STATES OF JERSEY

DRAFT HEALTH INSURANCE (MEDICAL BENEFIT) (AMENDMENT No. 3) (JERSEY) REGULATIONS 201-

---

Lodged au Greffe on 23rd March 2010
by the Minister for Social Security

STATES GREFFE

DRAFT HEALTH INSURANCE (MEDICAL BENEFIT) (AMENDMENT No. 3) (JERSEY) REGULATIONS 201-

REPORT

IMPROVING THE QUALITY OF JERSEY PRIMARY MEDICAL CARE

Summary

Primary medical care in Jersey has, in some ways, been lagging behind in terms of the developments seen in other parts of the world. This proposition sets out substantial first steps towards a better service for the people of Jersey, bringing primary care into the 21st Century. The report explains the main advances proposed and the reasons behind them –

- Improved health and primary care for the community developed in partnership between the States and doctors (GPs) as private practitioners.
- Averting an impending crisis if Jersey GPs were not able to satisfy the new General Medical Council requirements.
- Introducing regulation, performance-monitoring and quality information.
- New systems to underpin better organised care.
- Funded in the short term by an increase of £4 in the medical benefit paid from the Health Insurance Fund for each visit to the doctor (an increase from £15 to £19 per visit). In the medium term, this will be replaced by a more comprehensive solution requiring changes in the law. This would include a contract rewarding performance against quality standards.

The proposals bring together the strengths of the local Jersey system, such as the responsiveness and professionalism of local doctors, with new ways of working from other parts of the world, and tailor them to the Island's needs. This report describes the first steps on a journey towards appropriate modern primary care.

The proposals brought before the States in this report are the culmination of extensive joint work, negotiation and agreement involving Jersey family doctors (General Medical Practitioners) – represented by the Jersey Primary Care Body – and the States Departments of Social Security and Health and Social Services.

What's the problem and why are changes needed?

In Jersey there is a consensus among health care professionals that general medical practice on the Island needs updating in light of the improvements that have occurred in many countries over the last decade. Most pressing, in terms of timescales, is the need for Jersey General Practitioners (GPs) to be re-licensed with the General Medical Council (GMC). Current systems for governance and regulation of GPs in Jersey do not meet the new 'revalidation' requirements of the GMC. The GMC licenses all doctors practising in Jersey, including GPs.

There is a presumption that primary care in Jersey is generally good, but currently we are without the specific means of demonstrating this. There is a lack of robust health care information which means that patterns of illness, and the extent to which good quality care is delivered by GPs in Jersey, are unknown. Without this sort of information, strategies to prevent disease and improve health services are hampered. The challenges of the 21st Century, such as the ageing population and the increase in chronic medical conditions, require modern and excellent General Practice in order that Islanders' health needs are catered for, hospital admissions are reduced and health care resources are used cost-effectively.

Without the urgent progress recommended in this report to overcome these problems, the health system in the Island is likely to be unsustainable. If local GPs are unable to keep their GMC licence they will no longer be able to practice. The medical indemnity organisations have indicated they will only provide medical malpractice cover for GMC licensed doctors.

Improved primary care – what are the benefits for the Island?

The main goal for future General Practice in Jersey is to achieve improved health and care for the community delivered in partnership by doctors, nurses and others working together in teams centred on a General Practice surgery. This approach would be better for patients, better for GPs and be better co-ordinated working with States Departments. A further benefit would be to protect the Hospital's capacity to meet demand through a partnership approach between secondary care and a primary medical care system underpinned by sound local regulation.

One of the strengths of General Practice in Jersey is that doctors are available to see patients quickly when they are ill, offering prompt treatment and advice. This would continue under these proposals.

In addition, in the future, there would be a wider range of services available to patients. In particular new forms of health screening, such as additional health checks for cardio-vascular conditions, would aim to keep people free from disabling diseases. Health checks could save lives by preventing heart attacks and could mean fewer people suffering from the debilitating effects of heart failure. Patients suffering with chronic health problems such as bronchitis, diabetes and failing kidneys would be checked regularly and their treatment adjusted accordingly to keep them well and to avoid flare-ups in their condition.

A wider range of health care professionals and staff – such as practice-based nurses – would be available to see patients.

The new process of 'revalidation' with the General Medical Council

All doctors wishing to practise medicine in Jersey need to meet the requirements of the UK General Medical Council (GMC). Being registered and in good standing with

the GMC is a condition of being registered as a medical practitioner with Jersey's Royal Court. The underlying principle is that Jersey has always expected its doctors to meet as good a standard as is expected of doctors practising in the UK.

Since the publication in 2007 of a UK Government White Paper[1], all doctors registered with the GMC have been aware that continuing to practise medicine is contingent on revalidating their licences.

The main aim of revalidation is to ensure patient safety by reassuring the public that doctors are up-to-date and fit to practise. By making regular checks on doctors' standards of care, revalidation also 'levels up' the standards of care provided by all doctors to those of the best. In addition, those doctors who perform particularly poorly need to be identified quickly and helped to raise their standards or be rendered unfit to practise.

For GPs, achieving revalidation by the GMC will require provision of evidence, mainly through annual appraisal, that they meet the standards of good general practice as set out by the Royal College of General Practitioners (RCGP)[2]. An announcement was made by the GMC in early 2009 that if they had not already done so, all doctors must begin, from April 2009, to collect a portfolio of evidence on an ongoing basis in order to be ready to satisfy the revalidation process. Any doctor may be called to demonstrate how they meet the standards required as soon as 2011, and thereafter will be called back to revalidate on a 5-yearly basis. Any doctor failing to satisfy the GMC could therefore lose their license to practise from 2011.

Since 2006, two Jersey GPs have been suspended by the GMC and one GP has had restrictions placed on their practice subject to remedial measures. For all these cases, concerns had been longstanding and unresolved with potential risk to Jersey patients and no local means to intervene. It is likely that these problems could have been dealt with and resolved sooner had the local mechanisms proposed here been in place at that time.

MODERN SYSTEMS TO UNDERPIN BETTER-ORGANISED CARE

Regulation

Support for this proposition will enable necessary linked work to begin on the establishment of local accountability and regulation through a new 'Performers' List', linked to a new Primary Care Law.

It is proposed that to practise in Jersey a GP would be required to be on a 'Performers' List' with criteria underpinned by legislation which would include –

- Participation in:
    - annual appraisal;
    - local clinical governance, audit and complaints processes.
- Being in good standing with the GMC.
- Taking the following into account:

[1] Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century.
[2] Royal College of General Practitioners: RCGP Guide to the Revalidation of General Practitioners, London, April 2009 www.rcgp.org.uk/revalidation.aspx

- Police record;
- Disciplinary proceedings pending elsewhere;
- Any fitness to practise issues, e.g. health or performance concerns.

▪ A duty on the GP to report immediately any changes to the above.

▪ Procedures and criteria for suspension from practising: GPs could be suspended from the Performers' List if they breached any of its conditions.

Performers' List Regulations would be brought to the States in due course for the consideration of the Assembly.

Organised General Practice

During the last 2 years, GPs have formed, and are all members of, the Jersey Primary Care Body (PCB). The PCB has Terms of Reference and a Committee elected by its members which represents them. The Committee has endorsed this proposal and its members have been integral to drafting it. The Body would continue to have a central role in implementing this proposition if it is approved and in generating and taking forward future improvements to General Practice.

GPs, represented by the Jersey PCB, have agreed that in return for financial support for the new infrastructure costs needed to become ready for revalidation, the following added values would be assured –

- local regulation and accountability, with all costs associated with appraisal and revalidation met;
- access to health information by the States Public Health function;
- levelling up of best clinical practice, based on expert evidence, for the most common conditions – this would be achieved by working towards new 'quality practice' incentive payments. Once a new primary care law was in place, these would be funded through a quality contract based on the additional investment proposed later in this report;
- the GPs would cover the costs of remediation, retraining and lost income arising from suspension, other than during any brief initial period (up to a maximum of 4 weeks) of suspension 'without prejudice' whilst a preliminary investigation was undertaken to determine if formal performance, or rarely criminal procedures were possible, and where risk to patients was considered likely if a GP continued to work.

Appraisal and remediation

All Jersey GPs have already had their first annual appraisal delivered by The Wessex Deanery during 2009 and 2010. This demonstrates the commitment of Jersey GPs to respond to the quality requirements placed upon them. Wessex Deanery is the educational body that oversees undergraduate and postgraduate medical education, postgraduate specialist training and the appraisal system covering all medical professionals, including all GPs contracted in the Wessex Region (covering Dorset, Wiltshire, Hampshire and Isle of Wight).

In the event that a Jersey GP's performance become of concern, either through appraisal or by another route, remediation and/or retraining may be needed. The PCB

has been in negotiation with Wessex Local Medical Committees (LMCs) to commission a service from them to investigate and manage such instances. This organisation already carries out this function for Wessex in conjunction with the Primary Care Trust organisations for the area. For Jersey, this would involve a team from Wessex investigating and advising on the optimal way forward. Any retraining needed would be commissioned as appropriate either locally or on the mainland. Already Jersey GPs have become affiliated members and now have access to services and support from Wessex colleagues. Again this is an example of how Jersey GPs and the States can benefit from the advantages of economies of scale and specialist expertise that we couldn't hope to replicate if we had chosen to run this function ourselves. This approach also meets the needs of the States of Jersey to play its part in the local processes envisaged within the new GMC requirements.

Accountability

Both the GMC and Wessex LMC representatives have made it clear that in order for Jersey to meet the new expectations of revalidation and excellent General Medical Care, accountability to the States of Jersey is needed. GPs cannot be self-regulating. The establishment of a small team of a Primary Care Responsible Officer and associated administration and support would be essential. This would enable an arrangement consistent with that used for GPs contracted to Primary Care Trusts across the Wessex region (and similar to the rest of the UK). Our GPs would thus have an appropriate support infrastructure to enable them to meet the required contemporary standards.

Monitoring service standards through information indicators

It is proposed that a Jersey Quality Improvement Framework is introduced. The Framework would consist of a set of performance-related indicators which would be used to assess and monitor standards of routine care in Jersey General Practice. This would draw on some indicators from the UK Quality and Outcomes Framework[3] chosen for their relevance to Jersey health problems. This is a pragmatic and cost-effective approach since the majority of Jersey GPs' IT systems would collect the necessary data and analyse it using readily available UK software. It would be expensive and inefficient to create an entirely new system for Jersey involving research of the evidence base underpinning it when economies of scale are achievable by using an established, validated system.

The Jersey Quality Improvement Framework would promote and incentivise consistency of care for a number of common medical conditions that otherwise have the potential to cause significant ill-health, hospital admissions or early death such as heart disease, diabetes, stroke, asthma and chronic lung disease. The framework will also include indicators to assure organisational governance.

Organisational governance would include indicators covering:

- GMC License to Practise;
- Professional indemnity;
- Evidence of appraisals and keeping skills up-to-date;
- Inclusion on the Performers' list;

[3] Quality and Outcomes Framework guidance, 3rd revision, March 2009, www.bma.org.uk

- Practice complaints procedures;
- Compliance with data protection requirements;
- Medicines handling protocols;
- Human resources policies;
- Information for patients including a practice leaflet.

Proactive disease management would include indicators covering:

- Setting up and maintaining disease registers for patients with heart disease and circulation problems, chronic bronchitis, kidney disease, asthma, thyroid problems, depression, dementia and learning disabilities.
- Ensuring that standard tests and treatments are offered and reviewed regularly for patients on these registers
- Assessment of disease risk factors and offering advice: smoking cessation, a health check, Body Mass Index (BMI) and suicide risk.
- Seeing the doctor the patient chooses and promptly.

These indicators will make a real difference to patients' lives and mean that good intentions will be transformed into practise with the best care (proven by research) systematically and proactively offered to every patient, every year, in every practice across the Island. For example –

- Patients with depression would be regularly checked and treated and over time, screening and treatment should reduce the high rate of suicides on the Island.
- Patients with heart failure – a common condition – would be treated with effective medicines which should result in a better quality of life for sufferers and fewer hospital admissions.
- Patients would be able to complain about their care and be assured that they would be listened to and helped to reach a satisfactory conclusion.

Computer/information infrastructure

Supporting these advances and driving care improvements will require interactive computer systems and data that can be analysed. Existing GP systems will link into a new central repository for patients' records which could subsequently link into the new Health and Social Services computer system. The advantages envisaged include –

- compiling health records and disease registers at a single location;
- providing the basis for gauging whether performance standards had been met (which would be a prerequisite for the proposed extra remuneration in the future);
- providing robust data to guide the future development of health strategy and policy; and
- allowing patient records to be accessed electronically by the GP out-of-hours-co-operative.

Resource implications – paying for the improvements

General Medical Care is part-funded from the Health Insurance Fund which comprises the collective contributions of individuals, made broadly for this purpose. Each patient visit currently attracts a payment of £15 from the Health Insurance Fund to the GP. In addition, the patient pays on average £32 each time they see a GP. The Health Insurance Fund has been in surplus for some time (currently in excess of £76 million) and the value of the Medical Benefit has remained at £15 since 2004.

It is proposed that the Medical Benefit be increased from £15 to £19 to fund the improvements in Primary Medical Care. The rationale for this is that the people of Jersey have already paid into the fund for this service and the fund is not currently being used optimally to deliver comprehensive and high quality care.

In Jersey, GPs' remuneration is at present solely a function of the number of consultations. Remuneration based around the production of quality data is usual in primary care systems in the developed world and this proposal would bring the Island closer to the goal of securing quality as well as quantity.

The mechanism of paying a £4 quality component for each visit is, however, intended to be a temporary solution until the Health Insurance (Jersey) Law 1967 is updated. Then, contracts will be introduced with a global sum (equivalent to the value of the increase in Medical Benefit over the average number of GP visits over the period 2005–2009, an estimated £1.5 million (index-linked)) payable as a maximum against the highest level of performance required under the Jersey Quality Improvement Framework. This global sum would replace the £4 Medical Benefit increase which would cease. Once this global sum is created, only the practices that meet the quality standards would receive it. It is also envisaged that the remaining Medical Benefit would remain index-linked based on the current £15 value unless in the future this mechanism were to be superseded as a result of future negotiations with the PCB.

Support for this proposal, both by the States and the PCB, indicates support to developing the new contract and its underpinning new law, which will be brought back to the States for approval. However, in the meantime, the increase to Medical Benefit is the only measure possible within existing law and payment structures to fund the improvements set out in this report.

The other costs of the proposal, which it is proposed would also be funded from the Health Insurance Fund, would be the one-off costs and ongoing running costs of developing and implementing the central computer server which underpins the data requirements and the ongoing costs of a Primary Care Team. The Team would be accountable to the States and be required to provide independent local regulation with regard to linkages with the GMC, Wessex Deanery and Wessex Local Medical Committees and to administer the Performers' List. Whilst the central server project has yet to be fully scoped, costed and planned, it is believed the set-up costs would be within £1 million. The costs of the Primary Care Team are expected to be up to £200,000 per annum.

Whilst the Health Insurance Fund currently has a healthy accumulated surplus of in excess of £76 million and is running at an annual surplus, existing pressures upon the Fund are expected to result in an annual deficit within 5 years. It is estimated that the extra investment proposed above will bring forward to 2012/13 the year in which the Fund will move into annual deficit. Given that the accumulated surplus is sizable, the proposals mean that the Fund would not be exhausted until the early 2020s (estimates

are subject to actuarial review). Clearly, before 2020 this would need to be addressed and contributions increased.

Financial and manpower implications

The financial implications of the increase in the Medical Benefit from £15 to £19 amount to an estimated £1.5 million per annum, to be borne by the Health Insurance Fund.

There are no other financial or manpower implications arising from the amendment to the Medical Benefit directly, however as explicit in the report, other financial and manpower implications will arise in due course. These will be the subject of future States decisions as required.

Recommendation

States Members are asked to support this proposal. Supporting it will enable –

- An improvement in the consistency and quality of care in the Island, a likely reduction in hospital admissions and, over time, the improvement in the health of Islanders receiving a consistent standard of primary care equivalent to that of the best.
- a well-regulated health care system with accountable GPs practising and achieving revalidation by the GMC.
- Improved health information to inform strategic planning and the most cost-effective use of health care resources.

Explanatory Note

These Regulations amend the Health Insurance (Medical Benefit) (Jersey) Regulations 2005 to increase the general rate of medical benefit from £15 to £19 from 17th May 2010.

DRAFT HEALTH INSURANCE (MEDICAL BENEFIT) (AMENDMENT No. 3) (JERSEY) REGULATIONS 201-

Made *[date to be inserted]*

Coming into force *[date to be inserted]*

THE STATES, in pursuance of Articles 9 and 36 of the Health Insurance (Jersey) Law 1967[1], have made the following Regulations –

---

1 Interpretation

In these Regulations "principal Regulations" means the Health Insurance (Medical Benefit) (Jersey) Regulations 2005[2].

2 Regulation 2 amended

In Regulation 2(1) of the principal Regulations, for the amount "£15" there is substituted the amount "£19".

3 Regulation 4 amended

In Regulation 4 of the principal Regulations for the words "1st January 2010" there are substituted the words "17th May 2010".

4 Citation and commencement

These Regulations may be cited as the Health Insurance (Medical Benefit) (Amendment No. 3) (Jersey) Regulations 201- and come into force on 17th May 2010.

[1] *chapter 26.500*

[2] *chapter 26.500.18*