States of Jersey

# Peer Review of Reform of Health and Social Services

## **Draft Report**

June 2014

## Introduction

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

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

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

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

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

## The Case for Reform

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

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

The Panel was clear that the case for change was made and the selection of a new model for health and social care was the right one. Put simply, given the forecasted increased demand for health and social services based on changed demographics, business as usual and living within current means were simply not viable options as resources would have to increase significantly and major changes would be required around ways of working and configuration of services. The 2011 KPMG technical report which was commissioned to outline the funding options for the proposed reforms supports these assumptions. The scale of the increase in resources required is difficult to forecast accurately but the Panel was clear that it would be **substantial** from whichever perspective it was viewed. Where those resources would come from and how they could be utilised is discussed later in this report.

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

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

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

**System Reform**: An integrated service with users at its heart

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

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

**The current system**

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

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

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

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

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

challenge merits further consideration. Good governance must be at the heart of system reform.

**Information and IT**

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

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

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

**Management capacity**

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

needs to be resourced properly. Getting clinicians involved managerially and in leadership roles can often be a major source of support.

**A new model of Primary care**

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

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

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

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

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

## Hospital Services

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

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

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

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

**In summary these concerns are as follows:**

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

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

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

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

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

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

A final more general point is that given the overarching goal of strengthening integration across all health and social care services, we would strongly recommend that as the project develops it is crucial to recognise that it is part of the system reform approach which has been developed. To this end it is

vitally important as the project moves forward that its leaders look to the wider system and bring other stakeholders into the process. A fundamental part of the system reform will be to ensure the hospital looks outward to community and primary care services as well as third sector providers and of course patients and the public and behaves in a way which supports that approach. Our earlier reflections on the leadership of the whole system reform are relevant here.

**Sustainable funding mechanisms**

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

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

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

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

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

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

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

While option 4 is ruled out in the KPMG analysis, the projections and estimates they calculate could vary significantly given even modest assumptions about improvements in productivity over time. For example, productivity improvements amounting to around 0.75% pa (on top of the assumed 0.5% growth in revenues) would virtually eliminate the funding shortfall by 2040. In many projections of health spending, assumptions about productivity are nearly always very important (cf Office for Budget Responsibility (OBR) Fiscal Sustainability Report, 2013 and Derek Wanless's 2002 UK health care projections for example). We would suggest therefore that productivity assumptions be included in KPMG's sensitivity analyses.
They conclude that given the unlikelihood of political agreement to increase current income and other taxes, the preferred option would be to close the gap through a combination of higher/extended patient charges and a new revenue source which expands on and modifies the existing Health Insurance Fund (HIF). This would require a compulsory levy on personal income below £150,000 (including pension income) starting at 0.8% and growing up to 2040 to around 3.5%. The new HIF together with all other funding sources (including current tax revenue) would be rolled up into a '2040 Fund'. We comment on the arrangements for this below.

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

Figure 1: Revenue composition in 2014

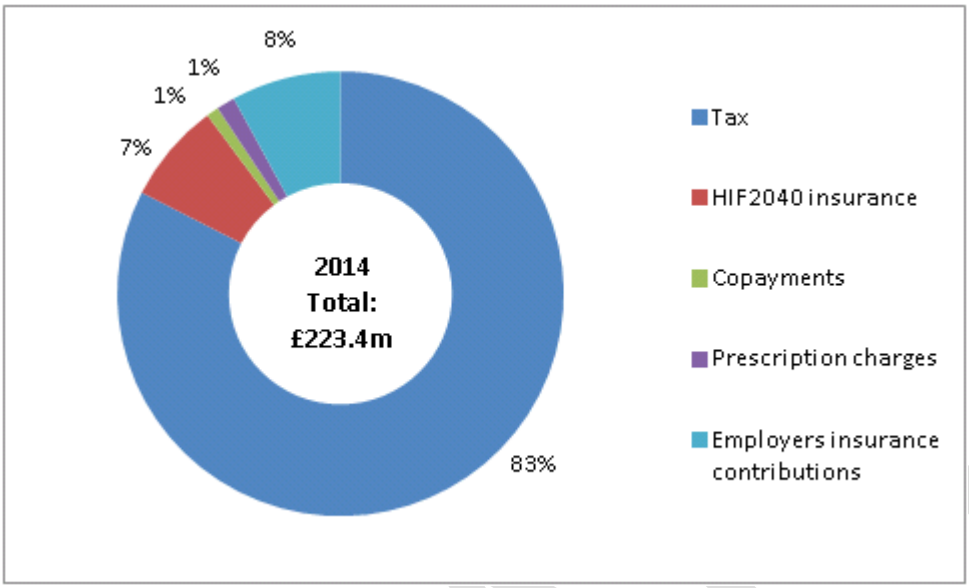
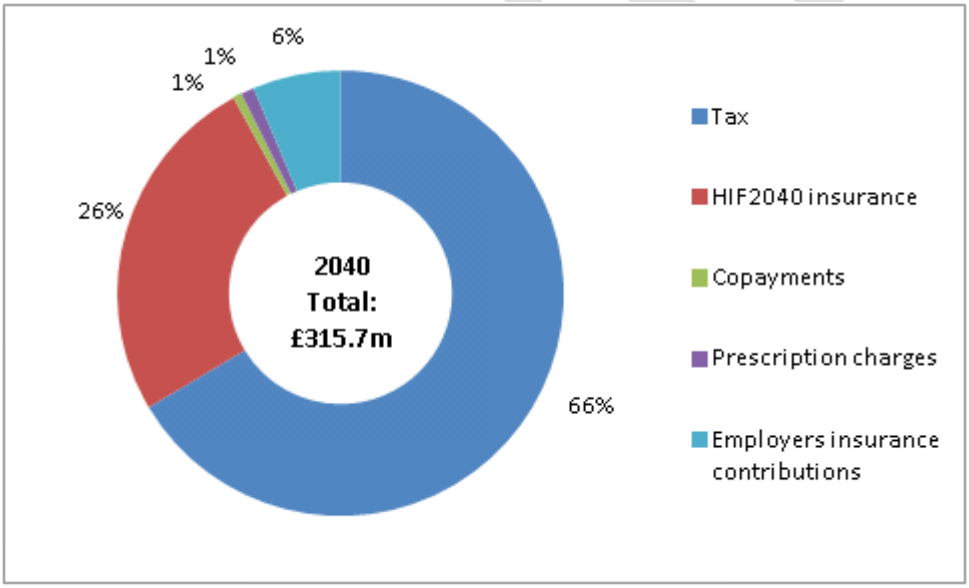



Figure 2: Revenue composition in 2040.




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

payment by the patient for other services such as care for long term health conditions. We would recommend that this capitation model as part of copayment be examined further.

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

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

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

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

Apart from powers to set contribution rates and oversee investments, it is unclear what powers and authority the 2040 Fund board would have to determine the details of spending across health and social care or its relationship with ministers and the determination of health policy. (We would

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

## Conclusion and recommendations

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

## Recommendations

We recommend:

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

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

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

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

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

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

7. That the governance arrangements for the integrated system be re-examined. We believe the current work is being well led, but there will be a requirement in the future for the leadership of the system to be more inclusive of clinicians in primary and secondary care and other representatives from within the system. This has to be a group which is accountable and has the authority and power to resolve problems for the benefit of patients. We are not recommending building any sort of replica of the system in the UK but rather ensuring accountability for those that are leading the system.

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

9. That the productivity assumptions be included in KPMG's sensitivity analyses. Any mitigation of rising costs must include a review of potential productivity in the system.

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

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

# Appendix 1

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

1) To receive a full briefing on the background and context to Report and Proposition P82/2012 including the underpinning technical report by KPMG, utilising the Bailiwick Model.

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

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

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

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

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

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

3) To consider and offer comment on progress to date across all aspects of the programme of reform for health and social services as set out in P82/2012 and, in particular, in the context of the overall States of Jersey Reform programme and latest strategic and system thinking emerging from expert organisations such as the King's Fund and the Nuffield Trust.

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

**Panel Members**

**Sir David Henshaw -** Expert Advisor to Reform POG (Local Government and Hospital)
**Dr Patrick Geoghegan -** Expert Advisor to Health and Social Services Minister (Mental Health and Community Services)
**Mr Andrew Williamson -** Expert Advisor to Health and Social Services Minister (Social Services and Health Commissioning)
**Dr Clare Gerada MBE MOM FRCPsych FRCP FRCGP - Chair of Primary care transformation board, NHS London Region and former Chair of Council of the Royal College of General Practitioners.**
**Prof John Appleby - Chief Economist, The King's Fund**

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