STATES OF JERSEY

Health, Social Service and Housing Scrutiny Panel
Health White Paper Review - GP Primary Care Group

FRIDAY, 13th July 2012

Panel:
Deputy K.L. Moore of St. Peter (Chairman)
Deputy J.A. Hilton of St. Helier
Deputy J.G. Reed of St. Ouen
Mr. G. Wistow (Adviser)

Witness:
Dr. P. Venn
Dr. B. Perchard

Also Present:
Ms. K. Boydens (Scrutiny Officer)

[10:30]

Deputy K.L. Moore of St. Peter (Chairman):

Thank you for coming to speak to us today. We very much appreciate your submissions. I have to start by making a few opening remarks for members of the public and media. If we just draw everyone's attention to the code of behaviour which is on the wall. Electronic devices, including mobile phones, should be switched to silent and the taking of visual images or audio recordings by the public will not be permitted. If you wish to eat or drink, please leave the room. Finally, I would ask that members of the public do not interfere with the proceedings, and as soon as the hearing is closed please would they be kind enough to leave quietly. Also they are not to communicate with ourselves or any witnesses until they are outside the building. We will start, for the record, by introducing ourselves individually. I am Deputy Moore, the Chairman of the Panel.

Deputy J.G. Reed of St. Ouen.

I am Deputy James Reed, panel member.

Mr. G. Wistow (Panel Adviser):

I am Gerald Wistow, I am the panel adviser.

Deputy J.A. Hilton of St. Helier (Vice Chairman):

I am Deputy Jackie Hilton, Vice Chairman of this panel.

Ms. K. Boydens (Scrutiny Officer):
I am Kellie Boydens, Scrutiny Officer.

Dr. B. Perchard (General Practitioner):
I am Byrony Perchard, I am a G.P. (General Practitioner).

Dr. P. Venn (General Practitioner):
Philippa Venn, I am a G.P.

The Deputy of St. Peter:
How much of a contribution have G.P.s as a group been invited make or been able to make towards the Green Paper and then the White Paper?

Dr. P. Venn:
Okay, first of all Bryony and I both have places on the steering group and have been involved very early on from the inception and the concept. We met the preferred people tendering for the White Paper provision very early on and we were involved then. So we have been to every meeting that existed surrounding the steering group and have representation there. We have also been invited to take our members to a variety workshops and particularly the very early workshop, the full day presentation at the Jersey Showground, the Trinity Showground. We have also been invited to put G.P.s into the outlying business cases to the business workshops there. We fed back to the G.P.s on a regular basis in private meetings and we have also fed back with electronic email communication as much as possible. Engaging G.P.s is quite a tricky thing to do and it is when things are about to change that they become more proactive and more reactive and engage with us. So that is always a challenge for us but we believe we have had information flow to them all the way through the process and we have been free to share information with them as and when it has been appropriate.

The Deputy of St. Peter:
What has been the general view of the whole group of G.P.s towards to the ideas put forward?

Dr. P. Venn:

I think most health professionals would look at that White Paper and find it very difficult to disagree with the broader concepts of the need for change, the need for investment and the move to community based provision for quite a lot of the services that are in the paper. That is the general feedback we have had from our colleagues about that. I think there are always issues between different professional groups about how services could be provided but we are very confident about the voice we have at the table that we can influence that and we can shape that. I think we are very much at a point where we are in an outlying business case stage, we are now at a point where we can ... as I say, we are confident in the voice that we have in that situation.

The Deputy of St. Peter:

Are you, as a group, happy with the involvement in the new services in the community, some of which may be led by nurses?

Dr. B. Perchard:

At this stage they are outline business cases so it is difficult to be very specific about whether we are happy with the way the service looks because we do not know precisely. The broad themes that are coming through the outlines business cases look reasonable.

Deputy J.A. Hilton:

So you have total involvement in the decision behind those outline business cases for the first 3 years. So representing the G.P.s you were involved in which services were going to be targeted?

Dr. B. Perchard:

The way the process was constructed is we had a number of meetings for each outline business case and we had G.P. representation, along with family nursing having representation, giving ideas as to what the service might shape up to look like. We have not written the papers or sat on the group that writes the papers but certainly I feel we have had opportunity to input into what the outline business cases look like. Of course the most critical part would be the outline business cases becoming full business cases when the services would be shaped up formally.

Dr. P. Venn:

But I think there is an understanding at the top of health that you cannot implement any of this change without the engagement of general practice and that also there is an understanding at the top of health that you need the buy-in of all stakeholders to implement change. There will always be issues and challenges from different professional groups about the way a model looks because we all believe we can do it in certain ways, but I think we are very confident in the fact that we can challenge and we will be heard, that we can influence and that the role of a sustainable primary care system with general practice at the centre is completely acknowledged by those who are making the changes.

The Deputy of St. Ouen:

Is it true to say that G.P.s generally are in support of the proposals contained in the White Paper which suggest that we should have community nurses, G.P.s can back away, not be involved in perhaps some of the more minor matters that you are dealing with now and that you are comfortable that you can pick up and deliver some of the proposals?

Dr. B. Perchard:

I think when you take a group of 80 professionals there will always be some disagreement but I think broadly speaking the profession is supportive of an increase in community nursing in Jersey. In fact most of us would say it is desperately needed.

Dr. P. Venn:

I think the other thing is it is not necessarily about increasingly community nursing, it is about the lower skilled workers, that is where we personally believe quite a lot of the development needs to happen. Again, we might challenge some of the work modelling on whether it is a nurse or healthcare assistant or what level of professional is engaged, but again the outline businesses are skeletons. They are a forum for discussion and I think we are also confident there has been a new appointment of a the workforce planner who absolutely understands that challenge is needed to some of those models but that is appropriate, that is healthy and that is evolutionary and you get a better system from challenge. So, again, we are feeling increasingly confident about the team that is being assembled at the top, the people who are being brought in from the outside to help deliver this. I guess that is something that needs to be acknowledged that I do not think Jersey has the skillset to deliver this from within. This is a massive programme of change and I think there

will be a transition period where we will need outside people to make sure that we do it in the most cost-effective, most productive and ultimately the patient outcomes at the centre of everything we do so we will need outside expertise. But certainly the key appointments that have been made recently are ones that we have confidence in and we do not always feel that necessarily but in this situation we are happy.

The Deputy of St. Ouen:

Can I just ask, with regards to the outline business cases, do the business cases that you describe include and identify funding and where funds will be allocated over the next 3 years?

Dr. P. Venn:

Broadly, I think again another really important focus that everyone needs to be aware of is that currently we are operating in a situation of silo differentiated funding, in other words we have patient fees coming in, we have got the health insurance fund, we have got Health and Social Services funding going into various organisations, that makes integration difficult. Genuine integration of services very difficult. I understand that as part of the White Paper there will also be a linkage to ensure that the behind all of this first 3 years the Treasury are looking at how the funding can be implemented. I am not necessarily talking about raising the cash to pay for this, I am talking about how the funding flows around the system and that is something that needs to be addressed as soon as can possibly be done to leave that, to defer that and to let that disappear into a vortex of legislation would be very, very dangerous to the whole process so that ability to address the integration of funding schemes is really important. It also goes to the integration of I.T. (information technology) as well, that is a really important support to the whole process of integrated healthcare.

The Deputy of St. Peter:

Do you as a group support the idea of introducing capitation perhaps rather than fees that are paid per visit?

Dr. B. Perchard:

We have not had discussions in that level of detail at this point. As an individual I can say broadly speaking probably, but what we have not done is have that level of discussion as to precisely what a funding mechanism might look like. We look forward to having that discussion because we consider it to be quite critical.

Dr. P. Venn:

We are very frustrated by the fact that we are tied to seeing a patient to be able to deliver a service, because we are on a hamster wheel, if we do not have people coming in in front of us we are not bringing income into our business which means it is very difficult for G.P.s to step back and develop services, to lead services and to make sure you are getting the best out of them. So we would welcome some uncoupling of the need for us to see a patient to generate income into the practice. How that is done is quite a sophisticated discussion and I think we need to look at models from elsewhere, Singapore, Germany, Holland, there are lots of models. But I think that absolutely imperative as part of it. I would be very sad to see the White Paper with all it suggests without that piece of work supporting it because that would be really futile and a waste of lots of people time.

The Deputy of St. Peter:

Is time not running out a little, this is due to be lodged in September, the end of September ...

Dr. P. Venn:

No, you have to invest now because you also have to recognise that everyone is on a period of change. These specialist nurses, different professionals that are being talked of do not just ... you know, we do not shake a tree and they fall out. They need training, they need recruiting, they need identifying. There is discussion about how the services look, et cetera. There is also money needed now to progress the process but they can go alongside as parallel pieces of work on the basis that once one has done the medium term, about 3 years, then one is able to seriously address that real integration in 3 years' time.

The Deputy of St. Ouen:

Just to finish off, I think you have already answered part of my question, it is just basically around what you would expect after this consultation on the White Paper has been completed. You have already said that you expect some additional funding to be provided. But how do you see your involvement developing and progressing following this consultation?

Dr. P. Venn:

I think implementing and getting to a point of implementing the full business cases, whatever they might look like, I think we will skill our businesses and model our

businesses depending on what those full business cases look like in their entirety. I think we are confident that Health do not see any funding that comes through as being their money to spend. There is other ways of spending that money and with other providers to spend that money. So it is not about ... actually there are ways of moving a system forward within some of the current funding streams we have. The ability, for example, from P.136 to contract with G.P.s, with other providers from out of the health insurance fund, those will be enablers that will allow us to move forward and start to develop the services and see how they look moving forward.

The Deputy of St. Ouen:

Currently you have not seen any detailed business cases that will support any proposed funding that will be required for the next 3 years, is that what you are saying?

Dr. B. Perchard:

We have seen the outline business cases.

Dr. P. Venn:

We also know the work is being done at the moment to get to the point where in November those full business cases will be written so that ... there will be further periods of engagement with all the professionals to do that. So that is work that is proposed and that is work that is happening alongside this consultation and lodging process.

The Deputy of St. Peter:

So throughout this first 3 year phase of the reforms you do not envisage the fee structure regarding primary care to change?

Dr. B. Perchard:

It may change in some situations. If you read the C.O.P.D. (Chronic obstructive pulmonary disease) outline business cases, certainly elements within there that may change the way patients, not necessarily we receive funding but the way patients are funded to attend to us. The one thing that we are very keen to find a way to resolve, but it is obviously not within our gift to do so, this is a political issue, is how do you help vulnerable people with multiple chronic conditions attend their general practitioner on a regular basis. Of course the world will say that strong primary care in which you have good access helps mitigate costs in secondary care.

[10:45]

This is a problem facing developed countries, how do they make their health system work, be affordable and sustainable and meet the needs of people with multiple chronic long-term conditions.

Deputy J.A. Hilton:
From your experience do you think patients on low income support with chronic conditions are well served by the low income support system or do you think there are gaps?

Dr. B. Perchard:
Where they have got existing household medical accounts it works well. But for patients that do not have household medical accounts it is undoubtedly an issue.

Dr. P. Venn:
Because they make not necessarily what one would consider the right choices about what to do with the money that comes into the household and that is one thing that we found really difficult. People do not understand that their cheque has changed and they are not getting their medical piece, they really do not have comprehension that their cheques may be changed a bit because that is to pay for their primary care. That is a disconnect between what the patients understand and the way income support is meant to be supporting their medical care.

The Deputy of St. Peter:
Shall we move on and talk about how you envisage your roles within the community structure that is being proposed. How do you anticipate that will work?

Dr. B. Perchard:
Well, hopefully a bit like it did in England before I came to Jersey. G.P.s were part of multidisciplinary teams, we had lots of people in our practices, it was brilliant and in Jersey it is a slightly old-fashioned system of having a G.P. working as a little individual. We work quite hard within my practice to try and bring people in but it is quite hard to ... you know, the system does not support that. So I would really hope to see this as part of a thriving multidisciplinary team out there in the community looking after our patients.

Dr. P. Venn:

I think there is a risk that G.P.s will become deskilled if we carry on with the current model. We all came over with the pet things that we enjoyed, we had done maybe a little bit more in hospital with certain skills so, you know, renal medicine or cardiology medicine, some people have done some gynaecology or ear, nose and throat and the system does not allow us to continue to use those skills. I think we welcome ... we do not want to go into a general practice surgery at the age 30 and come out at the age 65 having had people just walk in every day. We would like to be able to develop skills and, again, to a certain extent that is a little bit dependent on the funding flow changing because then we can step back. We can set up heart failure clinics, we can set up diabetes clinics, we can work more closely with the midwives, et cetera. I think you will find quite a lot of the G.P.s and the professionals ... and particularly if we look at what the G.P.s we might be recruiting into Jersey in 5 or 10 years' time will expect to do, they will expect to be able to continue those. That has to be a massive asset to the Island, because we have got quite a lot of skills out there in general practice which are not being used because there is not the mechanism to use them. So, you know, we embrace that professional development challenge, change, et cetera. There are always people who will not want to change, but we do not need everyone to change, we still need some people to see coughs and colds and all those sorts of things.

The Deputy of St. Peter:

How will the continuing professional development be achieved here if there is a lot of professional leadership and training required? Do we have the skill base here or would it be a problem to maintain that?

Dr. B. Perchard:

It should not be. We have a very good relationship with the Wessex Deanery. As G.P.s, in meeting the standards of the G.M.C. (General Medical Council) we have to go through appraisal, we have to have a professional development plan. This just bolsters that really. I do not see that ...

Dr. P. Venn:

Every year we all have to identify a professional development plan, we then have to take it back to our appraisal next year and say what we have done, have we enhanced it or whatever. We also have a very good relationship with the consultants

and I think we look forward to a situation whereby we can use those relationships and whereby we can use those consultant skills to enhance the community. If you talk to quite a few of the consultants, they have quite good ideas about how they might want to use G.P.s in the community. So it will be more of a ... it is more about the care being around the patient if you have got chronic respiratory problems the partnership care will be between the respiratory consultant at the hospital, maybe a specialist nurse in the community and the G.P., and we will all know what pathway that patient is on and more importantly the patient will know what pathway it is on, again with a little bit of a disconnect between coming out of hospital, coming back into general practice. That is what this will allow to happen.

The Deputy of St. Peter:

Such ideas as the community geriatrician that is potentially to be appointed, liaising, collaborating with that individual is a good example of that.

Dr. P. Venn:

We think we need a geriatrician across primary and secondary care. So some of their work will be in the hospital, some of their work on the front door when elderly people come in, some of their work will be a multidisciplinary team making sure that patients are able ... making sure the best use of social care and rehabilitation packages. There is lots of outcome work related to that. But I think to park a geriatrician in either the community or the hospital would be mirroring what we are doing now. You need to be able to have a system that supports a transition across the hospital to the community. That is the same with intermediate care.

Deputy J.A. Hilton:

It seems to me that Jersey has lacked behind quite considerably from the U.K. (United Kingdom) because as you explained, Bryony, the U.K. have had practices with lots of different services for a very long time. So are you both confident that what is on the table now will at least bring us up to that level? I want to just ... what is your vision? Can we do better than the way they do it in the U.K.

Dr. B. Perchard:

Undoubtedly.

Dr. P. Venn:

Yes.

Dr. B. Perchard:

It is nice to learn from other people, is it not? I quite fancy the idea of cherry picking the good bits from everywhere and see what we come up with but I think certainly since I have been in Jersey this is the best strategy that I have seen, that I believe gives us the clearest opportunity to move forward and develop and I think if we do not take that opportunity I worry we are just going to fall back into the doldrums for the next 5, 6, 7, 8 years until the demographic challenges that are facing Jersey become a real issue. I think that explains our engagement really because we are critically aware of what needs to be changed and what needs to be developed.

Dr. P. Venn:

I think there are lots of learning points as well from the U.K., for example, the explosion in practice nurses which was there really there to build a gap with G.P. numbers and in areas where it was difficult to recruit G.P.s, like Tower Hamlets and all those sorts of things. There were definitely advantage to that but they have been there long enough for us to understand that a practice nurse with a specialism in 3 or 4 things is not necessarily the best thing for the patient. So to sweat a patient on their heart failure management, their chest management, their diabetes management and their falls management is not necessarily the best thing for the patient. That is where the G.P. is really important because what the G.P. has the ability to do is to look at the whole patient and say: "You know, we do not need to push up that heart failure medicine because I am worried about the falling over at home, et cetera." I think to a certain extent there is an acknowledgement that there are other people ... so, for example, within a practice there is an increase in the role of healthcare professional who will take bloods, do E.C.G.s (electrocardiograms), do smears, et cetera, they do not need to be a trained nurse. They can be a cheaper resource who then ... they need supervision obviously but in actual fact it is like the concept of training nurses to do endoscopies, that works as well.

The Deputy of St. Peter:

A key part of this plan is that people remain in their own homes for a lot of their care or they will go to a step up, step down process if they are going to hospital and then leaving hospital after a short period of time. How possible do you think it will be for, and how willing will G.P.s be to attend people in their own homes rather than patients coming to the practice?

Dr. B. Perchard:

We do it all the time. We regularly home visit our elderly housebound infirm, anyone who is too sick to come up, that is not a new service provision for us. I would be really keen to see this step up, step down facility to come in because at the moment if we have an elderly lady who potentially gets a urinary tract infection who is a bit wobbly, you know, she was younger with more support in the home we would never send her into hospital but we have no option at this point because if we cannot make her safe within her own home that is the only other place of safety we have to refer to. Therefore having a step up, step down intermediate care support would be fantastic and would give us real options to be able to keep people in their homes and to care for them there.

Dr. P. Venn:

I think if the visiting load became massive then we would evolve our businesses accordingly. At the moment we all do our own visits but there is absolutely no ... and we have somebody on call for acute visits, there is nothing to say that we would not say we were going to skill this G.P. up to work 50 per cent of the time on the road and 50 per cent of the time in surgery. We are very flexible, we are very adaptive to whatever we need to do, obviously as a business it has to make sense for us financially but we can cut our cloth accordingly, that is not a problem for us.

The Deputy of St. Peter:

With the greatest of respect, the cost of home visits is quite an issue as we hear from the patient's perspective.

Dr. P. Venn:

But I think that is about how you support your vulnerable people. So by definition if a patient is going into a period of high intensity care, so we visited them, we pressed the button and we said this needs intermediate care, or they are coming out of hospital into a step down facility or whatever, then there needs to be something that is done about the funding stream to support that so that accessing us is not a barrier. It does not necessarily always need to be us that goes and sees them.

Dr. B. Perchard:

It would not need to be us.

Dr. P. Venn:

It would not need to a G.P. necessarily that went to see them but the mechanism to support them accessing whatever care structure was out there needs to be there and that is really where you are talking about the integration of fundings. So, for example, I would not know but you might say you are extreme elderly, over 85, who have had one hospital admission in a year would get a package that supported them to this level, et cetera. So there are lots of imaginative ways around it but we are not accountants, we do not know what they are.

Dr. B. Perchard:

I would not see us being the people that went in every day to tend to this person. We would go in as doctors to look at the care plan make sure it is appropriate, make sure the medical needs are being met and that is where I would refer to these community staff, healthcare assistants, nurses, they would then be delivering the care. Hopefully we would only be needed if there were issues.

Dr. P. Venn:

If there was a change in trajectory basically, in whatever way.

The Deputy of St. Ouen:

I think we would all subscribe to the new services that you describe and the way you would care for your patients but what I am struggling to understand is why has this not been provided in the past? What has been the barrier?

Dr. B. Perchard:

Funding. Money. It has not been funded.

The Deputy of St. Ouen:

Right, so it is literally about funding? The G.P.s are not properly remunerated?

Dr. B. Perchard:

We would not necessarily be the providers of these services. The whole of these outline business cases is not about general practice, it is about an integrated healthcare system. I would not see us as being the providers of the step up, step down service. I would see us as being professionals that work with a team who have provided that service. So we would be the medical support potentially but we are not necessarily the ones paying a healthcare assistant from the practice.

Dr. P. Venn:

So, for example, that elderly lady at home with the urinary infection, we get called to see them at 6.00 p.m., in actual fact she is a little bit confused, she has not drunk much and if she gets out of bed she might fall over. She does not need to go into hospital, she needs somebody there to make sure she takes the antibiotics we have prescribed, make sure she is offered food and make sure that if she does get up to go to bed at night she is not going to fall over. That is really low level intervention stuff which will mean that she does not go into a hospital bed. She will get better in 3 or 4 days' time, she will not have had the disruption of having to leave her home and everything that goes with that, but that is not necessarily about the G.P.s who provide the care, that is why you have to integrate your funding flows, because the money has to be with that lady, there has got to be a mechanism for that. It is not about it being Health and Social Services money or Family Nursing money or whatever, it has to be this lady has a need, who is best to provide it? Let us provide it and how we pay them is a different issue.

The Deputy of St. Ouen:

Right, so you do not see G.P.s providing a range of staff to support the service.

Dr. P. Venn:

That is a possible model. That is one model, and in actual fact in a lot of cases in America you have what is called accountable care organisations ... that would be a model that might potentially evolve but, again, I think that is about the skillset in the Island to deliver it. You are talking about them setting up a group of G.P.s as a business entity. I have to say I think you would alter the Health and Social Service domination of this and you might get a little bit more ... we are probably a bit more cost efficient and so we might do it in a slightly different way but we would need the support to do it.

[11:00]

We could not do that from a standing start. If you said to us: "Provide this" we would need the corporate support to do that. It is not insurmountable.

The Deputy of St. Ouen:

Just one last question so it is absolutely clear. So you are expecting that for the most part it will be the Health and Social Services Department itself that will take on these other ...

Dr. P. Venn:
No.

Dr. B. Perchard:
No, we see a role ... I think it is going to be a variable bag in terms of term of there will be the third sector, there will be us, there will be Family Nursing, Health and Social Services and I suspect there will be commissioning and people will be saying: "Right, here is the service that we want delivered, who is going to be best placed to provide it ..."

Dr. P. Venn:
Who wants to provide it? If we as a practice feel we would like to employ a 24 hour night sitter because that works the number of dependent patients we have got then we could do that.

The Deputy of St. Ouen:
Right, so there is flexibility there.

Dr. B. Perchard:
Absolutely.

Dr. P. Venn:
But that is about the flow being okay.

Dr. B. Perchard:
I would be much more anxious if this was just all about Health and Social Services getting a big pot or all the G.P.s just getting a pot, you know, I think this is a real opportunity ...

Dr. P. Venn:
But I do not think Health and Social Services want to deliver that. I think at the very top of that organisation they do not think this funding is all about them. I think they know that there is going to be different people providing it.

Mr. G. Wistow:

You mentioned the ideal would be to have money around the person and the person's needs rather than flowing through the different funding systems. Is any work being done on that?

Dr. P. Venn:

I think that has been raised ... my understand is that has been raised and that is something that will be happening alongside this first 3 years of implementation, yes. But that would be a piece of work that needs to be commissioned and that is where people need to look at different models. In Singapore everyone has a health medical account effectively, so a proportion of everyone's income goes into a health medical account and that pays for their basic healthcare provision, their screening, their population, you know, immunisations, et cetera. So there are different ways of doing it but those are the sort of decisions we need to take. I used to be a big proponent of an insured based system but we have to be realistic about whether or not we will get a big provider to come and provide for Jersey because we are such a bespoke service. It may well need to be a States administered funding if that is the case. But, again, I think that is a possibility. But I think there is also a big role around educating the public. I think we feel quite bruised and battered at the moment when everyone is talking about G.P. fees, et cetera. If we were starting from a funding system we would not start from where we are now and we have cost pressures like G.S.T. (Goods and Services Tax), lights, electricity, staff, like everybody else and so we do discount quite significantly but we have to protect our business by ability, because if we fall over because we are subsidising people, which is what happens quite a lot and is happening more and more, we are no use to you. You need us to be viable, you need us to be thriving, you need us to be energetic.

Mr. G. Wistow:

So, just to be clear, it is an issue that has been identified but they have not yet commissioned a solution?

Dr. P. Venn:

We have not been close enough to that work.

Dr. B. Perchard:

We have not been close enough to that piece of work.

Mr. G. Wistow:
So we should follow up a bit more.

Dr. P. Venn:
I think ... yes.

Mr. G. Wistow:
Because you are saying it is an extension precondition for implementing the new local services?

Dr. B. Perchard:
I think it is an essential long-term precondition, I do not think it is an essential short-term precondition. I think short-term we need to start changing the dynamics and the way we all start to work together and that does not necessarily require that. That is how I see the O.B.C.s (outline business cases), we need to begin the change but alongside of that I think the general practitioners are extremely keen to see a political solution to long-term viable funding of healthcare on the Island.

The Deputy of St. Peter:
But if we all start going down a particular path towards a certain end point that is agreed without the funding being agreed, you could end up at a junction where the government says: "Okay, so we are going to offer this funding, G.P.s look at it and other healthcare professionals and say: 'Cannot do that'."

Dr. B. Perchard:
To be honest, you tried that with New Direction.

Dr. P. Venn:
You have not come up with the right solution.

Dr. B. Perchard:
You have been around this little issue several times. I have seen Nigel Minihane's early papers on the integrated healthcare, you had New Direction, this is the most dynamic and robust process that I have seen. I think it would be a great mistake to say: "We cannot do it because all the boxes are not ticked." I think that would be a huge error because something needs to start changing, we need to begin to address

this issue, it is not something you are going to be able to say: “Oh look, overnight, bing, it is all done.”

Dr. P. Venn:

You are not going to be able to engage with the professionals in a way that you have done over this process as well and to a certain extent the public as well. I think if this falls over and then you try and resurrect it in some way or another in 2 or 3 or 4 years’ time, because that is what as a population we will need to do, you will find at lot of very cynical disenfranchised professionals who will just say: “No, I am not going to do that.” A lot of people worked really hard in every area, patient consultation, all those sort of things to get to this point and I think there is a will to make it happen. There will be bumps, there will always be bumps but I think it is a really opportune moment.

The Deputy of St. Ouen:

I will move on to community geriatrician, is that the way you pronounce it?

Dr. P. Venn:

Again, we see that as being an individual who leads this developed service across the 2 boundaries, between primary and secondary care. So they need to be a resource that is available to us as G.P.s, to community nurses and to people in hospital. So somebody gets into hospital, they get seen by the community geriatrician, a care package gets put into place, gets implemented, we try it at home, it does not work, we call them in, we meet again. Do you see what I mean, it has to be a very fluid position but desperately needed.

The Deputy of St. Ouen:

We do not have one now?

Dr. P. Venn:

No.

The Deputy of St. Ouen:

Who undertakes the role, if there is one?

Dr. P. Venn:

We do not have one.

The Deputy of St. Ouen:
Not at all?

Dr. P. Venn:
No, we do not have anyone, and I think there would be massive improvements in things like end of life care and hospital discharge plans and all those sorts of things if somebody with a real passion for geriatrics, a passionate geriatrician, was a normal asset to the community, but they need to be passionate, they need to be really switched on.

The Deputy of St. Ouen:
So you look at that individual as being supportive of the work and service that your provide within ...

Dr. B. Perchard:
Absolutely, yes. G.P.s are sort of mini care for the elderly, we do an awful lot of it but there are times where we need some additional support and we see this individual as being quite critical.

Deputy J.A. Hilton:
So is Mike Richardson the consultant geriatrician?

Dr. P. Venn:
But you ask that question and we are going to say no.

Dr. B. Perchard:
He also does a lot of the rheumatology, essentially he is a general physician, they are a dying breed, less and less of them around and he sometimes wears that hat but I do not think for enough of the time for him to be able to ... he does not have enough time resource to do this. He has other calls on his time, there are other expectations, he is also seeing all of our arthritis patients. So, no, he does not have that individual hat on.

Dr. P. Venn:
He looks after the P.O.R.S(?) programme, which by definition means he looks after osteoporosis, so by definition that is quite a significant proportion of the elderly

population. But, again, I think what we are seeing is that people are staying well longer and what I would consider an elderly person 10 or 20 years ago when I first came into practice is now no longer an elderly person. They are often looking after somebody else and they are volunteering here and they are doing all of that. Everyone is getting older and we are seeing more and more pathology because of the ageing population. So we are seeing people with comorbidities, we are seeing a lot more cancer, and I think because people are living past 75, 80 and by definition they are getting something like that.

The Deputy of St. Peter:

In your experiences, and looking at your colleagues and the way modern training seems to be going, there has been a lot of talk about sub-specialisation and you mentioned the breadth of Dr. Richardson's abilities. Do you feel confident that there will be younger doctors coming up through ranks to take over that kind of broad position?

Dr. B. Perchard:

Consultant training looks very, very different to how it used to look. There is absolutely no way that you will get general surgeons and general physicians in the old style coming through in future. They are sub-specialised quite early and very system orientated. So, no, I suspect that once your current generalist providers are approaching retirement you are really going to struggle to find trainees. You do not get general physicians who are also cardiologists any more. You just get cardiologists. It is a real challenge for an island of this size.

Dr. P. Venn:

The Royal College of G.P.s and the Royal College of Physicians are doing a joint training imitative at the moment on a hybrid doctor who does 50 per cent of the time in general practice and 50 per cent of the time in hospitals. That is quite an exciting beast, they piloting that in Scotland at the moment and, interestingly, talking to young, young doctors, people who have been away and have just finished training and things like that, that for them is becoming quite a possible career option. So there obviously quite a lot of development around that, which I think for Jersey could be quite exciting.

Dr. B. Perchard:

That has been driven by the rural communities in the U.K. of course. Jersey, although we are not big, our isolation relative to the rest of the U.K. probably puts us in similar requirements.

The Deputy of St. Ouen:

I do not want to dwell on the fact that in the White Paper it does mention that because of the cost of going to see a G.P. a lot of people are using A. and E. (Accident and Emergency) and it is flagged up as one of the major issues. Can you tell us what discussions and plans are going to be put in place to deal with this matter?

Dr. B. Perchard:

Well, there are some discussions ongoing at the moment, they are in their early stages because at the moment the G.P. out of hours service is sitting at the bank of the hospital. There is discussion about - at least in the first place - potentially collocating us so that we are in Accident and Emergency and therefore we can perhaps move to having a more integrated system. However, resolving the funding issue will always be quite critical to making sure that works.

The Deputy of St. Ouen:

Some suggest the easiest thing to do is just charge the people who go into A. and E.

Dr. P. Venn:

That is a political decision.

Dr. B. Perchard:

That is a decision that you guys need to make.

The Deputy of St. Ouen:

You do not necessarily support that as a good solution?

Dr. B. Perchard:

We support ...

Dr. P. Venn:

It is difficult to implement. It is very easy if someone comes in with a cough and cold and says: “I was too busy today to go to the doctor, I want to see a G.P.” that is easy,

ka-ching: “I am sorry, you have to go and see the G.P. who is sitting over there and you will be charged for that service. The difficulty is when someone has fallen off a trampoline and they have a slightly swollen wrist, we know it is not broken, probably A. and E. know it is not broken but is that an accident, is that an illness. It is how you triage it. It is really difficult when you are triaging children as well.

Dr. B. Perchard:

At the end of the day I also think it is sad if Accident and Emergency are overwhelmed with primary care and therefore is less able to do its job of providing care for accidents and emergencies. So I think somewhere a solution sits and I certainly think that solution on a service delivery front involves us probably spending some time being more integrated within Accident and Emergency. The funding solution ...

Dr. P. Venn:

There is a lot of evidence that G.P.s in A. and E. are much more cost efficient and give better clinical outcomes than having very junior doctors. We investigate less, we discharge less because we are used to managing risk in a different way to the way they are. But, again, that is about ...

Dr. B. Perchard:

I think we cost about a third less, that was the last statistic I saw.

Deputy J.A. Hilton:

At the moment the G.P. out of hours, what hours do you operate?

Dr. B. Perchard:

From 6.00 p.m. until 8.00 a.m.

Deputy J.A. Hilton:

So it is overnight?

Dr. B. Perchard:

It is overnight, weekends, bank holidays. We cannot open the surgery overnight because we ... so what happens is the doctor sits there with a phone and the population of Jersey at the other end of it.

The Deputy of St. Peter:

Going back to the G.P.s within A. and E. idea, is that common practice in other jurisdictions in the U.K., for example.

Dr. B. Perchard:

In the U.K. there are various schemes, some of which are more successful than others. The more successful schemes have G.P.s integrated within A. and E. as part of the team. The less successful schemes have them bolted on to the side down a corridor somewhere where they are not truly integrated. I think if it is well planned and well thought out it is an effective ... it is very effective and there are examples of good practice through the U.K.

[11:15]

The Deputy of St. Peter:

We have focused largely today on the elderly as a demographic issue but there are many other strands to the White Paper, for example, community detox is a big part of that. We have had conflicting reports, I think, of how effective community detox can be. What are your views?

Dr. B. Perchard:

That a well-designed, well evidence-based practice is critical.

Dr. P. Venn:

I think the issue is whether or not you consider alcoholism to be an illness, whether or not you consider it to be a psychological illness, in other words do you put in more psychological support with medical consequences? I think it is about how you look at that model. I do not particularly have strong views either way to be honest with you. At the end of the day a patient is going to go back to the community after their detox so you have to do whatever you are doing in the real world and I think I prefer doing those, but I do not have any strong views either way.

Dr. B. Perchard:

I guess as a doctor I think to see as evidence-based and if there are examples of good practice somewhere else then we can mirror some of those practices in Jersey. That would be good.

Mr. G. Wistow:

Thank you for describing the views of G.P.s. As somebody who does not know Jersey well at all I have now got a really clear picture of your sort of vision for the future of primary care. I guess what I am still trying to get a handle on is what the vision for the hospital system is. What would your vision be for the hospital, if we can implement the sort of primary care service you have talked about?

Dr. B. Perchard:

We have had lots of test about this about this, because the discussion is of is it a new hospital, is it a new hospital on the current, how big does your hospital need to be? It is quite difficult ...

Dr. P. Venn:

I think a lot will depend on how successful your step up, step down facility is. A lot will depend on who you can recruit and when because in a small population often a service develops around a particular individual because they are passionate and they care and they are good, or service falls because an individual is not the right individual. So I think one has to acknowledge there is a personality factor to all of this.

Dr. B. Perchard:

It will be nice to see once we have got the central server in and we have some more Island-wide data about how big does our cardiology service need to be, how big does our respiratory service need to be, because designing any sort of model before you know how big your problem is is really quite difficult. We think we are on the cusp of being able to say: “Ah, that is probably what it has got to look like.” But that data at the moment is locked into individual practices and ...

Dr. P. Venn:

I think the other thing is the estates do need investment and it does not matter where ... even if we were not doing anything about redesigning the healthcare, there needs to be a commitment to estates investment and I think maybe that has not been quite as robust as it should have been over the last 20 years or so. So I think exactly what it looks like is something that can be determined but from the point of view of identifying whether or not it is going to be a redevelopment, if it is going to be a new site or the funding to support that or the team to go ahead and do that work, that definitely needs to be done. I do not think you can get away from that. I think people

also need to have an understanding of what estate is out there in the private sector as well that might support some of this White Paper work. I think that piece of work needs to be done as a matter of urgency. Quite a few of the G.P.s have developed their own premises. We have room for a third room and we have built our building so we can put a third floor on top but we cannot pay for that. We do not want to pay for that because at the moment the type of service we are delivering is ... but if somebody wants to come along and put a third floor on top, then that might be an option. Do you see what I mean? I think there has to be a very active ... I think again the people needing this work understand that the 2 pieces of work for the transition side of things need to be developed and one is the primary care engagement and set up and the second thing is the funding stream. So those are slightly behind the others but they are acknowledged as being gaps, which are being addressed. So we are just about to ... there has just been appointed a very high calibre medical director for primary care which we are all very excited about and we are quite lucky to get him I think. But I think he may well be a really key man for the leadership of the transition.

The Deputy of St. Ouen:

When is it likely that this clearer picture will emerge regarding the needs of our community, linked into the unlocking of the data that is ...

Dr. B. Perchard:

I think the I.T. is coming in soon. We have been to lots of project meetings recently, the work is well progressed, I think it was optimistic they thought it might be the end of this year but realistically it is probably going to be within all practices, probably January next year, I think is my last understanding of it. But obviously it has to be ... you cannot just put it into every practice on one day so that will be a process that I suspect will be complete by January/February next year at which point we may well be able to start fishing for meaningful centralised health intelligence out of the system about what the disease registers look like, how big the problems are. The G.P.s have been very busy over the last 2 years sorting all that information out.

The Deputy of St. Ouen:

Am I right in saying that information will be only shared within the G.P. practices but also within the health service?

Dr. B. Perchard:

There are different ways of looking at it. As a G.P. practice I will only be able to look at my practice notes but anonymised centralised data on how many people are sitting in this box can be pulled out of the system ...

The Deputy of St. Ouen:
By the Health Department.

Dr. B. Perchard:
The primary care team will do it.

The Deputy of St. Ouen:
Right, okay. So it will mean that we will see that complete picture, it will not be part of a picture but ...

Dr. P. Venn:
I think the challenge is integrating that information in the secondary care as well. I think that is a piece of work that is ongoing. So in other words I have got 100 diabetics, how many of my diabetics have been into hospital in the 12 months, how long are they in, et cetera, et cetera. So it is about integrating that information so it is very useful for healthcare planning. It is all ...

Dr. B. Perchard:
Getting the hospital, getting secondary care I.T. systems to talk to primary care I.T. systems is a huge challenge. There is a system called Path Links that when I was training in the U.K. they had in place and some very old system. This is at least 12 years ago. Jersey has not managed it yet. The consequence of this is that someone in the hospital has to post the result out to the G.P., we have to wait all that time, then we have to pay someone to input it at this end. This is all very possible with the press of a button. It would seem that technical and budgetary challenges which, on the face of it, do not appear to be huge, have as yet to materialise. We also think that is quite important because that sets a precedent for all other sorts of data coming to us. We would love our system to be able to talk to the hospital system and we think that needs addressing quite urgently really.

Mr. G. Wistow:
Is that on a to do list?

Dr. B. Perchard:

I think it has just gone from being on a pilot that did not work to being now in a problem box nobody wants to open. We would love somebody to find a resolution, we are going to try again. But this is things like referrals, X-rays, all sorts of things. It would be nice to be able to take that for granted.

Mr. G. Wistow:

As you probably know, it has not been place ...

Dr. B. Perchard:

No, it has not got quite that far, has it? I just think that Jersey has this unique opportunity because it is small and it would be really lovely to see if we could get it right and then we could be an example for other places, which would be a lovely thing.

Deputy J.A. Hilton:

Can I just briefly ask you a question, it is about the outline business cases again. You mentioned your diabetic patients, my limited understanding of health problems is that I believe that obesity and diabetes type B are big problems and a growing problem. I was just slightly surprised to see in these outline business cases that that was not ... they had not ...

Dr. P. Venn:

Basically if you look at the chronic disease management one, there are 2 phases that would feed into that. There is the healthy lifestyles one which starts with alcohol, because of the big problem we have with alcohol, and that would go on to thinks like obesity et cetera. So that model of care would support tackling the obesity problem. The long-term condition one starts with C.O.P.D. and then moves on to diabetes and heart failure. But in actual fact there are things that are happening. We had an excellent meeting last night on heart failure, about how we might start to share the care, et cetera and it was really good and the professionals are doing some of it anyway. We are starting to look at how we can do it anyway. So it is there but we have got to start with one illness. The reason C.O.P.D. was chosen is because those frequent flyers, people who have got really difficult chest infections, they are the ones who cost an awful lot of money because they are bouncing in and out of hospital so often. Diabetics bounce in and out less often but the C.O.P.D. patients, the chesty ones, are just real high consumers and bed blockers.

Deputy J.A. Hilton:
Are they?

Dr. B. Perchard:
We have to pick one to begin with so ...

Mr. G. Wistow:
I just wonder if I could follow up the question I asked about the vision for hospital services. First of all, you spoke about the opportunities you feel you have to influence the plan generally. What opportunities are there at the moment for primary care to influence that discussion about the future of the hospital?

Dr. B. Perchard:
On the steering group I think both Philippa and I would say that we feel that we have a good voice. I do not think I would be speaking out of turn if I said that both primary care and secondary care in the Island have probably been working in ... well, we do talk to each other but it has been quite an isolated working relationship, it is very much they are over there and we are over here and we do have nice cordial relations, but they have not necessarily involved working together to design a system. I would see this as a real opportunity to start building that sort of relationship where secondary care can feed into the system and we can feed into the system. So everybody's needs are met because in the end I think that would benefit patients.

Dr. P. Venn:
I think also we are not experts in hospital care. We are not experts in how hospitals should look or how it should run. We know about the blurry bits around the edges and how we use it as professionals for our patients, for our clients, but how I.T. should run or how that should be serviced or how a theatre should run, that is a long time ago. I would not know what best practice was or turnaround times would be or usage should be. So that is remote from what we would ...

Dr. B. Perchard:
But services and what services we would start to get I absolutely see that we should have a place, and I would underline it, should have a place in putting forward leads. I think the new primary care ...

Dr. P. Venn:

The new primary care medical director will begin ...

Dr. B. Perchard:

Is going to be the one that ...

Dr. P. Venn:

He is external. The job description was that he has to continue to practice as a G.P. in the U.K. One of the other jobs he had been looking at was running a hospital trust. So he will have a complete concept of what could be ... the challenge to both of us, primary and secondary care, about how this ... because I think historically and through no fault of anybody's the whole of health in Jersey has been very heavily influenced by Health and Social Services. It has been a very top heavy system and I think everyone realises that is not sustainable but there is an individual who, for the first time, will be in the Island to give primary care a voice to make sure that the appropriate challenge is made.

Mr. G. Wistow:

And a policy perspective?

Dr. B. Perchard:

Yes, absolutely.

Dr. P. Venn:

Absolutely, and the individual concerned is a fixer, is a doer, is more ...

Mr. G. Wistow:

That is good. Can I just check that I have this right? The development of primary care is not an alternative to modernising the hospital, it is a complement, and what you want to see is much more whole systems working so that you can design a system right across primary care, social services and the hospital.

Dr. P. Venn:

Yes.

Dr. B. Perchard:

Absolutely.

Mr. G. Wistow:

Historically Jersey, like most parts of the world, has not been good at that sort of systems way of working. Can you point to ... you have said there is new individual who is going to give us a kick, is it actively on the agenda that sort of systems way of working at the moment or has it got to be put there?

Dr. B. Perchard:

I think it depends on whose agenda we are talking about. If we are talking about Health and Social Services and management of the structure within it we certainly feel there is a firm recognition if that is where they want to go. If they are talking about a wider political agenda, I do not know. I would certainly hope so.

[11:30]

Mr. G. Wistow:

Because the public needs to understand the ...

Dr. B. Perchard:

The public needs to really understand that. As a G.P., we can have a little bit of a role in that educational thing but this is a political outcome.

Dr. P. Venn:

The other thing is the public of Jersey have to make some choices. They live in a low tax economy but they want a first class healthy system and there are some situations where we do not necessarily need a gold standard service for everything. We can accept silver on the basis that we can access gold if we need to. I think that is something that the public need to make choices about. If you went to the absolute extreme of that model, we would not need an obstetric department, we would need some midwives. At 30 weeks we would fly every pregnant woman off the Island and we would bring them back when the baby was 6 weeks old. That is the most cost effective model. That is patently obviously not acceptable to the population of the Island and neither should it be. But that is the most cost effective model. So somewhere along that spectrum is the right way to be. I guess we get very frustrated because I think people do not take responsibility for funding their healthcare. There are lots of people who would like healthcare free at the point of delivery. We do not have a problem with that. We do not mind how we are paid, where the money comes

from et cetera, et cetera as long as we work in a good service and we have a living. That is fine. That is not a problem. But those are political decisions and I think if you look at what is happening elsewhere in the world people are starting to pay for their healthcare in some way or another. The U.K. is completely unique in that point of delivery and I think if you ask the U.K. they would love to start to bring in G.P. charges or charges at A. and E. for X-rays and things like that. So I think we would be very foolish to look to the U.K. for our solutions about how people access healthcare. I think we need to look elsewhere for that because there is a public responsibility.

The Deputy of St. Ouen:

Where would you point to? You say the ...

Dr. B. Perchard:

Well, we quite liked Singapore's model.

Dr. P. Venn:

Singapore, Holland.

Dr. B. Perchard:

Yes, there are models out there but, you know, there is no perfect model otherwise we would all be doing it. So I think it is about trying to work out what might work best in Jersey. It will not be perfect, there will be someone who does not like it but it is trying to ...

Dr. P. Venn:

But you have got the facility to do a health medical account through the social security scheme.

Mr. G. Wistow:

So you are kicking off a debate here that I do not think I have read in the papers.

Dr. P. Venn:

No, it is not there, it is just us. This is just us.

Mr. G. Wistow:

Yes, but what you are saying is that the public has some important decisions to make and there are at least 2 kinds of decisions. One is about the balance of different kinds of services within a whole system and the other is how it pays for it. If there is a White Paper that is being consulted, would you hope that the next version includes one or other of those more explicitly?

Dr. B. Perchard:

I am absolutely sure that explicitly in the next 3 years, within that period, we will have to have that debate.

Dr. P. Venn:

But you have to remember that people ... that is why, to a certain extent ... although it would be absolutely lovely to have the funding and the I.T. sorted day one, 1st January, et cetera, one also has to remember that one is taking one's whole Island - one's professionals, one's politicians and one's public - on a massive journey. We could never have had these sort of conversations 18 months ago until this piece of work had been done, and that goes from the healthcare assistant who is going out and giving drugs in the community to the consultants at the hospital, to the G.P.s, to you guys. It is an evolutionary process and that is why I think we have got to keep our foot on the gas. That is the key.

Dr. B. Perchard:

We consider this process to be a huge enabler at the beginning of a process of change.

The Deputy of St. Peter:

Thank you very much for your time. It has most useful and very interesting to hear your points of view. Thank you. I close the meeting.

[11:34]