



cutting through complexity™

A new system of health and social care [Appendices]

[...] April 2011



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Benchmarking overview

Jersey performance benchmarking

- Introduction
- Primary care and community health
- Secondary care
- Mental health
- Social care
- Comparator organisations

Jersey performance benchmarking

Introduction

- A benchmarking exercise has been carried out on a range of health and social care indicators comparing Jersey with UK and international comparators.
- The aim of the exercise has been to highlight area of strengths and challenges to help identify opportunities to consider in the development of health and social care services. It 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 strategic roadmap.
- The comparator organisations have been selected from a number of UK organisations and international island jurisdictions which have been chosen based on their comparability Jersey such as their expenditure on health and social care; demographics including population, rural/remote communities, and socio-economic factors.
- Benchmarking is an imperfect science. It should be used as a 'can opener' to investigate why an organisation differs from its peers, and enable its users to drill down further and ask the right supplementary questions.
- It should not be used in isolation but used in conjunction with other quantitative and qualitative data. In other words, there should be a triangulation of the evidence before drawing any conclusions.
- No one measure should be used in isolation but a set of indicators should be considered 'in the round', thus balancing factors such as cost, effectiveness (outcomes), standards, and quality.
- 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.

Primary and community care

- Number of GPs per 1,000 population.
- Number of registered Community Nurses per 100,000 population.
- Number of registered Allied Health Professionals (Community Services) per 100,000 population.

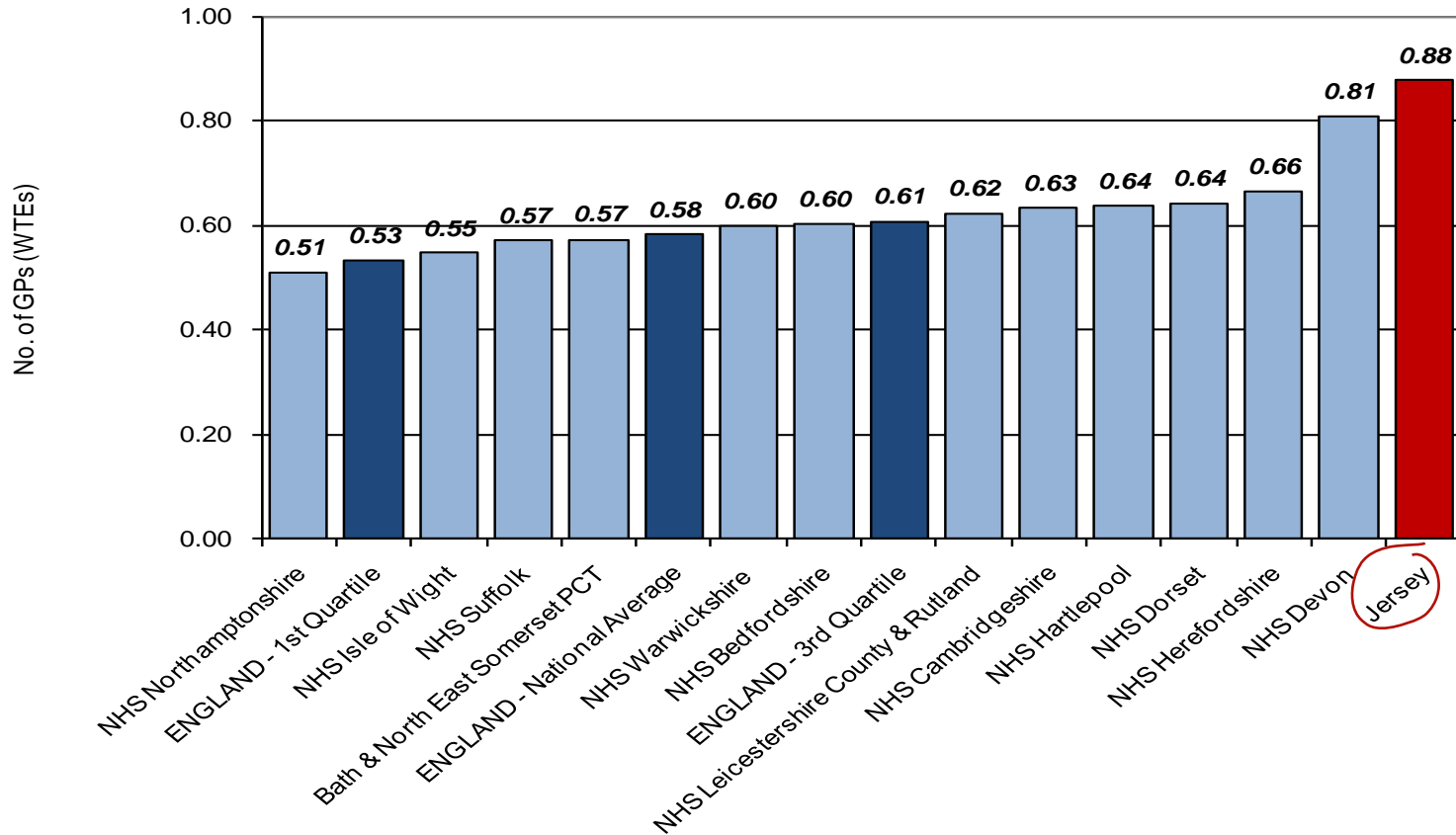
Primary and community care (cont.)

Number of GPs per 1,000 population

- The following charts compares the number of General Practitioners (full time equivalents) in Jersey per 1,000 population with other comparators.
- The English PCTs used are either coterminous with, or based principally around, a city/town with a population within 1,000 of the population size of Jersey.
- For UK comparators, the number of GPs in Jersey appears higher than both England and Wales. The national average and upper quartile for England equates to 0.58 and 0.61 GPs per 1,000 population respectively compared with 0.88 for Jersey. Similarly, Jersey was higher than the Wales national average and upper quartile at 0.66 and 0.69 respectively. The Scotland data appears higher than Jersey which may suggest that population density may be a key driver to the number of GPs per 1,000 population.
- Compared to international island jurisdictions, the number of GPs was also higher in Jersey than the Isle of Man (0.61), Guernsey (0.69) and Tasmania (0.71).
- This suggests that there may be opportunities to utilise and build upon the existing capacity and capability that exists within primary care 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 (and even social care) professionals.

Primary and community care (cont.)

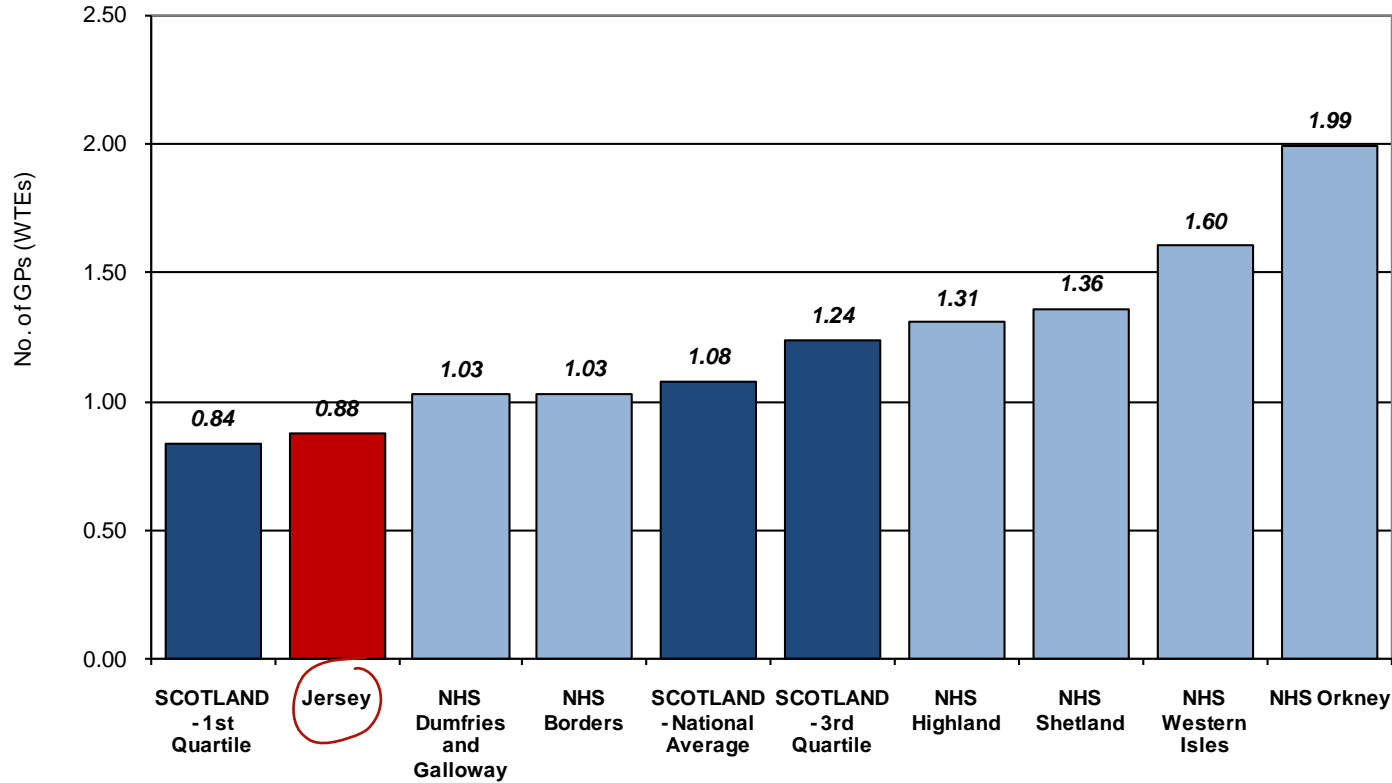
Number of General Practitioners per 1,000 population (England)



Source: NHS Information Centre; Jersey HSSD data; KPMG Analysis.

Primary and community care (cont.)

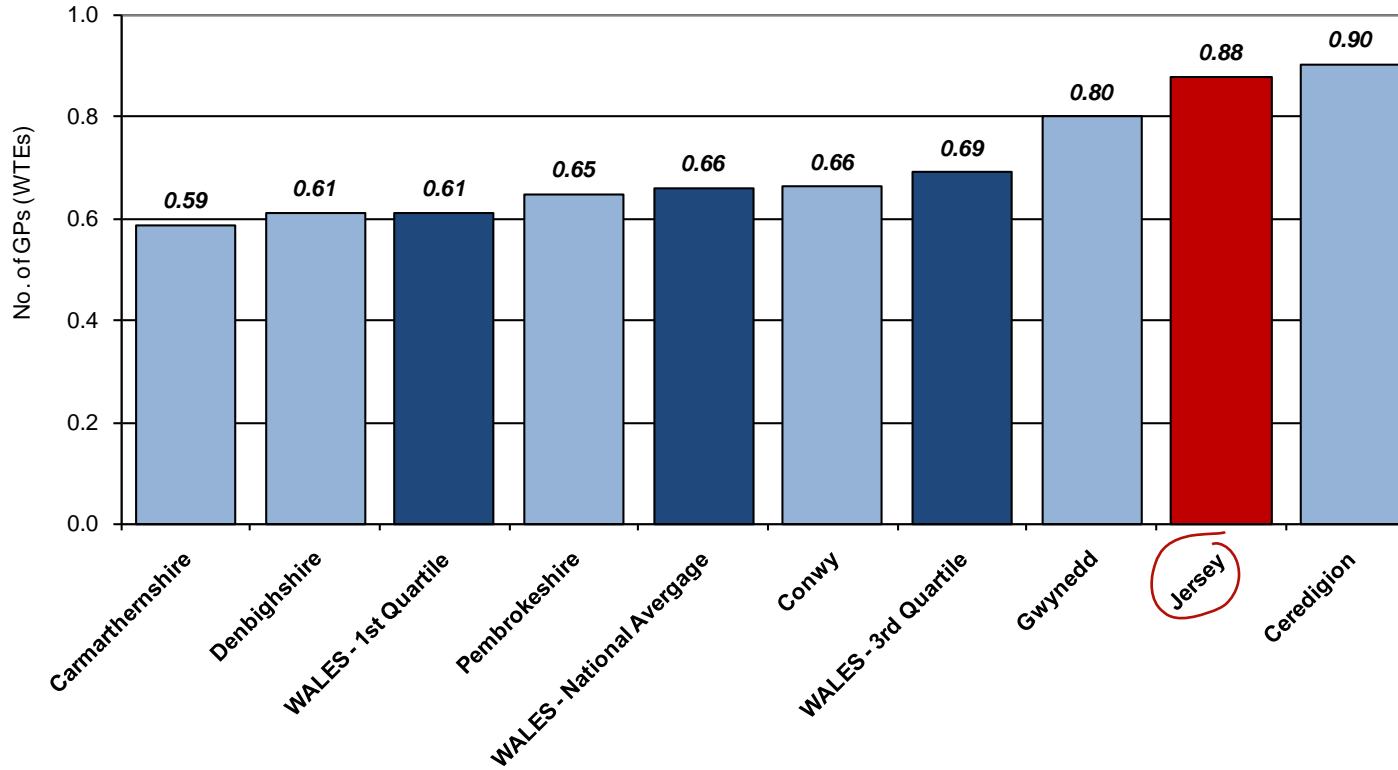
Number of General Practitioners per 1,000 population (Scotland)



Source: ISD Scotland; Jersey HSSD data ;KPMG Analysis.

Primary and community care (cont.)

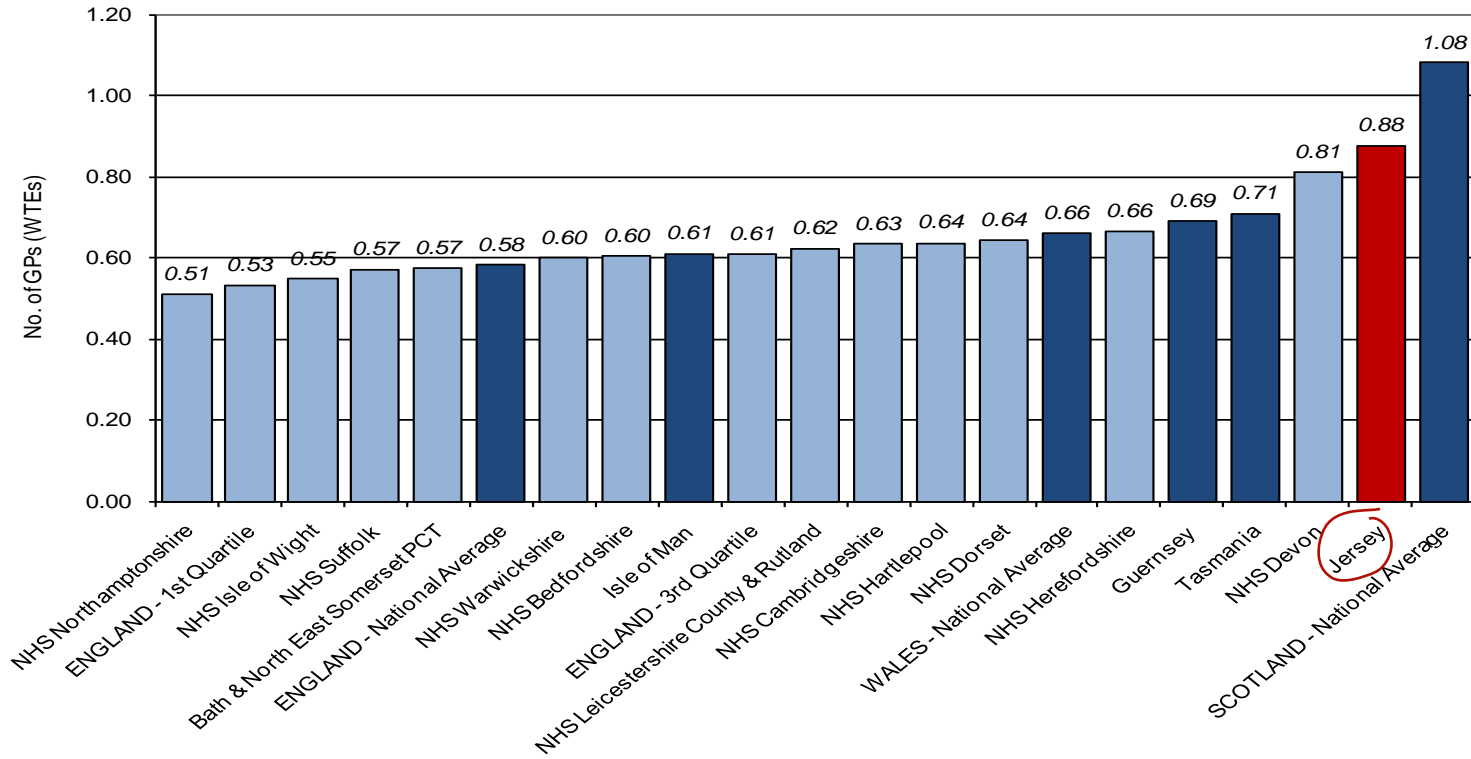
Number of General Practitioners per 1,000 population (Wales)



Source: Health Stats Wales ; Jersey HSSD data; KPMG Analysis.

Primary and community care (cont.)

Number of General Practitioners per 1,000 population (UK and Island Jurisdictions)



Source: NHS Information Centre; ISD Scotland; Health Stats Wales; OECD; Australian government health data ; Guernsey HSS Data; KPMG Analysis.

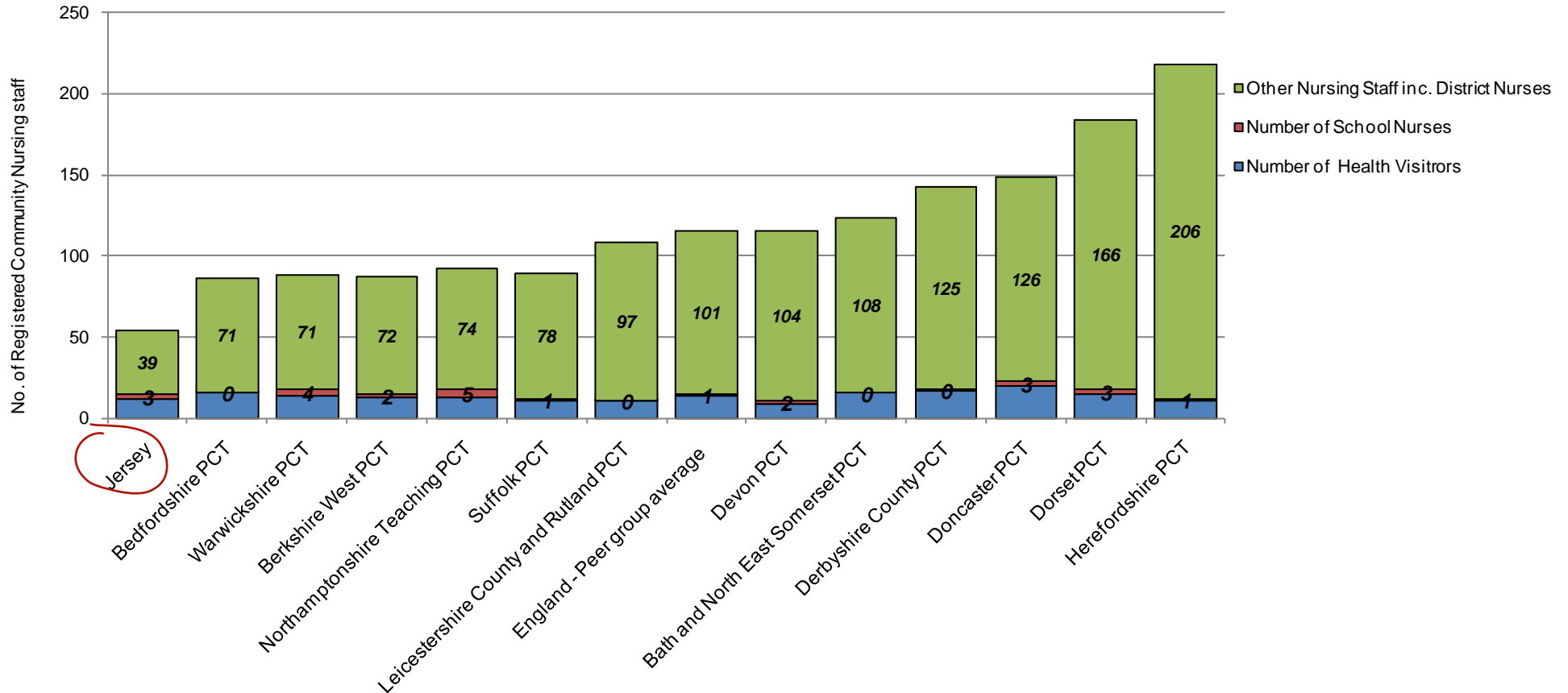
Primary and community care (cont.)

Number of Community Nurses per 100,000 population

- The number of community nursing staff was benchmarked against comparators which include District Nursing, Health Visiting and School Nursing staff per 100,000 population. For Jersey, this relates to staff within Family Nursing and Home Care.
- It should be noted that for English comparators, NHS Primary Care Trusts 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 used in this report may be lower than in practice.
- The results demonstrate that Jersey has a significantly low number of registered community nursing staff per 100,000 population compared to its peers. The comparator peer organisations have moved towards a more community care based model as compared to Jersey as well in addition to utilising a broader skill mix to Jersey which is based on a more medicalised model of care.
- 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.

Primary and community care (cont.)

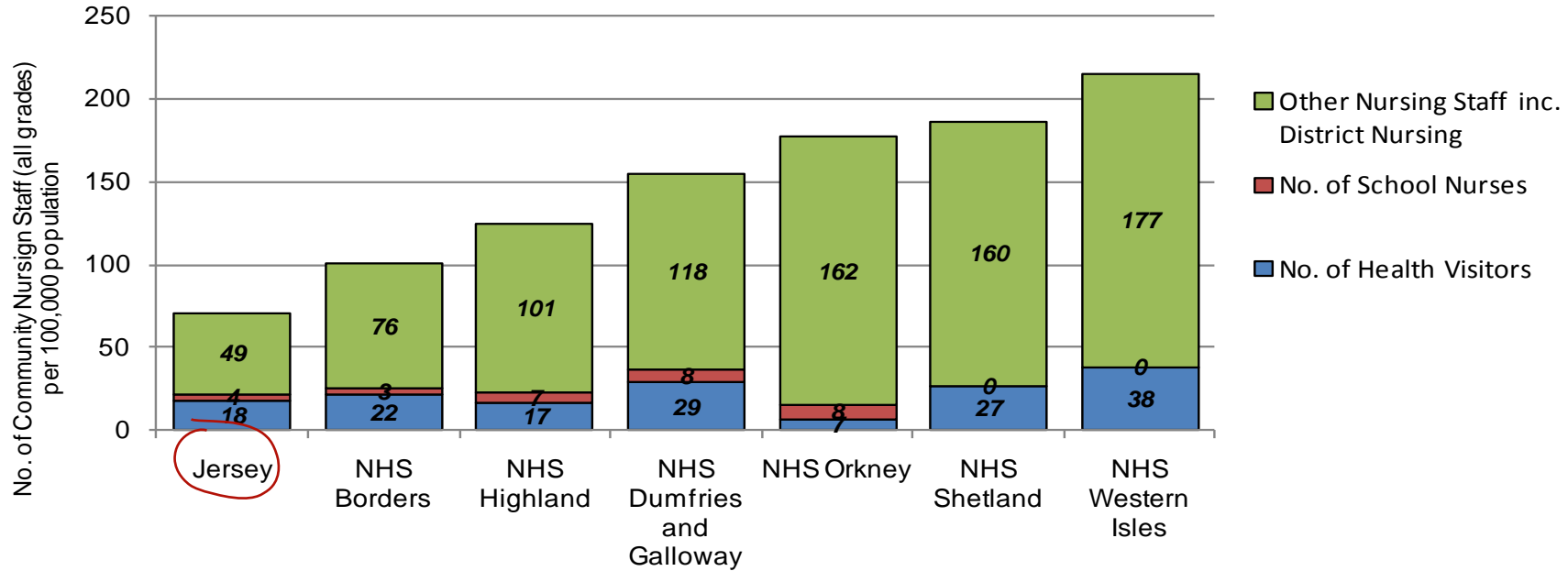
Number of Community Nurses per 100,000 population (England)



Source: NHS Information Centre; Jersey HSSD data; KPMG Analysis.

Primary and community care (cont.)

Number of Community Nurses (all grades) per 100,000 population (Scotland)



Source: ISD Scotland Jersey HSSD data; KPMG Analysis.

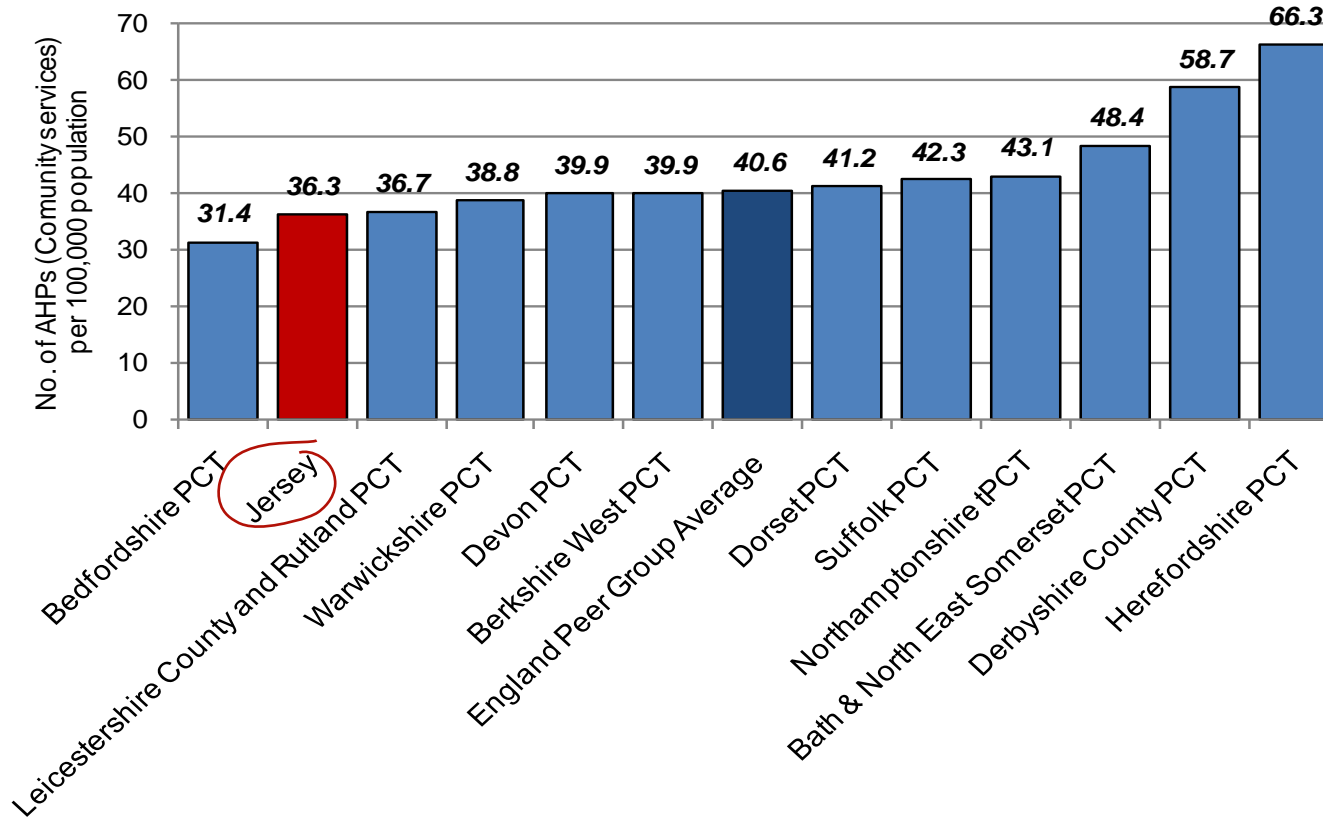
Primary and community care (cont.)

Registered Allied Health Professionals (Community services) per 100,000 population

- The number of registered Allied Health Professionals per 100,000 population working within Community Services in Jersey amounts to 36.3 full time equivalents (FTEs).
- While some community services in Jersey e.g. Physiotherapy are provided within the hospital, this has been included within community services grouping to be comparable with the English data.
- It should also be noted that this represents the number of professionally registered AHPs. As such, it does not include non registered allied health support staff e.g. physiotherapy helpers which are also an integral part of the service delivery team.
- Whilst the number of AHP staff appears slightly lower in Jersey than the English peer group average of 40.6 FTEs, Jersey is comparable with many of the English Primary Care Trusts between 36 and 39 FTEs per 100,000 population.

Primary and community care (cont.)

Registered Allied Health Professionals (Community Services) per 100,000 population



Source: NHS Information Centre; Jersey HSSD data; KPMG Analysis.

Secondary care

- Length of Stay (General Surgery)
- Occupied Bed Days per 100,000 population (General Surgery)
- Length of Stay (General Medicine)
- Occupied Bed Days per 100,000 population (General Medicine)
- Length of Stay (Obstetrics)
- Occupied Bed Days per 100,000 population (Obstetrics)
- Outpatients – Follow up to new ratio
- Number of Delayed Hospital Discharges (18+) per 100,000 population
- Jersey Delayed Hospital Discharges (18+) by reason
- A&E attendances per size of population
- Intensive Care Beds per 100,000 population
- Workforce – Medical staff by grade per 100,000 population
- Medical Staff Skill Mix by Grade
- Registered Nursing and Midwifery staff per 100,000 population
- Nursing and Midwifery staff (all grades) per 100,000 population
- Number of Nurses (all grades) per 100 Beds
- Registered Allied Health Professionals (Acute Care) per 100,000 population

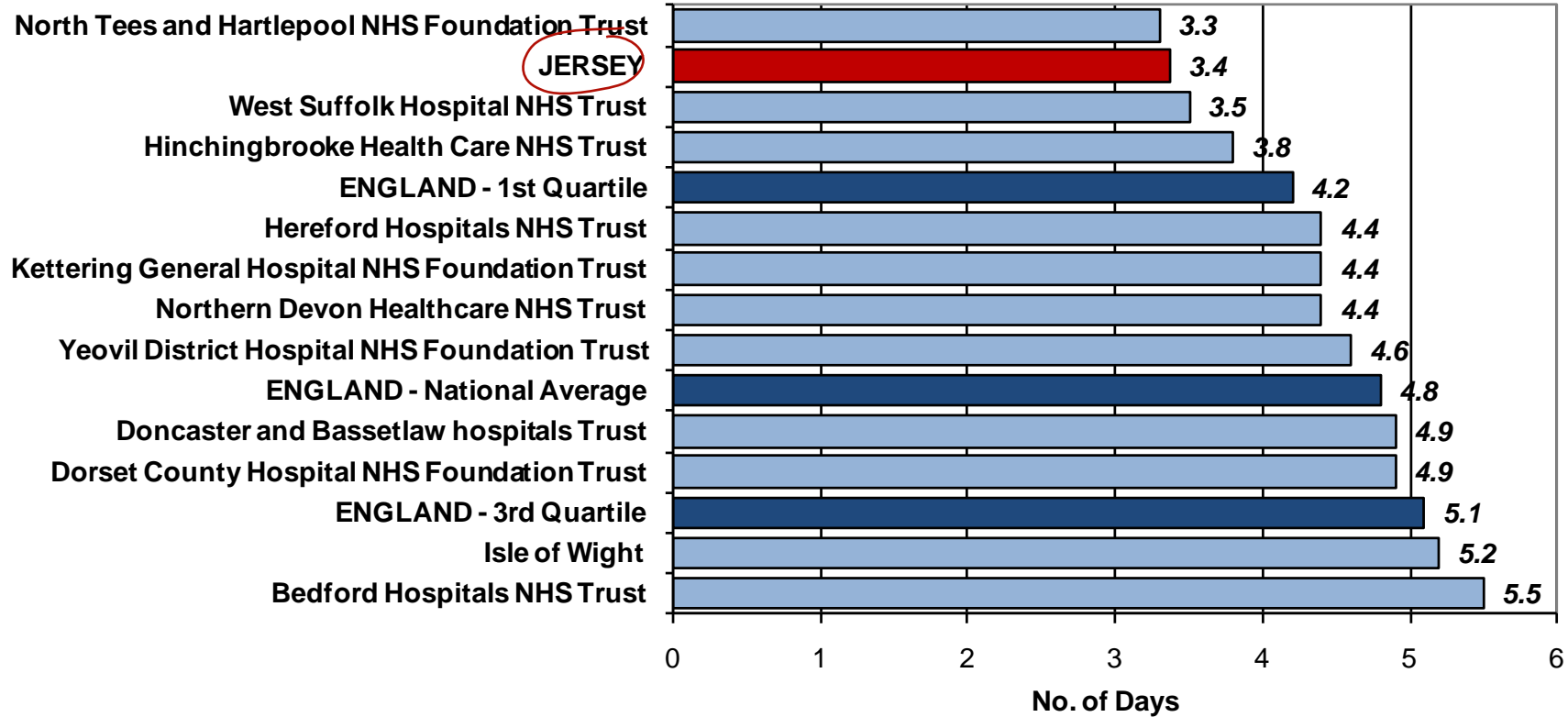
Secondary care – Length of stay

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 equates to 4.8 days (lower quartile 4.2 days). Similarly, the national averages for Scotland and Wales are also higher than Jersey with an average of 4.2 days in Scotland (lower quartile 3.8 days) and average of 5.2 days in Wales.
- Whilst the length of stay for general surgery is shorter in Jersey, this may reflect the case mix of procedures carried out in comparison to UK peers. One reason why the case mix 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.

Secondary care – Length of stay (cont.)

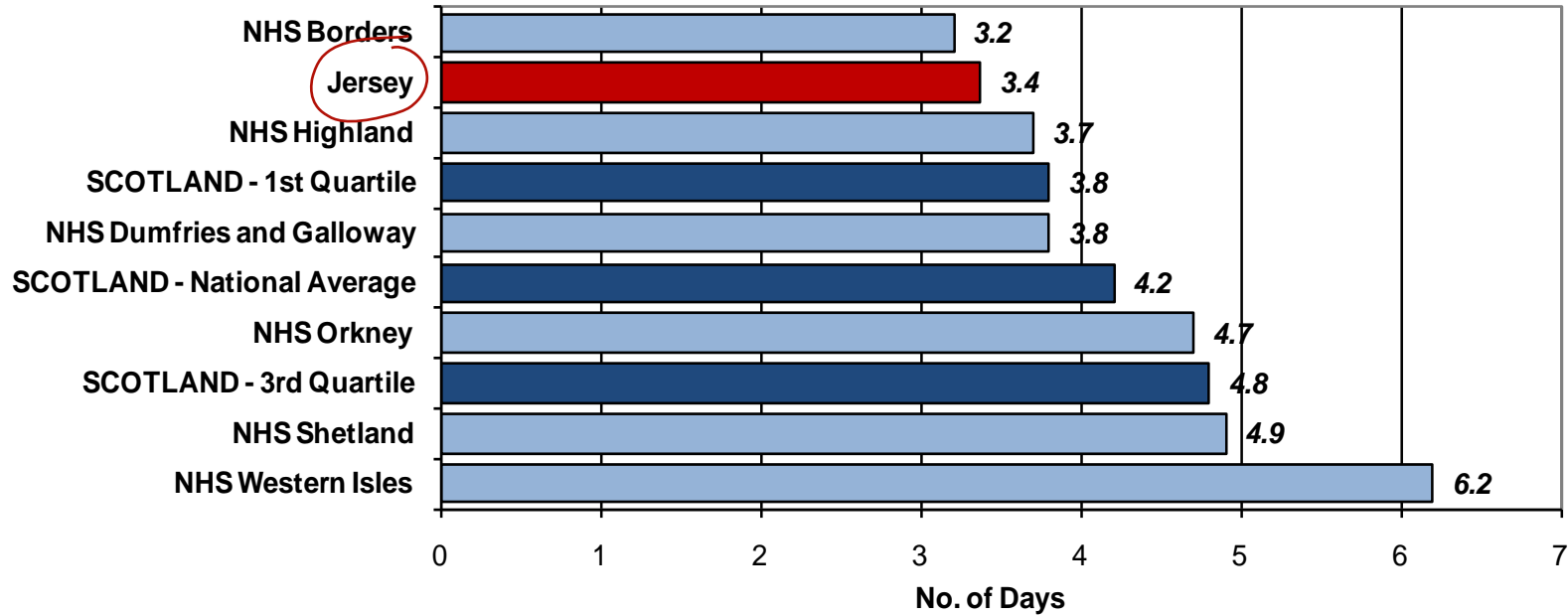
Length of Stay – General Surgery (England)



Source: Dr Foster Intelligence; Jersey HSSD data; KPMG analysis.

Secondary care – Length of stay (cont.)

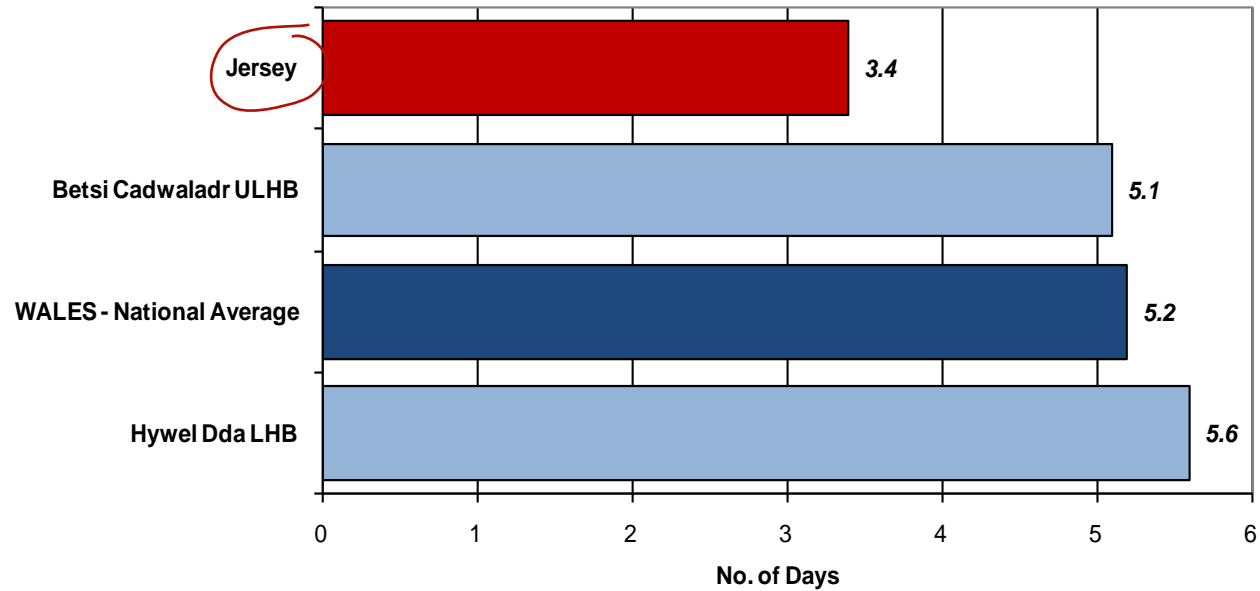
Length of Stay – General Surgery (Scotland)



Source: ISD Scotland; Jersey HSSD data; KPMG Analysis.

Secondary care – Length of stay (cont.)

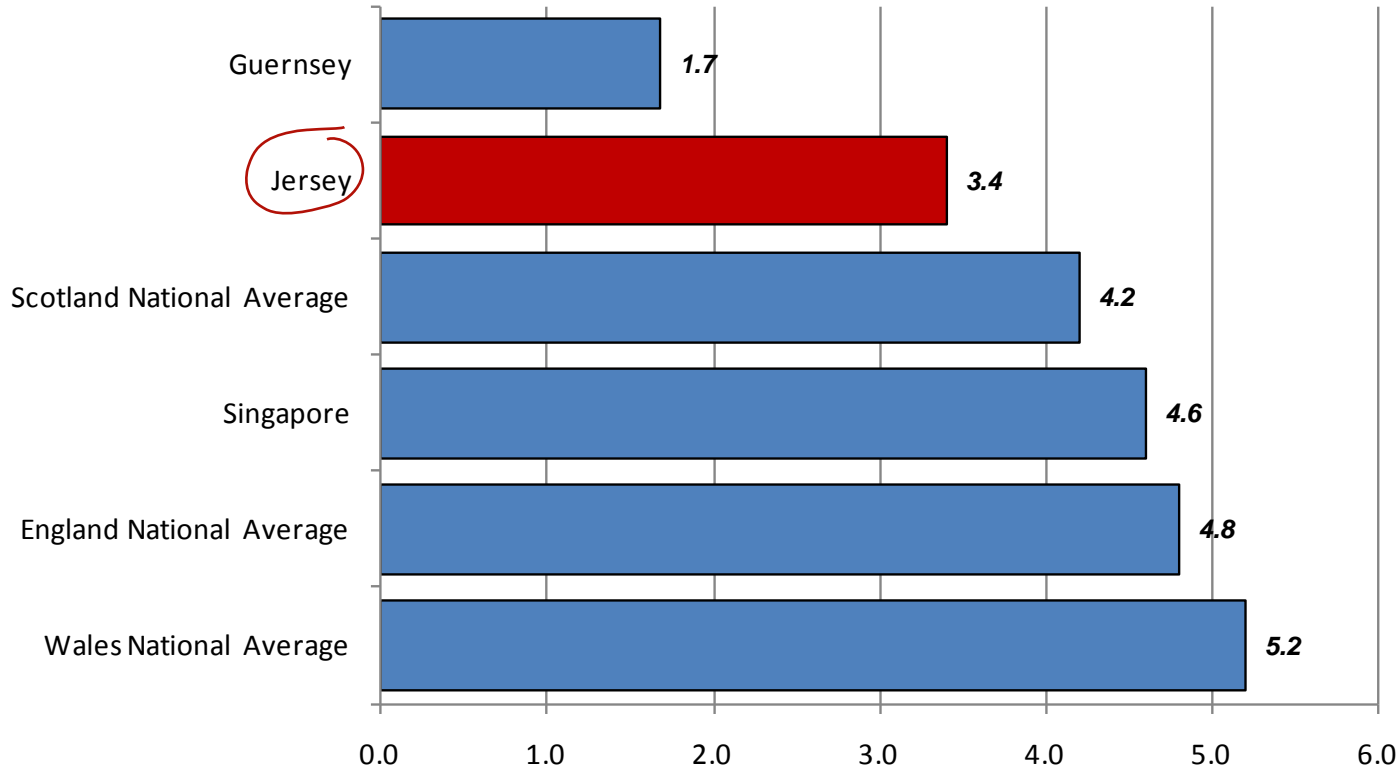
Length of Stay – General Surgery (Wales)



Source: Health Stats Wales; Jersey HSSD data; KPMG Analysis.

Secondary care – Length of stay (cont.)

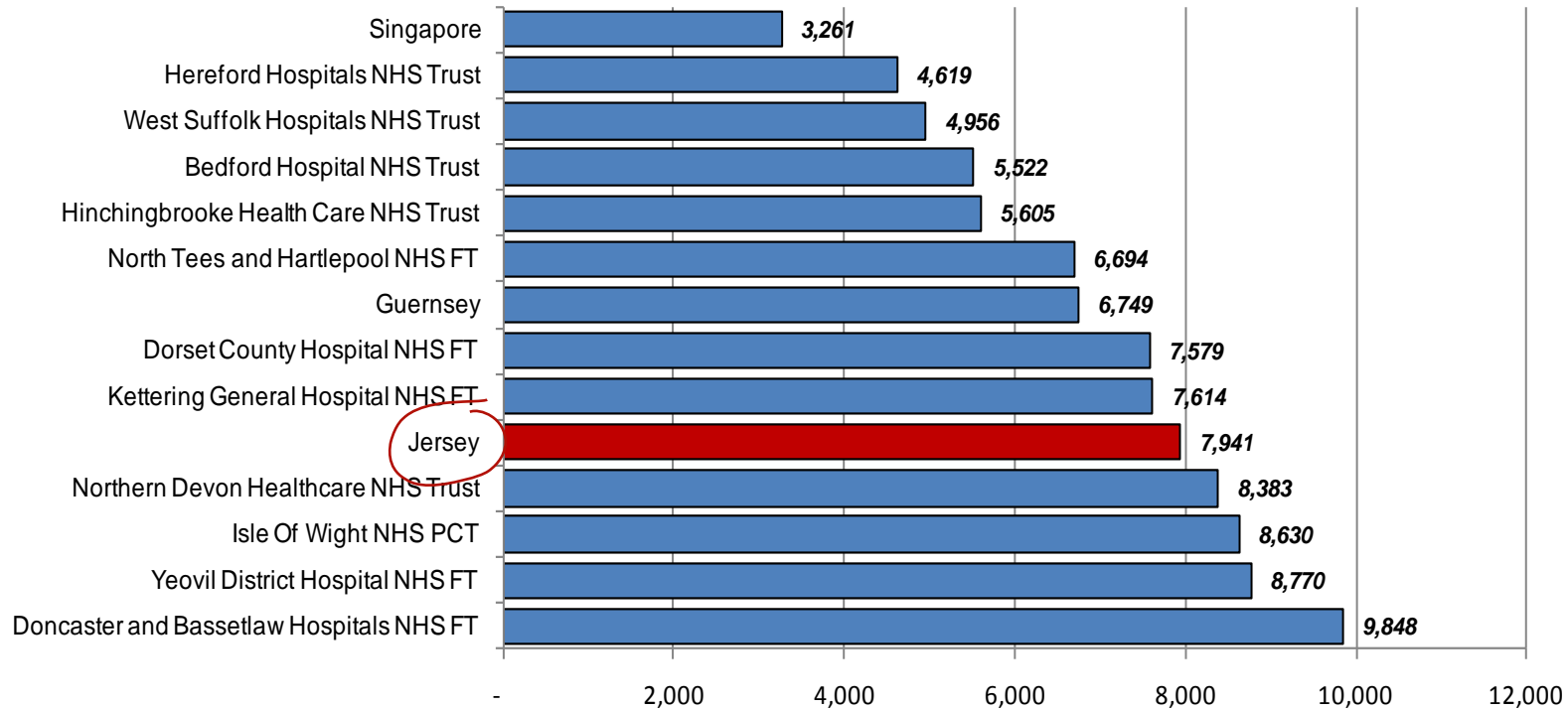
Length of Stay – General Surgery (UK and Island Jurisdictions)



Source: Dr Foster Intelligence, ISD Scotland; Health Stats Wales; Guernsey HSS Intelligence; Jersey HSSD data ;Singapore Ministry of Health.

Secondary care – Bed occupancy

Occupied Bed Days per 100,000 population – General Surgery (England and Island Jurisdictions)



Source: Dr. Foster Intelligence, Guernsey HSS Intelligence; Jersey HSSD data; Singapore Ministry of Health.

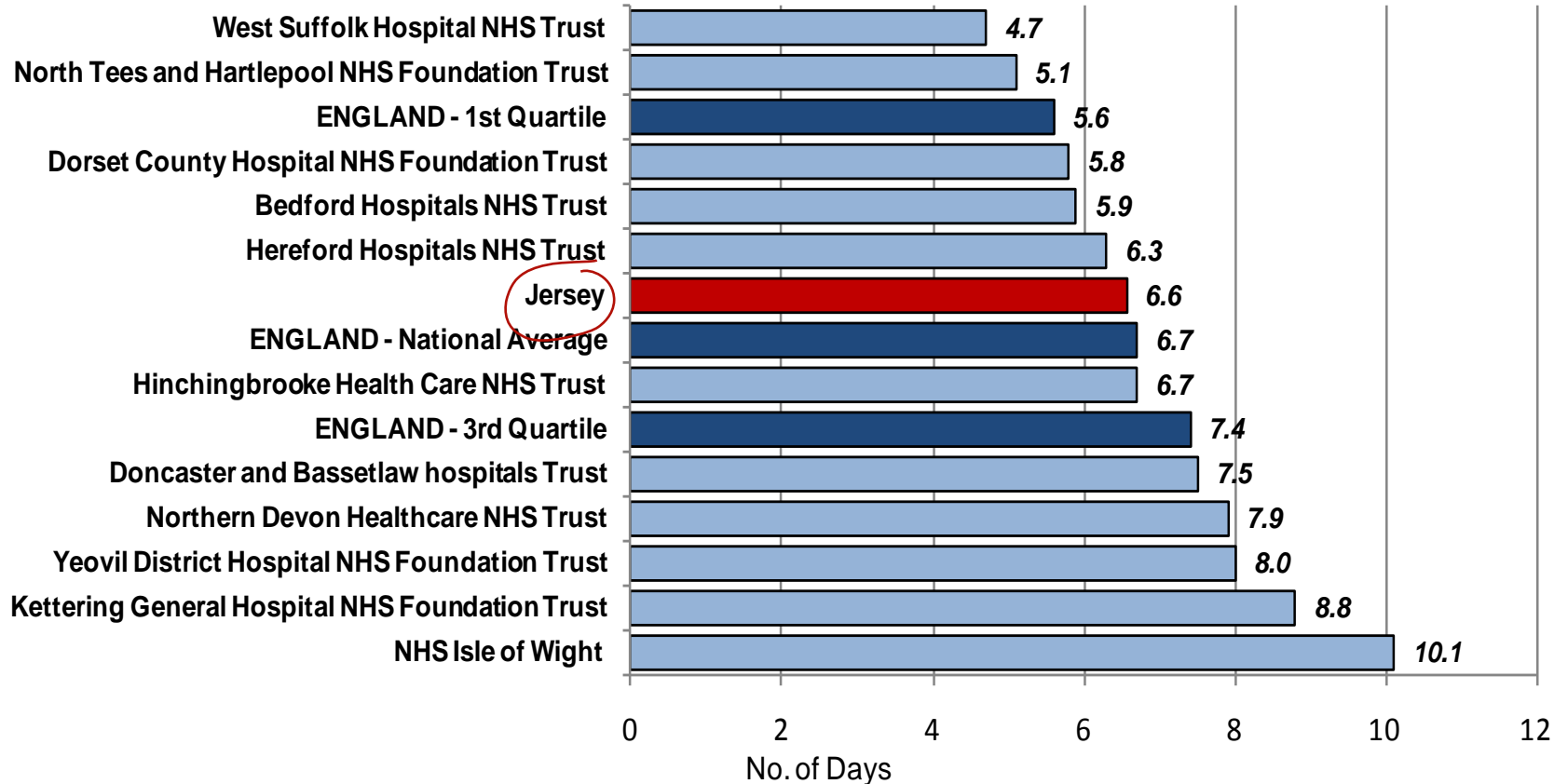
Secondary care – Length of stay

Length of Stay (General Medicine)

- The current length of stay for general medicine in Jersey is 6.6 days. This is slightly lower than the English national average of 6.7 days, although above the English lower quartile of 5.6 days.
- Whilst Jersey compares lower than the Welsh national average of 8 days, it is one the highest when compared to Scotland, 2.1 days higher than the national average of 4.5 days.
- This suggests that Jersey's length of stay for general medicine is on a par against its peers. However there is hear say evidence that older people are a relatively high proportion of this cohort.
- This may be caused partly by case mix as there may be a lower threshold for admission in Jersey than there is in the comparator sites.

Secondary care – Length of stay (cont.)

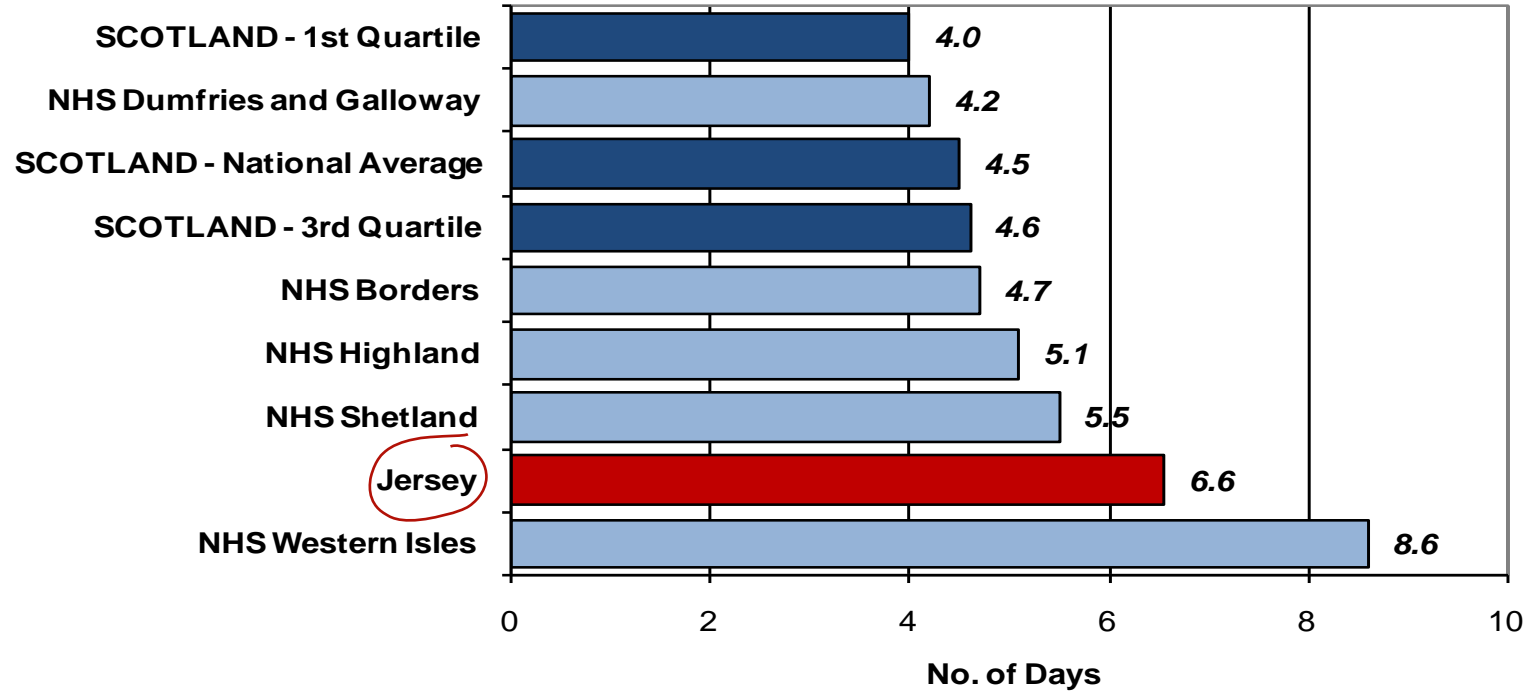
Length of Stay – General Medicine (England)



Source: Dr Foster Intelligence ; Jersey HSSD data; KPMG analysis.

Secondary care – Length of stay (cont.)

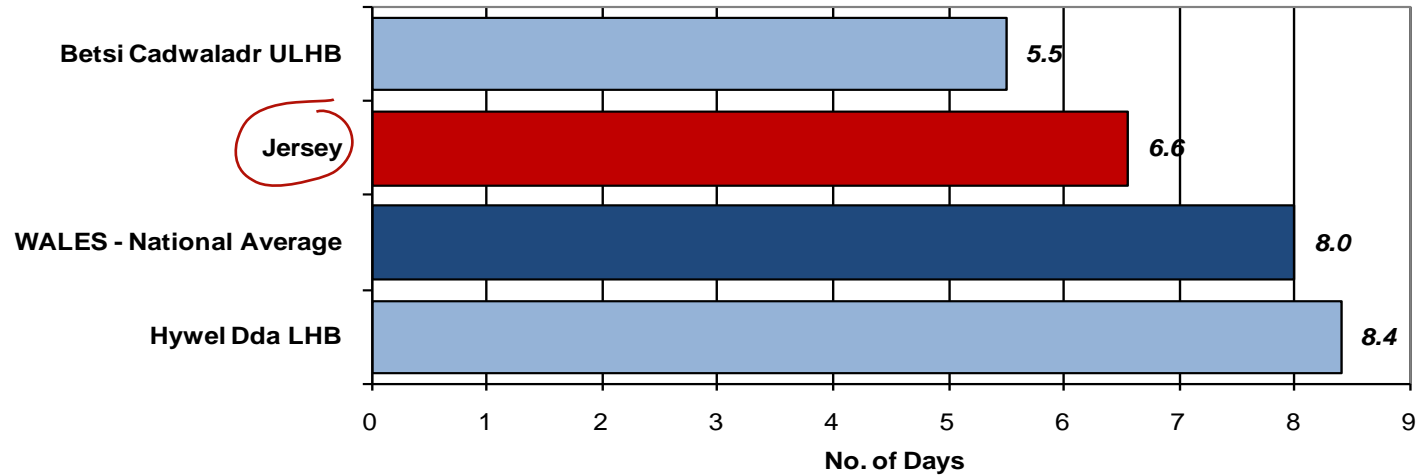
Length of Stay – General Medicine (Scotland)



Source: ISD Scotland ; Jersey HSSD data; KPMG Analysis.

Secondary care – Length of stay (cont.)

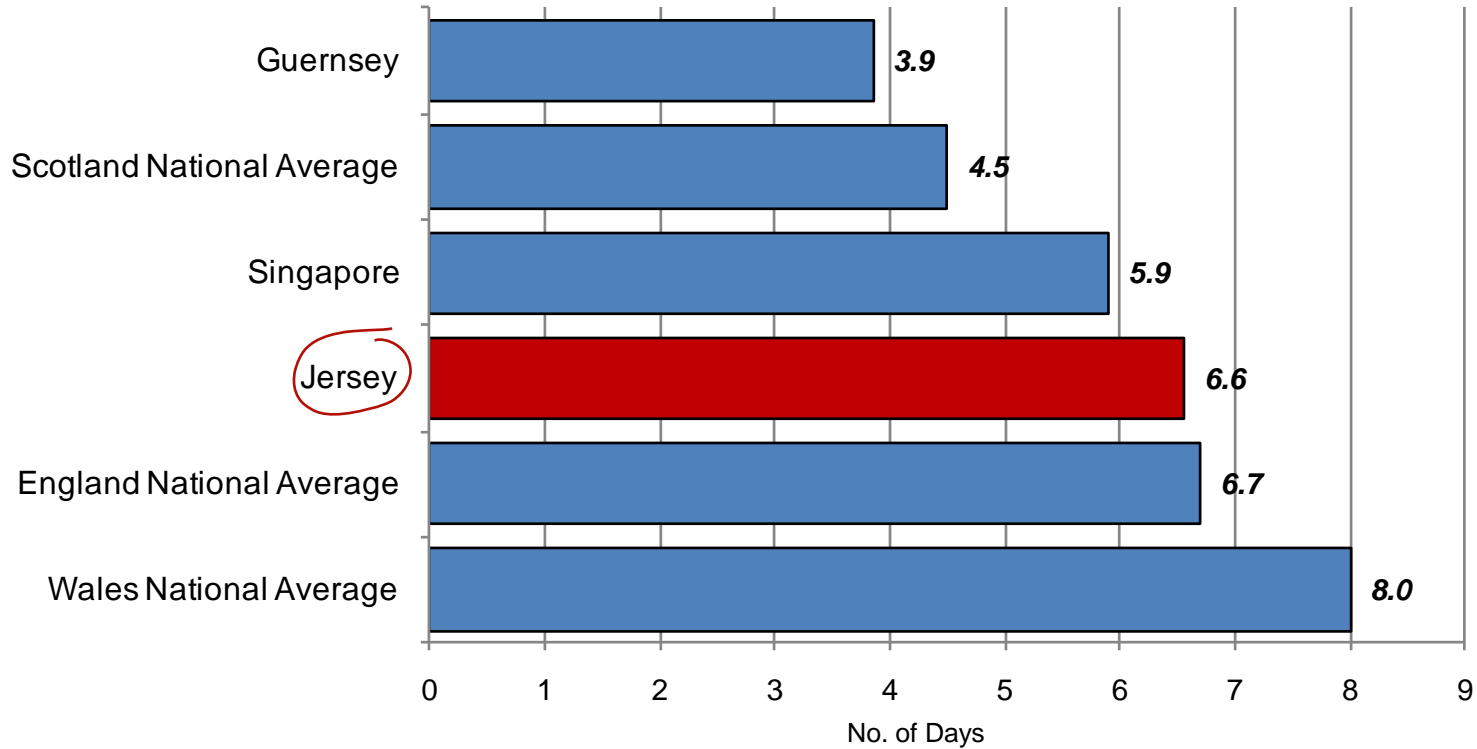
Length of Stay – General Medicine (Wales)



Source: Health Stats Wales; Jersey HSSD data; KPMG Analysis.

Secondary care – Length of stay (cont.)

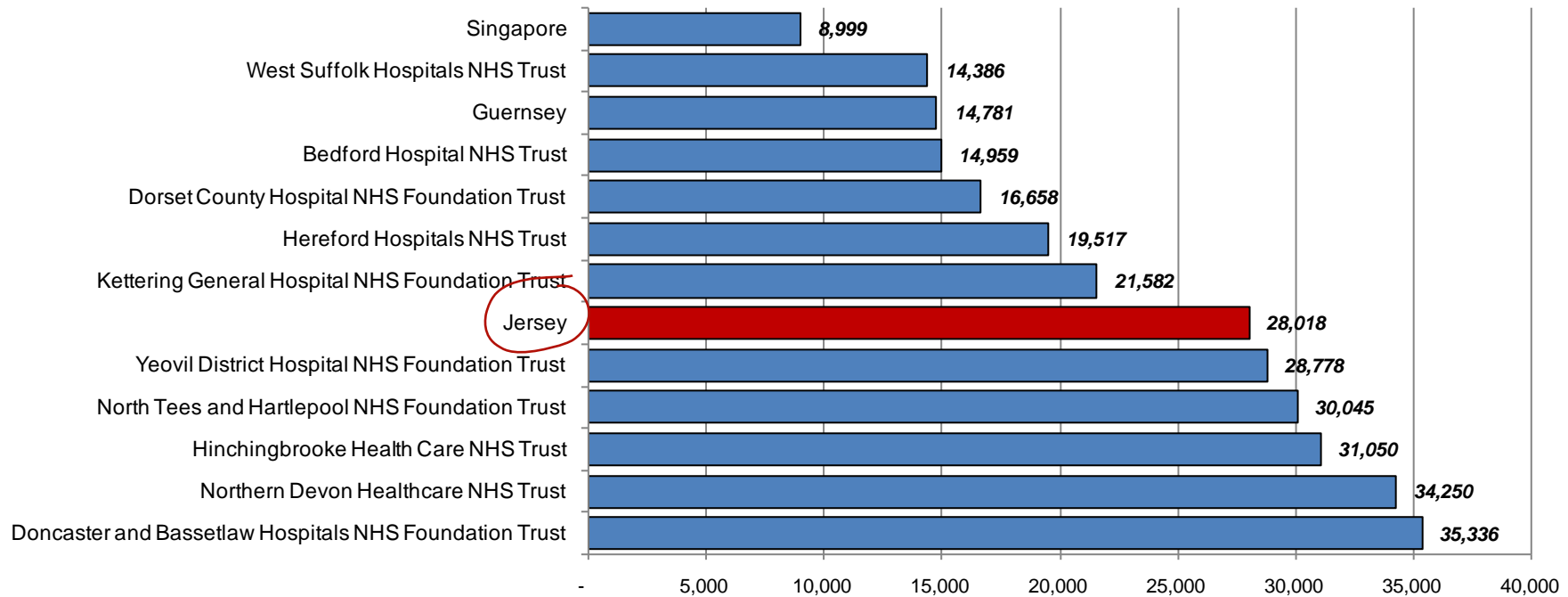
Length of Stay – General Medicine (UK and Island Jurisdictions)



Source: Dr Foster Intelligence, ISD Scotland; Health Stats Wales; Guernsey HSS Intelligence; Jersey HSSD data; Singapore Ministry of Health.

Secondary care – Bed occupancy

Occupied Bed Days per 100,000 population – General Medicine (England and Island Jurisdictions)



Source: Dr. Foster Intelligence, Guernsey HSS Intelligence; Jersey HSSD data; Singapore Ministry of Health.

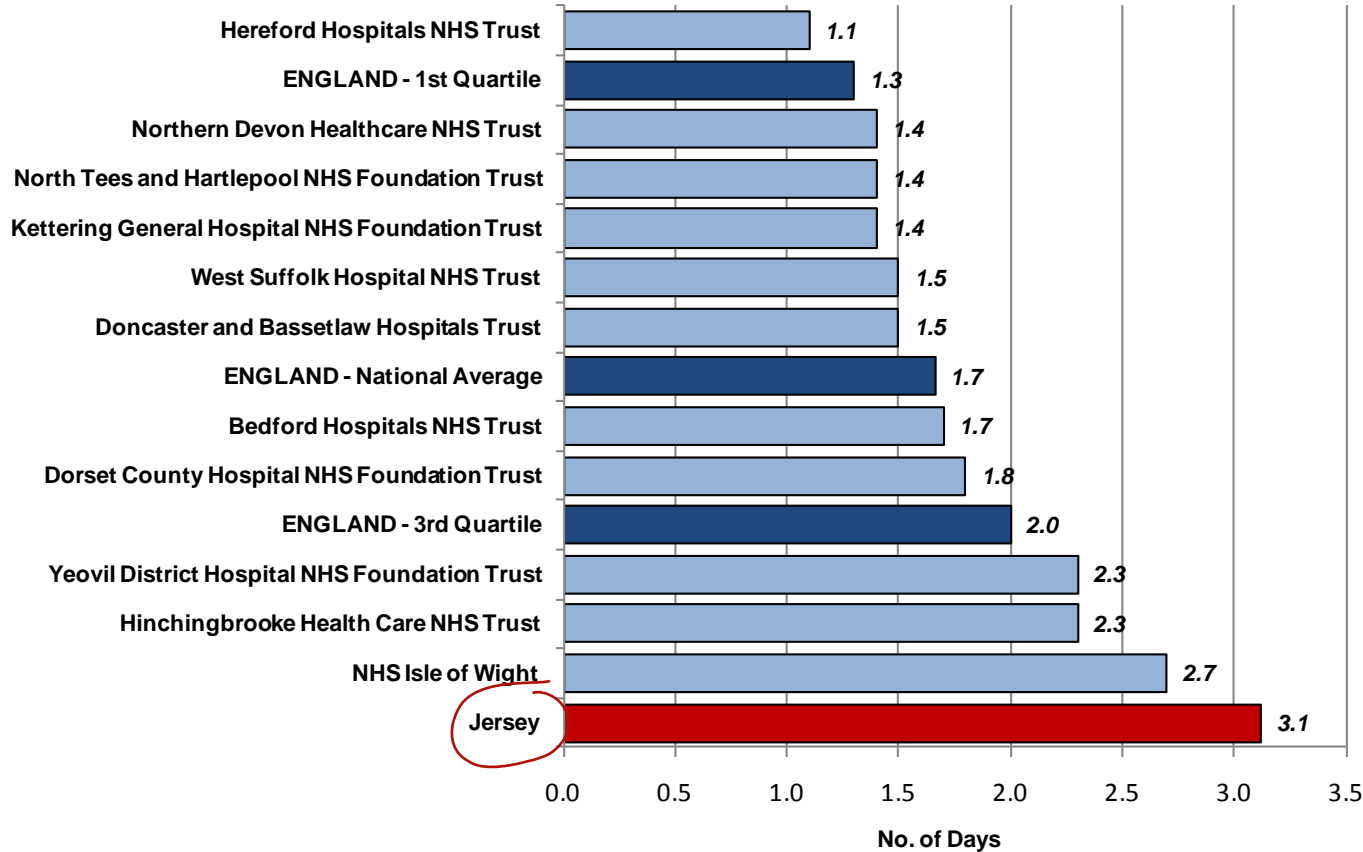
Secondary care – Length of stay

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.
- In England, the national average is currently 1.7 days, 1.4 days shorter than Jersey. Similarly, the national average for Scotland and Wales were equally shorter at 1.9 days and 1.7 days respectively. This may partly be due to the high rates of caesarean – section in Jersey at 32% compared with recommend rates average of 15% and UK average of 25%.
- 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 as compared to its peers.
- By offering choice of place of birth including more care in the home and increased access to midwifery led care, this may lead to a reduction in lengths of stay and number of beds required as low risk women are seen more at home.

Secondary care – Length of stay (cont.)

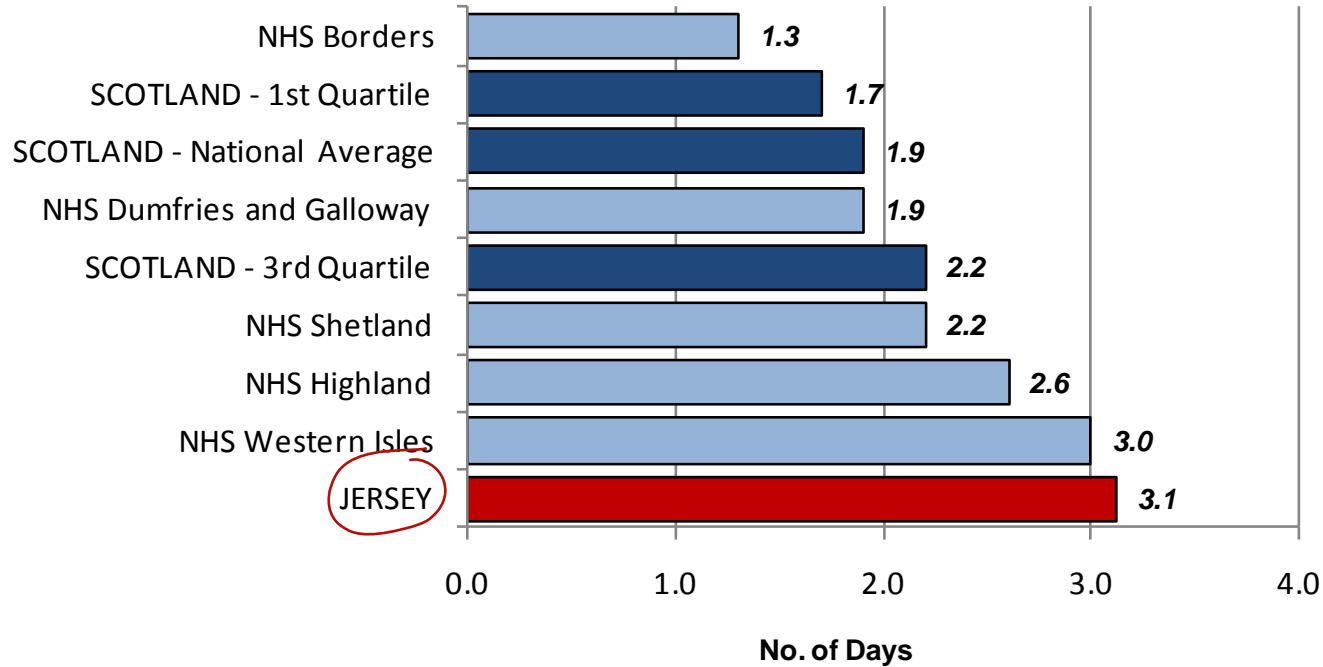
Length of Stay – Obstetrics (England)



Source: Dr. Foster Intelligence ; Jersey HSSD data; KPMG analysis.

Secondary care – Length of stay (cont.)

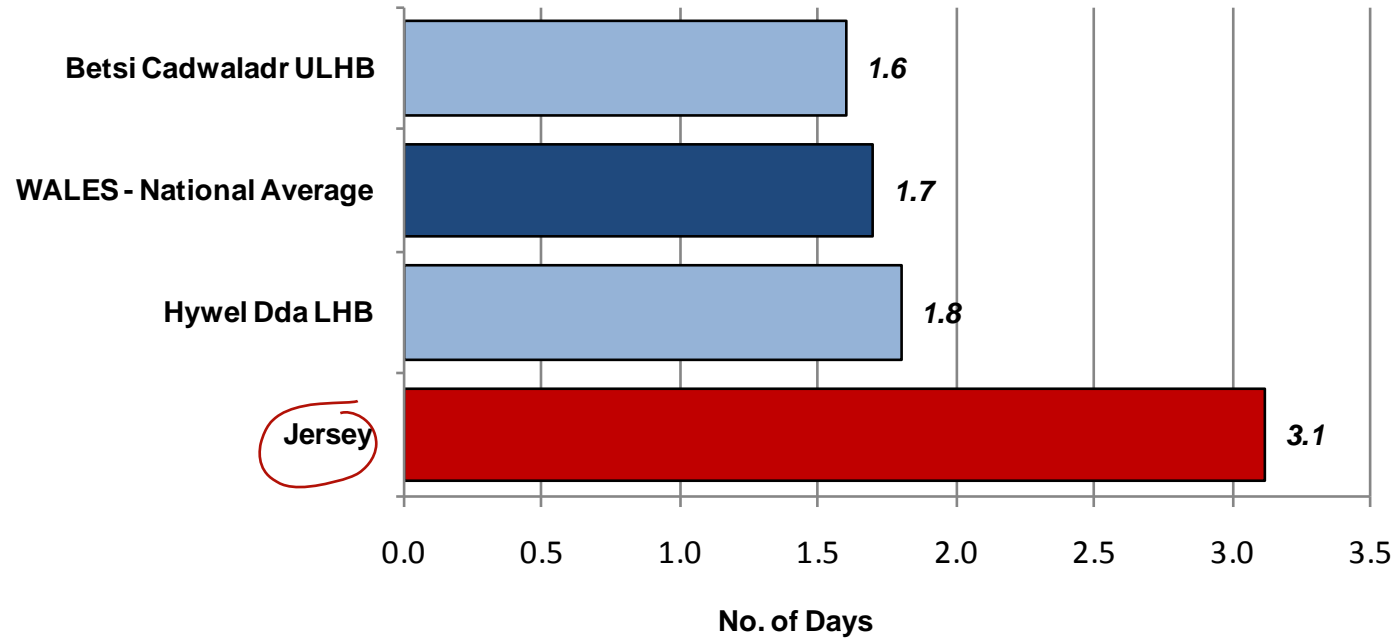
Length of Stay – Obstetrics (Scotland)



Source: ISD Scotland ; Jersey HSSD data; KPMG Analysis.

Secondary care – Length of stay (cont.)

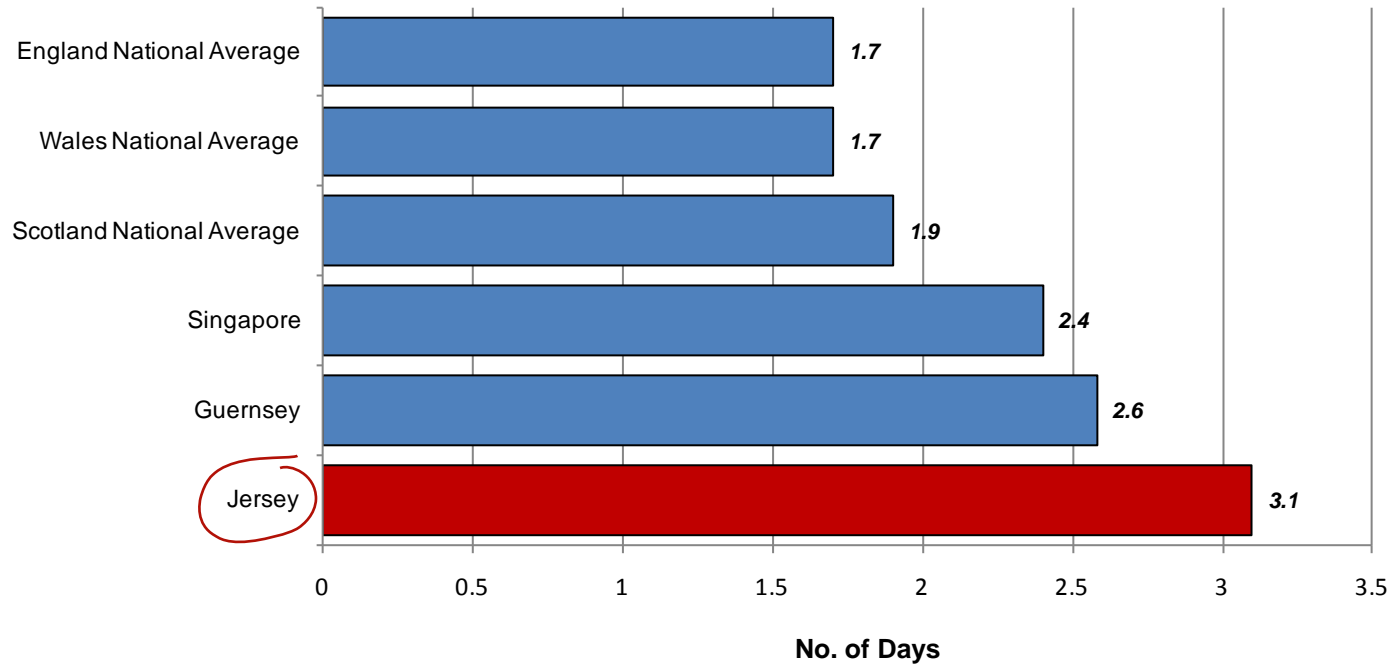
Length of Stay – Obstetrics (Wales)



Source: Health Stats Wales; Jersey HSSD data; KPMG Analysis.

Secondary care – Length of stay (cont.)

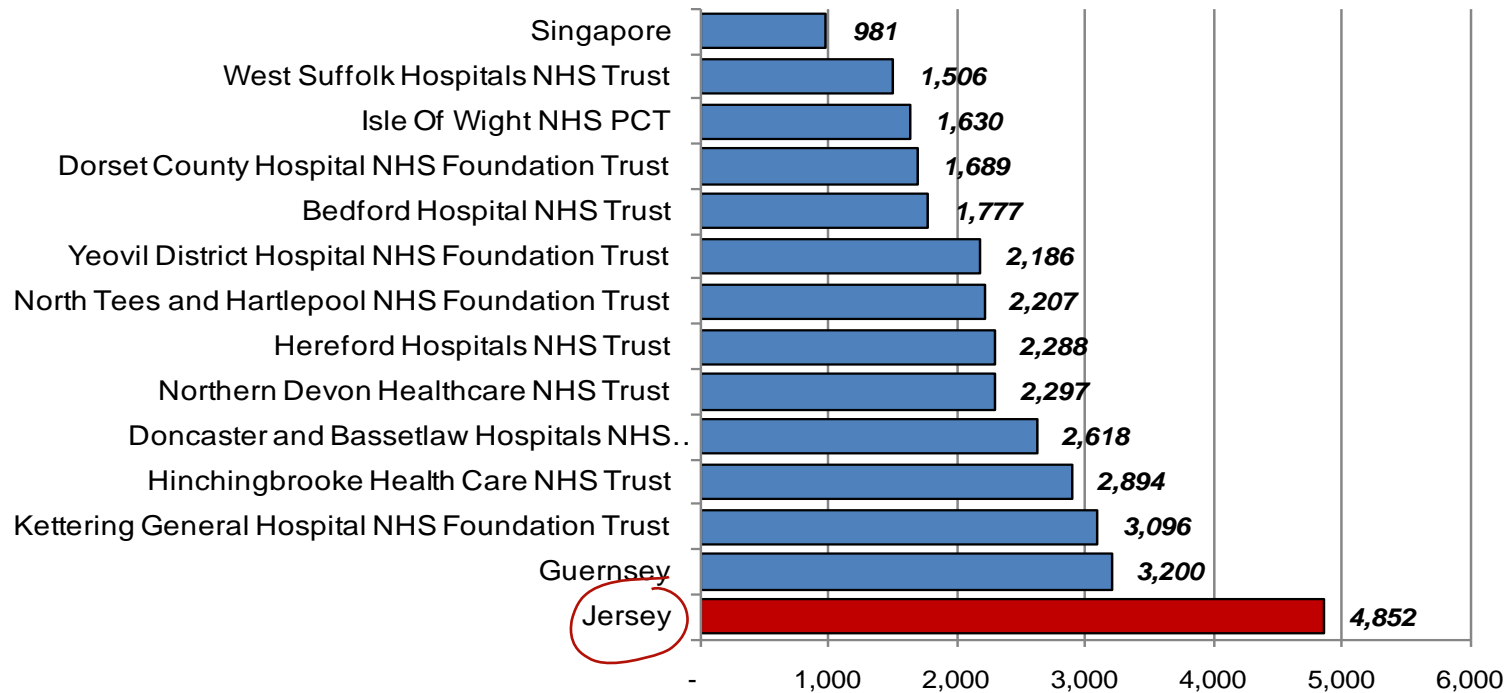
Length of Stay – Obstetrics (UK and Island Jurisdictions)



Source: Dr Foster Intelligence, ISD Scotland; Health Stats Wales; Guernsey HSS Intelligence; Jersey HSSD data; Singapore Ministry of Health.

Secondary care – Bed occupancy

Occupied Bed Days per 100,000 population – Obstetrics (England and Island Jurisdictions)



Source: Dr. Foster Intelligence, Guernsey HSS Intelligence; Jersey HSSD data; Singapore Ministry of Health.

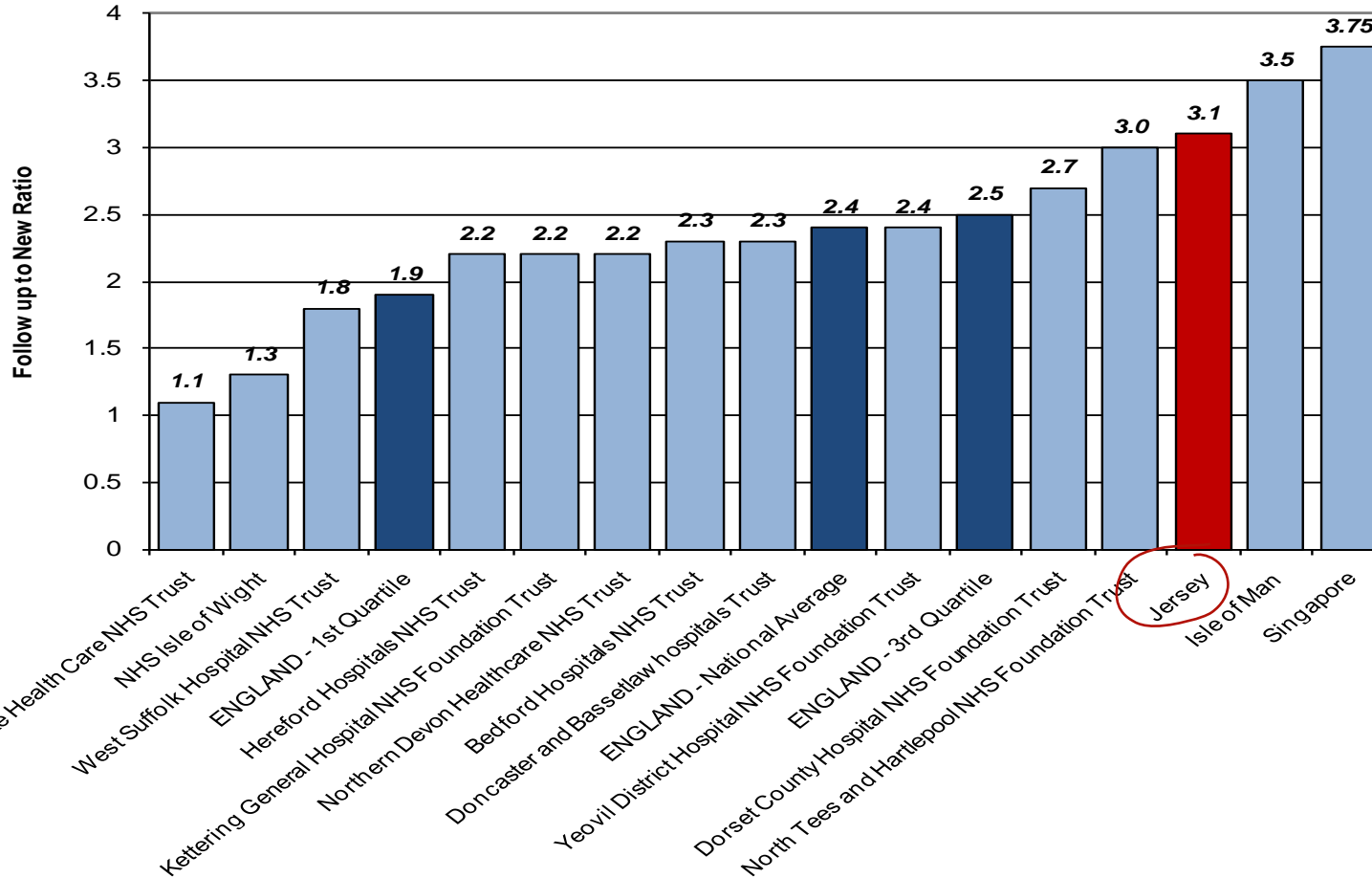
Secondary care – Outpatients

Outpatients – Follow up to new ratio

- The follow up to new ratio for outpatient appointments is relatively high in Jersey in comparison to its peers.
- Jersey's ratio of 3.1 follow up appointments to each new appointment is 0.7 higher than the English national average of 2.4 to 1, and also higher than the English upper quartile of 2.5 follow ups to each new appointment.
- This suggests that more patients are being followed up for longer in secondary care in Jersey than its comparator sites. This may be due to:
 - absence of a primary care based service provision;
 - a reluctance by secondary care clinicians to discharge patients back to community, potentially at the patients' request due to the funding model;
 - specialist activity carried out off-island with subsequent follow up appointments conducted in Jersey.
- Additional outpatient capacity could be created if more patients were followed up in the community. Also, DNA rates would need to be compared to see whether any spare capacity could be released for additional appointments.

Secondary care – Outpatients (cont.)

Outpatients – Follow up to new appointments ratio



Source: Dr Foster Intelligence, Isle of Man (Noble Hospital) data; Jersey HSSD data; Singapore Ministry of Health.

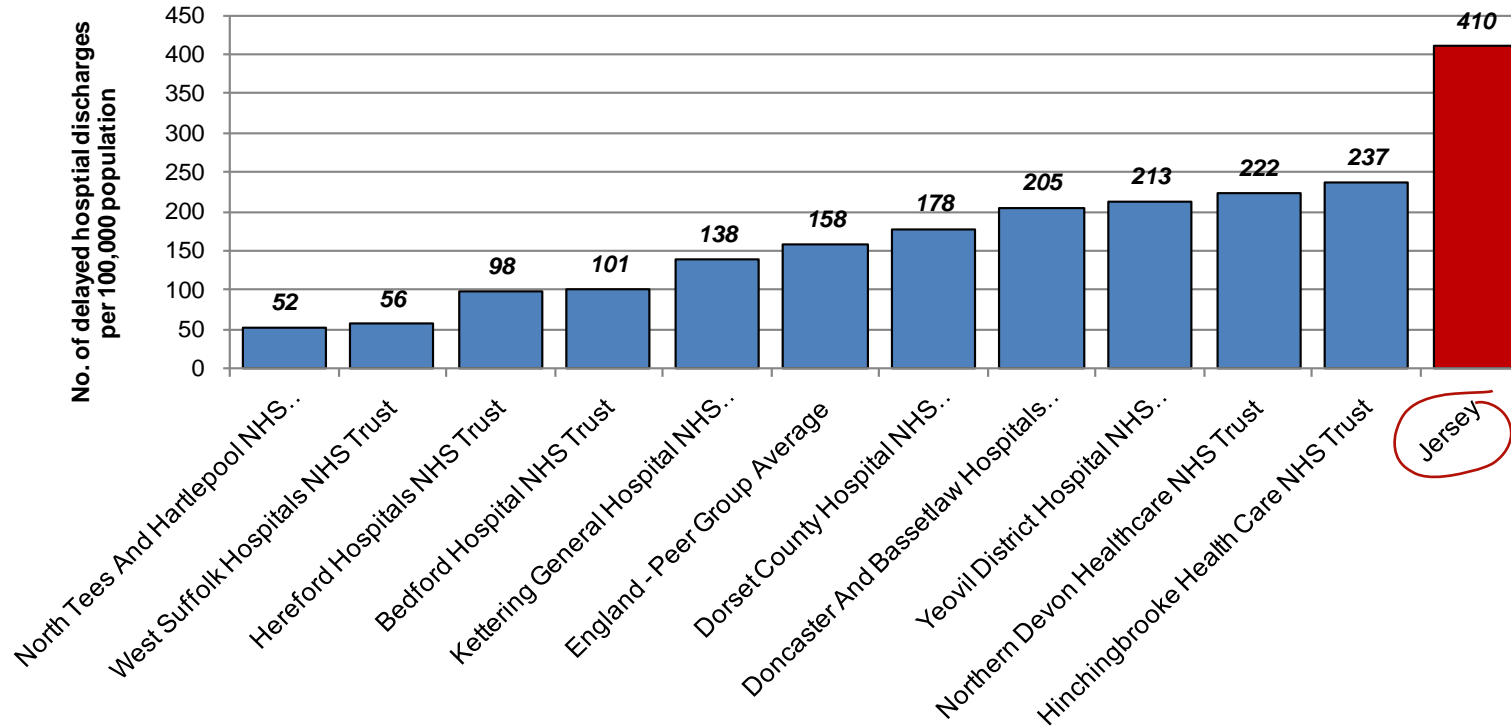
Secondary care – Delayed hospital discharges

Number of Delayed Hospital Discharges (18+) per 100,000 population

- Jersey has a high number of delayed hospital discharges which amounted to 369 incidences of delay in 2010. This equates to 410 delays per 100,000 population.
- This is significantly higher than the English Peer comparators and the upper quartile of 168 delays.
- Delayed hospital discharges in Jersey are mainly caused by Nursing/Residential Care home placements and adults awaiting rehabilitation within Samares unit, both of which account for 40% and 29% of the delays respectively.
- The number of delays caused by Nursing/Residential care home placements is largely due to the high number within nursing/residential care (as seen within the older adults social care benchmarking). This may suggest that the older adult population (65+) enter Nursing /Residential Care earlier than that the comparator organisations.
- Could this population group be supported to live more independently e.g. use of Telecare/Telemedicine?

Secondary care – Delayed hospital discharges (cont.)

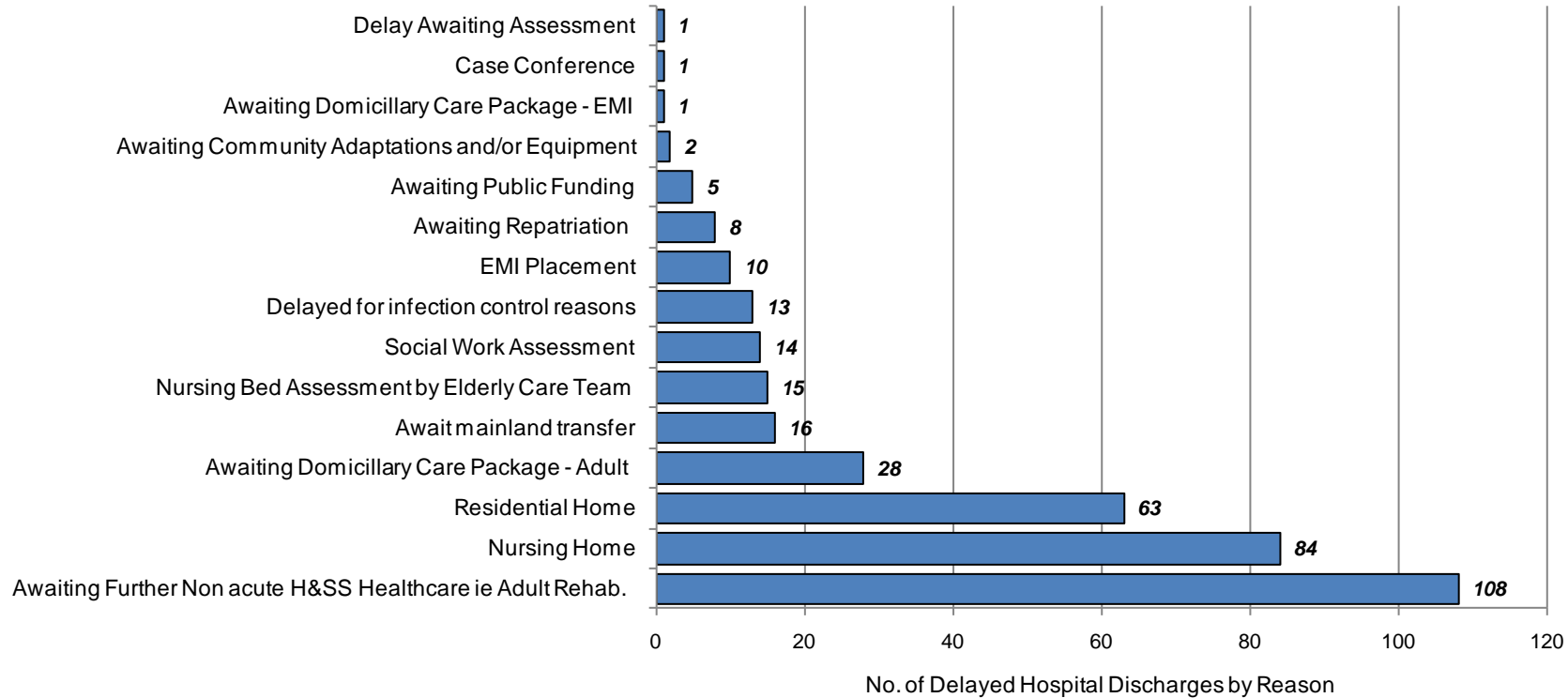
Number of Delayed Hospital Discharges (18+) per 100,000 population



Source: Department of Health; Jersey HSSD data ; KPMG Analysis.

Secondary care – Delayed hospital discharges (cont.)

Jersey Delayed Hospital Discharges (18+) by reason



Note: There were 369 total delayed discharges for HSSD in 2010.
Source: HSSD Analysis.

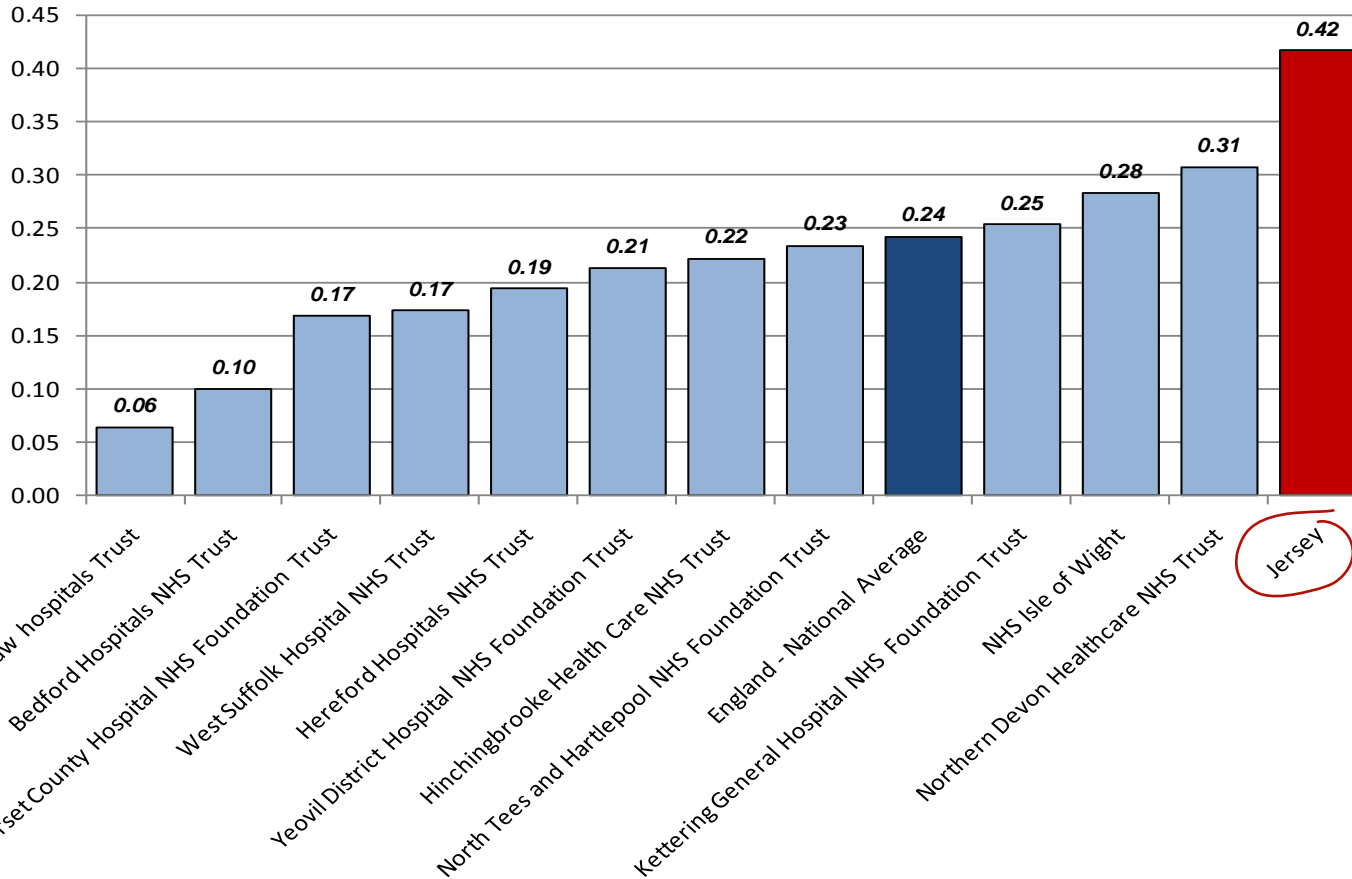
Secondary care – Unscheduled and critical care

Use of Accident and Emergency Service

- The number of Accident and Emergency (A&E) attendances per population size was used as an indicator for the use of the A&E service.
- A&E usage in Jersey is relatively high at 0.42 in comparison to its peers where national averages for both England and Scotland is estimated at 0.24 and 0.29 respectively.
- The high number of A&E attendances is likely to be driven by the Primary Care co-payment model which exists in Jersey, 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 play a role, for example the Portuguese and Polish population are more used to going directly to hospital than using primary care. Ease of access to the hospital may also play a role, as well as the lack of primary care teams in the community (for example community matrons who look after LTC patients in the UK).
- In addition to financial incentives, behavioural shifts to change how the Jersey population use and access healthcare services may help reduce the number of inappropriate A&E admissions.

Secondary care – Unscheduled and critical care (cont.)

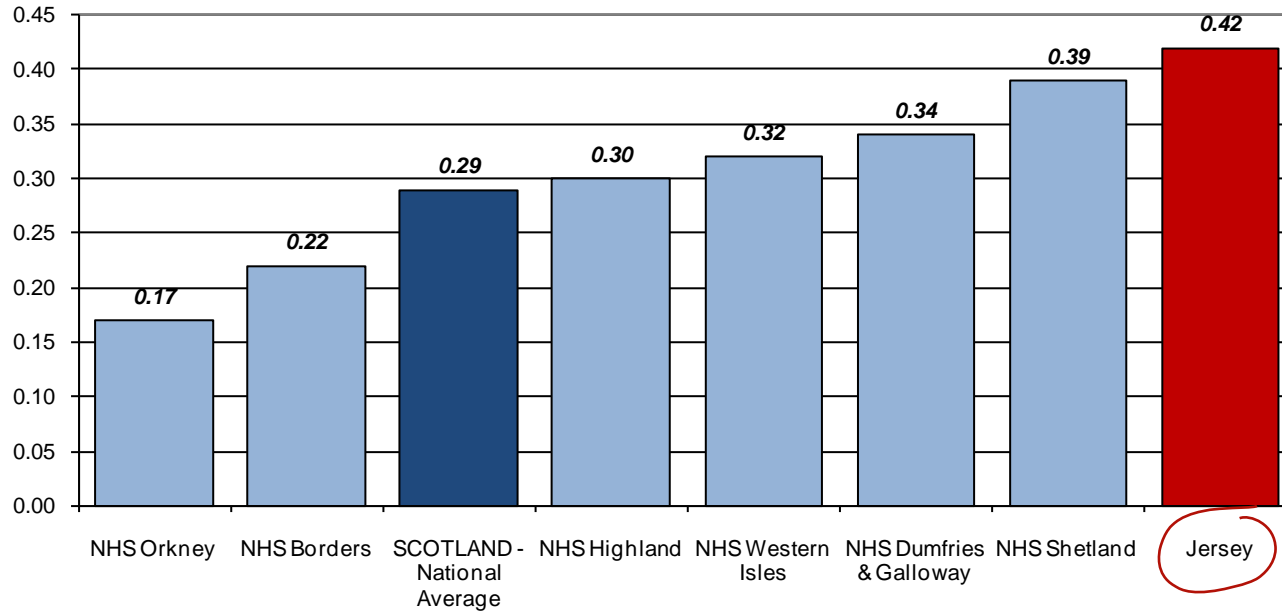
A&E attendances per size of population (England)



Source: HES Data 2008/09; Jersey HSSD data; KPMG analysis.

Secondary care – Unscheduled and critical care (cont.)

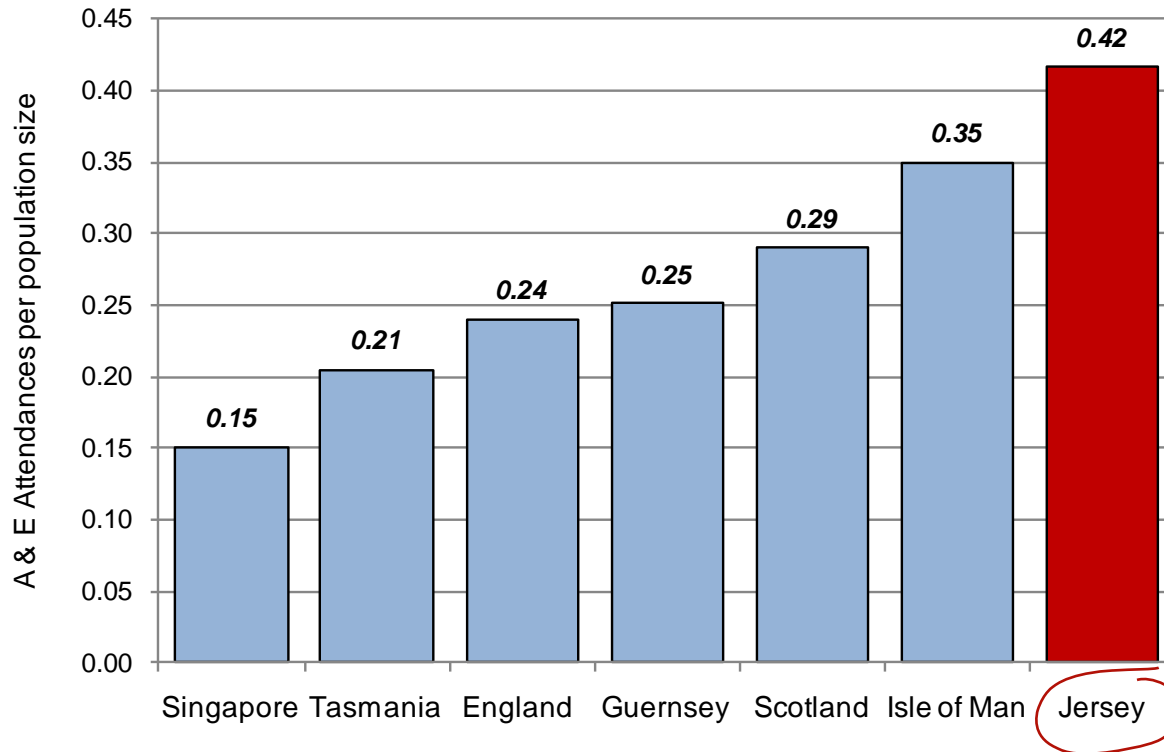
A&E attendances per size of population (Scotland)



Source: ISD Scotland; Jersey HSSD data; KPMG analysis.

Secondary care – Unscheduled and critical care (cont.)

A&E attendances per size of population (International/Island Jurisdictions)



Source: Guernsey HSS Intelligence; Tasmania (Health and Human Services); Isle of Man (Noble Hospital data); Jersey HSSD data; HES data; KPMG analysis.

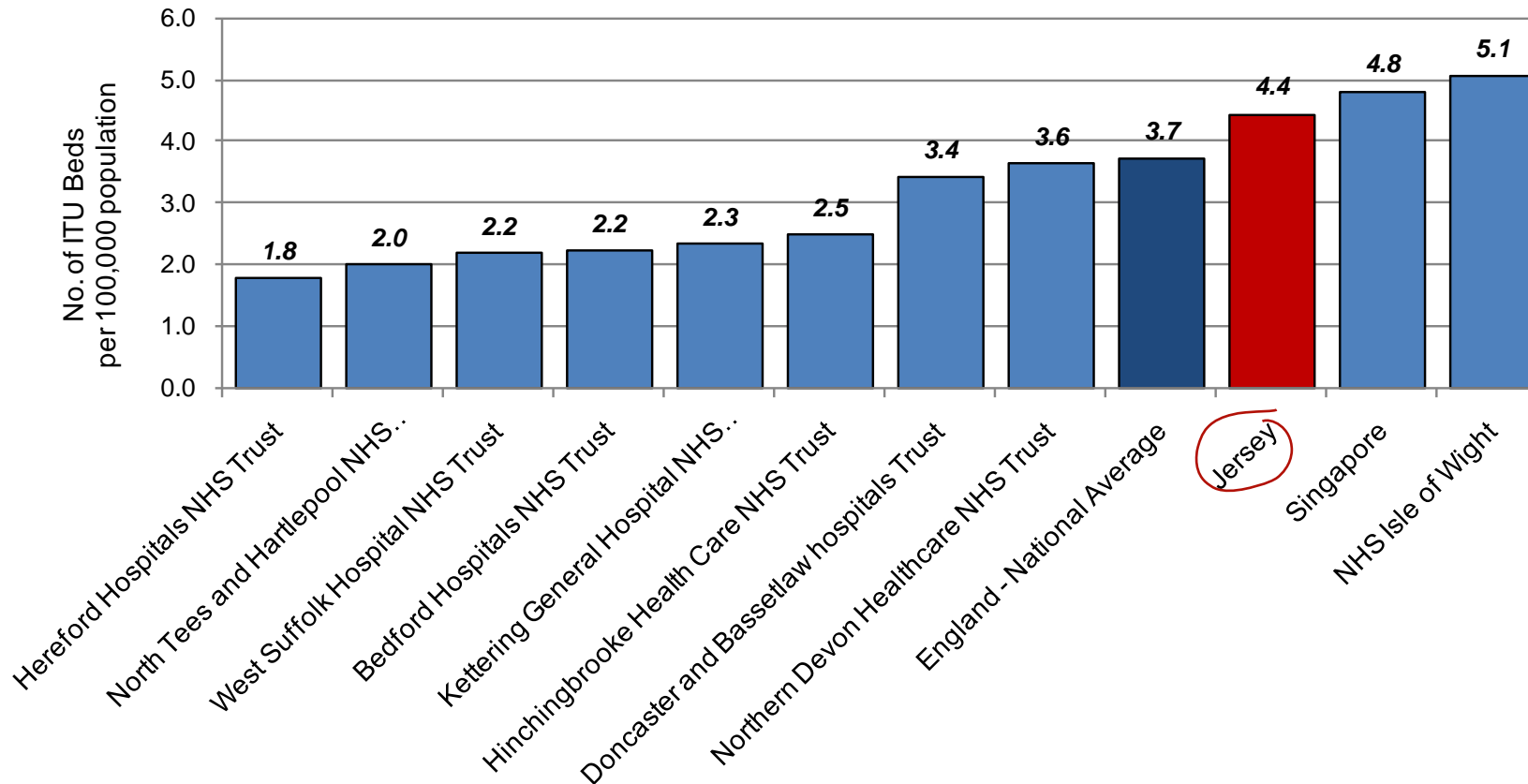
Secondary care – Unscheduled and critical care (cont.)

Critical Care Unit

- The number of Intensive Therapy Unit (ITU) beds per 100,000 population was used as an indicator to compare availability of beds for critical care against other comparators. The absolute number of ITU beds in Jersey is 4 beds for a population just under 90,000, however for benchmarking purposes, is inflated to 4.4 to account for the beds per 100,000 population.
- In comparison to England, the number of ITU beds in Jersey per 100,000 population is higher than some of the peer groups and just above the English national average of 3.7 beds.
- Whilst some of the peer comparators have a lower number of beds per 100,000 population, access to additional ITU beds is possible at other hospitals on a local or national basis if required. Hence, there may be a need to keep sufficient beds available in case transporting of patients to the main land is not possible either due to weather conditions or due to lack of availability of beds in the UK.
- Other reasons for the difference in numbers may also could include:
 - Different levels of acuity that can be looked after on the wards, due to staffing levels and skill mix;
 - Different admission thresholds for a critical care bed;
 - Different levels of care provided in critical care.

Secondary care – Unscheduled and critical care (cont.)

Intensive Care Beds per 100,000 population (England and island jurisdictions)



Source: HES Data, NHS Information Centre Data; Singapore Govt stats; Jersey HSSD data; KPMG analysis.

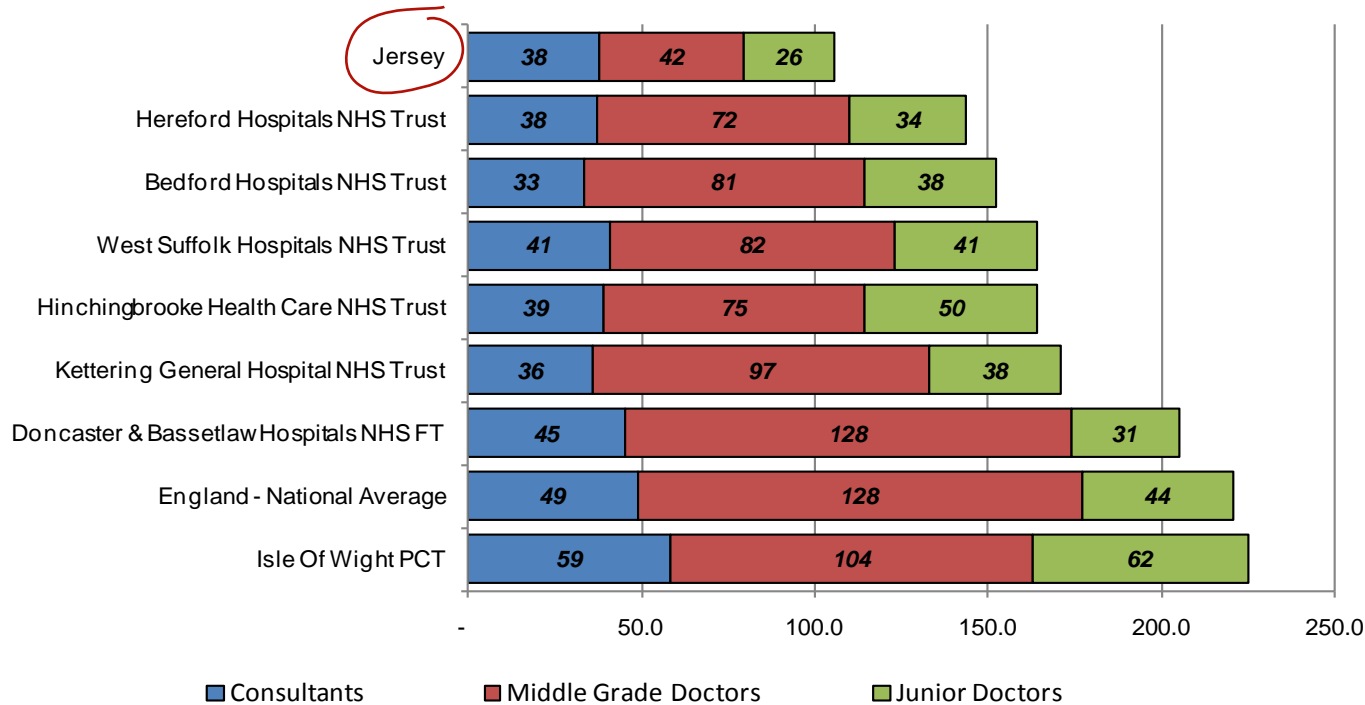
Secondary care – Workforce

Workforce – Medical staff by grade per 100,000 population

- Consultant numbers in Jersey are 38 FTE per 100,000 population compared with an English average of some 49. This could at least in part be explained by:
 - Sub-specialisation in hospitals in England, whilst consultants in Jersey deal with a relatively generalist case load.
 - Some Activity is sent off island, especially complex cases.
 - Visiting consultants flying into Jersey for specialist work has not been taken into account.
- It is interesting to note that in other island communities such as Shetland and the Western Isles the service appears to be more consultant provided, whereas Jersey relies more strongly on middle grade doctors (SpRs etc.)
- The number of junior doctors in training is equivalent to other island economies such as Shetlands, Orkney and may reflect limited access to standard training rotas.
- 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.

Secondary care – Workforce (cont.)

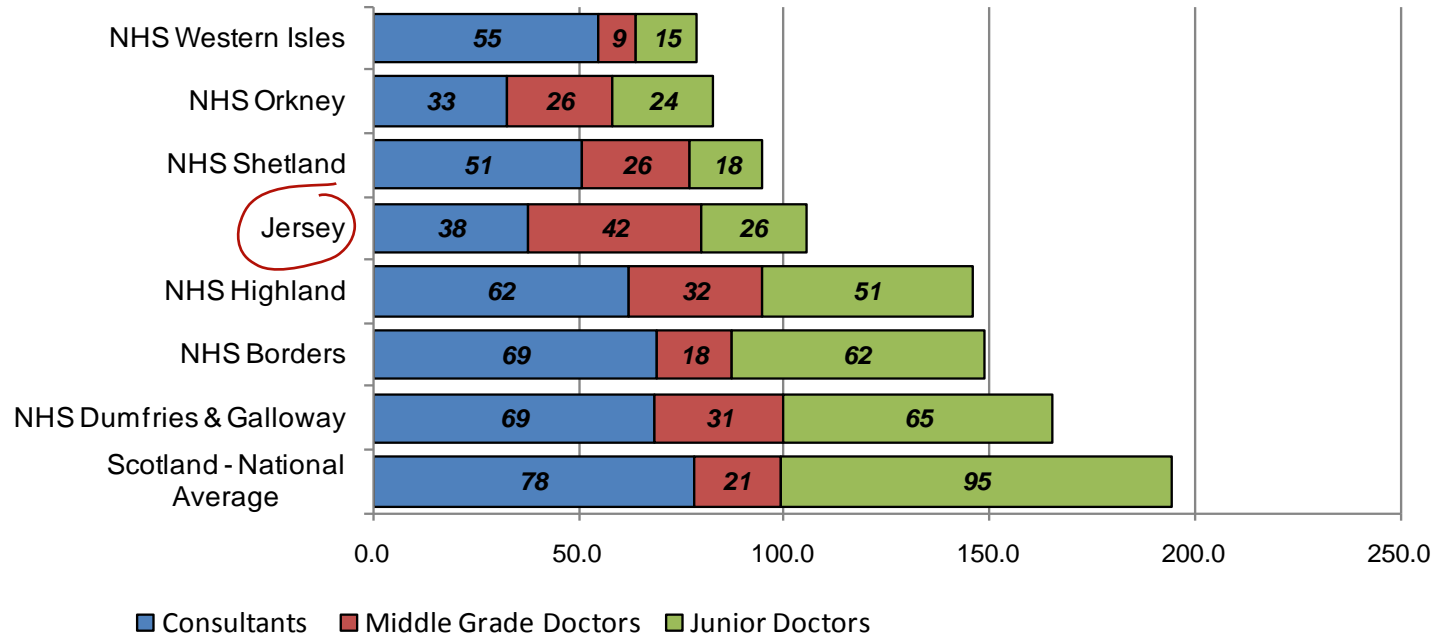
Workforce – Medical staff by grade per 100,000 population (England)



Source: NHS Information Centre; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

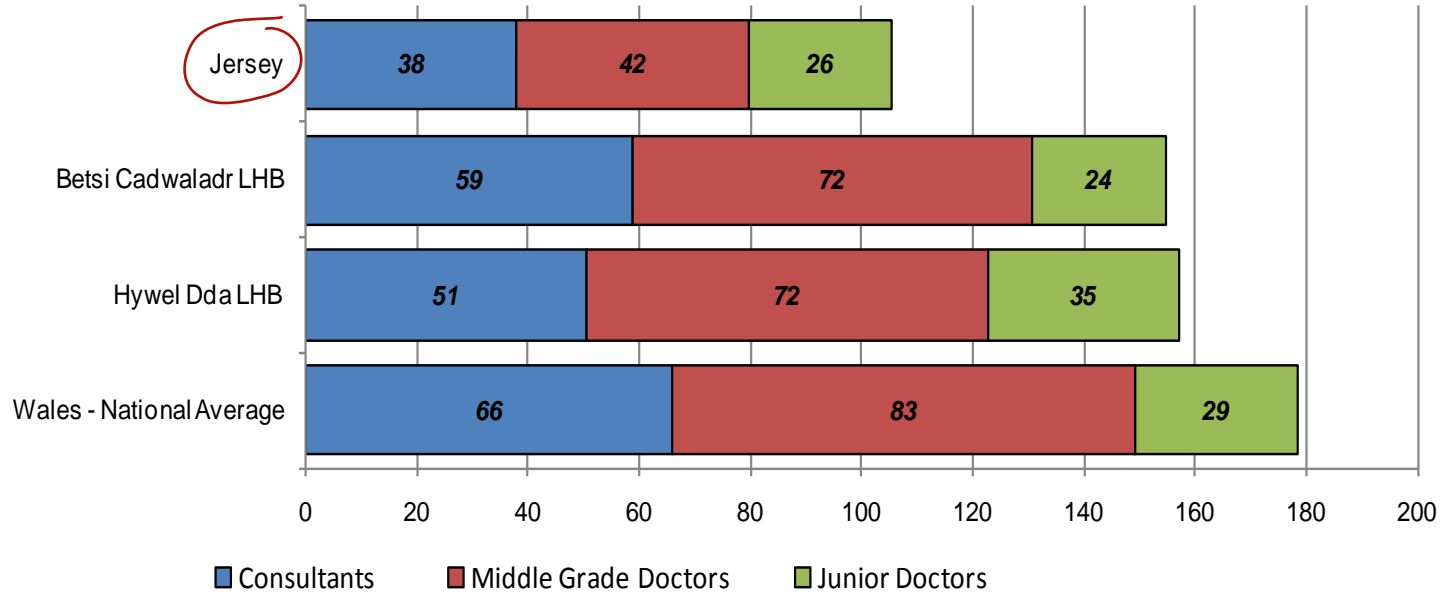
Workforce – Medical staff by grade per 100,000 population (Scotland)



Source: ISD Scotland; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

Workforce – Medical staff by grade per 100,000 population (Wales)



Source: Health stats Wales; Jersey HSSD data; KPMG analysis.

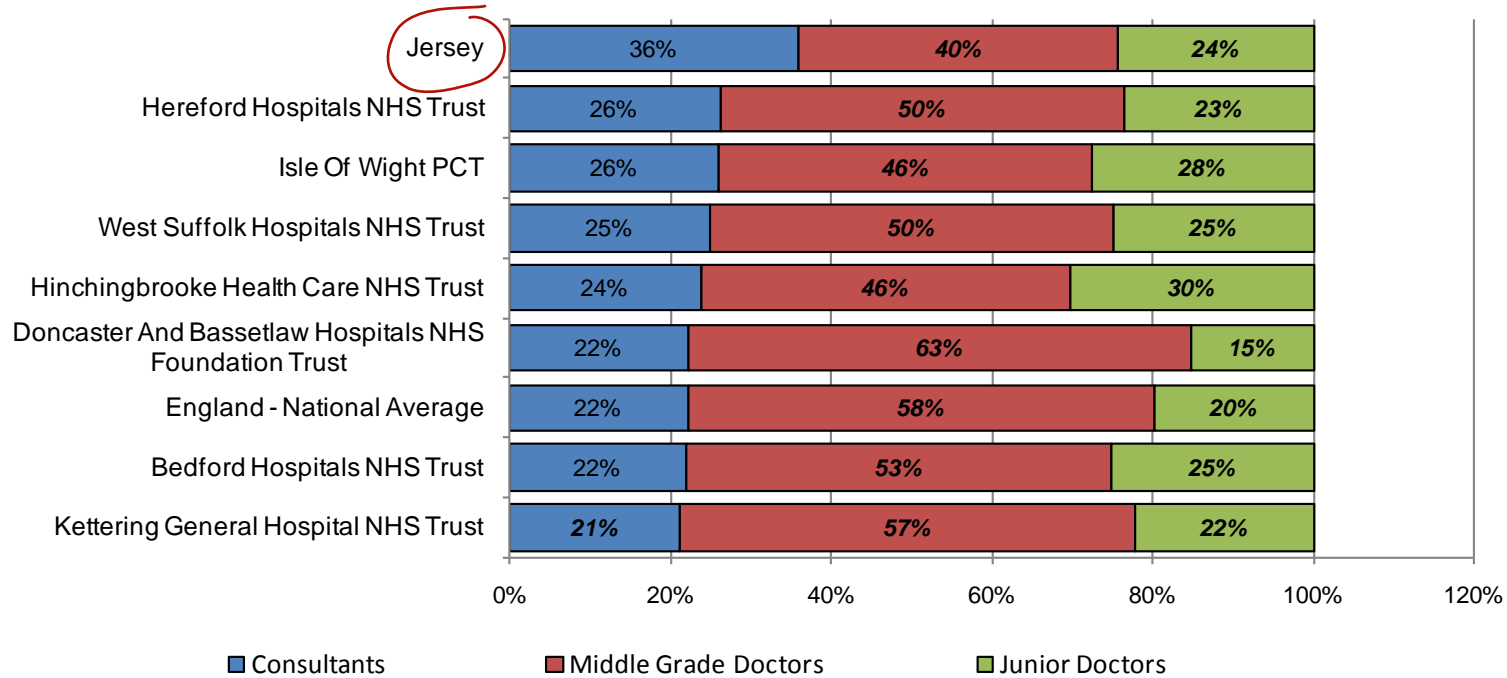
Secondary care – Workforce (cont.)

Medical Staff Skill Mix by Grade

- Compared to its English comparator sites, Jersey secondary care is delivered by proportionately significantly more consultants, and fewer middle grade doctors. The latter may be a reflection of reduced access to standard training rotations at middle grade levels (SpR etc.). Visiting consultants flying into Jersey for specialist work have not been taken into account.
- It is interesting to note that in most of the other island/remote communities such as Shetland and the Western Isles, the service appears to be more consultant provided, whereas Jersey relies proportionately more strongly on middle grade doctors (staff grades, SpRs).
- The number of junior doctors in training is proportionately lower than in some other island/remote economies such as the Shetlands and Orkney and may reflect more limited access to standard training rotas.
- In addition, the actual total number of doctors may be very different between the comparator sites e.g. NHS Western Isles with population of under 25,000, have 15 consultants (FTEs) out of a total medical workforce of only 21.6 (FTEs), which accounts of 70% of the medical workforce.
- There appears to be an opportunity to review the medical staff skill mix by grade in view of the significant proportional differences with comparator organisations.

Secondary care – Workforce (cont.)

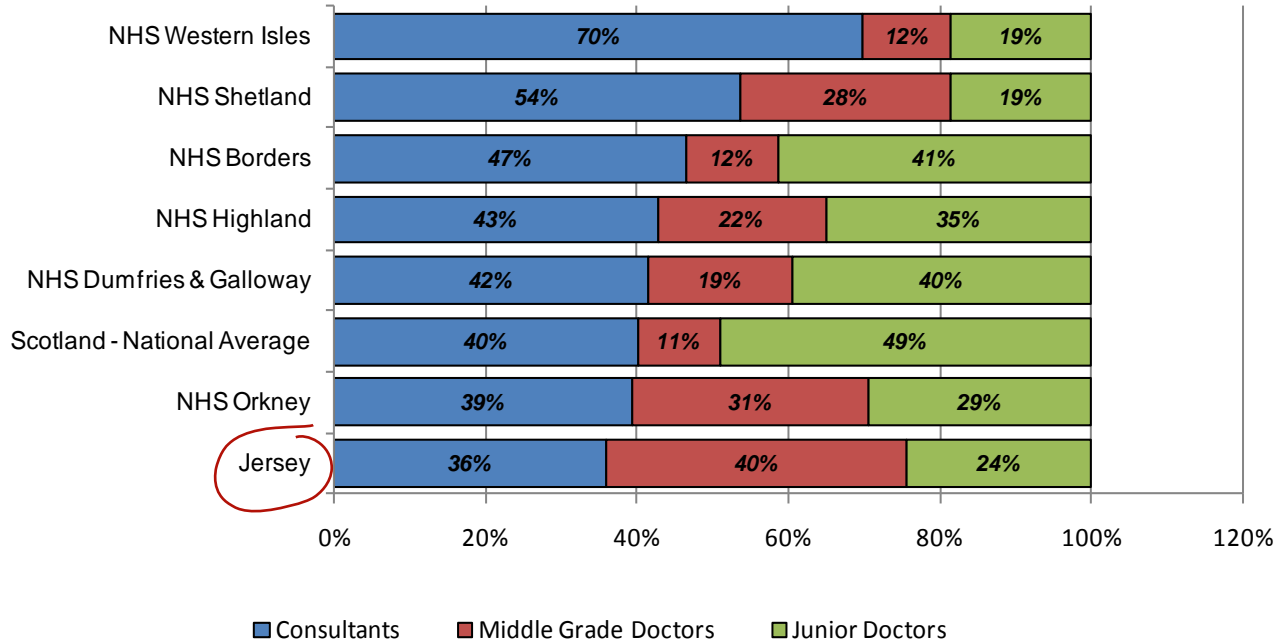
Medical Staff Skill Mix by Grade (England)



Source: NHS Information Centre; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

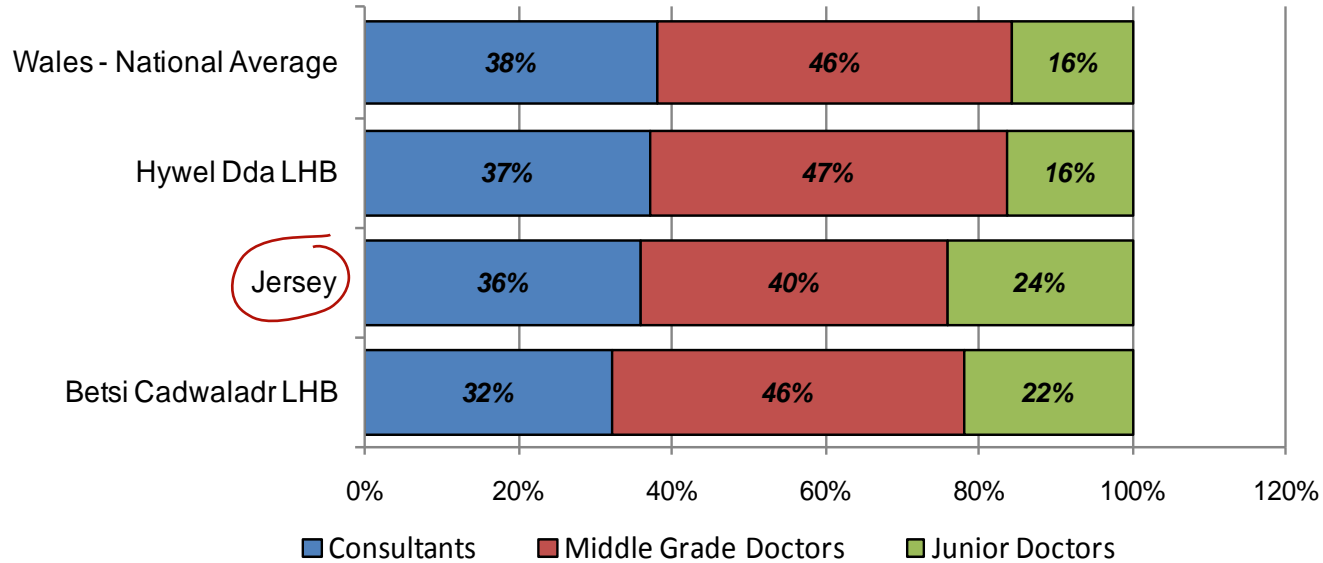
Medical Staff Skill Mix by Grade (Scotland)



Source: ISD Scotland; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

Medical Staff Skill Mix by Grade (Wales)



Source: Health stats Wales; Jersey HSSD data; KPMG analysis.

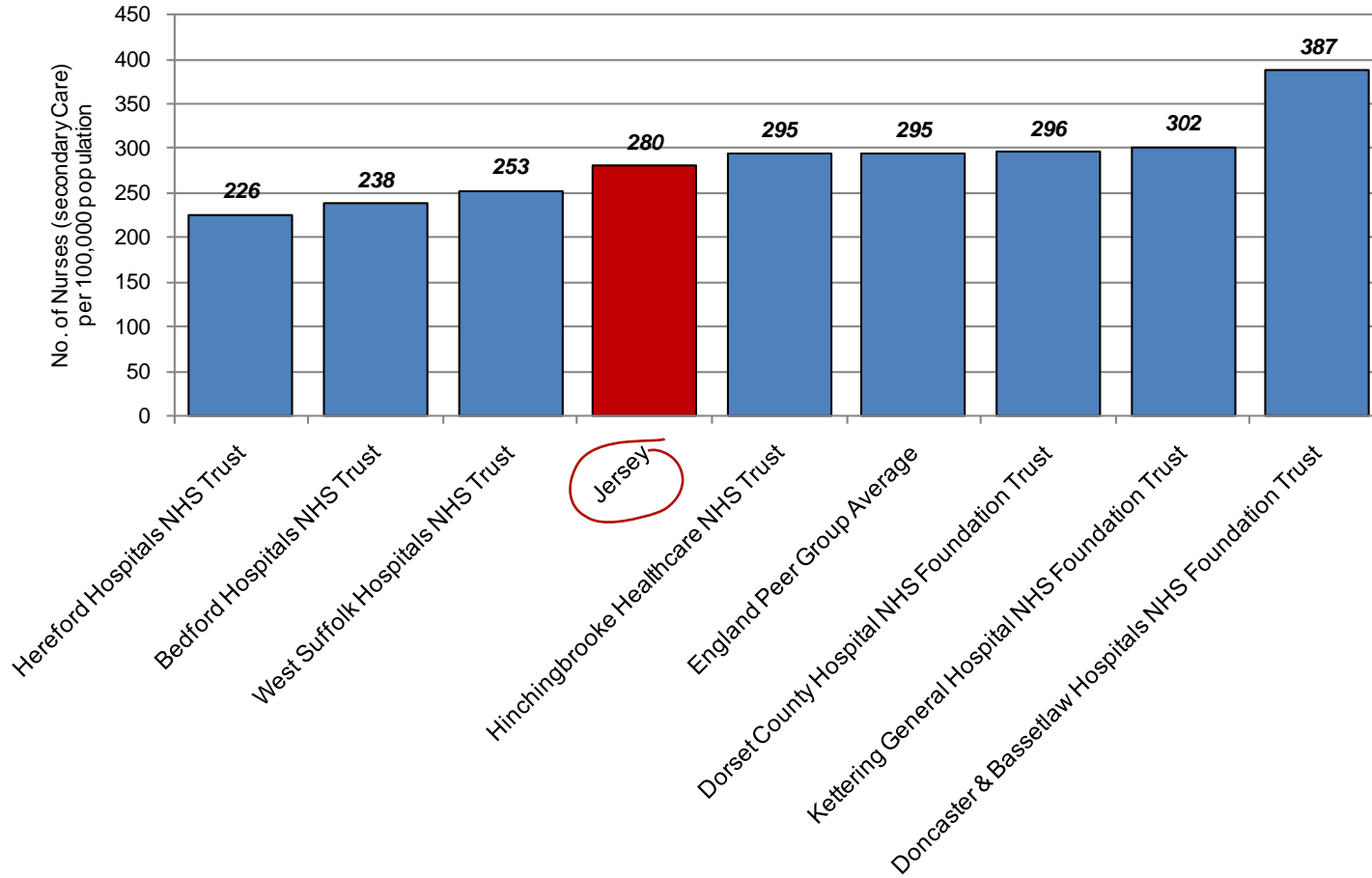
Secondary care – Workforce (cont.)

Nursing Staff per 100,000 population and Nurse to Bed ratio

- Jersey currently has 340 nursing staff (FTEs) employed within secondary care which equates 378 FTEs per 100,000 population which includes adult/paediatric nursing and midwifery staff. Within this, the number of professionally registered nursing and midwifery staff amount to 252 FTEs (or 280 per 100,000 population).
- 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 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.
- It should be noted that, the English comparator organisations with the lower number of registered nursing and midwifery secondary care staff e.g. Hereford, had the highest number of registered nursing staff for community care which implies a more community based service model.
- Jersey's midwifery staff should also be taken into consideration. Due to the secondary care midwifery model which exists in Jersey in comparison to UK comparators which follow a more community based model and offer choice for place of birth, this may also inflate the number of nursing staff within secondary care in Jersey.

Secondary care – Workforce (cont.)

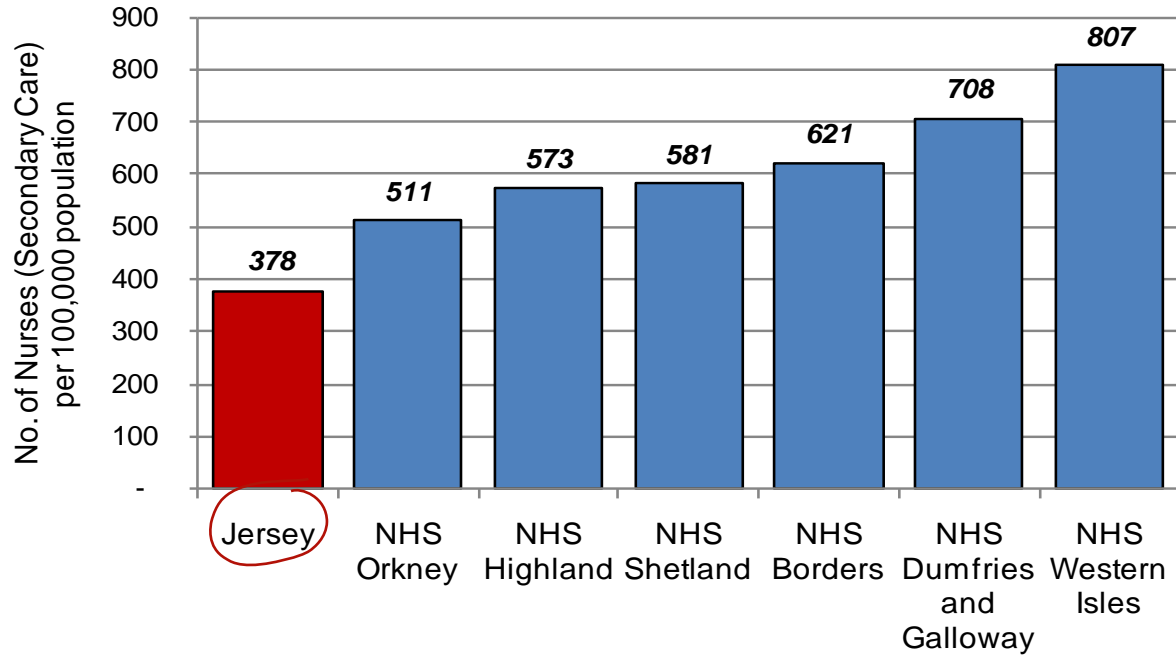
Registered Nursing and Midwifery staff per 100,000 population (England)



Source: NHS Information Centre; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

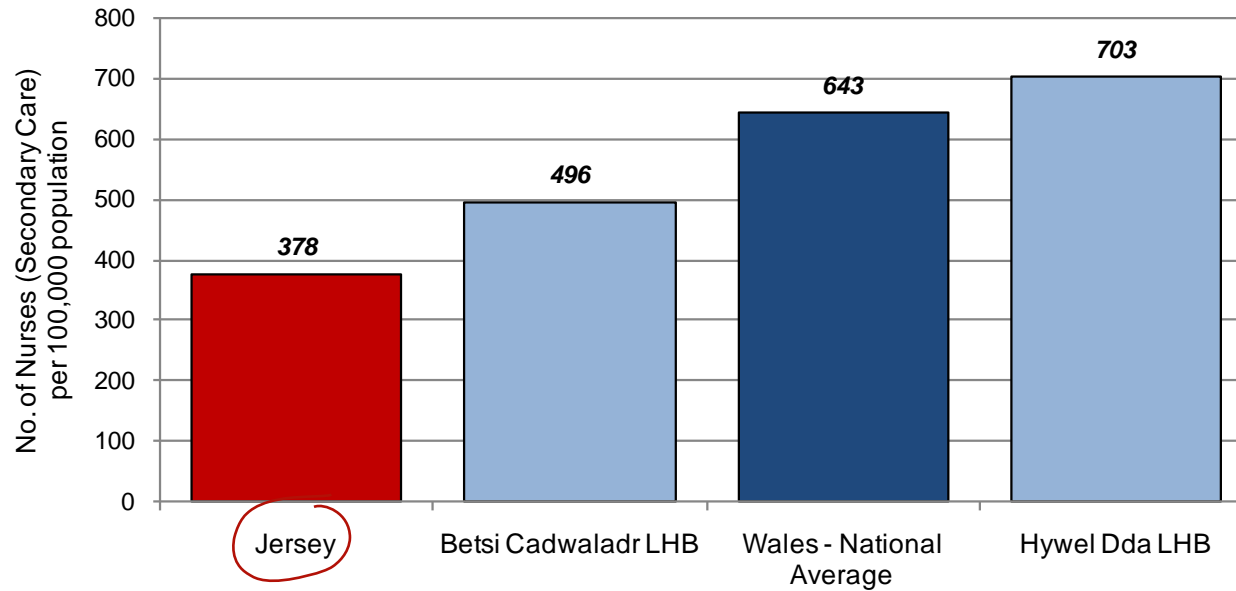
Nursing and Midwifery staff (all grades) per 100,000 population (Scotland)



Source: ISD Scotland; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

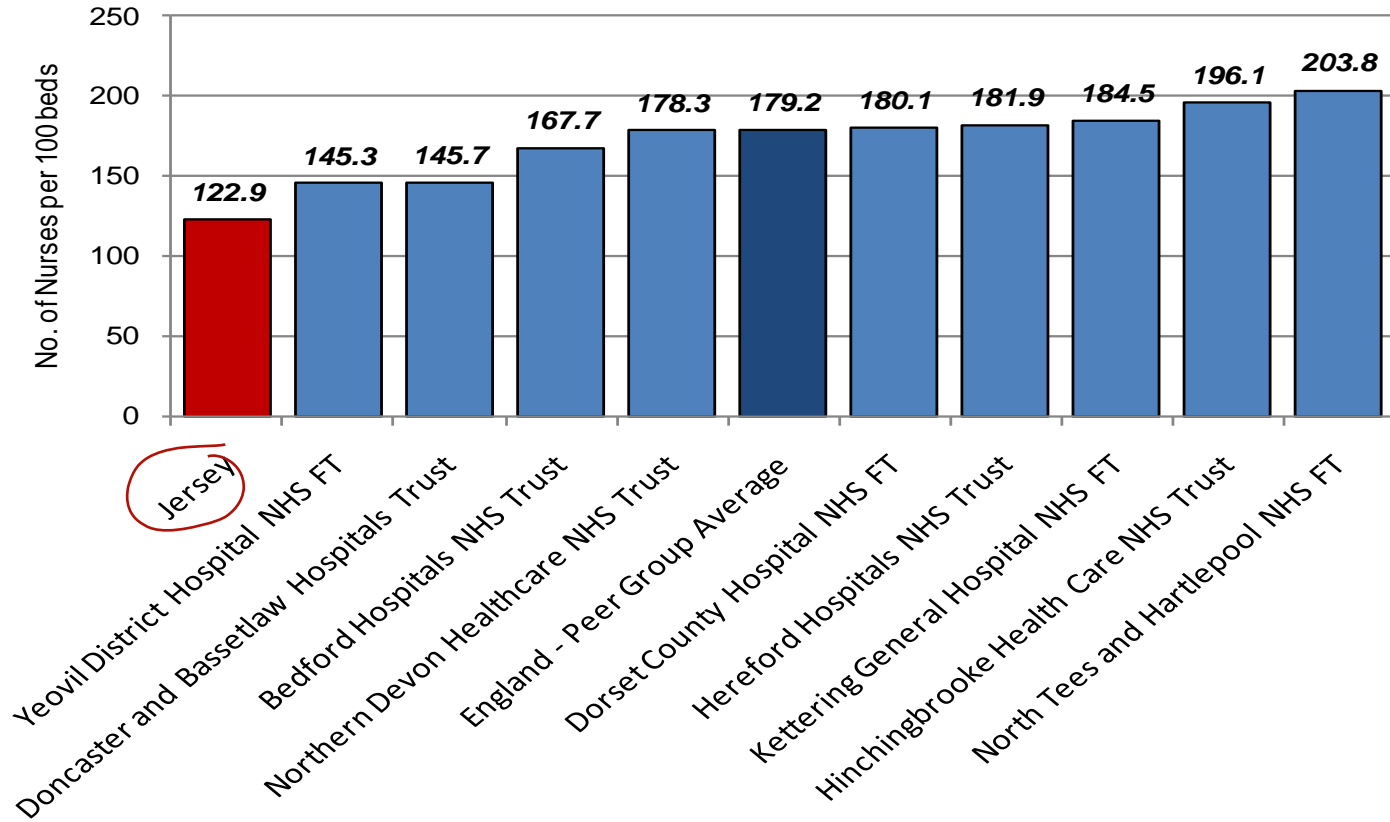
Nursing and Midwifery staff (all grades) per 100,000 population (Wales)



Source: Health stats Wales; Jersey HSSD data; KPMG analysis.

Secondary care – Workforce (cont.)

Number of Nurses (all grades) per 100 Beds – England



Source: Dr. Foster Intelligence; Jersey HSSD data; KPMG Analysis.

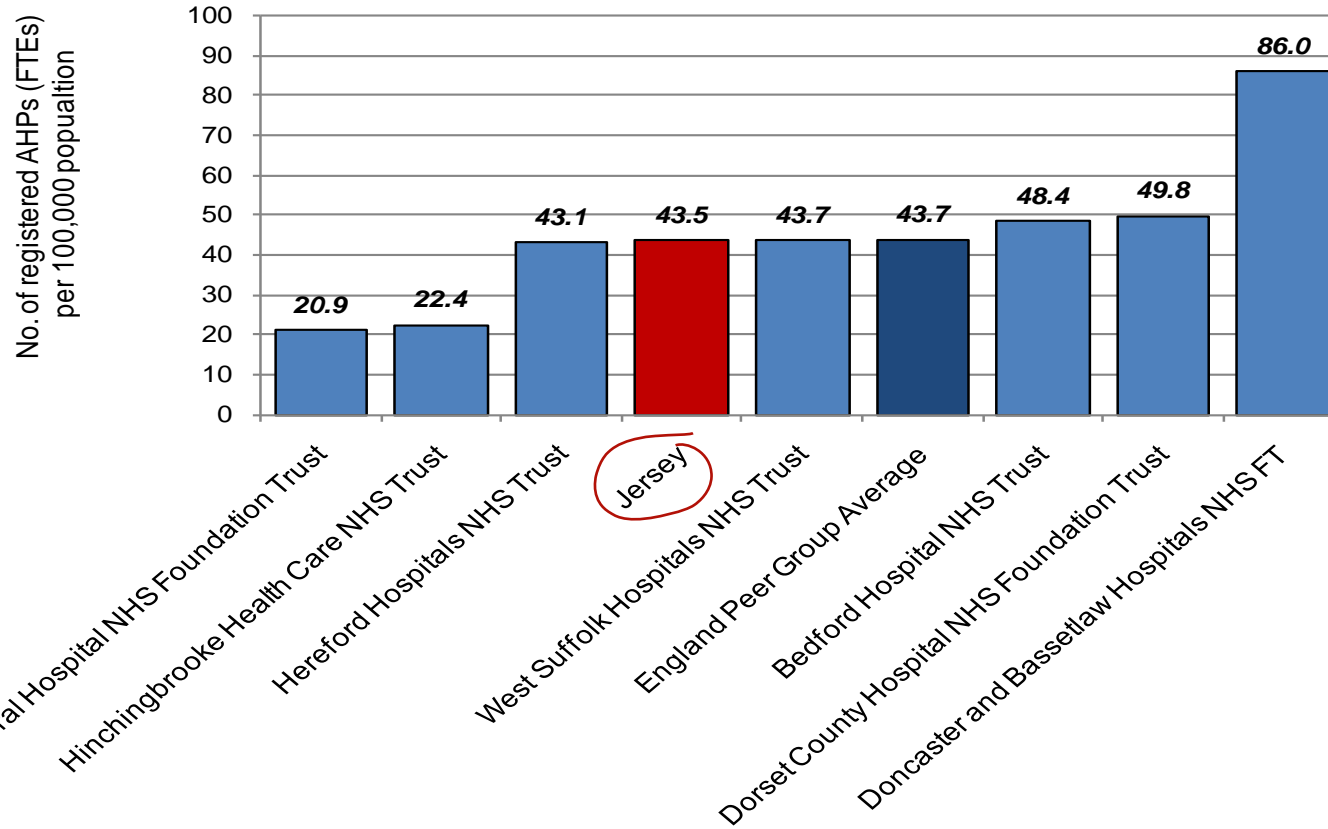
Secondary care – Workforce (cont.)

Registered Allied Health Professionals (Acute Care) per 100,000 population

- The number of registered Allied Health Professionals (AHPs) per 100,000 population working within acute Services in Jersey amounts to 43.5 FTEs (or 39.2 FTEs in absolute terms).
- This represents the number of professionally registered AHPs delivering acute services. As such, it does not include non registered allied health support staff e.g. physiotherapy helpers which are also an integral part of the service delivery team.
- Jersey is on par with the English peer comparators whose average amounts to 43.7 FTEs. It should be noted that for Jersey, this includes 2 FTEs (absolute number) who undertake GP direct access for Physiotherapy in the acute setting.
- The highest comparator is from a large English acute Foundation Trust which has a significantly high number of AHPs in comparison to other peer comparators. This may partly be due to the impact of the 'Transforming Community Services' agenda, where PCT provider arms have or are in the process of, transferring community services to acute and/or mental health organisations.

Secondary care – Workforce (cont.)

Registered Allied Health Professionals (Acute Care) per 100,000 population



Source: NHS Information Centre; HSSD data; KPMG analysis.

Mental health

- Number of Detainments under the Mental Health Act.
- Number of Mental Health Users per 100,000 population.
- All (adult and old age) Inpatient Admissions per 10,000 population.
- Adult (<65) Acute Inpatient Admissions per 10,000 population.
- Number of beds available versus recommended as per Sainsbury Report.

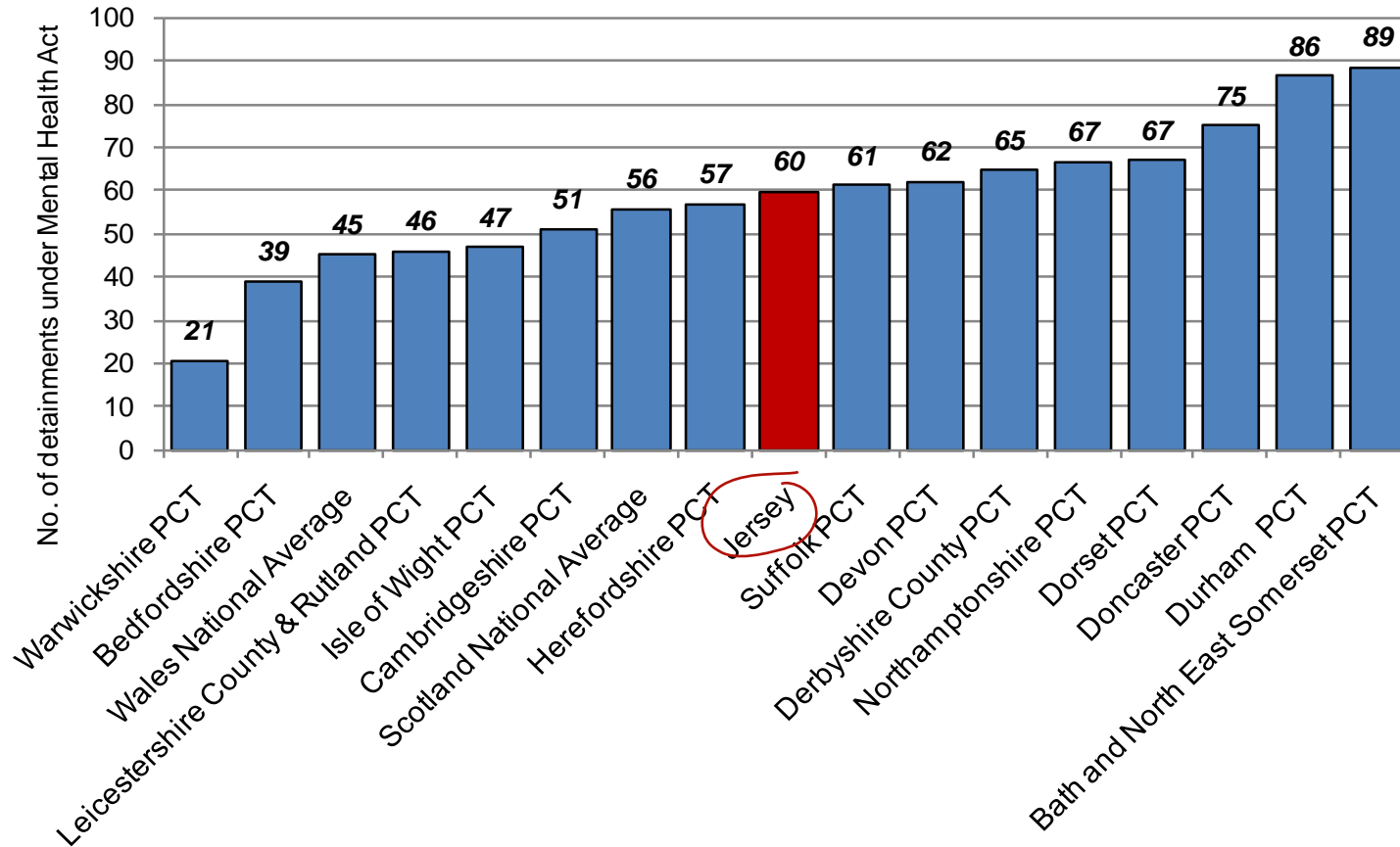
Mental health (cont.)

Number of Detainments under the Mental Health Act

- The number of detainments in Jersey per 100,000 population equated to 60 extrapolated upwards from the total of 54 split between adult (41) and older adult (13). This is on par with peer comparators within this group, although higher than the national average for both Scotland and Wales.
- The Mental Health Act in Jersey is different and does not have a criminal justice element to it as with the UK.
- There is a philosophy in Jersey to operate a least restrictive policy which could account for the on par results.

Mental health (cont.)

No. of Detainments under the Mental Health Act (per 100,000 population)



Source: NHS Information Centre; Health Stats Wales; ISD Scotland; Jersey HSSD data; KPMG Analysis.

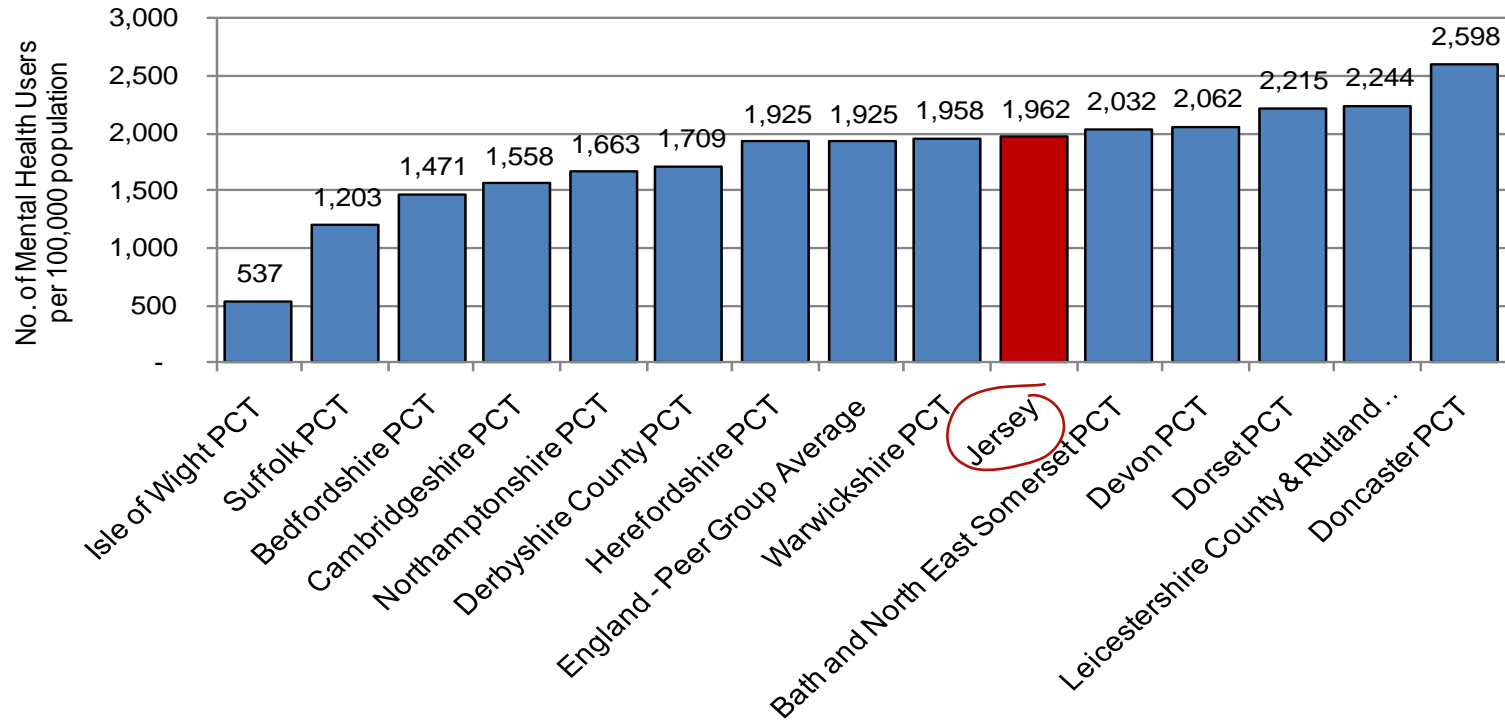
Mental health (cont.)

Number of Mental Health Users per 100,000 population

- The figures used to calculate this benchmark were caseload figures for Jersey (avoiding a potential double count for inpatients) against non-admitted in England to try to avoid a similar counting issue.
- Jersey appears to be on par with the majority of comparisons and almost exactly on the peer average of the English peer average of 1,925 mental health users per 100,000 population, suggesting a comparative prevalence.

Mental health (cont.)

Number of Mental Health Users per 100,000 population



Source: NHS Information Centre; Jersey HSSD data; KPMG Analysis.

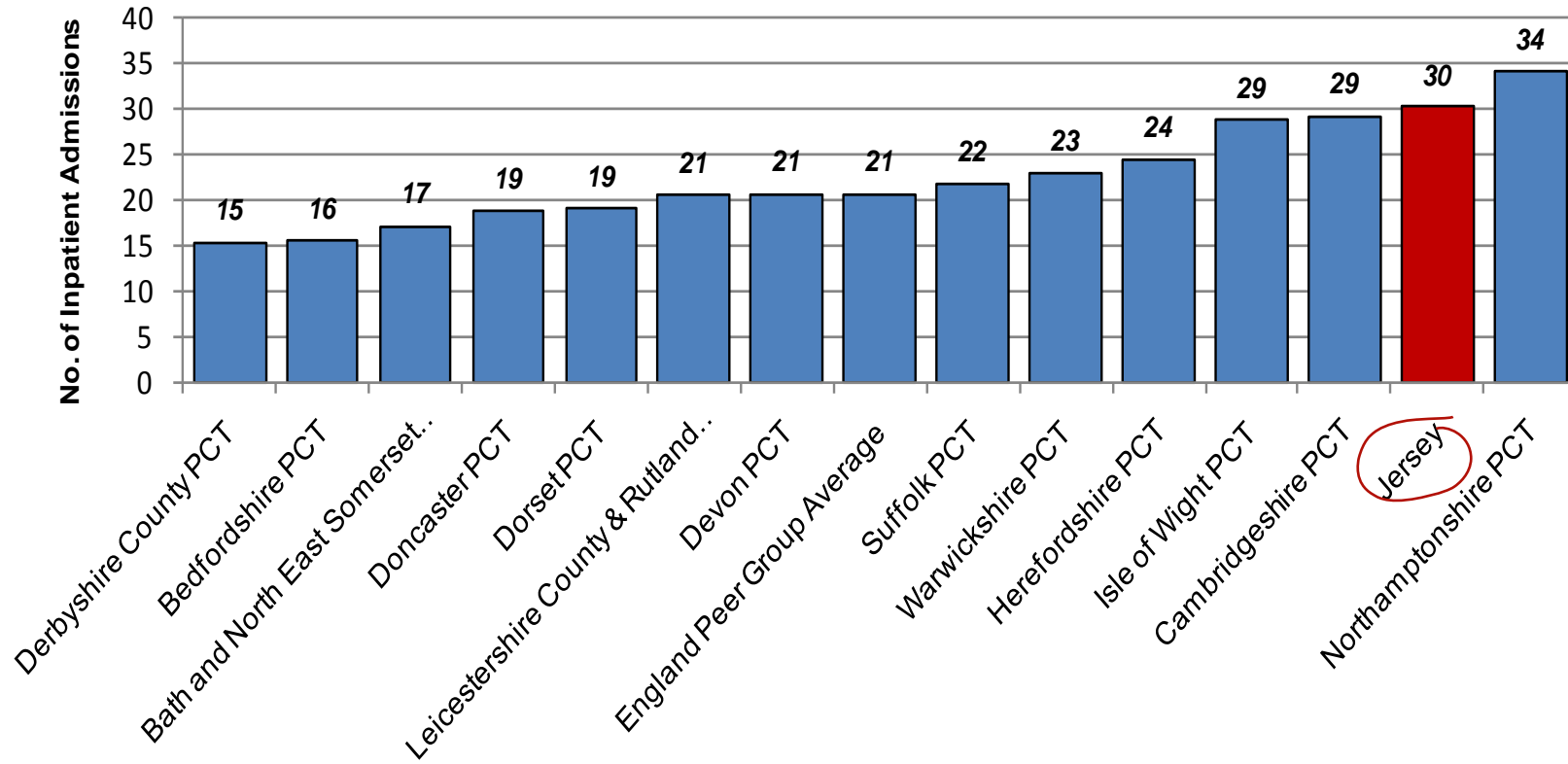
Mental health (cont.)

Acute Inpatient Admissions per 10,000 population

- There are two different comparisons for this benchmark due to the comparator data set. England compares adult plus older adult and Scotland and Wales just adult.
- The number of adult plus older adults is 30 per 100,000 population, which is high for the peer group with the average being 21 meaning Jersey has almost a third more.
- The previous data suggested that prevalence and patients using mental health services was not dissimilar and coupled with a low working age adult admission rate of 19 per 100,000 as per the Scotland and Wales comparator, this suggests the older adult model may be more inpatient focussed.
- Older adults have a greater inpatient based model and have a higher proportion of continuing care beds with a greater demand placed on the service and this may account for the difference. When the peer group mean for adults is taken into account as 38 this potentially evens the model potentially demonstrating that the adult model of care is more community focussed, whereas the older adults model is more inpatient focussed.

Mental health (cont.)

All (adult and old age) Inpatient Admissions per 10,000 population (England)

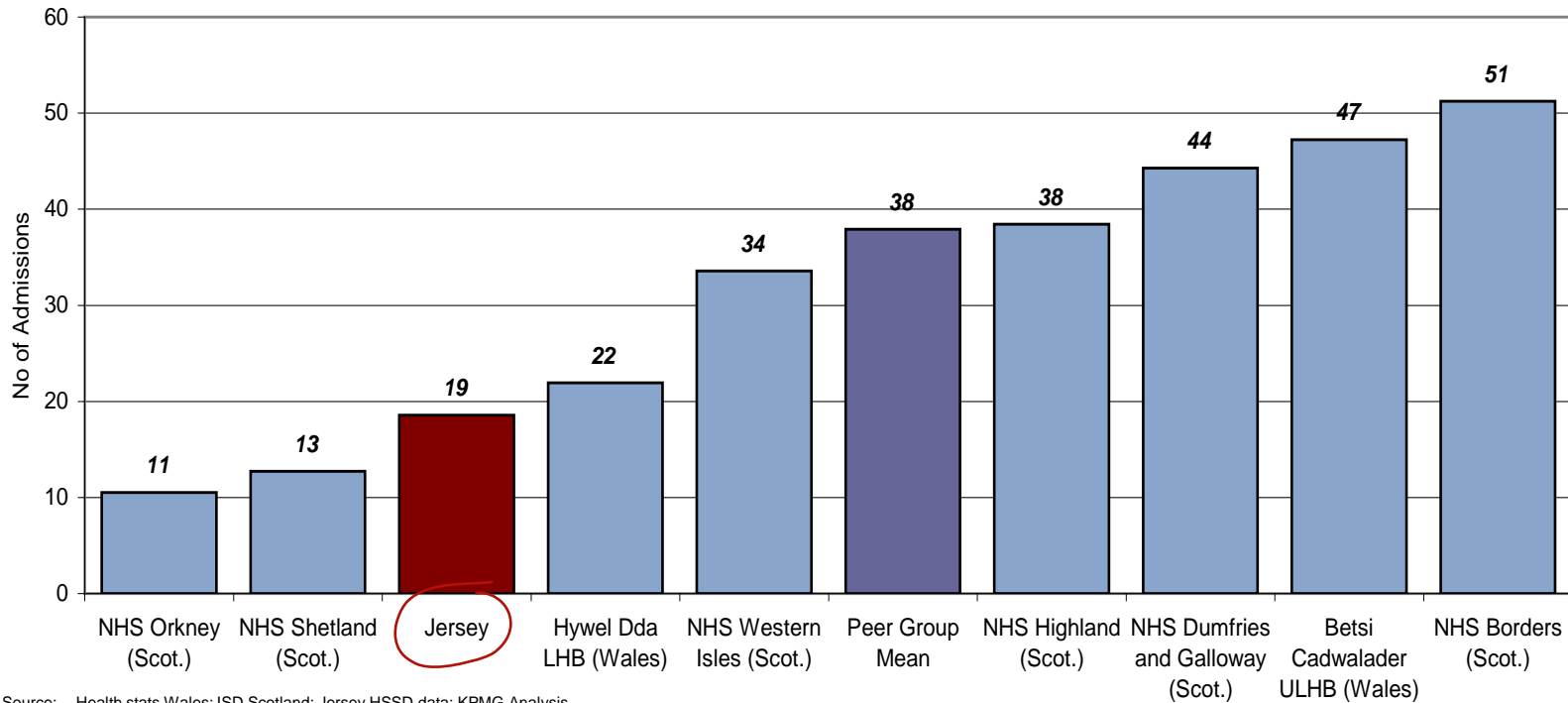


Source: NHS Information Centre; Jersey HSSD data ; KPMG Analysis.

Mental health (cont.)

Adult (<65) Acute Inpatient Admissions per 10,000 population (Scotland and Wales)

No of Admissions per 10,000 Population



Source: Health stats Wales; ISD Scotland; Jersey HSSD data; KPMG Analysis.

Mental health (cont.)

Number of beds available versus recommended as per Sainsbury Report

- Jersey is a small island with a small critical mass and therefore provision of high need service is often challenging.
- A comparison of the different types of inpatient beds against the Sainsbury Centre report recommendations^(a) has demonstrated where provision is focussed .
- It is recommended for a population of 100,000, 103 different type of care bed are provided whereas Jersey currently has 54 including 5 off island placements, however it could be argued there is additional capacity in Roseneath and the Shelter which increases this level of provision.
- Given the greater move towards community provision in adult mental health provision on Jersey and the immediate lack of critical mass, an optimum hybrid combination of inpatient provision may need to be considered in the future.

Source: (a) Delivering the Government's Mental Health Policies, Services, Staffing and Costs, Boardman and Parsonage, 2007 Sainsbury Centre.

Mental health (cont.)

No. of Mental Health Beds available versus recommended as per Sainsbury report (per 250,000 population)

Type of unit	No. of beds recommended for population of 250,000	No. of beds Jersey should have (per Sainsbury recommendation)	Actual No. of beds available	Number of off Island beds	Location of Jersey beds
Medium secure	21	7	-	5	Off island
PICU	8	3	3	-	Orchard House
Low secure	10	3	-	-	
Acute beds	80	27	14	-	Orchard House
Rehab/recovery	10	4	10	-	Clairevale Rd.
24 hr staffed hostel	30	10	10	-	Maison du Lac
High staffed Hostel	75	25	-	-	-
Day staffed Hostel	38	12	-	-	-
Unstaffed group home	38	12	12	0	Beech Rd., Old Mill House, Pomona Rd.
Totals	310	103	49	5	-

Source: Sainsbury Centre for Mental Health; States of Jersey Analysis.

Social care

- Children's referral rates per 10,000 (0 to 17 years).
- Number of Children in Need per 10,000 (0 to 17 years olds).
- Number of Children Looked After per 10,000 (0 to 17 years olds).
- Placements of Children Looked After.
- Percentage of Children with three or more placements during the year.
- Number of Adult Referrals by age group per 100,000 population.
- Adult Referrals by Source.
- Number of Home Care Service Users per 100,000 population (18+).
- Number of people 65 and over in Residential and Nursing care (per 10,000 population).

Social care (cont.)

Overview

- Due to the availability of comparable data with Jersey, the majority of Social care indicators have been based on English local authority data with some Scottish and Welsh data where comparable data has been available.
- A comparator group of 15 'near neighbour' English local authorities has been used, as well as an all-England comparator group. The smaller set comprises 14 unitary councils (used in a Jersey benchmarking study in 2004) which have similar levels of deprivation (or rather affluence) to the island, with the addition of the Isle of Wight.
- The majority of comparative data has been sourced from the English National Indicator Set and the NHS health and Social Care Information Centre, and has thus been subjected to a certain amount of validation.

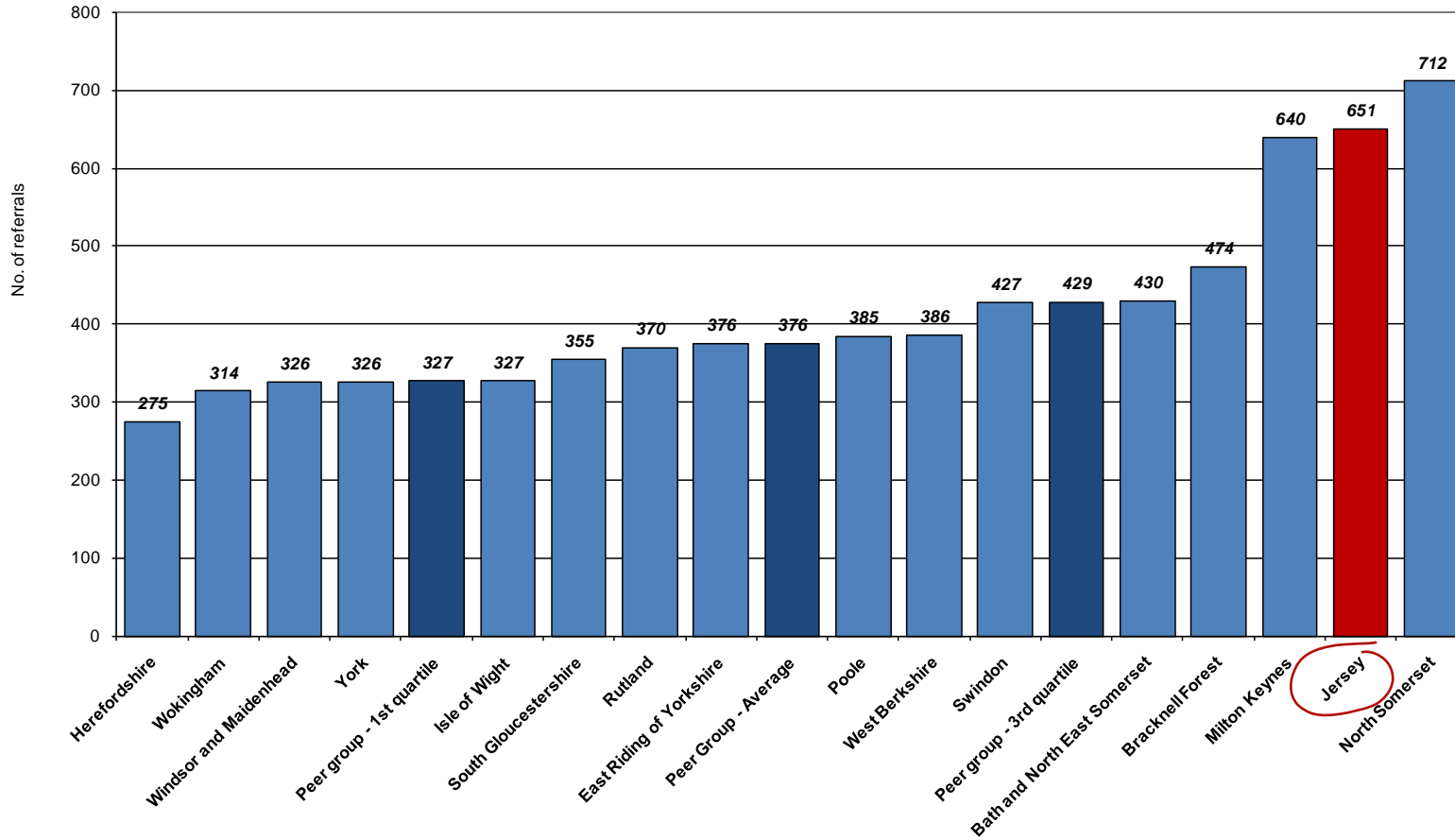
Social care – Children

Children referral rates per 10,000 (0 to 17 years)

- The rates of referral per 10,000 children (0 to 17 year olds) in Jersey currently amounts to 651 per annum.
- Jersey referral rates appear low when compared to Welsh comparator authorities whose national average is 707. However, the referral rates appear significantly higher when compared to English comparators, exceeded by only one of the comparative authorities and 70% higher than the average for the 15 English authorities.
- Hearsay 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.
- Referral rates are driven by two overriding factors; demographic need and partner awareness. The impact of investment in training with partner authorities, Jersey Social Services may have resulted in Jersey Social Services becoming overly aware of situations involving children and hence, very risk averse.
- Typically on Jersey, any police incident which involves a child is automatically referred to Children' Services, via an informal unstructured referral from the police.

Social care – Children (cont.)

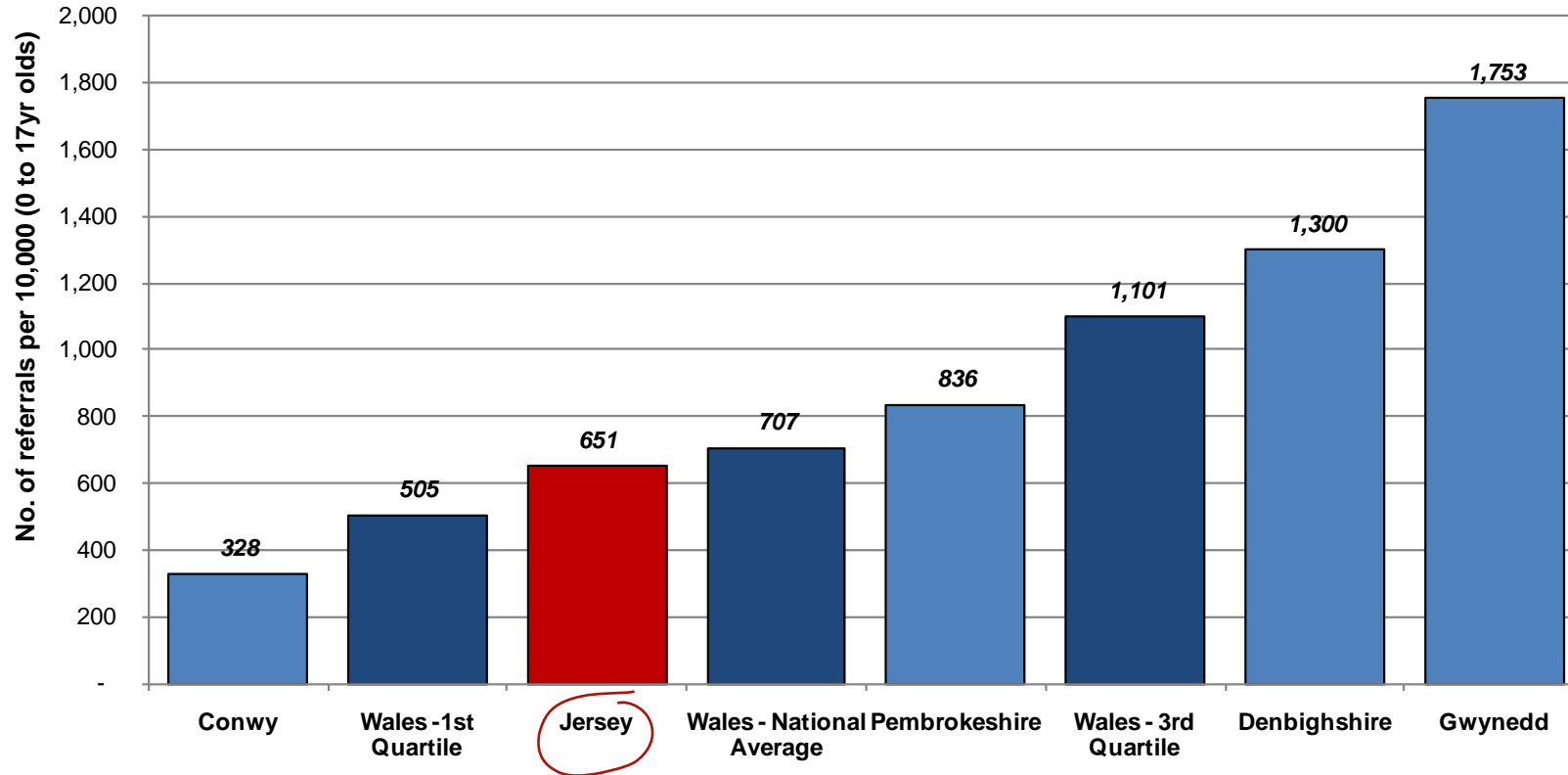
Children’s Referral Rates per 10,000 (0 to 17 years olds) – England



Source: DCSF; Jersey HSSD data; KPMG Analysis.

Social care – Children (cont.)

Children's Referral Rates per 10,000 (0 to 17 years olds) – Wales



Source: Stats Wales; Jersey HSSD data; KPMG Analysis.

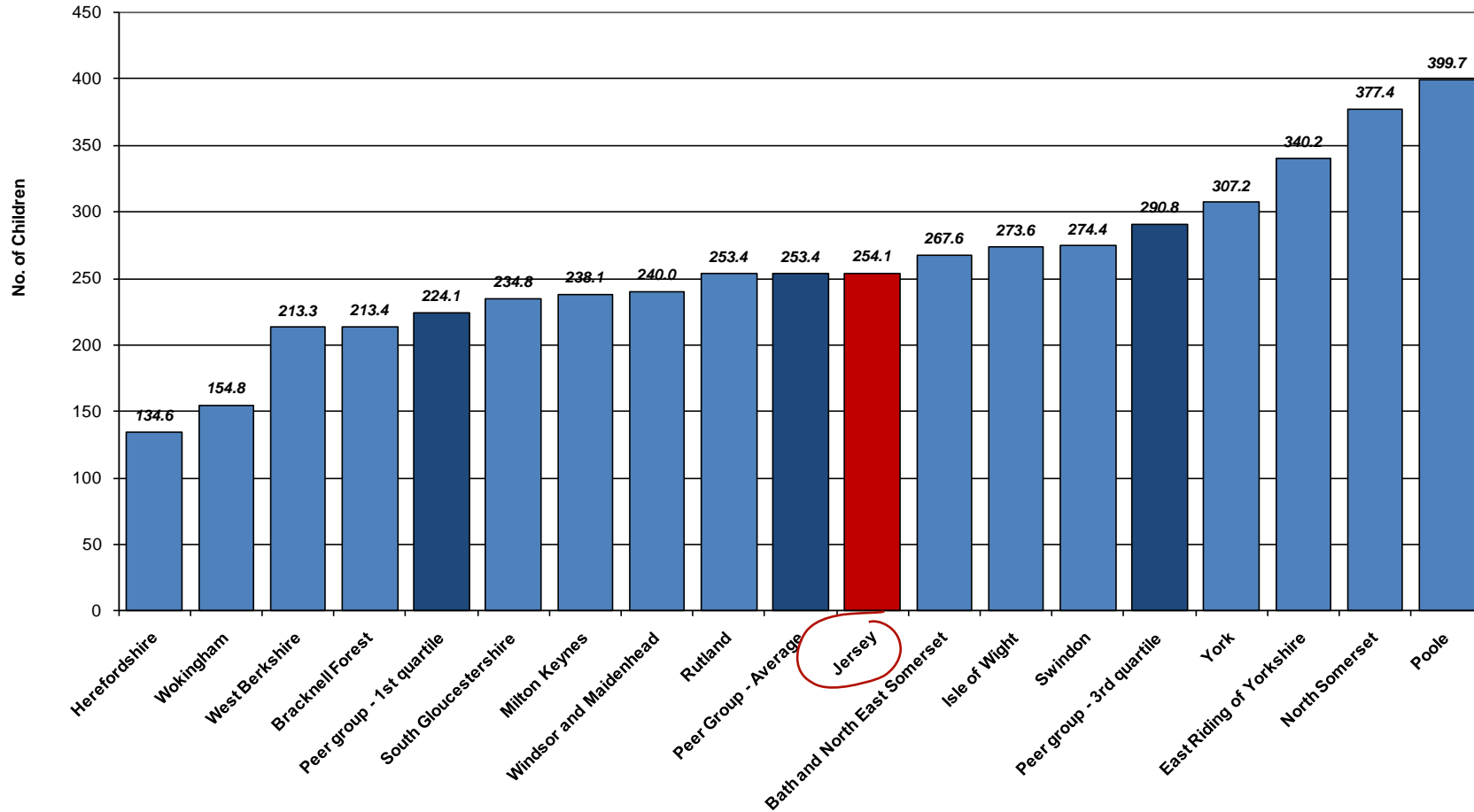
Social care – Children (cont.)

Number of Children in Need per 10,000 (0 to 17 years olds)

- The Children in Need (CIN) per 10,000 count of 254.1 is very close to the average for the basket of comparator authorities.
- The evidence that the rate of CIN per 10,000 approximately equals the comparator group average is prima facie evidence that Jersey receive a high proportion of inappropriate referrals. This may well be putting unnecessary pressure on the referral and assessment service in Social Care and suggests that steps should be taken with partner organisations to alleviate the issue through clearer guidance and protocols.
- An alternative explanation could also be that Jersey has higher levels of need i.e. children are relatively more at risk, and Social Services have higher thresholds of eligibility such that some children who might be deemed 'in need' in England are not in Jersey.

Social care – Children (cont.)

Number of Children in Need per 10,000 (0 to 17 years olds) – England



Source: DCSF; Jersey HSSD data; KPMG Analysis.

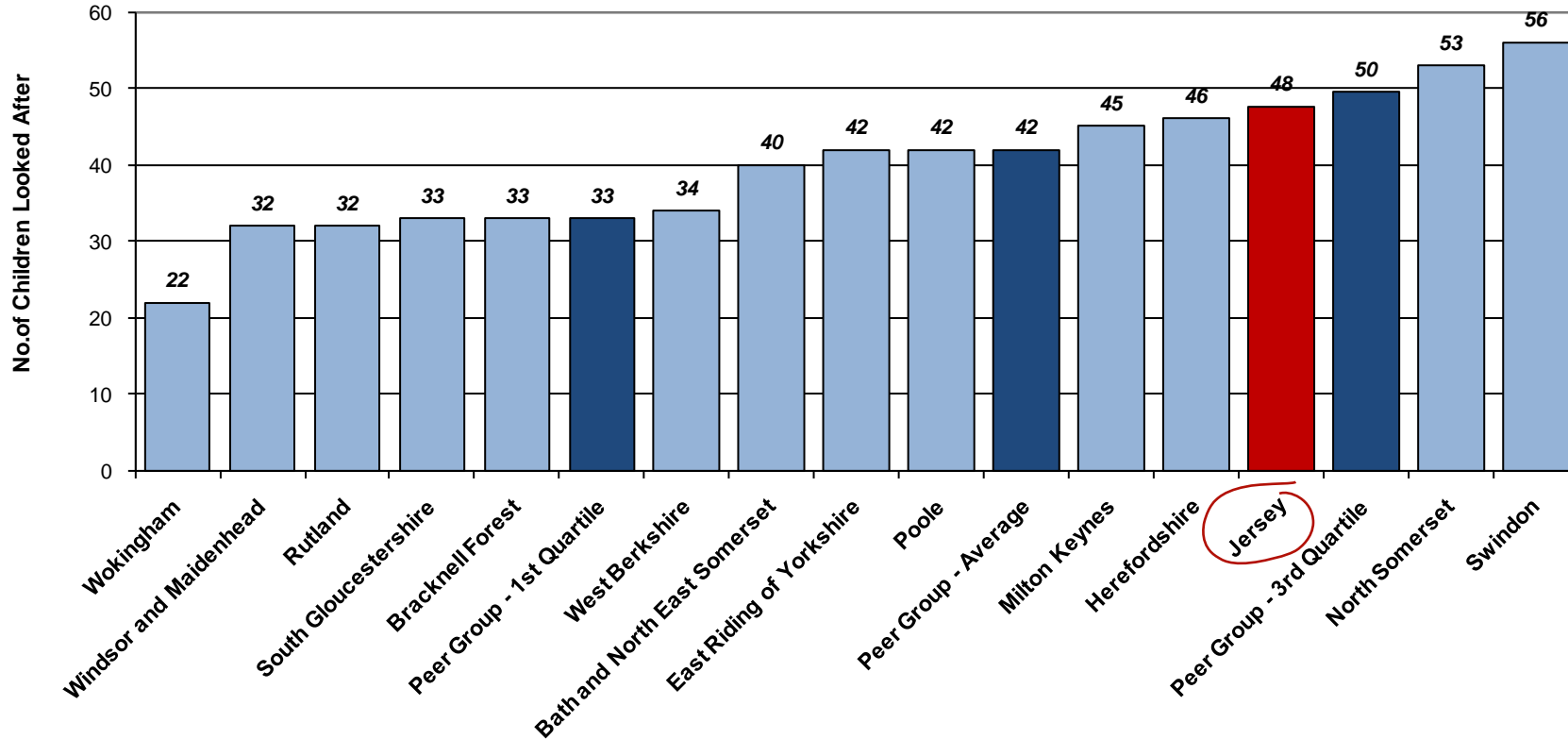
Social care – Children (cont.)

Number of Children Looked After per 10,000 (0 to 17 years olds)

- The proportion of Children Looked After (per 10,000 0 to 17 year olds) is at the upper quartile of the smaller English comparator group. With the CIN at the English average, this might suggest that the 'severity' mix of children in Jersey is higher.

Social care – Children (cont.)

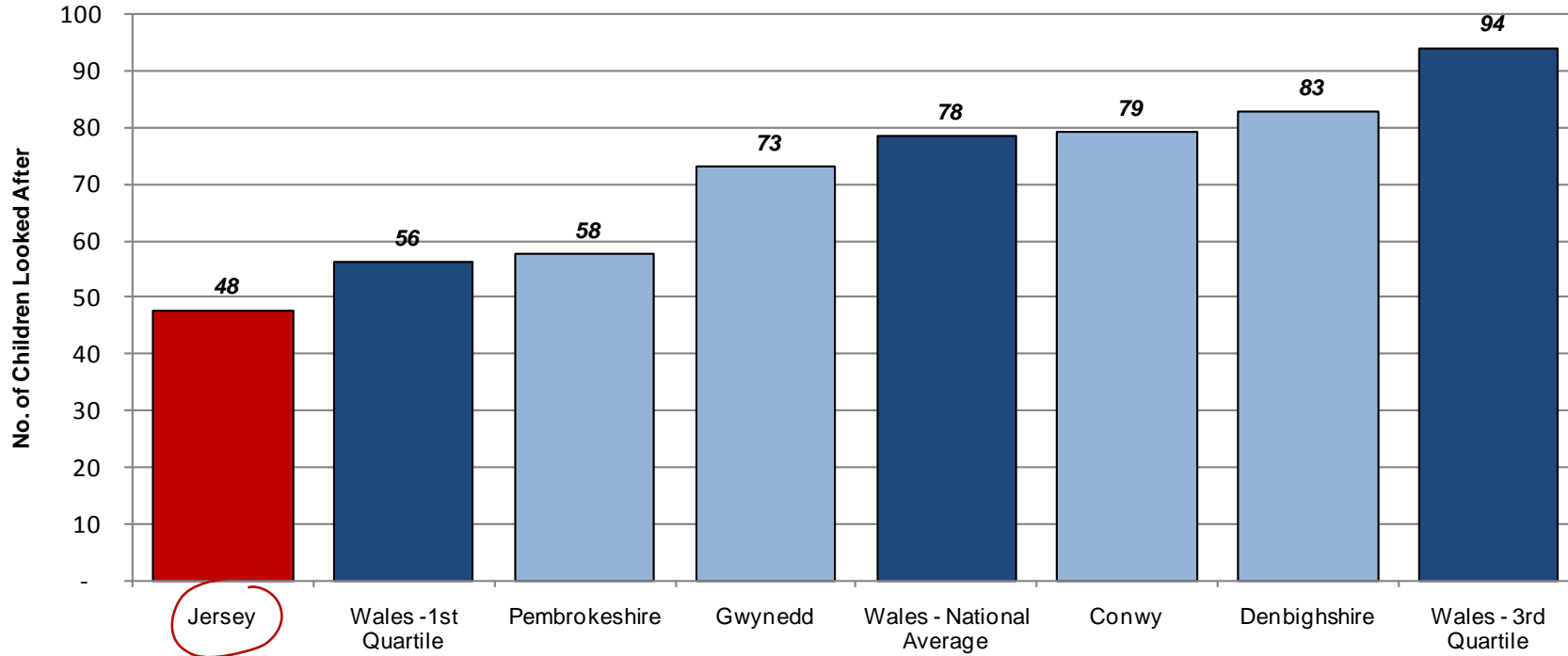
Number of Children Looked After per 10,000 (0 to 17 years olds) – England



Source: DCSF; Jersey HSSD data; KPMG Analysis.

Social care – Children (cont.)

Number of Children Looked After per 10,000 (0 to 17 years olds) – Wales



Source: StatsWales; Jersey HSSD data; KPMG Analysis.

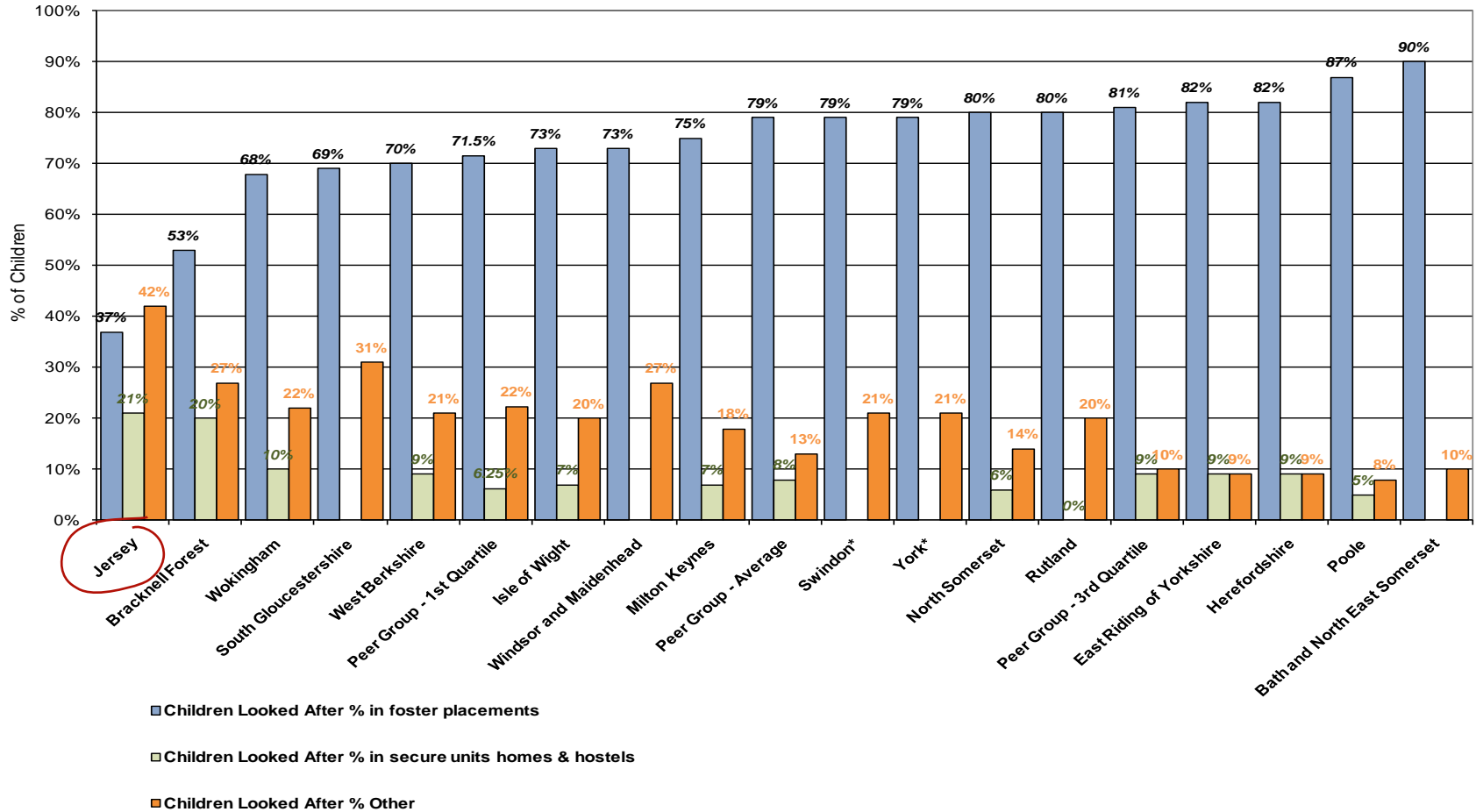
Social care – Children (cont.)

Placements of children looked after

- Jersey is an outlier in the distribution of placements for Children Looked After (CLA).
- 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 CLA in secure homes or hostels, 17% higher than Welsh national average of 3% and more than twice the English average of 8%.
- It is 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.

Social care – Children (cont.)

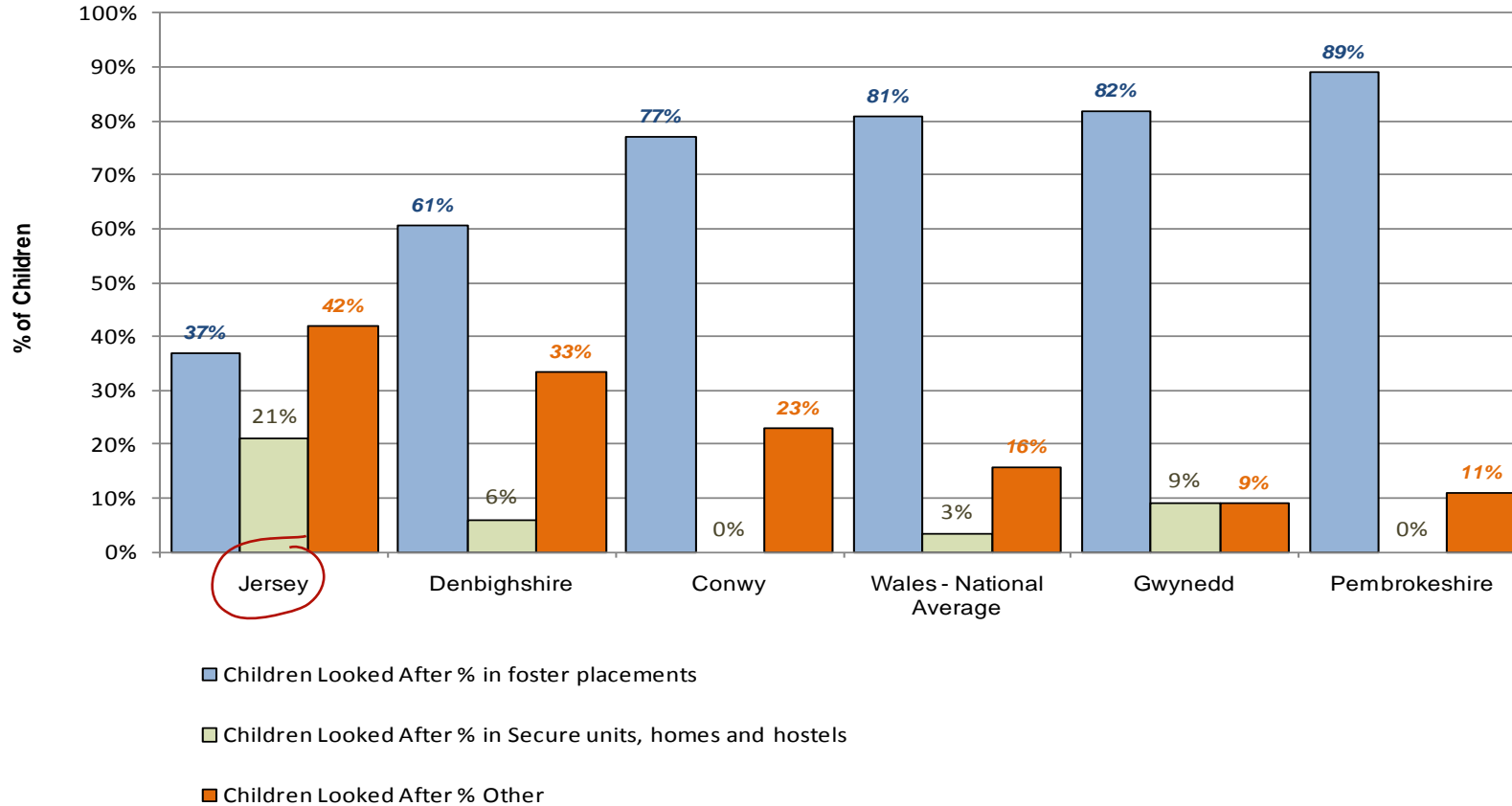
Placements of children looked after – England



Source: DCSF ; Jersey HSSD data; KPMG Analysis.

Social care – Children (cont.)

Placements of children looked after – Wales



Source: StatsWales; Jersey HSSD data; KPMG Analysis.

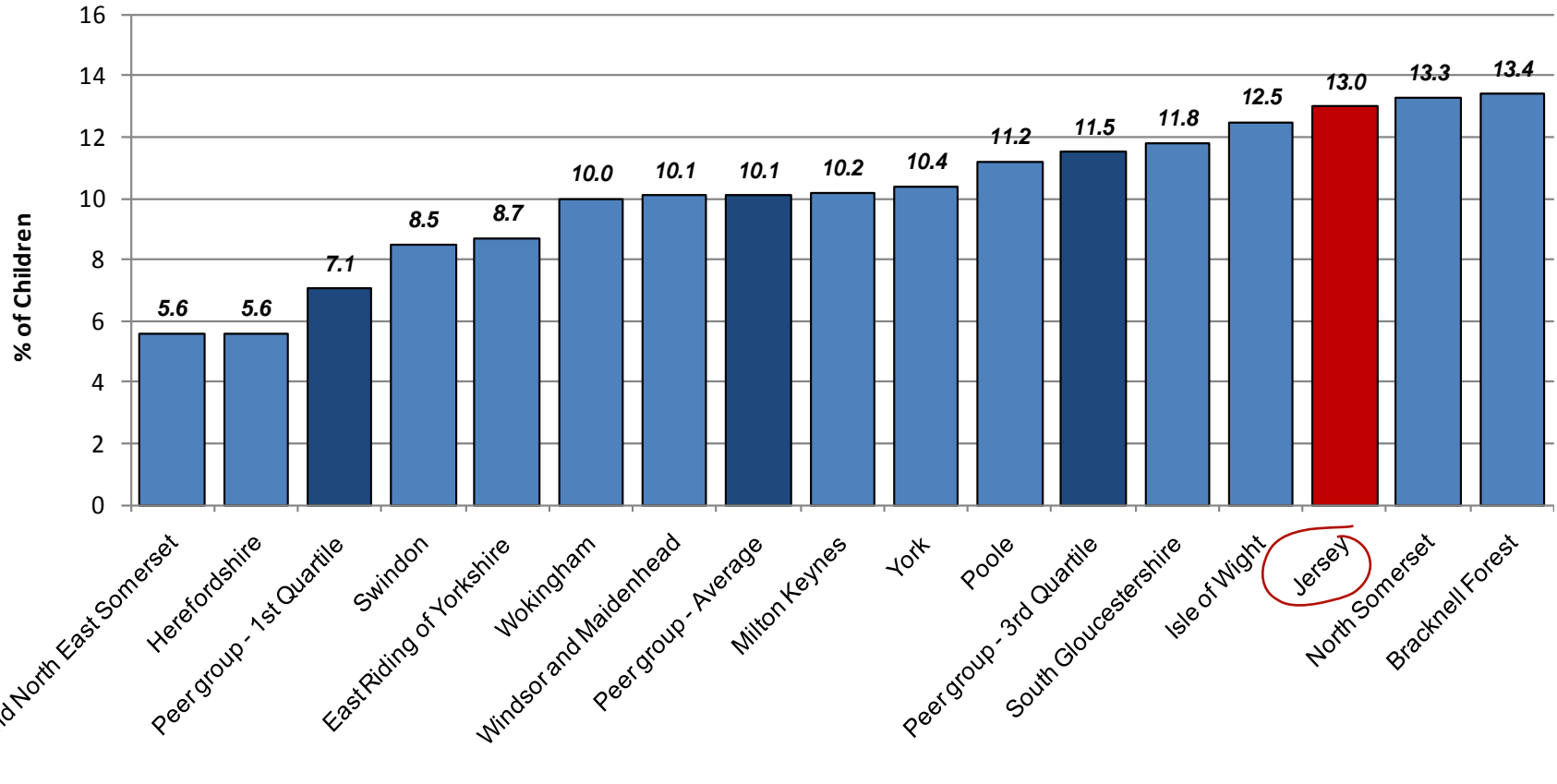
Social care – Children (cont.)

Stability of Placements

- In comparison to the Welsh and English authorities Jersey has the first and third highest amount of children with three or more placements within a year. Taking into account; the large number of steady kinship placements, the limited number of foster placements; Jersey would not be expected to rank this high in the comparator set.
- It is acknowledged that frequent movement in placements leads to lower outcomes for children. Sources which can contribute towards this problem can be the choice of placement and the assessment which underpins it.

Social care – Children (cont.)

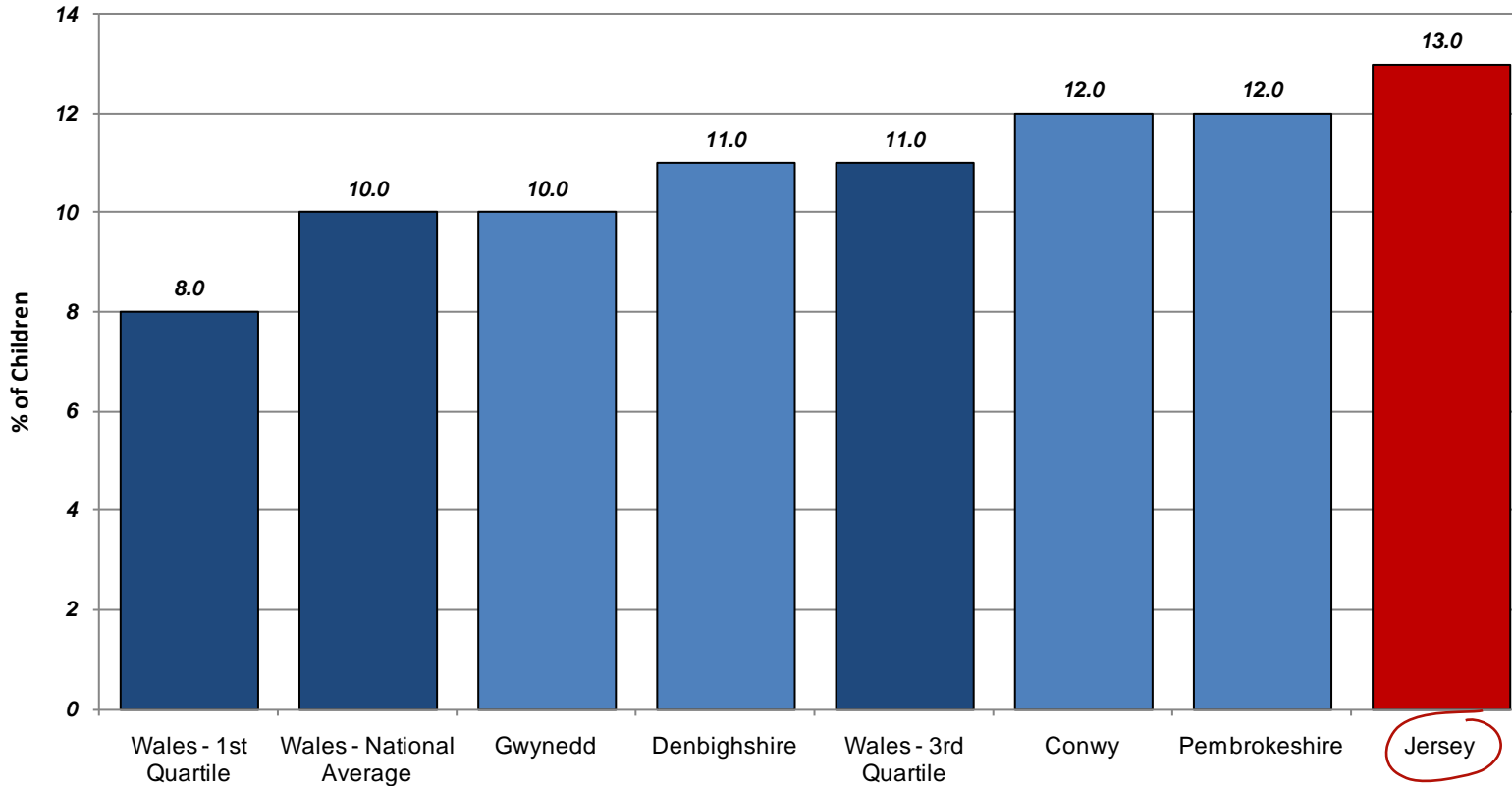
Percentage of Children with three or more placements during the year (England)



Source: DCSF; Jersey HSSD data; KPMG Analysis.

Social care – Children (cont.)

Percentage of Children with three or more placements during the year (Wales)



Source: StatsWales; Jersey HSSD data; KPMG Analysis.

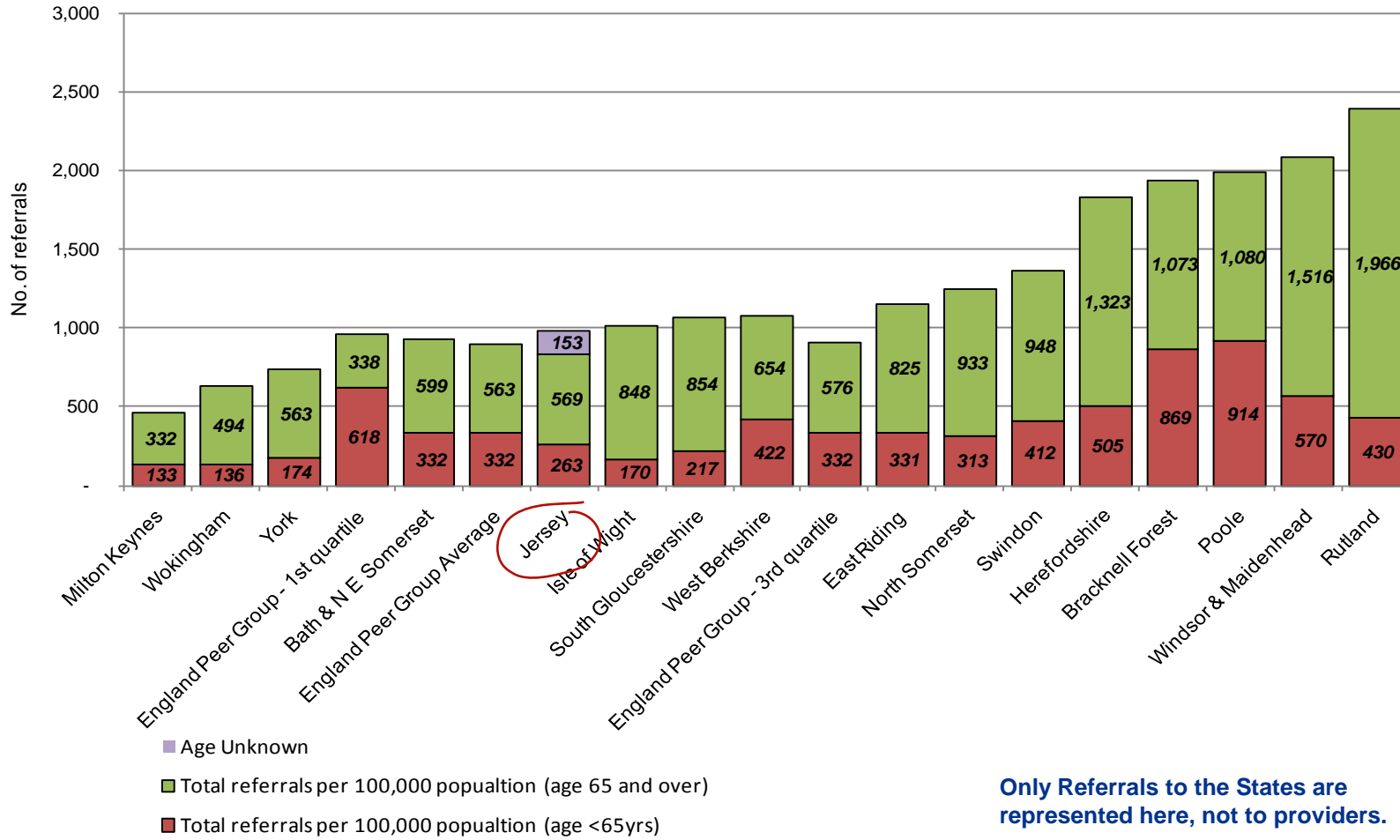
Social care – Adults

Number of Adult referrals per 100,000 population

- Jersey is in the median group for Younger and Older adults referrals, with a very similar profile to island neighbour, the isle of man.
- However, the figures exclude referrals to FNHC (due to them being an external provider) in this figure which would push Jersey up to be the biggest outlier. In addition, hearsay evidence has suggested that there is a large amount of referral's unrecorded due to the weak IT infrastructure in place.

Social care – Adults (cont.)

Number of referrals by age per 100,000 population (England)



Only Referrals to the States are represented here, not to providers.

Source: DCSF; Jersey HSSD data; KPMG Analysis.

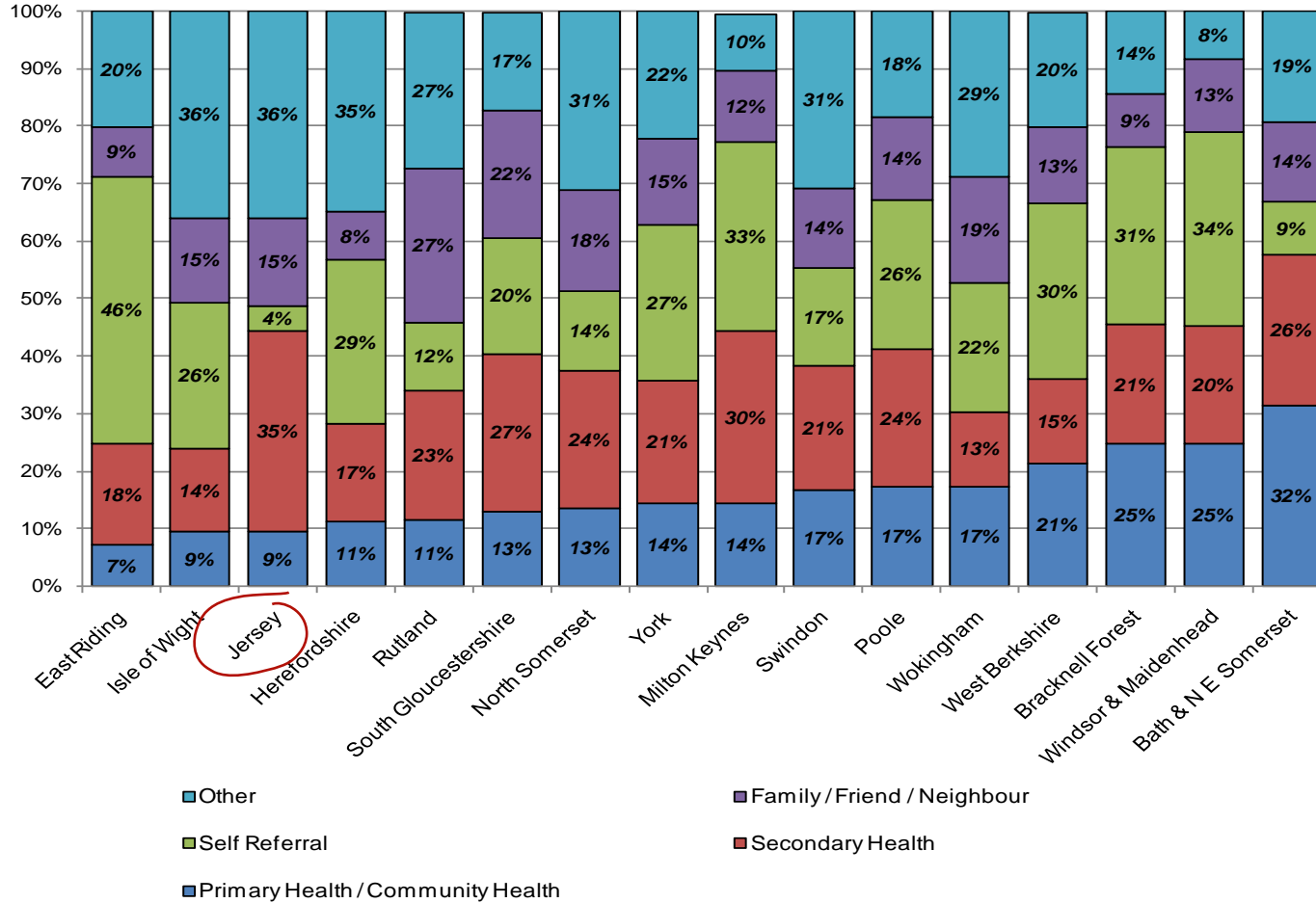
Social care – Adults (cont.)

Adult Referrals by Source

- Jersey has by far the largest number of referrals from the source of secondary care. Jersey receives 35% from secondary care a whole 5% more than the next nearest outlier.
- This type of trend is typically seen in very medicalised models which have perceptions of clear divides in the provision of care between social care and secondary care, as opposed to multi disciplinary approaches with phased step down care from hospitals.

Social care – Adults (cont.)

Adult Referrals by source



Source: DCSF; Jersey HSSD data; KPMG Analysis.

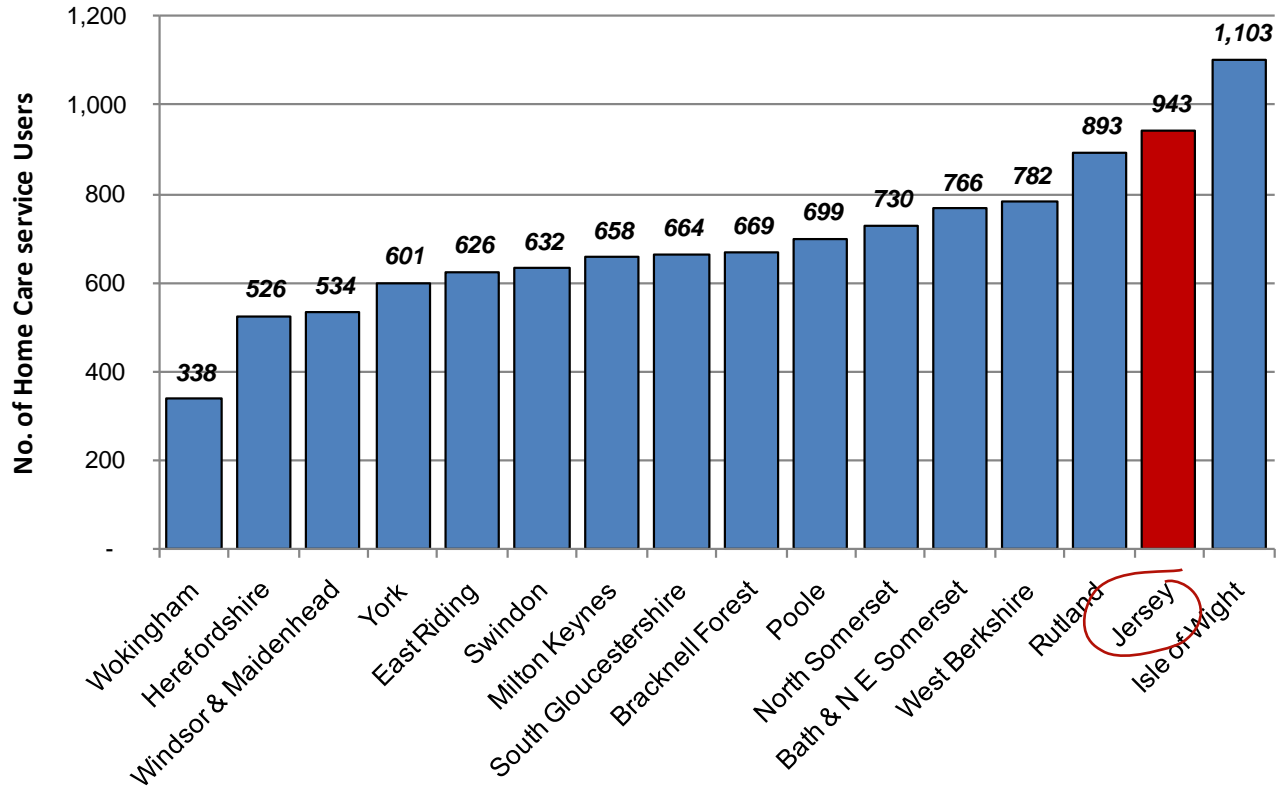
Social care – Adults (cont.)

Number of home care service users (per 100,000 population 18+)

- The number of home care service users in Jersey per 100,000 population (18+) amounts to 943. Whilst home care services are offered to adults (18+), the number of service users in Jersey mainly relates to those aged 65 and over.
- Jersey is higher when benchmarked against English peer comparators, exceeded by only one local authority within the peer group. However, is slightly lower than the Welsh national average of 963, which could be explained by the sparsely populated rural environment in which they are set.
- Large numbers of care in the home can be seen as a positive step which enhances levels of independence.

Social care – Adults (cont.)

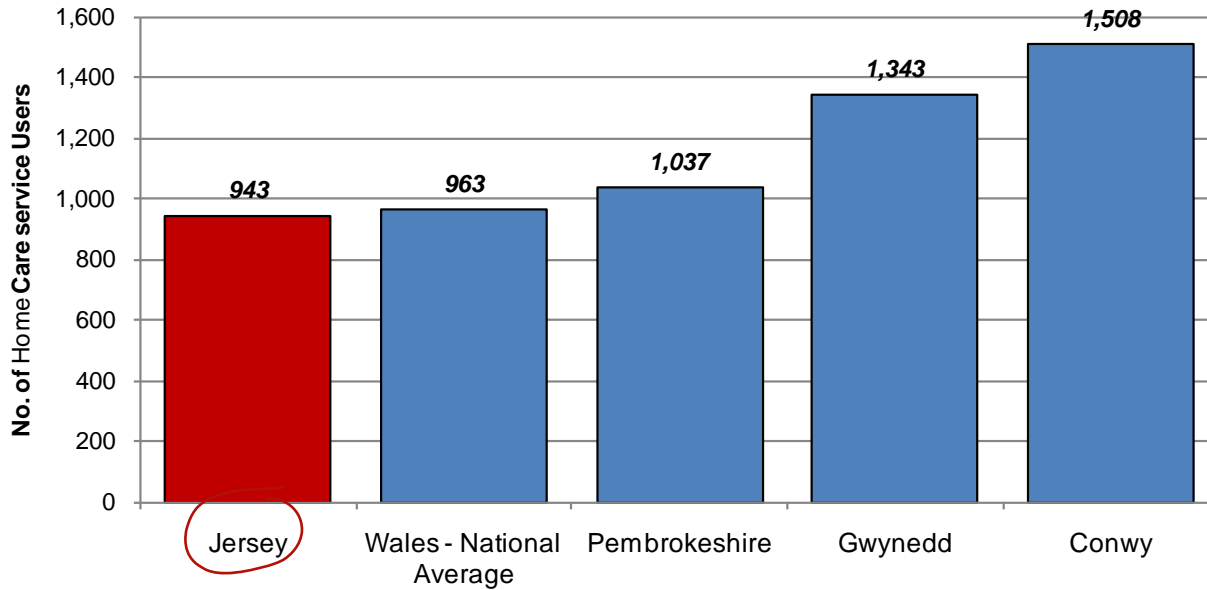
No. of Home Care Service Users per 100,000 population 18+ (England)



Source: NHS Information Centre; Jersey HSSD data; KPMG Analysis.

Social care – Adults (cont.)

No. of Home care service users per 100,000 population 18+ (Wales)



Source: Stats Wales; Jersey HSSD data; KPMG Analysis.

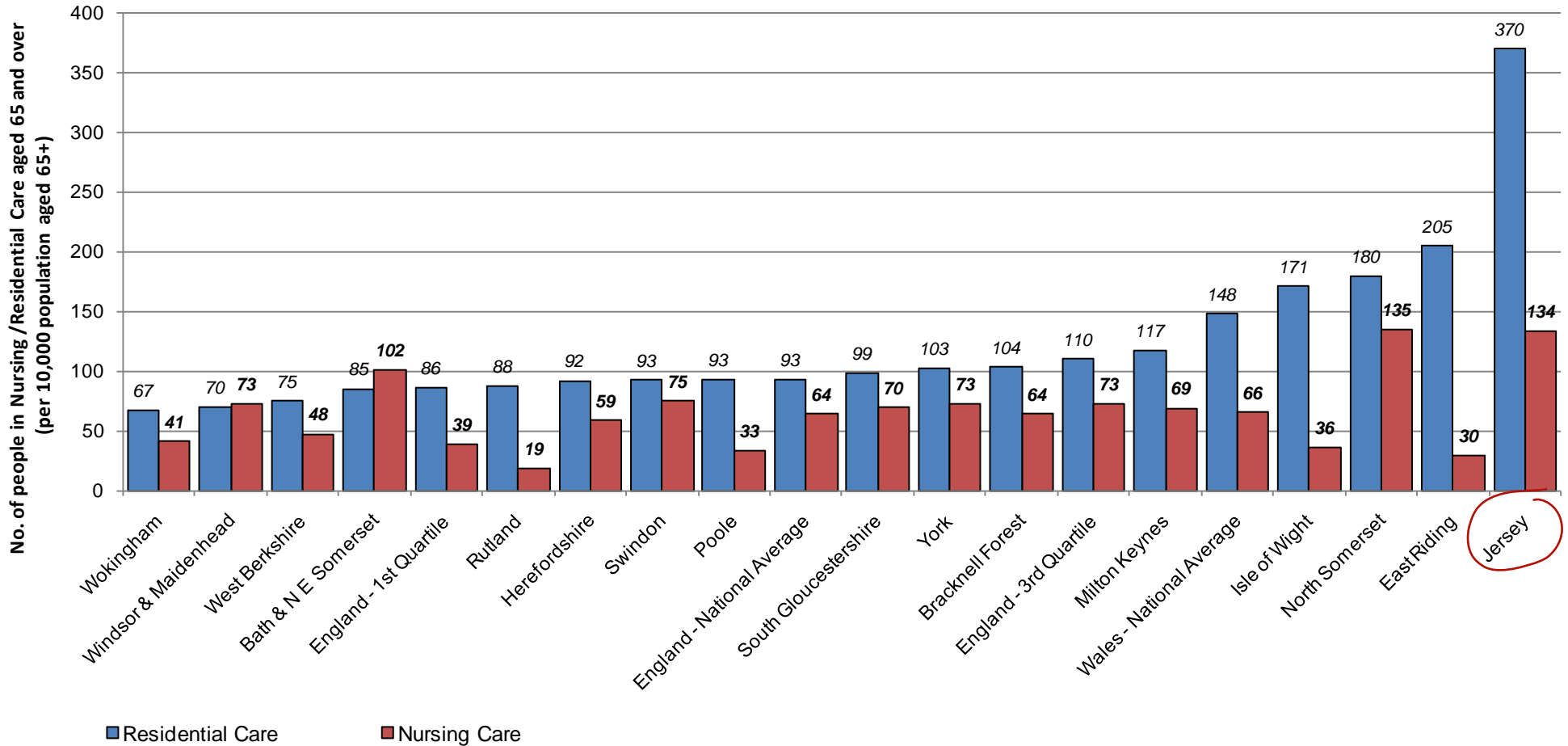
Social care – Older adults

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

- Jersey is a very strong outlier in this comparison. In both Residential and Nursing care they more than double the average of the comparators English authorities for Older Adults in care per 10,000 of the population.
- This agrees with hearsay knowledge from interviews with Jersey staff across the island. Having a large percentage of people in facility based care boosts their levels of dependence on care services and increases the speed of deterioration as opposed to keeping people independent for longer through care in the home.

Social Care – Older Adults (cont.)

Number of people 65 and over in Residential and Nursing Care (per 10,000 population aged 65+)



Source: NHS Information Centre; Jersey HSSD data; KPMG Analysis.

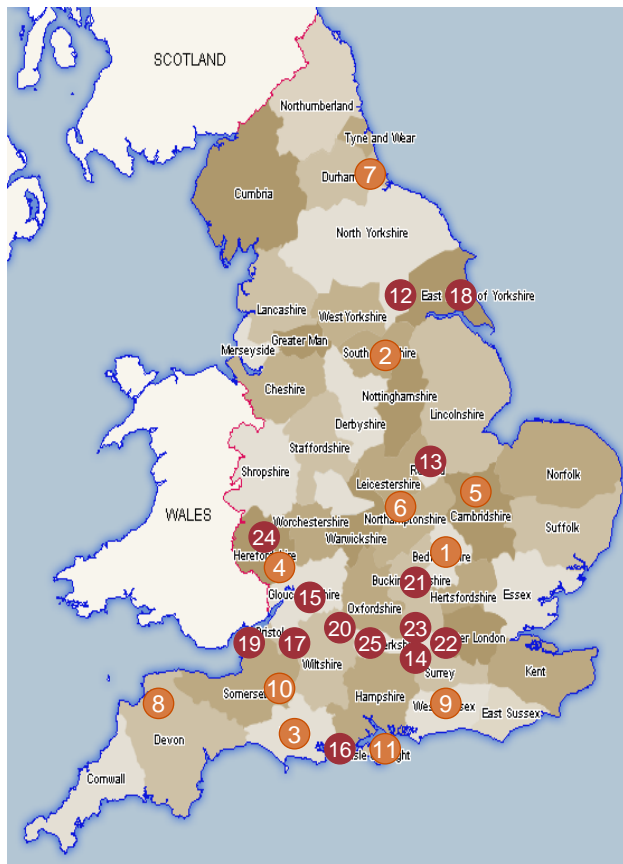


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Comparators

Comparators

U.K. (England)

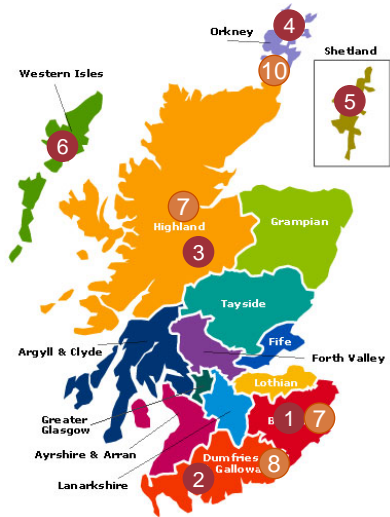


Organisation (Acute Hospitals)	Population Served	Turnover (£'m)	No of Hospitals
1. Bedfordshire NHS Trust	270,000	121.2	1
2. Doncaster and Bassetlaw Hospitals Trust	410,000	321	5
3. Dorset County Hospital NHS Foundation Trust	210,000	145.6	1
4. Hereford Hospitals NHS Trust	225,000	118	1
5. Hinchingsbrooke Health Care NHS Trust	161,000	91.6	1
6. Kettering General Hospital NHS Foundation Trust	300,000	150	1
7. North Tees and Hartlepool NHS Foundation Trust	400,000	257.2	2
8. Northern Devon Healthcare NHS Trust	165,000	128.5	6
9. West Suffolk Hospital NHS Trust	275,000	152.5	1
10. Yeovil District Hospital NHS Foundation Trust	180,000	104.4	1
11. NHS Isle of Wight	138,500	220	1

Organisation (Local Authorities)	Population	Turnover (£'m)	Organisation	Population	Turnover (£'m)
12. City of York Council	198,800	444.1	19. North Somerset Council	209,100	473.19m
13. Rutland County Council	38,400	160.5	20. Swindon Borough Council	198,800	556.01m
14. Wokingham Borough Council	161,900	328.7	21. Milton Keynes Council	236,700	864.19m
15. South Gloucestershire Council	262,200	608.9	22. Royal Borough of Windsor and Maidenhead Council	143,800	300.48m
16. Borough of Poole Council	141,200	351m	23. Bracknell Forest Council	115,100	261.9m
17. Bath and North East Somerset Council	177,700	447.3	24. Herefordshire Council	179,100	385.8m
18. East Riding of Yorkshire Council	337,000	735.3	25. West Berkshire Council	153,000	377.6m

Comparators (cont.)

U.K. (Scotland)



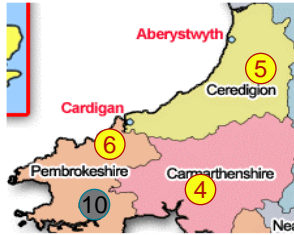
Organisation	Population Served	Turnover (£'m)	No of constituent Hospitals
1.NHS Borders	112,430	185.6	10 (Includes 9 Community hospitals)
2.NHS Dumfries and Galloway	148,580	264.7	12 (Includes 9 Community hospitals)
3.NHS Highland	309,900	543.3	18 (Includes 2 rural general hospital, 14 Community hospitals)
4.NHS Orkney	20,000	42.5	1 (community hospital)
5.NHS Shetland	21,980	45.8	2 (includes 1 community care of the elderly hospital)
6.NHS Western Isles	26,200	69.8	3 (includes 2 community hospitals)

Organisation	Turnover (£'m)	Organisation	Turnover (£'m)
7.Scottish Borders Council	315.73	9.Highland Council	712.42
8.Dumfries and Galloway Council	489.68	10.Orkney Islands Council	133.13

Comparators (cont.)

U.K. (Wales)

Betsi Cadwaladr ULHB region (a)
 – 6 Counties,
 – 3 counties



Hywel Dda LHB region

Note (a) – Covers 6 Counties in total across N. Wales, 3 selected as comparators.

International Island Jurisdictions

Country	Population Served	Annual Public Health Service Expenditure (\$m)
Guernsey	64,775	124
Isle of Man	80,491	245
Tasmania	514,617	1,970
Singapore	4,987,600	2,694

Organisation	Population Served	Turnover (£)	No of constituent Hospitals
Betsi Cadwaladr ULHB (a) 1.Gwynedd 2.Conwy 3.Denbighshire	676,000 118,400 111,700 93,065	1.2bn	25 (3 DGHs and 22 other smaller acute and community hospitals)
Hywel Dda Local Health Board 4.Carmarthenshire 5.Ceredigion 6.Pembrokeshire	372,320 178,119 78,200 116,001	614.4m	12 (includes 8 community hospitals)

Organisation	Turnover (£)	Organisation	Turnover (£)
7.Gwynedd County Council	349.66m	9.Denbighshire County Council	318.1m
8.Conwy County Council	318.66m	10.Pembrokeshire County Council	378.79m



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The economics context

A new system of health and social care

Appendices

- Benchmarking overview
- **The economics context**
- An 'as is' picture of health and social care (Dec 2010)
- Summary of stakeholder interviews (Nov 10 – Jan 11)

Jersey's health economy

International comparators

- Other island economies
- Other OECD

Options and recommendations

Appendices

1. Island economies in detail
2. Economic levers

Jersey's health economy

International comparators

- Other island economies
- Other OECD

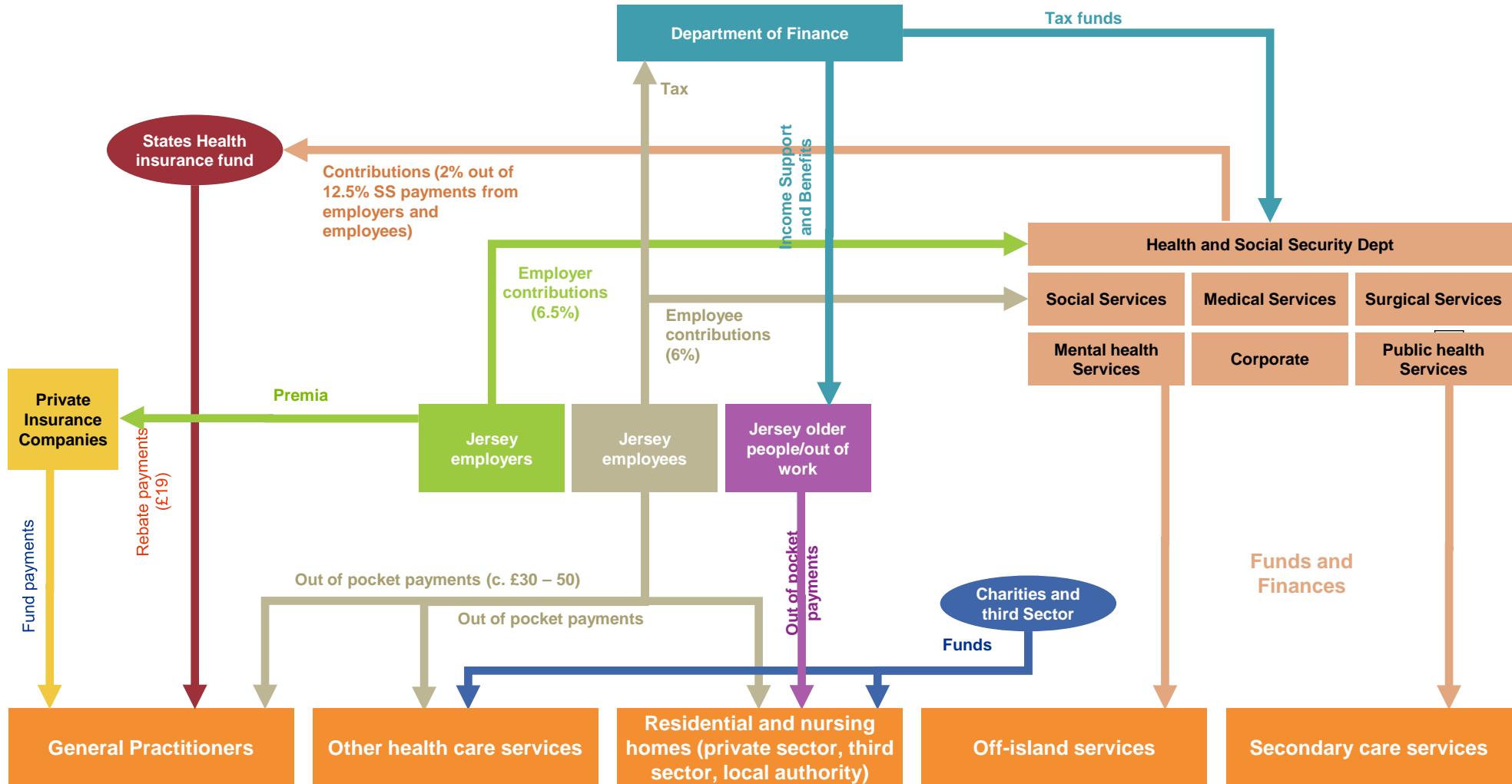
Options and recommendations

Appendices

1. Island economies in detail
2. Economic levers

Jersey's health economy

Financial wiring



Jersey's health economy

Jersey health expenditure: Health and social services department (HSSD) budget

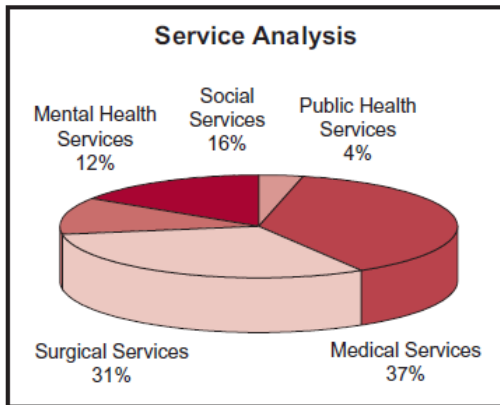
HSSD budget

- The HSSD had a net spend of £158 million in 2009. This was split by service as per the table below:

	Spend (£)
HSSD budget: of which	158m
Medical Services	57.8m
Surgical Services	47.5m
Social Services	24.1m
Mental Health Services	17.8m
Public Health Services	5.3m
Ambulance Services	4.9m

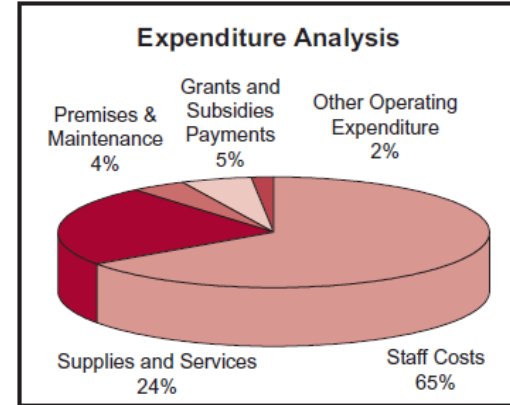
HSSD funding

- The chart below shows how HSSD spending was split:



HSSD expenditure

- The chart below shows how HSSD expenditure was broken down by operating cost:



Jersey's health economy

Taxation in Jersey

Department-led taxation regime

- The Treasury and Resources Department is responsible for setting, raising and collecting taxes on Jersey. Budgets are set annually, with the proposals set out in October. The Treasury Minister writes the Budget, in conjunction with the tax office.
- Personal income tax has been 20% since the 1970s and is not scheduled to change. The corporate tax regime is broadly zero. GST (Goods and Sales Tax) was introduced in 2009 at 3% and is scheduled to rise to 5% in 2011.
- The Social Security Department is also very active in this area, altering social security contributions from time to time. Currently, employer contributions are 6.5% and employee contributions are 6% of gross earnings. This is capped at £46,000 of earnings. These contributions are supposed to be hypothecated, in the sense that receipts flow directly into the Social Security Department.
- It is important to note that a third of Jersey's workforce is not subject to income tax, as the threshold is quite high.
- As part of the annual budget, the finance minister decides how much tax revenue is allocated to the HSSD.

Jersey's health economy

Income support and benefits

Generous income support and other benefits, for the eligible

- When Jersey residents make a claim for Income Support (IS) they need to contact the Social Security Department (not the Ministry of Finance). They are interviewed by an IS adviser and must bring proof of their circumstances and eligibility (e.g. birth certificate, rent book, payslips, bank statements). Assets, income and savings are all examined. If they have a medical condition, they are asked to complete a separate self-reporting form. Those eligible for IS are those who either:
- Live in a household where at least one adult has lived in Jersey continuously for at least 5 years immediately before making the claim; or has lived in Jersey for any consecutive period of at least 10 years before making a claim; or
- Are of working age and in full time work (at least 35 hours per week) or be exempt from full-time work.

In 2007, the distribution between IS, disability, pension and other benefits was as follows:

2007 Income Support and Benefits ^[1]	
Benefit	£ (percentage of total)
Social security expenditure	£155,428,000
Retirement/pensions	£116,510,000 (75%)
Incapacity	£20,330,000 (13%)
Invalidity	£15,930,000 (10.2%)

- The Social Security Department runs a multitude of pay-outs and benefits, which are very generous in comparison with the UK regime. For example, maternity payments are non-means tested and available to anyone who is expecting.
- Eligible Jersey residents (i.e. those who have lived on the island for at least five years) who are assessed as requiring long term residential care, are referred to the Social Security Department. If eligible, there are then clinical checks as well. After this, the Department asks for background information on assets, bank statements and income. Based on this information, if the person falls under a certain yearly threshold, they will receive income support (paid directly into the residential home) and placed into a home. The home could be a state-run institution, private sector, or charitable enterprise. There is a fixed daily rate, which is calculated according to the number of the days required. There is an adjustment made when the person is hospitalised.
- If the person has a house, but not enough income or assets, then the person will sign deeds on the house, which allows the Department to claw back the money once the person is deceased. In either case, the care home gets paid the same daily amount.
- Lastly, if the person is not eligible for IS (because they have enough income) then they will pay for private care out-of-pocket. If their funds are reduced, they can re-apply for IS at a later date.

Jersey's health economy

Health insurance premia and payments

A mixed economy, with both public and private elements

- Large medical insurance players such as AXA PPP and BUPA have specific Jersey health plans which are very similar to UK policies. The coverage typically (although not always) includes costs for both treatment in the UK and Jersey-based GP costs.
- Most large Jersey employers provide private health cover through the usual UK providers. Jersey residents can also buy coverage direct, or through intermediaries. Coverage is thought to be somewhat more expensive than in the UK.
- As well as private health insurance, the States of Jersey also operates a social insurance fund, established under the Health Insurance (Jersey) Law 1967. The Fund receives a set percentage allocation of all social security contributions collected under the Social Security Law, which is currently 2% (made up of a 0.8% contribution from employees and a 1.2% contribution from employers) of the 12.5% total contributions collected.
- The Law specifies that the Fund is to use the contributions received to meet primary health care costs, which are currently limited to medical and pharmaceutical benefits. Currently the Fund subsidises patients to the tune of £19 for each GP visit and also covers the cost of prescriptions dispensed by Community Pharmacists. The £19 rebate from the Fund is not applicable if anyone other than the GP sees the patient.
- Legislation is currently in train to change the payments system. In the future, payments will be made just to GPs, rather than other health professionals providing primary health care.
- Since 1967 the scope of primary care has expanded greatly and many different healthcare professions are now involved in first-line medical and healthcare treatment and care. Typically, primary care is provided in a community setting, such as a GP surgery or a health centre. In Jersey, some primary care services are delivered from the General Hospital. The Health and Social Services Department funds a number of primary care services, some of which are provided directly and some through third-party organisations, in particular Family Nursing and Home Care.

Jersey's health economy

Out-of-pocket payments

A direct relationship between health provider and consumer

- Average out-of-pocket costs for GP visits in Jersey over 2009 were £32 for surgery visits and £55 for home visits.
- These costs are not price controlled in any way, but self-regulated by market forces.
- GPs in Jersey are loosely organised into GP groups.
- Of the many (approximately 40 to 50) GPs interviewed by the KPMG project team, most thought that the co-payments from patients were a positive feature of the Jersey health economy, and would not want them abolished.
- In 2004-2005, the average household spent £156 on 'doctors services'. Adjusting for inflation this is equivalent to £189 per household in 2010, which gives an estimated total annual spend of £6.9 million on doctors services in Jersey in 2010.

The relationship between spending on health and income in Jersey

- The Jersey Household Expenditure Survey 2004 – 2005 has data on how spending on healthcare varies with income quintile, which is presented below:

	Income quintile					All
	Lowest	Second	Third	Fourth	Highest	
Health care spend per week (£)	8.40	8.90	16.00	15.30	26.00	14.70
Medical insurance spend per week (£)	2.50	2.40	3.70	5.50	11.90	5.00
Total household health spend (£)	10.90	11.30	19.70	20.80	37.90	19.70
Medical spending (percentage of total spending)	4.2%	3.2%	3.8%	2.7%	2.9%	3.1%

- The results of the survey show that in absolute terms, spending on health care varies significantly with income (i.e. those with higher incomes spend more on health care). Those in the highest income quintile spend three times as much on health as those in the lowest quintile.
- As a share of income, private health expenditure is highest for the lowest quintile and lowest for the two richest quintiles.
- Clearly, the greater the reliance on private health expenditure as a proportion of total health expenditure, the greater the disparity of health care between income groups.
- Co-payment charges are one reason why health spending is a greater proportionate burden on the least well off.

Jersey's health economy

Calculating health expenditure in Jersey

The Jersey Economics Unit has recently estimated health expenditure in Jersey during the period 2001 to 2007

This required an estimate of both private and public health expenditure

Private health expenditure

The Jersey Economics Unit estimated private health expenditure using two methods

Method 1: Referencing income tax claims:

- Claims for income tax relief for private health insurance premiums from individuals were used to estimate spending by individuals on private health insurance
- It was assumed that company-sponsored health schemes were of an equal magnitude to private insurance and that out-of-pocket expenditure was equal to the amount spent on premiums
- Patient's share of co-payments were based on past trends, and Family Nursing and Health Care (FNHC) spending was taken from the FNHC accounts

Method 2: Referencing the Household Expenditure Survey (HES) 2004/05

- Data from the HES was used to estimate household private expenditure on health (with adjustments made for changes in prices and number of households on Jersey)
- Again, it was assumed that spending on company sponsored health insurance schemes was equal to individual spending on health insurance schemes

Public health expenditure

- The Economics Unit have used the OECD definition of health expenditure for this calculation, and collected data from the States of Jersey Financial Accounts

The following slide details our estimation of health expenditure in Jersey in 2009

- We have calculated public health expenditure according to the OECD definition.
- We have estimated private health expenditure using the second method described above (by referring to the HES), and using the same assumption about the value of company insurance schemes as the Jersey Economics Unit.

Jersey's health economy

Estimating public and private health expenditure in Jersey

Public health expenditure in Jersey (2009)

- Calculating public health expenditure in Jersey according to the OECD definition requires several adjustments to the HSSD budget.
- Special Needs Services are not considered health expenditure by the OECD – we subtract this spending from the HSSD budget.
- Expenditure through the Health Insurance Fund is accounted for under the Social Security Department, but qualifies as health expenditure under the OECD definition – we add this to the HSSD budget.
- HSS capital expenditure is also added to the budget.
- The table below shows our estimate of public health expenditure in Jersey in 2009:

Public health expenditure	Spend (£)
HSSD budget less Special Needs Services:	133.4m
Health Insurance Fund	19.0m
HSS Capital Expenditure	7.5m
Total	159.9m

Private health expenditure in Jersey (2009)

- The table below shows the split of our estimate of private health expenditure in Jersey
- As detailed on the previous slide, this is calculated by adjusting the HES for changes in household numbers and prices since 2004-2005.

Private health expenditure	Spend (£)
Private insurance premia (private)	16.0m
Private insurance premia (company sponsored)	16.0m
Private spending on medical services	
Pharmacy and other medical products	8.2m
Doctors	6.9m
Dentists	11.9m
Opticians	4.1m
Other medical services	2.5m
Private spending on medical services (total)	33.6m
Total	65.6m

We have estimated health spending in Jersey, Guernsey and the Isle of Man in 2009

- We have estimated private expenditure in Guernsey and the Isle of Man using the same method as that we employed for Jersey*:

Country	GDP (current £m)	GDP (current £ per capita)	Public Health Service Expenditure (£m)	Private Health Service Expenditure (£m)	Total Health Service Expenditure (£m)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (£)
Jersey	3,621	39,444	160	66	226	4.4%	1.8%	6.2%	2462
Guernsey	1,903	30,248	80	33	100	4.2%	1.7%	5.3%	1606
Isle of Man	2,220	24,971	158	20	178	7.1%	0.9%	8.0%	2211

Jersey's health economy

International comparators

- Other island economies
- Other OECD

Options and recommendations

Appendices

1. Island economies in detail
2. Economic levers

International comparators

Island and small country comparators

In the following slides, we compare a number of island and small country health economies:

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP per capita (2005, PPP \$)	Population ('000s)	Public Health Service Expenditure (\$m)	Private Health Service Expenditure (\$m)	Total Health Service Expenditure (\$m)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (\$)
Jersey*	5,610	61,116	57,000	92	248	102	350	4.4%	1.8%	6.2%	3,814
Guernsey	2,949	46,867	44,600	62	124	51	155	4.2%	1.7%	5.3%	2,488
Isle of Man	3,440	38,690	35,000	80	245	31	276	7.1%	0.9%	8.0%	3,426
Gibraltar	1,416	27,468	38,200	29	113	14	127	8.0%	1.0%	9.0%	4,331
Bermuda	6,093	94,908	69,900	64	262	296	558	4.3%	4.9%	9.2%	8,665
Antigua	1,132	12,920	14,802	88	38	17	54	3.3%	1.5%	4.8%	620
Tasmania	23,239	45,984	36,847	508	1,870	654	2,524	8.0%	2.8%	10.9%	4,972
UK	2,174,530	35,165	32,084	61,838	152,208	33,411	185,619	7.0%	1.5%	8.5%	3,002
US	14,119,000	45,989	42,681	307,007	1,106,700	1,232,000	2,338,700	7.8%	8.7%	16.6%	7,618
Andorra	3,712	44,291	38,800	85	67	216	282	1.8%	5.8%	7.6%	3,312
Luxembourg	52,296	105,044	70,567	498	3,375	338	3,713	6.5%	0.6%	7.1%	7,458
Malta	7,449	12,920	20,627	415	433	126	559	5.8%	1.7%	7.5%	1,346

Country	Pay for visits to...?				
	GP	Dentist	Chiropodist	Physiotherapist	Optician
Jersey	Yes	Yes	Yes	Yes	Yes
Guernsey	Yes	Yes	Yes	Yes	Yes
Isle of Man	No	Yes*	No**	No**	Yes
Gibraltar	No	Yes	No	No	Yes
Bermuda	Yes	Yes	Yes	Yes	Yes
Antigua					
Tasmania					
UK	No	Yes*	No**	No	Yes
US	Yes	Yes	Yes	Yes	Yes
Andorra					
Luxembourg					
Malta					

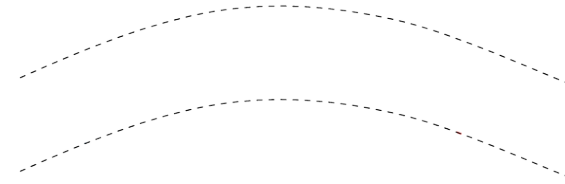
International comparators

Island and small country comparators (cont.)

The scatter charts to the right plot public and private health expenditure as a percentage of GDP against GDP per capita in purchasing power parity (PPP) terms.

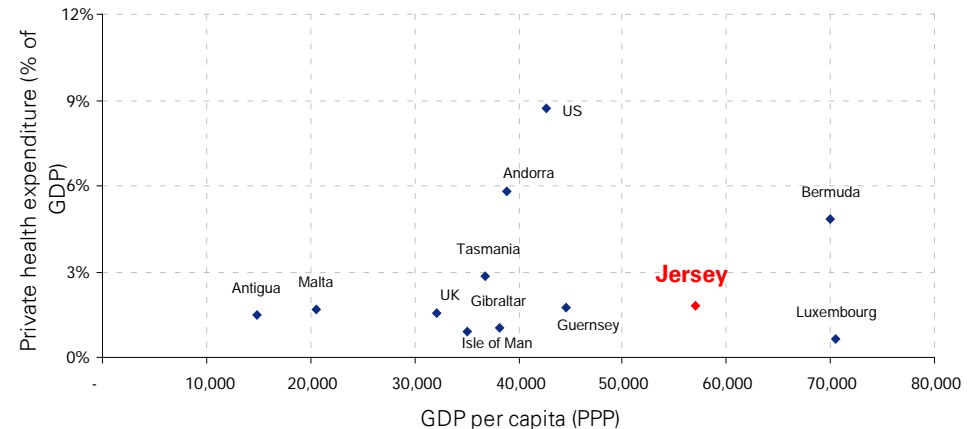
- Jersey is among the wealthiest jurisdictions shown.
- It spends a lower proportion of national income on public health care than several poorer jurisdictions.
- This is also true, to a lesser degree, of private health spending which forms a relatively constant proportion of GDP across the wealth spectrum.
- The clear exception is the high level of spending on private health is in the US, Andorra and Bermuda.
- However Jersey is by no means an outlier – and is very similar to several of the island economies in this comparison.
- In absolute terms Jersey's expenditure is in the middle of this group of comparators.

Public health expenditure (percentage GDP) and GDP per capita (PPP)



Source: World Health Organisation, IM F, KPMG analysis, CIA World Factbook.

Private health expenditure (percentage GDP) and GDP per capita (PPP)



Source: World Health Organisation, IM F, KPMG analysis, CIA World Factbook.

International comparators

Island and small country comparators (cont.)

The scatter charts to the right plot total health expenditure as a proportion of GDP and in absolute terms

- In absolute terms, the richest countries spend more on health than the poorest ones.
- There are wide variances in health care spend between jurisdictions with similar income levels due to differences in local characteristics (e.g. relatively high spend in Tasmania because of an ageing population and difficult geography).
- The charts show that as GDP per capita increases, so initially does health expenditure.
- Middle income countries spend a **higher proportion** of their income on health than poorer countries.
- However, the richest countries tend to spend a **lower proportion** of their income (but a higher absolute level) on health than the middle income countries.
- This could indicate that health spending has a ceiling beyond which diminishing returns set in.
- Appendix A has case studies for some of the countries used in this comparator group.

Total health expenditure (percentage GDP) and GDP per capita (PPP)



Total health expenditure per capita (\$) and GDP per capita (PPP)

Source: World Health Organisation, IMF, KPMG analysis, CIA World Factbook.

Jersey's health economy

International comparators

- Other island economies
- Other OECD

Options and recommendations

Appendices

1. Island economies in detail
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International comparators

Health expenditure in Jersey – OECD comparisons

Jersey Economics Unit research (April 2010)

- In April 2010, the Jersey Economics Unit estimated health expenditure in Jersey to inform a comparison of health spending in Jersey with the OECD.
- The findings from this research are summarised in the table below. This shows how Jersey's health expenditure ranked in the group of thirty comparator countries out of 30, both in absolute terms (i.e. actual money spent) and in relative terms (as a percentage of Gross National Income (GNI)).

	In absolute terms (rank of 30)	percentage of GNI (rank of 30)
Private health expenditure	7	25
Public health expenditure	13	28
Total health expenditure	13	30

Findings

- The table shows that in absolute terms Jersey is ranked close to the middle of the group. However, in relative terms Jersey ranks toward the bottom of the group – in fact its total health expenditure as a percentage of GNI is lower than every other country in the comparison.

KPMG analysis of OECD comparators

- In the following slides we present scatter charts to further illustrate how Jersey's health expenditure compares to other countries in the OECD.
- In this analysis, we have also compared health expenditure to GNI.
- Our analysis concentrates on health expenditure in the OECD in 2007, and we have used the estimates of Jersey health expenditure calculated by the Economics Unit described above.
- In order to estimate Jersey health expenditure in PPP terms, the Economics Unit have assumed that the PPP exchange rate is the same for Jersey as the UK (no PPP exchange rate is calculated for Jersey by the OECD). This implies that the cost of living is the same in Jersey as the UK. The Jersey Statistics Unit produces an annual report that compares prices for a range of products in the UK, Jersey and Guernsey. In 2010, this report found that meat prices were a quarter higher in Jersey than the UK, and that fresh fruit and vegetables were a third more expensive in Jersey. If the overall cost of living in Jersey is also higher, then the estimate of GDP in PPP terms that we have used for Jersey, will overstate Jersey's true wealth.

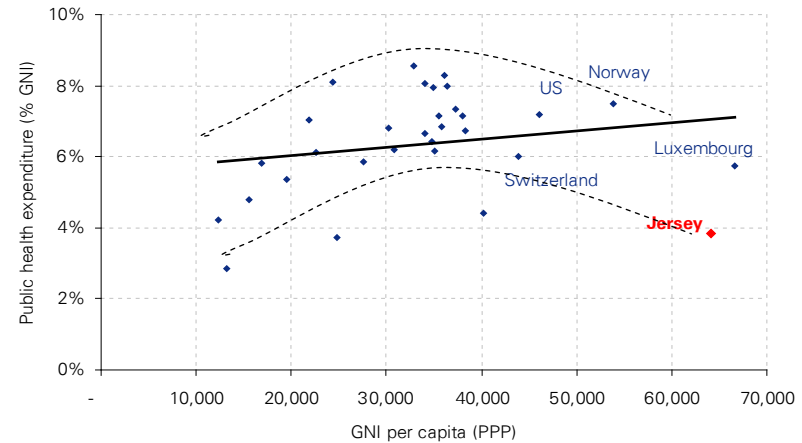
International comparators

Public and private health expenditure in the OECD

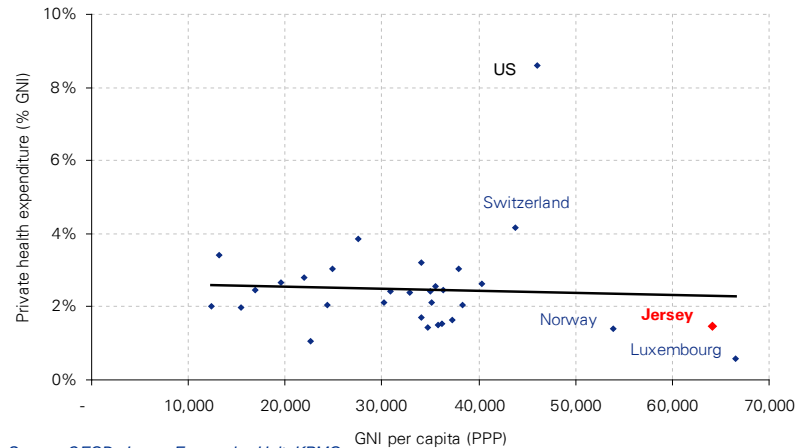
The scatter charts plot public and private health expenditure as a percentage of GNI against GNI per capita (PPP).

- Jersey is the second wealthiest jurisdiction in the group of OECD comparators.
- In this group of comparators Jersey is an outlier. It spends a lower proportion of national income on public health than almost all the other jurisdictions.
- The top chart shows that up to a point, public spending on health increases with GNI. At levels of GNI above \$40,000 the relationship is flat or declining.
- As with the island comparisons, private health spending forms a relatively constant proportion of GNI across the comparator countries.
- In absolute terms, Jersey's expenditure is in the middle of this group of comparators.
- The chart shows that the highest level of spending on private health, by far, is in the US.

GNI per capita (PPP) and public health expenditure (percentage GNI)



GNI per capita (PPP) and private health expenditure (percentage GNI)



Source: OECD, Jersey Economics Unit, KPMG.

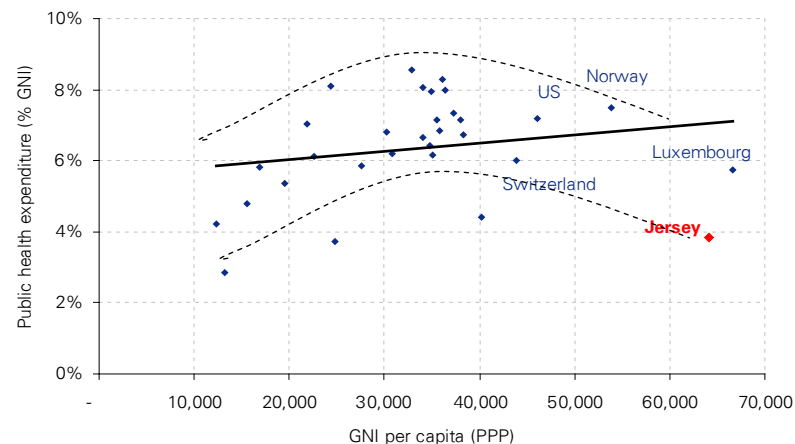
International comparators

Total health expenditure and tax revenues in the OECD

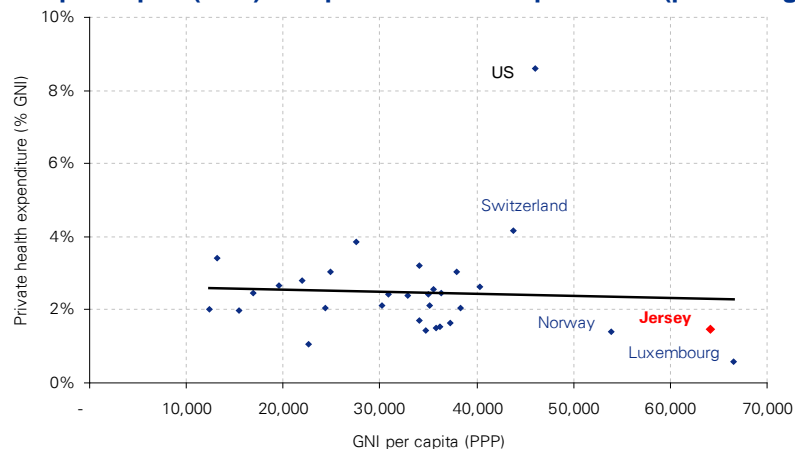
The scatter charts plot total health expenditure as a proportion of GNI and total health expenditure as a proportion of tax revenue against GNI (PPP) for the OECD

- Public health expenditure is much greater than private expenditure (roughly 2.5 times greater) in almost all the OECD countries considered.
- Consequently, the relationship between total health expenditure and GNI is largely driven by public health expenditure, and the chart to the right (top) reflects this.
- As with the island comparators the charts show that as GDP per capita increases, so initially does health expenditure.
- Middle income countries spend a **higher proportion** of their income on health than poorer countries.
- However, the richest countries tend to spend a **lower proportion** of their income on health than the middle income countries.
- The bottom chart to the right shows that as a proportion of tax revenue, Jersey's public health expenditure is roughly the same as the OECD average.
- Jersey's relatively low level of public spending on health care thus reflects its low tax revenues as a share of GDP.

GNI per capita (PPP) and public health expenditure (percentage GNI)



GNI per capita (PPP) and private health expenditure (percentage GNI)



Source: OECD, Jersey Economics Unit, KPMG.

International comparators

OECD comparator conclusions

Jersey's wealth

- Jersey is a wealthy jurisdiction. Our analysis shows that in GNI (PPP) terms Jersey is the second wealthiest country in our list of comparators (behind Luxembourg). However, this simple comparison may not accurately reflect Jersey's wealth in relation to the other comparator countries:
 - Firstly, as detailed above, the calculation of GNI in PPP terms for Jersey relies on an assumption about PPP exchange rates, which may overstate Jersey's true wealth.
 - Secondly, the wealth of Jersey's citizens may also be overstated due to the significant role of financial services in Jersey's economy (43% of GVA in 2009). This is because there are flows of income into Jersey due to the financial services companies registered there that contribute to Jersey's GVA, that will immediately flow out of Jersey to the employees of these companies working (and residing) elsewhere. This effect will be far more prevalent in Jersey than most, if not all, countries included in this comparison. These flows of income out of Jersey mean that a standard measurement of GNI may overstate the spending ability of Jersey's resident citizens.
- However, there is evidence confirming the wealth of Jersey's citizens. The Jersey Income Distribution Survey found that household incomes (before housing costs) are 64% higher in Jersey than in the UK. This is slightly less than the difference in GNI per capita. In 2007, GNI (PPP) was 79% higher in Jersey than in the UK.
- Furthermore, the low tax regime in Jersey means it is likely that for a given level of income Jersey citizens will have a higher level of disposable income than other countries in this comparison. This is particularly pertinent when considering the level of private health expenditure.

Jersey's health expenditure

- The analysis by the Jersey Economics Unit shows that in absolute terms health expenditure in Jersey is similar to the average for the OECD.
- However, as a proportion of GNI, total health expenditure in Jersey is lower than every country in the OECD comparison. This is due to the low level of both private and public health expenditure as a proportion of GNI.
- Our scatter charts show that as a proportion of GNI, health spending is lower in Jersey than one might expect it to be given its wealth, compared to the other countries in the OECD.
- However, when considering Jersey's capacity to spend on health (by comparing health spending to Jersey's tax revenues) Jersey's spending is at a similar level to that in the OECD.

International comparators

OECD comparator conclusions (cont.)

Could Jersey increase public health expenditure?

- At first glance it would appear that Jersey could afford to spend more on health – both through private and public channels.
- However, we have shown that as a proportion of tax revenue, Jersey's public health expenditure is not out of line with the rest of the OECD.
- This suggests that there is limited potential for Jersey to increase the proportion of its tax revenue that it spends on health. Furthermore, Jersey currently has a budget deficit equal to 3% of GVA, which is forecast to increase over the coming years in the Jersey Fiscal Strategy review (July 2010). This budgetary pressure is likely to constrain all public spending, making it more difficult to increase expenditure on health, by switching spending from other areas.
- If the above is true, an increase in public health expenditure would have to be financed by an increase in tax revenues.
- Jersey's low tax regime is an important feature of its economy – and a significant attraction of living there. It is not clear that an increase in taxes to finance an increase in health expenditure would be welcomed in Jersey. It is possible that Jersey residents adjust their expectations regarding the standard of public services they receive to reflect the low levels of tax they have to pay.
- Furthermore, Jersey has seen an increase in its taxes recently with the introduction of the Goods and Services Tax (GST). This would make an increase in taxes to fund an increase in spending on health even less palatable to the Jersey population.

Could Jersey increase private health expenditure?

- There seems to be no reason why the Jersey population could not increase the proportion of their income that they spend privately on health – they could afford to but they choose not to.

Possible explanations for the observations

- It is possible that the higher wealth of Jersey leads to a healthier population than countries with lower wealth in this comparison. A healthier population is likely to require less health care.
- We have drawn attention to the difference in income between Jersey and many of the countries in the OECD. However, within the larger countries there are likely to be areas with similar levels of income to Jersey – for instance parts of South-East England. It would be interesting, and perhaps more relevant to consider if any differences in public and private expenditure existed between Jersey and those areas of similar affluence.
- Another possibility is that the positive relationship between wealth and demand for healthcare only exists until a certain standard of health care is achieved. Once a certain level of health is attained, there is little that can be gained from further expenditure on health care. If Jersey is at a point where the marginal returns to health expenditure are low, then one would not expect that health expenditure would form the same proportion of GNI as in a country where the level of health was lower and there were still significant positive returns to health spending.
- The fact that Jersey citizens do not choose to spend more on health privately despite having (as a whole) the capacity to do so, suggests that they are satisfied with the level of health care they currently receive.
- This illustrates another key point; there are many factors to consider when judging whether a given level of health care is sufficient. An intra-country comparison of expenditure both in relative and absolute terms does not necessarily consider all these factors. These other factors include the efficiency of the health system, country demographics and the level of health care demanded by a population.

Jersey's health economy

International comparators

- Other island economies
- Other OECD

Options and recommendations

Appendices

1. Island economies in detail
2. Economic levers

Options and recommendations

Overview

In these final slides we consider

- What is the appropriate level of health spending in Jersey.
- What are the effects on health care of different methods of raising the revenue that pays for health care.
- Options and recommendations for funding.

Options and recommendations

The level of health spending in Jersey: public and private

What is the appropriate level of spending on health in Jersey?

- By government out of tax and social security revenues?
- By individuals, in the form of out-of-pocket payments and insurance premiums?

As regards public provision of health services, the comparison of Jersey with other island economies, and with the OECD, suggests:

- Jersey, as a relatively wealthy jurisdiction, could clearly afford to spend more
- Jersey's public spending on health is low, given how wealthy it is; this may be because Jersey's tax rates are low, and hence revenues are low as a share of GDP.
- As a share of tax revenues, Jersey's public health spending is above average;
- Jersey's important financial services sector is affected by the global recession, so the public finances are under strain as they are elsewhere (though to a much lesser extent than the UK)
- So if Jersey did decide to spend more on public health provision, this would mean either cutting other kinds of public spending, or putting up taxes/social security contributions
- Jersey is, by tradition and design, a low tax jurisdiction, so putting up taxes to pay for better public health provision may not be an option from a political perspective
- Does this also apply to social security contributions? It is a widely held, though erroneous, belief in the UK that 'Social security contributions pay for the Health Service'. Would the Jersey public be comfortable with improving the level of public health provision paid for out of higher social insurance payments?

As regards private provision of health services, the international comparisons suggest:

- Private spending on health as a share of GDP appears remarkably flat across the income distribution of nations – richer countries seem to spend a similar proportion of their income to poorer countries:
- There is a clear US/Europe split, with private health provision taking a much higher proportion of income in the US and in other countries within the US sphere of influence (e.g. Bermuda)
- There is nothing to stop Jersey spending more on private health provision, but this is not something that its citizens have so far chosen to do.

Options and recommendations

Economic effects of different methods of funding

There are, broadly, three main methods of funding for the States of Jersey to consider:

- Tax funding
- Insurance funding
- Co-payment (out of pocket) funding

Tax funding

- Tax-funded services are normally free at the point of use. If you can demonstrate a need, you will receive the recommended treatment.
- Tax-funded systems are progressive, in the sense of redistributing money from rich to poor. This is because
 - The better-off will bear more of the costs of providing health care, since they have higher incomes and pay more taxes
 - The better-off are also generally healthier than poorer people, so they may use the system less; however
 - The better-off are also generally more aware of their rights and more assertive in demanding them, and so may extract more from the system than the [...]
- The allocation of resources under a tax-funded system should in principle be driven by medical need rather than ability to pay. However:
 - In the absence of a cash rationing device, demand typically exceeds supply, which is then rationed by queuing. Those who get most out of systems rationed by queuing are those with spare time
 - So a tax funded system does not necessarily allocate resources with complete efficiency towards those with greatest medical need. It may confer most benefit on those who have the most spare time (the retired, the unemployed)
- Under tax funded systems, medical staff are typically salaried employees. From a purely economic perspective this gives them an incentive to minimise the amount of care they provide (since they get the same financial reward whether they have a lot or a little face-time with patients). There are positive and negative effects:
 - Positive: no 'gold-plating' – the treatment provided is the minimum needed to do the job, thus saving resources;
 - Positive: incentive for preventative medicine, since this will minimise the work load with no loss of salary;
 - Negative: no incentive to innovate or try more costly methods of treatment
- The above conclusions are modified if doctors are rewarded by a capitation fee, which gives a similar incentive for preventative medicine, but also provides some incentive to provide quality service in order to increase the number of patients

Options and recommendations

Economic effects of different methods of funding (cont.)

Insurance funding

- Insurance funded schemes can also be free at point of use. As under a publicly funded scheme, the patient who can demonstrate a medical need receives the treatment – provided he or she has the insurance cover
- The cost of private medical insurance can be high and is the same for rich and poor (or may be higher for the poor who have a greater probability of being ill). As a result:
 - The less well off bear an equal or larger share of the costs of health provision, and typically a very much higher share expressed as a proportion of their income
 - Private health insurance is thus a regressive way of paying for health care; : the poor bear a greater relative burden
 - In a free market private health insurance premiums will reflect the probability of becoming ill. So those with a history of illness pay more than the healthy. So under private health insurance schemes the sick, as well as the poor, may bear a higher relative burden
 - This so-called adverse selection problem can be overcome by replacing private insurance by social insurance, in which everyone bears an equal burden. This turns the scheme into one which closely resembles a tax-payer funded scheme
- Under an insurance scheme which pays for the cost of treating a given condition, medical practitioners have an incentive to maximise the treatments they provide. The virtues and vices of insurance-funded health schemes are the other side of those of tax-funded schemes:
 - Negative: an incentive for medical providers to over-provide in order to boost their incomes (gold-plating)
 - Negative: little incentive to provide preventative medicine, since this will reduce potential future income from providing cures
 - Positive: a strong incentive to innovate and develop new treatments for which patients can be charged
- The large literature on the economics of insurance bears out the simple observation, familiar to any car owner, that repairs done under an insurance contract are very much better, but also very much more expensive, than repairs for which the driver pays out of his own pocket.
- Over time insurance funding tends to drive the quality of care upwards – but also the cost. The large insurance-funded US health system provides some of the most advanced medical treatment in the world, but is also the most expensive system in the world

Options and recommendations

Economic effects of different methods of funding (cont.)

Co-payment funding

- Out-of-pocket payments discourage visits to the doctor by imposing a financial cost. The certain economic consequence is that some of those who would visit the doctor, if visits were free, would no longer do so. This may mean:
 - some genuinely sick people, who are also poor, do not get medical treatment that they need;
 - some people who might otherwise have made marginal, frivolous, visits to the doctor are discouraged from so doing
 - the second effect frees up the doctor's time, so that this scarce resource is better focussed on the genuinely sick
 - the winners from co-payment are the genuinely sick who can afford co-payments, who will get more face-time with doctors than under a free access system; the losers are the genuinely sick who are also poor who will get no time
- A change in the price of visits to the doctor raises the question of what is the closest substitute. In this case it is probably a visit to A&E. So co-payment has the effect of:
 - Reducing the demand for the services of doctors; and
 - Increasing the demand for A&E

Options and recommendations

Conclusions

Taxation options

- There is limited scope for varying taxation levels on Jersey. Jersey's economic success and attractiveness as a place for businesses to locate is based on its low taxation regime.

Social security options

- There is probably more appetite, and scope, for increasing employer and employee social security contributions. These contributions are payable directly to the Social Security Department, and are therefore hypothecated for social services. A percentage of the contributions flows directly to the State's Health Insurance Fund.
- In contrast to general taxation, it is easier for residents to understand the connection between what they pay in terms of contributions, and what they receive in terms of health and social care.

Insurance options

- The States of Jersey could consider ways of increasing insurance provision on the island, while maintaining equity and fairness. This could include, for example, a means-tested subsidy for insurance premia or some form of voucher scheme.

Co-payment options

- Co-payments provide the most direct observable link between what a resident pays and what a resident receives in terms of health and social care. They are popular with healthcare providers too.
- It may be possible to design a more robust, regulated system of co-payments with clear schedules of charges for different services (and, again, a rebate or subsidy scheme for those who cannot afford to pay out-of-pocket).



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Appendix A

Island case studies

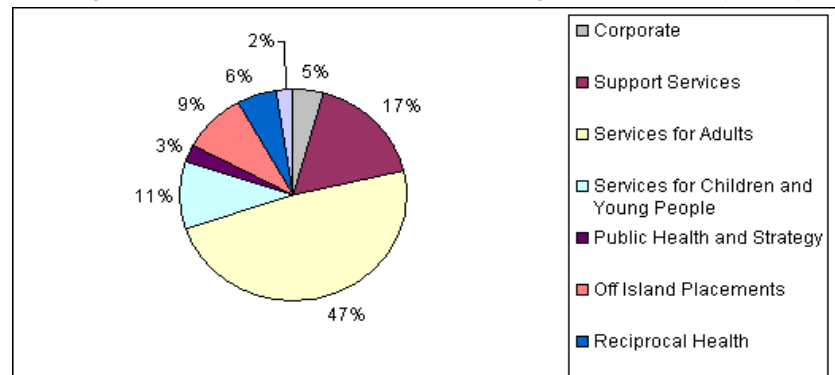
Appendix A

International case studies: Guernsey

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
Guernsey	2,949	46,867	44,600	62	4%	2%	5%	2,488

Similarities and differences with Jersey

- Guernsey's Health and Social Services Department is the largest employer on the island with over 2,100 people employed including clinical and non-clinical staff with an annual budget of £84 million. Around 65% of this budget is spent on payroll. By service, the budget breaks down as follows:



Source: http://www.gov.gg/ccm/cms-service/download/asset/?asset_id=7280030.

- Primary care doctors are in private practice and patients are required to pay for their visits to the surgery, for house calls and care provided in the Accident and Emergency Department. Patients must also pay for dental treatment, chiropody, physiotherapy and opticians. A number of Provident Associations and Friendly Societies run local private insurance schemes, as well as the large healthcare insurance providers, to assist with these charges.
- However, if a patient is referred for secondary care provided by the Medical Specialist Group, all care and in-patients facilities are free. This includes radiology and pathology, physiotherapy and other services. This second level care is funded by a compulsory health care insurance payable by the working population. Another level of insurance covers long term care. Patients may still choose to be treated privately and there is a private wing attached to the main hospital.
- Long-stay elderly care is mainly provided by private nursing and residential homes and those people requiring places are assessed on need and a level of funding is provided by the Social Security Department.
- Patients may be flown to the UK for specialist treatment.

Appendix A

International case studies: Isle of Man

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
Isle of Man	3,440	38,690	35,000	80	7%	1%	8%	3,426

An NHS system one hundredth the size of the UK's

- The Isle of Man's health service is run by their Health Service Directorate. In terms of primary care, the Directorate supervises Family Practitioner Services, which covers GP, dentist, pharmaceutical and ophthalmic services. These services are mainly provided through detailed service contracts between the Department and appropriately qualified self-employed practitioners who have been approved by the Department.
- Secondary (acute and intermediate) care is provided by the two hospitals on the island. In relation to Hospital and Specialist Services the Directorate directly provides and manages:
 - Noble's Hospital, and
 - Medical, Nursing and other services associated with Noble's Hospital including outreach services working in the community
 - In addition the Directorate secures the use of those hospital and specialist services outside the Island required to provide a comprehensive health service.
- Some patients requiring specialist treatment (transplant, burns, cancer etc.) are referred abroad. In 2006/07, 6,000 patient trips to the UK were made for treatment.

Revenue and Personnel Budget	Service Delivery Plan 2010 – Resources	
	2010/2011	Manpower
	£ in million	w.t.e
Health Services		
Hospital and Specialist Services	73,745	1,159.3
Primary Healthcare	52,342	320.8
Strategy and Performance	11,793	8.0
Total (Health Services)	(34,208)	
Core Services Group (including Estates Services Directorate)	103,672	1,488.1
Department Total	115.54	1,677.3
	Estimated Cost	2010-11
Capital Programme	£ in million	£ in million
Total	184.95	11.016

Source: http://www.gov.im/lib/docs/dhss/dh_sdp_2010.pdf.

Appendix A

International case studies: England

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
UK	2,174,530	35,165	35,200	61,838	7%	2%	9%	3,002

Ring-fenced, but massive efficiency improvements required ...

- In their recently published review of health expenditure, the House of Commons Select Committee on Health outlined how both health and social services are funded in England, and the forthcoming changes to central government funding, local government formula grant funding and the personal social services grant:
- Of the approximately £100 billion annual health budget, around 60% is used to pay staff. A further 20% pays for drugs and other supplies, with the remaining 20% split between buildings, equipment and training costs on the one hand and medical equipment, catering and cleaning on the other. Nearly 80% of the total budget is distributed by local trusts in line with the particular health priorities in their areas.
- The £100 billion comes directly from taxation. The 2008/9 budget roughly equates to a contribution (from taxation) of £1,980 for every man, woman and child in England.
- The Department of Health controls the NHS, headed by the secretary of state for health (who reports to the Prime Minister). The Department of Health controls England's 10 Strategic Health Authorities (SHAs), which oversee all NHS activities in England. In turn, each SHA supervises all the NHS trusts in its area. The devolved administrations of Scotland, Wales and Northern Ireland run their local NHS services separately.
- There is a private healthcare industry in the UK, which makes up around 18% of total healthcare spending.

Source of funding	2010/11 baseline	Spending review period
Health		
NHS budget	£98.7 billion	Increased by 0.4% in real terms
Social services		
Local government formula grant	£28.0 billion	Reduced by 26% in real terms
Personal Social Services grant	£1.3 billion	Increased by £1 billion in real terms
Contribution from NHS budget	£1.0 billion	

Source: <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/512/51202.htm>.

Appendix A

International case studies: Bermuda

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
Bermuda	6,093	94,908	69,900	64	4%	5%	9%	8,665

High medical inflation and an ageing population

- Bermuda has higher per capita health care costs than the USA and all other countries in the world. And these costs are only rising. In April 2010 it was reported that the cost of medical insurance in Bermuda had risen by 14.7% since February 2009, according to the latest government figures.
 - A health insurance boss, BF&M's CEO John Wright said Bermuda's medical inflation continued to rise at a higher rate than the overall inflation rate due to, in part, an ageing population and more visits to the doctor and higher costs for treatments for conditions such as heart disease cancer and diabetes.
 - In addition, he said, Bermuda was also faced with a rising frequency of outpatient visits on a per person basis, while medical insurance paid by Bermudians continued to be influenced by medical inflation rates, particularly in the US, where they are serviced if the treatment is not offered in Bermuda.
- In 2007 Former Opposition Leader Grant Gibbon said there had been a 70 percent increase in standard premiums in the past five years.
- Overall, with the new fees in 2007, while residents pay a somewhat lower rate than visitors, rates are now about 25% higher than they are in a similar-sized community hospital in the USA
- Surgical, medical and dental rates are extra and are covered in the Bermuda Hospitals Board (Medical and Dental Charges) Amendment Order.
- There is no national health plan in Bermuda. Local taxpayers and visitors pay for hospitalization and related services in several concurrent ways:
 - By the Bermuda Government Employment Tax, a percentage of gross salary payable by every local employee and employer.
 - Second, by the insurance premiums all employers and employees pay in mostly private sector health and hospitalization plans.
 - The Health Insurance Association of Bermuda (HIAB) requires every Bermuda employer, self employed person and non working spouse to be insured for at least the minimum level of health care benefits. Employers may insure these legal obligations either through the Bermuda Government's Department of Social Insurance or with a private insurer if an approved and registered member of HIAB.
 - When a child has both parents employed at separate places, one employer or the other will provide the coverage. In mid 2000, as part of a series of reforms to the Hospital Insurance Regulations enacted by the Bermuda legislature on March 12, Bermuda taxpayers will now fund home visits by nurses for treatment such as changing colostomy bags, stroke rehabilitation, changing bandages and administering medication.
 - By fees, non-residents pay for any services they require.

Appendix A

International case studies: Caribbean island nations

Antigua

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
Antigua	1,132	12,920	17,200	88	3%	1%	5%	620

- The Caribbean islands are much poorer than most of the other jurisdictions investigated.
- Antigua is one of the Caribbean's most prosperous islands, but its income per capita is less than a third of that in Jersey. State funding of health and social services amounts to around 12-14% of total state budget. On the island, there is 1 public general hospital, 1 private hospital, 1 hospital for the elderly, and 1 hospital for the mentally ill. Many patients travel abroad for magnetic resonance imaging (MRI) and treatment options such as radiotherapy and chemotherapy.

Cayman Islands

- Although we have been unable to locate specific data for the Cayman Islands we have done some qualitative research
- On the Cayman Islands, health insurance is required by law. . Employers must provide, at the very least, a standard health insurance contract for their employees from the very first day of employment, regardless of the type or length of their work permit. These provisions apply to those self employed including partners in a partnership. This requirement on employers extends to any dependant spouse and child living in the Islands. Employers are entitled to deduct (from the employee's wages) 50% of the premium cost for an individual employee and 100% for his or her dependants.
- Plans vary from the basic to the all-inclusive, which covers prescriptions, dental, optical and most outpatient services. The cost also varies with age. The average cost of a basic plan with dental and vision, for an individual, is CI\$181 per month and without dental and vision is CI\$105. These rates are usually about 30% less with a company plan.
- Some medical and dental practitioners accept local insurance 'on assignment' provided that the insurance company guarantees payment and the deductible has been met. This means that they will claim directly from the insurance company for work done on your behalf. Almost all medical practitioners will verify the patient's insurance coverage with the insurance company before they carry out any service.
- A broad range of medical services are available on Grand Cayman with two fully-equipped hospitals, numerous clinics and many private specialist doctors and general practitioners. The Cayman Islands also attract a wealth of visiting specialists. Healthcare and medications are quite costly, however.
- All public and private hospitals have radiological and laboratory facilities. Services include the addition of two-CT Scans and one MRI unit. There are four mammography units. Blood Banking facilities are at government hospitals; all blood donations are screened. Basic health insurance covers emergency care, hospitalizations and few outpatient services. Additional health insurance is provided by private companies, but regulated by government. In 2000, the Government contracted a health insurance company to provide health insurance to all its employees and their dependents.

Appendix A

International case studies: Gibraltar

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
Gibraltar	914	27,468	38,500	29	8%	1%	9%	4,331

Universal free healthcare at the point of delivery

- Gibraltar Health Authority is a department of the Government of Gibraltar and its purpose is to provide health care to the residents of Gibraltar, an overseas territory of the United Kingdom and home to over 27,000 residents.
- In Gibraltar, all citizens are entitled to free healthcare. British and EU citizens are also entitled to free healthcare during a stay of up to 30 days. St Bernard's Hospital is the only general civilian hospital. Its services include: orthopaedic trauma, maternity, surgical, medical and paediatric wards, two main operating theatres and an emergency back up theatre, a hydrotherapy pool with a full rehabilitation clinic, day surgery unit and cardiac rehabilitation, accident and emergency department with provision for major and minor incidents and ophthalmic clinics.
- Patients requiring treatment not available in Gibraltar receive private treatment in Spain or the UK paid for by the Government of Gibraltar.

Appendix A

International case studies: Tasmania, Australia

Country	GDP (current \$m)	GDP (current \$ per capita)	GDP (PPP per capita \$)	Population ('000s)	Public Health Expenditure (% of GDP)	Private Health Expenditure (% of GDP)	Total Health Expenditure (% of GDP)	Total health expenditure per capita (current \$)
Jersey	5,610	61,116	57,000	92	4%	2%	6%	3,814
Tasmania	23,239	45,984	36,847	508	8%	3%	11%	4,972

A mixed health economy of public and private care

- The island of Tasmania is Australia's smallest state, and a popular tourist destination. The total population of Tasmania is small (473,300) and, if current trends continue, it will reduce even further, for while the state attracts people from mainland Australia as visitors, it loses its own residents to permanent interstate migration.
- Issues such as high unemployment (8.5%) encourage Tasmanians to leave and seek work or education on the mainland. This has contributed to Tasmania having the lowest percentage of 15-65 year olds in Australia. It is, however, a popular place to retire to and has the second highest percentage of over 65 year olds in the country (South Australia has the highest percentage). It also recorded the only increase in aboriginal population in Australia during the 1986-1996 period. One of the consequences of supporting such a dispersed and ageing population is that heavy demands are placed upon the state's health services.
- The health care system in Tasmania is both public and private. Like the rest of Australia's states, Tasmania has a comprehensive range of health services to cover areas such as acute care, mental and community health and aged care. As with the other states a major focus in the health system is the provision of infrastructure to support the acute care needs of the population. The Department of Health and Human Services (DHHS) is responsible for the public health care sector in Tasmania and is one of the state's biggest employers. The major public hospitals are the Royal Hobart Hospital (Tasmania's only tertiary referral hospital), the Launceston General Hospital and the North West Regional Hospital. Each has an operating department and is capable of undertaking a broad range of surgical procedures. Private hospitals with operating departments include Hobart Private, Calvary, St Helens, St Vincents, St Lukes and Latrobe Hospitals.
- All health professions are represented in the Tasmanian health workforce although there are serious shortages for many, particularly in the rural areas. This is compounded by the lack of educational opportunities in Tasmania for people wishing to prepare for a career in a health discipline that is not medicine, nursing, pharmacy or social work. Because of this Tasmania finds it difficult to attract health care professionals from mainland Australia.
- The Tasmanian population is largely rural. Therefore morbidity and mortality rates reflect a rural rather than urban population.
- Decentralization means that health care takes place in a large number of rural settings and that the available health resources are spread thinly.
- The desire for a full range of health services in every town places enormous burdens on the health care service providers, so that the budget, and inability to provide full services to all towns, mean that the population must travel to get to health services.
- Tasmania's geography means that even relatively short distances on a map are long drives in reality, which adds further complications to healthcare provision on the island.



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Appendix B

Economic levers

Appendix B

Key questions

- **What payment and incentivisation mechanisms have the most positive impact on the behaviour of individuals, groups and communities?**
 - What drives behaviours around healthcare (e.g. choice, usage, access, ownership and responsibility for self-care and prevention)?
 - What factors influence **demand** for healthcare? (In both a macro and a micro sense e.g. disposable income, time, travel distance, acuity of need, information, availability of substitutes)
 - What factors influence **supply** of healthcare? (e.g. cost of facilities and labour, profitability, barriers to entry, regulatory environment)
 - What are the welfare impacts in the marketplace for healthcare?
 - What are the economics levers that can be employed to influence behaviours? (e.g. supplier-induced demand under different payment and incentivisation mechanisms; the tipping point in terms of the percentage of disposable income that drives more responsible choices)
 - How do societal factors (e.g. the social good/social ill concepts) influence the above?
 - What factors influence or contribute to market failures in healthcare.

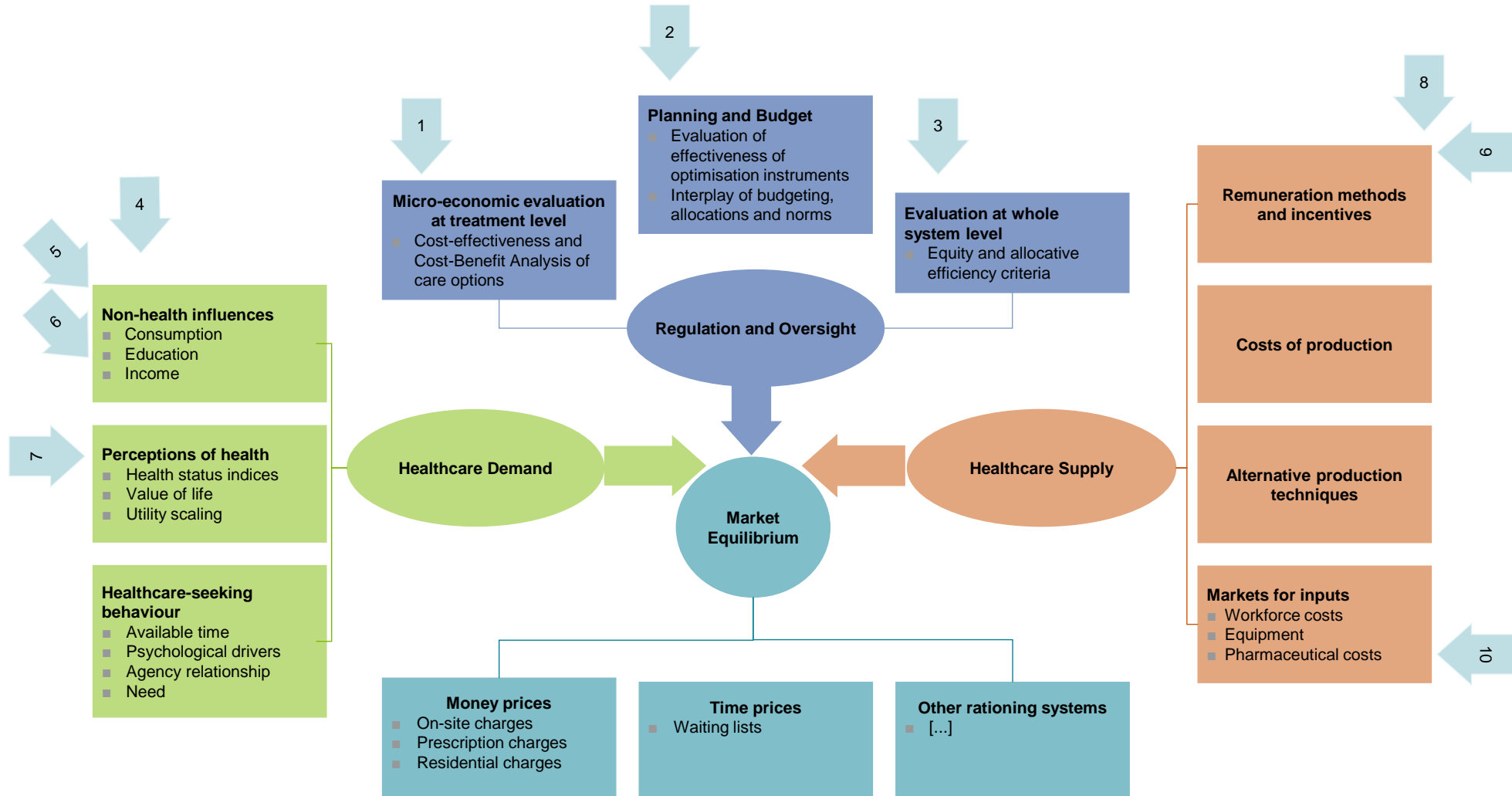
Incentives in healthcare

- Incentives generally fall into two fields: **financial** and **non-financial**.
- On the demand side, a financial incentive could be a prescription or appointment charge, whereas a non-financial incentive could be a waiting list.
- On the supply side, financial incentive would commonly be profit margin on provision, whereas a non-financial incentive could be professional reputation.

Driving behaviour in healthcare

- We need to think about both the behaviour of **individuals** (healthcare recipients), and the behaviour of healthcare **providers**.
- What are the **levers** that can be used to influence the balance of healthcare supply and demand, and at what point in the system are they influential?
- On the next slide, we present a stylised picture of the healthcare market, which illustrates where and how these levers can be used. Later, we discuss the levers in more detail.

Appendix B Economic levers



Appendix B

Economic levers (cont.)

The levers illustrated on the previous slide are as follows:

- Changing agreed thresholds within micro evaluations of treatments (e.g. cost per QALY of 'effective' treatment).
- Investment in new budget optimisation tools/training.
- Re-evaluation of 'Equity' in terms of Jersey health economy.
- Increasing health education e.g. healthy behaviours adopted early through school programmes.
- Providing means-tested benefits designed to improve health outcomes (e.g. maternity support).
- Increasing sales taxes on unhealthy goods and services e.g. cigarettes and alcohol.
- Changing perceptions of healthcare requirements e.g. state responsibilities versus individual responsibilities.
- Alternative incentive-based remuneration methods e.g. Payment by Results, outcome-based remuneration.
- Introduction of price-cap on GP services.
- Increased regulation of pharmaceuticals and medical equipment.



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**An 'as is' picture of
health and social
care
(December 2010)**

States of Jersey Population trend

Jersey has an aging demographic more stark than the UK with a drop from 2.1 workers per dependent now to 1.3 workers by 2030 which will put increasing demand on health services

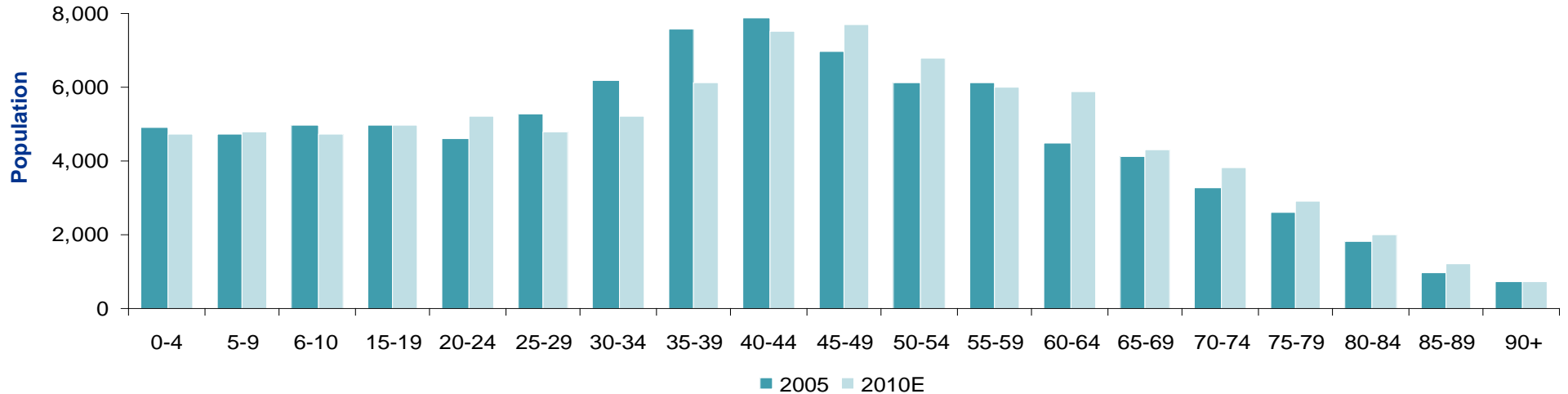
Ageing Population-net nil migration



States of Jersey

Age profile

Population by age



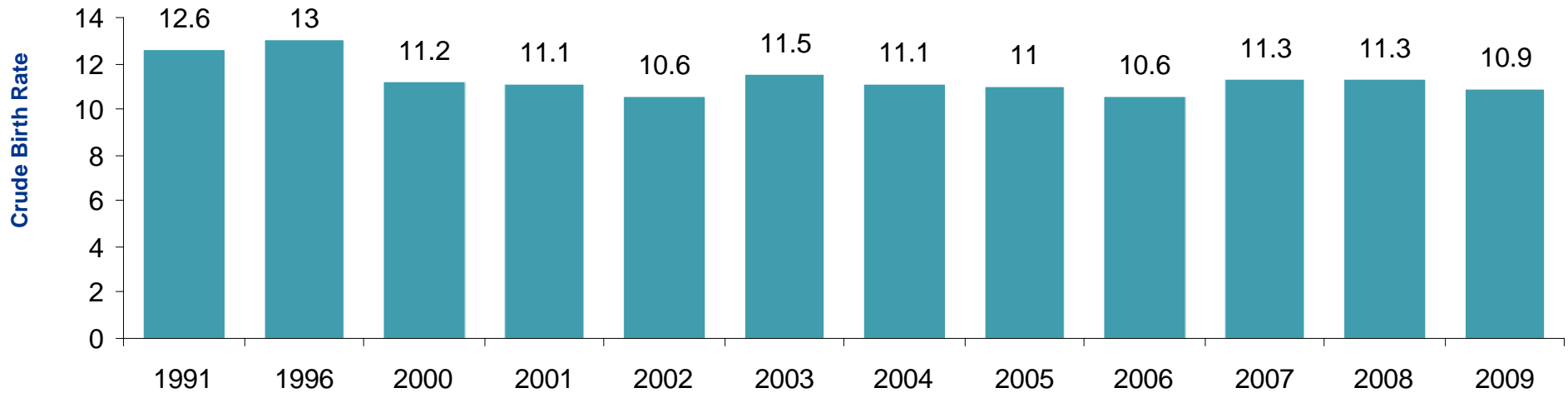
Age profile

- In 2005, 15,700 of Jersey citizens were under 15 years of age. This accounted for 18% of the total population.
- In 2005, 59,300 of Jersey citizens were between 15 and 64 years of age. This accounted for 67% of the total population. So Jersey had 67% of its population as working population in 2005.
- In 2005, 13,700 of Jersey citizens were above 65 years of age. This accounted for 15% of the total population.
- Estimated numbers for 2010 have approximately the same split across the age groups.

States of Jersey

Birth rates

Annual birth rate



Crude Birth rate

- The crude birth rate (CBR) is defined as the number of live births per 1,000 residents per annum.
- The CBR in 2009 was less than the average CBR between 2001 and 2008.
- 1,005 births took place in 2009 which is lower than 2007 and 2008 figures but higher than the average number of births between 2001 and 2008.

States of Jersey

Health indicators – general health status

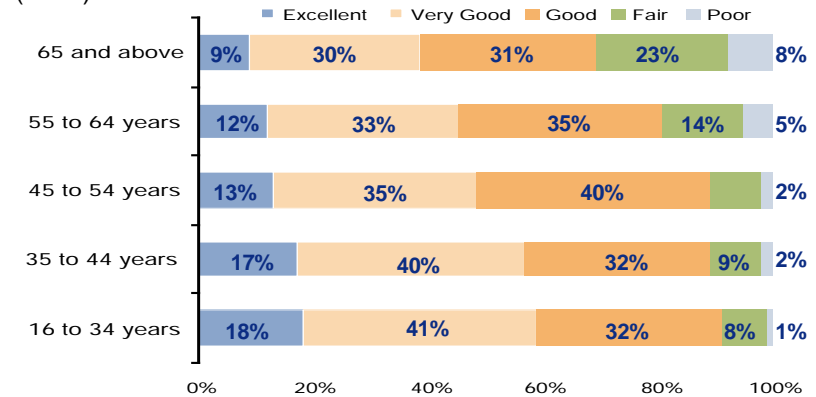
General health status

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 as compared to 70% of those aged 65 and over.

Health status

(2009)



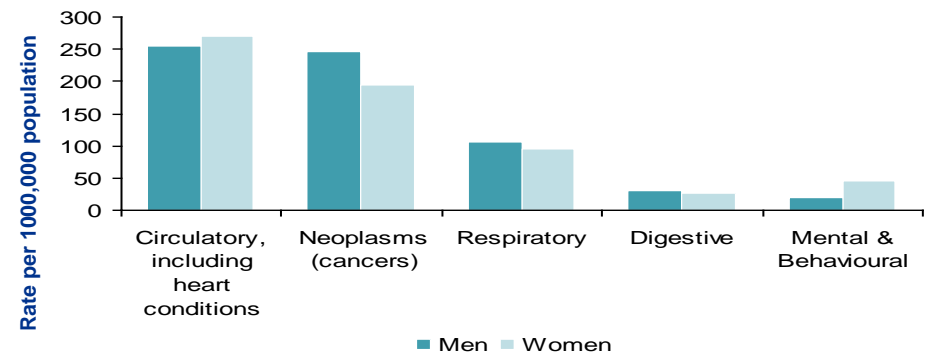
Causes of death

Circulatory diseases and cancer were the prime causes of death during 2004-2008.

Furthermore, the statistics for this period indicate that the proportion of deaths of people below 75 years were greater for cancer as compared to circulatory disease. In addition, men were more likely to die before 75 years, than women as a result of circulatory or digestive diseases or due to accidents.

Prime causes of death

Annual average, (2004-2008)



Source: Jersey Statistics Unit.

States of Jersey

Health indicators – causes of death

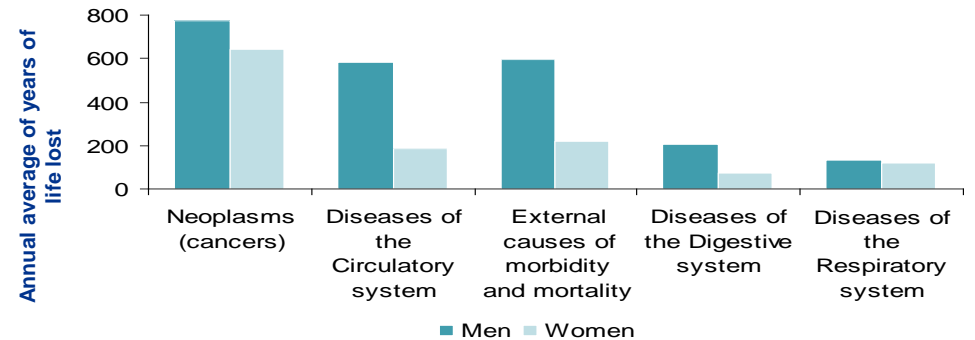
Cause of years of life lost

Cancer and circulatory diseases were the major causes of years of life lost between 2004-2008. Cancer caused more number of deaths in this period compared to the deaths caused by circulatory diseases.

On an average, for every life lost by a woman there were two lives lost by men in the period from 2004 to 2008.

Major causes of years of life lost

Annual average, (2004-2008)



Source: Jersey Statistics Unit.

States of Jersey

Health indicators – drug and alcohol

Drugs

In 2009, the Jersey Customs and Immigration Service accounted for 108 drug seizures that amounted to an approximate value of GBP 2.6 million. As compared to 2008, this number of seizures had increased by 15%.

Volume of drug seizures

	2007	2008	2009
Heroin (grams)	375	935	1,242
Ecstasy (tablets)	25,772	5,091	–
Cocaine (grams)	136	711	2,788
Cannabis (kgs)	8	48	114
Amphetamines (grams)	4	–	1,002
Amphetamines (tablets)	252	–	5,199
Class C (grams of powder)	250	–	1,005
Class C (tablets)	1,203	5,666	72,049

Source: Jersey Statistics Unit, States of Jersey website.

Alcohol

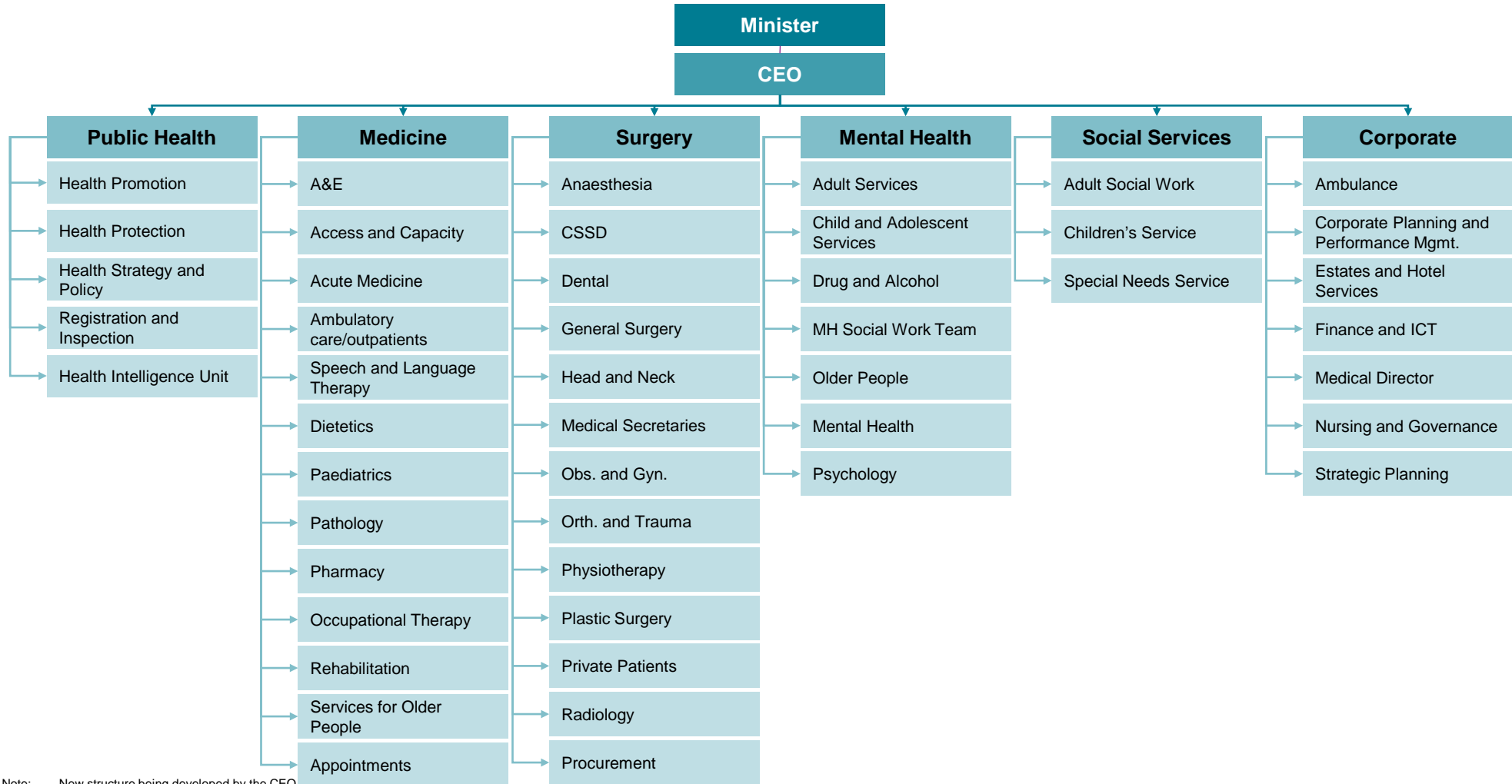
According to the 2008 Jersey Annual Social Survey, approximately half of the men (46%) and more than a third of women (35%) exceeded recommended daily levels of alcohol consumption (i.e. 3 to 4 units of alcohol per day)

Health and social care Service map

[Map to come]

States of Jersey

How is HSSD structured? (as at December 2010)



Note: New structure being developed by the CEO.

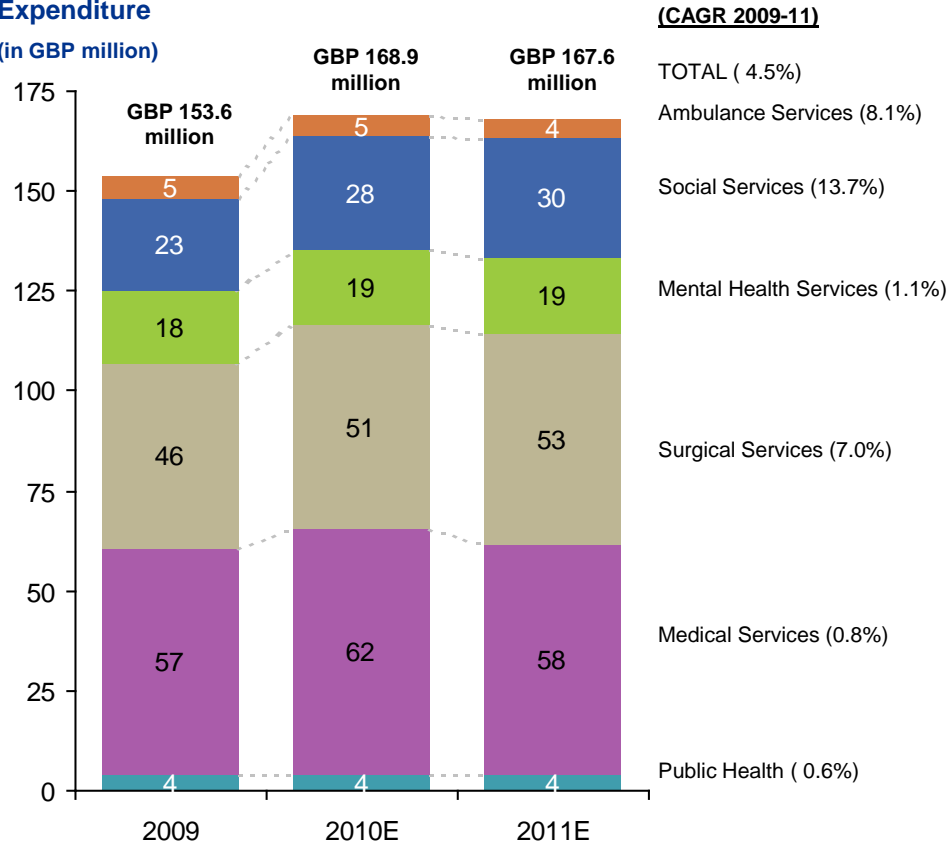
States of Jersey

How is budget split?

The 2010 budget for Health and Social care is £169m (£185m expenditure and £16m income) and in addition the GPs were paid £7.4m in 2010 (up to 23 December 2010) from the Employment and Social Security budget for approximately 450,000 appointment types. The actual spend in 2010 was £170.5m^(a)

Health and Social Services – Budgeted Net Expenditure

(in GBP million)



Note: (a) HSSD 2010 Ledger closed 26 January 2011.

Source: Jersey Health and Social Services (Annex to Business Plan 2011), Jersey Statistics Unit.

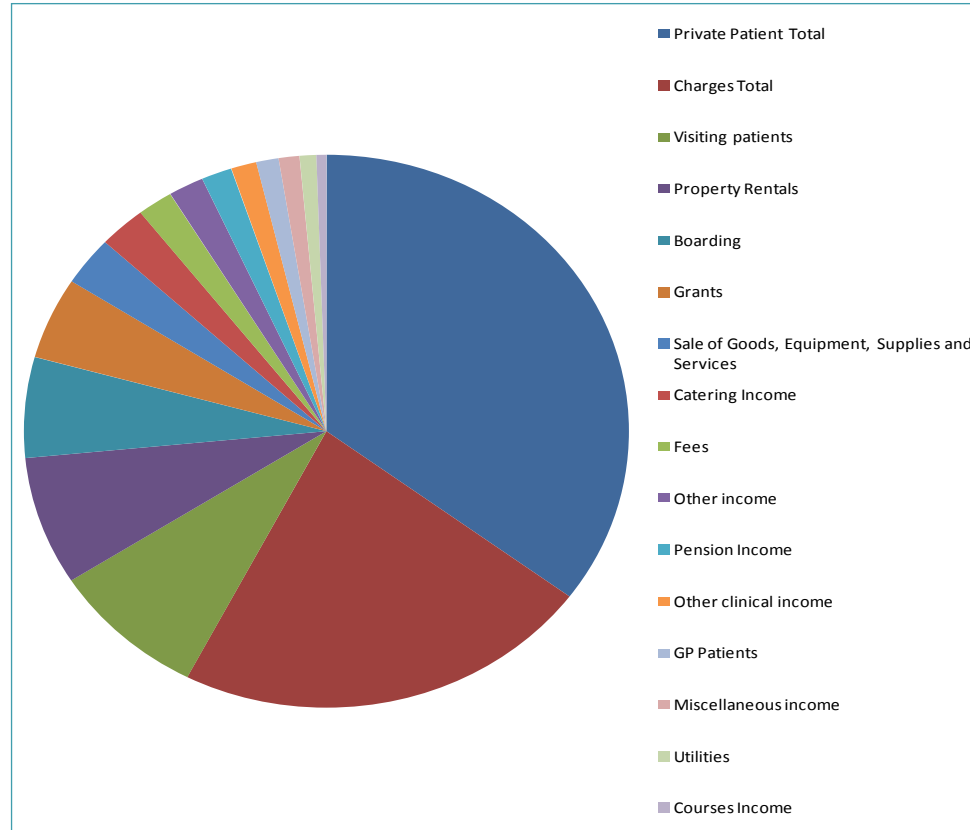
- There are currently **six** main areas of operation for the Health and Social Services department (outlined overleaf), however the structure of this is currently under review
- **Key projects and issues** for the department in 2011 are as follows:
 - **Primary care:**
Amendment of the Health Insurance Law, to transfer appropriate services into the primary care area. It is proposed to include the management of chronic diseases such as diabetes and asthma.
 - **Williamson Implementation Plan:**
The aim of this project is to modernise children’s services. As a part of this project, the development of the Children’s and Young People’s Plan is in progress and is expected to be launched towards end of 2010
 - **The sustainable hospital:**
The senior management team along with clinicians aim to develop a strategy for future development of the General Hospital
 - **Ageing demographics:**
Faced with an ageing demographic, the department is looking to develop plans for services such as dementia care, stroke care and rehabilitation as well as surgery for cataracts and hip replacement, etc.
 - **Suicide rate:**
Jersey is facing an increasing number of suicides year on year and is looking to implement recommendations to curb this issue

States of Jersey

How is the income split?

The 2010 budget expenditure for the Health and Social Care Department is £185m and the income received is £16m. The split of the income is outlined below.

Total Income Breakdown



- The main source of income is from private patients with £5.6m
- The remaining split is outlined below:

Income Categorisation	Income Value £
Private Patient Total	5,609,747
Charges Total	3,571,868
Visiting patients	1,331,476
Property Rentals	1,198,666
Boarding	936,813
Grants	761,404
Sale of Goods, Equipment, Supplies and Services	455,623
Catering Income	400,537
Fees	303,353
Other income	301,027
Pension Income	261,635
Other clinical income	216,471
GP Patients	193,306
Miscellaneous income	174,347
Utilities	143,197
Courses Income	84,686
Grand Total	15,944,156

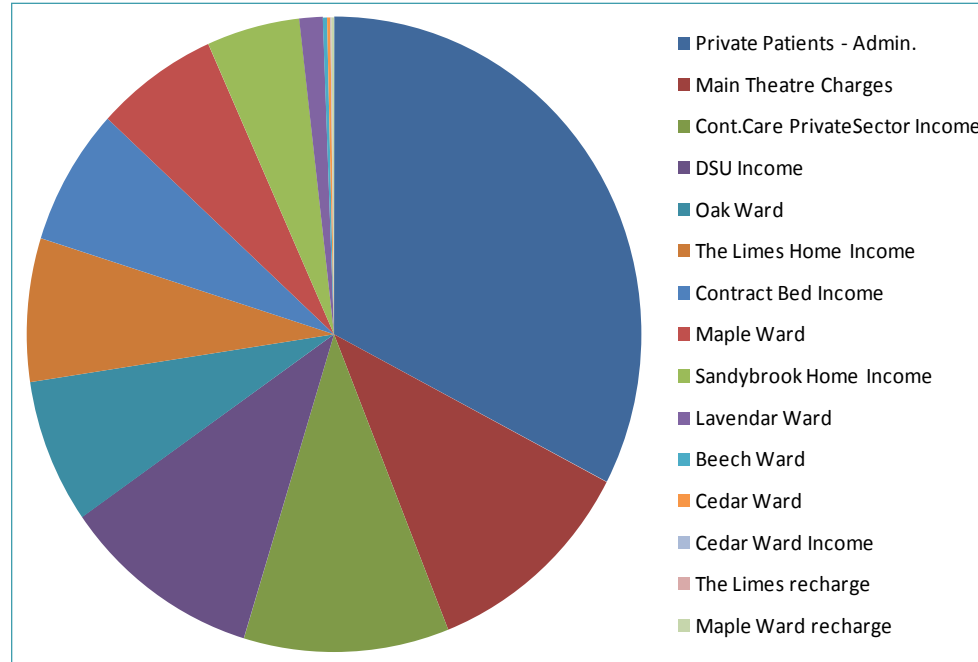
Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

How is the private patient income split?

The income of £16m is primarily comprised of private patient income which constitutes one third of the total – £5.6m of the £16m. This is broken down as outlined below:

Private Patient Income Breakdown



- The main source of income is from private patients with £5.6m which is split out as below:

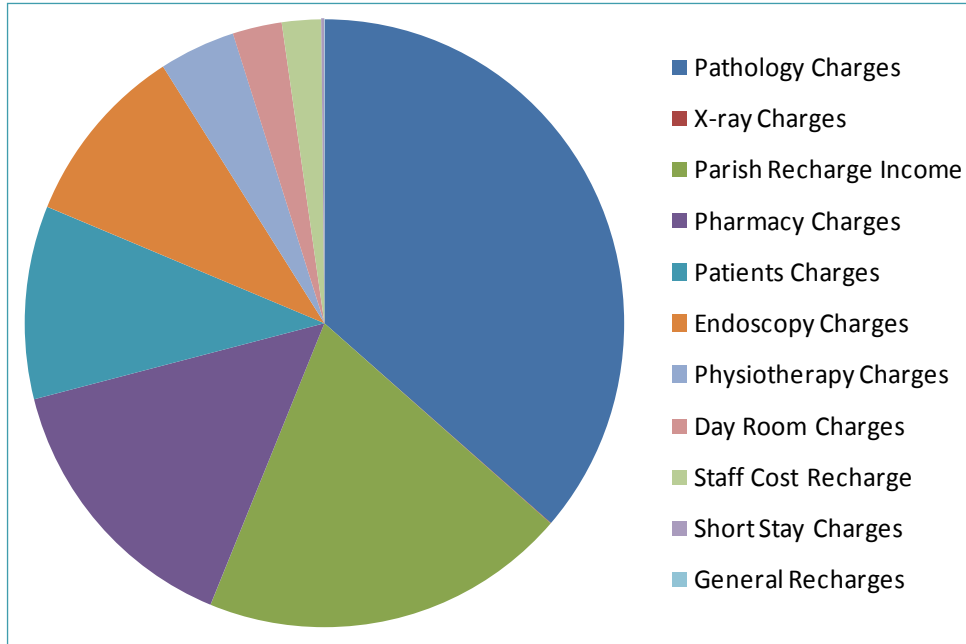
Private Patient Income Category	£
Private Patients – Admin.	1,840,209
Main Theatre Charges	634,412
Cont. Care Private Sector Income	605,797
DSU Income	591,538
Oak Ward	413,753
The Limes Home Income	411,150
Contract Bed Income	391,705
Maple Ward	363,302
Sandybrook Home Income	274,482
Lavendar Ward	68,629
Beech Ward	12,716
Cedar Ward	9,585
Cedar Ward Income	1,652
The Limes recharge	- 1,545
Maple Ward recharge	- 7,637
Total	5,609,747

Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

How is the income from additional charges split?

The second largest area for income generation is charges for pathology tests (which is in the region of £1m) and other diagnostic and therapy services including pharmacy. The breakdown is as set out in the table below.



■ The income generated by the charges for tests and other services amount to £3.57m broken down as below:

Income Categorisation		Income Value £
Charges	Pathology Charges	1,009,931
	X-ray Charges	795
	Parish Recharge Income	550,789
	Pharmacy Charges	410,191
	Patients Charges	284,353
	Endoscopy Charges	269,640
	Physiotherapy Charges	114,029
	Day Room Charges	73,941
	Staff Cost Recharge	58,718
	Short Stay Charges	4,270
	General Recharges	576
Charges Total		3,571,868

Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

How is spend allocated?

The table below demonstrates the total budget cost and how this is split between each of the Divisions between the HSSD. These figures differ slightly from the budgeted figures as they are the actuals from the Ledger Close of 26 January 2011. This is further broken down into Divisional and Speciality level overleaf.

Division	Cost
Ambulance	4,295,540
CEO and Corporate Planning	5,133,381
Estates	8,638,339
Finance and ICT	21,163,438
Human Resources	681,648
Managed Services	10,831,740
Medical Services	40,860,697
Mental Health	14,234,929
Public Health	4,537,142
Social Services	21,862,062
Surgical Services	38,268,479
Grand Total	170,507,395

Note: (a) Some small variances may be demonstrated due to allocation.

Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

How spend is allocated – Medical services

The table below shows the spend allocation for the medical services as per the actual spend from the ledger close of 26 January 2011.

Division	Service	Specialty	Cost (£)	
Medical Services	A&E		3,078,727	
	Older people residential and nursing		2,963,524	
	Specialty	Cardiology	355,411	
		Dermatology	444,675	
		Diabetes/Endocrinology	598,024	
		ENT	208,671	
		Gastroenterology	544,543	
		General Medicine	2,478,660	
		Nephrology	1,761,924	
		Oncology	1,474,407	
		Ophthalmology	298,907	
		Paediatric	1,259,843	
		Rheumatology	43,369	
		Specialty Total		9,468,434
		Therapies	Dietetics	172,834
		OT	2,399,537	
		SALT	632,354	
	Therapies Total		3,204,724	
	Ward		7,352,494	
	Central overheads		7,522,229	
	Other	GP OOH	103,726	
		Pathology	5,641,776	
		Pharmacy	1,525,063	
	Other Total		7,270,564	
Medical Services Total			40,860,697	

Note: (a) Some small variances may be demonstrated due to allocation and rounding.

Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

How spend is allocated – Surgical services

The table below shows the spend allocation for the surgical services as per the actual spend from the ledger close of 26 January 2011.

Division	Service	Specialty	Cost (£)
Surgical Services	Specialty	Dental	1,190,785
		ENT	599,162
		General Surgery	4,070,041
		Gynaecology	1,882,714
		Obstetrics	2,149,880
		Ophthalmology	612,180
		Trauma and Orthopaedic	1,354,380
		Urology	50,019
	Specialty Total		11,909,162
	Theatres	DSU	2,139,093
		Theatres	4,198,439
	Theatres Total		6,337,532
	Therapies	Audiology	606,378
		Chiropody	126,296
Orthoptics		129,881	
Physiotherapy		2,366,562	
Therapies Total		3,229,118	
Ward		9,991,437	
Other		3,565,846	
Central overheads		3,235,384	
Surgical Services Total			38,268,479

Note: (a) Some small variances may be demonstrated due to allocation and rounding .
Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

How spend is allocated – Mental health budget

The table below shows the allocation to mental health services as per the actual spend from the ledger close of 26 January 2011.

Division	Service	Specialty	Sub-service	Cost (£)
Mental Health	Adults	Adult Mental Health	Alcohol and Drugs	876,721
			Active recovery	1,300,073
			Acute IP	1,295,083
			Acute Liaison	1,206,999
			Maison du lac	417,319
			Recovery Unit	389,008
			Adult Mental Health Total	5,485,202
	Children		Special Needs Total	1,076,119
			Safeguarding and Community Support Total	688,788
			Children's Total	1,764,907
	Older people	MHOP	Community team	482,602
			Inpatient old age	4,267,729
			Memory Clinic	193,265
			Psychiatry	595,085
			Other	20,222
MHOP Total	5,558,896			
Central		Mental Health overheads	1,425,916	
Mental Health Total			14,234,929	

Note: (a) Some small variances may be demonstrated due to allocation and rounding .
Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

How spend is allocated – Mental health and social care budget

The table below shows the allocation to social services as per the actual spend from the ledger close of 26 January 2011.

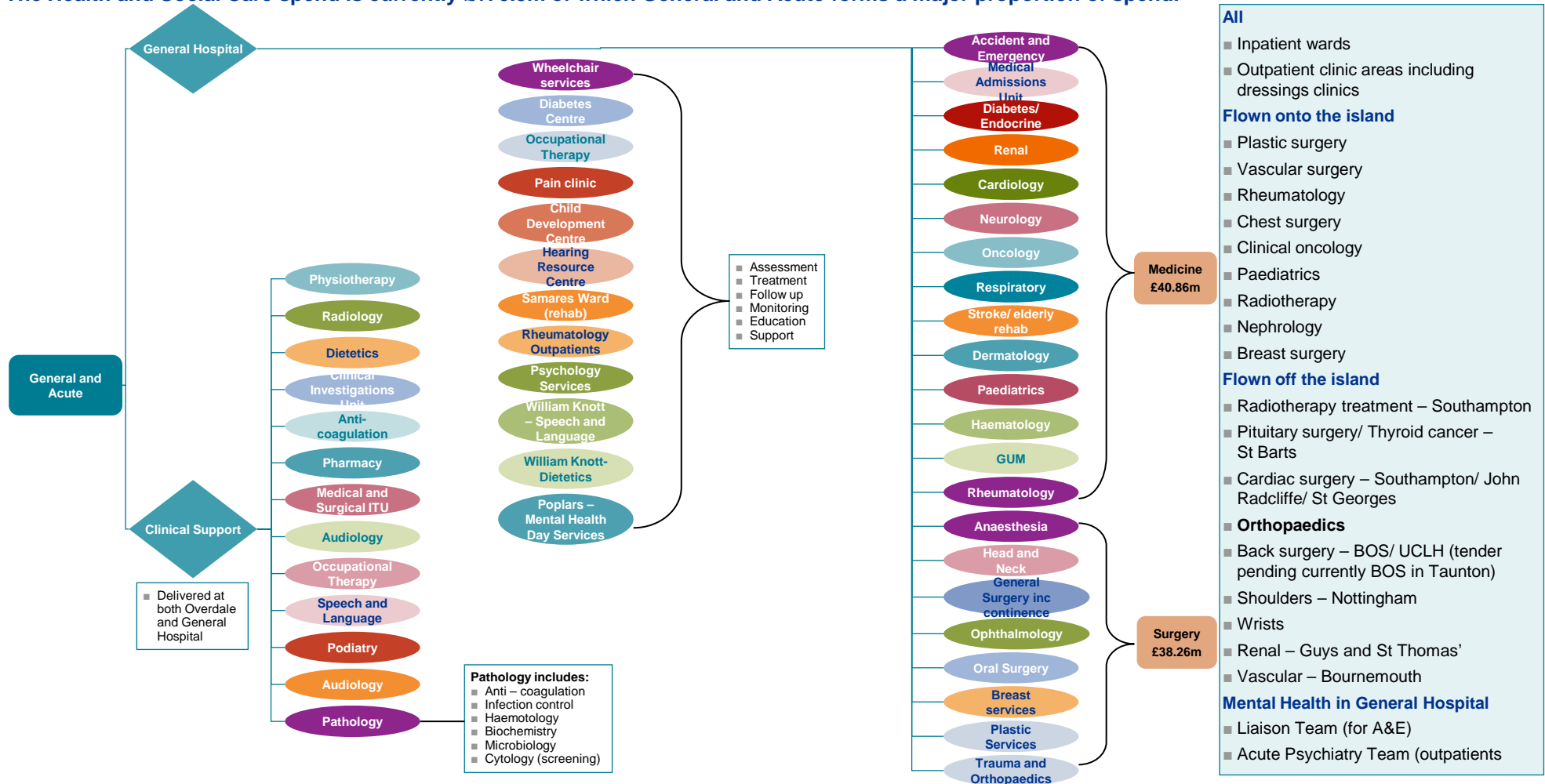
Division	Service	Specialty	Sub-service	Cost (£)
Social Services	Adults	Social work for adults		1,078,111
		Special Needs	Community nursing service	351,001
			Day service	754,275
			Residential services	3,966,943
			Social work service	5,688
			Therapy services	83,995
			Other	281,412
	Special Needs Total	5,443,315		
	Children	LAC	16+/leaving care	82,740
			Fostering and Adoption	459,833
			LAC	659,914
		LAC Total	1,202,487	
		Residential	Care leavers/hostel provision	340,404
			Intensive Support Team	264,514
			LAC Residential	2,784,938
			Respite services	472,534
	Secure Provision		612,150	
Residential Total	4,474,540			
Safeguarding and Community Support	Assessment and Child Protection	668,510		
	Community support	387,553		
Safeguarding and Community Support Total	1,056,062			
Central	Social Services		8,607,546	
Social Services Total				21,862,062
Grand Total				36,096,991

Note: (a) Some small variances may be demonstrated due to allocation and rounding .

Source: SS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey General and acute

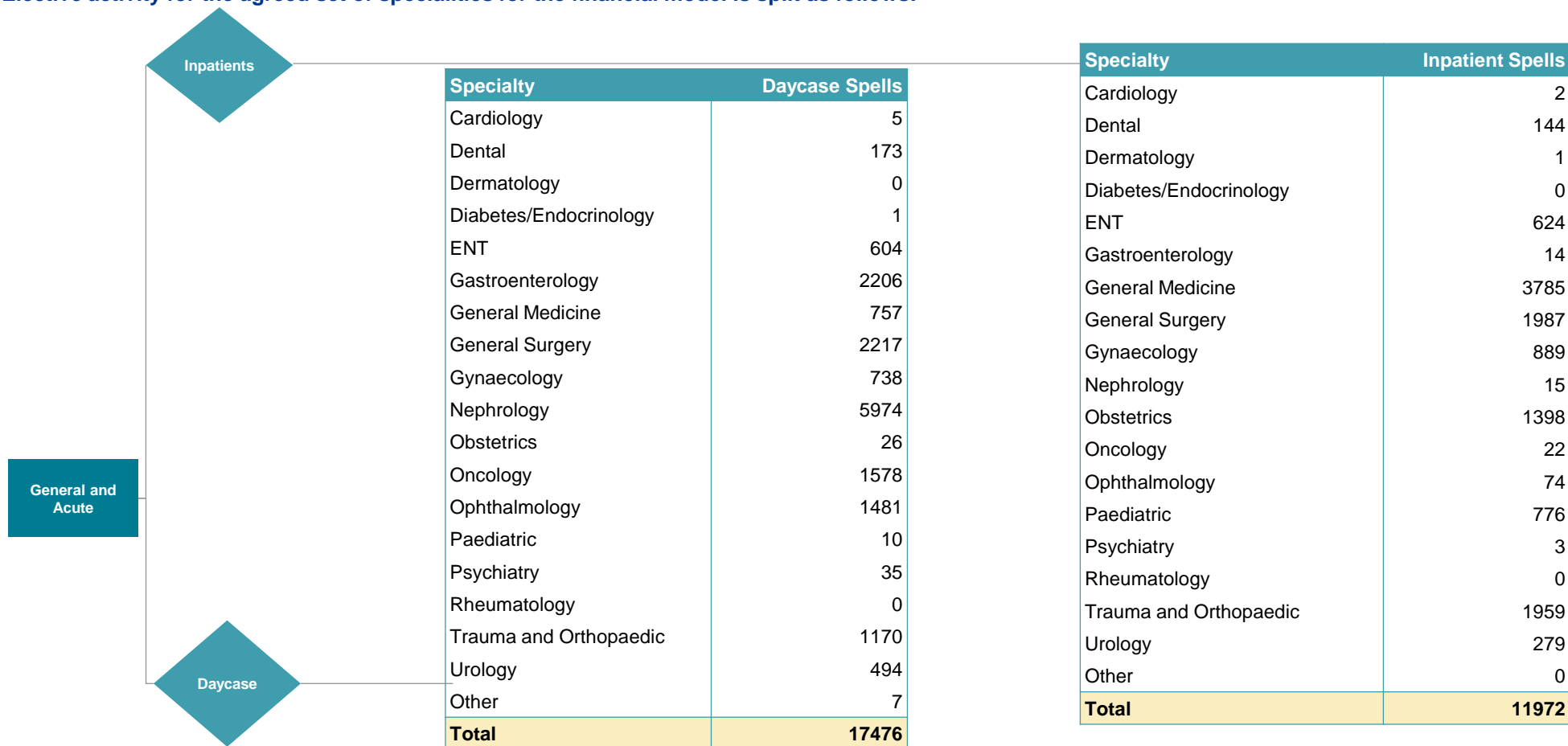
The Health and Social Care spend is currently £170.5m of which General and Acute forms a major proportion of spend.



States of Jersey

General and acute – inpatient activity

Elective activity for the agreed set of specialities for the financial model is split as follows:

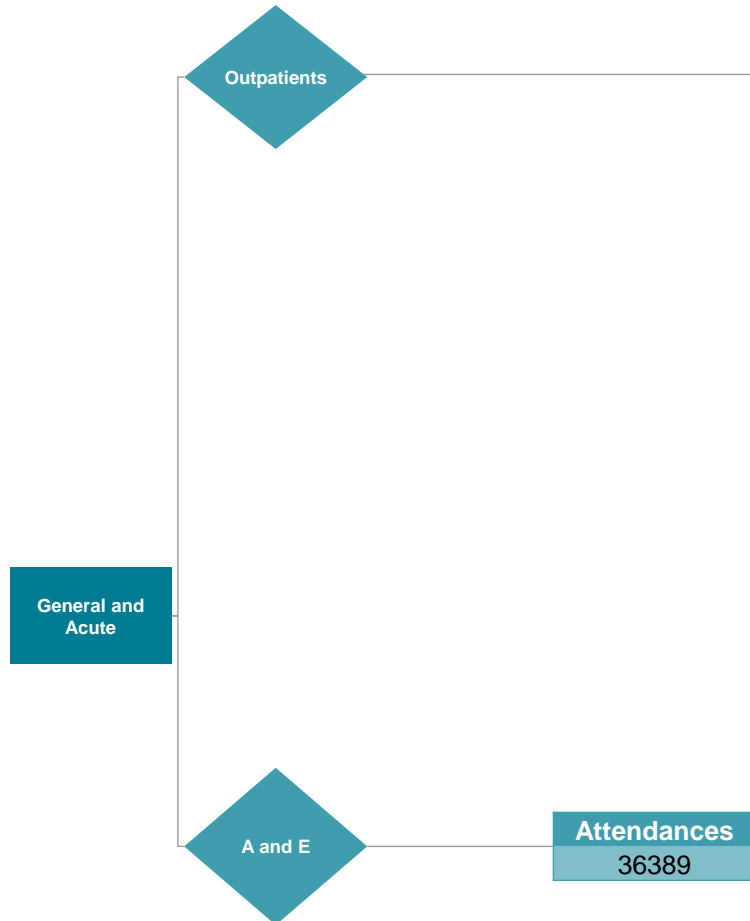


Note: Activity period 2010

Source: HSS 2010 Ledger and various activity figures from HSSD provided for the financial model.

States of Jersey General and acute – activity (outpatients and A&E)

Outpatient agreed specialities and A&E activity is split as below. Radiology and pathology data was not available at the time of reporting.

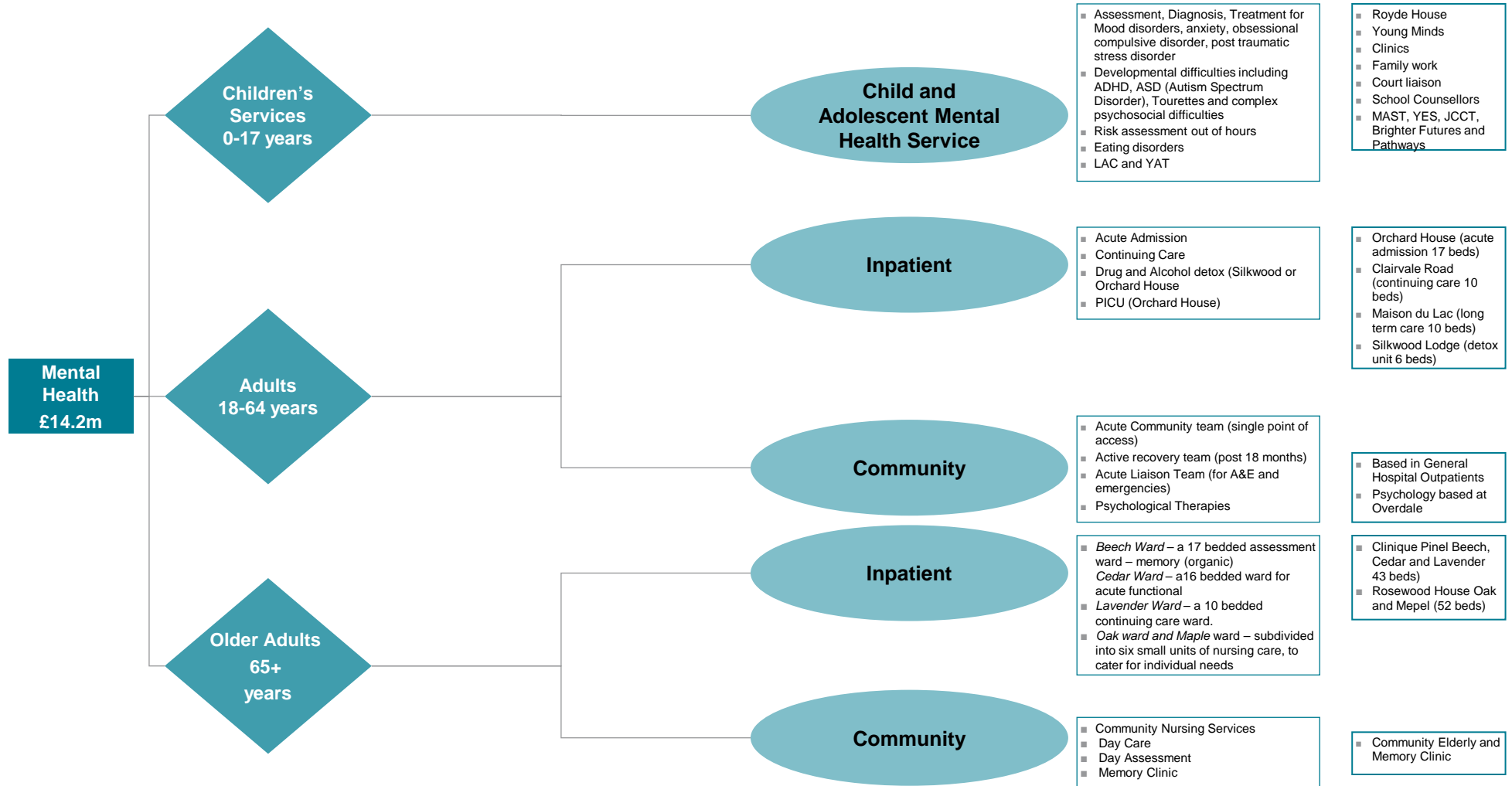


Specialty	Outpatient Appointments
Cardiology	2081
Dental	14081
Dermatology	8286
Diabetes/Endocrinology	2364
ENT	8891
Gastroenterology	1775
General Medicine	6676
General Surgery	16779
Gynaecology	12068
Nephrology	1199
Obstetrics	8979
Oncology	3418
Ophthalmology	15508
Paediatric	2621
Psychiatry	2330
Rheumatology	838
Trauma and Orthopaedic	13957
Total	137754

Note: Activity period 2010

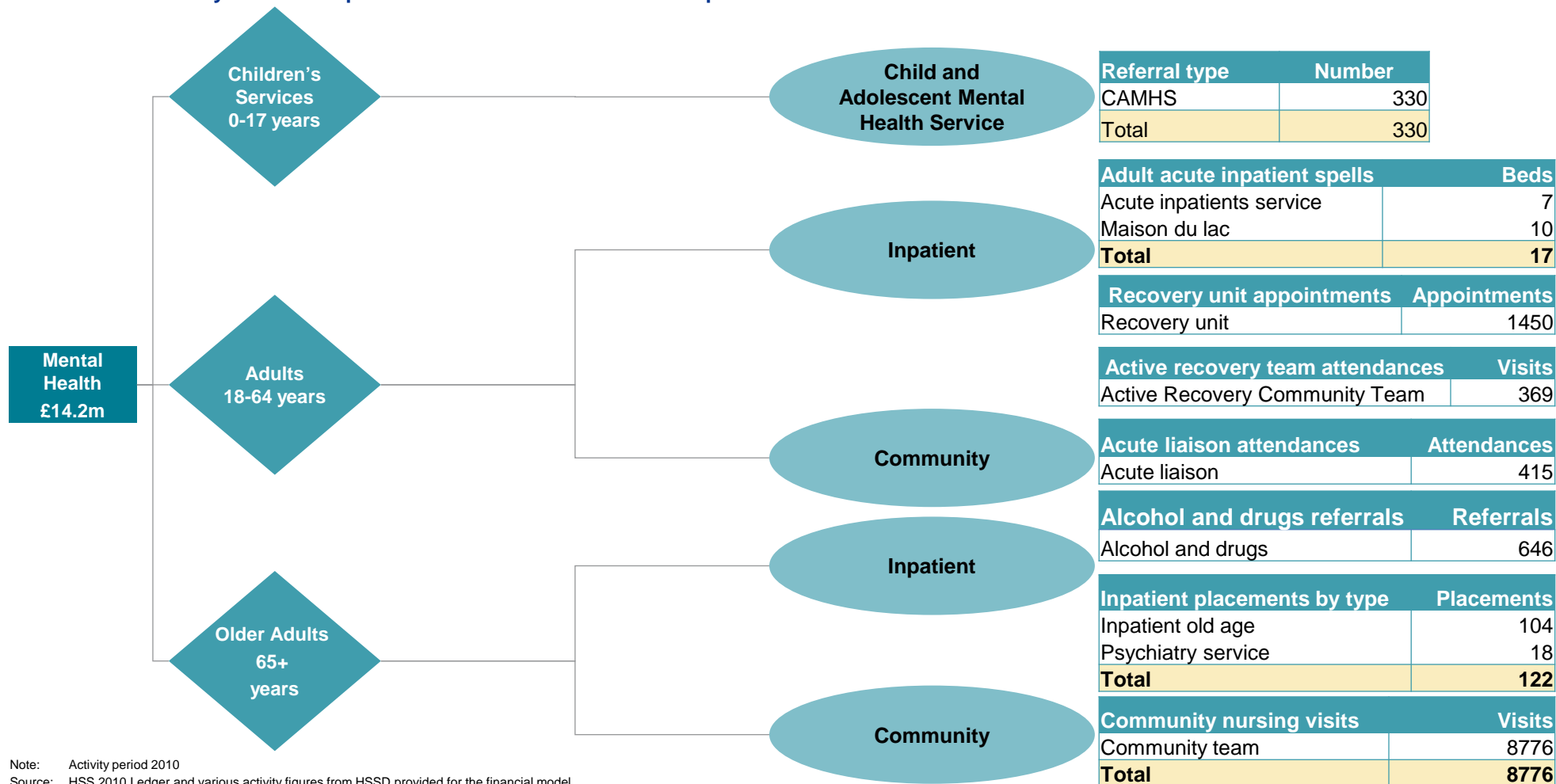
Source: HSS 2010 Ledger and various activity figures from HSSD provided for the financial model.

States of Jersey Mental health services



States of Jersey Mental health services

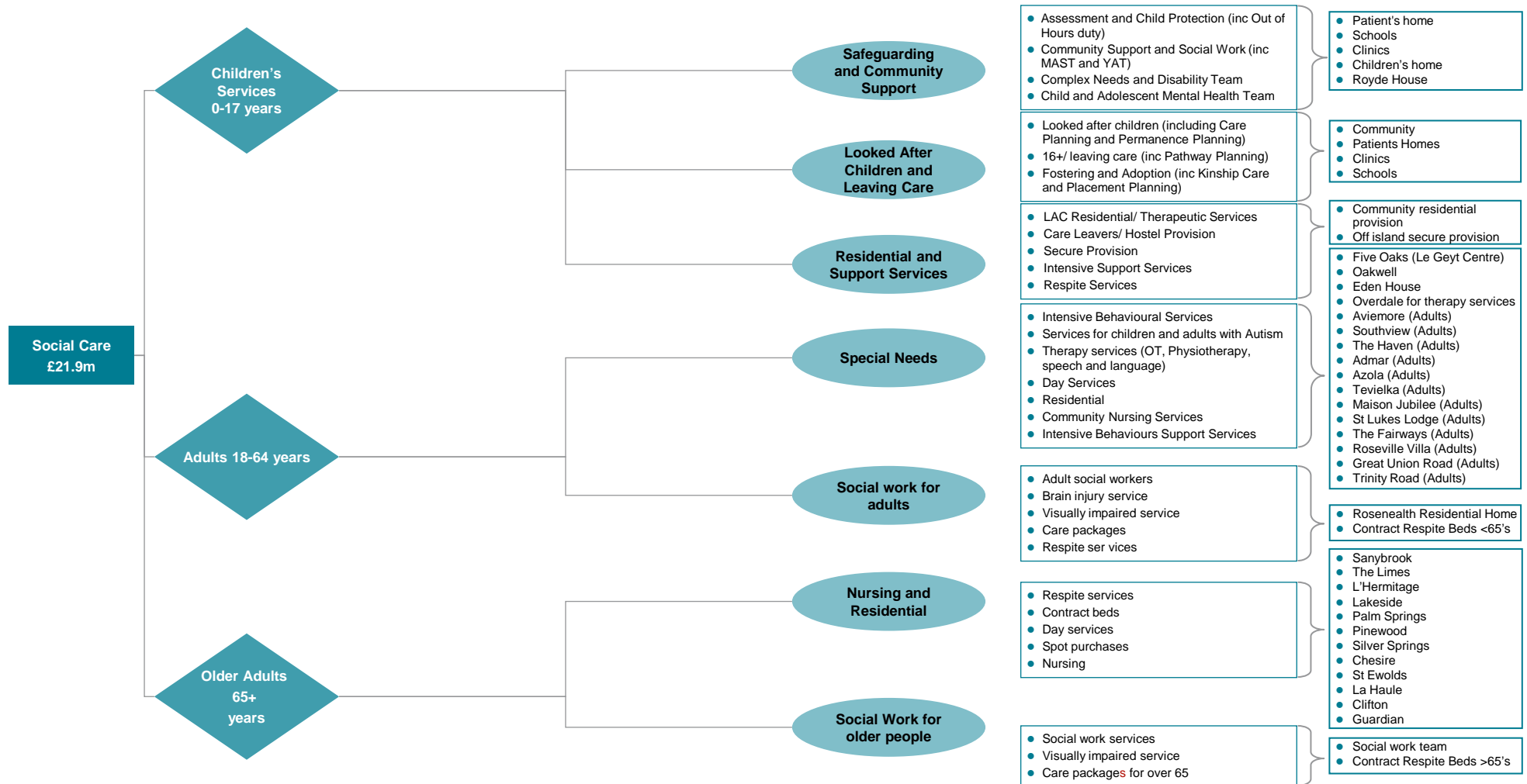
Mental Health activity for 2010 as provided for the financial model is split as follows:



Note: Activity period 2010

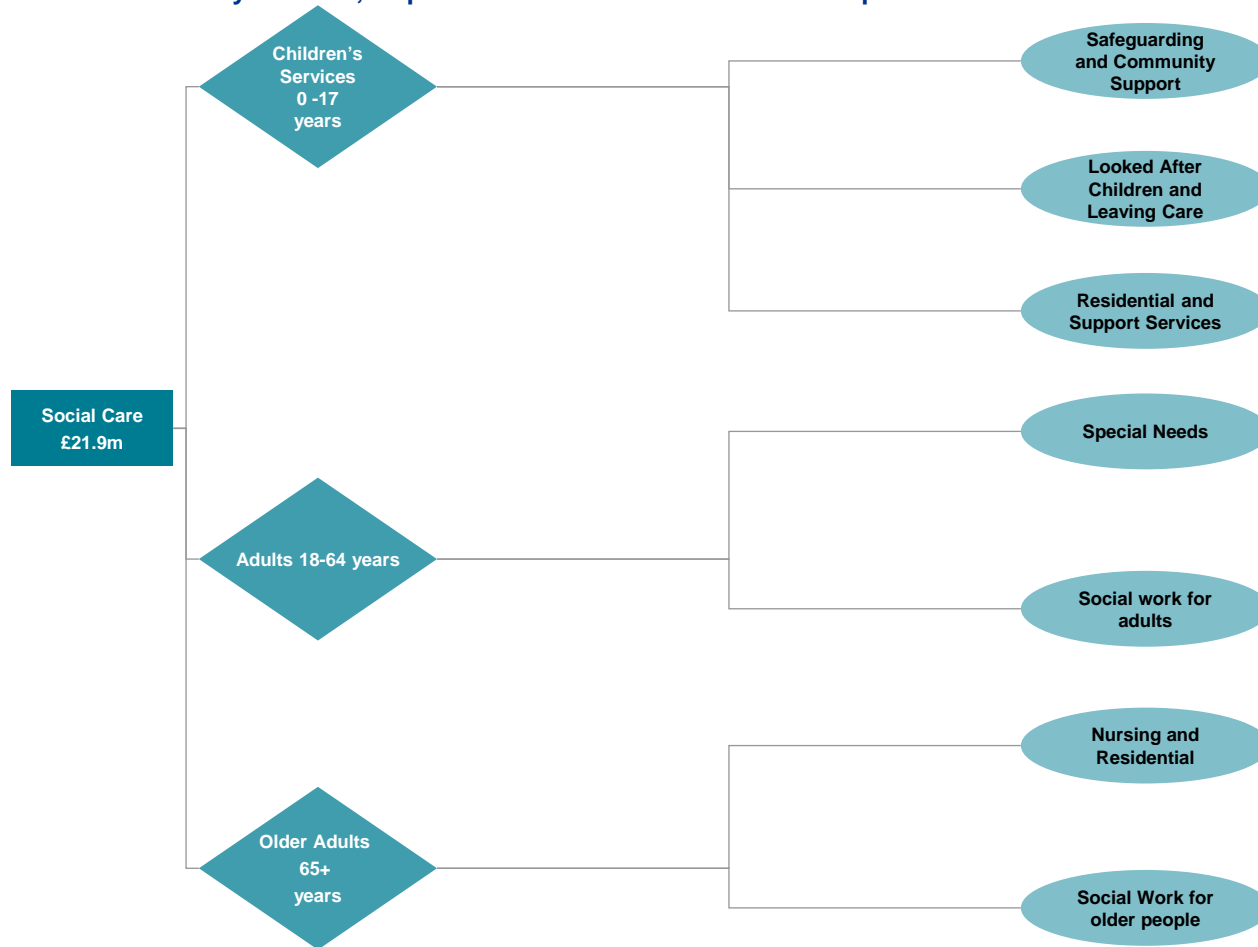
Source: HSS 2010 Ledger and various activity figures from HSSD provided for the financial model.

States of Jersey Social care



States of Jersey Social care

Social Care activity for 2010, as provided for the financial model is split as follows:



Referral type	Number
Safeguarding and Community Support (excl. CAMHS)	1390
Total	1390

Placement Type	Number
Foster Care	27
Family or Friends	23
Residential Care (incl. St Mark's Adolescent Centre)	18
Secure Unit	1
Supported in other ways	7
Total	77

No data available for residential placements at the time of reporting

	Referrals
Adult Social Work	285
Total	285

Residential nursing placements by type	Number of placements
The Limes	36
Sandbrook	28
Contract beds	44
Spot purchases	46
Respite	62
Total	216

No data available for social work for older adults

Note: Activity period 2010
Source: HSS 2010 Ledger and various activity figures from HSSD provided for the financial model.

How is healthcare commissioned outside HSSD provision?

In addition to the work that is delivered by the Health and Social Care Department there is additional healthcare that is commissioned from the UK, third sector and private healthcare. The total value of which is £27m, broken down in detail below

	Categorisation	Cost
Grants	KFG100 – F.N. Serv.s and Home Care Grant	5,946,553
	KFG120 – Shelter Trust	677,970
	KFG200 – Jersey Brook Adv. Centre Grant	281,432
	KFG250 – Women's Refuge	199,380
	KFG330 – Jersey Mencap Society	197,100
	KFG110 – Alcohol Advice Centre Grant	189,960
	KFG260 – NEMO	164,840
	KFG360 – Jersey Employment Trust	137,790
	KFG210 – Jsy Focus on Mental Health	117,920
	Other	151,540
	Grants Total	8,064,485
	Purchase of Health Care	KLS900 – Special Needs Mgt and Admin.
KTL300 – UK Placements – Ad Mental Hlth		881,535
KLC160 – UK Placements Children		736,317
KLA300 – Community Living		728,174
KLS500 – UK Placements		556,769
KLA600 – Under 65 Residential		386,603
KTN100 – Boarding Out Placements		291,616
KLS550 – Under 65's Placement		268,401
KTL400 – Silkworth Lodge		222,200
KLA700 – Adult Respite Services		176,896
KSP100 – Private Patients – Admin.		93,929
KSY400 – Physiotherapy – General Hosp.		88,061
KNY990 – Maternity Modern Matron		74,855
KLA200 – UK Placements Adults		66,860
KNR530 – Respite Care Pvt		36,174
Other	141,260	
Purchase of Health Care Total	5,817,950	
Health Care – SLA	KFH275 – UK Healthcare Contracts	5,023,520
Health Care – Non SLA	KFH275 – UK Healthcare Contracts	3,189,359
UK Healthcare Contracts Total	8,212,879	
Purchase Health Care – Nursing	KNR520 – Continuing Care Private Sector	2,512,692
	KNR530 – Respite Care Pvt	233,176
	KNR510 – Contract Beds	85,451
Purchase Health Care – Nursing Total	2,831,319	
Prch Pvt Home Beds – Nursing	1,800,649	
Subsidies	KNR510 – Contract Beds	217,690
	KFG170 – Citizen's Advice Bureau Grant	32,240
	KFG230 – Relate Grant	27,600
	KFG320 – Headway	11,650
	KFG280 – Jersey Family Mediation Serv.	7,880
	KFG370 – Hyperbaric Treatment Centre	4,310
Subsidies Total	301,370	
Prch Pvt Home Beds-Residential	KNR510 – Contract Beds	90,632
Doctors Fees	KHC200 – Childhood Immunisation	63,221
Nursery Care Placements Total		30,580
Grand Total		27,213,083

States of Jersey

How much activity is sent to the UK?

The UK activity can be further broken down as follows:

Specialty Group	Inpatient Spells		Outpatient Activity		Current Spend
	Activity (Spells)	Percentage	Attendances New	Attendances F/Up	
Clinical Oncology	196	17%	45	156	£ 739,037
Cardiac and Thoracic Surgery	174	15%	58	39	£ 1,248,909
Paediatrics	149	13%	73	254	£ 781,003
General Surgery	146	13%	39	30	£ 696,984
Urology	93	8%			£ 263,132
Neurology/Neurosurgery	59	5%	57	37	£ 467,994
Trauma and Orthopaedics/Spinal	58	5%	68	67	£ 403,170
Ophthalmology	40	4%	36	133	£ 98,223
General Medicine	13	1%			£ 68,483
Critical Care					£ 482,709
Exclusions					£ 373,111
Mental Health					£ 209,721
Nephrology			14	51	£ 144,708
Lysosomal Storage Disorders					£ 100,069
Other	223	19%	126	305	£ 883,535
Grand Total	1,151	100%	516	1072	£ 6,960,788

Source: HSSD provider expression of interest letter 28 01 11 v3.

States of Jersey

How much spend and activity is undertaken by FNHC?

HSSD has many contracts with the third and private sector the main one of which is Family Nursing and Homecare. The budget and activity for FNHC for 2010 is broken down as below:

FNHC Funding	£
Grant HSSD	5,948,563
Sale of Goods	652,979
Sale of Services	778,404
Hire and Rentals	5,324
Grants and Subs	31,728
Total	1,468,435

Community nursing visits	Visits
FNHC – Child and Family Services	22,484
FNHC – District Nursing (adult)	181,327
FNHC – Home Care Services (older adult)	94,149
Total	297,960

Source: (1) HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.
(2) FNHC data.

States of Jersey

Workforce breakdown – General and acute

The workforce associated with the delivery of care for the General and Acute is broken down as follows. At the time of reporting only clinical staff information was available. Further information on clinical staffing formulates part of the modelling next steps.

Consultants and Doctors by specialty	FTE
Cardiology	3
Dental	4.6
Dermatology	1
Diabetes/Endocrinology	0.7
ENT	5
Gastroenterology	2
General Medicine	10
General Surgery	29
Gynaecology	2
Nephrology	1
Obstetrics	8
Oncology	2.5
Ophthalmology	3
Paediatric	7.5
Psychiatry	0
Rheumatology	0
Trauma and Orthopaedic	12
Urology	1
Neurology	0
Cardiac and Thoracic Surgery	0
Total	92.3

Specialty nurses by specialty	FTE
Cardiology	1.8
Dental	6.88
Dermatology	3.43
Diabetes/Endocrinology	1.47
ENT	3.6
Gastroenterology	0
General Medicine	2.03
General Surgery	5.57
Gynaecology	31.94
Nephrology	14.83
Obstetrics	0
Oncology	6.87
Ophthalmology	6.53
Paediatric	0
Psychiatry	0
Rheumatology	0
Trauma and Orthopaedic	0
Urology	1
Neurology	0
Cardiac and Thoracic Surgery	0
Total	85.95

Ward staff by grade	FTE
Medical	
Nurse grade 4-6	82.62
Nurse grade 1-3	63.95
Other	5.38
Total	151.95
Surgical	
Nurse grade 4-6	122.06
Nurse grade 1-3	28.51
Other	7.61
Total	158.18
Paediatric	
Nurse grade 4-6	25.61
Nurse grade 1-3	9.05
Other	2.38
Total	37.04
Maternity	
Nurse grade 4-6	7.36
Nurse grade 1-3	0.85
Other	0
Total	8.21
Total ward staff	355.38

Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

Workforce breakdown – Mental health and social care

The workforce associated with the delivery of care for Mental Health and Social Care is broken down as follows. At the time of reporting only frontline staff information was available:

FTE by grade Social Care and Mental Health	FTE
Social worker	36
RCCO Care Worker	79
FSW Care Worker	12
Social worker assistant	4
Consultant	7
Middle grade doctors	5
Junior doctors	0
HPO	2
Nurse grade 4-7	125
Nurse grade 1-3	229
Other	34
Total	533

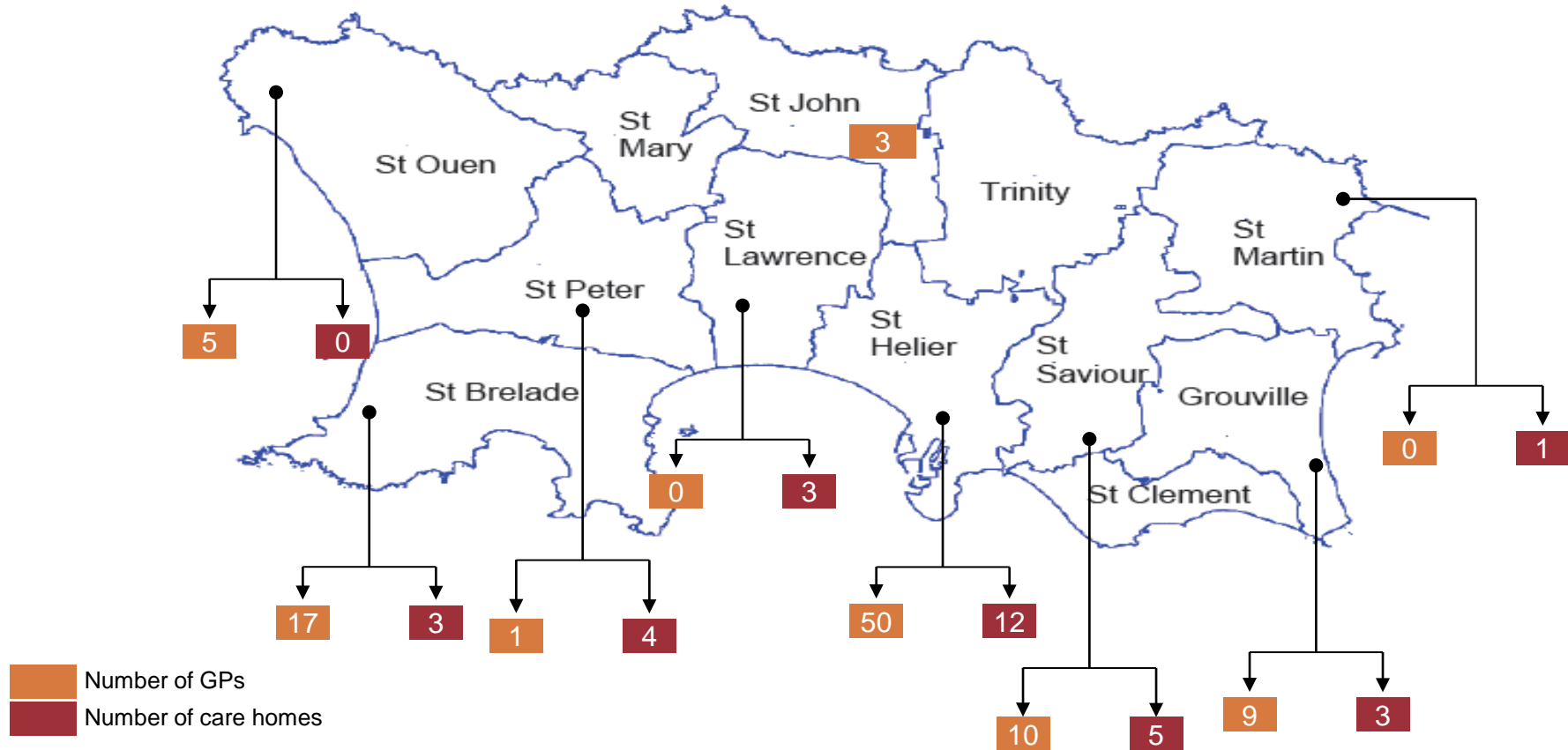
Source: HSS 2010 Ledger – Income Analysis from General Hospital Finance Department.

States of Jersey

Community provision (1) – map of services

States of Jersey (Map)

Presence of GPs and care homes across 12 Parishes of the States of Jersey

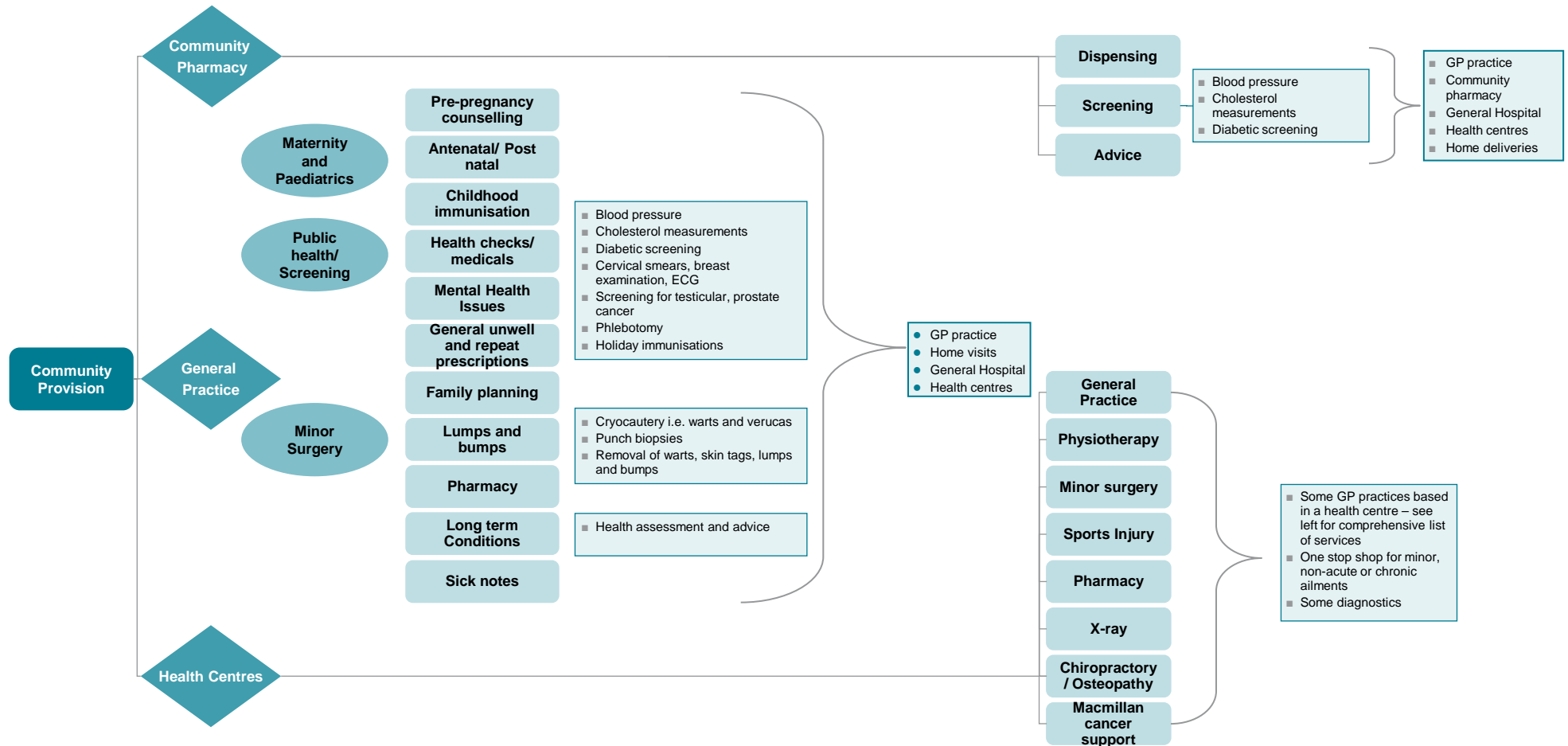


Source: Jersey Citizens Advice Bureau.

States of Jersey

Community provision (2) – GPs, pharmacies and health centres

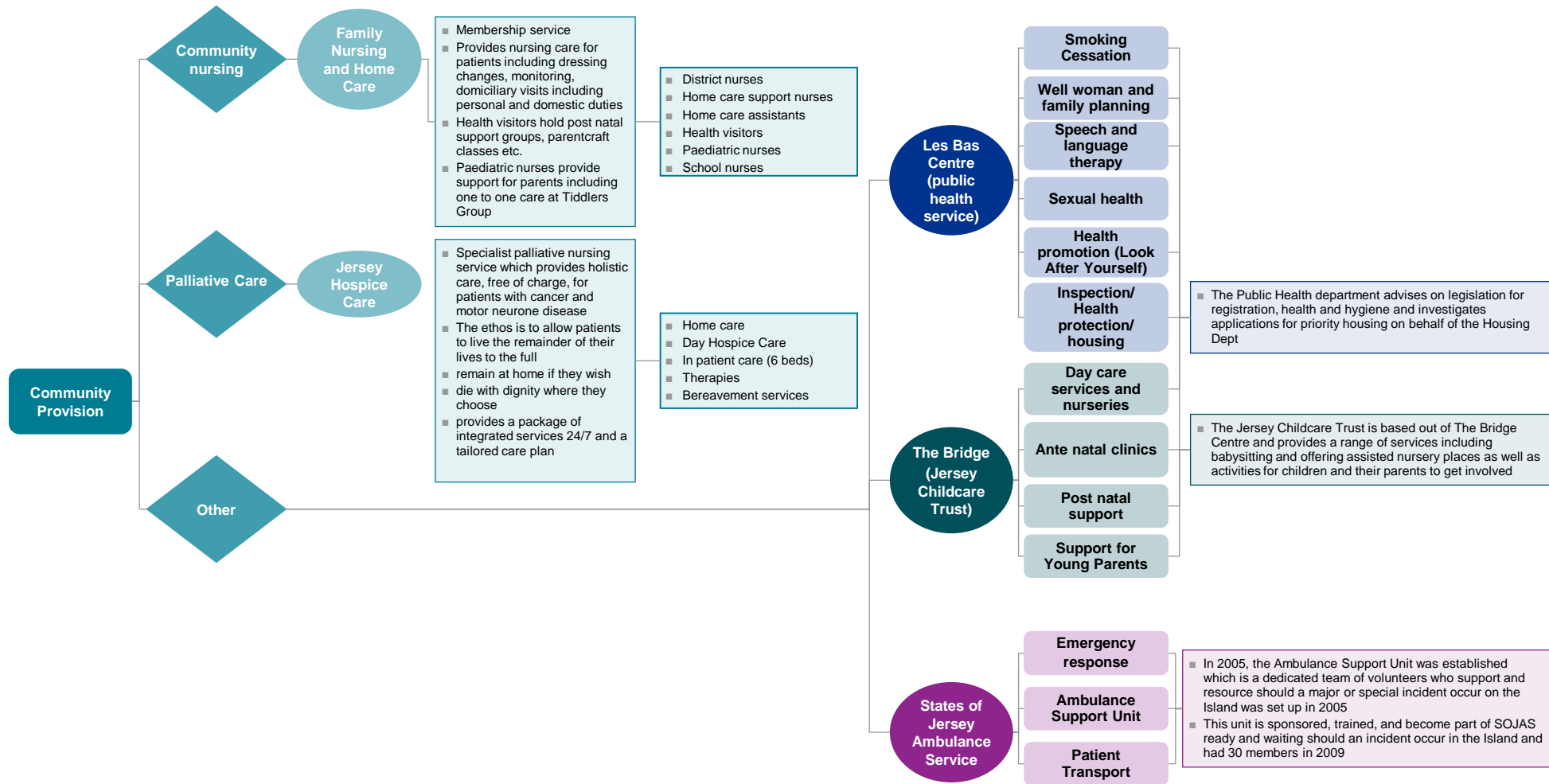
General Practice is under the government department of Employment and Social Security and does not directly impact on the Health and Social Care budget



States of Jersey

Community provision (3) – nursing, palliative care and other

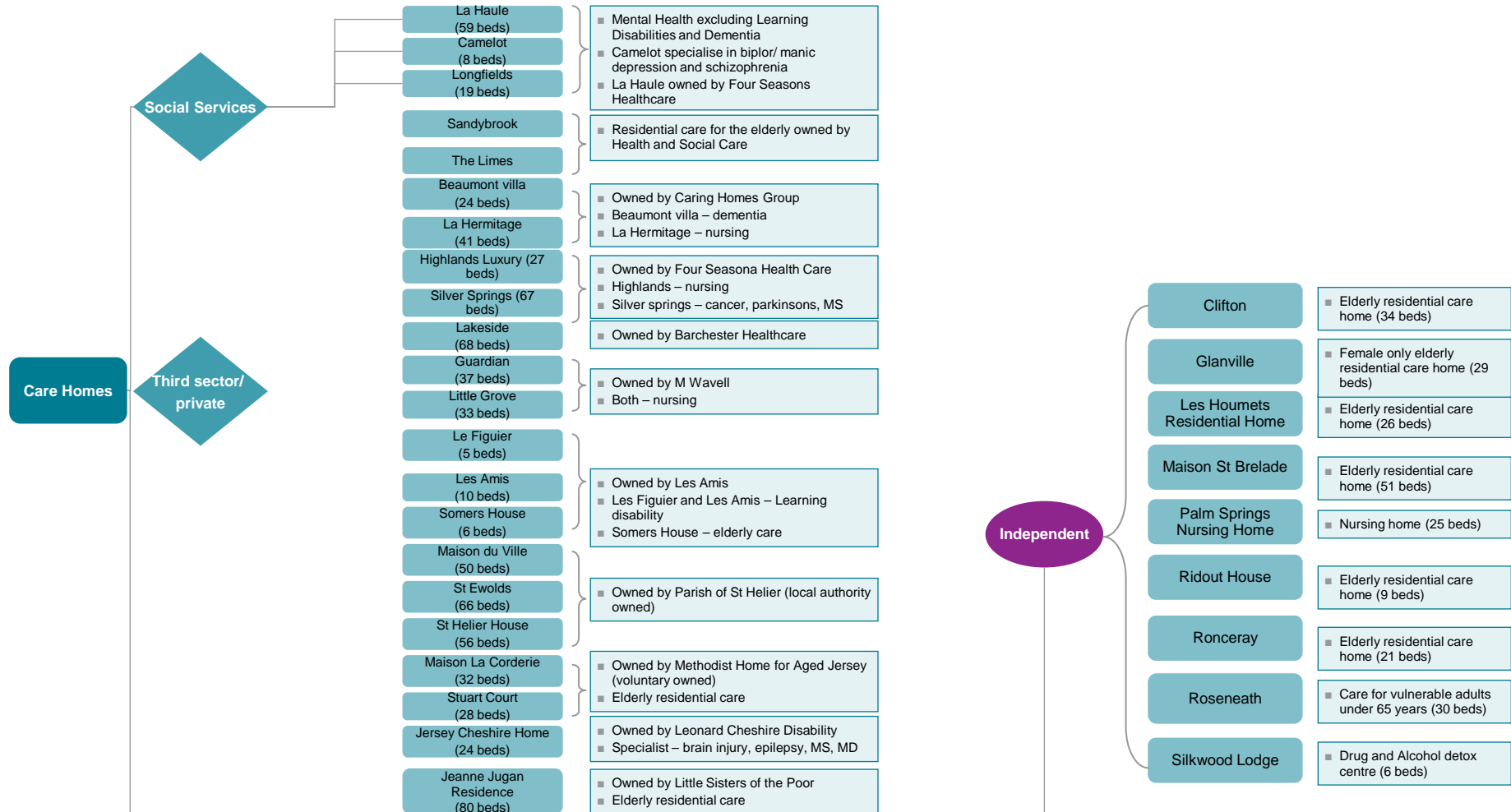
Community nursing is provided through a third sector provider – Family Nursing and Home Care and cancer palliative care through a charitable hospice



States of Jersey

Community provision (4) – care homes

There are 31 care homes in Jersey covering a range of different functions and owned by a mixture of the States, third sector and private.





cutting through complexity™

Summary of stakeholder interviews (Nov 10 – Jan 11)

Introduction

As part of the Development of a Strategic Roadmap for the future health and social care in Jersey, widespread stakeholder engagement was undertaken with over 75 individuals from representative aspects of the health and social care system (e.g. States of Jersey organisations, private providers and charitable organisations). Views were collected through one to one interviews and group meetings during November and December 2010.

The views expressed in this document represent a compilation of sentiments by the participants and are not necessarily the views of all stakeholders on the island. The sentiments should be viewed as qualitative data, they illustrate points of view not facts. These views are in no way purported to be the singular view of the stakeholders or the views of an individual.

The views are structured to provide a way of organising their thoughts, ideas and concerns in a systematic manner which should assist in the development of strategic solutions for the future design of the health and social care services in Jersey.

The following summary lists the key themes from the interviews under the following headings:

- Introduction
- Executive summary
- Strategic themes:
 - Create a sustainable service model
 - Ensure clinical/service viability
 - Ensure financial viability
 - How should health and social care be funded in the future?
 - Optimising estate utilisation
 - Workforce utilisation and development
 - Clinical governance
 - Use of business intelligence
- The future model

Executive summary

The issues identified from the information gathered through 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.

The top level themes identified from the conversations held can be summarised as follows:

- There is considerable scope for improvement of coordination, collaboration and communication between different services and service providers; some gaps in service provision were identified.
- 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.
- The development of an overall strategic plan as an overarching context for the development of the above was considered 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

Create a sustainable service model

General across the health and social care system

- Those interviewed felt that there was a wide perception of patient satisfaction generally being high. In spite of this a number of areas were identified as being in need of improvement (listed in the summary below), especially if the system is to remain sustainable and affordable in the long term.
- There was a sense that change has in the past not been easy to implement. It was said that for change to happen a debate would be required between politicians and the population, articulating perhaps some potentially unpopular but necessary options, including possible ways of funding the proposed changes. Some of those interviewed expressed a strong desire for change to happen now, and reported their respective services and staff to be ready for change.
- Rising patient expectations were reported to be putting increasing pressure on the health and social care system. Experience of other healthcare systems, had contributed to this and to a growing 'sense of entitlement'
- Different parts of the health/pharmacy and social care service are funded and/or regulated by different departments (HSSD and Social Security). This was reported to create inefficiencies and waste. Some suggested that realignment or a reallocation of services to States' departments might be beneficial.
- The combined payment system requiring patient contributions was said to prevent the less well off, and in particular children from less well off families, from receiving holistic primary care. In addition, patients with chronic diseases do not always receive the high quality long term condition management in the community which has shown elsewhere to keep patients well and out of hospital (e.g. patients reluctant to visit their GPs for monitoring purposes while they are feeling relatively well)
- There was some frustration by some stakeholders at the current apparent weakness of comprehensive strategic plans for health and social care on the island. In particular were mentioned: island strategies for older people, for homelessness, and an end of life strategy
- Professional and personal relationships were reported to play an important role within close knit communities on the island. This does not however always translate into effective and transparent working relationships between the services. Relationships were reported to be:
 - Inconsistent between primary care and the hospital: good between GPs and consultants (both in general and on an individual basis); competitive between the two services with the hospital being perceived to want to draw services from the community into the hospital setting; this is contributing to inefficient working across primary and secondary care in long term conditions management
 - Underdeveloped between some parts of the system and Family Nursing and Home Care (FNHC), including between GPs and health visiting and district nursing
 - Some of those interviewed mentioned the need for hospital consultants and GPs to work more closely together across the services and for this to be incentivised by a changed funding mechanism. This could result in better integrated care pathways which should include all stakeholders including FNHC, social care, care homes etc.
- Some gaps in service provision were highlighted, including (a) the absence of a dedicated stroke unit, (b) a dedicated geriatric service, (c) the limited provision of targeted complex care packages; (d) underdeveloped community services to facilitate discharge of patients back to the community, to include 24/7 nursing care and palliative care

Create a sustainable service model (cont.)

Public Health

- There was concern that the lack of a comprehensive and up to date population database impedes accurate assessments of population health needs. This database would also be required for a comprehensive call/recall system for screening services
- The need for specific island wide strategies was identified for older people, end of life and for homelessness. These strategies could include rapid access to geriatric care, prevention of inappropriate admissions to A&E from nursing homes, a review of use of and access to day care, review and development of re-ablement services, the use of step-up and step-down care
- Mental health of the population remains a concern, with high and rising suicide rates

Prevention

- Uptake of screening services could be improved (the patient is required to pay, apart from for mammography); it was quoted that some 64% of the eligible population takes part in mammography; additional uptake is limited by capacity
- Free childhood immunisations, 6 weeks baby checks, and smoking cessation services were commended
- Limited chronic disease management in the community was said to lead to preventable hospital admissions; the following areas for development were mentioned specifically:
 - Increase use of telehealth and telecare (personal alarms are used to date)
 - Develop community rapid response service
 - Increase patient knowledge and self care/management
 - Facilitate multi-disciplinary working across all relevant stakeholders

Primary Care

- Primary care was described as 'very good' by both hospital staff and GPs
- Many of the GPs spoken with considered the doctor/patient relationship as the main strength, along with continuity of care, good access and patient choice (multiple registrations not necessarily seen as a problem by GPs)
- Concerns were raised regarding those who cannot afford to pay for healthcare, it was reported that increasingly GPs have to reduce or waive the patient fee, or deal with the issues of patients' bad debt
- Some patients utilise A&E instead of attending a GP because they are not charged. Many GPs felt that A&E encouraged such attendances

Create a sustainable service model (cont.)

Primary Care (cont.)

- Having to pay to see the GP was seen as a barrier to Long Term Conditions management. The follow up of some patients in hospital clinics was viewed as being 'unnecessary' and excessively prolonged
- Community services were said to be underdeveloped with nursing staff having very limited roles and underdeveloped relationships with FNHC; Some GPs could not see a role for practice nurses in the future
- Several GPs stated that the rules on the application of rebates may not be consistently applied
- The Primary Care Body represent GP practices, although smaller practices which feel pressure to merge and are concerned about increasing costs, reported that they do not feel included in decision making processes
- Jersey was described by some as becoming increasingly less attractive a place in which to practise as a GP

Jersey General Hospital

- GPs and hospital staff felt that care provided in hospital was very good. However, they acknowledged that this perception was difficult to substantiate as clinical outcome data have yet to be collected;
- The staff were praised for their dedication and flexibility ('a lot of people go the extra mile'); the consultants were considered to be knowledgeable and approachable, willing to give advice which had helped create good relationships with GPs
- The hospital building was thought to be not fit for purpose in terms of quality of environment provided, space and lay out (mixed sex wards, insufficient single rooms, not enough space for outpatients etc.)
- Within the hospital there was a sense that the current service arrangements could not continue as they were, and changes would be required. A number of reasons were cited: recruitment challenges of consultants and middle grade doctors (see 'workforce'); funding pressures; governance and GMC revalidation requirements; single handed consultants; waiting lists over 3 months and growing (longest waiting time reported in interviews quoted as neurology: 12-18 months); increasing patient expectations; elderly cases were becoming more complex
- The re-strengthening of management was welcomed. Stakeholders hoped that change would become easier and more rapid. The following areas were mentioned that would benefit from change: (a) improved data collection and information provision; (b) increased clarity of clinical management roles; (c) managing doctors, which was considered difficult due to need for goodwill to ensure service flexibility and service dependence on few (or single) consultants

Create a sustainable service model (cont.)

Jersey General Hospital (cont.)

- It was reported that patients presenting with specific complaints (e.g. cardiology, neurology) were mostly cared for by consultants from different specialties, depending on the team that was on call when the patient presented in A&E. Some of those interviewed thought that a more specialist approach would be beneficial, with patients being referred to the specialty team straight after admission.
- There were said to be strained relationships between some consultants
- 'On ward' and 'off ward' rota were said to impede continuity of care. Some of those interviewed called for practice to be updated to increase efficiencies (e.g. some procedures done in theatre are done as day cases or in out-patients in the UK), to improve effective use of theatre capacity, and to reduce lengths of stay
- A need for additional bed capacity was expressed by hospital staff. However, those interviewed were also aware of the fact that current practice may be contributing to longer lengths of stay, which if addressed could reduce the perceived need for more beds.
- The latter was also exacerbated by difficult to discharge patients due to lack of community services and patients having to pay for GP services. Additional pressures on hospital services were created by inappropriate (from nursing homes) and preventable (Long Term Conditions) admissions. If services were developed in the community a number of services at present provided in the hospital could be moved creating additional space e.g. minor surgery, diabetic care and other LTCs

Care Homes

- The residential and nursing home care capacity on the island was said to be declining whilst demand was increasing; places were provided by both the States of Jersey and private providers. There were apparently no dedicated dementia homes. Each referred person was assessed by the care/nursing home which may mean that people with dementia may not be accepted if there was a risk that they may disturb other residents.
- A recent review of service provision apparently showed that people entered into nursing care at an early stage when they may only require 'hotel services'
- It was mentioned that there was limited ongoing assessment of the needs of care home residents. Such assessment would allow timely transfer from residential care to nursing home as the patient's condition deteriorated without admission to hospital triggering a change in level of care
- There were apparently a number of admissions to A&E from nursing homes especially at residents' end of life. This might be prevented if nursing home staff had enhanced skills, confidence and support to look after residents when their condition deteriorated and admission to A&E was not appropriate
- Impending Quality Assurance was thought to enforce higher standards in care homes which some thought might result in higher costs

Create a sustainable service model (cont.)

Family Nursing and Home Care (FNHC)

- FNHC was reported to be the largest provider of community nursing, health visiting and domiciliary care on the island, providing also some end of life care in care homes
- Some of those interviewed expressed the following:
 - Access:
 - Individuals needed to join FNHC as a member in order to access services; for those unable to pay the membership fee, the alternatives appeared limited
 - The organisation provided services under an SLA funded by HSSD (and partly subsidised by charitable funding). As the terms of the SLA were not widely known other services trying to organise care for patients found it difficult to assess what could be expected.
 - It was mentioned that the responsiveness of the organisation to requests appeared somewhat inconsistent
 - Services commissioned from FNHC could be enhanced, such as 24/7 care and night service, staffing levels during weekends etc.
 - Apparently the equipment available from FNHC (e.g. commodes etc.) had been reduced and created difficulties in service provision
 - Contract:
 - Some mentioned that increased transparency of what had been commissioned from FNHC would be helpful for all parties. This to include clarity around targets and key performance indicators expected from the SLA
 - A review of the length of contract would be beneficial in creating an environment in which longer term planning could be carried out by FNHC. In addition a review of the distribution system for subsidised clinical products may benefit multiple parties

Mental Health services

- Those interviewed mentioned a number of strengths:
 - A major increase in community based work had allowed more people to remain independent: it was reported that the team had moved from an 85% inpatient to 15% community ratio, to 55% inpatient and 45% community model over recent years
 - Although Jersey did not have Community Treatment Orders, this did not appear to be required as stakeholders felt that risk within the community was considered to be well managed. In addition the Mental Health Service also ran STORM training for other agencies such as the police, in order to support an understanding of how to manage risk in the community.

Create a sustainable service model (cont.)

Mental Health services (cont.)

- The workforce was praised for being flexible and knowledgeable. Low staff turnover was reported.
- A single point of access to acute psychiatry team with acute liaison team on call in A&E; short waiting times for psychiatry.
- Multi-disciplinary Mental Health assessment service for crises; referrals to this service was said to take pressure off health and social care service.
- There were also said to be a number of challenges:
- Due to low numbers there was no on island secure facility leading to several high cost off island placements.
- Some lack of capacity due to a number of vacancies not being filled (the service had also identified a need for 12 additional old age psychiatry nurses), resulting inter alia in a lack of medical cover for parts of the service (e.g. Drugs and Alcohol misuse, Learning Difficulties).
- Waiting times reported in interviews at over three months for psychology.
- Single inpatient unit for all conditions having to provide a wide range of care from detoxification and Learning Difficulties to old age psychiatry.
- Lack of psychological input for older adults, CAMHS and drug and alcohol services.
- Increasing need for old age psychiatry.
- A perception that there has been a historical lack of funding and poor infrastructure.
- Scope for strengthening of communication between staff within department and with other services.

Social Care

- The community model for both youth offending and for SEN were reported to have been very effective, as well as the facilitation of multi-agency working (through the Children's Executive); the integrated approach as implemented at the Bridge Centre was considered a success.
- Strengths mentioned were:
 - Relationships between individual professionals both within and external to the services; staff were motivated and flexible and prepared to go the extra mile; staff were reported to be ready for change; there was low staff turnover in SEN.
 - JCPC (Joint Child protection Committee) established and independently chaired.
 - Management information produced by Softbox.

Create a sustainable service model (cont.)

Social Care (cont.)

- Challenges mentioned included:
 - Coordination /communication between different services could be improved: between Behaviour Support Team and other services; between CAMHS and Children Services.
 - Placing 'Looked after Children'.
 - Pressure on social workers' time by the court.
 - Difficulty in recruitment and retention of social workers and other groups (see Workforce).
 - Some lack of resources; infrastructure in nursing homes could be improved.
- Systems and processes;
 - Variety of administrative systems were being used; lack of visibility of primary care information.
 - Different assessment processes used: one for nursing, one for social care; patients rushed into nursing homes; limited use of step up or step down care.
 - Clarity around thresholds for care could be improved.
 - Single Care Record was no longer being implemented; Integrated Care Service apparently not delivering key outcomes.
 - Data poor environment.

Third Sector

- Third sector organisations were attempting to reach groups of people for whom there appear to be limited specialist services or who for a variety of reasons found it more difficult to access existing generic services. This included vulnerable adults for example those with learning difficulties, mental health problems, drug and alcohol problems, the homeless. Individuals were being cared for and assisted in moving to more independent living.
- It was reported that input from generic services in order to assist in this process was difficult, for example mental health services for psychology input; access to primary care as Health Medical Account (HMA) apparently did not cover the required number of GP visits etc. input from social services. Such difficulty in obtaining required input was said to impede progress towards independent living.
- The funding of third sector organisations providing services varied from being largely States of Jersey grant aided to being 100% dependent on charitable funding.

Ensure clinical/service viability – overcoming the challenges of low patient volumes

Off Island referrals

- A wide variety of formal and informal arrangements were said to be in place with UK centres for treatment of Jersey patients:
 - Those interviewed stated that there were few formal contracts or Service Level Agreements; existing ones were said to be mostly held at departmental level; with few if any quality standards/clinical outcomes agreed.
 - Centres in the UK to which patients were referred UK were said to be often chosen by individual Jersey consultants, based on knowledge of an individual consultant or a specific service at the UK centre There was limited evidence that these decisions are based on independent clinical outcome data. Some of the Jersey consultants may not be aware of cost implications of referrals, partly because such information was said to be not easily available.
 - There was an overall sense of patients receiving a good service from tertiary centres. Some issues were reported such as: (a) waiting times and difficulty in finding beds at short notice (and cots); (b) delayed or complete lack of communication from the tertiary centre, resulting in the Jersey consultant not knowing what treatment the patient had received (reports of 8-10 weeks regular delays; on occasion no information was received at all, especially if an onward referral had been made to another specialist centre in the UK)
 - A number of consultants expressed the need for stronger relationships with a UK centre, based on a mature SLA with strong contract management. They suggested that a rotation of visiting doctors for delivery of specialist services on the island and rotating doctors in training should be part of such arrangements. As part of this arrangement they suggested that Jersey consultants should spend several days a month or year at the UK centre for case reviews, governance, Multi-disciplinary Team meetings, audit, learning etc. It was stressed that such an SLA should be based on clinical outcomes, patient care, costs, and safeguards for guaranteed staffing.
 - Some expressed a need for closer collaboration with Guernsey, including providing endoscopy services, sharing rheumatology capacity, and integrating the air ambulance (some collaboration already occurring at present (for example in cardiology)).

Visiting consultants

- A number of consultants from various specialties visited regularly from various UK centres, especially in orthopaedics, oncology and specialist paediatric services; existing arrangements were reported to be working well.

Ensure financial viability – overcome the diseconomies of scale

The current system

The current payment/co-payment system for services was seen as both a strength and a weakness. It was said to:

- Be liked by GPs as it provided a form of demand management and kept ‘trivial complaints’ at bay (3.6 visits to a GP per annum versus 5.6 pa in the UK was quoted from the Kings Fund).
- Compromise care for the poor and the less well off, especially children and patients with chronic diseases. Although these patients may go to A&E for primary care needs and/or be admitted to hospital for acute exacerbations, this was not considered optimum integrated or preventative care in the best interests of the patient.
- Limit the development of primary care teams and the practice nurse role as the SoJ's rebate was legally linked to clinical interactions between a patient and a doctor. The lack of mature community services in turn limited the ability of the hospital to discharge patients back to the community.
- Create barriers to collaboration between primary and secondary care to develop integrated care pathways.
- Access to community nursing and care services could be obtained by becoming a member of the FNHC. For those unable/unwilling to pay the membership fee the alternatives were limited. Dressings had to be paid in full and the costs drove patients into hospital dressing clinics.

Health insurance

- It was mentioned that some 40% of the population had private health insurance, however not everyone used it. This could be because top up payments were required in addition to what the insurance companies paid, or the insured may get cash back for being treated in the public system.
- The hospital had not yet developed full costing of private medical admissions. Also there was some concern that private patients did not pay for certain aspects of the care/facilities provided in the hospital during their inpatient stay.

How should we fund health and social care?

Future funding system:

- Some of those interviewed had considered other funding systems in different countries. Other jurisdictions were mentioned which were thought to have funding mechanisms potentially suitable for the island, including Canada, New Zealand, Guernsey (private insurance), Israel (health insurance choice of scheme).

Some of those interviewed said that the future funding system should:

- Address 'the quite stark health inequalities on the island'; a new system should also ensure good health and social care provision to the poor/less well off (including Long Term Condition management, and comprehensive care for patients with multiple morbidities).
- Either be a universal private health insurance, without tax increases, or a continuation of co-payments but ensuring the following.
 - Free healthcare and free medications; dressings on prescription; a review of all subsidised clinical products.
 - Abolishing GP prescribing charges so patients go to their GP for repeat prescriptions instead of the hospital (the hospital was said to have 5-6 times normal prescribing activity).
 - Abolish financial incentives for GPs to request investigations and for making referrals.
 - Adjust the system so that primary care became cheaper for the patient than secondary care; GPs to be given an amount per patient for Long Term Condition Management in the community and be rewarded for good clinical outcomes (opposing views from GPs regarding the funding of packages of care for Long Term Conditions).
 - Provide financial security for GPs.
- Means test all adults for social care, not just those who are over 65.

Clinical governance (in healthcare)

Culture

- It was reported that recent investigations of Serious Untoward Incidents (SUIs) had had a negative impact on the openness and willingness of some to discuss clinical practice within the hospital; consultants in hospital and GPs in their practices were said to be working in silos, with reportedly little sharing of information and discussion of practice with colleagues.
- There was limited patient and public involvement in the design and delivery of services.

Governance structure

- Hospital: concerns were expressed at the hiatus in governance structure with the previous committees no longer operating while the new committee structure was not yet in place; there were reported to be pockets of good practice in hospital where individual departments had set up their own arrangements which had resulted in inconsistencies across the organisation. It was reported that there was a lack of training to support adequate clinical governance.
- Primary care: there is no formal contract for the provision of general practice services between the States and GPs, (there is a recently introduced agreement for immunisations and '6-week' baby checks), there is an implied contract with patients. Accountability is to the patient or to the General Medical Council for professional regulation (fitness to practise) following a formal complaint to the GMC. Over the past two years processes for appraisal have been developed with and delivered by Wessex Local Medical Committee. The GPs have established a group (the Primary Care Body) of which one function is to support the successful revalidation of GPs. Arrangements have been made with Wessex regarding support for the investigation of poor performance though not currently enshrined in law. In August 2010, the States approved the use of the Health Insurance Fund to fund the development of Primary Care governance and delivery of standards of care, as proposed in P36/2010 on an interim basis and ahead of the development of new Primary Care legislation.

Risk management:

- Processes were in place for the investigation of SUIs were said to be established but to be in need of increased clarity and transparency. In addition, senior clinical involvement in investigations, action planning and implementation of action identified was said to be limited.
- Those interviewed perceived that there was limited learning from incidents with little evidence that action required following investigations had been implemented.
- A number of services were not subject to regular external independent inspections (hospital, domiciliary care, parts of social services etc.). Several of those interviewed would welcome such scrutiny.
- Policies and procedures were said to be in need of updating and revision.

Clinical governance (in healthcare) (cont.)

Data collection:

- Clinical outcomes and other relevant quality information were yet to be collected, which was said to be partly due to the quality of coding of clinical episodes
- Auditing in hospital was largely done by doctors in training. It was mentioned that there was no overall agreed audit programme in primary or secondary care. Audit in primary care was hampered by the format in which patient information was entered into computerised clinical systems, where used, making searches difficult or impossible.
- Systems for identifying and managing of poor performance were said to be weak both in primary and in secondary care. Appraisals for hospital doctors and nursing staff had been initiated but needed to be rolled out and strengthened. All GPs have been appraised by external appraisers at least once.

Optimising estate utilisation

- The Hospital was considered in general to be not fit for purpose:
 - The recent refurbishment of the A&E department and the expansion of the EAU were welcomed; apparently funding had been secured to upgrade critical care.
 - The equipment in the hospital was said to be good and up to date (some apparently bought with charitable funding).
 - The building had a number of ongoing problems: for example drainage and sewage leaks; ventilation; lack of en suite facilities on labour ward.
- HSSD was said to have some 250 properties, of which 220 were considered to be surplus to requirement, and some of which were considered to be not fit for purpose.
- It was mentioned that space in the hospital could be freed up by:
 - Updating practice and moving procedures from theatres to day case and out-patients.
 - Move services into the community such as minor surgery.
 - Reduce the number of beds through reduction in length of stay (which was reported to be higher than it could be); reduction in inappropriate admissions from nursing homes; reduction in preventable readmissions by improving chronic disease management in the community.
- Space could be freed up in other locations (e.g. Le Bas Centre by moving distribution of subsidised healthcare products from FNHC to community pharmacists).

Workforce utilisation and development

- Many people reported that the workforce across health and social care was committed, caring and flexible, 'going the extra mile'.
- Recruitment was said to be difficult for a number of groups for the following reasons:
 - Consultants: generalist skills and experience were required on the island but medical training and practice was increasingly specialised. The on call rotas on the island were likely to be considered onerous compared with the UK, limited locum cover for annual leave created build up of work while the consultant was away. However, private practice was considered a key attraction, as well as essential for the expected standard of living.
 - Other groups: middle grade doctors, nursing staff, allied health professionals, social workers, lower paid staff.
 - Key barriers to recruitment and retention were said to be salary in relation to cost of living, especially childcare .
- A number of aspects related to systems and processes were said to need strengthening:
 - Job descriptions for many clinical roles and training for corporate medical roles.
 - Job planning and appraisal which were said to be at an early stage of development.
 - Some consultants not yet on the new consultant contract.
 - Compliance by consultants with the 6 weeks rule (for annual leave or other absence) to facilitate planning of services.
 - HR policies in need of revision.
- Role development of nursing staff was said to be limited:
 - Little role development/expansion to date, but the legal process required for introduction of nurse prescribing was now underway.
 - Limited use of nursing staff in primary care, both in terms of numbers and competencies: this was reinforced by the rebate mechanism and GPs' perceptions of nurse competencies.
 - It was proposed that expansion of nursing roles could assist with difficult to fill middle grade doctors posts (e.g. nurse led GUM clinic), and help reduce lengths of stay through nurse led discharges.

Use of business intelligence

- It was mentioned that existing databases were not interlinked and therefore did not support joining up of services (for example Childhood Health Database, primary care data).
- There was limited use of the data available but there are examples of departments using data to carry out particular analyses, e.g. bed capacity, new to follow up ratios, dementia prevalence, frequent emergency admissions.
- It was mentioned that there was no single reconciled version between HR, Finance and Payroll data.
- Access to information on the island was considered to be difficult .
- Hospital staff indicated that a database to replace PAS was expected to improve data analysis although the timeframe for its implementation was under review.

An overview of what stakeholders would like to see for the future

Those interviewed highlighted a number of challenges with the current service provision which are mentioned on previous pages. During the interviews participants were asked what specifically they would want to see in a future model of care, and which aspects of the current model which they would want preserved. These were as follows:

- GPs asked that a new model of care in Jersey should (a) not resemble the NHS too closely, where they felt doctors were being replaced by other clinical staff in their direct contact with patients, (b) facilitate the less well off to receive holistic primary care, (c) strengthen management in the community of Long Term Conditions, (d) keep the co-payment system, with single registration
- Hospital staff stressed the importance of (a) defining the role of the hospital, whether this was stabilisation with shipping off the island to becoming a centre of excellence attracting patients from further afield, with clarity on off island referrals (b) a hospital fit for purpose, (c) transparency of public and private practices within the hospital, (d) clarification of conditions which should be managed from admission by relevant specialty team, (e) updating of practice to reduce waste and improve efficiencies, (f) robust and transparent clinical governance processes including for off island referrals and visiting specialists
- Mental Health: (a) increased psychiatric input into services and increased staffing levels, (b) improvement in training of nursing staff, also for hospital staff to be trained in mental health issues, (c) development of IAPT service (with Guernsey who have a neuropsychologist), (d) strengthening of multi-disciplinary working and clinical governance, (e) review of mental health strategy and services
- Social care: (a) development of strategy for older people, (b) development of re-ablement service and the personalisation agenda, (c) provision of low cost targeted packages of care, (d) use of generic family support workers, (e) enhancement of professional fostering
- Third sector: (a) to be part of the island wide strategy and service delivery with improved collaboration and signposting to their services; (b) elimination of barriers to service delivery including patient information and improved access to generic services for their clients e.g. social services and mental health input, (c) assessment and recognition of cost effectiveness of their services with proportionate financial support against clear SLAs
- Requests made regarding :
 - Databases: (a) a population database for Public Health purposes and for monitoring of use of care, underpinning screening services, (b) primary care data to be linked to Public Health, (c) interlinking of existing databases
 - Workforce: (a) clear workforce plan linked to strategy, costs and outcomes, supported by pay structures and terms and conditions; (b) enhance the integration of nursing workforce across primary (including FNHC) and secondary care for governance and quality standards, and to avoid duplication of services, (c) expansion of nursing roles

Summary of third sector interviews

Overall themes

- Positive attitude towards change – on the whole organisations seized the opportunity to have their say and outlined clear aspirations for the review.
- This is balanced against pockets of opposition regarding the decision to hold a Review, negativity about the States decision making process, and the extent to which the views of islanders will be taken into account.
- Common themes arising include:
 - Perceived gaps in HSS provision for particular needs and groups filled by charitable fundraising, volunteers or service level agreement:
 - Services for chronic illness including cancer, diabetes and liver conditions, older people, mental health.
 - Carers support including respite, transition services, disabilities.
 - Nursing shortages, hospital equipment, out of date buildings and inappropriate care environments (also in nursing and secure homes).
 - Current service inefficiencies.
 - Frustrations regarding working relationships with HSS (including formal and informal relationships). Some felt their knowledge and expertise was under-utilised and there was a reluctance among HSS to commission third sector providers even when this might prove more cost effective or better geared to address patient needs. In some cases a reluctance to share information and work in partnership.
 - Hospital staff lauded, and quality of individual consultants and nurses well regarded, but services deemed at capacity and struggling to cope with demand
 - Balance between managerial and front line HSS staff not right – practitioners not empowered to make the right decisions for their patients.
 - Services are not patient-centred but perceived to be organised according to the preferences of HSS – many patient organisations felt they better understood the needs of their client group.
 - Patient pathways not always clear, accompanied by unsystematic or late signposting to charities who could offer support.
 - A perception that health and safety at times over-prioritised – services perceived as risk-averse to the detriment of individual quality of life and effective service provision.

Strengths of current service

- High quality and commitment of HSS front-line staff working in the hospital and in the community.
- Relationships between third sector and individual practitioners/clinics deemed good on the whole.
- Individual consultants named and cited for excellence.

Summary of third sector interviews (cont.)

Weaknesses/challenges

Relationship between HSS and Third Sector

- There was a feeling that the third sector is providing services above and beyond the scope of agreed SLAs.
- Some cited a lack of communication and commitment to constructive working relationships with third sector – at times this has felt like deliberate ‘closing of the door’ (examples given in sexual health, dementia) and protectionist approach to delivery services. Lack of communication or strategic leadership resulting in decisions e.g. funding for posts that were not necessarily the right ones, or could have been better co-ordinated.
- Fundraising for services/equipment perceived to be fundamental (i.e. ultrasound scanners for breast clinic) – third sector organisations do take this on willingly but worry about long term sustainability of the service.
- Barriers/red tap identified around training provision and requirements (e.g. in dementia, autism, child protection). It was claimed that this has in some instances forced charities to incur additional and unnecessary costs.

Service/patient – related

- In dementia/Alzheimer’s a perceived lack of willingness to provide the right support in people’s homes and over-reliance on full time residential care due to concerns about risk (other factors: cost differential and preferences of patient). There were queries regarding if there is enough community support for people with mental health conditions.
- It was felt that some residential and respite settings were not fit for purpose for people with dementia
- It was reported that there is a lack of respite care for families. Gaps in provision for 14, 15, 16 year olds with autism and other learning disabilities – transition arrangements possibly weak and low levels of provision to support their residential/daily support needs.
- There were concerns expressed about pressures on staff trying to cope with demand e.g. in renal care
- Being ill deemed expensive and ‘hard work’ – pathways of care need to be smoothed out.
- Some felt that there is a lack of co-ordination of services on behalf of the user/patient – and so the patient feels lost in the system and unable to access what’s required. Key workers are not assigned to address this.
- Some examples of cost inefficiencies were claimed – e.g. contract management, cost of supplies and services, reluctance to use third sector buildings despite being more fit for purpose.
- Abolition of the reciprocal agreement deemed a negative step. Travelling off island for surgery presents a number of challenges:

Summary of third sector interviews (cont.)

Weaknesses/challenges

Service/patient – related (cont.)

- Isolating because families have to pay to travel to see sick relatives. Destabilising for families of patients with life threatening conditions, especially children.
- Traumatic having to travel when severely ill and recovering from major surgery.
- Could result in disjointed care. e.g. in breast reconstruction post cancer surgery – having to travel back and forth for different stages, process lasting a number of years so patient doesn't feel he/she has fully 'recovered' from condition.
- Mental health – it was suggested that there is some inappropriate management of patients by GPs and mental health social workers should be integrated within the main social work team.
- Interviewees felt that GP funding disincentivises appropriate use of primary care services especially among poor communities. e.g. diabetes should be managed by GP from day to day but patients don't want to pay for it.
- Portuguese and Polish communities 'can't get near' – cultural challenges in willingness to access support.

Summary of third sector interviews (cont.)

Vision for the future/opportunities

- Provide more support in communities and in people's homes – e.g. inappropriate and costly to locate family planning, sexual health services in a hospital setting, or move the majority of people with dementia or in full time residential support.
- A plea to give the voluntary sector a seat at the table with HSS when they plan and deliver the detail of services – it was felt that much more could be achieved, both in terms of cost savings/streamlining and better co-ordinated care for patients.
- Strong ambitions to deliver more services and support with the right commissioning arrangements in place.
- Increase specialist nursing posts in oncology, liver disease, 'admiral nurses', diabetes (cheaper than full time consultant) – up-skill islanders to fill new posts (fiscal stimulus fund mentioned).
- It was suggested that in renal care another trained nurse could mean more patients on dialysis at home rather than in hospital.
- Address the issue of payment for primary care and establish clear patient pathways which integrate third sector support and signposting.
- It was perceived that historic under-investment in mental health needs to be addressed both in the hospital and the community.
- Earlier intervention across all areas of care and swifter more appropriate referrals and signposting.
- More strategic planning and stronger leadership to navigate service re-design rather than poorly co-ordinated 'tinkering'
- Improve quality in hospitals (matron model on wards).
- Prioritise older people's provision.
- Improve pathways of care for the different site specific cancers (especially lung, head and neck cancer).

On island/off island

- Increase on island capability – 'Jersey should be self sufficient'.
- Not an opportunity to replicate NHS model – not right for Jersey. Jersey and Guernsey should work together on health.

Versus

- Greater use of off island providers to get quality cost effectively – maternity, A&E and older people provision should be the priority for the island.
- Think creatively about the use of specialist consultants on the island – i.e. fly consultants over periodically.

Appendix 1

Sample of interview questions (1)

Service provision/structure of respective service

- What services are provided by your organisation, by you and your team/describe your practice to me (dispensing, staff mix, do you use nurses /assistant AHPs, SWs, if so for what, if not why not). How do you know what services to provide, what is the link to Public Health, needs of the population, contract?
- What are the models of care, are there integrated care pathways, how are private and public healthcare/social care provided together/separately?
- What does it mean to be a GP/nurse/consultant/social worker/AHP/pharmacist etc. on Jersey?
- How do patients get to your service (walk in, referral by whom etc.) why do they come and what is the process from arrival (for Mental health services: how do the services get to the people in the community)?

Staffing

- Recruitment and retention – any issues, any particular group /specialty; policies and processes including for recruitment and integration of locums and agency staffing?
- Competency, training and learning: how do staff keep up-to-date (Sources of best practice (e.g. NICE), appraisal, CPD, revalidation); mandatory training compliance, time off for additional training?
- Staff surveys – outcomes and action plans?
- Medical leadership/structure – what contracts are doctors on, degree of job planning, how are doctors involved in decision making?

Governance

- How is effectiveness of care measured – how do they know they provide a good and safe service in line with evidence based best practice: which KPIs used, audits etc. how clinical records stored, who owns them and how are they shared?
- Who is responsible for clinical governance, how does this relate to corporate governance; what are the supporting structures/committees and information flows. At which level are decisions made?
- Who is responsible for and what are supporting structures for clinical audit, medicines management, implementation of NICE guidance?
- Risk, complaints and SUIs – what is the process for collecting and handling; what risk management processes are used; what is on the risk register. What is process for ensuring appropriate action is taken and evidenced?

Performance management/outcomes/ strengths and weaknesses of current system

- What are the strengths and weaknesses of the Jersey care system, how does it compare to systems elsewhere (UK, France, Guernsey etc.)?
- How are services performance managed, what metrics/KPIs/regulatory requirements are used: public health outcome measures, quality outcome measures, CQC, mental Health Act etc. Linking inputs to outputs to outcomes
- Perception of activity trends and type of activity (e.g. an increase in children who need complex care arrangements) – any reasons for these?

Appendix 1

Sample of interview questions (2)

Data

- What information is collected through what systems and how is it used?

Future developments/vision for the future/criteria for judging proposed developments

- What are the key challenges/issues now and in the future for health and social care in Jersey?
- What have been the/your biggest achievements in health and social care and how have they benefited patients/clients; which further improvements could be made and what would be needed for this?
- What are the main priorities for the future, what should the future health and social care provision look like, what would be needed and in what way would you like to be part of this?
- What improvement initiatives are already being developed that we should be aware of?

Political

- What do you think are the main strengths, and main weaknesses, of health and social care provision in Jersey? Thinking about the hospital, GPs, mental health services, care homes and social work?
- What do you think should be the main priorities for health and social care on the island?
- Top three values (can vary health values from social care) e.g. safe, high-quality, patient-centred, cost effective, caring, supporting independence?
- Key areas to prioritise – top three e.g. public health, cancer, alzheimer's?
- Key populations who need more support/care than they currently receive e.g. elderly, smokers?
- Have you been involved in any local or Jersey-wide initiatives or debates on the need for reform of particular health or social services? e.g. they may have discussed inappropriate use of A&E?
- What health and social care issues have been raised with you by local voters (in X Parish where appropriate) ?
- Are there any areas of the health and social care system that you feel are in need of urgent reform?
- Do you have any observations about how health and social care services have developed over the last 5/10 years? Has anything improved and has anything got worse?
- In your view are there any barriers to improving health and social care services? How do you think these could be overcome?

Appendix 1

Sample of interview questions (2)

Third Sector

- What do you think are the main strengths, and main weaknesses, of health and social care provision in Jersey?
- What do you think should be the main priorities for health and social care on the island?
- Could you please describe your organisation's relationship with health and social care services.
- Is there anything that you would change for the better, in terms of your relationship with health and social care services and the support you and those people you help get from HSS? If so what?
- What services provided by HSS are accessed by the people you help?
- Are there any particular areas where you would like your organisation to be able to deliver more for your those you help?+