

States of Jersey  
States Assembly



États de Jersey  
Assemblée des États

# Health and Social Security Scrutiny Sub-Panel

## **Future Hospital Project: Interim Report**



Presented to the States on 3rd November 2016

S.R.6/2016



## CONTENTS

1. Introduction.....	2
2. Future Hospital Project: Issues for Consideration .....	3
3. Appendix 1: Concerto - Summary of Key Issues .....	5
4. Appendix 2: Concerto - Main Report .....	8
5. Appendix 3: Initial Response – Health and Social Services Department and Department for Infrastructure .....	83
6. Appendix 4: Detailed Response – Health and Social Services Department and Department for Infrastructure .....	89



# 1. Introduction

## Context and Background

The Health and Social Services Department (“Health Department”) has been working on plans for a new hospital since 2012 when it lodged P.82/2012 “*Health and Social Services: A New Way Forward*”. The Health and Social Security Scrutiny Panel formed a Sub-Panel<sup>1</sup> in 2015 in order to scrutinise the future hospital project.

The Sub-Panel has been following the work of the Health Department since 2015 and has received numerous documents and several briefings from Officers. In order to assist the Sub-Panel with its review<sup>2</sup>, Concerto Partners LLP was appointed as its expert advisor. Concerto has reviewed over 100 health projects for the NHS, including new hospital construction projects and has helped other hospital trusts establish their own internal assurance functions.

Concerto issued the Sub-Panel with its main report in August, and a summary document in October 2016. The Sub-Panel has chosen to publish the Concerto reports (and accompanying documents) in order to assist Members in the forthcoming debate on the preferred site for the hospital. By publishing this information now, it is hoped that it will give Members sufficient time to digest the findings made by Concerto. The appendices include:

- Appendix 1 – Concerto’s summary document of key issues
- Appendix 2 – Concerto’s main report
- Appendix 3 – Initial response from the Health and Social Services Department and Department for Infrastructure
- Appendix 4 – Detailed response from the Health and Social Services Department and Department for Infrastructure

The key matters identified thus far are detailed in section 2 below.

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<sup>1</sup> Deputy Richard Renouf [Chairman], Deputy John Le Fondré [Vice-Chairman], Deputy Terry McDonald, Deputy Jackie Hilton and Connétable Chris Taylor

<sup>2</sup> The Sub-Panel Terms of Reference for the review can be viewed on the Scrutiny website [www.scrutiny@gov.je](http://www.scrutiny@gov.je)

## 2. Future Hospital Project: Issues for Consideration

At present, as a result of matters raised by Concerto, and also from documentation received from the Future Hospital project team, the Sub-Panel consider that the following should be drawn to the attention of Members:

1. **The longer term island-wide strategy** – An integrated strategy showing how all elements of the health service will fit and work together in the future. Concerto considers there should be a document defining the balance between the future models for acute, primary, social and community care, digitisation, off island solutions and workforce attraction, retention and management, together with aligned provision of shared back-office support functions. Concerto accepted that elements of that thinking exist, for example in P.82/2012, but there appears to be no integrated strategy spanning 10 years in detail and beyond to 20 to 60 years at a higher level<sup>3</sup>.

It is important that hospital services and services outside of the hospital are part of a continuum of care which should be planned as a whole system. The new hospital will be the most expensive capital project undertaken and therefore it should be demonstrated to be fit for the future and not just a replacement on a like for like basis of the existing building.

2. **The transition plan** – showing how all elements of the health service will evolve and how the financial, clinical and operational risks will be mitigated<sup>4</sup>.
3. **Governance of the future hospital project** – the structure of the project's management team and its experience of transforming health services and building new hospitals<sup>5</sup>.
4. **The preferred site including disruption, costs and risk** - the construction of a new hospital immediately adjacent to the existing hospital whilst it remains operational will raise added complexities. There will be costs arising from the need to temporarily relocate various functions, and the noise and inconvenience to existing patients should not be underestimated. Concerto states:

*“It scores unfavourably against the Waterfront and People's Park options in the independent option appraisal carried out by Gleeds. It carries risks about disruption to services and about patient nuisance. This solution is complex, involving temporary re-locations and dispersal of services. The disruption risks and consequences look understated”.*<sup>6</sup>

The Sub-Panel note the views expressed by Clinical Directors in point 5.6 of P.110/2016 and will investigate the impact of the anticipated disruption.

The Sub-Panel emphasises that these comments represent initial concerns, some of which are based solely on the Concerto reports. These areas will be investigated further during the next phase of the Sub-Panel's review.

<sup>3</sup> Appendix 1 – Summary document of key issues prepared by Concerto

<sup>4</sup> Appendix 1 – Summary document of key issues prepared by Concerto

<sup>5</sup> Appendix 1 – Summary document of key issues prepared by Concerto

<sup>6</sup> Appendix 1 – Summary document of key issues prepared by Concerto

## Supplementary remarks

The full Concerto reports are included in appendices 1 and 2 of the report. The Sub-Panel would draw Members' attention to the Concerto three page summary report (appendix 1). On 14th October the Health and Social Services Department and Department for Infrastructure produced a detailed response to Concerto's main report. Whilst both Departments partially agreed with some of the findings made by Concerto, they did not accept a number of other remarks. The more detailed response makes reference to the Proof of Concept report by Gleeds but it should be noted that this was only provided to the Sub-Panel on 7th October so could not be used as part of Concerto's review.

The Proposition detailing the preferred site (P.110/2016 "Future Hospital: Preferred Site") was lodged on 19th October by the Council of Ministers. The Sub-Panel will examine P.110/2016 during the next phase of the review in order to inform the States debate at the end of November. In particular the Sub-Panel, in liaison with Concerto, will examine the following:

- a) The reduced footprint of the building and the effect on clinical adjacencies
- b) Ensuring future flexibility and possible expansion
- c) Disturbance to the remaining hospital during building works and the associated risks
- d) Relocation of services, training and administration
- e) The impact of the creation of a dual site hospital by the use of Westaway Court
- f) High level analysis of costings and the anticipated revenue costs of the project

### 3. Appendix 1: Concerto - Summary of Key Issues



**Health and Social Security Scrutiny Panel  
States of Jersey**

***FINAL CONCLUSIONS FROM  
PRELIMINARY REVIEW:  
FUTURE HOSPITAL SUB-PANEL***

Dated 7<sup>th</sup> October 2016

Prepared by:

Rebecca Trewinnard – Concerto Partners

## Introduction

This report provides our conclusions on the Future Hospital project, following receipt of additional information from the project team. The report acknowledges the areas of good practice and then highlights key questions and outstanding issues.

## Scope of this review

Our brief from the sub-panel was to carry out a desk-top review of evidence supplied by the project team, supported by a day's interviews with members of the team. Not all of the team were available on the agreed day and some additional information was provided subsequently instead. The review was undertaken in July and August 2016, with supplementary follow-up work in September.

## Findings

We saw evidence of good practice in many areas. For example the original technical appraisal of the site options is strong. There is evidence of analysis and planning across the health services spectrum. The consultation process with clinicians and others in the healthcare economy looks extensive.

While the detailed thinking in individual service areas appears technically sound and with the right people engaged in the processes, our concerns are at a more strategic level.

We have not seen an integrated strategy showing how the whole health economy will fit and work together in the future. We were expecting to see a document defining the balance between the future models for acute, primary, social and community care, digitisation, off island solutions and workforce attraction, retention and management, together with aligned provision of shared back-office support functions. Elements of that thinking exist, for example in P.82/2012, but we have not seen an integrated strategy spanning 10 years in detail and beyond to 20 to 60 years at a higher level.

We would expect, but have not seen, a transition plan for the island's health services showing how the service models will evolve and how the financial, clinical and operational risks will be mitigated. As one part of the service solution develops, so others have to adjust over time.

Robust construction evaluations are in place; we would expect to see option appraisals for different healthcare models and systems and their bearing on the potential service solutions within the proposed hospital. An alternative, for example, would be a more dispersed revenue-based solution where the primacy is on a domiciliary / primary / community basis rather than acute.

Inevitably given the three points above, we have not seen a document tying the island-wide strategy to the specification for the new hospital.

The States recently announced that the preferred option is to build on an operational site immediately adjacent to the existing hospital. This option emerged at a late stage against five others, including phased demolition of the existing site. It scores unfavourably against the Waterfront and People's Park options in the independent option appraisal carried out by Gleeds. It carries risks about disruption to services and about patient nuisance. This solution is complex, involving temporary re-locations and dispersal of services. The disruption risks and consequences look understated.

Delivery of a new hospital is a complex matter, requiring a design brief that reflects the island-wide requirements followed by robust management of the design process and in due course construction, associated supply chains, costs, risks and transition. We are concerned that the project's management team lacks the senior leadership experience of service transformation and building new hospitals.

We would expect to see a regularly updated timetable for service transformation across the island, linked to a detailed timetable for the planning, construction and transition management at the new hospital. At the time of our review one could not be provided.

## Conclusions

Many of the individual components necessary for success are coming into place. We are, however, concerned about the longer term island-wide health strategy and about the unclear link between that and the services strategy for the new hospital. We have reservations about the project governance and the experience within the team of project managing phased hospital construction projects. Further, the site appraisal option places the preferred site below the People's Park and Waterfront options. In the round, we doubt that the combined best answer is emerging.

## Key questions for the Panel to consider / seek reassurance on

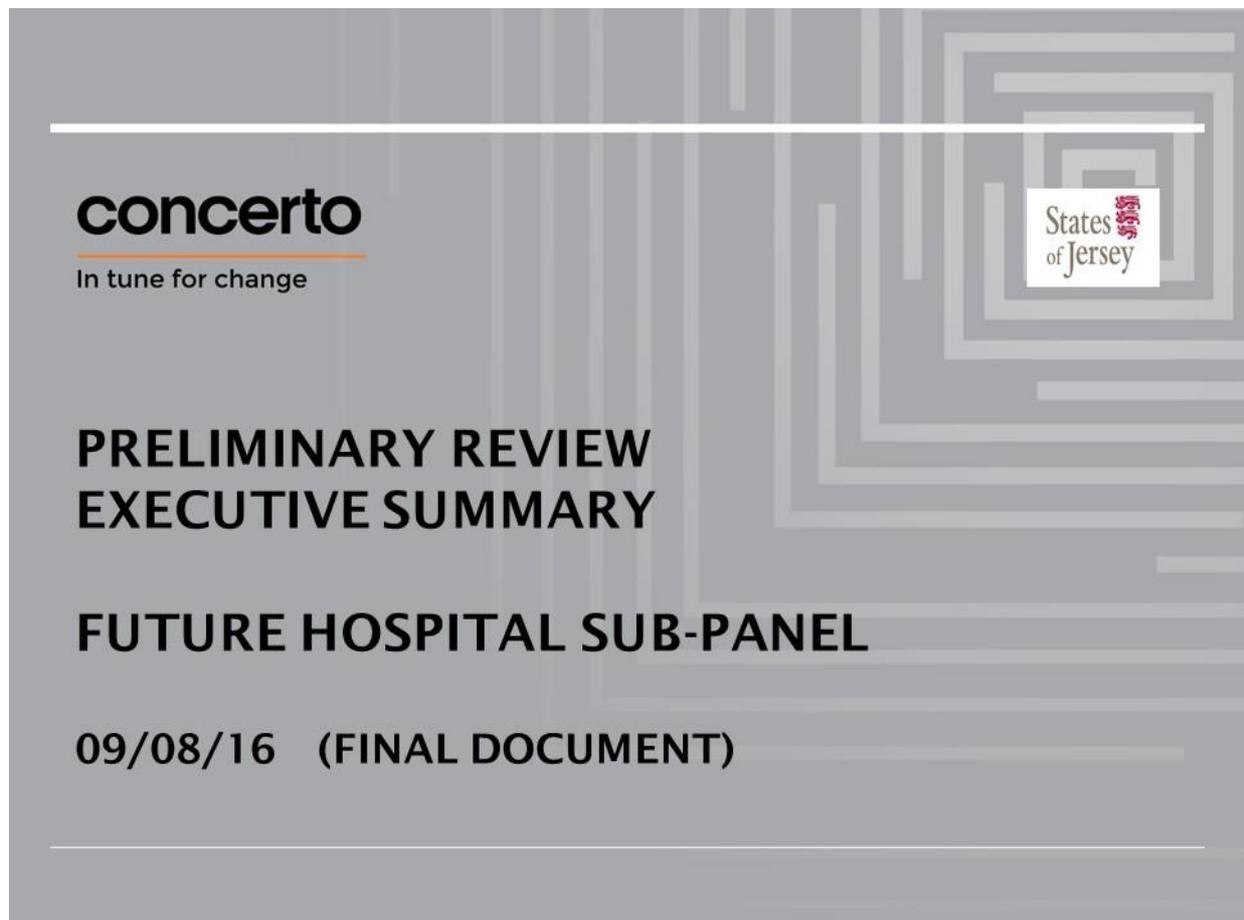
- When will a credible, regularly updated, robust timetable be in place linking the hospital to the island-wide service migrations?
- Does the physical solution provide flexibility for subsequent inexpensive adaptation or scaling?
- What justification is there in terms of value for money, risk and patient impact both during transition and in the long term, for the current site preference?
- How explicit is the balance or trade-off between the service specification, the construction costs, operating costs, construction time, transition time, and risks?
- When will the project recruit senior leadership experience of hospital new-builds?
- Is the governance effective, leading to challenge against group-think and enabling purposeful and timely decisions?

## Future assurance reviews

There are many ways around the world that governments obtain independent assurance on their major projects. Assurance activities are external to the project's management and provide a thorough independent view, giving early warning if there are issues or reassurance if all is well. There are usually two types of review: technical ones and project management ones.

In England, for example, NHS England and bodies such as NHS Improvement commission technical reviews of new builds. The Cabinet Office commissions Major Project Review Group assessments of complex projects, with review teams comprising experienced people from other departments and external specialists. This hospital project in Jersey would benefit from independent, external technical and project management assurance regimes.

## 4. Appendix 2: Concerto - Main Report



## OBJECTIVES AND SCOPE

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To consider matters of overall process in the development of the Future Hospital Project, such matters to include:

- a. The Future Hospital project brief
  - b. Timeline of the project
  - c. Political oversight
2. To examine the evaluation process of the site options for the Future Hospital Project, with particular regard to the following:
- a. Criteria used when assessing the sites
  - b. The justifications given to excluding some of the sites
3. To undertake a desktop study of the provision of off-Island and on-Island services at the hospital
4. To report to the States Assembly on the work undertaken

PLEASE NOTE THAT THIS REPORT HAS BEEN UPDATED FOLLOWING INFORMATION PROVIDED BY THE STATES IN JULY AT THE REQUEST OF CONCERTO AND A NUMBER OF "ONE TO ONE" INTERVIEWS WITH KEY PROJECT AND STAKEHOLDER STAFF

SPECIFICALLY THE SUB-PANEL WOULD LIKE CONCERTO TO EXAMINE THE FOLLOWING:

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Key Requirements from the Sub-Panel:

1. Comparability of other similar jurisdictions (i.e. similar population size) on what services are provided on-Island.
  2. In terms of what services are provided on-Island, in what areas are small jurisdictions vulnerable?
  3. How far do other isolated communities deal with the need for services that are deemed crucial?
  4. What national and international standards are there in terms of providing crucial services?
  5. What should Jersey be providing on-Island from a small jurisdiction point of view?
  6. What types of cost and negotiation is involved when procuring care off-Island?
  7. Is providing care off-Island more cost effective?
  8. What are the cost implications of providing care off-Island?
  9. What are the comparative costs in Europe?
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## TOP 3 FINDINGS

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1. Having received additional information from the States of Jersey, it is still our conclusion that there are significant and fundamental issues that threaten the affordability, effectiveness and management of the programme, before, during and after any implementation of a new hospital.
  2. It is essential that there is clearer executive leadership of the programme. At the moment the shared responsibility results in a programme with insufficient focus on delivery and on risk, relying on staff with extensive portfolios including operational leadership. It is recommended that there is one overall programme director, directly reporting to the Board, who has the responsibility for delivery across all workstreams of the programme.
  3. Site appraisal – The technical appraisal of the sites for the new acute facility is strong and follows best practice in the vast majority of aspects. The current preferred option is a rebuilding on the existing site. We are unable to find, however, strong justification for this decision based on the qualitative, quantitative, and financial analysis undertaken.
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## EXECUTIVE SUMMARY – FINDINGS ON MAIN TORS

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### **1. To consider the matters of overall process in the development of the Future Hospital Project.**

- Given the strategic issues facing healthcare in the States it is apparent that a “like for like” replacement is not a sustainable solution.
  - The hospital project must link to a broader set of strategic critical success factors and objectives that are clinically and financially driven
  - Work has been done to consider how services can be delivered in different ways that will be clinically safer, financially more sustainable, provide greater patient-centred care, and enable greater flexibility in the short term but there is concern that for the longer term (10 years plus) little planning has been done.
  - This project at this stage should not be politically-driven. It should be driven by the clinicians, payers and patients. Once the whole Island Clinical Strategy is agreed then political oversight and strong governance will be critical to realising the vision.
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## EXECUTIVE SUMMARY - FINDINGS ON MAIN TORS

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### **2. To examine the evaluation process of the site options for the Future Hospital Project**

- Site appraisal – The technical appraisal of the sites for the new acute facility is strong and follows best practice in the majority of aspects. The current preferred option is a rebuilding on the existing site. We can find, however, no evidence-based justification for this, based on the qualitative, quantitative, and financial analysis undertaken. At this juncture this report cannot support that decision nor the process behind it.
  - The technical elements of project completed are strong but they do not always link to the rest of the health service strategy. In essence the project, and thereby the specification for the hospital, has put the physical solutions before clinical pathways.
  - A key question is how the new facility can be made flexible so that it can meet the needs of continually evolving healthcare provision and best practice. The design, specification, and approach are predicated on a model that may, eventually, restrict and limit services rather than enable them.
  - There is concern amongst the workforce about how the decant plan will work and how services will be effected during the build. Many education and admin functions will be moved from the current site. At the time of writing this report no decant plans were available to review.
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## EXECUTIVE SUMMARY – DETAILED TORS

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### Provision of off-Island and on-Island services at the hospital

*1. Comparability of other similar jurisdictions (i.e. similar population size) on what services are provided on-Island*

- Our main report considers three jurisdictions in detail. The key finding is that each is considering or has already implemented fundamental changes to the healthcare service model, moving services from acute to community and placing greater emphasis on prevention, management of long-term conditions and flexibility in funding methods. All are considering new partnerships on and off-Island. Jersey could learn more from these experiences.

*2. In terms of what services are provided on-Island, in what areas are small jurisdictions vulnerable?*

- Our main report provides an analysis of the type of services that can be provided on-Island, both in acute and community settings and off-Island, both via tele-links and physically. Without recourse to significant analysis of activity, resources and funding, and most vitally what the local population wishes, a definitive list cannot be reached at this time.
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## EXECUTIVE SUMMARY – DETAILED TORS

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### Provision of off-Island and on-Island services at the hospital (cont..)

3. *How far do other isolated communities deal with the need for services that are deemed crucial?*

- Our main report provides a number of examples of what other communities deem to be crucial. The States should balance its over-arching provision of care ambitions against affordability constraints in determining its strategy

4. *What national and international standards are there in terms of providing crucial services?*

- Our main report provides a list of the most notable standards and accreditation schemes, and considers the implications for procurement and management information. No particular system provides an ideal fit. Examples from the commissioning process in NHS England indicate how this can be considered in contracts,
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## EXECUTIVE SUMMARY - DETAILED TORS

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### 3. Provision of off-Island and on-Island services at the hospital (cont.)

#### 5. *What should Jersey be providing on-Island from a small jurisdiction point of view?*

- Our main report provides suggestions by speciality and sub-specialty of services that can be provided in different locations and models. However without detailed knowledge of sustainable capabilities on the Island (both staff and infrastructure) and developing clinical pathways that work for the particular needs of Jersey residents, a definitive list cannot be reached at this stage.

#### 6. *What types of cost and negotiation is involved when procuring care off-Island?*

- There is little published evidence regarding this issue and the cost and support will depend on the number of contracts, the level of purchased activity, financial flows and governance and the management information required. In a comparable English CCG the commissioning cost alone would be in the order of £1.5m per annum.
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## EXECUTIVE SUMMARY – DETAILED TORS

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### Provision of off-Island and on-Island services at the hospital (cont.)

#### *7. Is providing care off-Island more cost effective?*

- Undoubtedly some care will be more cost effectively provided off-Island (it is likely that these services will also be the ones that are safer to provide off-Island). A robust answer to this question will require detailed analysis of care pathways, likely volume of activity, and discussions with potential providers. Some work has done to examine off-island options but there is reluctance to pursue this to its full potential.

#### *8. What are the cost implications of providing care off-Island?*

- Our report provides a list of the additional costs of providing care off-Island including insurance, transportation, carer accommodation, post-intervention care. The costs depend on the care pathway and to what extent care, especially post-intervention, can be managed on-Island.

#### *9. What are the comparative costs in Europe?*

- It is not possible to respond to this question without costs at an HRG or OPCS level from the States, which has not been made available.

## EXECUTIVE SUMMARY

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### **Other Island Experiences**

- Our report gives examples of how other Jurisdictions are working with similar issues and the extent to which their funding models meet or otherwise the demands of their populations. The States of Jersey could work more with some of these Jurisdictions, learning from their experiences.
- Shown within the report are some examples of what NHS Trusts and CCGs have done to reduce the size and use of their Acute Hospitals and provide care within Primary and Community Services. We recommend that the States of Jersey review this work and understand how it could fit into their health environment

### **Review of Management**

- The next steps in the programme need to be clinically and patient led, within clear affordability envelopes. Political oversight is needed to keep the balance right and ensure that the service models and care provision can be designed with the correct drivers. The Programme should have one Programme Director, not two. There is significant risk to this project due to the reliance on too few members of staff.
  - There needs to be an overall ICT Director for the Island which covers all areas of Health and Social Care including Primary Care.
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## EXECUTIVE SUMMARY

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### **Finance and Cost Considerations**

- Our main report suggests that, even though is not within the scope of this review, the States of Jersey should review the Health funding model.
  - The next phases of the various strategies depend on new funding. It is not clear when or if this will be available.
  - The integration of clinical services is essential and will provide economies of scale within the back-office as well as reinforcing the whole service approach. Economies of scale can be achieved by having one central admin function, with supporting finance, HR and IT support. This work does not seem to of taken place but should be before FBC.
  - The ICT programme seems to be behind many of the other pieces of work and could impact on the saving and new work practices
  - Reviewing what other private health estate is available will allow for a fully integrated state and private sector model to be costed.
  - Carrying out more in-depth future modelling will allow the Island to plan for the next 20 years. Detailed and extensive modelling has taken place for the next 10 years but not after this.
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## EXECUTIVE SUMMARY

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### **Other Considerations**

- It is important to ensure the correct models of care and the right level of support is in place for patients going off the Island; developing key Patient Pathways will help model how a patient's journey will work for certain medical conditions. This kind of scenario planning will help with understanding the clinical inputs as well as the cost implications for both the payers and the patients.
  - Details in our report show how the use of Tele-medicine and Tele-Health could help the Island with its health provision. The Isle of Man has included Tele-medicine within its whole Island health strategy and the States of Jersey could learn from this. This is planned but no funding is currently available for detailed pilots
  - The ICT programme is not integrated there are separate plans and strategies which, according to staff interviewed, are not delivering what has been promised
  - A lot of work has taken place re workplace planning and on-island training. There are concerns that if the training facilities have to be moved too far from the current location then essential accreditation will be lost.
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## SUMMARY OF RECOMMENDATIONS

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- We recommend that there is one overall programme director, directly reporting to the Board, who has the responsibility for delivery across all work streams of the programme.
  - There is too much reliance on too few people and not a balanced view on what is achievable and when. We recommend strengthening the team.
  - Appraisal of the options has followed good practice in identifying qualitative, quantitative and financial comparable benefits and costs. However this analysis does not strongly support the preferred option, which is identified as rebuilding on the existing site. If there are other reasons for this choice we recommend that they are properly considered and justified.
  - The new build solution on the current site will have a major effect the current workforce. We recommend that the operational, financial and clinical risks that are inherent in such a plan are more fully thought through.
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## SUMMARY OF RECOMMENDATIONS

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- We recommend that Jersey makes more effort to learn from other similar island jurisdictions.
  - Not enough progress has been made in relation to ICT and we recommend that an Island ICT Director manages the whole health economy ICT.
  - Some services have already gone off-Island and it is clear with the others can too. A lot of option analysis has been carried out, but not enough focus has been put into off-Island care. Work will be needed with the Insurers to ensure that Islanders can plan off-Island treatment. There is some very negative press on the internet re Off-Island treatments and this would need to be mitigated before going out to consultation.
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In tune for change

States  
of Jersey

**Health and Social Security Scrutiny Panel  
States of Jersey**

*PRELIMINARY REVIEW:*  
**FUTURE HOSPITAL SUB-PANEL**

Report  
Dated 11<sup>th</sup> August 2016

**Prepared by:**

Rebecca Trewinnard – Concerto Partners

## 1.0 EXECUTIVE SUMMARY

### 1.1 Executive Summary

The Executive Summary of this report has been written as a slide pack for presentation as agreed with the Sub-Panel. For completeness it is also included as Appendix 1 of this report.

### 1.2 Revision to the Final draft

Following submission of a final report in May 2016 a series of clarification interviews with key members of project staff and other stakeholders was organised as per the list below.

- Helen O’Shea, Managing Director, Jersey General Hospital
- Sarah Howard, Assistant Director of Finance - Modernisation, Health & Social Services
- Bernard Place, Project Director – Health Brief, Future Hospital Project
- Rachel Williams, Director - System Redesign & Delivery, Health & Social Services
- Jeff Tate, Head of Information Technology, Health & Social Services *interviewee unavailable*
- Rose Naylor, Chief Nurse, Health & Social Services

In addition further documentation was provided, including the following;

- Minutes of key meetings including Project Group and Scrutiny Committee,
- Outline Business Cases (2015) for acute, children’s, mental health, out of hospital services,
- Six facet report on existing hospital site,
- Project governance and management documents,
- Workforce project workstream documents,
- States’ Members workshop presentations.

The outputs of these two additional sources of information have been used to revise the original report from May.

## 2.0 OBJECTIVES AND SCOPE

The brief provided to the review team is shown in the table below, which also indicates which section of this report deals with each topic. Please note that many of the objectives are mentioned in more than one section so only the main references are provided below.

<b>Overall</b>	
1. To consider matters of overall process in the development of the Future Hospital Project, such matters to include:	
a. The Future Hospital project brief	Section 4.0

b. Timeline of the project	Section 6.0
c. Political oversight	Section 6.0
2. To examine the evaluation process of the site options for the Future Hospital Project, with particular regard to the following:	
a. Criteria used when assessing the sites	Section 3.5 AND 3.7
b. The justifications given to excluding some of the sites	Section 3.3
3. To undertake a desktop study of the provision of off-Island and on-Island services at the hospital	
	Section 8.1
4. To report to the States Assembly on the work undertaken	
	Not applicable
<b>Key issues</b>	
Specifically the Sub-Panel would like Concerto to examine the following:	
1. Comparability of other similar jurisdictions (i.e. similar population size) on what services are provided on-Island.	Section 5.0
2. In terms of what services are provided on-Island, in what areas are small jurisdictions vulnerable?	Section 5.0
3. How far do other isolated communities deal with the need for services that are deemed crucial?	Section 5.0
4. What national and international standards are there in terms of providing crucial services?	Section 4.4
5. What should Jersey be providing on-Island from a small jurisdiction point of view?	Section 8.1
6. What types of cost and negotiation is involved when procuring care off-Island?	Section 7.1
7. Is providing care off-Island more cost effective?	Section 7.2
8. What are the cost implications of providing care off-Island?	Section 7.3
9. What are the comparative costs in Europe?	Section 7.4

### 3.0 REVIEW OF ASSESSMENT PROCESS

#### 3.1 Sources

Although all documents have been reviewed three particular sources were used in the original report;

- CO021 Site Option Report, Appendix 2 – Verification of previous site deselection.
- CO021 Site Option Report, Appendix 22 – Benefits and risk analysis.
- Change request Number 4, Site Options Appraisal, April 2015.

Of the additional information received in June the States' Members workshop presentations and the results of the interviews with project staff are of particular relevance (see section 3.7).

### 3.2 Assessment process - review

We find that the assessment process adopted by the States closely follows best practice for option appraisal outlined in documents such as the UK's Department of Health Capital Investment Manual and subsequent accompanying guidance from HM Treasury and NHS England Project Appraisal Unit.

- A long-list of options, as broad as possible, is formulated.
- A simply "pass / fail" test is applied to this long-list to identify those options that support project critical issues (such as space available for development).
- The "short-listed" options are considered and developed in more detail, including basic design, ground investigations, discussions with planning authorities, development costs.
- The resultant options are assessed qualitatively against a series of weighted criteria, which should be linked to the project objectives and benefits that should be realised.
- The costs of the options are then considered, and, when combined with the qualitative assessment can demonstrate the option regarded as the best "value for money" proposition.

### 3.3 Review of long-list assessment

The project team carrying out the options assessment considered a wide range of site options. Rightly, the results of the original review in 2012 were evaluated again in most recent iteration of the project. Both of these actions are exemplar.

In general the reasons for rejecting a physical site option are clear. They usually relate to;

- Town and Country planning issues,
- Clinical adjacencies,
- Developable space available,
- Site use covenants.

Although the physical site options have been identified and appraised in some considerable detail, it would be more preferable to identify a small number of key success factors and constraints, preferably in respect of a whole health service strategy, against which each option would be assessed. This would provide a more transparent and objective, but not necessarily, different result. Clearly there has been a great deal of thought and discussion about the options. A significant number are rejected, fully or partially because they have insufficient developable space.

As noted later in this report there has been insufficient consideration of the potential for other models of healthcare delivery. Thus the option appraisal is only of sites, not of the best way of delivering the services required. In the opinion of this report this is a significant flaw and we have a low level of confidence that this process has identified the combined best answer. This fundamental issue is further discussed in the recommendation sections.

### 3.4 Development of the short-listed options

Before starting this section it should be made clear that the original process to choose the site, as shown in the Gleeds work of 2015 and 2016, was broadly done in the correct manner. The problem with that iteration is that the report has been based on the old clinical service and delivery model. Therefore, to ensure that the site and new build is correct it has to be based on the new service model which is discussed later in this report. Please note that issues with the workshops undertaken in 2016 are discussed in Section 3.7 below and these are of particular concern to the development of the project.

The short-listed options were developed by the project to a significant level of detail, which includes high-level design, planning considerations, site issues etc.

All options were designed at 85% of Health Building Notice (HBN) standards. As this is a comparison phase of the project, and it was equally applied to all options, this is of no consequence to the assessment. However, whilst including a “design challenge” is a reasonable step it can, when applied so broadly, provide significant issues later on in the development of the scheme as it is rarely possible to apply such savings equally across all types of accommodation.

If there are affordability issues it would be preferable to identify how space can be reduced and re-engineered in a more planned way that may also encompass changes to the model of service. In conclusion it is not a problem for the assessment but the development of the preferred option should not start with the assumption of all space being at 85% of HBN guidance.

It is also noted that no “Do nothing” or “Do minimum” option was included, which is generally regarded as best practice. These in essence will represent the status quo or the minimum that must be done to maintain services in some form. It is not suggested that these are genuine options but they do provide a very useful “control”. Additionally it is helpful in demonstrating that the case for change, the preferred option development and procurement all remain robust.

In section 5.7 of the Gleeds’ *‘Change Request Number 4’* document, a forecast of likely future hospital activity was completed to ensure facilities remained for long-term provision. *‘Appendix 9’* of the Gleeds’ report provides the details of this based on work previously conducted by Ernst and Young in 2012. It is strongly recommended that this should be revisited as, from this report, there appears to be a limited review of the potential for radical change in the provision of services, especially what will continue to require an acute hospital environment.

The impact of this omission (that calculations are based on current service model not the new one) to reflect emerging service models is perhaps also shown in the calculated accommodation space required of over 60,000m<sup>2</sup>, which is ameliorated through various means to around 46,000m<sup>2</sup> for options B to D and 57,000m<sup>2</sup> for option A. Districts in England with populations of around 100,000, and the acute health provision within that District, is shown below.

District	Acute m <sup>2</sup>	Type	Note
Dartford	59,000	Relatively new PFI	Serves a population of 340,000
Eastbourne	60,000	Mixed, old and new	Serves a population of 370,000 with some services shared with Hastings
Kettering	62,000	Old site	Serves a county-wide population with some services shared with Northampton
Welwyn Garden City, Herts	8,000	Community, new	Replaces an acute hospital of 32,000m <sup>2</sup> with around 50% activity moved to Stevenage serving a population of over 150,000

As will be noted in the table above hospitals in similar sized districts are slightly larger but serve much larger populations. As an island, Jersey cannot share services with other easily accessed facilities. However the model being pursued in Hertfordshire demonstrates the potential to move services into the community and out of acute facilities.

It is very clear that significant detailed work, following best practice guidance (for site option choice) has been conducted in the development of the plans, redevelopment potential and costs of the options provided. It is believed that non-estate revenue costs are not included in the analysis. It is reasonable to assume that these would be very similar between the options presented as they all provide a similar, building-led solution with little change in the service model. As noted previously this is a weakness of the project (note not of the assessment report).

### 3.5 Qualitative appraisal

The evaluation team has undertaken a highly detailed, methodical process to provide an objective assessment of the options under consideration. In general the observations noted below relate to the broader issue that this options appraisal exercise considers the technical elements of the development rather than its ability to support transformation and contemporary service models.

The criteria consider the fit of the option with physical indicators of space, form and design rather than consideration of services.

- There is, from an external view, elements of double-jeopardy in some of the criteria, i.e. that some issues are considered twice in the assessment. For example cost risk is best

reflected in contingency sums within the financial appraisal as it is a quantitative not qualitative issues. There also appears to be similarities in criteria 2.1 and 5.5 of 'Appendix 22' so effectively this is being assessed twice.

- Ideally there should be a clear direct link between the project objectives, the critical success factors and the appraisal criteria, i.e. the options should be appraised directly against what the project is required to achieve. An example of this is provided as Appendix 2.
- There are no criteria to assess how the options support the over-arching service strategy: it is assumed that all do equally. This is a significant flaw in the analysis and at the very least the options should assess the impact on service strategy.
- The strong emphasis on how the options impact on clinical services, patients, users and staff, almost 70% of the weighting points is excellent.

### 3.6 Financial appraisal

The professional team and its informed clients have undertaken a detailed analysis that demonstrates their understanding and experience. The details of the Generic Economic Model were not provided but this report has no reason to believe that any issues would be discovered in its application. The assumptions and methodology are wholly appropriate.

The options appraisal does not quantify the non-estate revenue costs, which as mentioned in a previous sub-section is a major concern.

A further issue is the level of Optimism Bias applied. Compared to experience of projects in England at a comparable stage (assumed to be Outline Business Case) this feels a little low. However as it is applied equally to the options it should have no material impact on the final analysis.

### 3.7 Current preferred options

It is understood that the project is now principally considering two options; the Waterfront site and rebuilding on the current General Hospital site, using a phased approach. It is not clear how this short list has been arrived at given the clear results from the formal qualitative and financial appraisal undertaken (and indeed shown in the States' Members presentations undertaken from March to July 2016). This report can only surmise from the evidence presented that it is perceived that rebuilding on the current General Hospital site is politically expedient and this has over-ruled any other consideration.

It is understood that the political dimension is important in any such decision, however placing it far above any other consideration considerably reduces the likelihood of achieving the benefits and outcomes required – the list of public sector projects in the UK that have suffered as a result of political expediency is a very long one.

This concern is further amplified by the nature of the preferred option, rebuilding a complex new facility on an existing (operational) site in multiple phases. The Optimism Bias process required by HM Treasury in the UK requires an additional risk cost of at least 25% for this type

of approach, more than double that for a greenfield new build option. As well as construction cost there is also insufficient consideration of the quality and financial risk to clinical and operational services of complex construction on the site. The programme too is optimistic in the extreme. This is not to say that rebuilding on the existing site is not possible nor indeed may not become the preferred option – however its current position as preferred option cannot be justified based on current knowledge or the assumptions made.

Overall it is the opinion of this report that the costs and risks, including to patients, of the preferred option of rebuilding on the existing site in a phased manner, has been fundamentally under-estimated. Without significant additional analysis the States is placing itself in danger of progressing a project that is unlikely to achieve what is required, may result in notable reductions in clinical and service quality, cannot be delivered within the budget available or in a reasonable timetable.

## 4.0 REVIEW OF BRIEF

### 4.1 Introduction

Clearly a lot of work has been put into the States' Primary Care Strategy and this has brought together many of the clinical teams on the Island. It is now clearer how this strategy will link into and be enabled by the other projects operating across the Island. Both Primary and Community Services are the future for healthcare provision on the Island and have to progress from their current status, which is quite visionary in places, into the next phases of pilot schemes and, eventually steady state. The next stages are dependent on additional funding and there did seem concern that this would be received.

Some of the work has been done but we have detailed below the areas which will facilitate the move of services out of Acute Provision into a Community Hub focus. The States' Primary Care Strategy is the basis of the section and this report highlights key sections as a reminder of the vision and recommendations put forward in that document. It is essential that the next steps are now actioned and implemented to facilitate the "out of hospital" strategy.

### 4.2 A Sustainable Primary Care Strategy for Jersey 2015 – 2020

Listed in these bullet points are the high level factors that we have found about the States of Jersey population and the issues it faces.

- The elderly population is rising disproportionately, Jersey could have as many as 28,000 people aged over 65 by 2035, compared to 14,000 in 2010 and will also see the number of people aged over 85 increase from 2,000 to 5,000.
- There is a clear pattern of increasing multiple-morbidities with age in the Jersey population, with over half of the population being found to have at least one of 40 long term conditions. Existing capacity is due to be exceeded in some services across the whole health system.
- Pressures created by demographics are no longer affordable using current funding mechanisms.
- Perverse incentives built up over many years mean that patients and providers can be hindered from making correct choices.
- A lack of integration reduces efficiency and damages patient experience.
- There are workforce recruitment issues across the health and social care system.

*Detailed below are extracts from the Primary Care Strategy for States of Jersey forwarded by Senator Andrew Green MBE, Health and Social Care Minister, States of Jersey.*

A new way forward for Health and Social Care (P82/21012), which outlined a vision for health and social care that is safe, sustainable and affordable, with integrated services delivered in partnership.

As a result of P82, more services are now provided in local community settings for example midwifery, enablement and sustained home visiting.

We understand that there are five ambitions for the Sustainable Primary Care Strategy. The ambitions set the direction of travel for primary care for the next 5 years working towards improved sustainability and a safe, effective and affordable system.

The 5 ambitions include:

### **1 - PATIENTS:**

- Understanding the population needs of the islanders.
- Support the people of Jersey to lead healthier lives and empower patients to manage their conditions better.
- Currently 70% of expenditure is on patients with long term conditions. So healthcare services must focus on the preventing and the managing of these conditions.

### **2 – PAYMENT**

Primary Care is a cost effective means of delivering healthcare

- Research suggests that too heavy a reliance on fee-for service or capitation is likely to reduce efficiency – a blend of these different approaches to payment is most likely to strike a better balance between incentivising responsiveness to patient needs and quality with cost-efficiency and budgetary control.
- Recently published NICE Clinical Guidance supports the development of the roles of primary care pharmacists.
- Patients and providers value the co-payment in General Practice as it gives a sense of worth to services being provided. The co-payment will continue to exist in General Practice.
- Different GP payment systems will be assessed jointly with stakeholders, with the support of a health economist. Options will be developed and evaluated and a preferred approach taken forward which may be a blend of systems. Pilots will be run to test new payment mechanism prior to implementation.
- The Health Insurance Law has recently been amended to allow the States to enter into contracts with providers. Using this new facility the States would like to explore the option of a pharmacy contract where a range of services could be “commissioned”.
- The future development of the Jersey Dental Fitness Scheme will be considered, alongside the 65+ Healthcare scheme and other dental spend.
- Funding of community nursing will be considered in the context of the other services covered in this strategy, HSSD funding, charitable funding and patient co-payment.

### **3 – PARTNERSHIPS**

Develop more integrated working across the whole system to enable improved efficiency and safety.

- “The patient’s perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to impose the patient’s perspective as the organising principle of service delivery”. *States of Jersey Primary Care Strategy*
- Achieving the benefits of integrated care requires strong system leadership, professional commitment, and good management. Systemic barriers to integrated care must be addressed if integrated care is to become a reality.
- Assess the role of Primary Care Leadership within the Health and Social Care system as a whole, including how Primary Care continues work with HSSD along with accountability and leadership for the Primary Care Strategy.
- The various funding streams within primary care will be reviewed and recommendations made to amalgamate budgets where possible, to simplify integrated working across primary care.
- Develop a Clinical Forum which will be the vehicle for building closer clinical working relationships between primary and secondary care, with clinicians from the hospital and a range of primary care providers.
- Alignment between strategic developments in health and social care to support the development of multidisciplinary working with primary care.

#### **4 – PEOPLE**

Assess and develop the primary care workforce and to provide career opportunities for people to develop the skills required to meet future challenges.

- Many EU countries report difficulties both in retaining and recruiting health staff. Reasons vary between EU countries. It can be due to unattractive jobs, poor management or few opportunities for promotion. Smaller island communities such as Jersey have additional specific issues
- In all the case studies in the Global Health Policy Summit report, there was a deliberate reshaping of the workforce away from the traditional hierarchical medical model, and towards a wider skill-based team approach. This reshaping increased the capacity of the system to respond to demand, and enabled quality to be delivered at a lower cost.
- Conduct a workforce survey and training needs analysis across primary care in order to produce a workforce strategy to assess the options to; Develop primary-care structures to encourage the appropriate range of healthcare professionals to enter and remain in primary care sector, fully utilising their professional training; Ensure that training and CPD opportunities fully support a sustainable primary care sector.

#### **5 – PROCESSES**

Develop governance and IT processes to support quality, safe, and efficient delivery of care.

- Continue with the current governance arrangements for General Practice. Consider expanding the existing Primary Care Governance Team in order to incorporate Pharmacists, Dentists and Optometrists.
- Introduce biannual patient satisfaction surveys with primary care services.
- The IT systems has moved to using the JY number as the unique patient identifier in line with the e-gov strategy.
- To enable this work, compulsory registration will be introduced whereby all patients will have to register with a preferred GP practice. Patients will still be allowed to move or change between practices.
- The Informatics Strategy states a number of aims for developing integrated record sharing between primary and secondary care. We will support these aims and ensure Primary Care is prioritised.

From what we can ascertain from the documents that we have been provided with, this document has not been considered during the site appraisal. If these ambitions were focused on they would form the basis for the Island to deliver the different model of care it needs and can afford over the next 10 plus years.

As we have stated through this document the Island must move to an integrated care model. Detailed within this document is how this can be achieved. What is needed is to define how the acute delivery model fits within this strategy and what can be provided on the Island going forward.

If the Information technology issues can be addressed as a matter of urgency, integration of services will be easier to deliver, reducing duplication and clinical risk. It will ease the patient journey by reducing duplicate questions and forms. It will ensure that delays are minimised and ultimately deliver the seamless patient experience every clinician wants.

### **4.3 The Role of Primary and Community Care**

Most healthcare services are faced with an increase in an older population and a rising prevalence of chronic disease bringing greater focus to unhealthy lifestyles and behaviours, often diseases of affluence and poverty.

Using primary and community care facilities to try to minimise the need for hospitalisation is key in controlling the spiralling costs of healthcare.

The report notes that the significant issues that affects the States of Jersey Primary Care include:

#### ***1. Payment mechanisms***

There are too many payment mechanisms that incentivise the wrong type of behaviour by clinicians.

#### ***2. Treating multiple conditions***

Care packages are not designed for those with multiple conditions. Primary care needs to become person-centric considering the whole episode rather than individual treatments

or interventions. Patients should have the minimum number of separate consultations necessary with primary and community care providers to treat all symptoms together rather than one at a time.

### **3. Availability of care**

Primary care practices typically offer short appointments during working week hours. Primary care needs to be accessible to all when needed, as close to 24 hours per day, 365 days per annum as is possible with the financial and clinical resources available. This avoids the escalation of issues to the point of hospital admission owing to people being unable to visit their own GP.

### **4. Preventative care**

At the moment Primary reactive not proactive. Jersey Healthcare providers have seen a shift from healthcare delivery to an increasing role in the prevention of disease and modifying patient behaviours. Care should be proactive and population-based where possible, for example, through early risk based cancer screening or through incentives to drive healthy lifestyle choices from insurers. Moving to a different model of service provision i.e. a 'hub' or mobile model.

### **5. Using technology**

Note: The Reviewer was scheduled to meet with an ICT representative but they were called away. The Reviewer sent questions after the day of the interviews and did receive a reply. Sadly some of these replies differ from those received from the other interviewees. Therefore, the author has had to make some assumptions where there is conflict in the information received.

Most of States of Jersey providers do use technology but the use of technological innovation effectively is not evidenced. If the Island moved to these enhanced services it could provide more effective and efficient ways to manage patient care. Remembering that different technology approaches are key to reaching the correct demographic within your population. For example, social media can be used to engage with the younger population, as can mobile applications with different 'skins'/'looks' applied to appeal to different age groups.

It is believed that EMIS has been rolled out to all Primary care services on the Island but the results had been mixed and there were differing user experiences. There seems to be an issue with engaging with EMIS and this is causing the Island a real issue.

There is some evidence that integration with secure health messaging, virtual visits (via telemedicine), e-scheduling, mobile solutions and e-consultations are part of the Island's strategy but has not been fully achieved yet.

It would be worth the Island reviewing its ICT strategy as it is now 3 years old. The report suggests moving to employing a dedicated ICT Director, for the whole health and social care economy.

## 6. Communication and Integration

It is clear that the previously poor communications between primary care providers, hospitals and specialist providers have improved but there is a lot of work to be done within the Primary Care providers. However, notwithstanding the work in this aspect, without a change in the funding model it is hard to understand how this part of the healthcare economy can be transformed.

In many countries including the UK, different area of care providers including acute, community and primary care have taken a strong first step toward improving quality through data sharing. In many case the care is not seamless and many health provider does not know the outcomes of their care. There are high level statistics and measures but the detailed analysis of the different components (diet, environment, social economic effect and the amount of support given to the individual are not measured) this therefore does not give the true outcome of that individual care). It has been proven that certain care pathways can benefit different social economic groups depending on age and demographics. In England web-based tools, such as SHAPE are being promoted by the Department of Health to allow easy access to critical strategic health and well-being information that enables better planning and review of historic activity information.

Primary care is vital in all healthcare systems. It provides the basis and support of all other healthcare provision. Most health interactions, whether physical or mental health related, start and end within primary care. It needs to be able to provide a full rounded service for its patients. It is essential for an Island based healthcare service to be able to provide rapid primary care service that meets the needs of the population and is affordable.

In 2015 a survey (States of Jersey Public Consultation, Health and Social Service White Paper: *“Caring for each other, Caring for ourselves”*) was carried out that showed many jersey residents were not attending their Primary Care Service. Significant numbers were visiting Accident and Emergency rather than going to their GP. The reason was there was a charge for visiting the GP but presenting at A&E incurs no fee. Many agreed that if a charge was made for visits to A&E for minor conditions they would go to their GP first, but this never happened.

Most people think of Primary Care as a means to an end and that any serious care, treatment or intervention has to occur in a hospital. This is not true and therefore the population’s understanding of primary care has to be changed to ensure that 21<sup>st</sup> healthcare can be provided in a way that works for the state as well as the individual.

Detailed in the table below are the staffing facts detailed within the A Sustainable Primary Care, Strategy for Jersey, 2015 – 2020. It shows that the Island has a good primary and community foundation to build from. Developing the pharmacies would enhance the services that could be provided outside of the Hospital environment. Community Nursing levels are quite low for this level of population. It is not clear what clinical competencies these staff have and further work is needed to understand what additional staff would be needed against what will be delivered in the Community environment.

Provider	Numbers	Funding	Governance	Services
<b>General Practitioners</b>	<p>Estimated (2015) 103 GPs (88 Full Time Equivalents (FTE) 0.88 FTE GPs per 1,000 population Comparators per 1000 population: England 0.70*; Scotland 0.80*; Wales 0.65; Northern Ireland 0.65; Isle of Man 0.61; Isle of Wight 0.55; Guernsey 0.69 and Tasmania 0.7136 <i>*UK numbers do not include trainee GP's which compromises 7% of workforce</i></p>	<p>The health and social care system in Jersey features a high level of patient payment in primary care. GP's set their own consultation fees and choose how much to charge each patient. These fees are on top of contract and quality payments to GP practices and a medical benefit subsidy (currently £20.28 in 2015) per consultation. This is managed by the Social Security Department and is currently (2015) funded from a ring- fenced Health Insurance Fund (HIF).</p>	<p>All medical practitioners in Jersey must be registered under the Medical Practitioners (Registration) (Jersey) Law 1960. Registration under this Law is, in turn, dependent on registration with a licence to practise with the General Medical Council (GMC) in the UK. Therefore, the GMC provides the primary licensing and any licence held in Jersey is secondary to that. Registered GP's can apply to be included on the performers list for general medical practitioners if they wish to be an approved medical practitioner for the purposes of the Health Insurance Law entitling practitioners to claim medical benefit. The Primary Care governance teams supports and administrates the process of GP revalidation and applications for the performers list.</p>	<p>Most GPs provide appointments 8 am-6 pm on weekdays and Saturday mornings, with some providing longer hours. Patients are usually able to be seen on the same day. GPs provide childhood immunisations and adult vaccinations; some offer specific clinics for Long Term Conditions, occupational health and specialist clinics including rheumatology, dermatology and sports injury. JDOC (Jersey Doctors on Call), is a co-operative model provided by a rota of Jersey GPs, providing Out of Hours services (6.30 pm – 8 am on weekdays, 12 noon Saturday – 8 am Monday and Bank Holidays).</p>

Provider	Numbers	Funding	Governance	Services
<b>Pharmacy</b>	80 pharmacists 0.8 FTE per 1000 Comparators per 1000 population: England ~0.8 (2010 figures), Singapore ~0.39 (2012 figures), Japan ~1.06 (2008 figures) 38	Pharmacists are funded through the Pharmaceutical Benefit, and their private retail business. The pharmaceutical benefit pays a dispensing fee and reimburses the cost of drugs.	Registration is required with both the General pharmaceutical Council (GPhC) and under the Pharmacists and Pharmacy Technicians (Registration) (Jersey) Law 2010 which is administered by the Chief Pharmacist based in HSSD	Pharmacies provide over the counter medicines and advice, dispense prescriptions and deliver enhanced services funded by the States e.g. smoking cessation. Approximately 12 community pharmacies provide basic health checks such as blood pressure, cholesterol and diabetic screening. Average opening times are 9am -6pm Monday – Friday and Saturday morning with some pharmacies open on Sunday.
<b>Nursing</b>	36 District nurses, 13 Health Visitors, 4 School nurses and 4 Children's community nurses. There are c. 5 practice nurses employed by GP practices. 0.52 FTE per 1000 Comparators per 1000 population: England 0.846; Scotland 1.124; Wales 1.052; Northern Ireland 1.00340	Community nursing services are provided by Family Nursing and Home Care (FNHC), a Government subsidised organisation with charitable status. Some GP practices employ a practice nurse, which is funded directly by patient visits	Registered nurses working in Jersey are required to be registered with the Nursing & Midwifery Council (NMC UK) and locally with the department of Health Social Services under the provisions of the Health Care (registration) (Jersey) law 1995).	FNHC provides district nursing, health visiting School nursing and Home Care, as well as out of hospital services (rapid response and reablement

#### 4.4 What national and international standards are there in terms of providing crucial services?

Providing healthcare, especially of an adequate standard, is a complex and challenging process. Healthcare is a vital and emotive issue—its importance pervades all aspects of societies, and it has medical, social, political, ethical, business, and financial ramifications. In any part of the world healthcare services can be provided either by the public sector or by the private sector, or by a combination of both, and the site of delivery of healthcare can be located in hospitals or be accessed through practitioners working in the community, such as general medical practitioners and dentists.

This is occurring in most parts of the developed world in a setting in which people are expressing ever-greater expectations of hospitals and healthcare services. This trend is especially strong where socialised medical systems exist. The USA manifests some differences here, and is an unusual and distinct oddity among developed Western countries. In 2007, 45.7 million of the overall US population (i.e. 15.3%) had no health insurance whatsoever yet in 2007 the USA spent nearly \$2.3 trillion on healthcare, or 16% of the country's gross domestic product, more than twice as much per capita as the OECD average. Because of this, some US citizens are having to look outside of their country to find affordable healthcare, through the medium of medical tourism, also known as "Global Healthcare"

There are no national or international standards in terms of providing an Island-based health service. Within this section we cover some of standards and accreditation that exist per country so that the Sub Panel can decide if they want to adopt any for use within this project.

##### *Healthcare and hospital accreditation*

Fundamentally healthcare and hospital accreditation is about improving how care is delivered to patients and the quality of the care they receive. Accreditation is one important component in patient safety. However, there is limited and contested evidence supporting the effectiveness of accreditation programs.

In countries such as the United Kingdom, the USA, Australia, New Zealand and Canada, sophisticated accreditation groups have grown up to survey hospitals (and, in some cases, healthcare in the community). Furthermore, other accreditation groups have been set up with openly declared remits to look after just one particular area of healthcare, such as laboratory medicine or psychiatric services or sexual health.

International standardisation groups also exist, but it must be pointed out that the mere achieving of set standards is not the only factor involved in quality accreditation - there is also the significant matter of the incorporating into participating hospitals systems of self-examination, problem solving and self-improvement, and hence there is more to accreditation than following some sort of overall "standardisation" process.

##### *Systems*

A number of larger countries engage in hospital accreditation that is provided internally. Taking the USA as an example, numerous groups provide accreditation for internal healthcare

organisations, including the AAAHC Accreditation Association for Ambulatory Health Care, doing business internationally as "Acreditas Global", Community Health Accreditation Program (CHAP), the Joint Commission, TJC, the Accreditation Commission for Health Care, Inc. (ACHC), the "Exemplary Provider Program" of The Compliance Team, American Accreditation Council (AAC), and the Healthcare Quality Association on Accreditation (HQAA).

Some other countries have looked towards accessing the services of the major international healthcare accreditation groups based in other countries to assess their healthcare services. There are many reasons for this, including cost, a desire to improve healthcare quality for one's own citizens (good governance is at the basis of all high-quality healthcare), or a desire to market one's healthcare services to "medical tourists". Some hospitals go for international healthcare accreditation as a de facto form of advertising.

### **Consumers**

If the States of Jersey is considering greater use of off-Island provision increasing number of Jersey residents will be regarded as "medical tourists". Whether purchasing services themselves as private individuals or through States-procured contracts, they will wish to understand the quality of the services they can expect and will look to the States and the providers to assist.

It is certainly not simply a matter of looking at hospital buildings and at mattresses, nor just an issue of looking only at the prices charged. What is often more important may include such issues as:

- Standards of governance in the hospital or clinic.
- The healthcare providing establishment's commitment to self-improvement, and to learn positively from errors.
- Overall medical ethical standards operating within the organization.
- The clinical staff's ethical standards and their personal and collective commitment to caring for patients and the wider community.
- Quality of the clinical staff, including their background educational attainment and training, and evidence of continuing professional development by those staff.
- Quality and ethical standards of the management and their personal and collective commitment to caring for patients and the wider community.
- Clinical track record of the hospital or clinic.
- Infection control track record of the hospital or clinic.
- Hospital may be located in a country where the environment and climate may bring a patient into contact with infectious and/or tropical diseases that are unfamiliar to them.
- Evidence of a robust, just and fair system to deal with complaints made by patients when things go wrong, as they inevitably will from time to time, and where appropriate to compensate the injured party in a fair and reasonable way.

Also, the intending medical tourist should check whether or not a hospital is wholly accredited by an international accreditation group, or if it is only partly accredited (e.g. for infection control), the latter being less inclined to create confidence in a potential consumer.

How does the person in the street access this type of quality information? This can be very difficult. Accreditation schemes well-recognised as providing services in the international healthcare accreditation field include;

- Accreditas Global, a division of AAAHC, INC., based in the USA,
- Accreditation Canada International (ACI) (based in Canada),
- Joint Commission International (JCI) (based in the USA),
- Australian Council for Healthcare Standards International, or ACHSI (based in Australia),
- Trent Accreditation Scheme (based in UK-Europe) The former Trent Scheme (which ended in 2010) was the first scheme to accredit a hospital in Asia, in Hong Kong in 2000.
- QHA Trent Accreditation, based in the UK
- Accreditation of France (La Haute Autorité de Santé) based in Paris, France.
- The King's Fund Organisation Audit, part of the London-based charity the King's Fund, was an especially strong tool and provided detailed organisational checklists for public and private-funded hospitals. The tool is now owned by CHKS ([www.chks.co.uk](http://www.chks.co.uk)).

It is not stated in the site appraisal whether any standards apart from HBNs have been followed or consulted. We would recommend that the Sub Panel review the CHKS tools.

### ***Umbrella organisations***

The International Society for Quality in Health Care (ISQua) is an umbrella organisation for such organisations providing international healthcare accreditation. Its offices are based in the Republic of Ireland. ISQua works to provide services to guide health professionals, providers, researchers, agencies, policy makers and consumers, to achieve excellence in healthcare delivery to all people, and to continuously improve the quality and safety of care, but does not actually survey or accredit hospitals or clinics itself.

The United Kingdom Accreditation Forum, or UKAF, is a UK-based umbrella organisation for organisations providing healthcare accreditation. Like ISQua, UKAF does not actually survey and accredit hospitals itself.

### ***Accreditation services***

With respect to hospital work, ISO (the International Organization for Standardization) is often mistakenly considered to be an international healthcare accreditation scheme. It is not, it is a system to demonstrate that administrative and other processes are properly considered and has appropriate governance.

## 5.0 OTHER ISLAND EXPERIENCES

### 5.1 Introduction

This section provides an overview of the health systems of three similar territories to Jersey and demonstrates that every Island is experiencing similar issues. Reviewing the experience in other healthcare systems, especially how they have planned to address these issues and improve outcomes can help the States of Jersey inform their whole Island Health Strategy.

### 5.2 Bermuda healthcare

#### *Overview*

Currently the Island compares well with other countries in the Organization for Economic Cooperation and Development (OECD) in terms of life expectancy, infant mortality rates and access to health care. But it fares poorly in terms of ensuring all residents have affordable health insurance coverage which provides a core set of services. Other goals include ensuring smarter use of overseas care, introducing an integrated health IT system, health promotion, and re-engineering the way health care is financed so it can be more cost-effective and ensure better value for money.

#### *The Plan*

Bermuda has developed a plan that sets out 11 health sector goals to improve access, quality and efficiency, which will be implemented over the next two to six years, with specific goals.

- Universal access to basic health coverage shall be assured for all residents of Bermuda.
- Basic health coverage shall include urgent physical and mental health care, hospitalisation, primary care, preventive care and health maintenance.
- Health coverage contributions shall be based on ability to pay.
- Streamlining use of overseas care to get the best value for money for the population.
- Mechanisms to pay healthcare providers and ensure optimal quality to patients and maximum efficiency to the healthcare system.
- An integrated health IT system including a range of information about demographics, medical history and billing. This shall be established throughout the health sector to improve efficiency and quality.
- Implement strategies to meet the healthcare needs of people with chronic illnesses, and physical, cognitive and mental disabilities.
- The quality of healthcare provisions shall be monitored and regulated.
- Introduction of health technology shall be regulated to ensure proper level and mix of resources to efficiently meet the healthcare needs of the population.
- Health professionals and organizations shall promote healthy lifestyles and maintenance of health conditions to curb the amount of chronic non-communicable diseases like heart disease, cancer and diabetes.

### ***Budgetary Issues and improved outcomes***

Bermuda has currently the highest spend on healthcare per capita. The Island is struggling to maintain this investment. They have looked to ways they can utilise skills and improved services by working with the USA. In 2016 The Bermuda Cancer and Health Centre has signed an agreement with a Boston-based counterpart to improve its radiotherapy services. The deal will see the Dana-Farber/Brigham and Women's Cancer Centre provide input into the development of the BCHC's on-island radiotherapy treatment facility and its corresponding programme.

As with other Islands Bermuda has realised it has to focus on treating ongoing conditions. Bermuda has the same health issues as any other country with changing eating habits and stressful life styles generating chronic conditions, Clinicians at the Bermuda Wellness and Outreach Centre have said that the Island needs a new philosophy with an emphasis on the preventive side and funding for lifestyle approach programmes.

More than 75 per cent of the island's population is overweight or obese, according to the Steps to a Well Bermuda 2014 survey, and a third of all adults reported a diagnosis of raised blood pressure or hypertension. Furthermore, the Well Bermuda health promotion strategy in 2008 highlighted that the leading cause of deaths in Bermuda was now circulatory diseases. The Bermuda Wellness and Outreach Centre was set up to promote wellness and to prevent medical problems from happening in the first place. However clinicians are clear that making this shift happen will take a concerted effort of all involved, from policymakers to insurance companies. As one noted

In terms of helping people to change, you need to create that environment, that support system. We also need to make sure that people have accurate information. Currently it costs \$100,000 to fly heart attack patients overseas for treatment, but by focusing on wellness, such events could be avoided and the money could be put towards preventing chronic conditions from happening.

Treating patients at home rather than in hospital has saved the island's healthcare system almost half-a-million dollars, according to the Bermuda Health Council (BHeC). Home Medical Services coverage is also benefiting Bermuda Hospitals Board (BHB) patients and freeing up emergency department services. \$437,520 had been saved through the Home Medical Services benefit between April 2014 and March 2015. New initiatives underway include

These are:

- An enhanced care pilot to better manage select chronic non-communicable diseases in uninsured and underinsured patients, as a result decreasing the probability of preventable, costly visits to the hospital;
- Diversification of Health Insurance Department programmes for HIP and Future Care that will allow more critical benefits that improve health and reduce costs (such as home healthcare, smoking cessation);
- Progression of a modernisation plan of services at the hospital.

Bermuda has introduced its first home dialysis service in 2015 and it is estimated to save the Healthcare system up to \$2 million a year.

In February 2015 a pilot health benefit has provided medical care for patients in their homes, while saving the Island's health system an estimated \$100,000. The Home Medical Services (HMS) pilot benefit was launched by the Bermuda Health Council in collaboration with stakeholders in October 2013. The HMS benefit allows patients to receive specific medical procedures in their home as part of their insurance policy. It was introduced under the Health Insurance (Standard Hospital Benefit) Regulations and the covered procedures and their fees are set and regulated by the BHeC.

### **5.3 British Virgin Islands**

Health care in the British Virgin Islands is predominantly provided by private healthcare providers with an overlay of public support. There is a single public hospital in the British Virgin Islands and one private hospital, with other islands having day clinics to serve non-emergency medical needs of residents of those islands.

Under the Public Hospital Ordinance (Cap 195) free medical treatment is available at all public facilities to the elderly (being persons who are 65 or older), children (being persons aged 16 or under), police officers, firemen, prison officers, public health workers, the mentally ill, indigent persons and prisoners. All other persons must pay for medical treatment received from public health care facilities, although the cost of health care is usually less expensive than from private health care providers.

#### **Administration**

The responsibility of operating the public health system is vested in a statutory body, the BVI Health Services Authority Board (BVI HSA). Peebles Hospital and the various clinics managed by the BVI HSA.

Public health care is effectively subsidised by pricing which is deliberately set below the actual cost of providing care. User fees are estimated to recover just 8% of the operating costs of primary and secondary health care services.

Expenditure on health accounts for approximately 17% of total government expenditure.

#### **Regulation**

All practising physicians are required to be registered under Medical Act, 2000. The legislation covers doctors, dentists, related health care professionals and pharmacists. Nursing professionals are separately regulated under the Nursing Act, 1976.

#### **Overseas health care**

Because of limited resources and problems of economies of scale, public health authorities will sometimes send critical cases overseas for treatment at larger facilities. In addition, many residents of the British Virgin Islands maintain private health insurance which allows them to access health care services in the United States.

### ***Territorial health issues***

Obesity, hypertension and diabetes are amongst the most prevalent of routine health issues in the British Virgin Islands. The British Virgin Islands also suffers from periodic outbreaks of Dengue fever, and was also heavily affected by the 2013–14 chikungunya outbreak.

### ***Social Security***

The British Virgin Islands operates a mandatory social security scheme. In practice because of the large number of migrant workers who leave the Territory before claiming benefits, the scheme is heavily over funded. Social security benefits include maternity, occupational injury, sickness and survivor's benefits. The Social Security Board (SSB) also has the ability to make ex gratia payments in case of need for uninsured persons requiring serious medical care.

### ***National Health Insurance***

Since approximately 2005 various British Virgin Islands governments have considered and commissioned studies into a proposed National Health Insurance (NHI) system. The concept has broad cross party support, and is seen as a way of alleviating the cash-drain caused by underwriting public health expenditure. However, the proposal remains controversial amongst the public, not least because of the perceived cost to the public in a country with traditionally low tax burdens.

Legislation was implemented to bring NHI into effect in 2014. Although the most recently proposal was for NHI to come into effect in October 2014, this did not happen. Implementation was pushed back first to January 2015, and then to September 2015. The most recent announcements have been to the effect that registration of persons will commence on 1 September 2015, and the scheme itself would come into effect on 1 January 2016.

NHI is intended to be funded by a mandatory 7.5% levy on salaries paid to person employed in the British Virgin Islands up to a capped amount of US\$5,791.50 per person. Half of this amount would be assessed against the employee and half against the employer. Where a person is married to a non-working spouse, they will be required to pay a contribution on behalf of their spouse as if the non-working spouse was paid the same salary as the working spouse (i.e. a working spouse will effectively pay double if their partner does not work).

Treatment received under NHI will be subject to a lifetime cap of US\$1,000,000 in treatment, and will remain subject to a co-pay requirement. Proposed co-pays are:

- 0% at community health clinics,
- 5% at the public hospital,
- 10% at private clinics in network,
- 40% at private clinics out of network (with a US\$100 deductible),
- 20% at overseas clinics in network (with a US\$500 deductible),
- 40% at overseas clinics out of network (needs to be pre-approved by Medical Review Committee).

### **Healthcare Agreement**

The British Virgin Islands have signed an agreement with the JIPA Network is a premier association of health care providers which reaches throughout the Caribbean, Central and South America and the United States. This has been done as part of the implementation process of the National Health Insurance.

The JIPA Network has a multi-specialty network of over 16,000 providers, including diagnostic facilities, treatment centres and hospitals. The network provides access to over 303,000 physicians, more than 5,000 hospitals, over 90,000 ancillary facilities and over 1 million health care professional service locations.

## **5.4 Isle of Man**

### **The Manx NHS**

The Manx NHS comes under the control of the Island's own Department of Health and Social Security, which provides a range of services - from hospitals and specialists to district nursing (similar to those provided by authorities in the United Kingdom).

Whilst very similar in structure to its UK counterpart, with which it retains close links, the Manx NHS is regarded as superior in many respects.

### **Department of Health & Social Security**

The Manx Department of Health and Social Security is responsible for family health services, i.e. doctors, dentists, opticians and chemists.

The legislation concerning these services is very similar to that of the United Kingdom - the Isle of Man legislation being almost without exception predominantly based on UK legislation.

### **Noble's Hospital**

In July 1996 the Manx Government agreed to the construction of a new hospital on land on the outskirts of Douglas, to replace the Island's largest hospital, Noble's. The new Noble's was completed in 2003 and in 2007, a new Hospice building was commissioned on land adjacent to the new hospital.

There is a northern community hospital, based on the existing Ramsey Cottage Hospital, and community health services are available in Port Erin in the south of the Island.

All are well-equipped and there are resident consultants in most specialities. The Island is also visited regularly by UK-based consultants.

### **Reciprocal Agreement**

The Reciprocal Health Agreement between the Isle of Man and the UK is mutually beneficial - it means that Manx residents receive free medical treatment in the UK, and vice versa.

### **Budget**

While the island's health service receives £138m from central government, its total spend will be in the region of £178.4m.

The remaining cash - about £40m - is generated from income such as National Insurance contributions, prescription charges and private patient fees.

### **Strategy**

The Isle of Man Government produced a Strategy document called Health and Social Care in the Isle of Man - the next five years, in August 2015. Many of the proposals were previously discussed in January 2011, when the then Department of Health published 'A Strategy for the Future of Health Services in the Isle of Man'. It included a vision of how services would look in 10 years. Key points were:

- The health service will become a true 'health' service and not just an illness service, by shifting emphasis from cure to prevention, screening and earlier intervention;
- Health services will be planned and designed around the health needs of the population;
- Vulnerable groups of all ages will receive appropriate care;
- The balance of care will move from hospital to community-based services.

The strategy focuses on many of the key issues affecting other jurisdictions. The Isle of Man first strategic goal is for people to take greater responsibility for their own health.

The second strategic goal is to help people stay well in their own homes and communities, avoiding hospital or residential care whenever possible. To achieve this they want to achieve a much closer integration of services working in the community. They need primary healthcare, mental health and social care services to work together to treat people as complete individuals instead of dealing with different aspects of their care in separate organisational silos.

The third strategic goal is to improve services for people who really do need care in hospital. They have modernised procedures in the Acute Hospital and are improving its performance. This will be done by switching more routine work into the community, closer to people's homes. This will free up the capacity of staff in the hospital to do the work that only they can do. They intend to use telemedicine and other advances in technology to deliver a high standard of care. They will ensure pathways are in place to enable patients to access specialised care from UK centres when it is not available on-Island.

The fourth strategic goal is to provide safeguards for people who cannot protect themselves. And the fifth strategic goal is to ensure that people receive good value health and social care.

The projected total Government expenditure on these services in 2014/15 was £234 million.

### 5.5 Summary of systems in similar territories

Country	Population	No of hospitals	Funding	Beds per 1,000 persons	Health care spend per capita	Reciprocal Healthcare Agreement
Bahamas	345,000	3	Public, non-mandatory private insurance, self-pay	3.76	\$1,819 (2014)	Yes
Barbados	300,000	1	Government funded, private insurance and self-pay	2.17	\$1,014 (2014)	No
Bermuda	65,000	2	Government subsidy, Government health insurance and mandatory private insurance	7.00	\$11,252 (2014) Highest in the world	None
British Virgin Islands	30,000	1	Government subsidy, non-mandatory private insurance	1.74	\$5,791 (2015)	No
The Cayman Islands	57,000	2	Indigent provision and Government subsidy, mandatory private insurance	2.76	\$1,500 (2014)	No
Gibraltar	27,000	1	Public Funding, private insurance	7.00	\$4,538 (2015)	Yes UK Spain
Guernsey	63,000	1	Public subsidy and private co-pay for primary care, secondary care Government funded, private insurance	3.97	\$2723 (2016)	Yes
Isle of Man	86,000	2	Government funded, private insurance	4.06	\$2,473 (2015)	Yes UK
Jamaica	2,700,000	23	Primary Government funded, charitable funding and private insurance	1.92	\$476	No
Malta	421,000	6	Mainly Government funded, private insurance and self-pay	4.45	\$3,072	Yes
The Turks and Caicos Islands	31,000	2	Government funded (national insurance plan), private insurance	0.94	\$215	Yes
Trinidad and Tobago	1,300,000	9	Government funded and private insurance	2.73	\$1,743	No

## 6.0 REVIEW OF MANAGEMENT

### 6.1 Governance and PMO

Note: The reviewer could not review the detailed Programme Plan because it was not ready in time for this report to be completed. The Critical Path was also not available for review but the author of this report was advised the Programme is a risk, therefore they were going to de-risk it by not putting very much on the critical path. This is considered a usual approach to a health construction project.

The project, and the strategies under consideration or implementation by the States of Jersey, have a strong, hierarchical governance structure. From the information provided it is evident too that there has been significant elected member and officer involvement and debate throughout the development of the scheme, in particular on the site and specification of the new hospital.

However there is much less evidence of reporting against the key success criteria and objectives of either the programme or the specific project. They are the key success factors that the programme / project must achieve, against which success, during development and construction and on completion, must be judged. In the information provided some criteria are alluded to, such as the need to provide the new facility by 2020, but, at least at a strategic level do not seem to form the core of the programme and project. As noted in other sections of this report the objectives and CSFs for the hospital project should support the objectives of the overall health strategy as well as directly inform processes such as the options appraisal.

Additionally whilst there is a role for the client department and some evidence of discussions with clinicians there was no actual evidence that they are at the centre of programme and project development. The role of patient / user / carer representatives seems even less explicit. Ensuring both of these groups understand the need for change, and support the proposals presented to drive that change will be critical.

Two key documents that were not identified during the review process was a Benefits Realisation Plan and a Post Project Evaluation strategy (PPE). The former it should be noted is not synonymous with the benefits appraisal criteria, although they should be linked. It is essential that both the programme and project not just identify the benefit required but also how they will be achieved, who is responsible and how success will be evaluated. The PPE strategy, whilst a long-term process, should be identified early in the process to ensure that data for baseline activity (i.e. pre-change) can be collected.

### 6.2 Timetable

Progress to date has been slow. The appraisal has taken much longer than it should have, especially given the stated desire to have a replacement in place by 2020. As noted above there has been insufficient emphasis and reporting placed upon time – finding the best option is of course very important, but so is the achievement of key success criteria.

The work completed to develop the site options show a reasonable project plan, noting of course that the options are now out of date. In particular there is sensible consideration of the pre-construction phase which is very often squeezed, generally to the detriment of the

project, in the author's experience. The construction period allocated is also reasonable and provides a proper balance between realism and contingency for the unknown.

## 7.0 FINANCE AND COST CONSIDERATIONS

### 7.1 Procuring care off-Island

The cost of procuring care and services off-Island very much depends on the scope of that procurement, from which country or entity The States are procuring, and the governance arrangements required.

One example of how much commissioning services will cost the States of Jersey is based on Corby Clinical Commissioning Group (CCG). The CCG serves a population of 73,000 and is responsible for commissioning around 80% of services (the rest being done regionally or nationally). The Corby CCG administration function has a yearly budget of £1.56 million.

This is a good comparison to the Jersey population as the States of Jersey will not be looking to procure off Island services for the whole 99,000 residents.

As with all healthcare commissioning the more accurate your activity levels can be then, the easier budgeting will be. As with all procurement buying more will result in economies of scale and marginal cost savings in the cost of that procurement. Part of the negotiations will need to include a clear and well scoped requirements document as well as clear KPIs to ensure quality and improved outcomes for the patients receiving the treatments. Monitoring of Off Islands services will be difficult and will require high quality data so that the States of Jersey can compare 'like for like services'.

### 7.2 Cost effectiveness of off-Island care

A provider undertaking a greater volume of work will generally be able to provide a service at a lower price thanks to economies of scale and greater ability to hold and smooth risk. Whilst this is slightly simplistic for healthcare it nevertheless is a reasonable initial touchstone. However there are several influencing factors that will determine the most cost effective location for services including;

- Type of services – clearly inpatient and specialist services will be significantly more cost effective off-Island.
- Location – Whilst French providers are closer the different standards and cost profile may mean that any savings in travel costs are reduced by higher clinical costs.
- Need for rehabilitation and post-operative care: if this must be conducted by the original clinician and cannot be done via telecare then any savings from the original treatment may be lost.
- Ability to purchase block contract – where significant activity can be contracted, even if from multiple locations, then better deals can be struck.
- Risk of medical complication requiring specialist support – where this is high then treatment on the Island may not, on balance, be cheaper.

Whilst financial sustainability is vital it should be noted that the first question must be to ensure that services are provided in the place most suitable for clinical risk, both at a population and at an individual patient level.

Appendix 3 provides an example of which medical specialities could be provided off-Island, on-Island or through other models.

### **7.3 Cost implications of providing care off-Island**

The principle cost of providing care off-Island will be the hospital, medical, nursing, and clinical support costs of the direct care or treatment. However in addition other costs that will need to be considered include;

- Travel of the patient, which may require specialist transport or support.
- Travel and accommodation for a carer, especially for longer-term conditions or admissions.
- Rehabilitation and post-admission care may require some travel back to the original clinician.
- Support for personal, medical, travel insurance where exclusions are likely to apply.
- An agreed price will have a set specification of services but where these are not met, for example additional diagnostics or longer length of stay, a premium rather than a marginal additional cost may be applied.

### **7.4 Comparative costs in Europe**

There is little or no substantive data available on this subject publically. Additionally to complete it significant volumetric data would be required from the States of Jersey – to provide a really useful picture activity and costs at an OPCS or HRG level would probably be required. It is therefore suggested that this should form a separate piece of work.

## **8.0 OTHER CONSIDERATIONS**

### **8.1 Provision of care and service on Island and off Island**

All users of healthcare question whether they are getting value for money, especially those who have to pay directly (i.e. not through taxation) for the services they receive. As part of a wider change in societal attitudes healthcare provision is becoming increasingly consumer driven.

Key issues that are effecting all healthcare provision but which is especially penitent to Island services include:

- Service capacity, utilisation and variation

- The role of primary and community care, especially in improving healthcare outcomes and well-being
- Creating the right financial incentives for providers and users – funding methods and payment reform
- Infrastructure – ensuring effective healthcare delivery

Many Island healthcare services are finding it difficult to control the use of high cost diagnostics and overseas treatments. At the moment many payment systems pay for care activities and do not reward avoidance of ill-health, management of long-term conditions, the integration of services or the outcomes of care. Even though many systems have been adapted to different models of pay – they all seem to suffer from a clear supply induced demand effect. To minimise the issues of capacity you must either restrict supply or reduce demand.

Essential Care Services	Primary Care Services	Inpatient Services	Catastrophic Only	Comprehensive
Package is limited to only the most essential intervention to avoid death and disease, for example, vaccines.	<p>Services limited to those that can be provided by a general practitioner (GP) in an outpatient setting.</p> <p>Drugs may or may not be included for primary care managed conditions.</p>	<p>Coverage includes only care that is provided in hospitals.</p> <p>Inpatient drugs linked to a specific intervention are typically included.</p> <p>Drugs required after discharge are not included.</p> <p>Potential bundling with pre-and-post hospitalisation follow-up visits.</p>	<p>Typically includes only the highest cost, non-elective procedures that could lead to financial ruin.</p> <p>Examples would include cancer treatment or dialysis.</p> <p>Potentially defined as all care in excess of certain expenditure.</p>	<p>Usually covers all nonexperimental care available to patients.</p> <p>In many cases, the lack of a specifically defined package determines the comprehensiveness of the package by availability of domestic supply.</p>

**Table 8.1 - Defining the package of services**

Island Governments and insurers can influence the cost of the system through the level of coverage they make available. Table 8.1 outlines some key options, or configurations, that may be considered in developing a basic package. Inevitably there can be significant variation between how these are defined. However the critical issue is to ensure that there is a clear, transparent set of principles that is easily understood.

With all healthcare commissioning there is a difficult balance between creating excess capacity in the healthcare system and providing effective care to patients.

For most cases it is not cost effective to provide all services locally and depending on the volume of cases, it may be more efficient and effective to use overseas specialist facilities rather than provide these services on island.

We know that the States of Jersey already commission some off Island services e.g. Oncology. Therefore, if there is relatively low demand on an island for a specialised medical treatment it may be more appropriate, from a cost and quality of care perspective, to transfer the care to a specialist overseas provider.

### ***Funding Methods and payment reform***

It must be ensured that any service that is provided is value for the Payers (insurance companies), providers and patients. It is clear that both insurers and governments are reviewing how they pay for services by either changing the coverage of the cover or by developing outcome based reviews. This can also be seen within the NHS in England and Wales where the commissioning based model has been developing over the last 5 years.

However application of a pure value for money model can move too far, leading to a focus only on low cost interventions, which can stop innovation and evolution. As stated previously healthcare services need to move away from the silo based that most Island services have followed and move to an outcome based payment approach.

Moving away from the micro-management approach where strict treatment criteria and pre-authorisation is essential but known to be expensive to operate and does not focus on the value for the patient. This approach fragments care and often moves the risk and responsibilities away from the care giver to the payer.

A further approach is to develop outcome measures to allow payment by performance. Standardisation of inputs and pathways are essential to this to allow for full transparency and accountability. This approach also requires good governance and end to end processes to be in place and audited.

As discussed previously discussed changing patient behaviour by directly restricting patient choice, by either redefining the patient journey and the introduction of payment systems can encourage the use of primary care rather than always going to hospital.

### ***Infrastructure***

Infrastructure is more than the bricks and mortar of the hospital. It is all the components that make an Island Healthcare provision function in an efficient and effective way. Lessons learnt show that too much focus is put on the buildings and specifically the acute hospital, as important as that is. Too often, in Island communities and even national systems, hospitals are over specified, take too long to bring into operation, too expensive to operate, and cannot be adapted to meet different care provisions – they are often not fit for purpose as soon as they open.

Whether on an Island or not buildings have to be developed so they can deliver flexible healthcare, that the accommodation can be used for many different services and that the patient is considered throughout the design. This is not just simply about design – capacity has also to be considered – for example care models in all specialities are increasingly moving away from inpatient to day case and outpatient based care and interventions. The latter require much less space, but much more specialist accommodation.

Additionally, there is little point in developing a hospital that cannot be staffed appropriately and sustainably. Relying on expensive agency staff or other short-term measures of recruitment will be increasingly inappropriate financially and in terms of patient safety. Reviewing the whole staffing strategy, medical, clinical, support and managerial, is key to understand how the hospital and wider Island provision will operate. Staffing shortages are effecting many countries healthcare provision so the Island must operate in an increasingly competitive market. Therefore looking on how the staff can be engaged, how their jobs are designed and professional development is guaranteed, together with items such as pay and conditions is essential. It may be seen as part of a broader review for key workers, especially as many of them will be in relatively lower paid roles in an area with a very high cost of living.

Technology is a tool that can enable better scheduling and management of care provision. It can ensure that the most cost evident service is being delivered while also ensuring that the patient is being given a better service.

Advanced analytical tools have allowed clinicians and researchers access to structured and unstructured data. Providing a wealth of information not previously available to providers and payers. This allows for healthcare systems to be reviewed and redesigned to ensure that patient centric care is provided.

To ensure we move always from silo based care, information sharing across both health and social care is essential. Moving to a multi-disciplinary team approach for most acute and chronic disease management has shown that there are better patient outcomes and reduced admissions.

Using the patient to monitor and ‘manage’ their own condition is still in its infancy but results are promising. Utilising data from mobile fitness tools (Apple Watch, Fit-bits etc.) as well as the wealth of fitness and medical apps has still not be explored formally on the Island.

### **Conclusion**

It is clear how a low-cost, high-quality health system can be built. Delivering it is, however a very different prospect, especially when the stakeholders have different, sometimes conflicting drivers and very different perspectives.

It is essential not to base the solution on the physical buildings involved in the delivery of care but to understand the strategic options and models that are available to the States of Jersey. Agreeing on what will be provided on the Island and by whom, needs not only

consultation but intense analysis of data and planning with clinicians, users and the general public.

To ensure the success of low-cost/high quality delivery requires excellent strategic and operational management. Clinicians must be empowered and be allowed to create the right environment for integrated healthcare with suitably strong management to ensure that political imperatives and operational needs are properly synchronised.

The aim for the Island to move to its own single electronic healthcare record (EPR) is essential to allow integration and greater collaboration on and off island. The Island needs to move to this end goal quicker especially if admin and non-clinical staff are going to be moved off the current site quickly to facilitate the decant plans discussed within the interviews. At present the solution is mixed and will require the movement of paper records across sites for at least some if not all of the building work. This will increase cost, reduce clinical efficacy and increase risk to the project.

Using an integrated electronic patient record allows for metrics to be used and for real-time data to be available. KPIS, targets and outcomes can be visible via a portal allowing transparency across the health economy. Use of the data throughout the patient journey is a powerful tool. Correct use of this data can drive improvements, quality of care and allow for much more detailed healthcare planning.

Payers need to move away from standard contracts and use outcome based payment mechanisms which focuses on the whole health of the population.

Both corporate and clinical governance process are essential for the success of this approach. Investment will be needed into governance and oversight to ensure that performance measurement is carried out and acted on.

Looking at the demographics of the population allows focus to be given to the high demand areas – more emphasis should be placed onto primary care and the prevention as well as the treatment of chronic conditions.

No one group can create a successful healthcare service. Payers, providers and patients all have their part to play.

## **8.2 Telehealth and Telecare**

The Island are using some Telehealth solutions but more focus needs to be placed on this. It is understood no additional work can be done until the next phase of funding is approved in September. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Telehealth is different from telemedicine because it refers to a wider scope of remote healthcare services than telemedicine. While telemedicine refers specifically to remote

clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

Telehealth is a powerful tool to help improve outcomes and lower costs. Telemedicine can serve as vital connective tissue for expanding healthcare organisation networks, when properly implemented and supported. Telehealth has the potential to reduce healthcare costs while simultaneously delivering medical services to underserved or rural communities. Advancements in mobile technology and applications, along with interest in cost-effective healthcare and rising populations, are driving the growth of telehealth.

Telehealth can provide benefits to individual patients, family members or health care providers, and to community organisations, healthcare facilities, and governments. Examples of the benefits of telehealth are given below.

### ***Direct and Indirect Benefits***

- Improve the way patients and their families' access information and learn.
- Result in improved health outcomes for patients.
- Empower consumers and communities by providing accessible health education and decision-making options.
- Improve the way healthcare providers deliver care, access information, and learn.
- Enhance recruitment and retention of healthcare providers in rural or remote areas.
- Lower healthcare costs, reduce travel, minimize time off work, and decrease patient waiting time.
- Decrease self-reported patient anxiety.
- Eliminate unnecessary repeat diagnostic procedures or tests.
- Improve and hasten early diagnostic capabilities.
- Improve administrative and communication capabilities.
- Improve emergency triage.

### ***Economic Benefits:***

- Increased research and development investment.
- New business focus for existing and new companies.
- Increased international competitiveness at local, regional, national, and international levels.
- Job creation.

Recent advances in information technology and telecommunications have made telehealth both affordable and feasible. As a result, telehealth has been recognised as a tool that holds

the promise to provide better health, more informed choices, and equitable access to timely, efficient, and quality healthcare and health information. Research is critical in order to continue to determine the impacts and benefits – and limitations - of telehealth.

Appendix 4 includes case studies from a number of different health economies and provides details of the benefits realised from the use of telecare, telemedicine and other ICT-based programmes.

## 9.0 RECOMMENDATIONS

From what we have read and learnt that the hospital project has been driven by the building and physical requirements rather than the clinical and service strategy and patient journey. There seems to have been little consideration or review of current community and primary care estate and how services could be moved out of the acute environment. These could not just be financially advantageous but is likely to be clinically more sustainable and provide a higher quality, more patient-focused service.

The report has benefitted from the provision of a second batch of documentation and a day of targeted interviews with key members of project and associated staff. The information gathered from this has informed this revision to the original report. It should be noted however that some items that were requested could not be provided in time for inclusion (such as the detailed programme plan). Additionally due to unavailability interviews could not be held with representatives of some key workstreams, such as ICT, although written responses to key questions were provided eventually.

It is still the opinion of this report that there are some very significant and fundamental issues relating to the project, which threaten the affordability, effectiveness and management of the programme, before, during and after any implementation of a new hospital.

Listed below are our recommendations to the Sub-Panel.

### 9.1 Whole health economy view

The hospital project must link to a service-wide strategy so that health provision is a coherent, integrated whole approach to well-being.

- a. The ultimate aim must be to identify the “end to end” healthcare provision that or how this is best provided clinically and financially.
- b. Integration of acute, community, and primary care services is essential to providing good services. This can only be done if we approach things as a whole health economy, not piecemeal.
- c. The service (like health systems everywhere) has massive pressure now and daunting issues building for the future – radical change is therefore needed to address the challenges of increasing need, workforce changes, ramping expectations, increasing patient complexity and life expectancy, inflationary

cost pressures. A “like for like” replacement of acute services is not a sustainable solution.

- d. Strategy must be health-outcome driven - at the moment is too input driven, particularly the acute hospital.
- e. Work has been done to consider how services can be delivered in different ways that will be clinically safer, financially more sustainable, provide greater patient-centred care, and enable greater flexibility in the short term but there is concern that the longer term 10 years plus little planning has been done.

## 9.2 Inclusivity

The strategy, and the work-streams, need to be approached in an inclusive way:

- a. Political oversight is vital but should principally consider the strategic elements, not the operational or detailed technical elements. This project at this stage should not be political. It should be driven by the clinicians, payers and patients. Once the whole Island Clinical Strategy is agreed then political oversight will be critical to realising the vision.
- b. Public / patient / carer ownership of change will be vital so they must be brought into the tent of discussions and development.
- c. An external “critical friend” would be a very helpful role to develop – this should not be part of the local establishment, nor part of one of the existing advisor, and must have no local axe to grind. Their primary task will be to continuously question whether the work-stream is focussing on the key success criteria and overall objectives.

## 9.3 System sustainability

Health services need to be considered to ensure that they are provided in the most clinically and financially sustainable way (both the service model and the physical location).

- a. Criteria need to reflect what is safe to do where (now and in the future), what we can afford to do in different places (whole episode not elemental costs), and what we must have locally to ensure reasonable access.
- b. For services to be provided on-Island what can only be done in an acute setting needs to be identified and what would be better provided in facilities in the community and whether a Community Hub (mobile service is something that should be considered). Some of this work has been done but the next phases are dependent on business case approval.
- c. For services to be provided off-Island what must be done by the patient travelling and what can be done via telecare or telemedicine. Again work has

started but not far enough advanced. The next phase is dependent on funding approval.

- d. In order to identify the best place to provide services the system will need to develop clinical pathways and undertake activity modelling. This has been started but not far enough advanced to demonstrate the effect on acute activity.
- e. Even though this is outside of the brief of the report we recommend that, as many other jurisdictions have done, the States of Jersey should review how healthcare can be funded sustainably in the future. Some of this work has been discussed in this document and was also considered in the work completed by KPMG in 2015. This work is about to start. It should not be underestimated how long this could take to complete.

#### **9.4 Joint purchasing**

As part of the overall approach to developing the service model the States of Jersey should consider the development of joint purchasing partnerships with similar communities and territories.

- a. There is the potential not just to benefit from economies of scale but also to share best practice and financial risks and to develop other inter-island services.
- b. Other Channel Islands are the obvious initial partners especially as likely to be using the same facilities off-Island.
- c. Other territories to consider include the Isle of Wight and the Isle of Man. Although part of, or very associated with, the NHS in England they are undertaking similar reviews and / or transformation as they face an almost identical set of issues.
- d. A strong theme in written and verbal evidence is that Jersey is unique. It does have individual pressures and issues of course. However the vast majority of the most important pressures and issues are shared with other island jurisdictions (and indeed the rest of the UK). Learning from others, and where possible sharing the burden with others, is not a sign of weakness but an understanding that learning from experience elsewhere is by far the cheapest way of developing a new project.

#### **9.5 Inputs to project**

The project would benefit from a much greater understanding of all of the inputs that enable good healthcare provision. There is a need to ensure that we understand what the Island already has; what are the opportunities, what are the constraints, which should include transportation, staffing and skill levels.

- a. ICT – Is essential for the success of this project. It is clear during the interviews that ICT has fallen behind the rest of the projects. There is some integration of solutions but there is no evidence of one overall plan and how this is linked into the Programme Plan. The report is extremely concerned by the fragmented approach to ICT.
- b. Workforce – Whilst the project has identified and analysed projections for ageing and demographics and the impact on service, the report does not believe that it has long-term sustainable plans to resolve recruitment and retention, especially given the noted ambitions for acute services. As affordable accommodation and housing seem to be a real issue for healthcare workers what can the States do to provide a more sustainable solution.
- c. Site appraisal – The technical appraisal of the sites for the new acute facility is strong and follows best practice in the vast majority of aspects. However the report understands that the current preferred option is a rebuilding on the existing site. We can find no evidence as to why this should be based on the qualitative, quantitative, and financial analysis undertaken in pain-staking detail previously. At this juncture the report cannot support this decision nor the process behind it.

## 9.6 Next steps

It would be foolish to throw out what has been done up to now in regard to the acute hospital project as it is certainly not all wasted. However the following must be considered;

- a. The technical elements of project completed are very strong but they do not link to the rest of the health service strategy. In essence currently the project, and thereby the specification for the hospital, has put bricks before clinical pathways.
- b. A key question is to ask how the new facility can be made flexible so that it can meet the needs of continually evolving healthcare provision and best practice. The design, specification, and approach are predicated on a very restricted model and may, eventually, restrict and limit services rather than enable them.
- c. As noted previously it is essential to review design and specification to consider how these support the local service strategy.
- d. There is currently no decant plan or Programme plan available to the report. This is of great concern to the report as affordability and timing of the project are not clear at this point.

- e. In summary the critical question to consider for the hospital project is “Does this enable the new service model and support the objectives of providing appropriate, safe services, with reasonable access at a cost that is affordable in the long-term?”
- f. It is essential going forward that there is clearer executive leadership of the programme. At the moment the shared responsibility, especially as this relies on staff with extensive portfolios including operational leadership, results in a programme with insufficient focus on delivery and on risk. It is recommended that there is one overall programme director, directly reporting to the Board, who has the responsibility for delivery across all workstreams of the programme. There are numerous examples of where uncertainty in this leadership, coupled with insufficient self-criticism and too much focus on one aspect (be it building or clinical services), has led to significant problems in projects or clinical services post implementation. From the author’s experiences this has happened in a number of high-profile schemes including, St Mary’s Paddington, Pembury, Hertfordshire, Maidstone, Hinchingsbrooke
- g. The States of Jersey to consider how it can best look to develop closer ties with other health economies to the benefit of all parties and to assist in both operational delivery and strategic planning for services.
- h. As a result of the evidence provided it is suggested that the States of Jersey would benefit from an ICT Director for the Island with responsibility for all elements of health and social care (including primary, community and acute) to address our stated concerns that current strategy is fragmented, led by different departments with different aims, and with insufficient senior skill sets and experience.
- i. The programme appears to be highly dependent on funding streams and business cases that have not yet been through the correct approval processes and which will heavily rely on consistent government policies and priorities over the next 10 years.
- j. The timeline, for a relatively small programme team, is very challenging in all phases, especially given the highly complex nature of the current preferred option of building on a clinical site whilst it remains operational. Note this concern is equal for the developmental (i.e. business case) and construction phases.

## APPENDIX TWO

### Suggestions for Welwyn Garden City LGH Project

<i>Project Objectives</i>	<i>Critical Success Factors</i>	<i>Appraisal Criteria</i>
<ul style="list-style-type: none"> <li>To enhance the therapeutic environment for patients and thereby deliver improved health outcomes and greater access</li> <li>To enhance the physical environment for patients thereby helping to enhance health care provision.</li> <li>To improve access and facilities for the disabled and to comply with other health and safety and statutory obligations.</li> </ul>	<ul style="list-style-type: none"> <li>Design based on contemporary service models and clinical requirements</li> <li>Full compliance with DDA and H&amp;S legislation</li> </ul>	<ul style="list-style-type: none"> <li>Building quality i.e. extent to which building will be able to be compliant and enable contemporary models and provide future proofing</li> </ul>
<ul style="list-style-type: none"> <li>Demonstrate PCT commitment to provision of community care based services for population served currently by QEII</li> <li>Enable the delivery of the DQHH Programme in E&amp;N Herts including service model redesign</li> </ul>	<ul style="list-style-type: none"> <li>Delivery of a visible investment in WGC area including LGH</li> <li>Delivery of the LGH and acute consolidation, as specified in the OBC, by end 2013</li> </ul>	<ul style="list-style-type: none"> <li>Access to care i.e. Option enables provision of a wide range of services</li> <li>Clinical quality</li> <li>Capacity i.e. degree to which option will have capacity and flexibility to accommodate current and future demands</li> </ul>
<ul style="list-style-type: none"> <li>Ensure 85% of WGC population can access urgent care facilities &lt; 20 minutes and 97% &lt; 30 minutes</li> <li>Maintain local access to community care services</li> </ul>	<ul style="list-style-type: none"> <li>Provision of urgent care services</li> <li>Enabling the reprovision of key outpatient services in line with the new care model</li> </ul>	
<ul style="list-style-type: none"> <li>Provide a designed for purpose, flexible, sustainable new building that enable the enhancement of local community services</li> </ul>	<ul style="list-style-type: none"> <li>Design to HBN principles</li> <li>Innovative design developed to BREEAM 'excellent' &amp; AEDT 'Excellent'</li> </ul>	<ul style="list-style-type: none"> <li>Sustainability (Health, social, economic, environmental)</li> </ul>
<ul style="list-style-type: none"> <li>Sustainable financial balance across the local health economy</li> </ul>	<ul style="list-style-type: none"> <li>Business case demonstrates affordable solution to PCT</li> </ul>	<ul style="list-style-type: none"> <li><i>Business Case approval</i></li> </ul>
<ul style="list-style-type: none"> <li>To facilitate achievement of service and estate performance targets</li> </ul>	<ul style="list-style-type: none"> <li>Contemporary design and technology utilised</li> </ul>	<ul style="list-style-type: none"> <li>Achievement of CIAMS targets</li> </ul>
<ul style="list-style-type: none"> <li>Ensure Public and Stakeholder engagement</li> </ul>	<ul style="list-style-type: none"> <li>Effective communication with these groups, events and feedback</li> </ul>	<ul style="list-style-type: none"> <li>Support for proposals and planning approval</li> </ul>
<ul style="list-style-type: none"> <li>Minimise disruption during a period of significant change by enabling a smooth transition between models of care</li> </ul>	<ul style="list-style-type: none"> <li>A full transition and change management plan both at project and programme level</li> </ul>	<ul style="list-style-type: none"> <li>Transition (i.e. Potential for project to "dovetail" with overarching programme)</li> </ul>

## APPENDIX THREE

### STATES OF JERSEY – HOSPITAL REVIEW PROJECT

#### HIGH LEVEL SERVICE MODEL

The tables below provide an example of how healthcare services could be provided in different locations or through different models. The allocation is **NOT** based on the requirements or opportunities specific to the States of Jersey but demonstrates the potential breadth of opportunities. A model specific to Jersey will need to be based on discussions with local clinicians to understand the safety and sustainability of services, with officers of the States to understand financial implications, and with elected members and the public to identify services that they feel **must** be provided on Island. In fact the process would need to be completed at an HRG (Health Resource Group) level as almost no speciality will be as clear cut as is suggested in the table.

The specialities below are based on the UK General Medical Council's approved list of specialities and sub-specialities training curricula. There is a multiplicity of potential models and locations but the table below simplifies this to a number of key opportunities;

- Inpatient services
  - On-Island – Undertaken within the Jersey acute facilities
  - Either – Could reasonably be undertaken on or off-Island
  - Mixed – Speciality has no clear preference for either off or on Island
  - Off-island – Should be undertaken off-Island
- Daycase services
  - Please note it is assumed that no daycase services would be provided off-Island for logistical and insurance reasons
- Outpatient services
  - On-Island acute = Should be undertaken in the Jersey acute facilities, usually because of the need for diagnostic support
  - On-Island community – Could be undertaken away from the Jersey acute facilities
  - Telemed(icine) to UK – Potential to use telemedicine to link to off-Island services
  - Off-Island – Activity needs to be done off-Island

## Inpatient services

On-island	Either	Mixed	Off-island	Comment
Anaesthetics				
<i>Anaesthetics</i>				
✓				A full anaesthetic service will be required, the vast majority based on the acute facility. If any community-based day case or outpatient procedures then this will need to be supported in terms of training and a peripartetic service
Intensive care medicine				
✓				Intensive care must be present as a requirement for any level of complex surgery and emergency care
Emergency medicine				
<i>Emergency medicine</i>				
✓				Assumed that at a minimum all patients will be stabilised on the island even if subsequent treatment (emergency or as part of rehabilitation) is off-island
Paediatric emergency medicine				
		✓		Assumed that although all patients will be stabilised on the island that there will need to be a greater proportion transferred at an earlier stage in clinical pathway
Pre-hospital emergency medicine				
✓				Out-of-hours GP and non-ED medicine included under this section
General practice				
✓				Specifically this refers to GP access beds, on-going rehabilitation (inpatient), “step down”, intermediate care and similar accommodation
Obstetrics and gynaecology				
<i>Gynaecological oncology</i>				
		✓		Assumed more complex oncology will need to be conducted off-island
Maternal and foetal medicine				
✓				There will be exceptions with especially high-risk patients
Reproductive medicine				
	✓			Dependent on local resources and clinical skills available
Urogynaecology				
✓				Pre-dominantly lower complexity
Ophthalmology				
✓				Assumed predominantly can be done locally provided local skills available
Paediatrics				
<i>Child mental health</i>				
		✓		Some services must be provided locally including initial intervention, crisis management, and on-going therapy
Neonatal medicine				
		✓		Provision of maternity and associated services will require some level of neo-nate on island but complex or long-term support may be better off-island

On-island	Either	Mixed	Off-island	Comment
Paediatric allergy, immunology and infectious diseases				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric clinical pharmacology and therapeutics				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric diabetes and endocrinology				
		✓		As specialist and relatively rare nature of service will be off-island but longer term management on-island
Paediatric emergency medicine				
✓				Some level of service required on island
Paediatric gastro-enterology, hepatology and nutrition				
		✓		As specialist and relatively rare nature of service will be off-island but longer term management on-island
Paediatric inherited metabolic medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric intensive care medicine				
		✓		Some level of intensive care must be provided on the island or will significantly limit elective surgical and emergency services that can be supported
Paediatric nephrology				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric neurodisability				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric neurology				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric oncology				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric palliative medicine				
		✓		It is assumed that longer-term and end stage management will be on-island but specialist service will be off-island
Paediatric respiratory medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric rheumatology				
			✓	Specialist and relatively rare nature of service suggests off-island
Pathology				
Chemical pathology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Metabolic medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Diagnostic neuropathology				
			✓	Specialist and relatively rare nature of service suggests off-island

On-island	Either	Mixed	Off-island	Comment
Forensic histopathology				
			✓	Specialist and relatively rare nature of service suggests off-island
Histopathology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Cytopathology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Medical microbiology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Medical virology				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric and perinatal pathology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Pharmaceutical medicine				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Physicians / General medicine				
Allergy				
			✓	Specialist and relatively rare nature of service suggests off-island
Audio vestibular medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Aviation and space medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Cardiology				
✓				Island should seek to provide a full service
Clinical genetics				
			✓	Specialist and relatively rare nature of service suggests off-island
Clinical neurophysiology				
		✓		Some support required for other services
Clinical pharmacology and therapeutics				
	✓			Dependent on local resources and clinical skills available
Dermatology				
✓				Island should seek to provide a full service
Endocrinology and diabetes mellitus				
	✓			Dependent on local resources and clinical skills available
Gastro-enterology				

On-island	Either	Mixed	Off-island	Comment
✓				Island should seek to provide a full service
Hepatology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
General (internal) medicine				
✓				Island should seek to provide a full service
Metabolic medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Genito-urinary medicine				
✓				Island should seek to provide a full service
Geriatric medicine				
✓				Island should seek to provide a full service
Haematology				
✓				Island should seek to provide a full service
Immunology				
	✓			Service specification will depend on local demand and clinical sustainability
Infectious diseases				
			✓	Specialist / relatively rare nature of service suggests off-island but some of emergency provision will be required
Medical oncology				
		✓		Assumed general services on island with specialist and support functions provided off-island
Medical ophthalmology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Neurology				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Nuclear medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Paediatric cardiology				
			✓	Specialist and relatively rare nature of service suggests off-island
Palliative medicine				
✓				Island should seek to provide crisis and longer-term care on island
Rehabilitation medicine				
✓				Island should seek to provide a full service
Renal medicine				
		✓		Assumed general services on island with a few specialist support functions provided off-island
Respiratory medicine				

On-island	Either	Mixed	Off-island	Comment
✓				Island should seek to provide a full service
Rheumatology				
✓				Island should seek to provide a full service
Stroke medicine				
✓				Island should seek to provide a full service
Tropical medicine				
			✓	Specialist and relatively rare nature of service suggests off-island
Psychiatry				
General psychiatry				
✓				Service expected
Rehabilitation psychiatry				
✓				Service expected
Substance misuse psychiatry				
		✓		Expected that inpatient may be off-island with some crisis beds locally
Child and adolescent psychiatry				
		✓		Some provision will be required on the island
Forensic psychiatry				
			✓	Specialist and relatively rare nature of service suggests off-island
Old age psychiatry				
✓				Strong service will be required
Liaison psychiatry				
✓				Expected service to be provided with any acute provision
Psychiatry of learning disability				
✓				Service expected
Medical psychotherapy				
			✓	Specialist and relatively rare nature of service suggests off-island
Radiology				
Clinical oncology				
		✓		Assumed general services on island with specialist and support functions provided off-island
Clinical radiology				
✓				Essential to enable location of other services on the island
Interventional radiology				
✓				Essential to enable location of other services on the island
Sexual and reproductive health				

On-island	Either	Mixed	Off-island	Comment
		✓		Some services can be done on island but more specialist such as IVF must be off island
<b>Surgery</b>				
<b>Cardiothoracic surgery</b>				
		✓		Will be important to retain service on the island but more specialist will need to be off island
<b>Congenital cardiac surgery</b>				
			✓	Assumed to be too specialist
<b>General surgery</b>				
✓				This refers to more basic, lower complexity
<b>Neurosurgery</b>				
		✓		Will be important to retain some basic service on the island but more specialist will need to be off island
<b>Oral and maxillo-facial surgery</b>				
		✓		Will be important to retain some basic service on the island but more specialist will need to be off island
<b>Otolaryngology</b>				
		✓		Will be important to retain some basic service on the island but more specialist will need to be off island
<b>Paediatric surgery</b>				
		✓		Assumed that the majority will be off-island but basic and post-operative care could be done on island
<b>Plastic surgery</b>				
			✓	Inpatient care will be off-island
<b>Trauma and orthopaedic surgery</b>				
		✓		Important to retain some service, especially Trauma on island but more specialist will be off island
<b>Urology</b>				
		✓		Important to retain some service on island but more specialist will be off island
<b>Vascular surgery</b>				
			✓	Specialist and relatively rare nature of service suggests off-island

**Please note that it is assumed that no patients would be sent off island for daycase services for clinical safety and insurance reasons**

## Outpatient services

On-island Acute	On-island community	Telemed to UK	Off-island	Comment
<b>Anaesthetics</b>				
<i>Anaesthetics</i>				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
<b>Emergency medicine</b>				
<i>Emergency medicine</i>				
✓	✓	✓		On island with some potential for limited telecare to UK
<b>Paediatric emergency medicine</b>				
✓	✓	✓		On island. Emergency outpatient very small part of activity
<b>Pre-hospital emergency medicine</b>				
✓	✓	✓		Out-of-hours GP and non-ED medicine included under this section
<b>General practice</b>				
✓	✓			On-island
<b>Obstetrics and gynaecology</b>				
<i>Gynaecological oncology</i>				
✓	✓		✓	Assumed pre and post care but that telecare not an option for specialist support
<i>Maternal and fetal medicine</i>				
✓	✓		✓	Assumed pre and post care but that telecare not an option for specialist support
<i>Reproductive medicine</i>				
✓	✓		✓	Assumed pre and post care but that telecare not an option for specialist support
<i>Urogynaecology</i>				
✓	✓		✓	Assumed pre and post care but that telecare not an option for specialist support
<b>Occupational medicine</b>				
✓	✓	✓		Assumption that no activity will require actual presence off island
<b>Ophthalmology</b>				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
<b>Paediatrics</b>				
<i>Child mental health</i>				
✓	✓		✓	Assumed pre and post care but that telecare not an option for specialist support
<i>Community child health</i>				
✓	✓	✓		Assumption that no activity will require actual presence off island
<b>Neonatal medicine</b>				
✓	✓		✓	Assumed pre and post care but that telecare not an option for specialist support
<b>Paediatric allergy, immunology and infectious diseases</b>				

On-island Acute	On-island community	Telemed to UK	Off-island	Comment
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Paediatric clinical pharmacology and therapeutics				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Paediatric diabetes and endocrinology				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Paediatric gastro-enterology, hepatology and nutrition				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Paediatric inherited metabolic medicine				
		✓	✓	Specialist so any outpatients will be acute based off -island
Paediatric nephrology				
		✓	✓	Specialist so any outpatients will be acute based off -island
Paediatric neurodisability				
		✓	✓	Specialist so any outpatients will be acute based off -island
Paediatric neurology				
		✓	✓	Specialist so any outpatients will be acute based off -island
Paediatric oncology				
		✓	✓	Specialist so any outpatients will be acute based off -island
Paediatric palliative medicine				
✓	✓	✓	✓	Specialist but generally aim must be to provide as much care on island as possible
Paediatric respiratory medicine				
		✓	✓	Specialist so any outpatients will be acute based off -island
Paediatric rheumatology				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Pathology				
Chemical pathology				
✓		✓		Services should be provided in acute in island with some specialist off island but this could be telecare
Metabolic medicine				
✓		✓		Services should be provided in acute in island with some specialist off island but this could be telecare
Diagnostic neuropathology				
		✓	✓	Services should be provided in acute in island with some specialist off island
Histopathology				
✓		✓		Services should be provided in acute in island with some specialist off island but this could be telecare
Cytopathology				
✓		✓		Services should be provided in acute in island with some specialist off island but this could be telecare
Medical microbiology				

On-island Acute	On-island community	Telemed to UK	Off-island	Comment
✓		✓		Services should be provided in acute in island with some specialist off island but this could be telecare
<b>Medical virology</b>				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
<b>Paediatric and perinatal pathology</b>				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
<b>Pharmaceutical medicine</b>				
✓		✓		Specialist so any outpatients will be acute based on -island
<b>Physicians / General medicine</b>				
<b>Allergy</b>				
✓		✓	✓	Specialist so any outpatients will be acute based on -island
<b>Audio vestibular medicine</b>				
✓	✓	✓	✓	Most off-island, preferably by telecare but some general follow-ups on island
<b>Aviation and space medicine</b>				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
<b>Cardiology</b>				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
<b>Clinical genetics</b>				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
<b>Clinical neurophysiology</b>				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
<b>Clinical pharmacology and therapeutics</b>				
		✓	✓	Specialist so any outpatients will be acute based off -island
<b>Dermatology</b>				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
<b>Endocrinology and diabetes mellitus</b>				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
<b>Gastro-enterology</b>				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
<b>Hepatology</b>				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
<b>General (internal) medicine</b>				
✓	✓			Assumption that no or little activity will require actual presence off island
<b>Metabolic medicine</b>				
✓		✓		Services should be provided in acute in island with some specialist off island but this could be telecare
<b>Genito-urinary medicine</b>				

On-island Acute	On-island community	Telemed to UK	Off-island	Comment
✓	✓			Assumption that no or little activity will require actual presence off island
Geriatric medicine				
✓	✓			Assumption that no or little activity will require actual presence off island
Haematology				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
Immunology				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Infectious diseases				
		✓	✓	So specialist that only can be provided off-island
Medical oncology				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Medical ophthalmology				
✓		✓	✓	Specialist so any outpatients will be acute based on -island
Neurology				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Nuclear medicine				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Paediatric cardiology				
		✓	✓	So specialist that only can be provided off-island
Palliative medicine				
✓	✓		✓	Assumed generally on island except for specialist but that telecare not an option for specialist support
Rehabilitation medicine				
✓	✓			Assumption that no or little activity will require actual presence off island
Renal medicine				
✓		✓	✓	Specialist so any outpatients will be acute based on -island
Respiratory medicine				
✓		✓	✓	Specialist so any outpatients will be acute based on -island
Rheumatology				
✓	✓	✓		Generally a mix of acute and community depending on pathway
Sport and exercise medicine				
	✓			Community provision required only potentially with rehab
Stroke medicine				
✓	✓			Assumption that no or little activity will require actual presence off island
Tropical medicine				
		✓	✓	So specialist that only can be provided off-island

On-island Acute	On-island community	Telemed to UK	Off-island	Comment
<b>Psychiatry</b>				
<b>General psychiatry</b>				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
<b>Rehabilitation psychiatry</b>				
✓	✓	✓		Assumption that no or little activity will require actual presence off island
<b>Substance misuse psychiatry</b>				
✓	✓			Assumption that no or little activity will require actual presence off island
<b>Child and adolescent psychiatry</b>				
	✓		✓	Assumed so specialist that must be off-island
<b>Forensic psychiatry</b>				
	✓		✓	Assumed so specialist that must be off-island
<b>Old age psychiatry</b>				
✓	✓			Assumption that no or little activity will require actual presence off island
<b>Liaison psychiatry</b>				
✓	✓			Assumption that no or little activity will require actual presence off island
<b>Psychiatry of learning disability</b>				
✓	✓		✓	Assumed generally on island except for specialist but that telecare not an option for specialist support
<b>Medical psychotherapy</b>				
✓	✓		✓	Assumed generally on island except for specialist but that telecare not an option for specialist support
<b>Public Health</b>				
✓	✓			Assumption that no or little activity will require actual presence off island
<b>Radiology</b>				
<b>Clinical oncology</b>				
✓		✓	✓	Specialist so any outpatients will be generally acute based on –island except immediately post treatment
<b>Clinical radiology</b>				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
<b>Interventional radiology</b>				
✓		✓	✓	Specialist so any outpatients will be generally acute based on –island except immediately post treatment
<b>Sexual and reproductive health</b>				
✓	✓			Assumption that no or little activity will require actual presence off island
<b>Surgery</b>				
<b>Cardiothoracic surgery</b>				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island

On-island Acute	On-island community	Telemed to UK	Off-island	Comment
Congenital cardiac surgery				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
General surgery				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
Neurosurgery				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Oral and maxillo-facial surgery				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
Otolaryngology				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
Paediatric surgery				
✓		✓	✓	Specialist so any outpatients will be acute based generally off -island
Plastic surgery				
✓			✓	Specialist so any outpatients will be acute based generally off -island
Trauma and orthopaedic surgery				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
Urology				
✓	✓	✓	✓	Most on-island but highly specialised (and post off-island procedures and care) off island preferably by tele
Vascular surgery				
✓	✓	✓	✓	Most off-island, preferably by telecare but some general follow-ups on island

## APPENDIX FOUR

### *Appendix 4 Case studies on Cost Savings*

**Objective:** To conduct a cost analysis of a telemedicine model for cancer care (tele-oncology) in northern Queensland, Australia, compared with the usual model of care from the perspective of the Townsville and other participating hospital and health services.

**Design:** Retrospective cost–savings analysis; and a one-way sensitivity analysis performed to test the robustness of findings in net savings.

**Participants and setting:** Records of all patients managed by means of tele-oncology at the Townsville Cancer Centre (TCC) and its six rural satellite centres in northern Queensland, Australia between 1 March 2007 and 30 November 2011.

**Main outcome measures:** Costs for set-up and staffing to manage the service, and savings from avoidance of travel expenses for specialist oncologists, patients and their escorts, and for aeromedical retrievals.

**Results:** There were 605 tele-oncology consultations with 147 patients over 56 months, at a total cost of \$442 276. The cost for project establishment was \$36 000, equipment/maintenance was \$143 271, and staff was \$261 520. The estimated travel expense avoided was \$762 394; this figure included the costs of travel for patients and escorts of \$658 760, aeromedical retrievals of \$52 400 and travel for specialists of \$47 634, as well as an estimate of accommodation costs for a proportion of patients of \$3600. This resulted in a net saving of \$320 118. Costs would have to increase by 72% to negate the savings.

**Conclusion:** The tele-oncology model of care at the TCC resulted in net savings, mainly due to avoidance of travel costs. Such savings could be redirected to enhancing rural resources and service capabilities. This tele-oncology model is applicable to geographically distant areas requiring lengthy travel.

### **Computer Weekly, September 2011**

Telehealth care enables patients to monitor their conditions using mobile technology. According to health minister Andrew Lansley, around 80% of face-to-face interactions with the NHS are unnecessary. Moving just 1% of those meetings online would save the health service around £250m a year, claims the minister for health.

Research from Ovum found 70% of NHS money goes into caring for people over the age of 65 and 60% of those suffer from chronic illness. With 10 million people 65 and over, a figure rapidly increasing, there is the potential to save a lot of money in this particular area.

Drew Provan, senior lecturer in haematology at The Royal London Hospital, Queen Mary's School of Medicine, believes it is imperative for the NHS to get as many patients out of hospital as possible. He says this can be done by enabling them to keep track of their blood pressure, temperature and other vital signs and then transmit that information back to a monitoring centre. A nurse should then be able to predict when they will become ill and intervene with a treatment, preventing that patient from having to be admitted to A&E, he says.

"In particular this could be used for patients with chronic disorders, such as diabetes and heart conditions, where all that needs checking is heart rate, blood pressure, weight and oxygen saturation. This could be used on apps on Androids and iPads, so the patient can keep a daily log which goes off to the centre looking after them," says Provan.

But the biggest difficulty at the moment is letting outside data into hospitals, he says. "Secondary care is much slower in adopting these systems because of data security. But that's a hurdle we will just have to work through as this kind of technology is already available in other countries."

It will also take investment from the healthcare budget which the Department of Health (DoH) will have to agree to. "I know DoH is keen to use mobile tech, and Andrew Lansley is very pro iPad and apps, but they haven't identified the areas where they want to use it with yet. There needs to be more discussion about which diseases are best to monitor and how to deploy devices in the community.

"There have been lots of pilots in the UK, but no-one has yet decided which format to use, which disease to treat and which devices to deploy. All the bits of that have to be joined up by someone and we appear to be nowhere near that strategy yet."

But Provan believes deployment doesn't need to be hugely expensive, as people could use relatively inexpensive devices such as an iPod touch, and then download an app which is usually free. All they would need to do is stand on scales, for example, and tap in the information to their iPod touch. Or use a digital thermometer to put under their tongue to transmit a message via Bluetooth to the device, he says.

"We need investment, there's been pilot after pilot but someone actually needs to bite the bullet. At the moment people have to take the whole day off work sometimes just to take a test, which is ridiculous in some cases," Provan said.

Paul Flynn, doctor and deputy chairman of the British Medical Association's Consultants Committee, says technology in the health services doesn't have the same uptake as the business sector for two main reasons.

"Firstly there's the issue of confidentiality and worries that information on patients could be accidentally or deliberately accessed. So hospitals tend to use closed networks, the second issue is the cost. In the long-term this technology might save money in various ways, but the problem is these savings won't be realised for some time. And there has to be an initial expenditure in order to save. The NHS is often looking at very demanding targets, without the capacity to take a loss this year because of the future savings in a year to come," he said. But Flynn also believes telehealth isn't a panacea for all patient conditions. "There are an awful lot of areas that are symptom-based and need more complex evaluations with the age-old instruments of eyes and ears."

The other big issue is that primary and secondary care have traditionally operated in silos. "They are in different and competing parts of the NHS. So while self-monitoring may lead to cost savings

in secondary care, the budget may have to come from primary care. The benefits that come about are a reduction in hospital admission, but primary care has to do the implementing."

Flynn says it is unlikely we will have the same amount of hospital units as we currently have. Rightly or wrongly, he says, technology can be used to justify such moves. "If you want to close down places, you are going to overstate benefits of potential for technology. And the potential is vast, but in terms of immediately realisable benefits, the case is sometimes overstated. There is an enormous potential there, but it shouldn't be used to replace doctors and nurses, although it can make their job easier and cut down on time wasting."

With major shake-ups in the NHS - particularly with changes in GP commissioning - it's difficult to say whether investment in telehealth will be accelerated or put on the backburner for the time being. But as we all experience the benefits of increased life expectancy, some of the onus of monitoring conditions will have to shift towards the patient, if the health service is to cope with an increased demand - and that is something the NHS has only limited time in delaying.

#### **Nuffield Trust : The impact of telehealth and telecare: the Whole System Demonstrator project**

The Whole System Demonstrator programme was set up by the Department of Health to show just what telehealth and telecare is capable of, to provide a clear evidence base to support important investment decisions and show how the technology supports people to live independently, take control and be responsible for their own health and care.

<http://www.nuffieldtrust.org.uk/node/485>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215264/dh\\_131689.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215264/dh_131689.pdf)

#### **Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services:**

<http://www.connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf>

## Examples – Case Studies

### Case Studies

In Scotland, **NHS Highland** has implemented a 'hub and spoke' model of remote rehabilitation classes; the 'hub' being a central location where the physiotherapist is based, delivering a standard rehabilitation class to a group of patients; the 'spokes' being one or a number of different remote centres where further groups of patients are based who can also take part in the class. This model offers a service not currently available in many remote locations where the sparsity of patients makes the formation of a class unfeasible.

The main 'hub' locations now running this service are:

- Caithness General Hospital (physiotherapy gym)
- Fort William Health Centre (physiotherapy gym)

The 'spoke' sites are:

- Lawson Memorial Hospital, Golspie (Cambusavie Unit)
- Broadford Hospital Skye (Main Physiotherapy Room)

To maximise the usage of equipment, and to reach as many remotely based patients as possible, ITTS have developed a flexible model which can move around to different locations, depending on demand. The sharing of equipment across different patients groups such as COPD, cardiac, stroke, etc. is also being encouraged.

Changes to the equipment procurement and installation process and staff shortages/changes in personnel delayed implementation but the new service is now up and running, as of August 2013.

A link between Fort William Health Centre and Broadford Hospital has now been established with classes running from October 2013.

It is hoped that the new service will be further extended to sites at Portree Hospital, Skye (hub) and Migdale Hospital, Bonar Bridge (spoke) at a later date.

### Case study

Hub: *Caithness General Hospital, Wick*

Spoke: *Lawson Memorial Hospital, Golspie*

A group exercise class for pulmonary rehabilitation is now up and running between the physiotherapy gyms at Caithness General Hospital (hub) and the remote Lawson Memorial Hospital in Golspie (spoke), 50 miles to the south.

Currently there is a physiotherapist at both sites. The aim will be for one physiotherapist to deliver the class to both locations with a technical instructor (TI) to assist at the remote end.

The class can take a maximum of 12 patients: 8 in Wick and a further 4 at the remote site in Golspie (this is determined by the size of the rooms).

Each patient is assessed and given a personalised exercise schedule which they then follow during the exercise class. There are a number of exercise stations: exercise bike, stairs, weights, etc. and

the patient works at each station until a certain time has passed or the correct number of repetitions has been completed. The physiotherapist is on hand to guide patients through the exercises and monitor their progress, checking blood oxygen saturation levels.

The patients can see, hear or even speak to each other over the VC and recent observations reveal both patients and staff are very accepting of the technology. An added benefit of the VC link is that it provides an opportunity for the delivery of shared patient education at the end of the class such as advice on diet or smoking cessation.

**Airedale NHS Foundation Trust** is an acute care provider with a unique range of digital healthcare solutions, which have been developed by their consultants working closely with their patients.

A few examples of how Telemedicine has helped to avoid 999 calls and hospital admissions, as well as examples of when Telemedicine has changed a diagnosis are below. We also have some more in depth case studies which can be accessed using the menu to the right hand side.

### **Case Study**

Carer's contacted the telehealth hub as they had a patient who they suspected was having a heart attack as the patient was complaining of chest pain, was short of breath and looked grey. Once the Telehealth Sister was linked up to the patient she was able to carry out a full assessment and question the patient on the nature of the pain. The patient described the pain as "tummy ache" and the sister was able to see the patient rubbing their lower abdomen, the patient also explained that the shortness of breath was normal and they had suffered from gallstones in the past.

What had at first been a suspected heart attack, which would require an emergency admission to A&E, turned out to be "trapped wind" which was sorted with some warm peppermint tea and paracetamol. Access to the hub here avoided a 111/999 call.

### **Case Study 2**

When carers discovered a patient, who had suffered from previous strokes, slumped in their chair and very drowsy they contacted the telehealth hub as they were worried it could be another stroke.

The Telehealth Sister watched the carers approach the patient who began to rouse, she advised them to sit the resident more comfortably in the chair when the resident became more alert and was able to speak to the nurse. The Telehealth Sister assessed the patient movement and it was clear that the patient had usual movement and power in their arms and legs and was gently walked back to their bedroom. The patient had fallen into a heavy sleep in the chair and the telehealth hub team monitored the patient overnight for any more similar episodes. Again a 111/999 call was avoided.

### **Case Study 3**

After taking anti biotics for a chest infection earlier in the day a patient was becoming very short of breath so carers contacted the Telehealth Hub, suspecting a worsening chest infection. As soon

as the Telehealth nurse saw the patient on the camera she was able to see a rash appearing on their face, suspecting a severe allergic reaction to the antibiotic rather than a worsening chest infection the nurse was able to advise the carers seek emergency advice.

## **Finland**

Finland continues to implement a remote rehabilitation service via VC to patients in the remote areas of Utajärvi, Vaala and Ii (northern Finland). A physiotherapist runs the class from her office to a group of 6 patients who connect via VC units installed in their own homes. These patients suffer from multimorbidity with chronic diseases such as stroke or heart disease and have difficulty accessing rehabilitation, either through distance or frailty or because of health staff resource limitations. Group-based rehabilitation will improve physical and social wellbeing of patients and in many cases enable them to stay at home for longer.

The first group class (6 patients) was run from January-June 2013; a second group began in September 2013.

Work is ongoing to improve broadband connections in the implementation area to allow more patients to use the service

## **Ireland**

ITTS Ireland have implemented this service for the rehabilitation of COPD patients based in the North County Clare area of Mid-West Ireland. Historically, a physiotherapist travelled to see each patient face-to-face. With patients spread across a wide geographical area, often in remote and hard-to-reach locations requiring a ferry trip (Aran Islands), this approach took a lot of time and resource. A centrally based physiotherapist is now able to take a class from the clinic and be joined by remote users via VC installed in the patients' homes (following a site safety assessment). Time saved travelling can be spent seeing more patients, thus addressing the long waiting list for rehabilitation services. The classes are also designed so as to provide social interaction for patients who, by very nature of their condition, may be subjected to social isolation.

Following the success of the first sessions in January-March 2013, an 8-week block of remote rehabilitation clinics was delivered to assist patients with chronic obstructive pulmonary disease (COPD) across the North County Clare area. A schedule of classes was carried out in October/November 2013 with feedback suggesting a positive experience for all involved. A further schedule of classes is planned for a new patient uptake in January 2014.

## **5. Appendix 3: Initial Response – Health and Social Services Department and Department for Infrastructure**

### **Comments from the Health and Social Services Department**

#### **1. Strategic understanding**

The conclusion that ‘the hospital project must link to a service-wide strategy’, and that ‘there seems to have been little consideration of...how services could be moved out of the acute environment’ is at odds with the work we have been doing for the past five years. A number of key documents explain the future direction of health and social care in Jersey, including P82/2012 ‘A New Way Forward for health and Social Care’, the Green Paper and White Paper ‘Caring for each other, Caring for ourselves’, the Mental Health Strategy and Primary Care Strategy. The agreed and published Acute Services Strategy was provided. In addition, Outline Business Cases relating to the Medium Term Financial Plan 2017-19 were provided. The Acute Service Outline Business Case in this group of documents sets out the strategic context in which acute services are provided, the challenges facing the General Hospital and wider health and social care on the Island and the service model which forms the start of the transformation in hospital care needed to meet these challenges

#### **2. Acute service model transformation**

No evidence is provided in the report to support the statement that ‘the hospital Project has been driven by the building and physical requirements rather than the clinical and service strategy’. The Acute Services Strategy, Acute Outline Business Case and the individual service plans all clearly demonstrate how the model of care and service delivery will be transformed whilst the new hospital is being developed. It is not clear how the Report can conclude that there is ‘little change in the service model’ and that ‘a ‘like-for-like’ replacement of acute services is not a sustainable solution’, when the documentation provided, and interview subject matter, clearly demonstrates that this is a key consideration and we are well progressed with planning and beginning to implement acute service model changes.

#### **3. Focus on Primary Care**

Section 4.3 of the Report entitled ‘Primary and Community’ appears to comprise large tracts of the Sustainable Primary Care strategy, but with extremely limited reference to the Out of Hospital Outline Business Case, P82/2012, the White Paper or the Mental Health strategy and Outline Business Case, all of which describe exactly the sort of changes that the Report suggests have been omitted from our strategic planning. In fact, this entire section of the Report is narrowly focused on GP services. Moreover, there appears to be a major omission throughout the Report, in that it makes no references to the investments in Primary and Community services from 2013, which have made a significant impact on the whole system, and which the Advisor was provided with information about.

#### 4. Comparisons with other jurisdictions

While HSSD accepts that comparisons with other health and social care systems can provide valuable insights, it is not clear what criteria are being used to provide comparison with Jersey. Hospitals, for example, with populations over 350,000 that are networked to other Trusts, tertiary centres, independent sector provision and good access networks would not, HSSD believes, be appropriate comparisons. The criteria that the Future Hospital Project has used to select comparators (utilising considerable EY experience) is 11 small to medium sized NHS general hospitals in rural settings and three island jurisdictions (Guernsey, Isle of Man and the Isle of Wight). All this information was available to the Advisor, but appears not to have been considered in the Report.

The criteria by which Bermuda and the British Virgin Islands are selected and against which criteria the performance of the Jersey health and social care system might be logically and systematically compared or benchmarked is not clear. There are more systematic reviews of other island and non-island health and social care systems available that have already informed HSSD insight into the challenges created on Jersey – what HSSD colloquially terms ‘the Island factor’.

While insights can be gained from commissioning models used in other jurisdictions, it is not clear in the Report how Corby CCG provides the necessary opportunity for systematic comparison with Jersey without fully accounting for the significant difference in population, health and social care activity, the number of local hospital providers, the inability for Corby to directly commission specialist services and the NHS commissioning guidance that does not apply to Jersey. It does acknowledge that the commissioning body, for a population of 73,000, has a running cost of over £1.5m, a cost that Jersey does not currently have and would not wish to acquire.

#### 5. Incorrect information

The Report appears not to include a fuller understanding of some important contextual factors about Jersey.

For example:

- The majority of care is funded by the States of Jersey, through the Health and Social Services Department. However, the Advisor infers that insurance companies fund care – for example in a statement that ‘value is provided for the Payers (insurance companies), providers and patients’.
- The Report then goes on to say that payers need to move away from standard contracts – but HSSD does not have any such contracts for on-Island services.
- The work undertaken in 2012 was by KPMG plc, not EY plc. The Report strongly recommends that this is revisited – but it has informed all subsequent Future Hospital work, including that undertaken by WS Atkins International and EY plc and our own detailed in-house modelling.

- Primary Care is fully private and independent – there isn't a 'States of Jersey Primary Care'
- EMIS does not cover all Primary Care services – in particular, it has not been introduced in Pharmacies, Dentists and optometrists.
- More work has not been moving off-island – quite the opposite where safe affordable and sustainable to do so.
- In some places, unattributed work has been inserted (table 8.1 appears to be a KPMG product derived from "A Review of 15 island health systems").

## 6. On-/Off-Island Care

Some statements are made without evidence, some of which are incorrect – for example, the report infers that HSSD is considering greater use of off-Island provision. HSSD's stated plan is to reduce off-Island provision. The approved and published Acute Service Strategy (which is not acknowledged in the Report) makes a very clear statement for the Department: HSSD will treat all patients on-island where clinically safe and financially viable to do so. If services would be more safe, sustainable and affordable when provided off-island then this would inform HSSD decision making.

The commissioning of services off-island could also have been better described in the Report. It portrays a limited awareness of the independent commissioning ability (and limitations) of HSSD or of the fact that, currently, Jersey residents are being potentially considered as Non-UK, Non-EU citizens and as such Jersey could be subjected to augmented tariff charges for NHS care provision. The Advisor suggests that France, being geographically closer, would potentially result in travel cost savings, yet there appears limited understanding of the lack of direct air links to the areas housing the major hospitals in France.

The Report is silent on the significant clinical risk to Jersey residents of not having adequate emergency provision on the island and the impact of having such provision has on the hospital and wider health and social care infrastructure of any island hospital. The Future Hospital has to be, and is, informed by this requirement to secure the safety of Islanders. A briefing note setting out how the provision of emergency care (ED for both trauma and medical emergencies, obstetrics for birth emergencies and so on) determines the need for a *deminimus* Jersey General Hospital, was also shared with the Advisor.

- ED needs to be supported by imaging, pathology and ward infrastructure
- ED and Obstetrics need operating theatre and ward infrastructure
- Emergency activity alone is not sufficient to utilise these and other hospital assets fully
- Elective activity allows more efficient resource utilisation (theatres, wards and support infrastructure)
- Private health care provision further utilises assets and incentivises clinician recruitment and retention without which the broad range of General Hospital services would not be able to be provided on-Island

## Comments from the Department for Infrastructure (Dfi)

It should be noted that no contact has been made between the Sub-Panel's Advisor and the Dfi members of the Project. Such contact would have provided a fuller assessment of the Project, its team and approach. In particular, this fuller understanding could have helped in the following areas:

### 1. Affordability concerns

The Report concludes that there are concerns about affordability but no formal proposals in this regard have yet been issued by the Treasury and Resources Department or requested from the Project's Senior Responsible Owner for funding, i.e. the Treasurer of the States. The Senior Responsible Owner for Delivery of the Project i.e. the Chief Officer of Dfi does not share the concerns set out in the Report. A discussion paper was provided to the Council of Ministers on 7<sup>th</sup> September 2016 and it is understood that previous correspondence between the Project and Sub Panel confirmed this would be provided to the Sub Panel during September.

### 2. Changes needed to Project Governance

The Report concludes that change to the Project leadership is necessary without having consulted the wider Project Governance team members on their view. This recommendation may be based on a misunderstanding of the Project Governance and its successful inter-departmental partnership working. The Project's Governance arrangements and terms of reference were available but not requested from the Project team. The political critique contained in the Report does not appear to have taken into account recent changes to establish the Future Hospital Political Oversight Group (FHPOG) (focused on Future Hospital delivery) replacing the Ministerial Oversight Group (focused on the wider range of P.82/2012 workstreams of which the Future Hospital was one. Again, the Terms of Reference for this FHPOG could have been made available if requested.

From the delivery perspective, with the Council of Minister's approval to recommending the preferred site in place, Dfi has already acted to strengthen the Project team with experts on relocation works, planning, architecture and civil engineering already identified or in place. Dfi recognises and has supported a similar strengthening of the Client HSSD team, which is underway.

### 3. Site assessment concerns

The Dfi Officers were pleased to note that, based on previous site assessment work, the Report concludes that this assessment is strong and based on a robust approach. As explained to the Sub-Panel, the formal site assessment for Option F – the extended General Hospital Site – has been undergoing assurance and has not yet been issued to the Sub Panel. This explains why there is insufficient evidence for a strong justification supporting the preferred site as this was not able to be taken into account. The Dfi team considers the issuing of the Report to be premature. A more comprehensive conclusion could be drawn once the Option F work could be taken into full account.

In relation to the evaluation of the site options, the Dfl contests that the site evaluation does not link directly to the approved Acute Service Strategy. This aspect of the Report may be based on a less than comprehensive review of the site selection process. Over half of the available technical scores are directly attributable to the acute service operation and outcomes and the weighting is entirely on the basis of the safe, sustainable and affordable delivery set out within P.82/2012. As the initial site selection process was undertaken to inform the development of P.82/2012, this criticism might have been reasonable in 2012, but in 2016 with an approved acute service strategy in place, the final conclusion of the site assessment in the report is less understandable.

#### **4. Concerns about strategic drivers and success factors**

In relation to the overall process being followed for the Project, the Dfl considers that the conclusions of the report on critical success factors and drivers for the Project appear underdetermined by the evidence. Had the Dfl been consulted, the Report could have been informed by the original Project Brief and the Strategic Brief for the Project, developed in 2013 and 2014. However, it is worth noting that the Project Brief for the preferred site is only now in preparation following the successful ‘proof of concept’ work. Therefore, it would be untimely at this stage to conclude on the delivery of the Project on this without reference to this information. It is also not the case that private patient provision has not been considered. A comprehensive assessment of the potential for private practice development was undertaken by EY plc, leaders in this field, in 2015.

#### **5. Lack of future flexibility and change planning**

The Dfl would argue that the flexibility being built into the capital delivery can evidentially demonstrate our reaction to the evolving health brief. The Project Team has ensured, in response to the need for future flexibility, that this has been the cornerstone of our design work in all options shortlisted since 2015. We recognise, as the Report indicates, that aspects of future healthcare provision may currently be unpredictable and that changes in healthcare can be rapid.

The condition of the current hospital assets, however, means that the States of Jersey can no longer ignore the fundamental issues with the physical infrastructure and the limitations it is increasingly placing on the evolution of best practice hospital services. We recognise the implementation of Option F raises challenges in relation to the relocation of hospital services, and it is right and proper that this is the current focus of attention for hospital staff. The Report incorrectly concludes that there is no decant plan in place. This has been extensively discussed and informed by the client and continues to develop and improve as the Project enters the Project Brief phase.

#### **6. Business case and modelling horizons**

P.82/2012 approved by the States made clear why any “Do Nothing” option would be unacceptable and therefore this should have informed the Report’s conclusions. However, directly as a result of a recommendation from our own internal Project Assurance, the

Project Board have already agreed to include a “De-Minimis option” for greater off-island delivery as a comparator in our outline business case. DfI understands from our Advisors that it remains best practice in developing hospitals to assess hospital service change over a 10-year horizon and plan for a 30-year horizon with future flexibility over the 60-year life cycle of the physical assets. The Report indicates that no modelling has taken place over the 60-year lifecycle. Such modelling *has* informed all of the previous site assessment work already provided to the Sub-Panel and informed the whole life costs.

## 6. Appendix 4: Detailed Response – Health and Social Services Department and Department for Infrastructure

HSSD/DfI Response to Scrutiny Advisor Concerto’s Report dated 11 <sup>th</sup> August 2016	
HSSD/DFI Response to Executive Summary of Scrutiny Advisor’s Report	
Scrutiny Advisor’s Recommendation	Response
<p>We recommend that there is one overall programme director, directly reporting to the Board, who has the responsibility for delivery across all work streams of the programme</p>	<p>In relation to the Future Hospital Project there is a single director whose focus is on delivery of the capital project – the FH Project Director (Delivery). This Director reports to the Future Hospital Project Board and could have been easily consulted in preparation of this Report if requested. The FH Project Director (Health Brief) has responsibility for delivering the health brief and for the linkage with other operational and transformational activity within the Department for Health and Social Services.</p> <p>The political-level governance arrangements for the project having been recently reviewed and changed following the adoption of the strategies for all areas of the health and social service transformation and transfer of responsibility for the capital project from Treasury and Resources to the Department for Infrastructure. The Ministerial Oversight Group (responsible for overseeing the transformation of health and social services set out in P82/2012) has been replaced by the Future Hospital Political Oversight Group (responsible for overseeing the delivery of the Future Hospital).</p> <p>The overall programme of health and social care transformation <i>including the Future Hospital</i> (i.e. all work streams of the HSSD transformation programme) has been subject to a robust governance structure since 2011, reporting to the Transformation Steering Group. The Director of System Redesign and Delivery (lead Director for the whole health and social care transformation programme) is a member of the Future Hospital Board as is the HSSD Chief Officer, HSSD Finance and Information Director and Hospital Managing Director.</p>
<p>There is too much reliance on too few people and not a balanced view on what is achievable and when. We recommend strengthening the team.</p>	<p>We agree with this recommendation. The Project team capacity and capability has recently been augmented as result of moving from the site selection to the detailed development process on the preferred site. This will need to continue and in doing so reflects the size and complexity of the programme 2016-2019 (covering the relocation works and the operationalisation of services in the new locations) and 2019 – 2024 (covering the construction, commissioning and ‘soft landing’ of the Future Hospital).</p> <p>The capability and capacity of the System Redesign and Delivery team has also recently been augmented, which will enable the focus on the broader system transformation to continue, particularly regarding ‘out of hospital’ (community and primary care) services and mental health. Work is ongoing to ensure strategic and operational alignment and joint working facilitated by this team, for example in ‘enabling transfers’ between hospital and other settings, in order to improve productivity and quality. This is essential in ensuring the future hospital is the right size, and that services continue to be improved and transformed in the meantime.</p>

	<p>In relation to a balanced view of what is achievable and when, the recent completion of the Proof of Concept for the preferred site approach sets this out clearly and has been supported by both Health and Social Service Client Department, Department for Infrastructure and Treasury and Resources representatives of the Project Governance.</p>
<p>Appraisal of the options has followed good practice in identifying qualitative, quantitative and financial comparable benefits and costs. However this analysis does not strongly support the preferred option, which is identified as rebuilding on the existing site. If there are other reasons for this choice we recommend that they are properly considered and justified</p>	<p>The Scrutiny Sub-Panel has been issued with the CR025 Report and with draft versions of the associated Report and Proposition proposing the Preferred Site where this is clearly established.. This sets out the proof of concept of building the Future Hospital on the extended current General Hospital Site. Whilst new build hospital on two other sites could out-perform the preferred site option, political alignment on these solutions could not be achieved. Therefore, the preferred site represents the best practicable option.</p>
<p>The new build solution on the current site will have a major effect on the current workforce. We recommend that the operational, financial and clinical risks that are inherent in such a plan are more fully thought through.</p>	<p>We agree with this recommendation, although it implies that this is not part of the normal development of such a significant project or is not in hand, both of which are incorrect. The Council of Ministers are charged under the States Assembly with bringing back detailed proposals for a new hospital including financial and manpower implications and their intent to do so during 2017 is clearly stated in the draft Report and Proposition that has been shared with the Sub Panel.</p>
<p>We recommend that Jersey makes more effort to learn from other similar island jurisdictions.</p>	<p>We do not accept that Jersey has not already learnt from other similar smaller Island jurisdictions. Gleeds Management Services were selected as Lead Technical Advisors in part because they demonstrated experience in working on Guernsey. EY plc (formerly Ernst and Young) as Financial Advisors to the Project, are using island benchmarks to inform benefit intervention analysis. Finally the Advisory Board, an international organisation experienced in advising health communities small and large across the world, acts as a reference point whenever a particular issue needs to be considered.</p> <p>Learning from elsewhere is not restricted to island communities. There are many illustrations where the redesign of health and social care generally and the Future Hospital Project more specifically has been informed by learning elsewhere. This is clear from the International evidence and best practice which is contained in the KPMG Technical Document from 2011 (publicly available), from the Outline Business Cases (which were provided to the reviewer) and from the Mental Health Strategy and Sustainable Primary Care Strategy, both of which referenced and evidenced International models. Currently, Skills for Health are working with the Department regarding workforce, Deloitte and Imperial College are advising the funding work-stream of the Sustainable Primary Care project and KPMG are advising on the future of health and social care governance. All of these engagements specifically require International best practice and alternative models to be presented and considered, in order for Jersey to learn from elsewhere but develop a system which is appropriate to the Island.</p> <p>From a Future Hospital perspective, visits have for example been undertaken by Project Team members to South Essex Partnership Trust, Cramlington Emergency Hospital, Edinburgh Royal Infirmary, Ebbw Vale South Wales, North Staffordshire, Great Ormond Street, Southmead Hospital Bristol, Altnagelvin Hospital Northern Ireland and Alicante in Spain.</p> <p>There has never been a view in the Project that Jersey is “unique”. What has been said is that whatever the learning is from other jurisdictions it must be contextualised to Jersey. We must not “lift and shift” solutions from other</p>

	<p>jurisdictions without testing whether they provide the opportunities for safe, sustainable and affordable care on Jersey.</p>
<p>Not enough progress has been made in relation to ICT and we recommend that an Island ICT Director manages the whole health economy ICT.</p>	<p>It is not clear from the report how this conclusion has been reached.</p> <p>The Health and Social Service Department’s 2013-2018 Informatics Strategy developed in conjunction with Capita, drawing on international experience, is based on four themes:</p> <ul style="list-style-type: none"> <li>• Data</li> <li>• Systems</li> <li>• Information</li> <li>• Services</li> </ul> <p>This Strategy was formally reviewed by the Health and Social Service Department’s Corporate Management Executive in June 2015. This review comprised three main elements:</p> <ul style="list-style-type: none"> <li>• Review and refresh the vision of the Informatics Strategy</li> <li>• Carry out a stocktake assessment of progress to date</li> <li>• Revise and update the action/implementation plan, setting out the specifics for the short (6-12 months) and medium (12-24 months) terms</li> </ul> <p>This review reported on and documented the significant achievement against the strategy to date. Another independent review assessed the Health and Social Service Department’s current and expected position against recognised national and international maturity models to provide assurance that progress to date and that planned for the future was appropriate and valid.</p> <p>The Health and Social Service Department’s submission into MTFP2, covering phase 2 of the strategy, includes funding bids for key elements of the strategy. Subject to the approval of the Assembly, phase 2 of the Strategy will be implemented over the coming years as planned.</p> <p>To consider the health economy in isolation, be it in terms of IT or any other aspect, is not appropriate. Health and social care is integrally linked and needs to be considered together. Equally, it is important to recognise that health and social care in the island is a mixed economy comprising a wide range of organisations and individuals, i.e. they are not part of one organisation that can be ‘directed’ by a single individual.</p> <p>A dedicated Programme Manager is currently being recruited to co-ordinate and manage the implementation of Phase 2 of the strategy, the main elements being:</p> <ul style="list-style-type: none"> <li>• Electronic Patient and Client record, including e-prescribing, new system for children’s social care etc.</li> <li>• Integration and data sharing between primary and secondary care</li> </ul> <p>The main organisations involved in the provision of primary and secondary care in the island share a common vision in terms of using information for the benefit of patients and are working together, through Digital Jersey, to develop a single digital health and social care strategy for the island. They also work closely together on the pan-Island Health and Social Care IT Strategy Group. This work is utilising international expertise as well as local on-island IT expertise as well as health and social care providers.</p>

	<p>In addition, Gleeds Management Services are providing best practice expertise to the Future Hospital Project via their sub-consultant the IT Health Partnership.</p>
<p>Some services have already gone off-Island and it is clear with the others can too. A lot of option analysis has been carried out, but not enough focus has being put into off-Island care. Work will be needed with the Insurers to ensure that Islanders can plan off-Island treatment. There is some very negative press on the internet re Off-Island treatments and this would need to be mitigated before going out to consultation.</p>	<p>The Acute Service Strategy sets out the strategic principles that:</p> <ol style="list-style-type: none"> <li>1. We will treat all patients on Island where clinically safe and financially viable to do so</li> <li>2. We will treat in the General and Future Hospital only those patients where is it clinically necessary to do so</li> </ol> <p>Where services would be more safe, sustainable and affordable if provided off Island, this would inform HSSD decision making.</p> <p>HSSD has a dedicated ‘Off Island’ team, who oversee the services provided. We also have an Off-Island Acute Commissioner, who has been reviewing, tendering and improving value for money and quality from our off-Island contracts. The associated plan was made available to the reviewer, as it had previously been sent to the Scrutiny Panel. This subject was also covered in the Concerto reviewer’s interview with the Director of System Redesign and Delivery, who provided examples of where quality and value for money had been improved through off-Island commissioning.</p> <p>The reviewer’s comment regarding work being needed with Insurers is not relevant to the Jersey context, as the care Islanders receive off-Island is publicly funded.</p> <p>We are also not aware of the ‘very negative press’ referred to in the report and would welcome this being provided where it exists. Our clinical and contractual relationship with a wide range of off Island hospital belie this recommendation. The balance between on-island and off island provision will inevitably change in response technological change, clinical and other accreditation standards.</p>

Main body of the report			
Section	page no.	Extract	Response
1.2	3	Revision to the final draft	
		Staff and Stakeholders interviewed	We do not consider this to be sufficiently complete list of stakeholders. Stakeholders were identified in response to questions sent in advance by reviewer
		Further documentation provided	We do not consider this to be a sufficiently complete set of documents to accurately inform the Report. The report also does not clarify that 30 additional documents were sent following the interviews, and that the interviewer raised 35 additional questions following the interview, which were responded to in writing but were not then followed up or clarified by the reviewer
<b>Section 2.0</b>	<b>4</b>	<b>Objectives and Scope</b>	
<b>Section 3.0</b>	<b>5</b>	<b>Review of Assessment Process</b>	
3.1	5	Sources	

	5	CO021 Site Option Report, Appendix 2 – Verification of previous site deselection. CO021 Site Option Report, Appendix 22 – Benefits and risk analysis. Change request Number 4, Site Options Appraisal, April 2015.	Any assessment of site suitability using this material only would be unrepresentative. The report is not informed by additional material that would be relevant to the scope and conclusion contained in the other reports such as the previous Site options Appraisal reports provided to the Sub-Panel – Change Request 4 (four site options appraisal) Change Request 18 (addition of People’s Park, Change Request 21 (inclusion of regeneration proposals for People’s Park) and the full Change Request 25 which focuses on the preferred Option F site.
3.2	5	Assessment process – review	
	5	We find that the assessment process adopted by the States closely follows best practice for option appraisal outlined in documents such as the UK’s Department of Health Capital Investment Manual and subsequent accompanying guidance from HM Treasury and NHS England Project Appraisal Unit.	The FH Project throughout has employed ‘industry standard’ approaches to hospital development and project management. We appreciate that this has been recognised in the report.
3.3	6	Review of long-list assessment	
	6	As noted later in this report there has been insufficient consideration of the potential for other models of healthcare delivery. Thus the option appraisal is only of sites, not of the best way of delivering the services required. In the opinion of this report this is a significant flaw and we have a low level of confidence that this process has identified the combined best answer. This fundamental issue is further discussed in the recommendation sections.	The report does not consider the model of healthcare set out in the Acute Service Strategy, the Acute Outline Business Case and the Service Plans, which were provided to the reviewer. These documents clearly outline the new service models, which inform how the Future Hospital will work and how services will be transformed, within a transformed whole health and social care economy, in the meantime. Evidence was also provided regarding how this transformation is progressing and the impact to date; again, this was not referred to in the report.  For the most part the new acute service model is ‘site agnostic’. A priority for the model is a response to the aging demographic, and the documents also demonstrate the integration and interaction with the rest of the whole system transformation programme.  Other priorities are also considered in the acute service model (patient safety, off island and on island services, future affordability challenges, technological change, workforce challenges and so on. The report does not appear to be informed by any of this material.
	6	Although the physical site options have been identified and appraised in some considerable detail, it would be more preferable to identify a small number of key success factors and constraints, preferably in respect of a whole health service strategy, against which each option would be assessed.	This conclusion is not accepted. All shortlisted sites were assessed using a comprehensive scoring system that recognised in both risks and benefits the clinical, operational patient and visitor effects, as well as the environmental, infrastructure, buildability, property and regeneration impacts and used weightings that addressed whether these contributed to safe, affordable and sustainable hospital. Focussing on key success factors only would have missed the need for a comprehensive assessment of both site and health factors.
	6	.....there has been insufficient consideration of the potential for	The various documents which are publicly available and/or provided to the reviewer demonstrate the breadth of other models

		<p>other models of healthcare delivery. Thus the option appraisal is only of sites, not of the best way of delivering the services required. In the opinion of this report this is a significant flaw and we have a low level of confidence that this process has identified the combined best answer.</p>	<p>of health and social care delivery that have been considered, both at a whole system level and at an individual service level.</p> <p>The new model of health and social care was presented as part of P82/2012 'A New Way Forward for Health and Social Care'. This was informed by the KPMG Technical document, and the Green and White Papers 'Caring for each other, Caring for ourselves'.</p> <p>Outline Business Cases have been produced for the proposed strategic changes (including hospital services); there clearly identify interdependencies and interactions with all parts of the health and social care system.</p> <p>The Mental Health Strategy and Sustainable Primary Care Strategy, both reference and evidence International models and propose new models of health and social care delivery which are appropriate for Jersey.</p> <p>Currently, Skills for Health are working with the Department regarding workforce, Deloitte and Imperial College are advising the funding work stream of the Sustainable Primary Care project and KPMG are advising on the future of health and social care governance. All of these engagement specifically require International best practice and alternative models to be presented and considered, in order for Jersey to learn from elsewhere but develop a system which is appropriate.</p> <p>Finally, it is worth noting that the approach taken to redesigning health and social care was reviewed in June 2014 by an Expert Panel which had been appointed by the Ministerial Oversight Group. They were provided with much the same documentation as the Concerto reviewer, and they concluded that:</p> <ul style="list-style-type: none"> <li>• The original work by KPMG had been 'comprehensive'</li> <li>• The case for change was made and the selection of a new model for health and social care was the right one</li> <li>• The consultation process was inclusive and thorough</li> </ul> <p>The Expert Panel recommended:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul> <p>This directly conflicts with the Concerto reviewer's conclusion that 'there has been insufficient consideration of the potential for other models of healthcare delivery'.</p>
3.4	6-9	Development of the shortlisted options	
		<p>Before starting this section it should be made clear that the original process to choose the site, as shown in the Gleeds work of 2015 and 2016, was broadly done in the correct manner. The problem with that</p>	<p>The report does not include any consideration of work undertaken to develop and understand the benefits of the Acute Service Strategy (nor any of the other strategies such as Mental Health and Sustainable Primary Care).</p>

		<p>iteration is that the report has been based on the old clinical service and delivery model. Therefore, to ensure that the site and new build is correct it has to be based on the new service model which is discussed later in this report.</p>	<p>This work is based on the new service model developed through considerable engagement with clinical and other stakeholders.</p> <p>We do not accept that iteration has not been addressed or we are using an old service model. Since 2015 site assessment work has been based upon the Acute Service Strategy and Service Plans that reflect this, as captured in the draft Future Hospital functional area assessment.</p> <p>The up-side of the repeated assessments carried out in 2015 and 2016 is that these were able to be informed by the developed acute service strategy and therefore capture the latest view of site suitability. However, all assessment has been informed by the strategic direction set by “Health and Social Services: A New Way Forward” (P.82/2012).</p>
	7	<p>Please note that issues with the workshops undertaken in 2016 are discussed in Section 3.7 below and these are of particular concern to the development of the project.</p>	<p>This particular concern is set out in three short paragraphs in Section 3.7</p> <p>“It is understood that the project is now principally considering two options; the Waterfront site and rebuilding on the current General Hospital site, using a phased approach”. This is factually incorrect. As indicated within the information conveyed to the Sub Panel, political alignment could not be achieved on the Waterfront site and therefore it, and other short-listed sites have been discounted from further consideration.</p> <p>“It is understood that the political dimension is important in any such decision, however placing it far above any other consideration considerably reduces the likelihood of achieving the benefits and outcomes required”. The Project has not at any time placed the ‘political dimension’ <i>far above</i> any other consideration. States Members, including those from Scrutiny, were clear that the States Assembly would need to have confidence in both the technical assessment of different site options and the public acceptability of any preferred option. The political dimension as the Report sets out “is important in any such decision”.</p> <p>“Overall it is the opinion of this report that until the outcome of the feasibility study is carried out the States could be placing itself in danger of progressing a project that is unlikely to achieve what is required. This may result in notable reductions in clinical and service quality and that it cannot be delivered within the budget available or in a reasonable timetable.” The Future Hospital Project objectives are to provide a modern hospital where services can be provided in a way that is safe, sustainable and affordable. The opinion of the report author that the feasibility study needs to precede site choice otherwise consequence “may” or “could” happen is not a basis for the conclusions set out in the report.</p>
	7	<p>All options were designed at 85% of Health Building Notice (HBN) standards. As this is a comparison phase of the project, and it was equally applied to all options, this is of no consequence to the</p>	<p>There is no intention “to apply such savings equally across all types of accommodation”. 15% derogations from HBN standards will be applied where safe to do so. This condition has always been a key part of engagement with clinical and other stakeholders.</p>

		assessment. However, whilst including a “design challenge” is a reasonable step it can, when applied so broadly, provide significant issues later on in the development of the scheme as it is rarely possible to apply such savings equally across all types of accommodation.	
	7	.....space can be reduced and re-engineered in a more planned way that may also encompass changes to the model of service.	<p>As the report notes HBN notes provide guidance. Spatial standards vary worldwide. Derogations within the NHS are not uncommon. The approach of the Project has always been that, where safe to do so, space in the FH Hospital will be reduced and re-engineered in a planned way through changes in the service models (for example, through improving theatre productivity with the implementation of ‘day of surgery’ and 23 Hour Units, improving new to follow ratios in outpatients, implementing an ambulatory emergency care model, coordinating care across the health and social care community through a Care Hub). These and many other changes in the service models are well described in the Outline Business Cases, provided for the reviewer. They do not appear to have informed the content of the report.</p> <p>The Gleeds site assessment reports provided to the Sub Panel all show how this might be achieved, based on extensive advisor experience.</p>
	7	It is also noted that no “Do nothing” or “Do minimum” option was included, which is generally regarded as best practice	<p>P.82/2012 made clear that “do nothing” was not an option given the poor state of the hospital buildings and the extensive changes to the hospital services proposed.</p> <p>Indeed, the Ministerial Oversight Group Expert Panel in June 2014 concluded that <i>‘a new hospital is indeed needed in Jersey. The current infrastructure has a limited life and ever-increasing maintenance requirements’</i>. They recommended <i>‘That the provision of a new hospital is pursued as quickly as possible’</i>.</p> <p>A “Do Minimum” will be undertaken during Outline Business Case stage to consider the impact of increasing off-Island provision. However, as reports to Ministers and the Project Board make clear, this is unlikely to result in a safe, sustainable or affordable option.</p>
	7	In section 5.7 of the Gleeds’ <i>‘Change Request Number 4’</i> document, a forecast of likely future hospital activity was completed to ensure facilities remained for long-term provision. <i>‘Appendix 9’</i> of the Gleeds’ report provides the details of this based on work previously conducted by Ernst and Young in 2012. It is strongly recommended that this should be revisited as, from this report, there appears to be a limited review of the potential for radical change in the provision of services,	<p>This is being done. The absence of consideration of this work and particularly the role of Ernst and Young, MJM Healthcare Planning and Skills for Health workforce planners mean the reviewer’s conclusion is not fully informed by the evidence. In addition, HSSD internal demand and capacity modelling related to the Future Hospital Project is refreshed annually with the previous full year activity data. Furthermore the EY activity analysis was undertaken in 2014 not 2012 – the work undertaken in 2012 was completed by KPMG.</p>

		especially what will continue to require an acute hospital environment.	
	8	<p>Districts in England with populations of around 100,000, and the acute health provision within that District, is shown below.</p> <p>However the model being pursued in Hertfordshire demonstrates the potential to move services into the community and out of acute facilities</p>	<p>It is not clear what criteria are being used to provide comparison with Jersey, and we do not recognise the similarities between the proposed comparator hospitals and Jersey. In particular, hospitals with populations over 350,000 that are networked to other Trusts, tertiary centres, independent sector provision and good access networks are not appropriate comparisons:</p> <ul style="list-style-type: none"> <li>• Dartford is a general hospital near other large general hospitals (Maidstone Hospital, which is itself part of the larger Maidstone and Tunbridge Wells NHS Trust) and Medway Maritime NHS Trust, and working in formal partnership with a tertiary centre, Guys and St Thomas' NHS Foundation Trust. Dartford does not service a population of 340,000 alone.</li> <li>• Eastbourne hospital is also close to other general hospitals (Hastings, Brighton) and does not service a population of 370,000 alone.</li> <li>• Kettering, a troubled hospital for many years, is close to a number of other hospitals which provide services to the area.</li> <li>• Welwyn Garden City is located close to several large general hospitals that can provide services for Welwyn Garden City residents in ways that are not possible in a relatively remote island like Jersey.</li> </ul> <p>All of the above 'comparators' are set within significant independent sector acute hospitals (Spire, BUPA etc.) and on road and rail infrastructure supporting care in tertiary centres.</p> <p>The criteria that the Future Hospital Project has used to select comparators (utilising considerable EY experience), is 11 small to medium sized rural NHS general hospitals and 3 island jurisdictions (Guernsey, Isle of Man and Isle of Wight). All this information was available to the author but appears not to have been considered.</p>
		It is believed that non-estate revenue costs are not included in the analysis. It is reasonable to assume that these would be very similar between the options presented as they all provide a similar, building-led solution with little change in the service model. As noted previously this is a weakness of the project	This is not the case. Since assessment commenced in 2012 all iterations of short-listed site assessment include a quantum of cost for all revenue activity in the hospital. In the latest iteration this quantum has been based upon the Health and Social Services Department in-house, detailed modelling. Current benefit modelling work will inform the revenue quantum in the Outline Business Case and thereafter.
3.5	9	Qualitative appraisal	
	9	In general the observations noted below [in the Concerto Report] relate to the broader issue that this options appraisal exercise considers the technical elements of the development rather than its ability to support transformation and contemporary service models.	The absence of any consideration of the broader strategic and transformation programme is a significant oversight. The reviewer was provided with numerous documents which explain clearly the future direction of health and social care in Jersey, including P82/2012 'A New Way Forward for health and Social Care', the Green Paper and White Paper 'Caring for each other, Caring for ourselves', the Mental Health Strategy and Primary Care Strategy.

			<p>She was also provided with all of the Outline Business Cases, and the Acute Services Strategy.</p> <p>The modelling work which determines the size of the future hospital is predicated on the strategic direction and the achievement of the transformation programme, particularly regarding the investment in and impact of Community and Primary care services, and the productivity improvements gained by remodelling care models and care pathways and changing the approach to hospital care, as clearly outlined in the Acute Services Strategy and OBC, and in the priority investments in the Ambulatory Emergency Care model.</p>
	9	<p>There is, from an external view, elements of double-jeopardy in some of the criteria, i.e. that some issues are considered twice in the assessment. For example cost risk is best reflected in contingency sums within the financial appraisal as it is a quantitative not qualitative issues. There also appears to be similarities in criteria 2.1 and 5.5 of <i>'Appendix 22'</i> so effectively this is being assessed twice.</p>	<p>We disagree. Cost risk is best captured in accordance with HM Treasury business case and risk guidance which as the report highlights is being followed robustly.</p> <p>Quantified risk assessment is and has been generated and will inform subsequent business case development.</p> <p>Risk allowances, contingencies and optimism bias have all been included in accordance with UK HM Treasury and NHS Guidelines.</p> <p>The risk assessment to compare sites is undertaken for just that – comparative assessment of the risk of implementing the proposed hospital approach on that site as opposed to others short-listed.</p> <p>No quantitative risk assessment is meaningfully possible or appropriate at the pre-feasibility stage.</p>
	9	<p>Ideally there should be a clear direct link between the project objectives, the critical success factors and the appraisal criteria, i.e. the options should be appraised directly against what the project is required to achieve. An example of this is provided as Appendix 2.</p>	<p>We agree and clear links between the project objectives (in the form of the Acute Service Strategy) and the benefit and risk appraisal criteria are apparent through a review of the scoring and weighting criteria.</p>
	9	<p>There are no criteria to assess how the options support the over-arching service strategy: it is assumed that all do equally. This is a significant flaw in the analysis and at the very least the options should assess the impact on service strategy.</p>	<p>We disagree. The assessment is informed by the Acute Service Strategy which in itself takes account of and aligns with the whole system transformation and strategy. The report does not seem to have been informed by a reading of the Acute Service Strategy, which was deliberately written to be site agnostic.</p> <p>The Acute Service Strategy is underpinned by the same best practice assumptions implied in the report; the HSSD Minister's Forward to the service strategy summarised this succinctly:</p> <p><i>This strategy therefore has as its foundation 3 key elements:</i></p> <ol style="list-style-type: none"> <li>1. Admission avoidance – doing all we can so that patients don't need to be cared for in Hospital in the first place</li> </ol>

			<p>2. Admission prevention – when Islanders do need to come to hospital making early decisions and providing treatments in ways that reduce the numbers needing to be admitted</p> <p>3. Early discharge – when Islanders do need to be admitted, making sure their care is as safe and clinically effective as possible so that they are able to return home or to care outside hospital at the earliest opportunity</p>
	9	The strong emphasis on how the options impact on clinical services, patients, users and staff, almost 70% of the weighting points is excellent.	Patients, users, their families and our staff will remain at the heart of all we do. This is clearly stated in the Acute Service Strategy.
3.6	9-10	Financial appraisal	
	10	A further issue is the level of Optimism Bias applied. Compared to experience of projects in England at a comparable stage (assumed to be Outline Business Case) this feels a little low.	Optimism Bias used by the Project is consistent with HM Treasury Guidance. Individual sites have bespoke optimism bias assessments and Independent Assurance has verified the assumptions and approach followed as reasonable.
3.7	10	Current preferred option	
	10	This report can only surmise from the evidence presented that it is perceived that rebuilding on the current General Hospital site is politically expedient and this has over-ruled any other consideration.	<p>Political assessment followed an exhaustive technical assessment process. The best performing option was not preferred politically and therefore the art of the possible has to be meaningfully applied to the technical assessment. This formed the basis of extensive political and public consultation.</p> <p>The report is not informed by the relevant evidence that would counter this “surmise” [Definition - a supposition that something may be true, even though there is no evidence to confirm it.].</p> <p>This section is an opinion expressed by the reviewer, rather than a conclusion drawn logically from the limited documentary evidence used. The list of questions (provided as Appendix 1 to this response) addressed by those interviewed (page 3 of report) does not cover any site related topics. The reviewer did not interview anyone with this responsibility from the Department for Infrastructure or Treasury and Resources. In the absence of such interviewees the conclusion can only be a “surmise”.</p>
<b>Section 4.0</b>	<b>12</b>	<b>Review of Brief</b>	
4.1	12	Introduction	
		Both Primary and Community Services are the future for healthcare provision on the Island and have to progress from their current status, which is quite visionary in places, into the next phases of pilot schemes and, eventually steady state. The next stages are dependent on additional	The report helpfully re-presents large sections from the Sustainable Primary Care Strategy, and indicates that this is ‘quite visionary in places’, which we appreciate.

		funding and there did seem concern that this would be received	
4.2	12-16	A Sustainable Primary Care Strategy for Jersey 2015-2020	
	12	Listed in these bullets points ..... Detailed below are extracts from the Primary Care Strategy	We are disappointed that there appears to be no analysis of the Sustainable Primary Care Strategy; indeed, the report comprises a 'Cut and paste' large sections of a strategy document which has already been published.
	15	From what we can ascertain from the documents that we have been provided with, this document has not been considered during the site appraisal. If these ambitions were focused on they would form the basis for the Island to deliver the different model of care it needs and can afford over the next 10 plus years.  As we have stated through this document the Island must move to an integrated care model. Detailed within this document is how this can be achieved. What is needed is to define how the acute delivery model fits within this strategy and what can be provided on the Island going forward.	The report does not consider the model of healthcare set out in the Acute Service Strategy, the Acute Outline Business Case and the Service Plans, which were provided to the reviewer and which clearly state the cross-system aims and the importance of Primary and Community services:  1. Integrated working across the health community supported by active clinical leadership in both secondary and primary care. This kind of working places a premium on the joint development, ownership and management of published and publically available patient pathways describing the whole patient journey unencumbered by organisational and professional boundaries. 2. Where the Hospital does only those activities that only a Hospital can do. The effect of this will be that acute in-patient beds will be occupied only by those who need that bed for sound clinical reasons
	16	If the Information technology issues can be addressed as a matter of urgency, integration of services will be easier to deliver, reducing duplication and clinical risk. It will ease the patient journey by reducing duplicate questions and forms. It will ensure that delays are minimised and ultimately deliver the seamless patient experience every clinician wants.	The Department's 2013-2018 Informatics Strategy developed in conjunction with Capita. Drawing on international experience, it sets out a strategy based on four themes: <ul style="list-style-type: none"><li>• Data</li><li>• Systems</li><li>• Information</li><li>• Services</li></ul> This Strategy was formally reviewed by the Department's Corporate Management Executive in June 2015. This review, comprised three main elements: <ul style="list-style-type: none"><li>• Review and refresh the vision of the Informatics Strategy</li><li>• Carry out a stocktake assessment of progress to date</li><li>• Revise and update the action/implementation plan, setting out the specifics for the short (6-12 months) and medium (12-24 months) terms</li></ul> This review reported on and documented the significant achievement against the strategy to date. Another independent review assessed the Department's current and expected position against recognised national and international maturity models to provide assurance that progress to date and that planned for the future was appropriate and valid.

			<p>The Department's submission into MTFP2, covering phase 2 of the strategy, includes funding bids for key elements of phase 2 of the strategy. Subject to the approval of the Assembly, phase 2 of the Strategy will be implemented over the coming years as planned.</p> <p>A dedicated Programme Manager is currently being recruited to co-ordinate and manage the implementation of Phase 2 of the strategy, the main elements being:</p> <ul style="list-style-type: none"> <li>• Electronic Patient and Client record, including e-prescribing, new system for children's social care etc.</li> <li>• Integration and data sharing between primary and secondary care</li> </ul> <p>In addition, Gleeds Management Services are providing best practice expertise to the Future Hospital Project via their sub-consultant the IT Health Partnership.</p>
4.3	16-21	The role of primary and community care	<p>Whilst being titled 'Primary and Community', this section makes extremely limited reference to the Out of Hospital Outline Business Case, P82/2012, the Green Paper, White Paper or the Mental Health strategy and Outline Business Case, all of which describe exactly the sort of changes that the Concerto reviewer is suggesting have been omitted from our strategic planning. In fact, that entire section is narrowly focused on GP services.</p> <p>Moreover, there appears to be a major omission throughout the report, in that it makes no references to the investments in Primary and Community services from 2013, which have made a significant impact on the whole system, and which the reviewer was provided with information about.</p> <p>The reviewer also refers to 'Primary Care' throughout, but appears to actually only be considering GP services; there is a passing mention of Pharmacists and no reference to Dentists, Optometrists or Community Nurses.</p>
	16	Most healthcare services are faced with an increase in an older population and a rising prevalence of chronic disease bringing greater focus to unhealthy lifestyles and behaviours, often diseases of affluence and poverty. Using primary and community care facilities to try to minimise the need for hospitalisation is key to controlling the spiralling costs of healthcare.	<p>This is one of the key drivers of the health and social care transformation, which is clearly outline in the KPMG Technical Document, P82/2012 '<i>A New Way Forward for Health and Social Care</i>', the Green and White Papers '<i>Caring for each other, Caring for ourselves</i>' and the Outline Business Cases, all of which were provided to the reviewer.</p> <p>The report re-states a number of the conclusions from the documents provided to the reviewer, but adds little value in terms of analysis. It also does not acknowledge the work that is already underway to address these issues. For example, the report states that '<i>there are too many payment mechanisms that incentivise the wrong type of behaviour by clinicians</i>'. No suggestions are made, and no reference is made to the Primary Care Strategy funding work stream, which is considering this issue.</p> <p>Finally, it is worth noting that the approach taken to redesigning health and social care was reviewed in June 2014 by an Expert Panel which had been appointed by the Ministerial Oversight</p>

			<p>Group. They were provided with much the same documentation as the Concerto reviewer, and they concluded that:</p> <ul style="list-style-type: none"> <li>• The original work by KPMG had been ‘comprehensive’</li> <li>• The case for change was made and the selection of a new model for health and social care was the right one</li> <li>• The consultation process was inclusive and thorough</li> </ul> <p>The Expert Panel recommended 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</p>
	17	Primary Care practices typically offer short appointments during working week hours	This statement is factually incorrect. Islanders appreciate that GPs are able to spend more time with them in appointments, and most GP practices are open until 6pm and on Saturdays.
	17	<i>Note: The Reviewer was scheduled to meet with an ICT representative but they were called away. The Reviewer sent questions after the day of the interviews and did receive a reply. Sadly some of these replies differ from those received from the other interviewees. Therefore, the author has had to make some assumptions where there is conflict in the information received.</i>	The Director for Finance and Information in HSSD is supported by ICT specialists from the Chief Minister's Department including Mr Jeff Tate who leads delivery of ICT infrastructure by that Department. Without the evidence as to how written replies from the Head of ICT Jeff Tate differed from those received from other interviewees it is difficult to respond to the assumptions made by the author. The answers provided by Jeff Tate are attached as Appendix 2
	18	It is believed that EMIS has been rolled out...but the results had been mixed and there were differing user experiences.	As the reviewer did not interview GPs, it is unclear from where this information has been elicited to inform this view.
	18	There is a lot of work to be done with Primary Care providers	The reviewer does not provide any detail as to what this might be.
	19	<p>In 2015 a survey (...White Paper) was carried out that showed many Jersey residents were not attending their Primary Care Service</p> <p>Significant numbers were visiting Accident and Emergency rather than going to their GP</p>	<p>This is factually incorrect. The White Paper was produced in 2012, not 2015, and no ‘survey’ was carried out in the White Paper. A questionnaire was sent with the Green Paper (in 2011), but the White Paper consultation comprised face-to-face meetings. We assume the reviewer is referring to the Jersey Consumer Council Primary Care work in 2013, which demonstrated that some residents were accessing the Emergency Department instead of their GP.</p> <p>The Jersey Consumer Council reported that 10% of almost 6,000 respondents visited A&amp;E rather than their GP; this is not a ‘significant’ number of people.</p>
	19-21	(in reference to the staffing tables cut from the Sustainable Primary Care Strategy) the Island has a good	<p>Only the tables for GPs and Pharmacies have been re-presented – the whole range of Primary Care has not been considered.</p> <p>In particular, no information is presented regarding Community Nursing, and the conclusion appears to ignore the 2 critical</p>

		primary and community foundation to build from	concerns raised in all of the health and social care strategy documentation, which are the paucity of Practice Nurses and the retirement profiles of doctors. The reviewers conclusion is misleading and incorrect, if it is referring to the existing and projected future workforce; this is the reason for us focusing on workforce as one of the four workstreams in the Sustainable Primary Care Strategy.
4.4	22-25	What national and international standards are there in terms of providing crucial services	
	22	There are no national or international standards in terms in terms of providing an Island-based health service. Within this section we cover some of standards and accreditation that exist per country so that the Sub Panel can decide if they want to adopt any for use within this project.	<p>The report is not clear about the scope of work in relation to this section. It asks Scrutiny to consider if they wish to recommend adoption of accreditation standards (it's not clear if this a decision of Scrutiny). The report then continues "Accreditation is one important component in patient safety. However, there is limited and contested evidence supporting the effectiveness of accreditation programs."</p> <p>This part to the report then appears to conflate two issues: 1) the merits of accreditation for Jersey healthcare services 2) the merits of accreditation for non-Jersey hospitals in which Jersey residents might receive care.</p> <p>It is difficult to respond to this section, which is not a systematic review of accreditation standards against which might inform a Jersey health system more generally or hospital services (on or off-Island) more specifically. It appears to be a list observations and opinions.</p> <p>Systematic reviews do exist but as the report sets out the evidence for their effectiveness is mixed. The Cochrane Library Database contains one such review: <i>Flodgren et al (2011) Effectiveness of external inspection of compliance with standards in improving healthcare organisation behaviour, healthcare professional behaviour or patient outcomes</i> and other sources (see for example <a href="http://intqhc.oxfordjournals.org/content/20/3/172">http://intqhc.oxfordjournals.org/content/20/3/172</a>) reflect this mixed picture.</p> <p>The Hospital adopts and meets UK accreditation standards described for radiology, laboratories and pharmacy.</p>
	25	<p>The King's Fund Organisation Audit, part of the London-based charity the King's Fund, was an especially strong tool and provided detailed organisational checklists for public and private-funded hospitals. The tool is now owned by CHKS (<a href="http://www.chks.co.uk">www.chks.co.uk</a>).</p> <p>It is not stated in the site appraisal whether any standards apart from HBNs have been followed or</p>	It is difficult to respond to a non-systematically provided list of accreditation organisations, where each has a distinctive scope, focus and commercial imperative. For example, CHKS is owned by Capita and provides benchmarking, healthcare intelligence and quality improvement consultancy services in the UK. It is not clear from the report why the tools of this particular organisation should be reviewed by the Sub-Panel.

		consulted. We would recommend that the Sub Panel review the CHKS tools.																	
<b>Section 5.0</b>	<b>26</b>	<b>Other Island Experiences</b>																	
5.1	26	Introduction																	
	26	<p>This section provides an overview of the health systems of three similar territories to Jersey and demonstrates that every Island is experiencing similar issues. Reviewing the experience in other healthcare systems, especially how they have planned to address these issues and improve outcomes can help the States of Jersey inform their whole Island Health Strategy.</p>	<p>HSSD agrees with the reports insight that learning from the experiences of other Island healthcare systems should inform the objective of both P82/2012, its related service strategies and the Future Hospital Project.</p> <p>We have been constantly considering International best practice and approaches in other jurisdictions since the whole health and social care economy transformation work started in 2010. This is clear from the KPMG Technical Document from 2011 (publicly available), from the Outline Business Cases (which were provided to the reviewer) and from the Mental Health Strategy and Sustainable Primary Care Strategy, both of which referenced and evidenced International models. Currently, Skills for Health are working with the Department regarding workforce, Deloitte and Imperial College are advising the funding workstream of the Sustainable Primary Care project and KPMG are advising on the future of health and social care governance. All of these engagements specifically require International best practice and alternative models to be presented and considered, in order for Jersey to learn from elsewhere but develop a system which is appropriate.</p> <p>The criteria by which the reviewer is suggesting Bermuda, British Virgin Islands and the Isle of Man and against which criteria the performance of the Jersey health and social care system might be logically and systematically compared or benchmarked is not clear. The description of health and social care in these jurisdictions might be complemented by more inclusive, broader or more systematic reviews that have already informed and continue to inform the redesign of Jersey health and social care. See for example KPMG review of 15 island healthcare systems (including Jersey and Guernsey) or the Commonwealth Fund International Healthcare System Profiles, World Health Organisation Series (Asia Pacific Observatory on Health Systems and Policies) and so on.</p>																
5.2	26-29	Bermuda healthcare	<p>A systematic review of Island health systems and comparison with Jersey would usually be derived from reviewing indicators that were common to each jurisdiction. Analytic comparisons and contrasts could then be made across each of these indicators i.e. “comparing apples with apples”. The three comparators in the Report do not appear to do this. Using section sub-headings alone <i>with Jersey absent as a comparator</i></p> <table border="1" data-bbox="821 1861 1355 2047"> <thead> <tr> <th></th> <th>Bermuda</th> <th>BVI</th> <th>Isle of Man</th> </tr> </thead> <tbody> <tr> <td>S1</td> <td>Overview</td> <td>Administration</td> <td>The Manx NHS</td> </tr> <tr> <td>S2</td> <td>The Plan</td> <td>Regulation</td> <td>Department of Health and Social Security</td> </tr> <tr> <td>S3</td> <td>Budgetary issues and</td> <td>Overseas health care</td> <td>Nobles Hospital</td> </tr> </tbody> </table>		Bermuda	BVI	Isle of Man	S1	Overview	Administration	The Manx NHS	S2	The Plan	Regulation	Department of Health and Social Security	S3	Budgetary issues and	Overseas health care	Nobles Hospital
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5.3	29-31	British Virgin Islands	See 5.2																				
5.4	32-34	Isle of Man	See 5.2																				
5.5	35	Summary of systems in similar territories																					
	35	Table p.35	<p>It is not possible to respond to this section other than to observe the wide variability in island health care systems and the risks in drawing comparisons from the table. For example:</p> <ul style="list-style-type: none"> <li>• Beds per 1000 population – the analysis is unclear about the type of beds and how they are counted? The OECD sets out for examination 4 categories of beds (hospital, curative, psychiatric and long term care) but excludes beds in private hospital</li> <li>• Single Island General Hospital or multiple Island General hospitals? Where a single General Hospital exists the resilience of that hospital is not directly comparable – a key reason why comparisons between Jersey and England are problematic</li> <li>• What are the characteristics of each health and social care economy with different blends of hospital and community services and the relative productivity and performance of each health and social care sector</li> </ul> <p>While external comparisons can be helpful, we find the approach in this whole section to be descriptive rather than analytic and simplistic rather than informed by the particular circumstances relevant to Jersey.</p>																				
<b>Section 6.0</b>	<b>36</b>	<b>Review of Management</b>																					
6.1	36-37	Governance and PMO																					
		<p><i>Note: The reviewer could not review the detailed Programme Plan because it was not ready in time for this report to be completed. The Critical Path was also not available for review but the author of this report was advised the Programme is a risk, therefore they were going to de-risk it by not putting very much on the critical path. This is considered a</i></p>	<p>The absence of any interviewees from DFI or Treasury or the FH Project Director (Delivery) not requested by the reviewer is responsible for this incompleteness in the report.</p> <p>There is an important distinction between an inflammatory statement “the Programme is a risk” and what would be a more accurate statement “the Programme has risk”. A comprehensive Programme and Project Risk Register has been maintained, with appropriate risk management interventions. We are not aware that the reviewer either requested or examined the risk register.</p>																				

		<i>usual approach to a health construction project.</i>	A draft programme has been developed as part of demonstrating the approach to delivery of the preferred site. A detailed programme has been produced as part of the proof of concept work and was only unavailable because no opportunity to discuss it or the critical path(s) it shows was requested. As the Project has only entered Project Briefing phase in July and a programme has been in place throughout, this comment is not in line with the evidence. The comments on critical path are not accurate.
	36	However there is much less evidence of reporting against the key success criteria and objectives of either the programme or the specific project. They are the key success factors that the programme / project must achieve, against which success, during development and construction and on completion, must be judged. In the information provided some criteria are alluded to, such as the need to provide the new facility by 2020, but, at least at a strategic level do not seem to form the core of the programme and project. As noted in other sections of this report the objectives and CSFs for the hospital project should support the objectives of the overall health strategy as well as directly inform processes such as the options appraisal.	<p>The key success criteria and objectives for the Project have been set out previously within the draft Project Brief in 2013 and subsequently in the Strategic Brief in 2014. Since then, the Project has been reviewing sites and as indicated above has only recently entered Project briefing phase again. As a result we would expect the critical success factors and objectives to be updated within the agreed brief and formalised within an updated Strategic Outline Business Case based upon the proof of concept work.</p> <p>The reviewer was provided with an overview of the success of P82/2012 investments, and was offered the detailed document which was previously sent to the Scrutiny Panel. The Outline Business Cases refer to previous investments.</p> <p>The Director of System Redesign and Delivery explained the performance monitoring systems for the P82 investment, clearly stating that each investment had a service specification and metrics / measure which were reported quarterly.</p> <p>The interaction between acute hospital and out of hospital services is clear. The new clinical model set out in the Acute Service Strategy illustrates with, for example Ambulatory Emergency Care, how this interaction works. The Benefits Plan included in the Acute Service OBC (provided for the reviewer) sets this out in more detail. We will be tracking the realisation of these benefits through a transformation metrics dashboard</p>
	36	Two key documents that were not identified during the review process was a Benefits Realisation Plan and a Post Project Evaluation strategy (PPE). The former it should be noted is not synonymous with the benefits appraisal criteria, although they should be linked. It is essential that both the programme and project not just identify the benefit required but also how they will be achieved, who is responsible and how success will be evaluated. The PPE strategy, whilst a long-term process, should be identified early in the process to ensure that data for baseline activity (i.e. pre-change) can be collected.	<p>A Benefit realisation plan will be produced once benefits (interventions) have been confirmed and consulted upon with the clinical and operational teams and appropriate responsibility for delivery will be confirmed at this time.</p> <p>The Project has now re-entered the Briefing phase and the operational handover and soft landings appraisal will be assessed as part of the process to develop the project brief and in accordance with good practice then undertaken as part of the requirements for RIBA Stage 7.</p>
6.2	37	Timetable	

		<p>Progress to date has been slow. The appraisal has taken much longer than it should have, especially given the stated desire to have a replacement in place by 2020. As noted above there has been insufficient emphasis and reporting placed upon time – finding the best option is of course very important, but so is the achievement of key success criteria.</p> <p>The work completed to develop the site options show a reasonable project plan, noting of course that the options are now out of date. In particular there is sensible consideration of the pre-construction phase which is very often squeezed, generally to the detriment of the project, in the author’s experience. The construction period allocated is also reasonable and provides a proper balance between realism and contingency for the unknown.</p>	<p>The progress of the Project reflects the complex and shifting requirement of the Jersey stakeholders reflected in the change from the Dual Site Option through a process that would have led to a public consultation on a number of options now to the preferred option.</p> <p>At each stage a robust appraisal process was undertaken with the required rigour set out in HM Treasury and other guidance.</p> <p>The reviewer did not request the programme of works, and did not interview key people either in SoJ or Gleeds Management Service responsible for this programme, therefore it is not possible to respond to the surmise about pre-construction and constructions phases.</p>
<b>Section 7.0</b>	<b>38</b>	<b>Finance and Cost Considerations</b>	
7.1	38	Procuring care off-island	
	38	<p>The cost of procuring care and services off-Island very much depends on the scope of that procurement, from which country or entity The States are procuring, and the governance arrangements required.</p> <p>One example of how much commissioning services will cost the States of Jersey is based on Corby Clinical Commissioning Group (CCG). The CCG serves a population of 73,000 and is responsible for commissioning around 80% of services (the rest being done regionally or nationally). The Corby CCG administration function has a yearly budget of £1.56 million.</p>	<p>The reviewer appears to misunderstand the ‘commissioning’ landscape in Jersey. The system of commissioning used in the NHS is not the commissioning model appropriate for Jersey. The Lansley reforms are considered to have be an expensive failure and significantly hindered productivity savings in the NHS.</p> <p>Using any Clinical Commissioning Group, Corby included, as a benchmark would be unwise at this point – notwithstanding the fact that there are significant differences in population, and that the commissioning body, for a population of 73,000, has a running cost of over £1.5m, a cost that Jersey does not currently have and would not wish to acquire.</p> <p>The report also omits the significant consideration of the residency status of Islanders, and the potential cost implications of the proposed Department of Health 150% tariff for overseas patients.</p>
7.2	38-39	Cost effectiveness of off-Island care	
	38	<p>However there are several influencing factors that will determine the most cost effective location for services including .....</p>	<p>The review does not consider the provision of emergency care on the Island and the implications of this for a <i>deminimis</i> general hospital for the Island. This is a serious flaw in the report; alarmingly the report is silent on the significant clinical risk to Jersey residents of not having adequate emergency provision on the island and the impact of having such provision has on the infrastructure of any island hospital.</p>

	39	Appendix 3 – which medical specialties could be provided off-Island, on-Island or through other models	If services would be more safe, sustainable and affordable when provided off island then this would inform HSSD decision making. The reviewer suggests what clinical services would be most appropriately cared for either on or off-Island, but (we understand) does not have clinical credentials for being able to make these judgements.
7.3	39	Cost implications of providing care off-Island	This section simply states that there are other costs to be considered which contribute to off-Island care. It offers no analysis or insight.
7.4	40	Comparative costs in Europe	
		There is little or no substantive data available on this subject publically. Additionally to complete it significant volumetric data would be required from the States of Jersey – to provide a really useful picture activity and costs at an OPCS or HRG level would probably be required. It is therefore suggested that this should form a separate piece of work.	While cost comparisons are helpful to identify possible efficiencies they should be treated with caution.  HSSD recognise however that better understanding of costs at service level is an important tool. For this reason service costing formed part of the 2016 MTFP and this work is now underway within the HSSD Finance Department.
<b>Section 8.0</b>	<b>41</b>	<b>Other Considerations</b>	
8.1	41-46	Provision of care and service on and off Island	
	41	Many Island healthcare services are finding it difficult to control the use of high cost diagnostics and overseas treatments. At the moment many payment systems pay for care activities and do not reward avoidance of ill-health, management of long-term conditions, the integration of services or the outcomes of care. Even though many systems have been adapted to different models of pay – they all seem to suffer from a clear supply induced demand effect. To minimise the issues of capacity you must either restrict supply or reduce demand.	This section contains a number of broad statements, which appear to have limited evidence or grounding, and/or are not sufficiently detailed to be of value. For example, the reviewer cites “many Island health care services”, but does not state which Island. The reviewer also states that “many payment systems pay for care activities and do not reward avoidance of ill-health, management of long-term conditions, the integration of services or the outcomes of care”, but is unclear about whether this refers to payment systems in Islands or payment systems more generally? If more generally this statement is not borne out by the evidence of reforms in payment systems being introduced worldwide to address the issues identified in the report.  The statement “To minimise the issues of capacity you must either restrict supply or reduce demand” is a simplistic view of capacity management. All health systems manage supply through prioritisation. Demand for healthcare always outstrips supply (often a proxy for affordability). Demand for health and social care services can be met either by increasing capacity (supply) or flow or <i>both</i> . The interaction between these factors informs the bespoke solution needed to meet health and social care needs for Jersey. These are set out by KPMG in P82/2012, EY in CRO04 (which both estimate the bed, operating theatre and outpatient capacity needed for a Hospital in a ‘do nothing’ scenario). ‘Interventions’ that attenuate the capacity effects of the ‘do nothing’ scenario relate to capacity <u>and</u> flow.
	42	Island Governments and insurers can influence the cost of the system through the level of coverage they	Table 8.1 is an unattributed table from a publicly available KPMG report.

		make available. Table 8.1 outlines some key options, or configurations, that may be considered in developing a basic package. Inevitably there can be significant variation between how these are defined. However the critical issue is to ensure that there is a clear, transparent set of principles that is easily understood.	<p>In the context of this report, it demonstrates an overly-simplistic understanding of the Jersey context. The Jersey context has been set out for Ministers in a Project Board paper considering the critical mass needed to sustain a <i>general</i> hospital on Jersey. The Acute Service Strategy is clear that “We will treat all patients on Island where clinically safe and financially viable to do so”. Services will only be provided on-Island that are safe, sustainable and affordable.</p> <p>HSSD is not clear what data the reviewer received relating to past and current off-Island activity. It is not clear either how the conclusions were drawn in the absence of any qualitative interviews with senior officers who manage services off Island.</p>
	42	However the critical issue is to ensure that there is a clear, transparent set of principles that is easily understood.	<p>The Acute Service Strategy sets out two simple principles:</p> <ol style="list-style-type: none"> <li>1. We will treat all patients on Island where clinically safe and financially viable to do so</li> <li>2. We will treat in the General and Future Hospital only those patients where is it clinically necessary to do so</li> </ol>
	43	<p>For most cases it is not cost effective to provide all services locally and depending on the volume of cases, it may be more efficient and effective to use overseas specialist facilities rather than provide these services on island.</p> <p>We know that the States of Jersey already commission some off Island services e.g. Oncology. Therefore, if there is relatively low demand on an island for a specialised medical treatment it may be more appropriate, from a cost and quality of care perspective, to transfer the care to a specialist overseas provider.</p>	<p>It is not clear how the report is informed by the HSSD data available describing current Jersey off-Island activity. These data were not requested, nor were key individuals interviewed who would have been able to provide context to the data. Both would have confirmed an approach to balancing on and off-Island provision in ways set out in the report.</p> <p>There are additional factors not covered in the report which formed part of a Project Board and Ministerial Briefing in March 2015.</p>
	43	It must be ensured that any service that is provided is for the Payers (insurance companies), providers and patients	In Jersey, the majority of care is funded by the States of Jersey, through our Department. However, the report infers that insurance companies fund care. It is not clear how the consideration of ‘insurers’ which might be relevant to other jurisdictions is relevant to the issues set out in this Report.
	44	As discussed previously discussed changing patient behaviour by directly restricting patient choice, by either redefining the patient journey and the introduction of payment systems can encourage the use of primary care rather than always going to hospital.	It is not clear how this section contributes to a cogent argument for payment reform. It sets out a number of views and principles non-systematically but loosely related to funding mechanism and payment reform. Secondary care user charges are alluded to (but not recommended). We consider that raising this issue without the necessary analytic framework through which the risks and benefits of such reform might be considered is unhelpful.

	44	Whether on an Island or not buildings have to be developed so they can deliver flexible healthcare, that the accommodation can be used for many different services and that the patient is considered throughout the design. This is not just simply about design – capacity has also to be considered – for example care models in all specialities are increasingly moving away from inpatient to day case and outpatient based care and interventions. The latter require much less space, but much more specialist accommodation.	<p>The report appears to ignore the Acute Service Strategy, P82/2012, the Green Paper, White Paper and other strategies which were provided, which clearly demonstrate that care models will continue to move from in-patient to day care operations, ambulatory processes in both emergency and elective care are planned and there will be productivity improvements leading to reduction in length of stay and outpatients new to follow up ratios.</p> <p>Workforce analysis also forms part of project briefing. We concur with the report about the risks in developing a hospital that outstrips the capacity and capability of the workforce. The Future Hospital Project has no appetite to do this and has consistently emphasised the need to ‘right size’ the building to ensure safe, sustainable and affordable care <i>in the Jersey context</i>.</p>
	45	Conclusion	<p>This mixed list of normative statements and opinions relating to infrastructure, funding, workforce, information and communication technology and patient self-care provides little opportunity to comment. For example in response to “It is essential not to base the solution on the physical buildings involved in the delivery of care but to understand the strategic options and models that are available to the States of Jersey” (p45), then the answer is we concur. If the report, however, is setting out that the current health and social care redesign (P82/2012) and the Future Hospital Project is a solution based on “physical building involved in the delivery of care” we do not.</p> <p>If the report is setting out the importance of “understanding the strategic options and models that are available to the States of Jersey” we agree. If, however, the report is setting out that the current health and social care redesign (P82/2012) and the Future Hospital Project is not informed by an “understanding of the strategic options and models that are available to the States of Jersey” we do not agree.</p> <p>Regrettably the report is currently written without the necessary clarity to enable a considered response.</p>
8.2	47-48	Telehealth and Telecare	
	48	The Island are using some Telehealth solutions but more focus needs to be placed on this	<p>Telehealth and telecare do form part of some current services, and are clearly noted in the Out of Hospital Outline Business Case as an important element of new pathways.</p> <p>Systematic reviews of telemedicine, telecare and telehealth are available to better inform these initiatives.</p>
<b>Section 9.0</b>	<b>49</b>	<b>Recommendations</b>	
9.1	49-50	Whole health economy view	
	49	From what we have read and learnt that the hospital project has been driven by the building and physical requirements rather than the clinical and service strategy and patient journey.	<p>The report at no point mentions the Acute Service Strategy, Outline Business Case or Service Plans, all of which were provided to the reviewer. We can only conclude, therefore, that these important documents did not inform the report. The absence of consideration of current benefit modelling work in progress with its focus on pathway redesign to realise the productivity</p>

			<p>improvement possible for current and Future Hospital also means that this statement is factually incorrect.</p> <p>Furthermore, the reviewer make no reference to the Out of Hospital Outline Business Case or Mental Health Strategy and Outline Business Case; again, important documents in terms of understanding the strategic context and the whole health and social care economy transformation, within which the Future Hospital is planned.</p>
	49	<p>There seems to have been little consideration or review of current community and primary care estate and how services could be moved out of the acute environment. These could not just be financially advantageous but is likely to be clinically more sustainable and provide a higher quality, more patient-focused service.</p>	<p>Moving care from the acute setting to Community and Primary Care is one of the key drivers of the health and social care transformation, which is clearly outlined in the KPMG Technical Document, P82/2012 'A New Way Forward for Health and Social Care', the Green and White Papers 'Caring for each other, Caring for ourselves' and the Outline Business Cases, all of which were provided to the reviewer.</p> <p>This was acknowledged by the Ministerial Oversight Group Expert Panel in June 2014, who were provided with much the same documentation as the Concerto reviewer, and they concluded that the case for change was made and the selection of a new model for health and social care was the right one.</p>
	49	<p>It is still the opinion of this report that there are some very significant and fundamental issues relating to the project, which threaten the affordability, effectiveness and management of the programme, before, during and after any implementation of a new hospital.</p>	<p>This "opinion" is unsupported by the evidence. The reviewer did not request data relating to affordability, effectiveness and management of the programme. Not to our knowledge did the reviewer request to interview officers from the Department for Infrastructure or Treasury and Resources.</p>
	49	<p>The hospital project must to link to a service-wide strategy so that health provision is a coherent, integrated whole approach to well-being.</p>	<p>The hospital project is linked to a service wide (and whole health and social care economy-wide) strategy (P82/2012) and the Acute Service Strategy is informed by this.</p> <p>Outline Business Cases have been produced for the proposed strategic changes (including hospital services); there clearly identify interdependencies and interactions with all parts of the health and social care system. These are overseen by the Transformation Steering Group, which has a cross-system remit and also incorporates Primary Care and voluntary sector organisations.</p>
	49	<p>The ultimate aim must be to identify the "end to end" healthcare provision that or how this is best provided clinically and financially.</p>	<p>Although this sentence does not make sense grammatically we understand it to mean that the pathway of care should be unencumbered by organisational or other boundaries.</p> <p>The integration of hospital, out of hospital and primary care is the foundation of P82/2012 and the service strategies for acute, mental health, primary care, children services and 'Out of Hospital' services, as clearly demonstrated in the Outline Business Cases.</p>
	49	<p>Integration of acute, community, and primary care services is essential</p>	<p>We concur. The integration of hospital, out of hospital and primary care is the foundation of P82/2012 and the service strategies for</p>

		to providing good services. This can only be done if we approach things as a whole health economy, not piecemeal.	acute, mental health, primary care, children services and 'Out of Hospital' services, as clearly demonstrated in the Outline Business Cases.
	50	The service (like health systems everywhere) has massive pressure now and daunting issues building for the future – radical change is therefore needed to address the challenges of increasing need, workforce changes, ramping expectations, increasing patient complexity and life expectancy, inflationary cost pressures. A “like for like” replacement of acute services is not a sustainable solution.	<p>We concur. The ageing population is one of the key drivers of the health and social care transformation, which is clearly outline in the KPMG Technical Document, P82/2012 '<i>A New Way Forward for Health and Social Care</i>', the Green and White Papers '<i>Caring for each other, Caring for ourselves</i>' and the Outline Business Cases, all of which were provided to the reviewer.</p> <p>Indeed, one of the key messages from the White Paper and P82 was 'doing nothing is not an option'.</p> <p>The Acute Service Strategy is clear throughout that “doing more of the same” will not be sufficient for the future acute health and social care needs of the Island.</p>
		Strategy must be health-outcome driven - at the moment is too input driven, particularly the acute hospital	<p>We concur that strategy must be health-outcome driven. HSSD is at the point in development like many health systems particularly in the NHS which are grappling with the challenges as to how precisely be this achieved. HSSD is making progress to meet this challenges.</p> <p>The reviewer was provided with an overview of the success of P82/2012 investments, and was offered the detailed document which was previously sent to the Scrutiny Panel. The Outline Business Cases refer to previous investments.</p> <p>The Director of System Redesign and Delivery explained the performance monitoring systems for the P82 investment, clearly stating that each investment had a service specification and metrics / measure which were reported quarterly. These include both input, output and outcome measures and, importantly, capture the views of service users and staff.</p>
	50	Work has been done to consider how services can be delivered in different ways that will be clinically safer, financially more sustainable, provide greater patient-centred care, and enable greater flexibility in the short term but there is concern that the longer term 10 years plus little planning has been done.	<p>Few new hospitals are informed by detailed planning horizons beyond 10 years. The future is too uncertain.</p> <p>It is factually incorrect to say that planning beyond this period has not been undertaken. KPMG and EY used planning assumptions for bed numbers beyond this period (EY to 2075, KPMG to 2040) and HSSD internal modelling to 2080 which is the far point of demography modelling by SoJ Population Office. The usefulness of such long projection is debatable. The key to using these data is that they point to the emphasis on future flexibility in design both for services and physical infrastructure.</p>
9.2	50	Inclusivity	
	50	The strategy, and the work-streams, need to be approached in an inclusive way:	We agree and they <i>are</i> being approached in an inclusive way. The integration of hospital, out of hospital and primary care is the foundation of P82/2012 and the service strategies for acute, mental health, primary care, children services and 'Out of Hospital' services, as clearly demonstrated in the Outline Business Cases. The strategies and plans have been co-produced with a range of

			stakeholders, including hospital clinicians, Primary Care and voluntary sector representatives.
	50	Political oversight is vital but should principally consider the strategic elements, not the operational or detailed technical elements. This project at this stage should not be political. It should be driven by the clinicians, payers and patients. Once the whole Island Clinical Strategy is agreed then political oversight will be critical to realising the vision.	P82/2012 and the service strategies for acute, mental health, primary care, children services and 'Out of Hospital' services have been co-produced with a range of stakeholders, including hospital clinicians, Primary Care and voluntary sector representatives. Once this was complete, political consideration was sought. However, in a small, Island jurisdiction, where the Minister is Corporate Sole, politicians are key stakeholders and must be involved, informed and consulted throughout any strategy development, particularly those which are as ambitious, complex and sensitive as the transformation of the whole health and social care economy and the building of a new hospital. The reviewer's comments highlight the lack of understanding of the context within which we operate in Jersey, the relative importance of our wide range of stakeholders and the factors required in order to progress change. The comments may indicate that the reviewer does not have experience of working in jurisdictions such as Jersey, and that large organisations such as the NHS have been used as the only frame of reference.
	50	Public / patient / carer ownership of change will be vital so they must be brought into the tent of discussions and development.	<p>We agree. Public, patient and care ownership of change is essential. This has been key to the ongoing strategic change – for example, the Mental Health strategy was co-produced using a Citizen's Panel (which is still active and involved in the implementation). Two large public consultations were held as part of the Green Paper and White Paper; Islanders clearly agreed that a new hospital is required, and also agreed that more services should be provided in Community and Primary settings; this is the strategy we have been implementing since 2013, which is showing demonstrable benefits but to which the reviewer did not refer in the report.</p> <p>The current engagement relating to the Future Hospital site is being externally assured by the Consultation Institute, an independent organisation experienced in the oversight of strategic service change like that required by the Future Hospital.</p>
	50	An external "critical friend" would be a very helpful role to develop – this should not be part of the local establishment, nor part of one of the existing advisor, and must have no local axe to grind. Their primary task will be to continuously question whether the work-stream is focussing on the key success criteria and overall objectives.	<p>The whole system transformational change programme had five 'critical friends' during its development; this was known as HASSMAP, the Health &amp; Social Services Ministerial Advisory Panel, and comprised senior, experienced health and social care professionals, including a large acute hospital Medical Director, ex-Director of Social Services, Chief Executive of a large Mental health Trust, GP, and a local businessman.</p> <p>In June 2014 the Ministerial Oversight Group appointed a Peer Review panel, comprising Sir David Henshaw former Chief Executive of Liverpool City Council, formerly Char NHS North West and Alder Hey Children's Hospital and currently Chair St Georges NHS Hospital Trust, Dr Clare Gerada formerly Chair of the Council of the Royal College of General Practitioners, John Appleby Chief Economist at The King's Fund, Andrew Williamson Chair of Coastal West Sussex CCG and formerly Chair of Cornwall and Isles of Scilly Primary Care Trust and Professor Patrick Geoghegan OBE former</p>

			<p>Chief Executive of the South Essex Partnership NHS Foundation Trust</p> <p>Their findings and recommendations have been noted in other sections of this response.</p> <p>The Kings Fund also acted as Critical Friend to the Sustainable Primary Care Strategy.</p>
9.3	51	System sustainability	
	51	Health services need to be considered to ensure that they are provided in the most clinically and financially sustainable way (both the service model and the physical location).	<p>We agree, and would point out that health <u>and social care</u> services must be considered. Throughout the report, the reviewer refers solely to health services; this indicates that the reviewer has perhaps not understood that the Department is an integrated health and social care organisation, and that the whole system transformation programme pertains to the whole health and social care system – including the voluntary sector.</p> <p>The five elements of the vision for health and social care in Jersey, as outlined in P82/2012, are safe, <u>sustainable</u>, affordable, integrated and delivered in partnership. These are at the heart of everything we do, and are the factors against which any service assessments and investment decisions are made.</p>
	51	Criteria need to reflect what is safe to do where (now and in the future), what we can afford to do in different places (whole episode not elemental costs), and what we must have locally to ensure reasonable access.	<p>We agree. The five elements of the vision for health and social care in Jersey, as outlined in P82/2012, are <u>safe</u>, sustainable, <u>affordable</u>, integrated and delivered in partnership. These are at the heart of everything we do, and are the factors against which any service assessments and investment decisions are made.</p> <p>The Acute Services Strategy clearly notes that care will be delivered on-Island <u>where safe to do so</u>.</p> <p>And the off-Island commissioning, tendering and contracting work has been focused on both improving the quality of services for patients, and reducing costs.</p> <p>The benefits work stream being undertaken in partnership with clinical and other stakeholders and delivered by EY, Gleeds Management Services and MJM Medical healthcare planners is predicated on identifying productivity opportunities that would then inform the design of the Future Hospital and the redesign of services that would characterise the transitional period before it opened.</p>
	51	For services to be provided on-Island what can only be done in an acute setting needs to be identified and what would be better provided in facilities in the community and whether a Community Hub (mobile service is something that should be considered). Some of this work has been done but the next phases are dependent on business case approval.	<p>We agree; these are the key factors in the whole system transformation programme.</p> <p>The reviewer is correct that the ongoing implementation is subject to business case approval; this is the system in Jersey, quite rightly, additional investment funding must be considered in a robust way, in order to ensure ongoing value for money for taxpayers.</p> <p>The reviewer was provided with the Outline Business Cases, which clearly demonstrate the strategic direction of increasing services in Community and Primary Care settings, the reasons for doing so, and the high level plans regarding investment priorities and new /</p>

			<p>improved services – including a client-focus and improved pathways in and out of hospital settings.</p> <p>The reviewer was also provided with information regarding the investments made in Phase 1 (2013 – 15), but did not refer to these in the report, in order to demonstrate progress towards the strategic aim that the reviewer has stated.</p>
	51	<p>In order to identify the best place to provide services the system will need to develop clinical pathways and undertake activity modelling. This has been started but not far enough advanced to demonstrate the effect on acute activity.</p>	<p>This work in progress. The reviewer was provided with the Outline Business Cases, which contain high level plans regarding investment priorities and new / improved services – including a client-focus and improved pathways in and out of hospital settings.</p> <p>In addition, the Out of Hospital OBC 2016 (which is in implementation) notes the appointment of a Clinical Forum Chair to lead cross-system pathway development. This role has already been appointed and is working across acute, Primary and Community settings. Other Phase 1 developments such as the Rapid Response team, specifically support improved pathways between care settings, in order to ensure Islanders can be cared for at home wherever possible. The reviewer was provided with information regarding Phase 1 implementation, but did not refer to it in the report.</p>
	51	<p>Even though this is outside of the brief of the report we recommend that, as many other jurisdictions have done, the States of Jersey should review how healthcare can be funded sustainably in the future. Some of this work has been discussed in this document and was also considered in the work completed by KPMG in 2015. This work is about to start. It should not be underestimated how long this could take to complete</p>	<p>We agree. Significant work has been undertaken by the Treasury and Resources Department to investigate the sustainable funding of both the capital and revenue elements of the Future Hospital supported by EY and other Strategic investment advisors. No attempt was made by the Reviewer to understand this work or access it.</p>
9.4	52	<p>Joint purchasing</p>	
	52	<p>As part of the overall approach to developing the service model the States of Jersey should consider the development of joint purchasing partnerships with similar communities and territories.</p>	<p>We agree, however, this subject area was not really covered in the information that was requested by the reviewer, and therefore it remains a statement in the report without any analysis, evidence or targeted recommendation which would assist in understanding the reviewer’s recommendation.</p> <p>Jersey has worked with Guernsey on procurements in the past, for example the Air Ambulance. We continue to liaise very regularly regarding off-Island acute provision, particularly as we face the same challenges (most notably the potential 150% tariff, to which the reviewer does not refer) and both send the majority of off-Island activity to the same acute provider in England. We have held a number of very productive meetings with commissioning colleagues in Guernsey and agreed a joint approach. Indeed, the potential for fully shared commissioning, including shared posts, has been considered.</p>

			<p>Tri-partite discussions have also taken place with the Isle of Man, again to share strategic plans and discuss joint approaches, however, as we do not share acute providers, joint commissioning / contracting is not relevant.</p> <p>This information could have been provided to the reviewer, had these questions been raised.</p>
	52	<p>There is the potential not just to benefit from economies of scale but also to share best practice and financial risks and to develop other inter-island services.</p>	<p>Discussions are ongoing with Guernsey regarding sharing of services and personnel.</p> <p>Discussions with the Isle of Man indicated that, due to the distance and lack of transport links, shared services are not appropriate.</p> <p>Strategic and operational discussions have commenced with the Isle of Wight, and we have used their Clinical Hub model as a basis for our own Care Hub.</p> <p>We are also members of the New Cavendish Group of innovative healthcare organisations facing similar pressure to these we face on Jersey.</p> <p>This information could have been provided to the reviewer, had these questions been raised.</p>
	52	<p>Other Channel Islands are the obvious initial partners especially as likely to be using the same facilities off-Island</p>	<p>We agree and have good working relationships with other Island health communities, in particular with Guernsey and the Isle of Wight. The Isle of Man use different acute providers, so joint working in this respect is not relevant, but we do maintain a relationship regarding strategic developments, as Island communities face similar challenges.</p> <p>We continue to liaise very regularly with Guernsey regarding off-Island acute provision, particularly as we face the same challenges and we send the majority of off-Island activity to the same acute provider in England. We have held a number of very productive meetings with commissioning colleagues in Guernsey and agreed a joint approach. Indeed, the potential for fully shared commissioning, including shared posts, has been considered.</p> <p>We are also members of the New Cavendish Group of innovative healthcare organisations facing similar pressure to these we face on Jersey.</p>
	52	<p>A strong theme in written and verbal evidence is that Jersey is unique. It does have individual pressures and issues of course. However the vast majority of the most important pressures and issues are shared with other island jurisdictions (and indeed the rest of the UK). Learning from others, and where possible sharing the burden with others, is not a sign of weakness but an understanding that learning from experience</p>	<p>There has <i>never</i> been a view that Jersey is “unique”, however, we have noted that small, isolated, Island communities have a different set of challenges to those faced in large areas with different structures, systems, provision and access (such as England). Understanding our particular challenges is key to ensuring the whole health and social care economy strategy is appropriate, and that the right decisions are made regarding, for example, the size of the future hospital and the service models.</p> <p>There are many illustrations where the redesign of health and social care generally and the Future Hospital Project more specifically has been informed by learning elsewhere; this is</p>

		elsewhere is by far the cheapest way of developing a new project.	<p>evidenced in the KPMG Technical Document, P82/2012, Outline Business Cases, Mental Health Strategy and Sustainable Primary Care Strategy.</p> <p>We are also members of the New Cavendish Group of innovative healthcare organisations facing similar pressure to these we face on Jersey.</p> <p>We have also undertaken visits to South Essex Partnership Trust, Cramlington Emergency Hospital, Edinburgh Royal Infirmary, South Wales, North Staffordshire, Great Ormond Street, Southmead Hospital Bristol, Altnagelvin Hospital Northern Ireland and Alicante in Spain. We have good relationships with Guernsey, Isle of Man and Isle of Wight and share strategic information and learning.</p>
9.5	52-53	Inputs to project	
	52	The project would benefit from a much greater understanding of all of the inputs that enable good healthcare provision. There is a need to ensure that we understand what the Island already has; what are the opportunities, what are the constraints, which should include transportation, staffing and skill levels.	We agree. The project has been and will continue to be informed by such considerations.
	53	ICT – Is essential for the success of this project. It is clear during the interviews that ICT has fallen behind the rest of the projects. There is some integration of solutions but there is no evidence of one overall plan and how this is linked into the Programme Plan. The report is extremely concerned by the fragmented approach to ICT.	<p>It is not clear how this conclusion has been reached.</p> <p>P82/2012 identified the use of information and technology as one of the key enablers to delivering the changes needed. This led to the restructuring of IT services within the Department and the establishment of an island wide group comprising members from all main stakeholders in the health and social care arena.</p> <p>The Department’s 2013-2018 Informatics Strategy was developed in conjunction with Capita, drawing on international experience and based on the issues set out in P82/2012, sets out a strategy based on four themes:</p> <ul style="list-style-type: none"> <li>• Data</li> <li>• Systems</li> <li>• Information</li> <li>• Services</li> </ul> <p>This Strategy was formally reviewed by the Department’s Corporate Management Executive in June 2015. This review, comprised three main elements:</p> <ul style="list-style-type: none"> <li>• Review and refresh the vision of the Informatics Strategy</li> <li>• Carry out a stocktake assessment of progress to date</li> <li>• Revise and update the action/implementation plan, setting out the specifics for the short (6-12 months) and medium (12-24 months) terms</li> </ul> <p>This review reported on and documented the significant achievement against the strategy to date. Another independent review assessed the Department’s current and expected position against recognised national and international maturity models to</p>

			<p>provide assurance that progress to date and that planned for the future was appropriate and valid.</p> <p>In addition, Gleeds Management Services are providing best practice expertise to the Future Hospital Project via their sub-consultant the IT Health Partnership.</p>
	53	<p>Workforce – Whilst the project has identified and analysed projections for ageing and demographics and the impact on service, the report does not believe that it has long-term sustainable plans to resolve recruitment and retention, especially given the noted ambitions for acute services. As affordable accommodation and housing seem to be a real issue for healthcare workers what can the States do to provide a more sustainable solution.</p>	<p>A Workforce Strategy and Plan is currently under development. Skills for Health are HSSD partners I this work. HSSD HR Director is Senior Responsible Officer for the Project. Skills for Health are also supporting the workforce strategy for Sustainable Primary Care, to ensure a whole system approach is considered.</p> <p>HSSD is currently working with the Strategic Housing Unit and local affordable housing providers to develop a sustainable key worker strategy for health and social care staff.</p>
	53	<p>Site appraisal – The technical appraisal of the sites for the new acute facility is strong and follows best practice in the vast majority of aspects. However the report understands that the current preferred option is a rebuilding on the existing site. We can find no evidence as to why this should be based on the qualitative, quantitative, and financial analysis undertaken in pain-staking detail previously. At this juncture the report cannot support this decision nor the process behind it.</p>	<p>The reviewer did not have access to proof of concept report or set out questions or request an interview with politicians or officers from the Department of Infrastructure, Treasury and Resources or the Project Board through which the reviewer would have reached a different conclusion. These sources would have confirmed the qualitative, quantitative and financial analysis painstakingly detailed previously.</p> <p>The conclusion the report is therefore underdetermined by the evidence.</p>
9.6	53-55	Next steps	
	53	<p>The technical elements of project completed are very strong but they do not link to the rest of the health service strategy. In essence currently the project, and thereby the specification for the hospital, has put bricks before clinical pathways.</p>	<p>We disagree with this conclusion. The future hospital work is underpinned by the whole health and social care economy transformation and strategy (P82/2012), and the need to transform services in advance of a new building is clearly outlined in the Acute Service Strategy, Acute outline Business Case and service Plans. Various documents which were also provided which clearly demonstrate how a system-wide approach is being taken, for example each of the Outline Business Cases contains a section regarding integration and interdependencies. The whole programme is overseen by a Steering Group, which ensures that integrated service transformation remains a high priority.</p> <p>The report does not consider the acute service benefit intervention modelling work which will benchmark bed numbers and type, outpatient and theatre productivity against NHS and Island peers, identify productively opportunities agreed through clinical engagement which interventions can work in a Jersey context, then</p>

			<p>model these interventions before finally ensuring that activity, workforce and design considerations inform the future hospital design and operational safety, sustainability and affordability.</p> <p>The 'specification' (by which we understand the reports means the Hospital 'brief') has not yet been concluded. The Sub Panel will be aware of the date for the completion of the brief.</p>
	53	<p>A key question is to ask how the new facility can be made flexible so that it can meet the needs of continually evolving healthcare provision and best practice. The design, specification, and approach are predicated on a very restricted model and may, eventually, restrict and limit services rather than enable them</p>	<p>The proof of concept report contains a high level approach to future flexibility should the Hospital need to expand and the other site assessment reports provided show that future flexibility of the way shown has been undertaken for all shortlisted options.</p> <p>This would be informed by the design flexibility characteristic of new hospitals where, through repeatable room design, standardisation and healthcare planning, the need for future flexibility to meet currently unknown service needs is a key part of any project.</p>
	54	<p>As noted previously it is essential to review design and specification to consider how these support the local service strategy.</p>	<p>This is continually under review. Review of the Acute Service Strategy forms part of CR026. The transformation metrics under development within HSSD will indicate progress towards the necessary whole systems transformation needed to ensure the service model, hospital design, capacity and patient flow meet the needs of the Island within the whole health and social care economy transformation.</p>
	54	<p>There is currently no decant plan or Programme plan available to the report. This is of great concern to the report as affordability and timing of the project are not clear at this point.</p>	<p>There is such a plan and this is further set out within the proof of concept report. In addition, briefs for work streams that contribute the elements in this plan are in development which is now appropriate for the stage of development of the project.</p>
	54	<p>In summary the critical question to consider for the hospital project is "Does this enable the new service model and support the objectives of providing appropriate, safe services, with reasonable access at a cost that is affordable in the long-term?"</p>	<p>The future hospital work is underpinned by the whole health and social care economy transformation and strategy (P82/2012), and the need to transform services in advance of a new building is clearly outlined in the Acute Service Strategy, Acute outline Business Case and service Plans. Various documents which were also provided which clearly demonstrate how a system-wide approach is being taken, for example each of the Outline Business Cases contains a section regarding integration and interdependencies. The whole programme is overseen by a Steering Group, which ensures that integrated service transformation remains a high priority.</p> <p>Therefore, at proof of concept level we have a reasonable assurance that the service model changes (across the whole system, and in acute services), along with the new hospital build, should ensure that the health and social care of the future is safe, sustainable, affordable, integrated and delivered in partnership.</p>
	54	<p>It is essential going forward that there is clearer executive leadership of the programme. At the moment the shared responsibility, especially as this relies on staff with extensive</p>	<p>If this recommendations refers to the Future Hospital Project there is a single director whose focus is on delivery and risk – the FH Project Director (Delivery). This Director reports to the Future Hospital Project Board and could have been easily consulted in preparation of this Report</p>

		<p>portfolios including operational leadership, results in a programme with insufficient focus on delivery and on risk. It is recommended that there is one overall programme director, directly reporting to the Board, who has the responsibility for delivery across all work streams of the programme.</p>	<p>The political-level governance arrangements having been recently reviewed and changed with the Ministerial Oversight Group (responsible for overseeing the transformation of health and social services set out in P82/2012) replaced by the Future Hospital Political Oversight Group (responsible for overseeing the delivery of the Future Hospital).</p> <p>The overall programme of health and social care transformation <i>including the Future Hospital</i> (i.e. all work streams of the HSSD transformation programme) has been subject to a robust governance structure since 2011, reporting to the Transformation Steering Group. The Director of System Redesign and Delivery (lead Director for the whole health and social care transformation programme) is a member of the Future Hospital Board as is the HSSD Chief Officer, HSSD Finance and Information Director and Hospital Managing Director.</p>
	55	<p>The States of Jersey to consider how it can best look to develop closer ties with other health economies to the benefit of all parties and to assist in both operational delivery and strategic planning for services</p>	<p>We agree and have good working relationships with other Island health communities, in particular with Guernsey and the Isle of Wight. We also have good operational working relationships with a range of acute providers, including University Hospital Southampton, John Radcliffe Hospital and Portsmouth.</p> <p>Tripartate discussions have also taken place with Guernsey and the Isle of Man, to share strategic plans and discuss joint approaches. Strategic and operational discussions have commenced with the Isle of Wight, and we have used their Clinical Hub model as a basis for our own Care Hub.</p> <p>We continue to liaise very regularly with Guernsey regarding off-Island acute provision, as we send the majority of off-Island activity to the same acute provider in England. We have held a number of very productive meetings with commissioning colleagues in Guernsey and agreed a joint approach. Indeed, the potential for fully shared commissioning, including shared posts, has been considered.</p> <p>We are also members of the New Cavendish Group of innovative healthcare organisations facing similar pressure to these we face on Jersey.</p>
	55	<p>As a result of the evidence provided it is suggested that the States of Jersey would benefit from an ICT Director for the Island with responsibility for all elements of health and social care (including primary, community and acute) to address our stated concerns that current strategy is fragmented, led by different departments with different aims, and with insufficient senior skill sets and experience.</p>	<p>Health and social care is integrally linked and needs to be considered together. Equally, it is important to recognise that health and social care in the island is a mixed economy comprising a wide range of organisations and individuals, i.e. they are not part of one organisation that can be 'directed' by a single individual.</p> <p>However, a dedicated Programme Manager is currently being recruited to co-ordinate and manage the implementation of Phase 2 of the strategy, the main elements being:</p> <ul style="list-style-type: none"> <li>• Electronic Patient and Client record, including e-prescribing, new system for children's social care etc.</li> <li>• Integration and data sharing between primary and secondary care</li> </ul>

			<p>A great deal of work is already underway to enable progress to be made in the area of data sharing and integration.</p> <p>The main organisations involved in the provision of primary and secondary care in the island share a common vision in terms of using information for the benefit of patients and are working together, through Digital Jersey, to develop a single digital health and social care strategy for the island. This work is utilising international expertise as well as local on-island IT expertise as well as health and social care providers.</p>
	55	<p>The programme appears to be highly dependent on funding streams and business cases that have not yet been through the correct approval processes and which will heavily rely on consistent government policies and priorities over the next 10 years.</p>	<p>The programme is dependent on funding streams yet to be agreed by the States Assembly. This is expected to be debated by the States Assembly in tandem with the site choice during 2016. The scale of cost was set out in the Addition to the MTFP 2017-2019 approved by the States in September 2016.</p> <p>Consistency of government policies and priorities over the next 10 years is of course generally beneficial to health and social care where long term benefits can accrue from longer term policies.</p>
	55	<p>The timeline, for a relatively small programme team, is very challenging in all phases, especially given the highly complex nature of the current preferred option of building on a clinical site whilst it remains operational. Note this concern is equal for the developmental (i.e. business case) and construction phases.</p>	<p>We agree with this recommendation.</p> <p>The Project team capacity and capability has recently been augmented. This will need to continue and in doing so reflect the size and complexity of the programme 2016-2019 (covering the relocation works and the operationalisation of services in the new locations) and 2019 – 2024 (covering the construction, commissioning and ‘soft landing’ of the Future Hospital).</p>

<https://www.kpmg.com/BS/en/IssuesAndInsights/ArticlesPublications/Documents/2015-07%20Regional%20Healthcare%20Survey.pdf>

[Commonwealth Fund International Healthcare System Profiles](http://international.commonwealthfund.org/)

<http://international.commonwealthfund.org/>

<http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm>

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