on, for those with conditions such as dementia

Telecare services would include a staffed monitoring centre who receive alarm notifications and can then speak with the service user to assess their need or, if the service user is not contactable, can dispatch a rapid response team to their home.

The cost per patient for telecare would average £10,000 p.a.<sup>210</sup>. Staffing costs, e.g. for multi-professional community teams, are outlined later in this scenario.

This is just one example of additional support in the home, it is fully acknowledged that further adaptations such as stair-lifts, hand rails, access slopes, adapted kitchen equipment is available and supported through social care, therapies as well as third sector staff. Further detail on other adaptations can be found in the 'Self Care' section of this document.

<sup>210</sup> RRP costs from Tunstall Care

## Care in the community

A range of community services would be developed (see Gwent Frailty model above as an example). The aim of these services would be to care for people outside of an acute or residential care setting, thereby avoiding expensive long term care. This would include:

- 24 hour nursing and home care – an expansion of the current district nursing and home care service, in order to provide support to people in their own homes throughout the day and night. The volumes, intensity and caseloads of this service would need to be reviewed, to ensure that staff are meeting needs and prioritising their care and support.
- A night sitting service to support older adults living alone, or situations where a carer needs night respite. It should be noted that each individual would be assessed for need, as night monitoring could be undertaken by telecare equipment, depending on the needs of the service user and their situation.<sup>211</sup>
- Rapid Response Teams – which could be linked to the emergency triple digit number<sup>212</sup> for the dispatch of an experienced person to care for the service user in their own home to stabilise them and work towards preventing admission to hospital. This would link with the telecare alarm system and could also combine with the telehealth monitoring and response team
- Step up care – to provide short term care for service users/patients who do not need acute care but are too unwell to be cared for in their own homes. This would help to avoid unnecessary admissions to acute care and avoid a culture of dependence
- Step down care – this can provide a viable alternative to nursing care, and reduces the dependence on long term residential or nursing care, thereby supporting service users in the community by providing short term support for those who are fit for discharge but due to their other care needs (e.g. the need to re-learn some activities of daily living), they are not able to return immediately home. In 2010 5,070 bed days were accounted for by delayed discharges, one of the reasons for which is a delay in the provision of long term nursing care beds (see scenario one for the waiting times in 2010)
- ‘Virtual ward’ – providing care in the patient’s home and outreach to nursing homes to support individuals outside of hospital. The detail of this is described in the ‘Acute’ section of this scenario – Gwent Frailty model<sup>213</sup>
- Reablement and intensive support staff, caring for patients in their own homes in the early days following discharge from hospital. The focus would be on supporting service users in caring for themselves rather than undertaking tasks for them, thereby increasing independence and increasing the likelihood that the service user can continue to live in the community rather than in long term care
- Residential and day respite care. The carers’ strategy highlights the enormous physical and mental health impact on unpaid carers in Jersey. A range of respite services would be developed to ease the physical and psychological burden on carers and enable them to live more productive lives
- Residential and day rehabilitation, which may form part of a reablement service and involve the use of various therapies including physiotherapy and occupational therapy

<sup>211</sup> Although it is noted that the practicalities are currently under review due to the cost of offering this service limited to £1,000 per week as any more tips the individual into the care home criteria – Helen Hooper 18 April 2011

<sup>212</sup> See the acute scenario 3 single point of access option

<sup>213</sup> Gwent ‘Happily Independent; Strategic Vision for Gwent Frailty Programme, 2009

- Greater use of aids, adaptations and equipment in the home to provide a safer environment and allow the elderly to stay longer in their homes.

In addition, a reablement team could be established to strengthen the model as set out in the acute section which would comprise of additional resourcing. Reablement is designed to *“help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central, as is reassessment.”* Reablement a cost effective route to better outcomes from SCIE, which goes on to say, *“Occupational therapy skills are central to reablement.”*<sup>214</sup>

A potential reablement team such as the Gwent reablement model<sup>215</sup> for a 70 – 90,000 total population comprising of Boroughs, similar to Jersey’s population and Parish geography (although more rural) could contain:

- 5 Occupational therapists (£250k p.a)<sup>216</sup>
- 5 physiotherapists (£250k p.a)
- 2 social workers (£120k p.a)<sup>217</sup>
- 2 care co-ordinators (120k p.a)<sup>218</sup>

with support from the generic workers as outlined in the Frailty model as well as sessional support from Dietetics, speech and language therapy, psychiatric nursing, podiatry, community pharmacy.

It is estimated that this service would cost an additional £1m to set up based on 2010 salary. In addition to this would be the additional adaptation costs, however it is assumed that by 2013, as set out in the Long-term Care Benefit White Paper, funding will be available for providing a great level of home care as an alternative to residential care.<sup>219</sup> In addition, this would also need to consider the impact of the current States provision of elements such as:

- Cottage Homes of which the Housing Department currently has 2 complexes providing 78 units (64 at Victoria Cottage Homes and 14 units at George V Cottage Homes). These are predominantly for people over the age of 60m fully retired and have less than £14k p.a savings for a couple or £10k p.a as an individual<sup>220</sup>

<sup>214</sup> Francis, J; Fisher M; Rutter D; Reablement: a cost effective route to better outcomes: Social Care Institute for Excellence: Research Briefing 36; April 2011 p1

<sup>215</sup> Based on the Gwent reablement model from Gwent ‘Happily Independent; Strategic Vision for Gwent Frailty Programme, 2009

<sup>216</sup> Estimated salaries based on £50,000 for an OT and physiotherapist based on 2010 ledger cost of £2,150,000 for 45 therapy staff

<sup>217</sup> Based on 2010 ledger cost of £60,000 for a social worker

<sup>218</sup> Assumed care co-ordinators will be social workers at £60,000

<sup>219</sup> Long-term care funding white paper; Social Security Department; States of Jersey; November 2010; p23

<sup>220</sup> States of Jersey, Independent Living for Retired People

<http://www.gov.je/Home/RentingBuying/StatesHousing/AssistedLiving/Pages/CottageHomes.aspx>

accessed 27 April 2011

- Supported Housing – which spans the age range from 18+ and includes Older Adults as part of its remit. Individuals must be referred via a registered agency and assessed to see if they are eligible for supported States provided housing<sup>221</sup>
- Medical adaptations – mainly for individuals who are disabled and living in States accommodation. This is assessed by a Occupational Therapist who determines the need and then this is means tested for implementation unless Income Support partially or fully pay the tenants rent<sup>222</sup>

At this stage, the impact of the proposed options as outlined across the whole of HSSD including the elements outlined above and the additional new models of care would need to be assessed prior to the commitment of further investment by the States in Extra Care Housing.

#### 8.5.1.5 End of Life care pathway

The care principles of privacy, dignity and choice are of paramount importance when applied to end of life care.

The end of life care pathway would be revised and a wider range of settings made available to support people in their choice, supporting their privacy and dignity in palliative care.

During 2010 there were 228 hospital admissions for older adults towards the end of life, accounting for 3,446 bed days, an average of 15 days per person. In a professional judgement gained from a conversation with the medical director it was estimated that 70% of these older adults could be moved onto an end of life care pathway, resulting in the equivalent of almost 2,500 bed days moved out of acute care and into an end of life care pathway in the community. In addition, this could potentially support 2% of those in residential based care such as nursing and residential homes onto an end of life care pathway that allows them to die in a setting they consider to be their own home.

A new model of care is in the process of being developed with the recent employment (April 2011) of one Palliative Care Nurse Specialist and one Liverpool Care Pathway Nurse. This could potentially be enhanced with the additional employment of two community palliative care nurses. However, the service they might provide could also be enhanced by a range of health and social care workers and could include the night sitter service.

#### 8.5.1.6 Contracting for quality

##### *Market management*

Currently the majority of the service provision is undertaken by the States of Jersey. This can be an expensive model due to the overheads incurred through the lack of critical mass in some areas. To drive value from both internal and external services provided to older adults, market management in Jersey would to be introduced. This would involve diversifying the current (external) market which is estimated at approximately £8m of which almost £5m is for older adults services (including third

<sup>221</sup> States of Jersey, Supported Housing

<http://www.gov.je/Home/RentingBuying/StatesHousing/AssistedLiving/Pages/SupportedHousingGroup.aspx> accessed 27 April 2011

<sup>222</sup> States of Jersey, Medical Adaptations

<http://www.gov.je/Home/RentingBuying/StatesHousing/AssistedLiving/Pages/MedicalAdaptations.aspx> accessed 27 April 2011

sector grants and private suppliers). It is anticipated to grow in line with demographics to a level in excess of £10.4m in 2020 of which £6m is for older adults services.

Actions required would be:

- Review all service provision by the States and other providers and identify services that could be subjected to competitive tendering
- Manage the market by consulting with existing and potentially new providers about how they might diversify, offer new services, or work differently to help meet users' needs
- Produce a clear statement of scope (coproduced with service users) and demonstrate how this would meet Jersey older adults service user outcomes
- Stimulate the market to attract new entrants, and ensure value for money and consistency of service provision, access, care and quality. This could particularly be for the provision of services in areas where there are potential gaps in the market. The provision of choice between quality services will be essential to the development of a personalised approach.
- Produce robust contracts for external providers and Service Level Agreements for States provision with clear KPIs (including quality and outcome measures)
- Rigorous performance management, which monitors and quality assures service delivery. This includes benchmarking of provider performance on a like for like basis
- Indicators of potential failure or underperformance, with collaborative working with providers to manage the situation
- Mental health, social care and therapy staff working together (and with service users) to develop specifications that enable the market to develop services to address gaps in provision
- Decommission providers which no longer meet outcomes or provide value

This would be supported by the citizen's portal, which would contain real time information on service availability.

Good market management underpinned by strong procurement could be expected to deliver a 10% reduction in external spend. This would equate to £500k in 2011, rising year on year to c£600k in 2020.

### *Contract management*

Contract management aims to improve quality and consistency, ensure adherence to contractual standards and drive value for money.

Currently the Registration and Inspection Team in Public Health assesses external providers, but direct States provision has historically not been included. From 2012, the new Inspection and Registration of Homes Care Standards will apply to States-run nursing and residential care homes and will require an estimated £3.4m capital investment and require increased funding of approximately £1m per year<sup>223</sup>.

<sup>223</sup> Report produced by Jersey Regulation and Inspection Manager, Public Health Services, 2010

Contract Managers would continuously assess and improve services against an agreed framework and KPIs (based on outcomes and value). The frequency of assessment would be determined by the level of risk, and active performance management would be employed to ensure services are meeting agreed quality standards. There should be better performance management and the contract managers would assess service providers on a periodically, predominantly on outcome basis to review performance outcome. Penalty clauses and redress for poor performance should be part of the process to ensure high quality service and good outcomes are continually delivered.

### 8.5.2 Staffing and cost implications

The table below outlines the benefits and implications including staffing, capital and revenue, for each of the options described. The costs of any additional management and infrastructure for any additional posts are not outlined here as until the new operating model is determined, the associated costs including IT, office space and expenses cannot be estimated as it may be that a virtual office approach is adopted or a centralisation of staffing into one building, both of which have different costings attached. There these costs have not been outlined in the table below and are considered that this level of detail will formulate part of the outline business case.

The table has not been totalled as it is considered that the options above could be undertaken separately as they are not co-dependent.

Description	Implications	Set up costs	First year running costs
<b>Streamlined processes set in a single care pathway</b>	<p>Modest revenue savings through the elimination of duplicated assessments by professional care workers. More relevant and effective care packages for individuals which reduces risk and delays the onset of accessing higher intensity settings of care</p> <p>At this stage it would not be prudent to speculate on potential savings, but this approach is regarded widely as good practice</p>	<p>Based on population size the proportional implementation cost is deemed to be 70% of the IBSEN study size £250k<sup>224</sup></p> <p>IT implementation £120k<sup>225</sup>.</p> <p>£10k per new staff member recruitment costs including advertisement, expenses and relocation package per individual for those recruited from the UK</p>	<p>Care Coordinators c£540k p.a<sup>226</sup></p> <p>Brokerage/ Procurement Roles to manage contracting c£100k p.a</p>
<b>Enhanced community care</b>	<p>Over the next five years Jersey will migrate 20% of its State funded service users from residential based settings of care to community based settings of care. On the basis of the cost of 31 places @ £750 per week, gross savings will be in excess of £1.2 m p.a. Community services are estimated at £13.5k per person p.a – total almost £420k. This leads to a net saving of nearly £800k p.a</p>	<p>£90k set up costs for additional nurses (based on recruitment from the UK as detailed above)</p> <p>Note – within the 'Acute' section an Integrated Multi-disciplinary team is outlined with £1.36m worth of additional staffing costs included of which c£400k is for an OT, 3 reablement officers and a social worker. This is not repeated here to ensure no double counting of cost</p>	<p>Administrative staff c £50k p.a</p> <p>Generic workers c £450k p.a<sup>227</sup></p> <p>Occupational therapists c£250k p.a<sup>228</sup></p> <p>Physiotherapists c£250k p.a</p> <p>Social workers c£120k p.a<sup>229</sup></p> <p>Care co-ordinators c £120k p.a<sup>230</sup></p> <p>Additional sessional costs from a range of clinicians including podiatry, speech and language therapy, psychiatric nursing and dietetics estimated at £250k p.a</p>
<b>Telecare and telehealth</b>	<p>A full business case needs to be developed to assess the cost effectiveness. International studies demonstrate that assistive technology can have a significant impact in keeping people out of hospital.</p>	<p>Set-up for Telecare- c£300k capital investment</p> <p>Costs associated with telehealth are included in the 'Self Care' section</p>	<p>Recurrent telecare repurchase and repair cost c £60k p.a for 30 users</p> <p>Costs associated with telehealth are included in the 'Self Care' section</p>
<b>End of life care</b>	<p>Release hospital resources (beds and ward nurses) but would require investment from palliative care nurses working in the community. This may be</p>	<p>Composing an end of life strategy c£100k<sup>231</sup></p> <p>Operational training and setup costs estimated at 3 months of</p>	<p>Palliative care nurses c£90k p.a<sup>232</sup></p> <p>GP sessions or consultant</p>

<sup>224</sup> Based on the IBSEN UK pilots review minimum cost for implementation based on £128,000 redeployment of resource to support and a further £229,950 of additional resource to implement

<sup>225</sup> Based on the planned QuickHeart solution which was in Birmingham excess of £200,000

<sup>226</sup> This is based on an average coordinator to service user ratio of 1-20

<sup>227</sup> Based on a 1:3 ratio and moving 30 individuals out of residential care back into the community

<sup>228</sup> Estimated salaries based on £50,000 for an OT and physiotherapist based on 2010 ledger cost of £2,150,000 for 45 therapy staff

<sup>229</sup> Based on 2010 ledger cost of £60,000 for a social worker

<sup>230</sup> Assumed care co-ordinators will be social workers at £60,000

Description	Implications	Set up costs	First year running costs
	financially neutral, or it might even have a small net cost, but it would have a significant quality impact in terms of enabling people to die with dignity in a setting of their choice.	salary c£45k	costs - 0.5 p.a to support an outreach within the community and into nursing homes as appropriate - c£65k p.a
<b>Personal budgets</b>	Care packages more appropriate to service users needs, leading to less dependency and delaying the need for more intensive levels of care.  Investment in IT would be required, and in “market making” and diversifying provision to offer service users more choice.	Audit framework and operation model for older adults social care c£70k <sup>233</sup>  Taking a scaled down implementation cost of 70% of the minimum design and implementation cost due to the comparative size of Jersey - c£250k <sup>234</sup> .  IT implementation c£120k <sup>235</sup>  Benefits estimated at 10% - >£500k p.a <sup>236</sup>	Social care inspectors c£220k p.a  Assessment staff c£240k p.a  Brokerage/ Procurement Roles to manage contracting c£100k p.a  Strategic Commissioners/Market Managers c £120k p.a

### 8.5.3 Funding implications

The Long Term Care scheme introduces a new funding mechanism in April 2013. This has not been modelled as part of this strategic scenario.

### 8.5.4 Benefits

#### 8.5.4.1 Service user/carer

- Increased independence and support in the home, from a range of services provided 24-hours
- A more streamlined service, with each service user having a care co-ordinator organising the care and reducing duplication of service provision
- Single assessment which reduces duplication, and an agreed care plan / care pathway, with coordinated service provided from a multidisciplinary team
- Enhanced support for carers, including respite care, to ease the physical and psychological pressure
- Access to information regarding service availability, supported by a care navigator

<sup>231</sup> Based on 80 days of senior effort at an average cost of £1000 per day

<sup>232</sup> Based on additional nursing to the new Palliative Care Nurse and the Liverpool Care Pathway Nurse due to start on Jersey in April 2011 (funding previously secured but not available in time for the modelling)

<sup>233</sup> Based on 100 days Moderate/Senior time, at an average of £700 a day.

<sup>234</sup> Based on the IBSEN UK pilots review minimum cost for implementation based on £128,000 redeployment of resource to support and a further £229,950 of additional resource to implement

<sup>235</sup> Based on a similar implementation in a UK local authority

<sup>236</sup> Based on a figure of external spend from the HSSD General Ledger 2010

- Reduced unnecessary admissions to hospital or nursing care due to strengthening of care in the community (including step up and step down care) and the introduction of telecare to monitor service users, which also promotes higher levels of independence and choice and empowerment
- Reablement and rehabilitation services which improve activities of daily living and support the service user at home
- Improved choice and control through personal budgets, enabling the service user to design their own care to meet their needs and preferences
- Improved quality of care, including supporting those patients who wish to die at home

#### 8.5.4.2 Workforce

- The ethos for the Community and Social Services is to have person-centred care. All the options in this scenario support a reduction in duplication and enable staff to work together to deliver services in a co-ordinated way that supports community based rather than residential care
- The introduction of a standard way of working through process changes which supports teams to work more efficiently and effectively and be redeployed where necessary
- Enhanced roles, providing more attractive career paths
- Improved team working to improve communication
- The ability to support more service users and carers in their own homes, which should increase job satisfaction
- Increased staffing, which should reduce pressure and sickness absence
- Stronger commissioning and procurement and performance management and skilling up key staff to support contract management
- Upskilling of current staff to support their further development and only looking to further recruitment only if there is a supporting business case and the skills are not available on the island

#### 8.5.4.3 Quality

- Services designed to meet individual needs, with choice by the service user
- Improved independence and choice increases the service user's perception of the quality of care delivered
- Increased coordination reduces risk and improves integration of care with needs
- A more co-ordinated approach to care, increasing the care delivered in the home or in nursing homes to allow patients to die with dignity
- Quality is defined and delivered through the contract management process for the new entrants to the market in both private and the third sector
- Ability to feedback on services by service users will increase a transparency and drive quality and performance

#### 8.5.4.4 Business

- Improved value for money as care provision is based on need and is robustly managed
- Improved information availability with the introduction of the service catalogue, care navigators to support service users and care coordinators to manage the care received reducing potential duplication and therefore cost

- Increased value for money through robust contract management and monitoring
- Transparency in service outputs against agreed KPIs, which could drive a robust payment mechanism, incentivising care delivery to meet States objectives

### 8.5.5 Risks

- There needs to be an acceptance that services do not always have to be provided by the States but can be provided as equally efficiently and effectively but the private and third sectors
- Additional investment would be required to develop new roles and recruit new staff (or retrain existing staff), which may not be available
- The public may not accept responsibility for choosing their own care – and culturally, service users may seek residential care as a first option
- Staffing challenges may continue
- Some staff might be resistant to changing services or roles
  
- A lack of critical mass of take-up could mean that personalisation does not benefit from economies of scale and becomes unviable

The introduction of private providers into the market place for provision of residential and nursing homes could put the market at risk of economic pressure and uncertainty from higher risk of closure in the future

## 8.5.6 Implementation timetable

Initiative	Timescale	Action
<b>Single care pathway</b>	June 2011	Review of current entries to service provision across health, social care and the third sector
	October 2011	Procurement of IT package to develop the information hub
	October 2011 - January 2012	Redesign the pathway with single point of access and overarching care co-ordinators
	November 2011	Recruitment to citizen's portal posts/care coordinator posts
	February 2012	Population of information hub catalogue
	March – April 2012	Training of care coordinator
	June 2012	Pilot commences
	October 2012	Review of pilot
	January 2013	Phased roll out
<b>Personalisation and diversify the market</b>	May 2011	Introduce a person-centric philosophy across the department (personal budgets may require a change in legislation to implement)
	September 2011	Undertake a review of all service provision by the States and other providers and identify services that could be tendered
	April 2012	Manage the market by consulting with existing and potentially new providers about how they might diversify, offer new services, or work differently to help meet users' needs
	June 2012	Market stimulated to attract new entrants. This could particularly be for provision of services in areas where there are potential gaps in the market, such as adult eating disorders or further private psychological therapies
	September 2012	Competitive tendering to stimulate the market and ensure value for money and consistency of service provision, access, care and quality
	January 2013	Subject to legislative changes develop an approach to individual/ guided budgets based on review of previous
	January - April 2013	Develop the robust governance arrangements around the development of individual/ guided budgets including the access, co-ordination, delivery and standards compliance
	April 2013	Pilot a cohort of personal budgets
	August 2013	Review and revision of governance arrangements
	October 2013	Phased roll out of individual/ guided budgets across service users
March 2014	Full roll out completed	
<b>End of life care</b> <sup>237</sup>	April 2011	Palliative Care Nurse and Liverpool Care Pathway Nurse (Macmillan funded) commence employment on Jersey (funding agreed prior to this work)

<sup>237</sup> Developed in conjunction with the virtual ward in the Acute Care option and the Care in the Community Older Adults option

Initiative	Timescale	Action
	June 2011	Review the current Rosewood Jersey End of Life Care Pathway and the Liverpool Care Pathway to develop and agree the overarching Jersey End of Life Pathway
	July 2011	Develop a business case for resource from GP or consultant to undertake outreach into the nursing homes to support the end of life care pathway
	September 2011	Bring together all stakeholders in delivering end of life care to patients including third sector parish provision and private sector nurses homes. Agree the implementation plan, timetable and required commitment
	October 2011	Recruitment of remaining GP/ Consultant and nurses/ social care staff to complete the team
	November 2011 – March 2012	Develop the associated training plan and roll out to the nursing homes across the island
	April 2012	Start to monitor the number of patients transferred into hospital shortly before dying
	September 2012 – April 2013	Work with the hospice to roll out the Gold Standard Framework <sup>238</sup> for cancer care – in conjunction with the strengthened community nursing team (to be phased in as team is phased in – see Emergency Care section for more details)
<b>Community Care and care in the home</b>		See timeline in 'Acute' section – it is envisaged that this would be implemented simultaneously

### 8.5.7 Strategic Imperatives met/unmet

Service design principle	Met/unmet	Justification
<b>Create a sustainable service model</b>	Met	<p>Services develop to meet the needs of the older adult population, with improved coordination and integration</p> <p>Providing the services achieve their goal of maintaining older adults in their own homes, and reduce the demand for long term residential care, the capacity in residential care remains sufficient and the benefits of the community model are realised</p> <p>Service failures are minimised through proactive quality and contract management</p> <p>The prioritisation of social care and mental health for older people grows provision strategically on the island</p> <p>Commissioning aligns providers in advance of the growth of 85+ demographic to ensure beds and capable staff are available</p>
<b>Ensure</b>	Met	Sustainable community based care would be developed, enabling people

<sup>238</sup> Marie Curie Palliative Care Institute - **Improving care for all people near the end of life provided by frontline generalist staff in any setting** <http://www.goldstandardsframework.nhs.uk/>

Service design principle	Met/unmet	Justification
<b>Clinical/service viability</b>		to stay in their own home through support from a range of community services, supported by Telecare, aids, adaptations and equipment Through the introduction of strong market management to manage and grow supply of nursing care through providers, beds are procured in line with need and deliver value Personal budgets support choice, and service users would choose those services deemed to be most valuable / effective, when provided with information on which to make informed decisions
<b>Ensure financial viability</b>	Met	The introduction of telecare would allow for greater efficiency In addition, more care is provided in non estates-based facilities, which helps to relieve capacity and financial pressures
<b>Optimising estate utilisation</b>	Met	Intermediate care would encourage more work in the community but would be an effective redistribution of resource Services outside of residential settings are developed, mitigating the capacity pressures on estates-based services, including acute care settings
<b>Workforce utilisation and development</b>	Met	The introduction of a single care pathway integrates care for older adults, providing improved workforce prioritisation Care coordinators guide people through the process and alleviate the pressure on health and social care staff Enhanced roles are developed, providing more attractive career paths for all professionals Palliative care enables confidence in care staff to allow people to die in a non residential environment
<b>Clinical governance</b>	Met	Integrated multidisciplinary teams would improve coordination and communication between professions Clinical and professional leadership would be required in order to protect vulnerable older adults and ensure safeguarding requirements are achieved
<b>Use of business intelligence</b>	Met	Increased information would be available from risk stratification and health needs assessment for targeting and service decision making Improved contracting would require increased information, and robust management of contracts against agreed KPIs The citizen's portal would also provide information on service availability and outcomes

## 8.6 Younger Adults Social Care and Mental Health

The new model would deliver person-centred services, in safe, appropriate, flexible environments. The market would be diversified, with standardised, high quality delivery of services in a single care pathway.

The model would develop using key principles:

- Working in partnership with service users to empower and enable them to have more involvement in how their services are delivered

- A move away from residential care and institutionalisation towards an increase in community provision, to allow service users to integrate and live productive and independent lives within the Jersey society. This includes the training of relevant agencies to allow the management of risk and complex needs in the community, including GPs, the police, ambulance service etc.
- The establishment of a single care pathway with an enhanced psycho-social single point of access and a common assessment framework spanning both mental health and social care. It is envisaged that this will have a link back into community services through primary care, to integrate with the physical health needs of the service user
- The development of Tier 1 and 2 services with early intervention techniques including Improving Access to Psychological Therapies and an extended GP role, to reduce the number of people requiring acute intervention later in the care pathway. This has been shown to potentially reduce the number of second episodes of illness due to stress or anxiety by 120 episodes per annum<sup>239</sup>
- A move towards personalisation and needs-driven individual budgets, providing choice for service users and supporting the service provider in meeting their outcomes (outside of the non-core offering of prescriptive services e.g. rehabilitation). Individuals supported by care co-ordinators to help them to determine their own care provision plan
- An increase in the plurality of provision through the development of third sector and private sector providers, thereby moving monopoly provision away from the States
- The development of safe, appropriate and flexible environments for both patients/service users and staff. This would be across both health and social care and support the lack of critical mass of certain types of patients such as adolescents with mental health problems and any patient requiring Psychiatric Intensive Care

## 8.6.1 Outline of Service

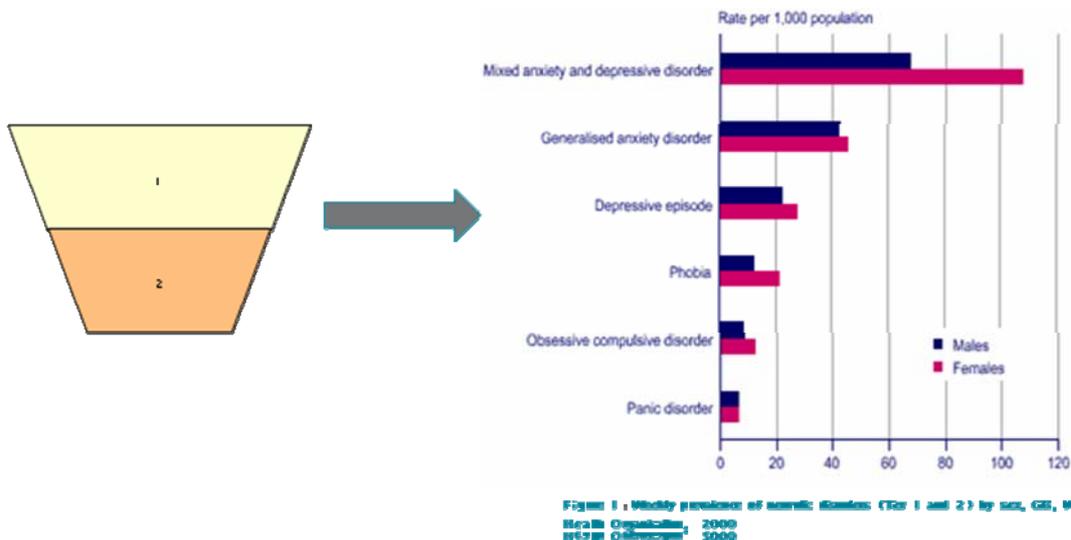
### 8.6.1.1 Development of Tier 1 and 2 Services

The introduction of the Improving Access to Psychological Therapies (IAPT) would cater for service users displaying symptoms from Tier 1 and 2 mild to moderate mental health issues, whilst retaining the current level of secondary services.

The diagram below highlights the types of disorders this may include:

Figure 74: Mental health tiers

<sup>239</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010



Measures such as Cognitive Behavioural Therapy (CBT) or Talking Therapy (TT), delivered by psychologists and psychological therapists, have been put in place in countries such as the UK and Australia to reduce the number of patients becoming so unwell that they require secondary care services.

Currently in Jersey there is approximately an 8 week wait for psychological services although, of the patients who do access these services and receive treatment, one third are able to overcome their symptoms once they have embarked on the treatment programme.<sup>240</sup>

In 2007, IAPT services were introduced into the UK and within 1 year demonstrated an improvement in employment status – the IAPT pathfinders in England saw a 16% improvement in employment in 1 year with 49% of patients stating they no longer had a mental health problem.<sup>241</sup>

NICE guidelines<sup>242</sup> and a recent study<sup>243</sup> demonstrated that CBT was as effective as antidepressants to treat recurrent depression and therefore the introduction of an IAPT or Tier 1/2 services could support the States in reducing their high medication rate.

The February 2011 the UK policy *No Health Without Mental Health* highlighted that access to Talking Therapies resulted in a reduction in the need for inpatient facilities and people taking their own life<sup>244</sup>. The Jersey Annual Social Survey (2009) identified increasing rates of death from suicide and undetermined injury as a key concern in Jersey.<sup>245</sup> The introduction of an IAPT, or similar service, could support the approach to reducing these rates in the future.

<sup>240</sup> Interview with Dr Tracy Wade, Head of Psychological Services November 2010

<sup>241</sup> IAPT pathfinders achievements and challenges; Department of Health; October 2008, p5

<sup>242</sup> Summary of NICE guidelines offering Cognitive Behavioural Therapies; April 2008 and updated December 2010

<http://www.nice.org.uk/usingguidance/commissioningguides/cognitivebehaviouraltherapyservice/summarycbtinterventions.jsp>

<sup>243</sup> Barclay; Mindfulness CBT as effective as antidepressants in preventing depression relapse: Medscape: 14 December 2010

<sup>244</sup> No Health Without Mental Health, HM Government, UK, 2 February 2011, p8

<sup>245</sup> Jersey Annual Social Survey, States of Jersey 2009, HSSD quoted in Strategic Plan 2009-2014. States of Jersey.

### 8.6.1.2 Safe, appropriate, flexible environments

Stakeholders identified a need for a more appropriate model of inpatient service provision for the island that will allow for a range of service user needs to be met within one unit. An enhanced facility, based at Overdale, would create flexible inpatient facilities to meet the requirements for current service, additional legislative changes and flexible capacity that can be used as step up/step down care. The facility would include a range of services, would support the repatriation of appropriate patients from off island and would create a safe environment for service users and staff. It would provide services for:

- Psychiatric Intensive Care
- adolescents requiring inpatient care
- patients requiring low secure facilities or a step up facility from the inpatient unit
- mentally disordered offenders low secure
- acute younger adults inpatient facilities.

In 2007, the Sainsbury Centre<sup>246</sup> identified the number of beds that would be required for a population of 250,000 by 2010. The table below pro-rates this for the population of Jersey.

Figure 75: Projected demand for younger adults mental health

Category of bed	Number recommended for 250,000 pop (1)	Number Jersey should have	Number Jersey have on island	Number Jersey have off island
Medium Secure	21	7	0	5
PICU	8	3	3	
Low secure	10	3	0	
Acute beds	80	27	14	

In 2010, the average bed utilisation was 43%. This was considered an anomaly year so the figures from 2009 have been used. In 2009, the average adult mental health inpatient bed utilisation in Jersey was almost 60%. Based on these occupancy rates the average bed requirement for the activity was 10 beds in 2009. This requirement is projected to remain broadly stable, based on prevalence and population, until it reduces to 9 by 2029 (as the Adult population of Jersey is projected to decline in the period to 2020). It is noted here that the fluctuations in demand indicate that there remains a requirement for the 17 beds currently provided – although, as outlined in scenario 2, different resourcing models could be considered to ensure that staffing intensity responds to demand.

The new, flexible unit would therefore be able to be delivered from a development of the current estate footprint at Overdale, using capital from the sale of the St Saviours. It is envisaged that due to the peak demand exceeding 17 beds in some cases, the new build would retain the same number of mental health inpatient beds but would, through a “hub and spoke” model, offer greater flexibility of bed usage. This flexible design would require meticulous planning and would consideration for

<sup>246</sup> Delivering the Government’s Mental Health Policies, Services, Staffing and Costs, Boardman and Parsonage, 2007 Sainsbury Centre

adolescent care, psychiatric intensive care, the potential change to the way mentally disorder offenders are detained and the potential resulting need for low secure provision.

It is envisaged that this new facility could also house a 20 bedded step up/step down nurse-led unit accessed through a community team and based on the Gwent Frailty model<sup>247</sup> (outlined fully in the 'Acute' section of this scenario).

### 8.6.1.3 Special Needs and Social Care

The model would mirror that developed for older adults, i.e.:

- Personalisation, with personal budgets where appropriate
- Single care pathway, with a multidisciplinary health, social care and third sector teams co-located in a building to allow easier access for the public
- Development of the care co-ordinator role to support individuals to determine their own care plan
- Care provided outside of a residential setting
- Contracting for quality

### 8.6.2 Activity Implications

The new service model supports the further delivery of person-centric care, with a focus on quality improvement rather than a shift in activity.

Service	Projected change in 2020
<b>Tier 1 Tier 2 Services</b>	<ul style="list-style-type: none"> <li>■ Reduction in Short Term Incapacity Allowance claims by up to 120 per year<sup>248</sup> and reduction in duration of subsequent episodes reduced by 40% (from 112 days to 63 days) equating to an estimated saving of almost £1.2m<sup>249</sup> in short term incapacity benefit payments (Social Security budget benefit)</li> <li>■ One third of patients who access psychological services would be able to be discharged – i.e. 40 patients no longer requiring treatment</li> </ul>

<sup>247</sup> Gwent 'Happily Independent; Strategic Vision for Gwent Frailty Programme, 2009

<sup>248</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p5

<sup>249</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p5

Service	Projected change in 2020
<b>Safe, appropriate, flexible environments</b>	<ul style="list-style-type: none"> <li>■ Improved quality of service provision</li> <li>■ Potential to repatriate up to 3 of the current 5 off island placements, which could retain up to £750k spend back into the Jersey health economy</li> </ul>
<b>Single care pathway</b>	<ul style="list-style-type: none"> <li>■ Improved process to reduce duplication of assessment, elements of care delivery and review across health, social care and the third sector</li> <li>■ Activity levels may increase or decrease following the introduction of consistently applied eligibility criteria</li> </ul>
<b>Personalisation</b>	<ul style="list-style-type: none"> <li>■ A shift in activity between suppliers as service users exercise choice</li> </ul>
<b>Diversify the market</b>	<ul style="list-style-type: none"> <li>■ On the assumption that this allows individuals to purchase their care from a range of suppliers and introduces a breadth of services this should increase quality and reduce cost simply due to the introduction of competition. This is determined as a quality initiative, delivering the person-centric vision of the Community and Social Services team, rather than a quantifiable activity shift.<sup>250</sup></li> </ul>
<b>Total</b>	<ul style="list-style-type: none"> <li>■ Improved processes with reduced duplication</li> <li>■ Potential reduction in State provided care in estates-based facilities</li> <li>■ Increase in home based care</li> </ul>

### 8.6.3 Staffing Implications

#### 8.6.3.1 Mental Health – Development of Tier 1 and Tier 2 services

The staffing set out in the table below was identified by the Psychology Department for a full Improving Access to Psychological Therapy (IAPT) service<sup>251</sup>. This is caveated by the fact that each of the IAPT pathfinders in the UK were set up with c£200k initial funding.<sup>252</sup>

Staffing	Number of staff required (fte)	Cost (based on Jersey business case) <sup>253</sup>
High Intensity Worker (CSG 10)	4	c£215k p.a
Psychological Well-being Practitioner (CSG 8)	4	c£168k p.a
Workplace Project Officer (CSG 9)	1	c£47k p.a
Administrator (CSG 5)	1	c£30k p.a
<b>Total</b>		<b>c£460k p.a</b>

<sup>250</sup> Further detailed work would be required once the potential new services and entrants to market are tested

<sup>251</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p4

<sup>252</sup> IAPT pathfinders achievements and challenges; Department of Health; October 2008, p5

<sup>253</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p4

#### 8.6.3.2 Safe, appropriate, flexible environments

The flexible accommodation would be based initially on the currently staffing model but may require a staffing redesign based on the type and intensity of service provision. It is envisaged that this would be determined as part of the detailed planning and business case production.

As outlined in scenario 2, more flexible staffing models such as annualised hours would support the service in matching staff intensity to demand, enabling staffing levels to be flexed according to occupancy and the needs of service users.

#### 8.6.3.3 Special Needs and Social Care

It is assumed that the majority of the initiatives would affect the older adult population, and therefore the details of the staffing implications are fully outlined within that section of this document.

#### 8.6.4 Revenue and capital implications

The revenue and capital implications for Special Needs and Social Care are fully outlined within the Older Adults section of this document.

Description	Impact	Set up costs	Additional annual running costs at 2020 (£)
<b>Tier 1 and Tier 2 Services</b>	Reduction in Short Term Incapacity Allowance claims by up to 120 per year <sup>254</sup> and reduction in duration of subsequent episodes by 40% (from 112 days to 63 days)  One third of service users who access psychological services (40 service users) are able to be discharged	c£686k <sup>255</sup>	c£612k p.a. <sup>256</sup>
<b>Safe, appropriate, flexible environments</b>	Redevelopment of Overdale site to develop a 'hub and spoke' approach to deliver mental health services including the step up/step down unit for health	£30m capital funded through the sale of St Saviour <sup>257</sup>	Maintenance for adults social services in 2010 was £340k p.a. <sup>258</sup> Special Needs Service (assumed for residential care) - £1.1m p.a. <sup>259</sup> Acute inpatient care - cost c£1.25m p.a in salary costs for 24 staff <sup>260</sup> Active Recovery Team c£2m p.a. <sup>261</sup> [Additional nursing for step up/step down unit contained in the 'Acute' strategic scenario c£1m p.a]

It is noted that the Health Billing Notes and estate requirements may also increase the cost of delivery of inpatient services in the future. However, these have not been costed at this time, but will be included in the costings at a more detailed stage of business case development.

## 8.6.5 Funding implications

### 8.6.5.1 Tier 1 and 2, and safe, appropriate, flexible environments

No changes to funding would be required

### 8.6.5.2 Special Needs and Social Care

Means testing does not currently exist for younger adults accessing services, although this mechanism is in place for older adult's services.

<sup>254</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p5

<sup>255</sup> Based on costing within Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p4 including furniture, fixtures and fitting, IT, training and self help book scheme

<sup>256</sup> Based on costing within Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010 p4 including staff costs, IT licence fees, computerised CBT, ongoing room rental, supplies, and staff CPD

<sup>257</sup> Estimate based on reprovision of Orchard House (17 beds), Maison du Lac (10 beds) plus step up/step down facility (£5m). Industry standard £2,000 per metre squared

<sup>258</sup> HSSD General Ledger year end 2010

<sup>259</sup> HSSD General Ledger year end 2010

<sup>260</sup> HSSD General Ledger year end 2010

<sup>261</sup> HSSD General Ledger year end 2010

At the point of the development of a common assessment framework, consideration may need to be given to the equalising the approach, with means testing across both younger and older adult services.

## 8.6.6 Benefits

### 8.6.6.1 Service user/carer

- The core elements of the current service would be retained, providing minimal disruption for mental health service users and their carers
- Early access to Talking Therapies could minimise the impact of an episode of depression or anxiety, and also has the potential to reduce the incidence of relapse or acute episodes. The business case for reducing the cost of common mental health problems acknowledged that this could prevent 120 episodes<sup>262</sup> per annum of second absences from work, which traditionally have been for longer periods of time and therefore costly to Social Security. A fast return to work also improves self esteem, independence and confidence for service users, and reduces the physical and psychological pressure on carers
- A reduction in prescriptions for mild anxiety and depression could improve self-care for patients
- Diversification of the market and personalisation is more likely to empower service users
- Support for patients to access a range of services across health, social care and the third sector to tailor care provision to the needs of the individual
- A purpose built, flexible unit would offer modern inpatient care as an enhanced model of care. It is anticipated this would be a 'hub and spoke' model which would allow for the flexible use of estate so that current challenges such as the accommodation of an adolescent can be overcome.

### 8.6.6.2 Workforce

- The workforce would have a wider range of involvement in the holistic needs of the service user
- The care co-ordinator role offers the opportunity for career enhancement and job satisfaction, guiding the service user and enabling choice and control
- Non-medical prescribing increases the number and type of roles that could be available in the future
- Recruitment and retention may be enhanced through the development of innovative models of care and the associated role redesign

### 8.6.6.3 Quality

- Introducing Tier 1 and 2 services should improve the range of care provided to patients and potentially reduce the pressure on inpatient and secondary care services over time
- Diversification of the market drives a performance management culture and improves the quality of care provided

<sup>262</sup> Early Intervention Paper v8 Reducing the Cost of Common Mental Health Problems; Business Case for IPAT Service 2010

- New flexible inpatient unit acts as a hub for all younger adult mental health provision, collocating the joint CMHT with inpatient facilities, sharing information and supporting the end-to-end care pathway

#### 8.6.6.4 Business

- Benefit for States of Jersey from the reduction in sickness due to depression and anxiety and therefore associated Social Security payments
- The population benefits from the improvement of the mental health and wellbeing of those of working age, assisting the economy through further generation of taxes

#### 8.6.7 Risks

- Recruitment and retention of the right type of staff remains a challenge. Changing to a new service delivery model, which is more flexible and patient centric, may compound this, and staff will need to be supported through the change
- Investment would be required to introduce the IAPT service. This has been estimated to be approximately £700k (although UK pathfinders started with £200k in 2007)
- Unmet need might be identified, reducing the savings predicted through an increase in demand
- The diminishing number of service users of this age range could undermine the critical mass required to diversify service provision
- Funding arrangements currently present a challenge, with the spend being by HSSD and the benefit being mostly to reduce sickness absence in working age adults benefiting Social Security

## 8.6.8 Implementation timetable

Initiative	Timescale	Action
<b>Development of Tier 1/Tier 2 Services</b>	June 2011	Business planning to develop the community team
	October 2011	Workforce plan to develop and fund new roles
	January 2012	Funding agreement for new model
	March 2012	Advertisement for community team roles - phased
	September 2012	Establishment of initial community team (nursing team at Overdale to be recruited post build)
<b>Development of Overdale site</b>	June 2011	Business planning for development of the Overdale site for the movement of services from the St Saviour site
	January 2012	Capital investment funding agreed
	April 2012	Phased building commences - repatriation of patients to be built in
	March 2014	Build completed
	March 2014	Repatriation of patients from Orchard House and Maison Du Lac completed
	June 2015	Full sale of St Saviour site – capital receipt
<b>Single care pathway</b>	June 2011	Review of current service provision across health, social care and the third sector
	October 2011	Procurement of IT package to develop the citizen's portal
	October 2011 - January 2012	Redesign the pathway with single point of access and care co-ordinators
	November 2011	Recruitment to citizen's portal and care co-ordinator posts
	February 2012	Population of citizen's portal
	March – April 2012	Training of care co-ordinators
	June 2012	Pilot commences
	October 2012	Review of pilot
	January 2013	Phased roll out
<b>Personalisation and diversify the market</b>	May 2011	Introduce a person-centric philosophy across the department
	September 2011	Undertake a review of all service provision by the States and other providers and identify services that could be tendered
	April 2012	Manage the market by consulting with existing and potentially new providers about how they might diversify, offer new services, or work differently to help meet users' needs
	June 2012	Market stimulated to attract new entrants. This could particularly be for provision of services in areas where there are potential gaps in the market, such as adult eating disorders or further private psychological therapies

Initiative	Timescale	Action
	September 2012	Competitive tendering to stimulate the market and ensure value for money and consistency of service provision, access, care and quality
	January 2013	Subject to legislative changes develop an approach to guided budgets based on review of previous

### 8.6.9 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Met	Strengthening the current service provision and the introduction of additional services to support the population further in the future Tier 1/ 2 services provide additional community support to maintain service users independence, offering early intervention for low level mental health needs The development of Overdale provides a safe environment for the future in a flexible service model – with its flexibility being critical for sustainability as the younger adult population declines
<b>Ensure Clinical/service viability</b>	Met	Co-ordinated approach to care including the third sector, to strengthen the care for service users Health and social care teams working together to meet the needs of service users, supporting one another and working to the same objective
<b>Ensure financial viability</b>	Met	Capital investment is required to improve the quality of the service provision The preventative aspects of Tier 1 / 2 services should assist with ongoing financial viability, and the repatriation of service users, enabled through the flexible environment, ensures spend is retained within Jersey
<b>Optimising estate utilisation</b>	Met at cost	Integrates estate provision across health and social care through the development of the Overdale site and the sale of St Saviour
<b>Workforce utilisation and development</b>	Met at cost	Additional roles created to support workforce development, career enhancement and recruitment and retention. However, this requires investment particularly in psychology and nursing, and training and support in new roles and working practices
<b>Clinical governance</b>	Met	Services more integrated across health, social care and the third sector to develop clinical leadership and support the risk management strategies for managing complex service users within the community Improved quality and flexibility of inpatient facilities should also support safety
<b>Use of business intelligence</b>	Met at cost	An investment in IT for the information hub as well as a co-ordinated approach to a single care pathway is required

## 8.7 The Child

### 8.7.1 Outline of service

The overriding focus for children's services is to improve outcomes for children measured in terms of their health, social well-being and educational attainment. Achieving that aim requires close working between States departments and the independent and third sectors, with a shared vision and objectives.

In December 2010, the Children's Policy Group released for consultation, the Strategic Framework for the Children's and Young People's Plan. The consultation is until 15 February 2011 and the revised approach is due out in Spring/ Summer 2011. This plan has four key principles and seven key outcomes<sup>263</sup>.

### **Our vision**

We want all children and young people to grow up in a safe, supportive Island community in which they achieve their full potential and lead happy, healthy lives.

### **Our principles**

Four core principles underpin this vision:

1. the welfare of all children is a principle consideration
2. a focus on early intervention in order to prevent problems developing and escalating thus reducing the need for high cost targeted and specialist services
3. services must be designed and commissioned based on need, impact, effectiveness, efficiency and value for money
4. we must work in partnership across sectors to ensure best use of knowledge, expertise and resources

### **Seven outcomes**

Seven key outcomes have been identified which will help make our vision a reality. These outcomes will be delivered in accordance with our principles.

We want all children and young people to:

1. be healthy
2. be safe
3. achieve
4. grow in a stimulating, nurturing environment
5. be responsible and respected
6. have a voice and be heard
7. move confidently into adulthood

It is envisaged that the strategic options to follow are in line with the vision, principles and outcomes which the Children's Policy Group wish to achieve for the children and young people of Jersey.

<sup>263</sup> Children and Young People, A strategic framework for Jersey; Consultation Summary; December 2010 p5

When children are referred to Social Services they should have one timely multi-disciplinary assessment using a consistent framework. Each child should have an allocated social worker - a care “coordinator” - who would help “navigate” him/her (and his/her family) in agreeing a suitable care package.

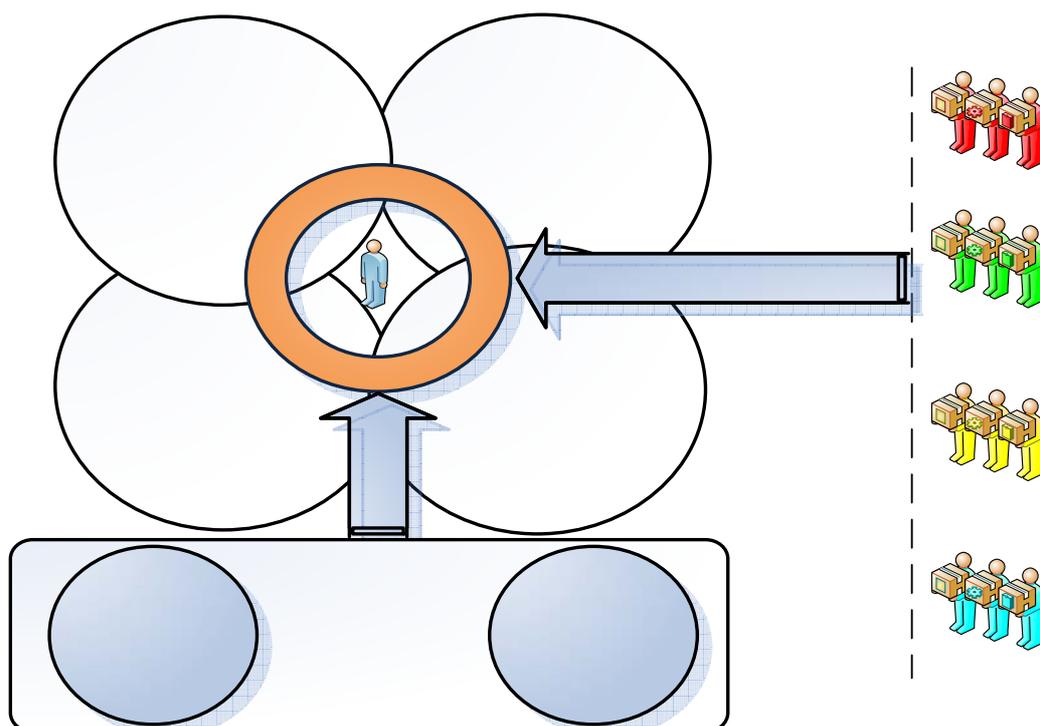
Where children need to be accommodated by the care system, because earlier interventions either were not undertaken or unsuccessful, they should be placed in settings which offer permanence and stability.

Where children come from complex families there should be a holistic approach to addressing the needs of the child and the family.

The recent re-structuring of Social Services is totally consistent with this vision and approach.

This vision is illustrated schematically below.

Figure 76: Example service structure for The Child



To fulfil this ambition there are several initiatives which the States should develop both to enhance services and facilitate their implementation. These are:

- early intervention
- services “wrapped around” the child
- diversify provision through market management
- a professional fostering service

- a fully integrated service delivery model

#### 8.7.1.1 Early Intervention

Early intervention is designed to improve outcomes for children and reduce the need for (higher cost) reactive services later in both childhood and adulthood. Several studies suggest that targeted early intervention in the life of a child can save significant costs later in life. Some Western European countries such as Denmark, Finland and Sweden have invested relatively heavily in preventative services. In the UK the Children's Services Development Group - a coalition of eight providers of foster care, residential care and specialist educational services - has estimated that a £1 investment in early intervention leads to a £9.20 saving in later life. Further support is provided by a Greater London Authority study (January 2011) that makes the case for early intervention based on benefits such as reduced emotional and behavioural disturbance, teenage pregnancy rates, and youth offending. The Oregon study in the US that, for every \$1 spent on up to 18 years old the downstream value was \$7, based for example on reduced offending and better educational outcomes. In all cases the benefits are the result of better health and reduced crime as well as the need for less social care. Of course, with this "invest to save" approach it can be several years before the benefits are realised. And whilst the logic of this approach is strong, more compelling long term evidence is likely to be required before early intervention strategies are adopted universally.

The appetite to invest in early intervention is a further consideration. Traditionally, many local authorities in the UK have expended significant efforts in keeping children with their birth parents, but the appropriateness of this is sometimes challenged. For example, in their publication *In Loco Parentis* Demos (supported by Barnardo's) describe the adverse effect on the child of "delay, drift and impermanence" when earlier action might achieve greater stability and ultimately better outcomes. The UK government is also encouraging a speedier approach to adoption services where it is clear there is no possibility of reintegrating a child with his/her birth parents. These are social work practice management issues which need further consideration in the Jersey context.

Although this concept is not entirely new for Jersey, an early intervention service would formally be established, piloted and evaluated. Two community based Early Intervention workers<sup>264</sup> would be deployed (or redeployed) and their portfolio of work would comprise vulnerable children (and their families), based on risk profiling and the output of the common assessment framework where the child was profiled as being at risk of developing negative outcomes. Initially they would focus on targeting potentially "at risk" children from pre-birth to 5 years old, as research has indicated that that this is the most impactful time for interventions.

Early intervention workers would:

- Agree and secure a complete package of support to combat the potential negative outcomes before they materialise, including access to CAMHS and educational services where appropriate
- Ensure that a child's assessment of need (and that of his/her family) is matched with the services they receive

<sup>264</sup> If additional posts required it is anticipated that this would be at the cost of 2 social worker assistants at 2010 salary of £40,000 each - £80,000 cost

- Deliver targeted services at tier 1 and/ or tier 2 levels to support children in the early years. Their work may be focused as much on parenting skills as the direct needs of the child.
- Ensure the various agencies and departments work collaboratively - it is anticipated that these roles would be employed through the HSSD, however, this role could alternatively be commissioned from the third sector or could span into education.

The success of this approach is measured by the reduction in the risk (and ultimately the occurrence) of children being looked after and accessing foster care or residential care at significantly higher cost. Benchmarking of Jersey against UK comparators indicated that 20% of current Looked After Children may be capable of being reintegrated into families. It is estimated, however, that a potential saving of £600k per annum could be made by 2020 by implementing a phased approach to reduce the number of Looked After Children by 12% between 2013 and 2017.

Deploying the early intervention model at scale in Jersey would require some service reconfiguration, for example in switching to a more community based midwifery service. Ultimately the States needs to identify the type of service that best meets the needs of the island, taking full account of UK and wider experience. Whatever the decision, an early intervention service should not be established in a way that risks compromising the level and quality of frontline services.

Whilst the full cost of such a service will be borne by social services, many benefits will accrue over time to other departments e.g. police, education, and social security. Therefore, any early intervention service needs to be viewed in a States-wide context with support from other departments (through direct funding or staff time).

#### 8.7.1.2 Wrap around the child

“Wrap around the child” is, as the name implies, a child-centric approach which is underpinned by multi-disciplinary working especially between health and social care. It is important that the Parishes and third sector partners are fully integrated into this way of working and not delivering services which are disparate or not closely linked to States-run services.

Each child in the care system would have an allocated professional, who will act as a care coordinator, and may be a social worker, nurse, or other care worker. That person is responsible for coordinating the care for the child, ensuring a multi-professional assessment based on a Common Assessment Framework, and then overseeing and reviewing the delivery of the agreed package.

Introducing this care co-ordinator role is not about adding another layer of bureaucracy. It aims to utilise trained and experienced professionals in a role which enables a more seamless and targeted set of services to be provided. Therefore, it is assumed that although some new posts may be created it is anticipated that this change of practice would be implemented by redeploying current professionals within the Community and Social Services team.

Where appropriate, the Common Assessment Framework will consider the needs of the family as well as the child, supporting them to meet the identified needs of the child. The care coordinator would lead case conferences for “complex families” i.e. those families which place a disproportionate financial burden on States services.

The assessment process would be aided by technology, with forms completed on line and available to all members of the multidisciplinary team, as well as the child and his/her family. Using technology in this way would help embed multi-disciplinary working into practice management, avoid duplication, and help ensure a coherent approach. The citizens' portal would provide real time information regarding service availability, self care, family support groups etc, to assist the child and family with feeling more in control of their situation.

GPs and school liaison officers (with appropriate training) would act as the main referral gateway for child and adolescent mental health, although referrals would be received from any source. They would refer directly into the newly established Early Intervention service. Again, there would be a common assessment (including a psycho-social assessment) and a consideration of family relationships, to identify negative influences and early signs of the need for intervention.

Other features of a "wrap around" children's service include:

- Volunteers taking on a larger role in the delivery of children's services, but as part of an overall support network commissioned and performance managed by the States
- Closer working with support agencies such as The Bridge, to secure access to a wider range of services and practices, and to inform the management of complex families
- More community based services with outreach roles to help identify and stop complex families propagating negative behaviours which present a risk to children. Examples would include a community midwifery service, a parenting partnership champion, and a high intensity family preservation service

### 8.7.1.3 Managing and diversifying provision

Provision of health and social care for children and their families in Jersey is currently dissipated across multiple agencies (physical and mental health, social care, police, housing, education, private sector and third sector). This diversity of provision is very necessary provided that the States, as commissioner, ensures that it facilitates a coordinated way of delivering service which represents good value for money.

However, many departments and agencies work to some extent in isolation, and within a remit that they (themselves) have determined. The States does not always have clear information about service provision or the performance of service providers. Often there are no robust contractual arrangements between the States and a third party provider – instead, Service Level Agreement specify indicative activity levels against a level of grant funding.

Managing and diversifying the child and family provision for Jersey would require market management, as outlined in the 'Older Adults' section of this scenario. This would include working with existing and potentially new providers to discuss what services they might provide and how, in order to help the States achieve its goals and secure value for money.

Overall, more robust commissioning, procurement, and supplier management is required. But such a commercial approach should not undermine an ethos of partnership working or result in adversarial relationships. However, it does mean that the States has to clarify its service requirements and how they fit into the overall care system, understand exactly what activity it is receiving for what cost, and actively performance manage all contracts and service level agreements. It should view competitive

tendering as the norm rather than the exception, and should minimise spot purchasing in favour of longer term call off contracts. It is difficult to predict the benefits of a more commercial approach, but evidence from the UK suggest that savings of the order of 10% to 15% in third party spend should be readily achievable the size and culture of Jersey may mean that this would need to be moderated down to 5-10%.

Features of this approach will include:

- Collating cost and activity data for each service to project demand, unmet demand and understand the financial consequences
- Predictive modelling to project the impact of demographic pressures, changes in placement settings and changes in the approach to care management
- Comparing services on a like for like basis to identify those that may benefit from outsourcing. Some services would require improved data accuracy and integrity to enable meaningful benchmarking
- More mature working through partnerships with the third sector and private providers to consider how outcomes and value for money can be improved
- Identifying and targeting gaps in Jersey's provision (such as transition to adulthood, or 13 years+ Looked After Children), then shaping and developing market provision
- A culture which enables staff to develop and innovate in order to boost productivity and be more creative in designing and delivering services
- Commissioning collaborative models e.g. with Guernsey, with the UK, or between States services, for dealing with low incidence and high cost provision which can lead to excess/unused capacity e.g. the children's secure unit
- Incentivise suppliers by using payment mechanisms such as risk/reward based on the achievement of individual child outcomes

#### 8.7.1.4 Professional fostering

Professional fostering would reduce the demand on facility based care, improve outcomes for children and reduce costs. The cost reduction is predicated on moving sufficient children out of facilities and into fostering, such that some fixed and semi-fixed costs could be released.

Professionalising and increasing the status and profile of fostering would hopefully lead to an increase in applications to become a professional foster carer. It should also incentivise adept foster parents to take on more challenging children. However, anecdotal evidence suggests that, at present the supply of foster carers is constrained by the high proportion of households where both adults work – it is estimated, for example, that over 80% of women of a working age are in paid employment. The payment levels for professional foster carers should reflect this constraint.

Adoption would remain an appropriate solution for children who will not return to their birth parents. Enhancing the adoption process would require children to be identified early and matched to potential adoptive parents in an initial fostering role with an opportunity to progress to adoption if the child cannot return to their parents. For example, the charity Coram has a unique partnership with the London Borough of Harrow that is focused on improving care management decision making and is resulting in children being placed earlier and quicker, and in greater numbers. It has been rated as an outstanding feature in Ofsted's report of 2010.

Features of professional fostering would include:

- A focus on moving children aged 12-20 with challenging behaviour or complex needs into a fostering family environment
- Using professional fostering both as a long term arrangement or as a respite model, with the aim of reducing reoffending rates and boosting the employment rates of young adults and those in transition
- Incentivising foster carers to take on children by paying an increased grant, broadly equivalent to Jersey average earnings
- Financing this initiative (at least in part) from the saving made by moving children out of institutionalised settings or an off island environment
- Integrating the foster family into a team of carers and specialists to provide the appropriate level of care to meet the child's needs
- Supporting foster carers with specialist training to handle complex needs or challenging behaviour
- Adopting a buddy system between foster carers to provide community support
- Reconciling professional fostering with any working time directive which is applied in Jersey
- Considering a multi-tiered system of professional fostering in which remuneration is proportionate to a child's assessed level of need, as introduced in The Isle of Man
- Developing a points system similar to that of the Youth Justice Board to reward and incentivise positive behaviour amongst complex children
- Linking fostering to adoption – known as a “concurrency” model - to minimise the time spent in care by those children who have no prospect of returning to their family environment

The principal aim of professional fostering is not to outsource placements to independent fostering agencies. Rather, it is focussed on the States supplementing its current supply of foster carers who could potentially foster more complex children. This model is not a 'one size fits all' solution; the varying levels of complexity of children means that it would only be suitable for some cases.

Given the challenges faced by Jersey i.e. a high proportion of families where both adults work and households that lack spare bedrooms, it is anticipated that 10% of Looked After Children could be placed with professional foster carers.

This may incur additional costs as the saving in residential care may not outweigh the cost of the foster care (estimated to be £36k p.a per foster family, therefore a total of £300k p.a based on 9 children), however there would be better outcomes and future prospects for the child. It is anticipated that the two care co-ordinators would work intensively to place the children, with a caseload of 4-5 children each.<sup>265</sup>

Combining this with a concurrent model of adoption – the Harrow model above – provides an opportunity to take children out of the care system altogether by providing high quality, personalised support in a family setting. Reducing residential care placements by a critical mass would support the reduction of fixed and semi-fixed costs.

<sup>265</sup> Period of 2012 – 2017 modelled for placements to be intensively managed and to move from 1 – 9 moved from residential to foster care in this period

### 8.7.1.5 Integration

The welfare of children is the responsibility of multiple agencies. Integrated working requires agreed processes to identify needs and wrap services around the child to meet those needs. It should ensure there are no gaps or overlaps between services in health, social care and education, and those provided by other departments and agencies.

A partnership working approach needs to:

- Identify the key stakeholders (inc education, mental health, third sector)
- Agree the governance mechanism e.g. children's strategy steering group
- Agree common aims and objectives
- Map 'as is' services, and in so doing identify gaps and overlaps, and then map the re-designed "to be" services
- Map processes, from referral through to completion and follow-up
- Identify communications routes between agencies and assess effectiveness
- Agree Key Performance Indicators (preferably outcome measures) for each service
- Agree funding routes and budgets
- Agree and implement an action plan, with full accountability and frequent progress monitoring

Jersey already undertakes some of the above. However, some stakeholders have expressed a view that further work is required. The aim would be that, by 2012, the States of Jersey has a compelling, multi agency delivery plan, which is owned by all relevant agencies, a clear action plan to achieving this vision, and has made significant progress towards the goal of delivering outcome-based, integrated services to meet the needs of children and their families.

Examples of opportunities for increased integration include:

- In 2010 there were 1390 safeguarding referrals. A recent social care audit revealed that more than 80% of these referrals were from the police and almost 50% of these were declared "No Further Action" after investigation. This phenomenon is not uncommon with UK local authorities where police forces are taking a risk averse approach to domestic violence incidents they attend. However, it suggests that in Jersey there needs to be more collaborative working to stem the flow of inappropriate referrals.
- Child and Adult Mental Health Services (CAMHS) and Children's Services have been managed separately, although following Williamson's recommendations the proposed organisational restructure is seeking to amalgamate these services within a Children's Directorate
- Uncertainty and inconsistent views have been expressed by professional staff regarding the extent to which it is possible, legally or ethically, to share data and intelligence about children. Clearly, the better intelligence available in a child's assessment the more likely it is that the correct decision will be taken, the right package will be assembled, and the desirable outcomes will be achieved. Moreover, lessons learned from serious case reviews in the UK indicate that a lack of communication between agencies is a fundamental issue leading to "missed opportunities" to provide appropriate care to children. It is imperative that there is a clear position statement and agreement on a data sharing protocol that does not lead professionals to different interpretations.

Features of the integrated approach will include:

- A Children’s Directorate, amalgamating Children’s Services and CAMHS, including education services (in particular educational psychologists) to provide a child-centred, co-ordinated approach
- Enhanced Tier 1 and 2 Early Intervention services, delivered in primary care and/or through community services, either as outreach from HSSD or by an enhanced GP role
- Early involvement of partners e.g. GP and other agencies, to enable children and their families to gain access to the right support quickly, thus promoting stability and avoiding service gaps or a ‘revolving door’ situation
- A training programme on mental health issues for partner agencies e.g. schools, third sector, so that they can confidently identify, refer and support children

### 8.7.2 Activity Implications

Due to the fact that the options are inextricably linked, it is projected that there would be a composite change in activity, which is outlined below. These activity changes are based on 12% of children (approximately 9 children) moving from residential to foster care and a 12% reduction in children entering the Looked After Children system due to early intervention initiatives (phased in between 2013 and 2017). In addition:

- More activity would be delivered through partner organisations and providers
- The activity type remains broadly the same but levels reduce
- Activity levels would diminish and activity type would move away from facility based care towards a more community setting of care
- Service provision becomes more integrated, delivered wherever possible in a community setting

Grouping	Projected change to 2020
<b>Safeguarding referrals</b>	Reduction from 1390 referrals in 2010 to c1225 referrals p.a in 2020
<b>Looked After Children</b>	Reduction from 77 children in 2010 to c62 children in 2020
<b>CAMHS referrals</b>	Reduction from 330 referrals in 2010 to just less than 280 referrals p.a in 2020
<b>FNHC child visits</b>	Reduction from 22,484 visits in 2010 to c21,000 visits p.a in 2020

### 8.7.3 Staffing Implications

A range of professionals are involved in early identification of issues and the referral of children into early intervention services. It should be noted that not all staff are outlined below, and the current service delivery model and associated staffing will need to be considered as part of the development and operationalisation of the integrated, holistic children’s model of care.

Primarily, the strategic scenarios outlined here would require a substitution of roles rather than a significant number of additional posts, therefore, redeployment and if necessary, retraining, of the existing workforce would be more likely than large scale recruitment. For example:

- A new role of care coordinator would be created to provide support to complex families and children. This does not necessarily require additional recruitment as it could be undertaken by redeployed of social workers or other appropriate care professionals
- Staffing structure and coverage would be reviewed holistically, taking into account coverage across private, public and third sector with gaps and overlaps identified and addressed
- More staff would be deployed onto Earlier Intervention programmes – estimated to be two additional posts at a cost of £80k p.a.<sup>266</sup>
- Staff would be deployed from facility based care towards more support based roles for foster carers – estimated to be two social workers at a cost of £120k p.a.<sup>267</sup>
- It is estimated that as staff retire or leave, the staffing structure is reviewed and adapted to accommodate the new way of working.

<sup>266</sup> Based on the 2010 social worker assistant salary of £40,000

<sup>267</sup> Based on the 2010 social worker salary of £60,000

	Number of staff	Projected cost in 2020 (£)
<b>Children's Safeguarding and Community Support (excluding CAMHS)</b>	■ Slight reduction in staffing – staff to be redeployed	Redeploy social worker post to care co-ordinator role in the professional fostering team – cost at 2010 salary £60k p.a
<b>Looked After Children</b>	■ Slight reduction in staffing – staff to be redeployed	Redeploy social worker post to care co-ordinator role in the professional fostering team – cost at 2010 salary £60k p.a
<b>Secure</b>	■ Staffing establishments as at 2010	Reviewed in line with the professional fostering strategy and the future operational policy for the secure unit i.e. work more closely with Guernsey
<b>Residential</b>	■ Staffing establishments as at 2010	Reviewed in line with the professional fostering strategy
<b>Respite Care</b>	■ Slight reduction in staffing – staff to be redeployed	Reviewed in line with demand for respite care
<b>CAMHS</b>	■ Staffing establishments as at 2010	Review in line with the introduction of the early intervention service and 2 additional social care assistants – cost £80k p.a
<b>Speech and Language Therapy</b>	■ Staffing establishments as at 2010	Reviewed as part of the overall service model
<b>Occupational Therapy<sup>268</sup></b>	■ Increase in staffing establishment by 3 fte occupational therapists	Reviewed as part of the full social care strategy to move from residential to community care across all age bands
<b>Psychology<sup>269</sup></b>	■ Staffing establishment increases by 1 fte	Review in line with the introduction of the early intervention workers in the children's service but also the introduction of the tier 1 and 2 service in younger adults

#### 8.7.4 Revenue and capital implications

As noted above, most of the changes to service provision are cost neutral, as they involve a redeployment of existing staff. Other staffing changes involve a reduction of 1 RCCO care worker (respite), and an increase of 2 social care assistants as Early Intervention Workers and 2 Care Coordinators (as social workers) with a net cost implication of approximately £170k.<sup>270</sup> There are

<sup>268</sup> The numbers are for the occupational therapist department and therefore is not specific to children but is noted here for completeness

<sup>269</sup> The numbers are for the psychology department and therefore is not specific to children but is noted here for completeness

<sup>270</sup> Based on £200,000 additional costs for 2 EI workers and 2 CC minus the saving from the FSW care worker on £30,000 salary based on HSSD ledger 2010 of £206,000 salary costs for 7 staff

revenue implications attached to the additional Early Intervention workers of approximately £80k p.a<sup>271</sup>.

Operational costs such as office space, IT, infrastructure and license costs would need to be considered, subject to agreement in principle, as part of the development of a business case.

### 8.7.5 Funding implications

No changes to funding mechanisms would be required as the introduction of the early intervention option (saving c£600k p.a) could offset the cost of the introduction of the professional fosters (costing c£300k p.a).

### 8.7.6 Benefits

#### 8.7.6.1 Service user / carer

- Supporting children earlier has the potential to greatly improve the outcomes and life chances for the children and young people of Jersey
- Services which are 'wrapped around the child', working across agencies including education, would ensure that the care package meets a multiplicity of needs for the child and their family, and also provides a very clear focus for all professionals involved in their care
- Children would be looked after in foster families, reducing the need for longer term residential care and providing a better opportunity to integrate, have stability and support and improve life chances
- Children who are unable to return to their birth family would be identified early and adopted, providing stability by reducing the number of foster parents he/she has, or the time spent in residential care
- A Common Assessment Framework would enable a multiplicity of needs to be assessed and services planned to meet these needs in a coordinated manner
- Care coordination would assist the child and their family with feeling in control of their situation. It would offer choice and support independence
- Closer working between multiple agencies

#### 8.7.6.2 Quality

In addition to the quality benefits above,

- Improved sharing of information between professionals reduces duplication and gaps in provision and therefore reduces risk

#### 8.7.6.3 Workforce

- Retraining and redeploying staff and developing them to focus in key areas could also improve recruitment and retention and staff morale
- Integrated working fosters team spirit, with the focus on the child's needs. This can improve morale and job satisfaction
- A Children's Directorate should provide clear leadership for those professionals involved in the care of children

<sup>271</sup> Based on the 2010 salary of a social worker assistant of £40,000

### 8.7.7 Risks

- Cultural risks regarding professional fostering - there may be a limited pool of appropriate foster carers on the island. However this should not dissuade the Community and Social Services team from considering the option given the potential benefits for the child
- The success of 'wrap around the child' requires an integrated approach across agencies such as education, criminal justice, housing and police and the potential to pool staff and budgets as necessary and relevant
- Staff may be resistant to change, particularly to a new Children's Directorate
- Challenges with sharing information across agencies
- The Common Assessment Framework would need to consider a range of care needs without becoming unwieldy and time consuming
- The care coordinator role may require a change in focus / mindset for some professionals

## 8.7.8 Implementation Timetable

Initiative	Timescale	Action
<b>Early Intervention</b>	September 2011	Develop business case to include a plan for a pilot
	October – December 2011	Detailed planning for pilot; indentifying staff, developing processes, identifying a subset of children for the pilot
	January – November 2012	Pilot
	December 2012	Evaluation of pilot
	January 2013	Phased roll out programme
<b>Wrap Around The Child</b>	September 2011	Develop business case focussing on the inter-agency operating model that would facilitate the approach Design and agree a common assessment framework
	October – December 2011	Identify cohort of children and families Detailed process design and identification of the lead professionals
	January 2012	Implement the common assessment framework
<b>Managing and diversifying provision</b>	September 2011	Statement of outcomes/ outputs and key performance indicators to be standard for all suppliers
	October – December 2011	Implement new performance management regimes for all services providers, States and external. Where appropriate discuss and renegotiate existing service contracts Conduct soft market testing of potential suppliers
	January 2012	Embark on an incremental programme of re-specifying and retendering contracts and renegotiating SLAs
<b>Professional Fostering</b>	September 2011	Develop a business case for the introduction of professional fostering
	October – December 2011	Subject to approval in principle, renegotiate or agree a new package for foster carers (the differentiated scale of payments) Identify the care coordinators
	January – June 2012	Identify suitable children Advertise and recruit to expand supply of foster carers and in readiness enhance the current support network for foster carers
	July 2012 onwards	Phased programme of placements
<b>Integration</b>	September 2011	Identify the agencies involved in integration
	November – January 2012	Develop a memorandum of understanding for the principles of how the agencies will work together Determine which budgets/ posts could be pooled across States departments such as education and HSSD
	February – March 2012	Determine if there are any legislative requirements for pooled budgets and shared working
	April 2012	Agree protocol and begin 'shadow form' of new ways of working Commence any legislative requirements

The above implementation plans will depend on more integrated working between the States department and external agencies. There will need to be a removal of any barriers to integrated working to allow pooling of budgets, virtual or real, and pooling of staff across departments. This will enable the implementation of the single process with a single line of responsibility and accountability.

The direction of travel of these proposals for integrated working, align wholly with the Children and Young People's plan currently out for consultation.

## 8.8 Strategic Imperatives met/unmet

Service design principle	Met/Unmet	Justification
<b>Create a sustainable service model</b>	Met	<ul style="list-style-type: none"> <li>■ An integrated model for children’s health and social care leads to a seamless service which meets the needs of children and their families</li> <li>■ The Children’s Directorate would take a lead role and would ensure all services for children are identified, planned and monitored to ensure service sustainability, productivity and appropriateness</li> <li>■ The quality of service is increased, leading to improved health and social care outcomes</li> <li>■ Joint working across multiple agencies further support the sustainability of services</li> </ul>
<b>Ensure Clinical/service viability</b>	Met	<ul style="list-style-type: none"> <li>■ The model creates an improved system for identifying and managing children’s health and social care. This includes better management of safeguarding referrals through collaborative working, and access to a wider range of services to better manage complex needs</li> <li>■ It also creates a culture of continuous improvement so that future needs of children are identified and services are developed accordingly</li> <li>■ Diversifying and managing provision drives value for money and quality benefits, with robust contracts agreed, incentivised and monitored</li> </ul>
<b>Ensure financial viability</b>	Met	<ul style="list-style-type: none"> <li>■ An integrated approach creates efficiencies for service delivery through early involvement of partners or agencies to gain access to the right support quickly</li> <li>■ The improvement in the level and quality of service provided ultimately helps to improve children’s health and social care and the benefits associated with improved outcomes</li> <li>■ Diversifying and managing provision drives value for money and quality benefits, with robust contracts agreed, incentivised and monitored</li> </ul>
<b>Optimising estate utilisation</b>	Met	<ul style="list-style-type: none"> <li>■ Activity would move away from facility based care towards a more community foster setting of care. This creates capacity to provide other health and social care services within the same facilities such as community support groups, as outlined in the ‘Self Care’ section of this scenario</li> </ul>
<b>Workforce utilisation and development</b>	Met	<ul style="list-style-type: none"> <li>■ Adopting an integrated multi-disciplinary approach to children’s health and social care services leads to an improvement in practice, reducing duplication and enabling staff to develop and innovate. This would improve productivity and creativity in designing and delivering services</li> <li>■ Integrated working, supported by the Children’s Directorate, along with enhanced roles such as the care coordinator, would provide more attractive career paths for professionals and enable skills to be optimised</li> </ul>
<b>Clinical governance</b>	Met	<ul style="list-style-type: none"> <li>■ “Wrap around the Child” and “Early intervention” provides improved access to a wider range of services and helps to identify, manage and support complex needs</li> <li>■ The Children’s Directorate would take a strong leadership role, supporting all professionals</li> <li>■ Closer working with other departments and agencies would reduce gaps in service</li> <li>■ The Common Assessment Framework and an agreed care plan would ensure that the multiple inputs from care professionals are coordinated, minimising risk and supporting safeguarding</li> </ul>
<b>Use of business intelligence</b>	Met at cost	<ul style="list-style-type: none"> <li>■ Investment in IT through an information hub, combined with a coordinated approach to a single care pathway leads to robust business intelligence to evaluate the outcomes of children’s health and social care, leading to an</li> </ul>

Service design principle	Met/Unmet	Justification
		improved approach for assessing on future needs and services requirements.

## 9 Enablers and levers

Aside from a robust and cohesive approach to redesigning health and social care services, the right environment and tools must be adopted in order to help facilitate success. The following key enablers and levers should be considered when attention turns to the development of detailed service planning and implementation.

Figure 77: Enablers and levers



### 9.1 Clinical and service professional leadership

Health and social care economies that have strong clinical and professional leadership are more likely to be successful in implementing large scale change. Clinical and service leaders must be fully engaged in, and understand, the development and implementation of any change. They must also be visible and vocal leaders in order to bring their peers with them on the change journey.

### 9.2 Strategic alignment

Island wide strategic objectives between all key stakeholders need to be aligned between not only health and social care, but together with primary care providers and key third sector organisations. Incentives, performance and financial, need to be developed so that the right behaviours are encouraged. For example, either working within existing funding legislation, or using new approaches, an outcome based approach should be developed in order to encourage joint achievement of goals, rather than an activity and transactional nature of funding that encourages organisational introspection and silo working.

### **9.3 Visibility, reporting and informatics**

Data must support decision making in the ongoing development and implementation of this work. Metrics must be defined that provide reassurance of progress and the impacts of system change, as well as provide guidance to staff who are the subject of change and evidence for stakeholder communications and engagement.

### **9.4 Programme management**

The implementation of a new system of the scale of this work needs to be managed using a formal and professional programme management and implementation approach. This is crucial when dealing particularly with services the public depend on, such as health and social care, in order to mitigate risk and to clearly evidence the effective use of public funds.

### **9.5 Communications and stakeholder engagement**

Building confidence in a programme of change is critical to success. A focused approach to communications, coordinated by a long term plan and strategy, will help ensure that targeted, consistent messages reach both staff and the public. Communication of early successes will generate momentum for change.

### **9.6 Knowledge sharing and learning**

The process of implementing change will go through periods of success and challenge. To facilitate a culture of learning dedicated time should be protected to step away from day to day tasks and consider learning points from the experience of staff and stakeholders. This will be difficult, as taking time away from busy operational and front line roles is not easy, however the rewards of ensuring that best practice and successful approaches are disseminated across those taking the programme forward will mean risks to delivery are mitigated and successes are shared.

### **9.7 Benefits realisation and tracking**

Defined outcomes should be identified and agreed across the health and social care economy in order to clarify what success looks like. What success means should also be clearly defined, for example the resultant impacts upon resources, staffing and capacity. Using this approach progress towards set goals can be clearly monitored and decisions made about how efficiencies created can be re-utilised by the system.

### **9.8 Clinical and service governance**

In periods of change it can be difficult to maintain quality standards while staff and the public become accustomed to new ways of working. It is also essential that new methods of working either replicate or improve upon prior quality and delivery standards. Clear agreements should be reached across all key stakeholders regarding what the levels of expectation are in terms of quality and service delivery, and performance management metrics agreed so that any reduction in quality can be preventing or swiftly identified and rectified.

## 10 Conclusion and recommendations

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 costs of health and social care delivery in Jersey 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. 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 SoJ 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.

The potential changes to health and social care in Jersey are significant. It is imperative that, in developing the business case, the detail of the future model and the implementation / transition plans are fully considered, to ensure the ongoing viability of the service and to ensure stakeholders are fully supported through the change.

### *Next steps*

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

- 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
- 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 in order to secure approval for the implementation of a strategic change programme
- Secure the required change management capacity (leadership, governance and resources) to plan and effect the implementation of the new model of services
- 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.

# 11 References

## 11.1 Self care

Coulter A, Ellins J; Effectiveness of strategies for informing, educating and involving patients. *BMJ* 335:24-7, 2007

Health Promotion International, 15; 259-67

Cost effectiveness of the Expert Patients Programme (EPP) for patients with chronic conditions; *Journal of Epidemiology and Community Health*; Vol.62, Issue 4

Delivering the 'Diabetes Education and Self Management for Ongoing and Newly Diagnosed' (DESMOND) programme for people with newly diagnosed type 2 diabetes: cost effectiveness analysis, *British Medical Journal*, Aug 2010

Whole System Demonstrators : An overview of Telehealth and Telecare; Department of Health; June 2009

Health for life; HSSD, States of Jersey 2010

States of Jersey Tobacco Strategy, HSSD, 2010

Switch On: The Case for Telehealth, KPMG 2010 citing South East Essex COPD pilot site case study

### *Internet References*

Northumbria COPD Integrated Care Pilot <http://www.northoftyne.nhs.uk/news/press-releases/integrated-care-pilot-for-chronic-obstructive-pulmonary-disorder-copd-in-north-tyneside>

## 11.2 Primary Care

QResearch® and The Health and Social Care Information Centre, 2009. Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database. Available at: [http://www.ic.nhs.uk/webfiles/publications/gp/Trends\\_in\\_Consultation\\_Rates\\_in\\_General\\_Practice\\_19\\_95\\_96\\_to\\_2008\\_09.pdf](http://www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_Rates_in_General_Practice_19_95_96_to_2008_09.pdf)

Draft Health Insurance (Medical Benefit) (Amendment No. 3) (Jersey) Regulations 201 May P36/2010. Available at: <http://www.statesassembly.gov.je/documents/propositions/6879-43900-2332010.pdf>

Kings Fund and Department of Health, UK, December 2006. Combined Predictive Model Final Report & Technical Documentation. Available at: <http://www.kingsfund.org.uk/document.rm?id=6744>

Merrill Matthews, 1th January 2006. Medicare's Hidden Administrative Costs: A comparison of Medicare and the Private Sector: Council for Affordable Health Insurance. Available at: [http://www.cahi.org/cahi\\_contents/resources/pdf/CAHI\\_Medicare\\_Admin\\_Final\\_Publication.pdf](http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf)

The Information Centre for Health and Social Care. Available at:  
<http://www.ic.nhs.uk/services/prescribing-support-unit-psu/using-the-service/reference/asures/patient-denominators/astro-pus>

The Johns Hopkins ACG System. <http://www.acg.jhsph.org/>

## 11.3 Acute Care

London Health observatory, February 2007, Save to invest  
<http://www.lho.org.uk/Download/Public/11334/1/Save%20To%20Invest%20-%20Commissioning%20for%20Equity.pdf>

Clinical evidence for enhanced recovery in surgery – MSK, NHS Enhanced Recovery Programme, 2010  
[http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/enhanced\\_recovery\\_programme.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html)

Branch et al; Medicines Management in Theatre, 1993

F Dockerty et al; The effect of reminder calls in reducing non-attendance rates at care of the elderly clinics, 2000

Audit Commission, 2003. Health; Acute Hospital Portfolio: Operating Theatres, Review of National Findings

Bradford Royal Infirmary [www.yorkon.co.uk/bradford-hospital.html](http://www.yorkon.co.uk/bradford-hospital.html) (accessed on 8 March 2011)

Trevor Myers Associates, Mainland Health Activity, October 2010

NHS Modernisation Agency, 2004, 10 High Impact Changes

Primary Care and Emergency Departments; Report from the Primary Care Foundation March 2010 p5

Ambulance Economies; Fischer et al; Journal of Public Health Medicine; 2000; 22 p413-21

Nurse Practitioners: A Healthy Future for New Zealand: Ministry of Health; December 2009

High Impact Actions for Nursing and Midwifery, NHS Institute for Innovation and Improvement; 2009

A vision for emergency and urgent care, NHS Confederation and the Ambulance Network p10 -12, 2008

North East Ambulance Service: Next Stage of Our Vision; May 2008

NHS Manchester Intermediate Care Model, March 2010

Central PBC Commissioning Brief for Clinical Board Urgent care for Children Paediatric A&E September 2010

Cooke et al; Discharge from triage: modelling the potential in different types of emergency department 2003; 20; 131-133; <http://emj.bmj.com/content/20/2/131.abstract>

Cooke et al; Towards Faster Treatment: Reducing attendances and waits at A&E departments; DH; Service Delivery Organisation; October 2005; <http://www.sdo.nihr.ac.uk/files/adhoc/29-briefing-paper.pdf>

Edwards, Jones and While; Evaluating nurse prescribing in acute care: a case study; 3 February 2011; Journal of the Association of Nurse Prescribing: <http://anp.org.uk/category/journals/>

Gwent 'Happily Independent; Strategic Vision for Gwent Frailty Programme, 2009

Frailty Concept/Hospital without Walls, Professor Pradeep Khanna, Aneurin Bevan Health Board

Royal College of Surgeons: Guidance to Trauma for commissioners: November 2009

#### *Internet references*

<http://www.yorkon.co.uk/bradford-hospital.html>

<http://www.rcplondon.ac.uk/specialty/acute-medicine>

[http://www.eoedeanery.nhs.uk/medical/page.php?page\\_id=846](http://www.eoedeanery.nhs.uk/medical/page.php?page_id=846)

Research Literature Review on Nurse Prescribing; Scottish Government, 2004; <http://www.scotland.gov.uk/Publications/2004/08/19843/42006>

Nick Trigg report 3 February 2011 <http://www.bbc.co.uk/news/health-12287880>

## **11.4 Older Adult, social care and mental health**

Glendinning, Challis, Fernandex, IBSEN Personalisation Pilot Review, 2008

NHS Article, Daily Telegraph, No 48,444. 2011

Scott & Knapp, The Cost of Social Exclusion, 2001

Long-term care funding white paper; Social Security Department; States of Jersey; November 2010

Public Health Census of Nursing Homes, undertaken by Mark Richardson, Social Security Department, September 2010

Francis, J; Fisher M; Rutter D; Reablement: a cost effective route to better outcomes: Social Care

Institute for Excellence: Research Briefing 36; April 2011 [http://www.towerhamlets.gov.uk/lgsi/601-650/640\\_activities\\_for\\_older\\_peopl.aspx](http://www.towerhamlets.gov.uk/lgsi/601-650/640_activities_for_older_peopl.aspx)

Gwent 'Happily Independent; Strategic Vision for Gwent Frailty Programme, 2009

States of Jersey, Independent Living for Retired People

<http://www.gov.je/Home/RentingBuying/StatesHousing/AssistedLiving/Pages/CottageHomes.aspx>  
accessed 27 April 2011

States of Jersey, Supported Housing

<http://www.gov.je/Home/RentingBuying/StatesHousing/AssistedLiving/Pages/SupportedHousingGroup.aspx> accessed 27 April 2011

States of Jersey, Medical Adaptations

<http://www.gov.je/Home/RentingBuying/StatesHousing/AssistedLiving/Pages/MedicalAdaptations.aspx> accessed 27 April 2011

New Horizons, HM Government, UK , December 2009

Paths to Personalisation in Mental Health, National Mental Health Development Unit, 2010

Carr S: Personal budgets and international contexts: lessons from Home and abroad: Journal of Care Services Management 5 (1), January 2011

Happily Independent, Strategic Vision for Gwent Frailty Programme, 2009

Liverpool / Marie Curie Care Pathway, Core Documentation V12, 2009

Liverpool / Marie Curie Care Pathway Summary, <http://www.goldstandardsframework.nhs.uk/>

Personalisation House of Commons Select Committee Report, 2010

Report produced by Jersey Regulation and Inspection Manager, Public Health Services, 2010

## 11.5 Younger adult, social care and mental health

Department of Health Programme Budgets, 2009/10

IAPT pathfinders achievements and challenges; Department of Health; October 2008,

Summary of NICE guidelines offering Cognitive Behavioural Therapies; April 2008 and updated December 2010

<http://www.nice.org.uk/usingguidance/commissioningguides/cognitivebehaviouraltherapyservice/summarycbtinterventions.jsp>

Barclay; Mindfulness CBT as effective as antidepressants in preventing depression relapse:  
Medscape: 14 December 2010

No Health Without Mental Health, HM Government, UK, 2 February 2011

Jersey Annual Social Survey, States of Jersey 2009, HSSD quoted in Strategic Plan 2009-2014.  
States of Jersey.

Delivering the Government's Mental Health Policies, Services, Staffing and Costs, Boardman and  
Parsonage, 2007 Sainsbury Centre

Gwent 'Happily Independent'; Strategic Vision for Gwent Frailty Programme, 2009

We need to talk report, Mind, 2010

Improving Access to Psychological Therapies, Department of Health May 2007

The Depression Report; Lord Layard; Centre for Mental Health; 2006

New Horizons, HM Government, UK , December 2009

## **11.6 The Child**

Hannon, Bazalgette, Wood, In Loco Parentis, 2010

Service Birmingham's Looked After Children System ITT, 2008

DCSF, Early Intervention: Securing Good Outcomes, 2010

Children and Young People, A strategic framework for Jersey; Consultation Summary; December  
2010 p5

Commissioning Green Paper Response, Children in Need Charity, 2011

Concurrency in Harrow, Coram Report 2010

Havering ICS Review and Improvement Report, 2010

Looked After Children Social Work Practices Pilot, DWP, 2010

Intensive Fostering Report, Youth Justice Board, 2010

Jackson, S, 'Care past and present' in Chase, E, Simon, A and Jackson, S (eds), In Care and After: A  
positive perspective (London: Routledge, 2006)

Masson, J, Care Profiling Study (London: Ministry of Justice, 2008).

## 12 Glossary

<b>Acronym</b>	<b>Definition</b>
A&E	Accident and Emergency
ACO	Accountable Care Organizations
AHP	Allied Health Professional
BMJ	British Medical Journal
C&SS	Community & Social Services
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CHD	Coronary Heart Disease
CLA	Child Looked After
CMHT	Community Mental Health Teams
COPD	Chronic Obstructive Pulmonary Disease
CRB	Criminal Records Bureau
CSG	Cancer Screening Guidance
CSR	Comprehensive Spending Review
CYPP	Children & Young Peoples Plan
DAFNE	Dose Adjustment For Normal Eating
DESMOND	Diabetes Education and Self Management for the Newly Diagnosed
DNA	Did Not Attend
EAU	Emergency Assessment Unit
ED	Emergency Department
ENT	Ears Nose and Throat
EPP	Expert Patient Programme
FNHC	Family Nursing and Home Care
FSW	Family Social Worker
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GMC	General Medical Council
GNI	Gross National Income
GP(s)	General Practitioners
HCA	Health Care Assistant
HIF	Health Insurance Fund
HNA	Health Needs Assessment
HSSD	Health and Social Services Department
IAPT	Improving Access to Psychological Therapies
IBSEN	Individual Budgets Evaluation Network
ICPW	Integrated Care Pathway and Wellness
ICR	Integrated Care Record
IT	Information Technology
ITU	Intensive Therapy Unit
IVF	In Vitro Fertilisation
KPI	Key Performance Indicators
LAC	Looked After Children
LoS	Length of Stay
LTC	Long Term Care
LTC	Long Term Condition
LTCB	Long Term Care Benefit
MDT	Multi Disciplinary Team
MH	Mental Health

MOG	Ministerial Oversight Group
NHS	National Health Service
ODP	Operating Department Practitioner
OOH	Out Of Hours (service)
pa / p.a.	Per Annum
PAS	Patient Admin System
PAU	Paediatric Assessment Unit
PCT	Primary Care Trust
PID	Programme Initiation Document
QOF	Quality Outcomes Framework
RCCO	Residential Children's Care Officer
RPI	Retail Price Index
SALT	Speech And Language Therapy
SCIE	Social Care Institute of Excellence
SoJ	States of Jersey
T&O	Trauma & Orthopaedics
TT	Talking Therapy
TTO	To Take Out
UK	United Kingdom
US	United States
UTI	Urinary Tract Infection
WHO	World Health Organisation

# 13 Appendices

## 14 Appendix 1: The review process

An internally produced strategy, 'New Directions' proposed the strategic direction for health and social care in Jersey, across a range of service areas. Whilst it laid down some good foundations it became clear, as 2010 progressed, that a more comprehensive strategy would now be required. The Comprehensive Spending Review also focused on ensuring that health and social care services on the island are not only effective and provide value for money, but also fit for the future.

The ambitions laid out in New Directions, together with the imperatives of the Comprehensive Spending Review, increased the priority for considering a major health and social services review, in order to consider a wide range of strategic scenarios and progress the health and social care strategic vision. Building on previous work carried out, and completed in the context of a challenging economic environment, this review would have the task of identifying a safe, sustainable and affordable approach to health and social services for the residents of Jersey.

To support this work, in November 2010, the States of Jersey engaged KPMG to:

- Plan, design and deliver a rapid strategy development process that engages political, clinical, professional and managerial leaders from the health and social care system and stakeholder representatives from key third sector partners
- Produce a costed strategic roadmap for health, healthcare and social care in Jersey, creating an ambitious but financially viable vision
- Undertake the strategic scenario modelling, costing and risk assessment that will underpin this reshaping of the health and social care system and against which progress can be measured over the strategic period 2012 to 2020.

The KPMG team comprised a range of experienced, senior specialists, the majority of which were former health and social care practitioners themselves. This specifically included clinicians, in order to facilitate effective engagement with key clinical stakeholders across the hospital and GP community. Specialist public affairs consultancy, Weber Shandwick, were also a part of this team, to drive the development of a comprehensive and robust communications programme to support the work and produce the green paper for public consultation.

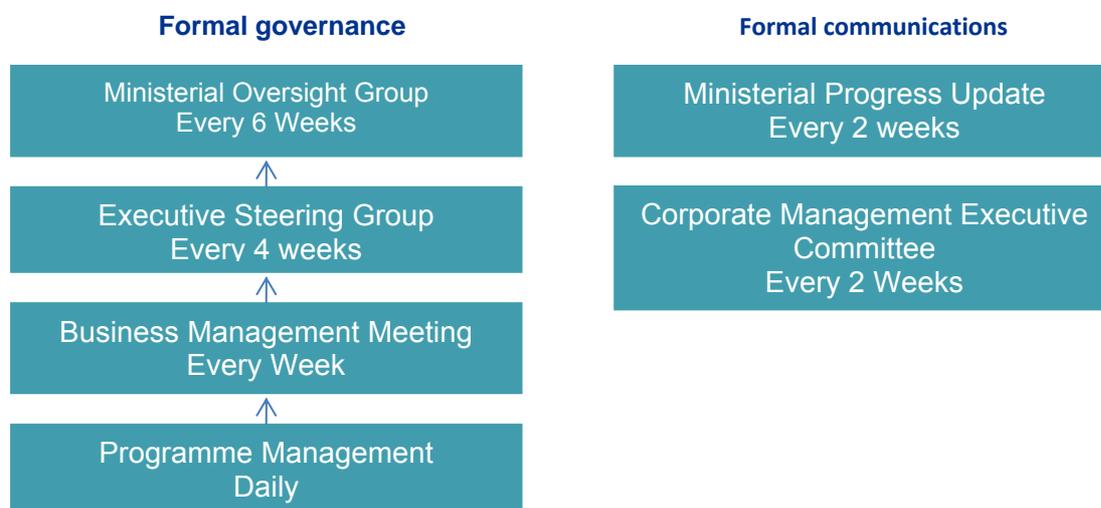
### 14.1 Project management

A pragmatic project management approach has been adopted. This incorporates:

- A co-located project team, of KPMG and Jersey HSSD staff
- Regular meetings with, and reporting to the project SRO, Julie Garbutt, and to the Steering Group and Ministerial Oversight Group, using weekly 'flash reports'
- Risk and issue management
- Stakeholder engagement, building on existing communication channels.

## 14.2 Project governance

A robust governance and programme management infrastructure has been implemented, led by Julie Garbutt, Chief Executive of the Health and Social Services Department. The work has Ministerial Sponsorship from Deputy Anne Pryke, Health and Social Services Minister:



These groups have worked together to help ensure:

- Visibility over the work at senior levels within the States of Jersey
- Clear accountability, to achieve progress according to the agreed timelines and plan
- Risk and issue management, including agreeing mitigation and management actions
- Quality assurance.

The respective roles and responsibilities for individuals are:

**Project sponsor** – overall accountability for all aspects of the work: Julie Garbutt, Chief Executive of the Health and Social Services Department.

**Project director** – responsible for ensuring progress is achieved and risks and issues managed: James Le Feuvre, Director of Strategy.

**Senior users** – responsible for ensuring key delivery arms of HSSD are represented and consulted as part of the development work:

- Andrew McLaughlin, Managing Director, General Hospital
- Stuart Brook, Director of Social Care and Community Services
- Susan Turnbull, Acting Medical Officer of Health
- Russell Pearson, Director of Finance and Information

**Ministerial Oversight Group (MOG)** – accountable for ensuring the wider implications of any proposed changes are considered and challenged. The MOG meets at key milestone dates throughout the programme and before any deliverables are taken to the Council of Ministers. It is chaired by the Terry Le Sueur, Chief Minister, with political membership including the Ministers for:

- Health & Social Services (Deputy Anne Pryke)
- Social Security (Deputy Ian Gorst)
- Treasury & Resources (Senator Philip Ozouf)
- Deputy Judy Martin
- Deputy Eddie Noel
- Connetable John Refault.

Officers in attendance include:

- Chief Executive of the Chief Minister's Department (Bill Ogley)
- States of Jersey Treasurer (Laura Rowley)
- Chief Officer of the Social Security Department (Richard Bell)
- Health and Social Services Chief Executive (Julie Garbutt).

**Executive steering group** – approves key project documentation, provides direction, guidance and arbitration on issues and actively engages in risk mitigation. It is responsible for signing off all deliverables and making recommendations for the Ministerial meetings and Ministerial Oversight Group, and members act as champions within their own organisation, providing visible leadership and commitment. The Executive Steering Group benefits from the input of CMEX (Corporate Management Executive) members and other key stakeholders. The CMEX group currently meets fortnightly and is chaired by Julie Garbutt. The Executive Steering Group convenes at the start of every second CMEX (every four weeks).

**Business management meeting** – held weekly, to enable the Project Sponsor to be kept fully informed of project activity at a detailed level and to enable challenge. Attendees include James Le Feuvre, Peter Scanlon, Scott Maslin and other project staff as necessary.

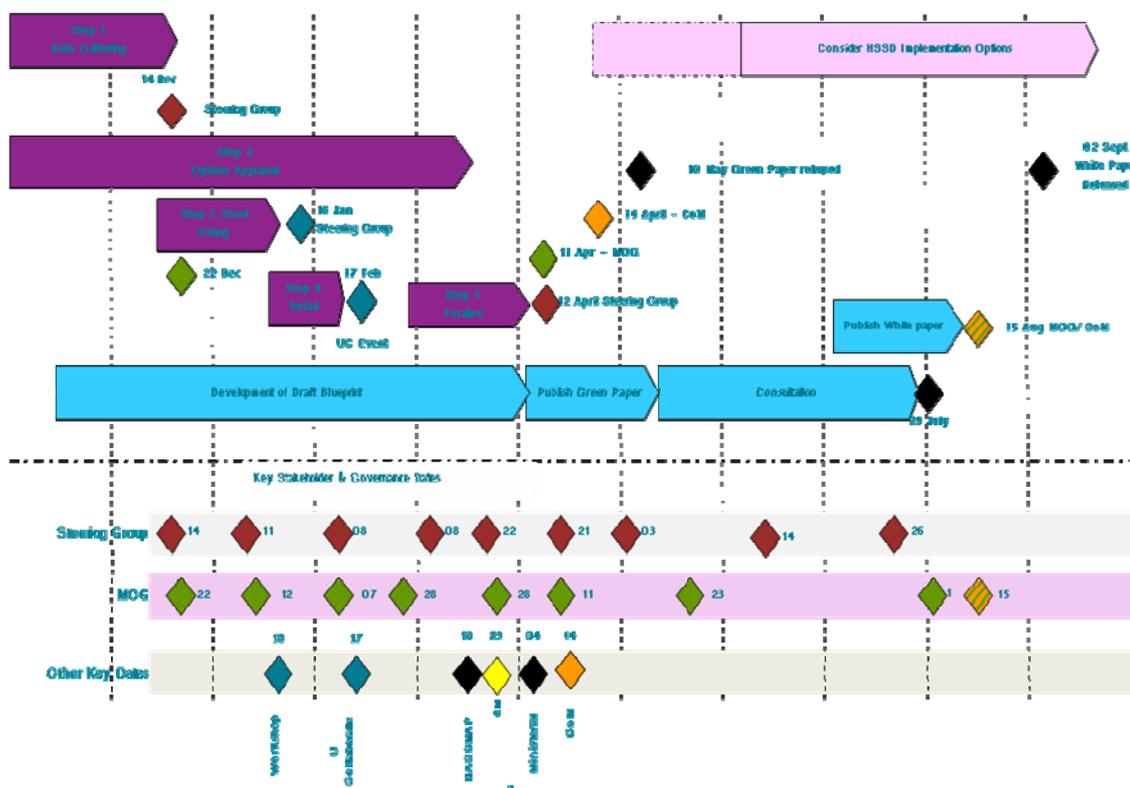
**Programme management** – a joint KPMG/States of Jersey team are co-located within the Hospital.

### 14.3 Stakeholder engagement

Stakeholder engagement is critical to the success of programmes. Significant efforts have been expended in ensuring that stakeholders contribute in full to the vision for health and social care in Jersey and are able to champion this work. In particular, that they:

- Understand the need for change.
- Contribute to the development of the need for change.
- Develop and agree with the criteria by which options will be assessed
- Outline current and future constraints to service development.
- Identify issues and challenges in current practice.
- Consider alternative service approaches, including ways of working.
- Build consensus on the way forward.
- Are consulted on the elements of the developing approach which require their particular skills and knowledge e.g. on safety or clinical governance.
- Are kept updated on progress.

The timeline below presents the overview of the programme to date, including the key stakeholder engagement activities, workshops and meetings:



As part of the development of the future system for health and social care in Jersey, widespread stakeholder engagement has been undertaken including:

- Interviews with over 100 individuals and groups from representative aspects of the health and social care system, including States of Jersey organisations, private providers and charitable organisations
- A key stakeholder workshop, held in January 2011, with over 40 representatives
- A U Collaborate event, held in February 2011, bringing together over 100 people for a rapid and intense development day to explore system change options for the future
- A series of 'drop in' sessions held across a variety of HSSD venues attended by over 150 members of frontline staff in six locations

The emerging options have also been periodically developed with, and challenged by, a range of senior stakeholder groups, including:

- Health & Social Services Department Corporate Management Executive
- Health & Social Services Ministerial Advisory Panel
- States of Jersey Corporate Management Board
- States of Jersey Scrutiny Committee
- Health & Social Services peers from Guernsey and the Isle of Man

## 14.4 Benchmarking

Benchmarking has been undertaken on a range of health and social care indicators comparing Jersey with UK and international comparators.

Benchmarking is not intended to provide definitive answers as to why Jersey's performance may differ from its comparators, but as a tool to support the development of the future strategy for health and social care. It should not be used in isolation, but in conjunction with other quantitative and qualitative data to triangulate the evidence before drawing any conclusions. Contextual factors, such as the environment in which a service is delivered, should be taken into account in interpreting the output of benchmarking. However, there can be tendency for the effect of these external factors to be exaggerated in explaining variations between an organisation and its comparator group.

The comparator organisations have been selected from a number of UK organisations and international island jurisdictions. They have been selected in consultation with key stakeholders, based on their comparability with Jersey in aspects such as expenditure on health and social care; demographics, rural/remote communities and socio-economic factors. The peer group for Jersey comprised:

Organisation (Acute hospital)	Population served	Turnover (£m)	No of hospitals
Bedfordshire NHS Trust	270,000	121.2	1
Doncaster and Bassetlaw Hospitals Trust	410,000	321	5
Dorset County Hospital NHS Foundation Trust	210,000	145.6	1
Hereford Hospitals NHS Trust	225,000	118	1
Hinchingbrooke Health Care NHS Trust	161,000	91.6	1
Kettering General Hospital NHS Foundation Trust	300,000	150	1
North Tees and Hartlepool NHS Foundation Trust	400,000	257.2	2
Northern Devon Healthcare NHS Trust	165,000	128.5	6
West Suffolk Hospitals NHS Trust	275,000	152.5	1
Yeovil District Hospital NHS Foundation Trust	180,000	104.4	1
NHS Isle of Wight	138,500	220	1

Source: Most recently available annual reports for each individual Trust, predominantly 2009/10.

Organisation (Local Authorities)	Population	Turnover (£m)(a)
City of York Council	198,800	444.1
Rutland County Council	38,400	160.5
Wokingham Borough Council	161,900	328.7
South Gloucestershire Council	262,200	608.9

Organisation (Local Authorities)	Population	Turnover (£m)(a)
Borough of Poole Council	141,20	351.0
Bath & North East Somerset Council	177,700	447.3
East Riding of Yorkshire Council	337,000	735.3
North Somerset Council	209,100	473.2
Swindon Borough Council	198,800	556.0
Milton Keynes Council	236,700	864.2
Royal Borough of Windsor & Maidenhead Council	143,800	300.5
Bracknell Forest Council	115,100	261.9
Herefordshire Council	179,100	358.8
West Berkshire Council	153,000	377.6

Note: (a) Represents total organisation turnover not just social care spend.  
Source: Most recently available annual reports for each individual Trust, predominantly 2009/10.

A range of metrics were benchmarked. These included:

- General Practitioners (full time equivalents) in Jersey per 1,000 population, as an indicator of general practice service provision in Jersey as compared with other UK and island jurisdictions
- Professionally registered community nursing staff, including District Nursing, Health Visiting and School Nursing staff per 100,000 populations. For Jersey, this relates to staff within Family Nursing and Home Care
- Length of stay in hospital
- Accident and Emergency A&E attendances per population
- Mental Health Users per 100,000 population
- Medical staff by grade
- Registered Nursing Staff
- Caseloads against non-admitted in England
- Children referral rates
- Placements of Children Looked After
- Adult Referrals (aged 18+) by Source
- Number of people 65 and over in Residential and Nursing care

The results of benchmarking were presented to stakeholders in order to test and challenge the outputs of the work and to assist in the development of strategic scenarios, for example by identifying the elements for which there may be benefit in changing practice, staffing models and service delivery.

## 14.5 Modelling

As part of our work we have created an activity, resource and cost model of health and social care in Jersey. The model builds from economic, demographic, financial and operational data to enable an assessment to be made of how known or expected changes (e.g. demographics) are likely to change demand for all types of health and social care services. It also allows scenarios of different service scenarios to be assessed for their likely resource and financial implications, thereby allowing different options and scenarios to be relatively assessed.

The Model is, by definition, an approximate description of the likely future demand which the services will experience, and is based upon assumptions about an uncertain future. However, the modelling is detailed and aims to identify potential impacts in as much detail as possible given the data available.

The Model applies trends such as drugs inflation, staff cost inflation and demographic change to the 2010 baseline, to illustrate the potential impacts on activity, resources and cost over the long term. Population forecasts were analysed in detail in five year age bands by gender and combined with detailed activity analysis to generate an activity forecast, by specialty for each age/gender category. This analysis enables the impact of the ageing population to be forecast.

To put this into context, the example below sets out the way in which the Model would change if a particular specialty were redesigned to be delivered off-island for elective cases:

- The number of in-patient spells would reduce in line with the current age and gender profile.
- Demand for in-patient consultant time would reduce.
- The number of consultants required would reduce with corresponding reductions in associated financial cost.
- Other specialty staff and supplies would reduce, such as middle grades, junior doctors and specialty nurses, whose role is related directly to the specialty business unit in the ledger.
- The bed days associated with the reduced spells would reduce, and therefore the required number of beds would reduce and bed capacity can be reduced accordingly.
- Ward staff and supplies will then be reduced in line with the reduction in capacity.
- Theatre demand will be impacted through the reduction of inpatient spells.
- Associated resources such as radiology, pathology and therapies would reduce in line with reduced inpatient spells.
- Commissioning costs associated with purchasing healthcare would increase in line with an assumed cost per patient (currently set at the average unit cost in 2010).
- Certain overhead costs such as housekeeping and catering would decrease in line with the reduction in bed days.
- Fixed costs such as estates would not be impacted and so will effectively be spread across a narrower cost base.

The modelling approach has been reviewed and understood by relevant staff, including Russell Pearson, Sarah Howard, and Madeline Simpson. The Model is available to Jersey, and Jersey staff will be trained in its use prior to being handed over as an ongoing business planning tool.

## 14.6 Economic assessment

A review of the economic approach to funding health and social care services in Jersey has been undertaken in order to develop an understanding of how services are currently funded, the implications of this on existing service delivery, and what considerations would there be in changing these funding streams.

The work comprised:

- A summary of the health and social care macroeconomic structure in Jersey
- International comparisons of health and social care funding levels and approaches, including other island jurisdiction and OECD nations
- Options and considerations in relation to Jersey's economic approach to health and social care.

The work was completed through a combination of desk top research and interviews with key economics leads within the States of Jersey statistics and economics functions.

