

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

A PARTNERSHIP OF PURPOSE: TRANSFORMING BAILIWICK HEALTH AND CARE

The States are asked to decide whether, after consideration of the Policy Letter entitled "A Partnership of Purpose: Transforming Bailiwick Health and Care", dated 9th November 2017, they are of the opinion:-

1. To reaffirm the States of Guernsey's commitment to a process of transformation of health and care services in the Bailiwick of Guernsey, based on the key aims of:
 - **Prevention:** supporting islanders to live healthier lives;
 - **User-centred care:** joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;
 - **Fair access to care:** ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;
 - **Proportionate governance:** ensuring clear boundaries exist between commissioning, provision and regulation;
 - **Direct access to services:** enabling people to self-refer to services where appropriate;
 - **Effective community care:** improving out-of-hospital services through the development of Community Hubs for health and wellbeing, supported by a Health and Care Campus at the PEH site delivering integrated secondary care and a Satellite Campus in Alderney;
 - **Focus on quality:** measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;
 - **A universal offering:** giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;
 - **Partnership approach:** recognising the value of public, private and third sector organisations, and ensuring people can access the right provider; and

- **Empowered providers and integrated teams:** supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.
2. To direct the Committee *for* Health & Social Care to develop a health and care system premised on a Partnership of Purpose bringing together providers to deliver integrated care which places the user at its centre and provides greater focus on prevention, support and care in the community and makes every contact count;
 3. To direct the Committee *for* Health & Social Care and the States' Trading Supervisory Board to work together to identify suitable sites for the development of Community Hubs;
 4. To direct the Committee *for* Health & Social Care to work together with all health and care providers to produce a schedule of primary, secondary and tertiary health and care services that shall be publicly available as the Universal Offer either fully-subsidised or at an agreed rate;
 5. To direct the Committee *for* Health & Social Care, the Committee *for* Employment & Social Security and the Policy & Resources Committee, together with any non-States' bodies affected, to consider how the current States' funding of health and care can be reorganised to support the Universal Offer and, if necessary, to report back to the States at the earliest opportunity;
 6. To direct the Committee *for* Health & Social Care to work with:-
 - the Committee *for* Employment & Social Security to create a Care Passport for islanders, establishing their individual entitlement to health and care services and to explore how it could be linked with existing benefits or new opportunities to encourage individuals to save for their costs of care, in an individual Health Savings Account, a compulsory insurance scheme, or otherwise;
 - the Policy & Resources Committee and representatives of the voluntary sector, to explore a scheme of "community credits" to incentivise more volunteering within the health and care system;
 7. To agree that the Committee *for* Health & Social Care should investigate ways in which a technological interface could be developed that serves to

create an aggregated service user record from the various patient records maintained across health and care providers;

8. To agree that, in line with the States of Guernsey's Digital Strategy, the Committee *for* Health & Social Care shall seek to provide user-friendly online access to services, including providing service users with secure access to their own summary care record, where appropriate, their Care Passport and information on maintaining their own health and wellbeing;
9. To agree that the processing of health and care data should be premised on the equally important dual functions of protecting the integrity and confidentiality of such data and its sharing, where in the interests of the service user or the delivery of a public health function, and to direct the Committee *for* Health & Social Care and the Committee *for* Home Affairs to explore legal or practical mechanisms to achieve this;
10. To agree that the Committee *for* Health & Social Care shall be responsible, in accordance with its mandate, for:
 - Setting health and care policy for the Bailiwick;
 - Commissioning, or otherwise ensuring the provision of, health and care services, through the Partnership of Purpose;
 - Conducting a series of Health Needs Assessments, constituting a Comprehensive Health Needs Assessment for the Bailiwick, in order to plan ongoing service delivery with a view to improving health and wellbeing and reducing health inequalities;
 - Ensuring the good governance of health and care services;
 - Managing the public budget for health and care; and
 - Ensuring that there is effective regulation of health and care;
11. To agree that the Committee *for* Health & Social Care should report back to the States on the legislative changes needed to disband the roles of Medical Officer of Health and Chief Medical Officer and, where relevant, transfer their functions to existing services or statutory officials whilst exploring the potential for creating reciprocal arrangements for the independent challenge and peer review of respective health and care policy on a regular or ad hoc basis by other small jurisdictions;
12. To direct the Policy & Resources Committee to undertake a strategic review of the terms and conditions attached to nursing and midwifery professionals

employed by the States of Guernsey, and to consider whether such a review may also be appropriate in respect of any other staff group;

13. To direct the Committee *for* Education, Sport & Culture, together with the Committee *for* Health & Social Care, to review the training and education provided by the Institute for Health and Social Care Studies to ensure that it continues to meet the health and care needs of the Bailiwick, and to explore options for supporting a wider range of on- and off-island training opportunities;
14. To agree that the Committee *for* Health & Social Care shall review the processes used to:-
 - consider the merits of whether new drugs or medical treatments should be funded to ensure that a consistent approach is used across all decision-making bodies (including the Committee *for* Employment & Social Security's Prescribing Benefit Advisory Committee);
 - determine access to child or adult social care services, along with reviewing the transition between the two;
 - access long-term care in the community or in residential or nursing homes and work with the Committee *for* Employment & Social Security to produce a single assessment process in accordance with the resolutions of the Supported Living and Ageing Well Strategy;

and in so doing ensure that clear, user-friendly information about the processes and criteria shall be made publicly available;

15. To affirm that the States, in all its policy decisions, should consider the impact of those decisions on health and wellbeing, and make use of any opportunities to improve health or reduce health inequalities, across all government policies;
16. To direct the Committee *for* Health & Social Care, working with other States' Committees and voluntary and private sector organisations, to establish a Bailiwick Health and Wellbeing Commission that shall be responsible for health promotion and health improvement activities within the Bailiwick;
17. To direct the Committee *for* Health & Social Care to report to the States in 2018 with proposals for the comprehensive regulation of health and care services and practitioners;

18. To direct the Committee *for* Health & Social Care to:-
- Develop, market and manage an attractive private offer in addition to its universal provision which should be run, as far as possible, on a commercial basis;
 - Investigate opportunities to incentivise people to use their private insurance where that option is available;
 - Work with the Committee *for* Economic Development and other interested parties to explore whether the Bailiwick could develop and market itself as a “destination for health and wellbeing”;
19. To note that the Committee *for* Health & Social Care will continue to work with the Alderney community and the States of Alderney to rebuild confidence in health and care services, including those provided by the satellite campus, and ensure that they are proportionate and responsive to the needs of the island;
20. To direct the Policy & Resources Committee, as part of its ongoing work through the Sark Liaison Group, to engage with the Sark Authorities to establish the merits and cost implications of closer working in respect of health and care, and to report back to the States with recommendations;
21. To direct the Policy & Resources Committee to consider, as part of future budgets, what steps, if any, are required, over and above the transformation of health and care, to ensure the sustainability of funding for health and care services;
22. To increase the authority delegated to the Policy & Resources Committee to approve funding from the Transformation and Transition Fund for Transforming Health and Social Care Services by £2,000,000 to £3,500,000.

The above Propositions have been submitted to Her Majesty's Procureur for advice on any legal or constitutional implications in accordance with Rule 4(1) of the Rules of Procedure of the States of Deliberation and their Committees.

THE STATES OF DELIBERATION
of the
ISLAND OF GUERNSEY

COMMITTEE *FOR* HEALTH & SOCIAL CARE

A PARTNERSHIP OF PURPOSE: TRANSFORMING BAILIWICK HEALTH AND CARE

The Presiding Officer
States of Guernsey
Royal Court House
St Peter Port

9th November 2017

Dear Sir

Executive Summary

- 1.1 The Committee *for* Health & Social Care (“the Committee”) proposes to tackle some of the deep-seated challenges within the Bailiwick’s health and care system through a partnership approach open to all health and care providers – voluntary, independent, and public-sector or States-commissioned – working with the islands’ populations. The proposals in this Policy Letter will change the landscape of health and care – physically, virtually and financially – in order to improve islanders’ health and wellbeing at all ages, provide more joined-up services, and help to mitigate rising health and care costs.
- 1.2 There are few countries in the Western world which could deny that health and care is becoming increasingly unsustainable. Long-term and chronic conditions – from dementia and cancer to arthritis and diabetes – now dominate populations’ health and care needs, with nearly two-thirds of people over the age of 60, in the UK, having at least one such condition. £7 of every £10 spent on health and care is for treatment or care related to long-term conditions,¹ and that continues to grow, with people over retirement age spending twice as much on health and care as younger generations.

¹ <https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity>

- 1.3 The current delivery of health and care is unsustainable due to an ageing population, medical inflation and high expectations. Modelling done by KPMG, working together with the Office of the Committee, suggests that real terms public spending on health and care will increase from £193m in 2017 to £214m by 2027, if nothing changes in the way that health and care is provided. If the States' financial framework remains the same, this will put significant pressure on other public sector budgets, or on taxation.
- 1.4 To date, the Committee has been addressing its financial challenges through various service improvements. These have been very successful in terms of saving money and in improving outcomes for service users. However, greater efficiencies alone are not the solution. Neither is it possible to look only at the services provided by the States of Guernsey – long-term conditions and ageing populations substantially affect the demand for primary care and voluntary services too. The solution requires system-wide change, and improvements in the overall health and wellbeing of the population. More fundamental change is needed to address:-
- The current fragmentation of the system
 - The current focus on the needs of the provider rather than the user
 - Inequality of access
 - The difficulty experienced by islanders in finding and accessing services
 - The limited attention given to prevention and early intervention
- 1.5 While we have to accept that the delivery of health and care will get more expensive, by adopting an innovative programme of transformation we can mitigate this overall increase. Modelling by KPMG (reflecting similar findings by BDO two years earlier) showed that service changes could reduce costs by at least £8m, and potentially as much as £17m, over the same period: substantially slowing down the rate of increase in health and care spending.
- 1.6 The Committee would stress that spending on health and care should not be viewed solely as a debt or a burden. It is also a significant benefit to the Bailiwick and its population, improving people's health, wellbeing and quality of life, and ensuring the Bailiwick remains an attractive place to live and work, raise a family and do business. Good health and economic activity and productivity are linked – a healthy economy needs a healthy society.

- 1.7 As part of the 2016 Budget Report, the States approved funding of up to £1m from the Transformation and Transition Fund to develop a programme to transform health and care. Work has progressed well, with the identified primary objective of the programme to ensure that “by 2025, we have designed, built and transitioned to a delivery model for these services that is both sustainable and affordable within the context of the long term fiscal and demographic forecasts.”
- 1.8 The Committee recognises that the wider political backdrop against which this transformation is being recommended has changed significantly since the 2020 Vision was first proposed. The introduction of Public Sector Reform and the creation of the Policy & Resource Plan have together increased the States’ capability and capacity for implementing change. The Committee’s Transformation Programme is fully aligned to this wider corporate commitment to transformation, articulated through the four pillars of Public Sector Reform (improving customer engagement and satisfaction, delivering and demonstrating value for money, improving staff engagement and satisfaction and enhancing organisational performance measurement and management) and the priorities of the Policy & Resource Plan. In line with the Policy & Resource Plan phase 1 priorities, the proposed transformation demonstrates the Committee’s commitment to achieving a healthy community and the associated priorities:-
- Focusing on the promotion of health and wellbeing, and the prevention of, early intervention in, and protection from negative health outcomes;
 - Supporting the continuing transformation of the health and social care system, across and in partnership with the public, private and voluntary sectors;
 - Providing health and social care services that respect individual needs and promote independence and personal responsibility;
 - Providing timely and appropriate diagnosis, treatment, support and care, based on need, for all those who need to access it;
 - Treating mental health with equal consideration and priority to physical health; and
 - Encouraging and facilitating active lifestyles, and access to Guernsey’s rich natural and cultural environment, for the benefit of the community’s health and mental wellbeing, recognising the many social determinants of health.

- 1.9 As Members will be aware, a costing and benchmarking exercise was carried out by BDO in 2015, which identified potential savings in the delivery of health and care services of between £7m and £24m achievable over the medium to long-term. To achieve the higher end of the estimate, which incorporates savings available from the totality of spend on health and care across all committee budgets, it was recognised that significant changes to both the current operating model for health and care services and the systems and processes that underpin them would be necessary. Recognising that the States of Guernsey does not currently have the skills or experience available to successfully deliver the necessary new Target Operating Model in isolation, KPMG were appointed to provide a tailored “end to end” methodology and support the internal programme team in respect of the initial scoping of the future model, driving progress and providing the required additional insight, capability and capacity where necessary. The appended Report represents a summary of the combined team’s work in this regard.
- 1.10 Over the first phase of its Transformation Programme, which has led to the drafting of this policy letter, the Committee and KPMG engaged with health and care providers and professionals, States Members, charities, volunteers, and members of the wider community in a series of activities looking at what a “good system” of health and care in the Bailiwick would look like. The key principles established as a result were:
- **Prevention:** supporting islanders to live healthier lives;
 - **User-centred care:** joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;
 - **Fair access to care:** ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;
 - **Proportionate governance and regulation:** ensuring clear boundaries exist between commissioning, provision and regulation;
 - **Direct access to services:** enabling people to self-refer to services where appropriate;
 - **Effective community care:** improving out-of-hospital services and enabling people to receive care closer to home;
 - **Focus on quality:** measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;
 - **A universal offering:** giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;

- **Partnership approach:** recognising the value of public, private and third sector organisations, and ensuring people can access the right provider; and
- **Empowered providers and integrated teams:** supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.

- 1.11 These aims have helped the Committee develop its new model of health and care and the proposals in this Policy Letter set out a medium to long term prioritised programme of reform which will, incrementally over the next five to ten years, deliver sustainable improvements to health and care services across the Bailiwick, with the benefits being felt for decades. The Committee wishes to develop a health and care system premised on a Partnership of Purpose, bringing together providers to deliver integrated care which places the user at its centre and provides greater focus on prevention, support and care in the community and makes every contact count.
- 1.12 The critical foundation of the Committee's proposals is **prevention and health promotion**. Over past decades, multi-pronged tobacco control strategies have massively reduced cigarette smoking in Western countries, which are now starting to save health systems billions of pounds in smoking-related diseases. However, we are not yet doing enough to tackle other major risk factors which contribute to poor physical and mental health – including alcohol, diet, physical inactivity, substance misuse and addiction, among others. One in three Bailiwick children is overweight by the age of nine, in a pattern that will lead to another generation at risk of multiple long-term conditions (and the treatment and care that follow) as they grow older.
- 1.13 We need to do more. The States needs to consider health in all policies, and health and care providers need to make every contact count - using every opportunity to improve the health and wellbeing of individuals and the population as a whole. To give this added impetus, the Committee will create a Bailiwick Health and Wellbeing Commission, separate from the States and in partnership with community organisations, in order to raise awareness, encourage healthy lifestyle choices and otherwise take steps to improve islanders' general health and wellbeing. It will bring together teams currently working in the States, as well as other independent organisations to provide accessible services, supporting islanders to make healthier choices and recognising the relationship between mental and physical health.

- 1.14 The Committee recognises the importance of understanding public expectations. While international trends show that the public increasingly, and understandably, expect improved standards of care, more information about their treatment, greater involvement in the decisions about their care and access to the latest treatments, it is evident from the work done by KPMG that the level of public expectation appears to be exceptionally high. In part attributable to the size of the jurisdiction, the Islands' comparatively high standard of living and a community engaged with the public sector, Islanders typically expect a standard and speed of care not experienced elsewhere. The Committee wishes to understand these expectations and enter a proactive conversation with the public so as to inform a future universal health and care offering. Part of this will include raising awareness of the costs of delivering health and care services. Missed appointments, wasted medicines, failing to follow advice, all costs money. Money which could otherwise be used for new treatments or other initiatives.
- 1.15 However, the Bailiwick can't wait a generation for health and care costs to come down. The modelling done by KPMG suggests that health and care costs will outstrip the available funding within ten years. In the shorter term, more joined-up services, earlier intervention to avoid decline and digital transformation of health and care will be essential in order to reduce costs. The proposals in this Policy Letter reflect these imperatives and set out a vision for increasingly integrated health and care services delivering high quality care.
- 1.16 KPMG identify four areas for development: Out-of-Hospital reform, Finance and Accountability reform, Organisation and Governance reform, and Technology reform. The Committee considers that these changes can best be achieved through a collaborative approach, delivered through a **Partnership of Purpose**. This will bring together health and care providers to collectively develop and deliver health and care with shared outcomes. The Partnership will be open to all health and care providers fulfilling set criteria and they will work towards common standards of customer service and quality.
- 1.17 Health and care services provided by the **Partnership of Purpose** will be more joined up physically through a number of easily accessible sites called **Community Hubs**, linked to a Main Campus at the PEH site, with a Satellite Campus in Alderney. A Principal Community Hub will be established that brings together a range of community services currently scattered across

Guernsey and a **walk-in clinic** will be established at the PEH Campus to offer convenient access to medical and social services.

- 1.18 Services will also be joined up digitally, and much more use will be made of apps, telehealth and telecare (remote consultations or follow-ups) and other technological advances. A “single patient view” will be created, linking the disparate health and care IT systems to create a virtual aggregated patient record.
- 1.19 Providers are starting to feel the pressure of rising demand and are concerned about safely and effectively meeting the needs of older people with multiple conditions. The benefits to them of the **Partnership of Purpose** will be that they can work together to improve islanders’ health and wellbeing, and share the benefits of transformation. Particular steps will be taken to ensure that voluntary organisations are supported, and continue to form an integral part of the health and care system in future.
- 1.20 Wherever appropriate, opportunities will be taken to expand the skills of front-line health and care professionals, as well as their ability to signpost effectively to other services and to make every contact count, so that people with multiple conditions don’t find themselves constantly bouncing between multiple practitioners in order to have their needs met.
- 1.21 For islanders, the emphasis of this transformation Policy Letter is on improving health outcomes, through effective commissioning and independent regulation, and on ensuring that there is equitable and affordable access to health and care for the whole population of the Bailiwick through the development of a **Universal Offer** of services and a **Care Passport** that will set out individual entitlements. The **Universal Offer** will be a range of health and care services, either free or at subsidised rates, provided by the **Partnership of Purpose**. This will represent the core set of services that all Bailiwick residents should have access to, will enable greater equity of access and bring down the barriers to islanders getting the care they need when they need it.
- 1.22 Each islander will have their own individual entitlement to health and care services, known as their **Care Passport**. For most islanders at any one time this will be equal to the **Universal Offer**, but for others at some stage of their lives, for example pregnant women, or people with specified health conditions, the

Care Passport may give them entitlement to additional services or reduce certain costs.

- 1.23 The creation of a **Bailiwick Health and Wellbeing Commission**, bringing together the public, private and third sectors, will help raise awareness, encourage healthy lifestyle choices and take proactive steps to improve islanders' general health and wellbeing, mentally and physically. The Universal Offer will include social prescribing schemes such as arts activities, mindfulness, group learning, gardening and cooking that will help people take greater responsibility for their health and care.
- 1.24 A user app will be available, and will develop over time to reflect the views of service users. It is, at this stage, envisaged that it will begin as a directory of services provided by the **Partnership of Purpose** but will evolve to enable appointments to be booked directly and eventually become the primary means by which islanders can find details of the **Universal Offer**, access their **Care Passport** and know their entitlement to health and care services.
- 1.25 **Information**, in all its forms, will be central to the transformation of health and care. Comprehensive Population Needs Assessments, carried out routinely, will provide the Committee with regular updates on population health and care needs, and help identify gaps in preventive services or in treatment and care. A Health Intelligence Unit within the Committee *for* Health & Social Care will be responsible for analysing data and providing the information to enable it to commission the appropriate services. The principle that 'to care appropriately, you must share appropriately' will be at the heart of this Transformation Programme. Islanders should feel confident that information about their health is securely safeguarded, accurate and shared appropriately when that is in their interest. Finally, much greater transparency for the public (as service users and as taxpayers) in respect of the range of health and care services available, their cost, and their quality standards, will be critical.
- 1.26 An independent **Care Regulator** will be established, providing appropriate and proportionate regulation to all providers of health and care in the Bailiwick, including those provided by the States of Guernsey.

- 1.27 The newly established **CareWatch**, comprising representatives from the Bailiwick community will also have an important part to play in ensuring islanders' voices are heard.
- 1.28 The proposals set out in this Policy Letter challenge current ways of working, and some will no doubt require intense engagement between the States of Guernsey and other providers. However, they also offer an exciting opportunity to work differently together, combining learning from other jurisdictions with best practice here, in order to slow down the rising costs of care and keep islanders healthy and well for longer. The window available for this kind of progressive transformation, rather than more radical disruption, narrows from year to year. However, by Government, private sector, third sector and each and every one of us working together, over the coming years we can put in place a model of health and care that can truly help deliver the key vision of making the Bailiwick one of the happiest and healthiest communities in the world.

Introduction

- 2.1 The challenges facing health and care services, in the Bailiwick and around the world, are well-known. Demographic shift means more people are living for longer, but often with increasing frailties and multiple health conditions requiring ongoing medication, treatment or care. Health budgets prove difficult to control, with cost increases that outpace inflation, and unpredictable expenses arising from accidents, major illnesses or new treatments and technologies. Many different professionals and organisations are involved in providing treatment and care, sometimes with different or competing incentives, and patients and service users feel as though they are passed from pillar to post, rather than receiving joined-up care that reflects their needs and circumstances.
- 2.2 Because these problems are well-known, they are not discussed in depth here. The Committee *for* Health & Social Care recommends that this Policy Letter is read in conjunction with the "Future 2020 Vision for Health and Social Care" (published by its predecessor, HSSD, in 2011² and updated in 2013³); the benchmarking report produced for HSSD by BDO in 2015⁴; and the

² All referenced documents can be found at: <https://www.gov.gg/healthtransformation> Billet d'État VIII (Volume 1), May 2011

³ Billet d'État I, January 2013

⁴ The Executive Summary can be found as Appendix II of the 2016 Budget, Billet d'État XIX, October 2015

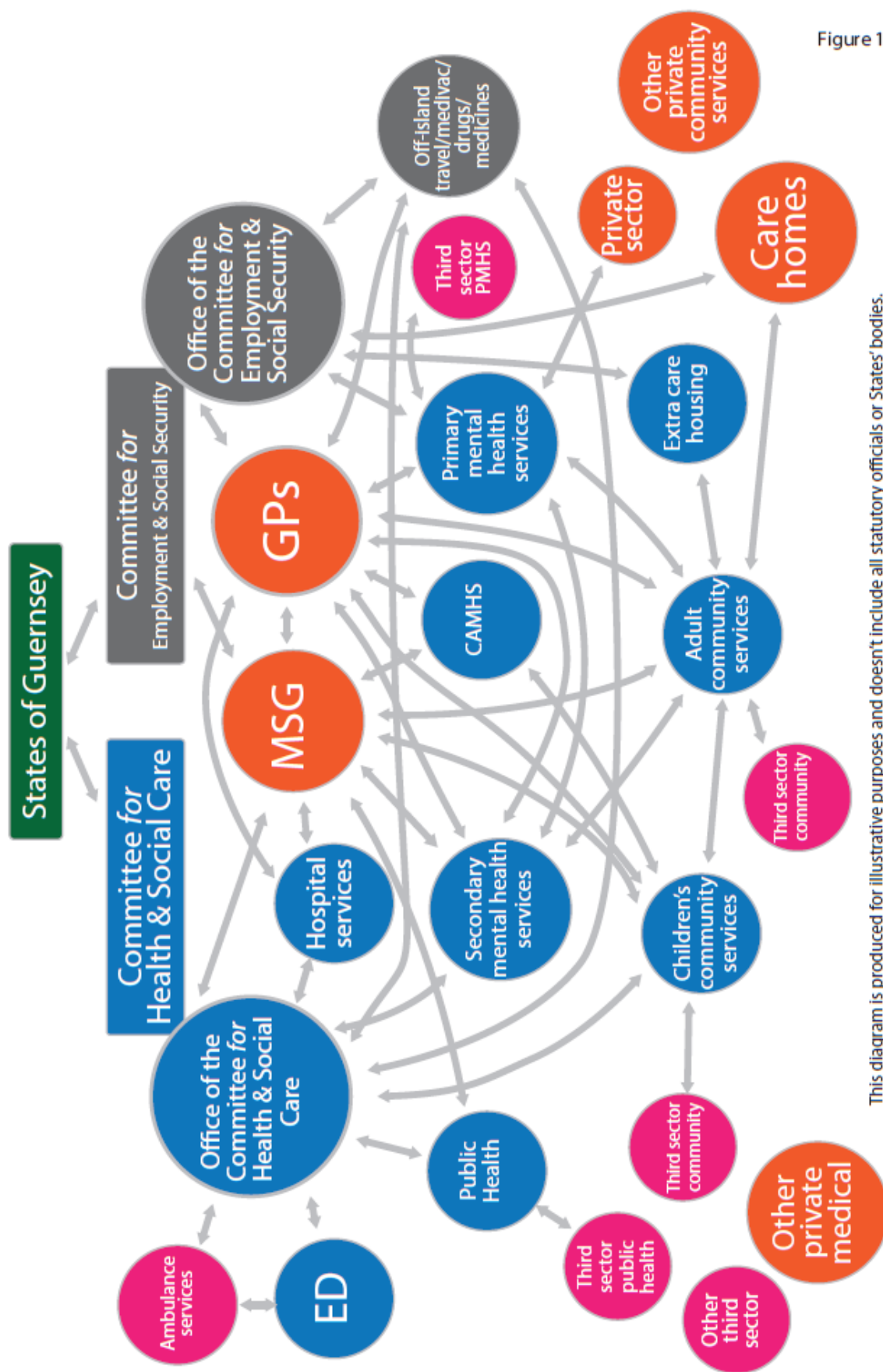
Committee's submission to Phase Two of the Policy & Resource Plan in June 2017⁵. Collectively, these reports highlight the financial and demographic challenges facing the system, and the need for change, a view which is validated by the summary report produced by KPMG that is appended to this Policy Letter.

- 2.3 These reports together provide valuable context, setting out current problems and future trends, and establishing the direction the health and care system will need to take in order to mitigate these challenges. This direction of travel – towards a more preventive health system, with care closer to home, more integration between services, and an emphasis on personal responsibility – has been accepted and endorsed by successive States over the past decade.
- 2.4 Throughout this Policy Letter and the appended Report, reference is made to “health and care services” as opposed to the more traditional “health and social care services.” This is a deliberate and conscious evolution of language. Social work is fundamental in terms of facilitating social change and remains a fundamental part of the health and care services provision. However, in practice, with the need for social or long-term care becoming increasingly important, the boundaries between social care and health care are becoming increasingly blurred. The Committee is keen within this context to adopt the term “care” in its broadest definition, incorporating care from professional providers, informal care being provided by friends and family and personal responsibility and self-care. Health therefore takes on the wider meaning of ensuring a healthy population focusing on overall health improvement and reducing health inequalities.
- 2.5 This Policy Letter focuses on solutions. It concurs with KPMG's assessment that “the Bailiwick of Guernsey has a fantastic opportunity to enjoy genuinely world class health and care services” and seeks to provide mechanisms through which this can be achieved. It confronts the fundamental challenge of improving quality of service and quality of life, while containing, as far as possible, the rising costs of providing care. It recognises that this will require preserving and developing good practice, wherever it occurs (among private providers as well as the public sector), while transforming elements of the current system that do not serve our Islands well.

⁵ Billet d'État XII (Volume 1), June 2017

2.6 In each section of this policy letter, the Committee has aimed to be clear about what it is seeking to achieve and the next steps that will need to be taken, following the States' decision, in order to progress. As is clearly articulated within the KPMG Report, the success of a future operating model depends on far more than simply good and consistent management but genuine transformation. This Policy Letter seeks to demonstrate both to the Assembly, but more importantly the wider public, a firm commitment to this transformation through what is effectively a roadmap for transformation, articulated as a series of tangible and prioritised improvements. The complexity of the current system and the ambitious but equally achievable, clear system resulting from the proposals is shown in the following two diagrams:-

Current system of Health and Care



This diagram is produced for illustrative purposes and doesn't include all statutory officials or States' bodies.

The Future Model of Health and Care

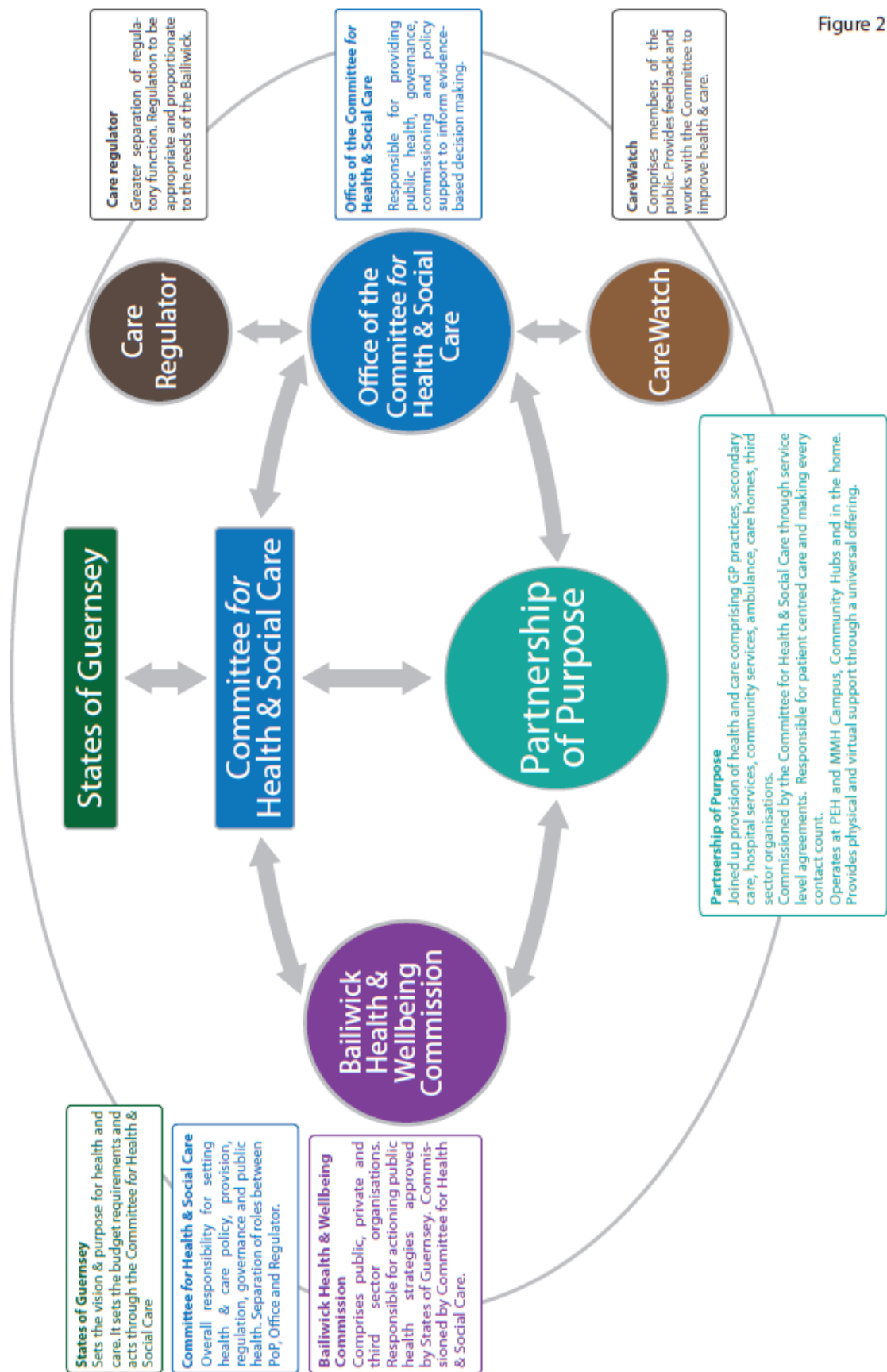


Figure 2

2.7 In the course of developing its transformation plans, the Committee conducted a number of engagement exercises involving the public, healthcare professionals, politicians and civil servants, to understand what a “good system” would look like. This extensive engagement has informed every aspect of the work on the transformation of health and care. It has also allowed the Committee to formulate a set of key aims for the future of the system, which have been used to shape and evaluate the recommendations in this policy letter. These can be summarised as follows, and are set out in more detail in Appendix 1:

- **Prevention:** supporting islanders to live healthier lives;
- **User-centred care:** joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;
- **Fair access to care:** ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;
- **Proportionate governance:** ensuring clear boundaries exist between commissioning, provision and regulation;
- **Direct access to services:** enabling people to self-refer to services where appropriate;
- **Effective community care:** improving out-of-hospital services and enabling people to receive care closer to home;
- **Focus on quality:** measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;
- **A universal offering:** giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;
- **Partnership approach:** recognising the value of public, private and third sector organisations, and ensuring people can access the right provider; and
- **Empowered providers and integrated teams:** supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.

2.8 In addition to establishing the key aims, the engagement with clinicians, practitioners, the public and the third sector was used to inform the tangible solutions which are contained within this Policy Letter. The Guernsey

Disability Alliance, for example, have made clear publically that their members' priorities include:-

- A person-centred community care and support system;
- Access in all its forms (buildings, policies, customer services);
- Respite care available according to need;
- Information about existing support services; and
- Timely and comprehensive access to general health services.

2.9 Such feedback, along with the vast array of other comments, queries and observations made throughout the multiple engagement exercises, has helped inform the proposals set out in this Policy Letter, and will continue to do so throughout the programme's prioritised implementation. There is a clear commitment to a process of continuous development, both in terms of the strategic direction of health and care services and the operational day-to-day service delivery.

2.10 The States are asked to endorse the key aims for the future health and care system.

Recommendations

To reaffirm the States of Guernsey's commitment to a process of transformation of health and care services in the Bailiwick of Guernsey, based on the key aims of:

- **Prevention:** supporting islanders to live healthier lives;
- **User-centred care:** joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;
- **Fair access to care:** ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;
- **Proportionate governance:** ensuring clear boundaries exist between commissioning, provision and regulation;
- **Direct access to services:** enabling people to self-refer to services where appropriate;
- **Effective community care:** improving out-of-hospital services through the development of Community Hubs for health and wellbeing, supported by a Health and Care Campus at the PEH site delivering integrated secondary care and a Satellite Campus in Alderney;

- **Focus on quality:** measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;
- **A universal offering:** giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;
- **Partnership approach:** recognising the value of public, private and third sector organisations, and ensuring people can access the right provider; and
- **Empowered providers and integrated teams:** supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.

To direct the Committee for Health & Social Care to develop a health and care system premised on a Partnership of Purpose bringing together providers to deliver integrated care which places the user at its centre and provides greater focus on prevention, support and care in the community and makes every contact count;

Structure of the Policy Letter

- 3.1 The Policy Letter develops proposals for the continued evolution of health and care services in four key areas:-
- Out-of-hospital Reform
 - Finance and Accountability Reform
 - Organisation and Governance Reform
 - Technology Reform
- 3.2 **Section A** deals with the **user experience**: how people will access health and care services, where those services will be located, the kind of services that will be available and the fees that may be charged.
- 3.3 **Section B** deals with the **organisational structure**: the legal and contractual arrangements that will exist between different organisations providing health and care; the future role of the Committee *for* Health & Social Care; and the culture, professional development, and terms and conditions of professionals working within the system.
- 3.4 **Section C** deals with the **needs analysis** that informs what the health and care system will provide, and to whom: the role of Health and Care Needs Assessments and ongoing management information and population health intelligence; and the way that access to services and funding of new treatments will be evaluated and prioritised.
- 3.5 **Section D** discusses the creation of an **environment for health and care**: the role that every States' body plays in improving islanders' health and wellbeing; the creation of a Commission that will bring together public services and civil society to promote good health; the role of regulation and standards in ensuring that health and care services remain person-centred; and the important function of health as an economic enabler.
- 3.6 **Section E** discusses specific implications for **Alderney and Sark**.
- 3.7 **Section F** discusses the **alternative options** considered, the **risks and benefits** of the Committee's preferred option, both financial and non-financial, and the **cost of delivery**.

Section A: User Experience

Context

- 4.1 The Committee's preferred model for the future of the health and care system seeks to better integrate the services provided by many of the organisations that exist today, including privately-run GP practices, the Medical Specialist Group, and a range of private and voluntary services related to health or care, as well as public services ranging from the acute hospital and mental health centre, to child protection services and extra-care housing. The model focuses on bringing these services closer together physically and virtually, through a Partnership of Purpose (discussed in the next section), in order to deliver integrated health and care to islanders.
- 4.2 The Committee is not recommending that all providers of health and care services should be immediately subsumed into one organisation at this time. The model may naturally evolve in that direction and the States may wish to hasten or slow the process in due course. For the time being, the Committee recommends an approach that preserves the many aspects of our system that work well for the Bailiwick, while focusing on strengthening those areas where current provision is weak, poorly coordinated, or ineffective in meeting islanders' needs. Opportunity must be taken to consolidate the locations from which services are delivered at the PEH Campus and Community Hubs to improve access and an ever more integrated provision.

Health and Care Campus and Community Hubs

- 4.3 At the moment, health and care services are scattered across the islands. GP practices, opticians, physiotherapists, counselling and talking therapies, dentists, wheelchair services and equipment providers, emergency care, community services, chest and heart clinics, and many other services which cater for islanders' health and wellbeing, operate largely independently of each other across a wide variety of sites.
- 4.4 In the future, islanders will be able to deal with multiple health and care needs in one visit, either by visiting their Health and Care Campus at the PEH site, typically focusing on specialist secondary and acute care requirements, or by going to their local Community Hub for broader health and wellbeing needs.

- 4.5 Community Hubs will be sites which include a number of first-port-of-call services (such as GPs, opticians, pharmacists, physiotherapists, memory clinics, counsellors or dentists) and community services (such as providers of aids and adaptations, health promotion services, or clinics for long-term health conditions). The Committee will work with other organisations to identify sites for Hubs – which may be developed around existing GP practices or community centres, the extra-care housing sites or Beau Sejour Leisure Centre, among other potential options. Through Community Hubs, it will be possible for islanders to directly access services which currently require referral. This direct access will enable islanders, particularly those with long term conditions, to increase the control they have over their own lives and health and care needs, and enable more expedient care.
- 4.6 The Committee intends to develop a principal Community Hub within this term and will work with the States' Trading Supervisory Board to identify a suitable site. The Committee believes that the footprint and location of the former King Edward VII Hospital would be a viable location to house both public-facing services and many of the Committee's child and adult social services, which are currently located in many ageing and unsuitable properties. This could also provide a base for shared back-office support for a small number of local health and care charities –potentially enabling the release of scarce resources to allow greater efficiency- and the Committee would explore the need for this further with the voluntary sector. The Committee will work closely with the States' Trading Supervisory Board to identify the requirements of the principal Community Hub site and how this can best be achieved with the States of Guernsey's property and real estate portfolio.
- 4.7 The backbone of the system will continue to be the Health and Care Campus on the PEH site. This will, with the exception of the Emergency Department and a new Walk-In Clinic, focus on the delivery of secondary health care, including the acute hospital and the mental health centre, and diagnostics. A key aim will be to develop the Health and Care Campus at every available opportunity through integration of health and care specialists, enabling closer cooperation in respect of the management and delivery of services, the potential for shared core and back-office services, and improved working practices. There would be a Satellite Campus based in Alderney, and supported by the PEH Campus, to ensure that services delivered in Alderney

are responsive to the Island's specific circumstances and more remote situation.

- 4.8 Community Hubs build on the aims of extra-care housing, which was designed to provide a base for additional social or health care services that could be delivered to people in the adjacent community (outreach services) as well as hosting community services for the benefits of their residents (in-reach services). It would be possible for a whole range of services to be provided in these Hubs, based on demand and the needs of the surrounding population – for example: flu clinics; specialist nurse clinics relating to the management of long term conditions, including those related to mental health; healthy living clinics such as smoking cessation, obesity management and alcohol and drug services; third sector advice and expertise; and carer support workshops and information sessions.
- 4.9 The inclusion of the third sector within the Community Hub network is vital. It will therefore be essential under the new system that commissioning of services is timely and appropriate. The current process can be overly bureaucratic, especially for smaller third sector organisations providing services through the use of volunteers. The Committee therefore believes it is essential that a new commissioning structure is put in place that reflects the different services required and funding to be provided.
- 4.10 Providing guidance and support for matters relating to health and care, Community Hubs will be an opportunity to combine statutory, private and third sector services in a way that effectively supports coordinated care. The Hubs will also be supported by improved IT, to ensure that best use is made of telehealth opportunities (e.g. for remote diagnosis or check-ups).

User-Centred Care, Closer to Home

- 4.11 Providing user-centred care is a key aim of the new model for health and care. As set out in the KPMG report, the delivery of services within a hospital setting is not simply more expensive, but often does not provide the optimum care and experience.
- 4.12 Service users should not be viewed as “consumers” of particular interventions or treatments (such as a consultation, prescription or operation for a given health condition), but as people with a lifelong health ‘journey’ and needs

that will change and evolve in the course of their lives, as a result of particular illnesses or conditions. Their care should be responsive to the full context of their lives, and help them to achieve what they would consider a good quality of life.

- 4.13 This must be coupled with an emphasis on personal responsibility: encouraging people to make the decisions that will enable them to maintain their health and wellbeing, and to actively participate in managing their own care. For patients who struggle to speak for themselves, this will require effective advocacy, as discussed in later sections.
- 4.14 One aspect of user-centred care may be the greater use of social prescribing. There is a growing recognition both locally and internationally of the merits of social prescribing where healthcare professionals refer people to a range of non-clinical services. Such an approach recognises the range of social, economic and environmental factors which can affect health and seeks to address people's needs in a holistic way. Social prescribing schemes can include volunteering, arts activities, mindfulness, group learning, gardening, cookery and a range of sports. To support the positive work already ongoing in this regard within Primary Care, the Committee intends to create a "Bailiwick Map" of local groups and activities that can serve as a key resource for social prescribing.
- 4.15 In order to deliver effective user-centred care, there needs to be good communication between the many professionals and organisations involved in providing health and care services. Some of this will happen naturally as a result of moving services onto a smaller number of shared sites, either at the PEH Campus or at one of the Community Hubs; but processes will need to be embedded to ensure communication happens regularly and well. The Committee believes that service users should always feel as though their health and care needs are being met by an integrated team, even if the professionals in that team are employed by more than one different organisation.
- 4.16 Service users are also more likely to receive care that is responsive to their needs if the number of different contacts they have with the health and care system is minimised. This means exploring every opportunity to develop "enhanced practitioner" roles and otherwise maximise the skills of health and care practitioners, so that people do not have to deal with multiple

professionals in order to have key needs met. This trend can already be seen, for example, in the recent decision to expand nurse- and pharmacist-led prescribing locally.

- 4.17 In delivering care closer to home, there is also a need to recognise that where care is being provided or heavily supported by family members, balancing the responsibilities of caring for a loved one with wider family and work commitments impacts on the physical and mental well-being of care-givers themselves. It is estimated that there are between 2,000 and 4,000 people providing unpaid voluntary care across the Bailiwick. Temporary respite care can provide opportunity for carers to take time to prioritise their own health and wellbeing, confident that their loved one is being cared for.
- 4.18 An ethos of “person-centred care, closer to home” is most likely to succeed if family carers are included, and their relationship with the person they care for and their role in care-giving is properly understood and respected, as part of the overall picture of care and support. The care-giving relationship is seldom one way – with older couples, for example, often being mutually dependent on each other for multiple things. To provide “person-centred care” which enables people with long-term conditions to enjoy meaningful lives, it is important to understand, not just the individual and their preferences, but also their wider context, relationships and responsibilities, including the care they receive from others and the care they give.
- 4.19 In particular, it is important to consider how carers can be properly supported: for example, by assessing their needs alongside the needs of the person they care for, and by providing timely access to appropriate respite care outside the home or within it. The Committee will work together with the Committee *for* Employment & Social Security and the Policy & Resources Committee, as well as the voluntary sector, to meet the needs of carers, as identified in the Supported Living and Ageing Well Strategy (SLAWS). The Committee is of the view that caring for carers is closely tied up with the whole transformation of health and care. It will therefore develop an Action Plan for Carers setting out the level of support and services that carers should be entitled to receive and will report on the specific issues identified through SLAWS in its annual Policy & Resource Plan updates, which will also include an overall update on progress with this Transformation Programme. This approach will fulfil the States’ resolution set out in SLAWS to develop a Carers’ Strategy.

- 4.20 The aim of providing person-centred care, closer to home, ties in closely with the review of long-term care funding, which was another recommendation of SLAWS. This work, which is being progressed by the Committee *for* Employment & Social Security, looks at two key issues: first, how to make sure that funding for long-term care is put on a sustainable footing, given that many more people are likely to need it in future; and second, how to ensure that financial support is available for people to receive care in their own home, on similar terms to the support that is available for people who move into a residential or nursing home. As well as giving people more flexibility to choose home-based care rather than institutional care, or to do so for longer than they otherwise would have done, this work will also help to ensure greater transparency and fairness in relation to the costs of long-term care – which, again, is consistent with the spirit of this policy letter.

Universal Offer

- 4.21 The creation of Community Hubs will lead to tangible changes in the way that people interact with health and care services and professionals in their day-to-day lives. The other main change is less physically obvious but equally important – the establishment of a “universal offer” of health and care services that will be available to islanders.
- 4.22 Ever since the first contract was drawn up between the States and the Medical Specialist Group, there has been a list of specialist services, or service areas, that are provided to the public under the contract. This has been more fully developed in the most recent contract, and includes services provided by both MSG and the States of Guernsey. The Committee believes that a full schedule of primary, secondary and tertiary health and care services, either fully-subsidised or at agreed rates, should now be drawn up. This would ensure that, as recommended by KPMG, there is a “more transparent, open and honest relationship with the public” in respect of the availability of services and also ensure that public funds are protected so that universal healthcare requirements are met and the most vulnerable are protected.
- 4.23 The services on this schedule will constitute the Universal Offer – they will be a core set of services that all Bailiwick residents should have access to. Some of them will be completely universal (such as primary care consultations), while others will be available to all people who meet the necessary health

criteria (for example, cancer screening services, which are offered to people of a certain age, gender or risk status; or specialist services, which are available to people who are appropriately referred from primary care).

- 4.24 The creation of a Universal Offer, which makes it clear what services the States will ensure are provided (either directly or by other organisations within the system), is consistent with the principle of Universal Health Coverage, which is promoted by the World Health Organisation and embraced by most countries worldwide, in both developed and developing economies.
- 4.25 It is expected that the Universal Offer will include most services currently provided within the health and care system. Where appropriate, it will also stipulate the timeframes within which such services should be provided. The aim of developing an “offer” is not to ration the services currently available, but to give the public a very clear statement of what services they can expect to receive, within what timeframe, and to help people understand the cost of those services. It may however be timely to consider whether access to public healthcare should be linked in any way to residency requirements.
- 4.26 As at present, some services within the Universal Offer will be free of charge, and others will be available at an agreed price, as prescriptions currently are. The Committee believes there needs to be greater distinction between the services that are available free, or at a fixed price, to those met through private payments. There is also a need to consider the eligibility for a state subsidy to access some services to ensure the costs do not continue to be a barrier to receiving care for those on low incomes. The Committee is of the opinion that some services which are currently charged for may need to become free-of-charge (or charges set at a lower price at least in certain circumstances) but this may have to be balanced by introducing charges elsewhere in the system.
- 4.27 Under the current system, islanders are unaware of the cost of delivering individual episodes of healthcare. The Committee contends that as part of developing a more transparent relationship with the public, steps should be taken to calculate, and in turn publish, indicative costs of some of the most common procedures.
- 4.28 A lack of cost measurement data currently means that it is difficult to establish the relationship between the cost of services (to both the individual and public purse) and outcomes and where government subsidies should best

be directed. The absence of data is disappointing, but to a degree unsurprising. Obtaining accurate cost measurement across health and care is challenging due to a combination of fragmentation in the system and the complexity of how care itself is delivered, incorporating a number of different resources including infrastructure, equipment and people. Steps will be taken to address this in the future. Within a new integrated system, it would not be expected for funding streams to distort the supply and efficiency of care. Steps should be taken to reward effective and efficient providers and to incentivise others to improve as part of the Service Levels underpinning the Partnership of Purpose by agreeing evidence-based schedules of charges.

- 4.29 This approach would only extend to those treatments and interventions falling under the Universal Offer. For other “non-core” services, providers will have discretion to determine their fees independently. Indeed, this will be encouraged as providers seek to differentiate their offer to best meet the needs of the service users. To illustrate, primary care consultations are a fundamental health and care offering. The Committee is clear that the price of such a service should not be barrier for those on low incomes accessing the care they need. However, if a practice made a commercial decision to offer appointments into the evening or over the weekend, and mindful of the attraction to some islanders, decided to charge a premium fee, this would not, as long as it did not negatively impact on the core delivery, fall within any agreed schedule of fees.
- 4.30 The current support available through Supplementary Benefit to a large extent protects the most vulnerable from the financial hardship that ill health can cause. The Social Welfare Benefits Investigation Committee’s work is estimated, using 2017 figures, to bring an additional 746 households, comprising 1,776 individuals, into scope of free medical and para-medical cover. However, for those Islanders just above the relevant thresholds, providers have expressed concerns that the costs of obtaining healthcare can be prohibitive.
- 4.31 The Committee believes that any work to rebalance how the public purse funds the health and care system should bear in mind this challenge, and seek to identify alternative mechanisms to support Islanders who may struggle to fund private healthcare insurance.

- 4.32 One aspect of delivering care closer to the community will be the establishment of a walk-in clinic, potentially at the PEH campus, specifically designed to offer convenient access to a range of medical and social services. The service would be universally available, with users not needing an appointment. The aim would be for the clinic to be available at convenient times, complementing traditional GP services. It would be, itself, complemented by a virtual offering. The Committee notes that such an approach is in line with the Lightfoot Report⁶ which recommended that the minor injuries treatment room then offered by the St John Ambulance and Rescue Service would “be best served clinically if this service were integrated into the hospital service”. It was noted that this would both ensure an appropriate service and maximise the use of hospital resources. While St John has since closed their facility, the Committee believe that there is a requirement for such a service locally.
- 4.33 The Committee is committed to working with other organisations in the health and care system, to develop this Universal Offer and to establish appropriate prices for the services within it. This process will require close working with the Committee for Employment & Social Security and the Policy & Resources Committee, along with any non-States bodies affected. If, as appears likely, this involves departing from existing principles (such as providing all secondary care free at the point of use) or reorganising States-approved funding (such as the £12 grant per GP consultation), the proposals will be brought back to the States for final approval.

Care Passport

- 4.34 The Committee intends for every islander to have a Care Passport: a statement of their individual entitlement to health and care services.
- 4.35 For most islanders, for the majority of their lives, their entitlement will be to the Universal Offer of services available through the Partnership of Purpose or through contracted off-island providers. The Universal Offer will comprise a combination of services available either free of charge at point of delivery and those where a proportionate charge is payable at a rate agreed between the Committee and the provider. If islanders wish to access health or care services

⁶ The St John Ambulance and Rescue Service Review FINAL REPORT 23 May 2013 By Lightfoot Solutions UK Limited <https://www.gov.gg/CHttpHandler.ashx?id=84888&p=0>

that do not form part of the “offer”, or within a more rapid timeframe, they will of course be able to purchase them privately.

- 4.36 However, for some islanders at some stages of their lives – pregnant women, say, or older people, or people with specified health conditions – their Care Passport may give them an entitlement to additional services or may reduce certain costs. For example, people with multiple long-term conditions, who require a high number of repeat prescriptions, may receive an additional States subsidy to bring down the cost of those prescriptions.
- 4.37 Against the background of focused prevention and early intervention, and more integrated and user-centred care, the Committee is also keen to explore whether there are opportunities to support islanders’ personal finances in respect of expenditure relating to ill-health. There are various mechanisms through which this could be achieved, including through a “Health Savings Account”, the introduction of a universal insurance scheme or another variant appropriate to the needs of the Bailiwick.
- 4.38 This will be subject of a further comprehensive policy letter, following work with other Committees, highlighting a series of possibilities and assessing their appropriateness in the Bailiwick context. The Policy Letter is likely to include an assessment of:-
- A “Health Savings Account” - an account into which islanders could save directly, and/or opt to have certain benefits (such as Family Allowance) credited to, and providing a form of additional financial protection for islanders without private health insurance;
 - A universal insurance scheme covering primary care, either entirely or substantively covering the costs, mirroring that currently in place for secondary care;
 - A compulsory insurance scheme using private providers;
 - The use of Community Credits (see below).

Digital Health: Apps and Patient Records

- 4.39 Technology will be central to the future of the Bailiwick health and care system and is recognised by KPMG as being a central consideration. In line with the States of Guernsey’s Digital Strategy, the Committee is committed to ensuring that technology will serve a vital role in engaging the people of the

Bailiwick in managing their own health and care, joining up health and care data to improve understanding of the population's needs and develop services to meet those needs by aggregating data to create a joined up view of health and care records.

- 4.40 The Committee is mindful of the inherent challenges associated with the delivery of digital and technological projects. The constant evolution of technology means that programmes need to adapt to the latest opportunity. The Committee will therefore seek to adopt an incremental and evolutionary approach, building a solid IT infrastructure which in turn has the capacity to act as an enabler for more innovative options in the future. Recognising that one size doesn't fit all, the NHS are trialling a smartphone consultation scheme in London through which registered patients will be able to access their traditional GP using digital technology. While this is not suitable for all patients - it has been estimated that 20% of patients require a face-to-face consultation - it has the potential to enable faster access to practitioners for patients and free up time for doctors.
- 4.41 Since this political term began, the Committee and its partners have already begun to introduce telehealth services: for example, Guernsey-based consultants providing remote consultations or follow-ups to patients in Alderney, where appropriate, or UK-based specialists remotely supporting patients in both islands. Within other jurisdictions, this technology is rapidly changing health and care to make it more accessible, enabling direct access to clinicians from within the home.
- 4.42 The role of telehealth services will continue to expand. The Committee anticipates that people who attend Community Hubs will have the option to access a range of virtual services as well as face-to-face health and care services. This could include anything from private rooms for talking therapy sessions or post-operative follow-up consultations via teleconferencing, to the provision of a digital directory of services or general health and wellbeing information. It will be critical for all Community Hubs to have the connectivity and IT facilities to support high-quality virtual services, as well as enabling on-site providers to have access to all the technology they need.
- 4.43 The Committee is keen for health and care partners to embrace new ways of working which take advantage of technology and a broad base of professionals to make care more economically accessible and sustainable.

This is particularly important for people at risk of, or who have, long-term conditions requiring repeat prescriptions, regular interventions, support or treatment which the current GP demand led model of care makes expensive. For example, there will be opportunities to use technology around the home to support the provision of health and care services. Technology can help people to manage their medications or other aspects of their long-term conditions more effectively; can connect people to a wide range of virtual support; and can alert care providers to a developing crisis and ensure timely intervention.

- 4.44 Digital technology will also make it possible for health and care services to be increasingly personalised. The Committee intends for individuals to be able to access their Care Passport as a digital application, and will commission the necessary design work to enable this, subject to approval of this Policy Letter and release of the necessary funding from the Transformation and Transition Fund. The app will also include general information about health and care services in the Bailiwick, and guidance on managing one's health and wellbeing. The Committee will explore whether it would be possible for such an app to interface with established lifestyle applications in order to support health improvement strategies.
- 4.45 In all this, the privacy and security of patient data must be paramount. Health and care services need users to disclose personal and sensitive data and this is only possible if islanders trust that such information will remain confidential and is subject to inherent safeguards. However, the Committee believes it must be made clear that good sharing of information, when sharing is appropriate, is as important as maintaining confidentiality. There is no contradiction between ensuring services rigorously protect the confidentiality of personal information whilst also proactively sharing information to optimise the care delivered.
- 4.46 Sharing information is vital to provide a seamless, integrated service. Health and care professionals should have the confidence and a duty to share information in the best interests of their patients, in line with the policies of their regulators and professional bodies. This should lead towards a single patient view, containing the core data necessary for the majority of health and care interactions – name, address, relevant chronic conditions, allergies etc - with the ability for health and care professionals to “break glass” to access more sensitive or privileged information on a case-by-case basis when

it is necessary. Triggering the “break glass process” would create an audit which could subsequently be monitored.

- 4.47 In addition, people need to be able to see their own confidential data by gaining access to their files, allowing them to make choices and participate actively in their own care. While this is already facilitated through the data protection legislation, this needs to be supported practically. It needs to be recognised that promoting access is just one element. If access is designed to empower users to take part in decisions about their own care in a genuine partnership with professionals, people need help understanding the records. Records are designed to support the professional care for the patient and working in partnership with patients to ensure records are understood is an essential part of redesigning services. There is, therefore, a broader consideration in respect of improving islanders’ health literacy.
- 4.48 Additionally, anonymised patient data needs to be shared to enable the health and social care system to plan, develop, innovate, conduct research and be publicly accountable for the services it delivers to the Bailiwick. With the exception of screening programmes (which requires contact details), most health improvement activities in public health do not require personal confidential data about individuals to be shared, but do require a strong evidence base.
- 4.49 In respect of screening programmes, such programmes may be formally adopted in the Bailiwick where they have unequivocal support from NICE through the National Screening Committee, or there are particular local circumstances which lead to a specific screening programme being identified as being of merit locally. Effective screening relies on being able to contact individuals who fit the relevant demographic or health profile, and this may therefore require the States of Guernsey, or other screening providers, to access databases containing such information. In this case, the Committee believes that the benefit of offering screening to the individuals concerned outweighs any potential harm due to loss of autonomy in relation to their data. Individuals would, of course, remain entitled to decline the offer of screening should they choose to.
- 4.50 The Committee believes that the objectives set out above in relation to data are straightforward and, for the most part, uncontroversial. However, the practical arrangements for delivering them have to date been unsatisfactory.

While both the new data protection legislation and the creation of the Partnership of Purpose will go some way to address this, the Committee believes that further steps need to be taken to ensure the practical application.

- 4.51 The Committee recognises that experience across the States, and beyond, illustrate the challenges associated with the delivery of programmes which are reliant on the development and implementation of an information technology infrastructure, but fail to recognise the broad organisational changes needed. It accepted that, despite many positive developments, the goal of the Electronic Health and Social Care Record, creating a single, integrated record, is still a long way from being achieved. Rather than a focus on a single patient record, the Committee believes that the emphasis should instead be on finding a way of aggregating data from multiple services and providers, an approach that is now being adopted across the world in respect of health records.
- 4.52 In the absence of overarching data, it is difficult to take a strategic overview of what's really happening across the health and care system and this hinders data-driven decision-making. However, rather than a full integrated system, the same outcomes can be achieved through creating a framework which enables the aggregation of data. By creating an interface which “pulls through” data from the various patient records maintained by different providers or different parts of the system, a high-level, strategic oversight can be obtained. The Committee is entering the next phase of upgrading its IT systems, and will seek to adopt this approach towards patient records. Such an approach would have additional consequential benefits in terms of better ensuring the accuracy of data held and compliance with the data protection principles.

Vulnerable People – Protection and Safeguarding

- 4.53 For vulnerable people – which may include people with deteriorating health, people with diminished capacity to make their own decisions or manage their own affairs, or people experiencing a physical or mental health crisis – part of the improved user experience will be a greater degree of support or safeguarding where this is needed.

- 4.54 The Committee has already agreed, as part of its dementia framework, to look at introducing Dementia Advisers or Admiral Nurses to help people with dementia and their carers access the services they need in a timely way. Such roles would naturally fit with the development of Community Hubs. A more generic “care navigator” role might be able to support people with a significantly wider range of conditions, rather than only those with dementia. The Committee anticipates that such “care navigators” could be based in or near GP practices, so that they can provide almost-instant help and guidance to people who may just have been diagnosed with a serious or progressive condition, among others.
- 4.55 The Committee is enhancing its internal safeguarding arrangements, by developing a multi-agency support hub (MASH) for vulnerable adults, to mirror the arrangements already in place for children. Broader developments in governance and regulation (discussed below), as well as the introduction of a Capacity law, will further ensure that vulnerable people are protected within the health and care system and are able to flourish in the community.

Recommendations

To direct the Committee for Health & Social Care and the States’ Trading Supervisory Board to work together to identify suitable sites for the development of Community Hubs;

To direct the Committee for Health & Social Care to work together with all health and care providers to produce a schedule of primary, secondary and tertiary health and care services that shall be publicly available as the Universal Offer either fully-subsidised or at an agreed rate;

To direct the Committee for Health & Social Care, the Committee for Employment & Social Security and the Policy & Resources Committee, together with any non-States’ bodies affected, to consider how the current States’ funding of health and care can be reorganised to support the Universal Offer and, if necessary, to report back to the States at the earliest opportunity;

To direct the Committee for Health & Social Care to work with:-

- the Committee for Employment & Social Security to create a Care Passport for islanders, establishing their individual entitlement to health and care services and to explore how it could be linked with existing benefits or new opportunities to encourage individuals to save for their costs of care, in an individual Health Savings Account, a compulsory insurance scheme or otherwise;*
- the Policy & Resources Committee and representatives of the voluntary sector, to explore a scheme of “community credits” to incentivise more volunteering within the health and care system;*

To agree that the Committee for Health & Social Care should investigate ways in which a technological interface could be developed that serves to create an aggregated service user record from the various patient records maintained across health and care providers;

To agree that, in line with the States of Guernsey’s Digital Strategy, the Committee for Health & Social Care shall seek to provide user-friendly online access to services, including providing service users with secure access to their own summary care record, where appropriate, their Care Passport and information on maintaining their own health and wellbeing;

To agree that the processing of health and care data should be premised on the equally important dual functions of protecting the integrity and confidentiality of such data and its sharing, where in the interests of the service user or the delivery of a public health function, and to direct the Committee for Health & Social Care and the Committee for Home Affairs to explore legal or practical mechanisms to achieve this;

Section B: Organisational Structure

A Partnership of Purpose

- 5.1 The current fragmented system of health and care provision, although it contains many pockets of excellent practice, must be held largely responsible for the fact that islanders do not experience a coherent, joined-up service. This fragmented nature compounds difficulties relating to the lack of control over demand, perverse financial incentives, over reliance on the acute setting and lack of capacity in terms of both physical infrastructure and staffing. This is one of the core problems that the Committee aimed to resolve through its Transformation work.
- 5.2 The Committee considered some fairly radical models, from taking in-house the majority of services that are currently provided independently (including GP and specialist health services), at one extreme, to outsourcing all services into an independent Integrated Care Organisation at the other. Both of these extremes would have had the advantage of merging all core health and care services into a single organisation with shared incentives, working together for the benefit of the patient. However, they would also have required massive organisational upheaval and substantial, costly, and potentially commercially challenging negotiations.
- 5.3 The Committee is therefore recommending an approach which will facilitate much closer working between organisations, and the sharing of goals and incentives, without, for the moment, massive organisational change.
- 5.4 A Partnership of Purpose will bring together providers of health and care services across the Bailiwick, collectively sharing power and responsibility for health and care. The Partnership would be open to all health and care providers fulfilling set criteria and demonstrably upholding a commitment to work collaboratively to enhance the care and services that individuals receive.
- 5.5 Participants in the partnership will work towards common standards of customer service and quality and shared health and wellbeing outcomes. They will exercise shared leadership, and have shared ownership and responsibility for what happens, primarily focusing on improving current pathways both in terms of patient experience and outcome and reducing the overall cost. This is an exciting opportunity for health and care providers to collectively define their shared purpose and values and consider the impact that the successful

delivery of joined-up services could have on the Bailiwick. To support closer working, service level agreements will incentivise and reward actions and behaviours that improve the access and reduce the costs of services.

- 5.6 Providers in the Partnership of Purpose will be subject to a Quality and Outcomes Framework. The Framework will reward quality care and help to standardise improvements in the delivery of services. Measurements will be set annually in conjunction with providers, and designed to measure the broad range of health and care services including the management of common chronic diseases, public health concerns, and the implementation of preventative measures.
- 5.7 As described above, the Committee's aim is to deliver a range of essential health and care services, known as the Universal Offer, through trusted providers based (or virtually accessible) at Community Hubs, the PEH Campus or Satellite Campus in Alderney. The Committee will negotiate Service Level Agreements with private and voluntary sector providers of health and care, to secure their involvement in this.
- 5.8 This Partnership of Purpose will provide an opportunity to offer joined-up health and care services to the people of the Bailiwick, meeting common standards of quality and working towards shared objectives. It will be a coalition of organisations working within a shared framework, bound together by Service Level Agreements, and participating equally in the management of the system (discussed further below). The "Partnership of Purpose" badge will enable services provided as part of the Bailiwick's Universal Offer to be easily identified by the public. However, the Partnership will not subsume individual provider organisations – they will retain their own identity and branding, and will continue to have the ability to offer whatever range of services they see fit, beyond the core provision of the Universal Offer.
- 5.9 The Committee believes that the benefits of this approach will ultimately be self-evident. However, it is likely that a significant period of negotiations will be needed in order to reach working arrangements that are acceptable to the States and to other providers within the system.
- 5.10 Although negotiations will not be so substantial or fraught as if the Committee were seeking to bring all health and care provision in-house, or outsource its own staff and service provision to a new entity, the Committee anticipates

that they will still be challenging. For example, while some providers recognise the importance of more collaborative working and data-sharing, emphasising a more joined-up approach to patient health and wellbeing, this is not yet universal or consistent.

- 5.11 The States therefore needs to consider how it can encourage participation in the Partnership of Purpose. This is likely to include a combination of incentives and regulation. For organisations where there is no existing contractual relationship with the States of Guernsey, this might include, for example, revising the criteria relating to States' grants or subsidies, or to professional privileges, so that access to them is, to some extent, conditional on participation in the Partnership.
- 5.12 To illustrate by a possible mechanism adopted elsewhere, NHS England, under the Quality Payments Scheme, offers financial rewards for community pharmacies which improve the quality of care for patients by meeting certain criteria on the themes of clinical effectiveness, patient safety and patient experience. While the Committee does not at this stage envisage the creation of an additional "reward scheme" per se, by considering the full funding available across the system, it may be possible for those participating in the Partnership of Purpose, and therefore committing to the States' endorsed ethos, values and standards, to receive funding over those non-participating bodies, who may see a substantial drop in their funding. Subject to States approval, the Committee will work together with the Committee *for* Employment & Social Security to explore these options.
- 5.13 Positive collaborative working is already ongoing and will be supported further by the Partnership of Purpose moving forward. For example, in response to concerns in respect of a 35% increase in referrals to the Orthopaedic Department from Primary Care over the last five years, a six month pilot of an Adult Musculoskeletal Service took place within Primary Care. Through the pilot, some 268 patients were seen, with 194 returning patient satisfaction questionnaires. There was a 100% satisfaction of the service from the patients (although seven patients expressed concern that they had to wait too long for an appointment) and feedback from clinical and clerical staff was equally supportive. Most significantly, the arrangements enabled easier access to services (by allowing a patient to book directly via the Practice Reception as soon as they have seen the GP) and also a significant reduction in the number of referrals to the Orthopaedic Department and to

the Acute Pain Service. A closer relationship through the Partnership of Purpose may highlight further opportunities for improving patient pathways.

- 5.14 The process of specifying a schedule of services that will constitute the Bailiwick's Universal Offer, and of developing Service Level Agreements with various organisations – and, where necessary, rewiring the system of grants and subsidies that the States currently offers to some health and care providers within the system – will be the single largest and most important piece of work in the next stage of the Committee's Transformation Programme. There will need to be modelling and data analysis will have to take place to ensure the system best utilises the available finances in order to support islanders. The Service Level Agreements will be proactively managed and performance driven through the monitoring of Key Performance Indicators so to ensure the effectiveness of service delivery and the appropriate management of public funds.
- 5.15 The Committee believes that, in considering the current system of grants and subsidies, there is potential to be radical in the new funding models considered. The available finances need to be arranged in such a way that best supports the needs of individual islanders. One of the aims of reorganising the public funding should be to protect islanders from financial hardship associated with seeking care. This is particularly relevant in terms of primary care. At the moment, for example, the GP subsidy is provided to all islanders, whereas a more focused application may go further in addressing concerns in respect of equality of access.
- 5.16 The Committee believes that the first focus of the health and care system must be on providing people with integrated care and support, to maintain their health and wellbeing. Substantial improvements in this regard can be achieved by bringing public, private and voluntary sector providers closer together within the framework of a Partnership of Purpose. Improved health and wellbeing within the Bailiwick, with services provided on a more sustainable basis, is the guiding principle of the Committee's transformation work – rather than significant organisational change.
- 5.17 Organisational change will, in general, be an evolutionary process. This is reflected in the new contract negotiated with the Medical Specialist Group in 2017, which provides, in the first instance, for patients to experience more integrated specialist care (provided by both MSG and the States of Guernsey)

and for the two organisations to cooperate more closely in the management and delivery of services – but which allows the Committee to give notice in respect of some or all services, and move to provide them in-house or commission them from another provider, if the contract does not result in the delivery of appropriate, good quality and cost-effective health and care services.

- 5.18 In light of its engagement with other health and care providers to date, and with its own staff, the Committee believes that there is a considerable will to work together to make a Partnership of Purpose-type approach to the Bailiwick health and care system a success. But the Committee does not shy away from difficult decisions, and will take action to re-commission services, or directly provide alternatives itself, if aspects of the system are consistently not delivering.

Role of the Committee *for* Health & Social Care

- 5.19 Some of the options for the future target operating model, identified in the first phase of the Committee’s Transformation Programme, would have involved outsourcing all aspects of health and care provision, management and commissioning to an independent organisation.
- 5.20 The Committee recognised that this fully-devolved approach would not be acceptable to the States which, in its recent reorganisation of the functions of government, made it clear that the Committee *for* Health & Social Care should be ultimately accountable for “protecting, promoting and improving the health and wellbeing of individuals and of the community.”
- 5.21 The Partnership of Purpose approach ensures that the Committee retains, in accordance with its mandate, the core responsibilities of:
- Setting health and care policy for the Bailiwick;
 - Commissioning, or otherwise ensuring the provision of, health and care services;
 - Ensuring the good governance of health and care services;
 - Managing the public budget for health and care; and
 - Ensuring that there is effective regulation of health and care.
- 5.22 The Office of the Committee *for* Health & Social Care will therefore continue to be supported by senior officers or advisers responsible for population-level

health intelligence, health and care strategy and governance, and commissioning of health and care services.

- 5.23 However, it is the Committee's intention to introduce Service Standards for the health and care services and facilities which it provides directly (such as Hospital Services, Community Services and Children's Services), and to create a clear separation between those responsible for the operational management of these services, and the advisers to the Committee. This will enable the "provider arm" of the Committee to participate in the Partnership of Purpose on the same footing as independent provider organisations, and to be accountable to the Committee for its performance against the Partnership's shared outcomes framework in the same way as those other organisations. There is no intention, at present, to move the Committee's provider function into a separate organisation, as has sometimes been suggested in the past. However, the Committee also does not rule this out as a potential future evolution of the system.
- 5.24 Both the Committees *for* Employment & Social Security and Health & Social Care have already identified the importance of a strong commissioning function, coupled with an equally strong monitoring process and have agreed to jointly resource this requirement through a dedicated Client Team. This Commissioning function will be the primary interface between the Committee and the Partnership of Purpose. It will be responsible for the drawing up and ongoing monitoring performance against contracts (for directly-commissioned services), Service Level Agreements and Service Standards. The Committee will be ultimately accountable to the States for the performance of the health and care system and, in particular, for the management of public funds invested in that system.

Role of the Partnership

- 5.25 One of the main attractions of the Partnership of Purpose to independent health and care providers may be the opportunity to participate, to a far more substantial extent than at present, in the management and future planning of the health and care system. Significantly, the Partnership will have the potential to evolve over time, both in terms of its membership and responsibilities, ensuring that it remains proportionate to local needs.
- 5.26 By bringing together qualifying providers of health and care services across the Bailiwick in a proportionate framework in which they collectively share

power and responsibility for health and care, there will be the opportunity for providers to define their shared purpose and values. The intention is that the Partnership of Purpose will be led by a group comprising direct or indirect representatives of all the participating health and care providers, including the services directly provided by the Committee, which shall, by virtue of its accountability to the Committee for the cost and quality of service delivery, be chaired by the Committee's Chief Secretary, at least during its initial inception. This will enable clear monitoring processes to be put in place, ensuring that the actions of the Partnership of Purpose are appropriately evidenced based and monitored.

- 5.27 The Committee intends to develop a Health and Wellbeing Outcomes Framework for the Bailiwick, which will be updated and recommended to the States for approval on a periodic basis – likely to be once every States term at most. This will provide the overall strategic framework within which the Bailiwick's health and care system will operate and will effectively be a series of objectives which the States agree in terms of health outcomes for Islanders. These will tangibly build upon the Policy & Resource Plan phase 1 priorities – for example the promotion of health and wellbeing, prevention and early intervention, encouraging and facilitating active lifestyles - by setting out how these priorities will be assessed.
- 5.28 From year to year, the Committee will develop and publish Commissioning Intentions – a process that will start, in respect of specialist care only, as part of the new contract with the Medical Specialist Group from 2018 onwards – which will set out its specific ambitions for health and care services in the following year.
- 5.29 The first step to support the Partnership would be the consolidation of the total spend and associated budget for all health and care with the Committee from the Committee *for* Employment & Social Security. This will enable full visibility of public spend across health and care and enable thematic multidisciplinary budgets to be set for programme areas or disciplines. Through this approach, the Partnership of Purpose will be able to make recommendations in respect of the allocation of funds.
- 5.30 Over time, it may be that, following the direction of the Health and Wellbeing Outcomes Framework, and the more specific direction of the annual Commissioning Intentions, it will be the responsibility of the various health

and care providers who are participating in the Partnership of Purpose to decide how best to allocate available funds and organise the provision of services among themselves, in order to best achieve the States' aims and benefit the wider population.

- 5.31 Terms of reference for the Partnership will be set by the Committee as part of the process of finalising Service Level Agreements with participating organisations. In broad terms, the Committee anticipates that there will be a Council of some form made up of representatives of all the participating organisations – although, in order to keep it to a manageable size, it may be that some of these are delegates elected to represent a number of smaller organisations with similar functions or made up of professionals with similar qualifications. The Committee's "provider arm" will be represented on the same basis as independent organisations, so that it has no greater, and no less, of a say in the running of the health and care service than its peers.
- 5.32 Throughout the process of negotiating Service Level Agreements and developing the shape of the Partnership of Purpose, the Committee will of course be taking legal advice to ensure that this coalition will have the necessary powers and authority to be capable of exercising the functions devolved to it, and of being held accountable for them. In all this, the need to distinguish between the collective performance of the Partnership and the performance of its constituent organisations will need to be considered, as will the need to preserve the individual identity, autonomy and internal governance functions of those organisations.
- 5.33 Developing a Partnership of Purpose, and managing it effectively, will require providers to invest time and energy into fostering opportunities for shared work, and to develop trust and openness. Its function will evolve over time in line with practical experience. Most importantly, integrated decision-making at senior level should lead to better information-sharing between organisations and more integrated health and care service provision at the front line.

Role of Public Health

- 5.34 In the last States' term, the former Health and Social Services Department was directed, by resolution of the States, to review the role of the Medical Officer

of Health⁷. The Committee has since conducted an internal review of the role, and the Public Health function in general, and has also sought recommendations from Jersey.

- 5.35 The Committee has concluded that the role of Medical Officer of Health, as an independent statutory function, is now largely obsolete, although certain key public health functions, such as reporting of infectious diseases, are clearly still necessary. The Committee considers that these functions can be transferred to other existing services or statutory officials, enabling the Medical Officer of Health role to be disbanded. The Committee will therefore carry out a review of public health laws, and report to the States with the legislative changes necessary to achieve these transfers.
- 5.36 However, a strong Public Health function is essential if the Committee and the States are to be well-informed about population health and care needs, and to make sensible strategic decisions about health and care policy. The Committee has concluded that it would be appropriate for this function to be headed up by a Director of Public Health, who has a role similar to that of Directors of Public Health in the UK – employed by the Committee, but capable of advising all States' bodies on aspects of policy which impact on health and wellbeing.
- 5.37 In reviewing the role of the Medical Officer of Health, the Committee also concluded that the functions of the Chief Medical Officer, which was another role generally held by the Medical Officer of Health, now largely fall under the remit of either the Medical Director or the Director of Public Health. The Committee therefore proposes that any such functions which are enshrined in law should be transferred, in the same manner as the functions of the Medical Officer of Health.

⁷ **The Medical Officer of Health** has certain statutory responsibilities which involve protecting the public's health through public health laws, aircraft and vessel ordinances, education laws and immigration law. The MOH also has a statutory duty to authorise the import and export of drugs to the island and a responsibility for Health Protection, including pandemic preparedness and response to environmental hazards such as radiation of chemicals. The MOH also currently has the role of Medical Inspector under the 1971 Immigration Act.

The Chief Medical Officer is responsible for advising on policy, strategy, legislation and regulation in respect of health matters.

The **Director of Public Health** is the lead officer for the three domains of Public Health, Health Improvement, Health Protection and Healthcare Public Health. The post provides leadership and expertise in respect of a range of health issues, including outbreaks of disease, emergency preparedness, the social determinants of health and wellbeing and encouraging behaviour change that promotes health and wellbeing.

- 5.38 While the Committee believes that the Medical Officer of Health / Chief Medical Officer role is no longer needed as a standalone, statutory office, the Committee recognises that, in disbanding this role, it risks losing or appearing to lose a function which is capable of providing the States with independent advice and challenge on its health and care policies. The Committee agrees that independent challenge is invaluable to the policy-making process and the governance of the health and care system.
- 5.39 The Committee therefore intends to enter into negotiations with other jurisdictions – which may include other small islands, such as Jersey, the Isle of Man or Malta, and/or local authorities in the UK – to find one or more partner jurisdictions that would be willing to offer regular or *ad hoc* advice and challenge to the Committee and the States in respect of health and care policy, potentially on a reciprocal basis.

Staff Terms & Conditions, and Culture

- 5.40 Transformation is not really about organisations as contractual entities, entering agreements, monitoring performance, managing budgets. It is much more about the people who make them come to life – the staff who carry out their core functions on a day-to-day basis.
- 5.41 For new ways of working to be a success, staff at every level of the organisation have to understand their purpose and accept it as a valid aim. The Committee is conscious that it has a lot of internal work to do, to ensure that the culture, in every part of the organisation, is one where staff are committed to the key aims set out in this Policy Letter – and, importantly, where they feel empowered to make changes in their working practices in order to do so. The Committee is committed to investing in building the kind of positive, innovative, open, learning (not blame) based culture that will be essential to its success. This approach is fully in line with the Care Values Framework.⁸
- 5.42 The KPMG Report references the importance of continued recruitment, training and retention of staff in order for any future model to work. While the Committee has taken positive steps to improve and enhance the marketing of vacancies, the international shortages of nurses and midwives,

⁸ <https://gov.gg/CHttpHandler.ashx?id=106450&p=0>

and Guernsey's relatively unattractive market position, means that the benefits of doing so have been limited.

- 5.43 The Committee is therefore pleased to note that within Phase 2b of the Policy & Resource Plan, the Policy & Resources Committee have recognised the importance of the future provision of health and care being "supported by work on the recruitment and retention of nurses." The Committee welcomes the Policy & Resources Committee's support in this regard as the critical issue of staff terms and conditions – vital to staff morale and engagement – is outside the Committee's authority to change and has a clear connection to the broader corporate programme of Public Sector Reform.
- 5.44 As is also set out in the 2018 Budget, one of the reasons for the anticipated underspend of £4.7million in 2017 by the Committee is the number of managed vacancies being temporarily carried. A project is ongoing to assess vacant positions with a view to rebasing the overall establishment, but statistics clearly show that turnover rates in Guernsey are high with, using April 2017 figures, a vacancy factor of 18%. Steps are being taken to address this through a number of key initiatives. However there is recognition that a more fundamental review of staff terms and conditions is required to reflect the technical and complex nature of modern nursing. This will provide opportunity to consider how the overall package can be seen as competitive, both compared to that offered by other jurisdictions and for similarly-skilled positions within the public sector. The Committee is fully supportive of the steps being taken by the Policy & Resources Committee to scope out the possible merits of pay and conditions harmonisation across the public sector, and would welcome any steps to remove the perception of pay disparity within the organisation.
- 5.45 More broadly, the Committee is mindful that every opportunity should be taken to encourage islanders to enter the health and care workforce, and this means that the island's training resources need to be used to best effect. The Committee recommends that the Committee *for* Education, Sport & Culture be directed to review the training and education provided by the Institute of Health and Social Care Studies, which came under its remit in 2016, and to consider whether any other on- or off-island training opportunities should also be promoted or supported.

Recommendations

To agree that the Committee for Health & Social Care shall be responsible, in accordance with its mandate, for:

- *Setting health and care policy for the Bailiwick;*
- *Commissioning, or otherwise ensuring the provision of, health and care services, through the Partnership of Purpose;*
- *Conducting a series of Health Needs Assessments, constituting a Comprehensive Health Needs Assessment for the Bailiwick, in order to plan ongoing service delivery with a view to improving health and wellbeing and reducing health inequalities;*
- *Ensuring the good governance of health and care services;*
- *Managing the public budget for health and care; and*
- *Ensuring that there is effective regulation of health and care;*

To agree that the Committee for Health & Social Care should report back to the Assembly on the legislative changes needed to disband the roles of Medical Officer of Health and Chief Medical Officer and, where relevant, transfer their functions to existing services or statutory officials whilst exploring the potential for creating reciprocal arrangements for the independent challenge and peer review of respective health and care policy on a regular or ad hoc basis by other small jurisdictions;

To direct the Policy & Resources Committee to undertake a strategic review of the terms and conditions attached to nursing and midwifery professionals employed by the States of Guernsey, and to consider whether such a review may also be appropriate in respect of any other staff group;

To direct the Committee for Education, Sport & Culture, together with the Committee for Health & Social Care, to review the training and education provided by the Institute for Health and Social Care Studies to ensure that it continues to meet the health and care needs of the Bailiwick, and to explore options for supporting a wider range of on- and off-island training opportunities;

Section C: Needs Analysis

Population Needs Assessments and Commissioning Intentions

- 6.1 A Population Needs Assessment is a process for establishing the health and care needs of a group of people. One or more assessments may be carried out – often looking at the needs of a particular age group, or people with a particular condition – in order to build up a picture of the needs of the whole population, and to establish where there may be gaps in services or issues needing priority attention. Such assessments are commonly used by local authorities in the UK, and are publicly available.
- 6.2 At present, the Committee is supported by a small but hardworking Health Intelligence team, who produce information about population-level health needs, in particular, within the Bailiwick. The latest Guernsey and Alderney Health Profile, which is the most complete picture we have of physical and mental health needs in the islands⁹ confirms the ageing demographic. However a primary challenge for the Committee is that the information it currently has on islanders' health and wellbeing, at a population and patient level, is not really adequate to allow it to formulate strategic goals in terms of how those health outcomes should change. As noted in KPMG's report, there are pockets of clinical concerns in key areas and a Population Needs Assessment will provide opportunity to explore this further.
- 6.3 In order to be able to produce a comprehensive Population Needs Assessment on a regular basis to inform health and care policy-making, the Committee will need to increase the capacity of its Health Intelligence team. In order to increase the team to a size able to provide timely, comprehensive information, a further three posts are necessary, costing in the region of £170,000 per annum. The Committee anticipates being able to fund these posts from within existing resources through savings achieved to date by organisational changes. It will also rely on other provider organisations agreeing to share population-level data, which will be a core requirement of the Partnership of Purpose.
- 6.4 The data obtained through the Population Needs Assessment will be used to define need, guide decision making, set and prioritise goals and targets, and monitor progress. It will allow the Committee to shape and update the Health

⁹ The Health Profile for Guernsey and Alderney 2013-2015 can be found online at <https://www.gov.gg/CHttpHandler.ashx?id=104975&p=0>

and Wellbeing Outcomes Framework, as well as informing its annual Commissioning Intentions, by identifying the issues most in need of attention. It should be made clear that, as a consequence of carrying out such assessments, the Committee may identify areas where the health and care system invests significant resources for an issue that, in terms of population size or health impact, is relatively small. In other words, Population Needs Assessments may be used to inform decisions to disinvest from services, as well as decisions to invest. Only through understanding the population's health and care needs, will it be possible for there to be a much greater focus on prevention and supported self-management in the community.

- 6.5 It is anticipated that, given the changing demographic, the first Population Needs Assessment will focus on "Older People", covering both care and support needs (for example the maintenance and sustainability of key services, access to Primary and Secondary Care, access to information and advice, integrated management of mental health and physical health issues, integration of health, housing and social care, social isolation and loneliness while maintaining independence, practical help with day-to-day tasks, the needs of those with dementia and their carers, digital inclusion and intergenerational integration in communities) along with prevention issues (for example financial management, healthy environment and behaviours, falls prevention, outcomes-based commissioning for domiciliary care).

Access Frameworks and Prioritisation

- 6.6 The Committee, for the past few years, has been developing a process of evaluating whether new medicines, treatments or other health-related investments are value for money and worth investing in. These processes have not been without their challenges, as they have inevitably resulted in some drugs and treatments being turned down. However, the general approach represents a fair and responsible way of managing the health budget.
- 6.7 The Committee is of the view that this process should continue to be used, and to evolve. However, it recognises that public understanding of the process is limited, and more easily accessible public information and perhaps education is necessary, in order to ensure that people understand how these decisions, which can have a life-changing impact, are made.

- 6.8 Moreover, in order to ensure that there is consistency in decision-making, The Committee intends to carry out an internal review of all sub-committees which have a role in reviewing the merits of new treatments or interventions, considering whether they remain appropriate or if there is potential for consolidation and if they are using comparable processes and evaluation criteria. This review will be done in partnership with the Committee *for* Employment & Social Security, in particular, as some decision-making, such as that of the Prescribing Benefit Advisory Committee, fall within its remit rather than that of the Committee.
- 6.9 More recently, the Committee has recognised the need to introduce criteria to define eligibility for, and access to, community and social care services, and is developing a process for doing so. This already happens, to a certain extent, with the criteria employed by the Needs Assessment Panel for residential and nursing care, and the Committee considers that this particular evaluation process must be expanded to include all long-term care (including care in a person's own home), in accordance with the recommendations of SLAWS. The Committee also recognises the importance of successful transitions between adult and children services and is in the process of commissioning a focused review in this regard.
- 6.10 The Committee recognises the importance of recording data both on eligibility for, and on access to, social care, community and long-term care services. This will help it to identify any service gaps and, if appropriate, to recommend further investment by the States. This will become more important as the population ages, and more people need some form of care or assistance in their day-to-day lives.

Horizon Scanning and Ongoing Learning

- 6.11 Collecting data about health needs and gaps, and responding to that information, is not the only way that health and care policy should be developed, although it is fundamental.
- 6.12 Most people working within the health and care system are qualified professionals with a duty to undertake continuous professional development. As individuals, they carry on learning throughout their career, sharing ideas and insights with peers on- and off-island, and using that to improve their practice.

- 6.13 However, as an organisation, the Committee is not nearly so good at learning from peers, sharing insights, or scanning the horizon for new developments – all of which is vital to the development of good health and care policy. As part of the transformation of health and care, the Committee will aim to develop its capability in this area – including by creating more opportunities for professionals to share learning with each other, across team and even organisational boundaries; and by empowering and encouraging individuals and teams to access the senior management team and the Committee to share ideas, insights and opportunities. As a response to this more collaborative and inclusive approach, positive steps are already beginning to be felt, for example the successful pilot of the Adult Musculoskeletal Service within Primary Care which delivers both improved outcomes for patients and financial savings, improved hip and knee pathways and the greater use of video conferencing, particularly in respect of Alderney.

Recommendations

To agree that the Committee for Health & Social Care shall review the processes used to:-

- consider the merits of whether new drugs or medical treatments should be funded to ensure that a consistent approach is used across all decision-making bodies (including the Committee for Employment & Social Security's Prescribing Benefit Advisory Committee);*
- determine access to child or adult social care services, along with reviewing the transition between the two;*
- access long-term care in the community or in residential or nursing homes and work with the Committee for Employment & Social Security to produce a single assessment process in accordance with the resolutions of the Supported Living and Ageing Well Strategy;*

and in so doing ensure that clear, user-friendly information about the processes and criteria shall be made publicly available;

Section D: An Environment for Health

Health in All Policies

- 7.1 The KPMG report has, in line with earlier reports, clearly demonstrated that the health and care system, working alone, cannot solve some of the key issues which lead to its unsustainability – including the general health and wellbeing of the population. The determinants of health – the social, cultural and economic factors that have a recognised impact on health and wellbeing – require the whole of government to take responsibility and to take action.
- 7.2 In Guernsey and Alderney, a Healthy Lifestyle Survey¹⁰ has been carried out every five years since 1988, most recently in 2013. While 80% of respondents reported their general health as good or very good, the proportion of adults rating their health as very good was associated with higher income and younger age. The Survey demonstrated some significant inequalities locally, including:
- 26% of people who rented their homes smoked compared to 8% who owned their homes. 25% of people in low income households (less than £20,000 per year) smoked compared to 3% in high income households (more than £100,000 per year);
 - In respect of alcohol use, adults from the lowest income category (less than £10,000 per year) had both the highest level of abstinence (33%), and the highest levels of higher risk drinking (8%) and possible dependence (2%); and
 - 24% of adults living in low income households (less than £20,000 per year) had low mental wellbeing compared with 12.1% of those in higher income households. The proportion of adults with low mental wellbeing was higher among those living in States' Housing or Guernsey Housing Association's rental properties than those with other living arrangements (although numbers were low).
- 7.3 The findings above are unsurprising in light of experiences in other jurisdictions. Professor Sir Michael Marmot (Chair of a 2010 independent review of evidence-based strategies for reducing health inequalities in England and the WHO's Commission on Social Determinants of Health) has identified that there is no biological reason for most health inequalities.

¹⁰ <https://www.gov.gg/article/154885/Healthy-Lifestyle-Survey>

Health is predominantly related to how society itself is organised or, more importantly, most health inequalities result from factors which governments can take steps to address.

7.4 As part of the 2020 Vision, the States resolved that all States Departments should contribute to the Vision's framework, having recognised that education, employment, housing and other policy factors have a key impact on health and wellbeing. The Policy & Resource Plan has similarly recognised the need for a concerted effort and investment across government to support the determinants of good health and wellbeing.

7.5 In this respect, the key messages from the "Fair Society, Healthy Lives" review of health inequalities in England are also applicable to the Bailiwick. That is:

- Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life;
- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health;
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health;
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage;
- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities, for example productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs; and
- Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals.

7.6 The review found that reducing health inequalities required action on six policy objectives:

- Give every child the best start in life;

- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities; and
- Strengthen the role and impact of ill-health prevention.

7.7 The World Health Organisation's Commission on Social Determinants of Health 2008 Report "Closing the Gap in a Generation" made clear that "health and health equality may not be the aim of all social policies but they will be a fundamental result."

7.8 The health and care system, and indeed this Policy Letter, is not about the fixing of broken bones or the administration of medicine. It is about something far more fundamental and central to each and every islander. It is the practical realisation of a system which can give effect to the Assembly's stated ambition to make Guernsey the happiest and healthiest place on earth.

7.9 Every Committee has its part to play in realising this admirable aspiration and acknowledging the implications that a broad range of factors can have on health. By way of example:-

- Committee *for* Education, Sport & Culture - early childhood experiences and education lay critical foundations for life. It has a vital role in developing the physical, social/emotional and language/cognitive abilities of children creating lifelong habits;
- Committee *for* Environment & Infrastructure - car dependency impacts on air quality and physical activity, in turn affecting health;
- Committee *for* Employment & Social Security - both employment and working conditions have powerful effects on health equality. Where these are positive, it can lead to financial security, social status, personal development, social relationships and self-esteem;
- Policy & Resources Committee - policy coherence has been shown to be vital in supporting health equality. The policies of Committees should seek to complement each other in the delivery of key aims and this is a process which has started through the Policy & Resource Plan and needs to be further promoted.

- 7.10 This responsibility extends beyond the public sector to the private and third sectors and importantly to each and every islander. In the 2013 Guernsey and Alderney Health and Wellbeing Survey, a fifth of all adults regularly volunteered for a charity and almost a fifth regularly volunteered with another type of organisation (e.g. community group, youth club). In line with experiences in other jurisdictions, adults that regularly engaged in activities or volunteering tended to have better mental wellbeing than those that did not engage in these social actions. This community spirit, both in respect of formal and informal volunteering, is already prevalent in the Bailiwick and as a small community, there is opportunity to develop this even further.

Making Every Contact Count

- 7.11 Every day there are thousands of interactions between health and care providers and the public. There is scope to use these interactions to deliver opportunistic healthy lifestyle information in a way which is consistent and concise, and which provides islanders with the tools to improve their physical and mental health. This ethos of “Making Every Contact Count” will be fundamental to the Partnership of Purpose and should be supported more broadly across the Public Sector wherever possible.
- 7.12 A simple, but illustrative, example of the potential of making every contact count is shown through cervical screening. The cervical screening programme is designed to detect abnormal cells on the cervix. Such cells don’t necessarily pose an immediate threat to the woman but can potentially develop into cancer into the future. Women who are found to have such cells are referred to a Gynaecologist at the MSG who in addition to providing the necessary treatment, provides information on risk factors and signposting to relevant support services. One of the risk factors is smoking – the risk is 46% higher in current smokers - so the opportunity is taken to highlight the availability of local smoking cessation services. This is a simple but highly effective example of the provision of opportunistic healthy lifestyle information. Such an approach has the potential to expand exponentially across the wider public sector.
- 7.13 It is important to remember that for many people it is difficult to talk about matters relating to their health and care. This may be because of fear of embarrassment or being a burden, because they don’t know help is available, or because they don’t know who to talk to. Making every contact count goes

some way to address this. However, to ensure that it is successful, there needs to be appropriate technology and data sharing so that people do not find themselves having to repeat the same information multiple times. Making sure that health and care professionals are able to connect people directly and seamlessly with services that can help them, if they cannot do so themselves, reflects the ethos of “making every contact count”, and is fundamental to the transformation described here.

Early Years

- 7.14 As identified by Sir Michael Marmot in “Fair Society, Healthy Lives”, getting the right start in life is fundamental to good health and wellbeing – while the legacy of a traumatic childhood, for many people, continues to have all sorts of consequences in their adult lives.
- 7.15 The States has already made a clear commitment to improving the lives of children and young people, through its Children and Young People’s Plan, approved in February 2016. This recognises that every States’ Committee, and civil society as a whole, has a role to play in ensuring that children and teenagers in the Bailiwick are safe, happy and flourishing.
- 7.16 In the past few years, the Committee has taken many steps to improve the services that it provides directly to children and young people, including child protection for the most vulnerable. At this stage, transition between children’s and adults’ services, for people who will need some form of lifelong care or support, remains a particular weak point, and the Committee is already working to review and strengthen this area. Getting transitions right will be essential in delivering the person-centred care, discussed above, which all islanders deserve.
- 7.17 Getting the early years right, and especially focusing on those who are most vulnerable, will always be a priority for the Committee. This formative period is so pivotal, in terms of life chances and outcomes, that without it there can be no question of achieving meaningful transformation.

Bailiwick Health and Wellbeing Commission

- 7.18 The concept of a Bailiwick Health and Wellbeing Commission (or a “Bailiwick Health Trust”, as it was initially called) was first put forward in the Bailiwick Healthy Weight Strategy.

- 7.19 It was recognised that health promotion initiatives – especially messages about healthier lifestyle choices and behaviour change – could gain more momentum if they were identified, promoted, and delivered, by civil society, rather than by government, with the support and expertise of the public health function. It was also seen as an effective way of increasing the resources available to support health promotion, by bringing together public, private and voluntary organisations with a common purpose.
- 7.20 Having discussed and refined the idea further with voluntary sector representatives, the Committee has concluded that a Health and Wellbeing Commission, with dynamic, independent leadership, would be a more effective way of coordinating the efforts of private and public partners and delivering health promotion and improvement services than the current in-house model. It has also recognised that there are other small teams, particularly within the Committee *for* Education, Sport & Culture and the Committee *for the* Environment & Infrastructure, which have a health-promoting role. The Committee is currently in discussion with these Committees to consider whether those teams could also form part of the Health and Wellbeing Commission and has been pleased by the Committees' responses. More broadly, it is envisaged that each and every Committee will, to varying degrees, have a part to play in supporting the role of the Commission.
- 7.21 In the same manner as the Youth Commission and the Sports Commission, both of which were formerly government services, it is intended that the Health and Wellbeing Commission will also work with and alongside independent organisations, hoping in time to bring them under its umbrella, and will be able to raise part of its funding from non-government sources.
- 7.22 A strong focus on promoting and improving health and wellbeing is fundamental to the success of transformation – particularly to the ongoing sustainability of health and care services. It is only by people choosing to live healthier lives, and to avoid more of the risky behaviours that lead to ill-health, that current patterns of declining health in older age will be broken. We are in the age of the non-communicable disease – conditions such as cancer, heart disease and dementia, which are not generally transmitted by infection, but rather have a very strong link to lifestyle choices and environmental factors. So while life expectancy continues to rise, the number of years spent in poor health, often with multiple long-term conditions,

remains significant. Only society-wide action to improve health and wellbeing, both physical and mental, will make sure that people live in good health, well into the last years of life.

- 7.23 The Bailiwick Health and Wellbeing Commission will, over time, commission and deliver services to implement the actions associated with the States-approved public health strategies (Healthy Weight, Drug and Alcohol, Tobacco, Mental Health and Wellbeing and Breastfeeding). It will use its broad membership to provide accessible services to the public, supporting Islanders to make healthier choices and recognising the relationship between mental and physical health.
- 7.24 The success of this approach will also depend on Islanders taking personal responsibility for their health and wellbeing. Lifestyle factors play a significant role in health outcomes. Put simply, the best person to prevent long-term conditions developing is not the doctor - it's each and every individual. And the person most involved in the day-to-day management of long-term conditions, where they arise, is not a health or care professional, but the person themselves. The role of the Commission will be to inform, support and empower islanders to take as much control as possible over their own health and wellbeing, now and in future.

Community Credits

- 7.25 The transformation of health and care will be marked not only by an ethos of personal responsibility, but also of responsibility for one's friends and family, and the wider community.
- 7.26 It is well recognised that factors such as general health, unemployment, or ageing can lead to loneliness or social isolation, leading to its own problems and challenges. It has been shown internationally that social networks have as much influence on mortality as common lifestyle and clinical risks, such as moderate smoking, excessive alcohol consumption or obesity. Social support is particularly important in terms of increasing resilience, promoting recovery from illness, and encouraging self-regulation and willpower. We know however that for some people it is difficult to build, and maintain, a social network. As a community, we need to both facilitate opportunities for Islanders to benefit from social opportunities and more broadly take a collective responsibility for each other's health and wellbeing.

- 7.27 One way of encouraging this may be to develop in conjunction with the voluntary sector a scheme of “community credits”. This could allow certain kinds of volunteering or informal care-giving to be recognised and awarded ‘credits’. These credits would have a value which the recipient could use either for themselves, or to transfer them to benefit a friend or family member. The credits could be exchanged for voluntary assistance, either now or in the future, or even for activities that promote good health and wellbeing, such as sporting activities. This form of “social currency” would be one way to recognise those islanders who support others within their community, and incentivise others to do the same.
- 7.28 Japan has amongst the longest overall life expectancy in the world and has faced challenges relating to a rapidly ageing population, decline in the capacity of family to care for the elder members and sky-rocketing healthcare costs. The Fureai Kippu (literally ‘ticket for a caring relationship’) are a variety of national schemes designed to develop networks of mutual support dedicated to providing elderly care. Individuals are able to earn time-credits by providing care to elderly people or people with disabilities, and these credits can then be transferred to relatives or friends in need of care, or be saved for the future when sick or old.
- 7.29 Such an approach has also been adopted in areas of the UK. For example in Dorset, there is a model of community credits, where credits can be earned in a variety of ways, such as visiting an elderly person, offering a skill or helping with certain organisations. These can then be exchanged at a number of local attractions, for example sporting facilities and museums.
- 7.30 To be successful, a model of health and care community credits would need the full support of the States of Guernsey, the private and third sectors. The mechanisms of such a scheme would need to be fully explored so to ensure that it was fair and equitable, did not disadvantage islanders and – most importantly – that it respected and did not undermine the altruism which generally underpins volunteering and informal caregiving in the community. The Committee does not have a scheme design in mind at present, but wishes to explore this concept further with the voluntary sector, in order to establish its potential.

Regulation and Standards

- 7.31 In larger jurisdictions, there is usually a clear separation between organisations which provide health and care services (for example, NHS Foundation Trusts in the UK); organisations which purchase those services on behalf of their local population (for example, Clinical Commissioning Groups); and organisations which regulate services and professionals, and hold them to acceptable standards of quality and safety (for example, the UK's Care Quality Commission). This separation helps to ensure that there is independent challenge and an emphasis on quality throughout the system.
- 7.32 By contrast, the Committee's mandate includes elements of all three of these roles. The Bailiwick has never succeeded in establishing a wholly independent regulatory function for health and care, although successive States have recognised that this would be desirable. KPMG have similarly stressed the role for separate, but proportionate, regulatory arrangements locally.
- 7.33 Elements of the health and care system are regulated: in particular, professionals are registered with their UK regulatory body (such as the Nursing and Midwifery Council, the General Pharmaceutical Council, or the General Medical Council) and most now undergo rigorous processes of reassessment and "revalidation" of fitness to practice. Currently premises on which health is provided are not regulated and there is very limited regulation of services – GP practices are required to meet certain standards in order to register locally; residential and nursing homes have a limited inspection regime, with few enforcement powers; while most services, including those provided by the Committee in its hospitals and the community, have no regulatory oversight at all.
- 7.34 Although the Committee has done much to improve internal governance processes in the past few years, it recognises that independent oversight is also essential. However, any regulatory regime must be proportionate, and must adopt standards of safety and quality that are acceptable to islanders and realistic in respect of the small size and relative remoteness of the Bailiwick.
- 7.35 Work to develop comprehensive regulation for health and care has already begun, and the Committee will be seeking to explore the options for working with other jurisdictions including Jersey in this regard. Since 2006, the States

of Jersey have been working on a new umbrella regulatory framework covering its health and social care economy, culminating in the enactment of new primary legislation The Regulation of Care (Jersey) Law 2014. The law seeks to ensure that all services delivering care and support are regulated and monitored against safety standards and quality of care provided to vulnerable people. In tandem with the development of the Law, the States of Jersey has established an independent commission which is responsible for regulating care providers both in the public and private sectors and to implement the ethos of the law.

- 7.36 The Committee's officers have met with Jersey counterparts, including the Commission to discuss opportunities and additionally undertaken an initial fact finding exercise with local stakeholders. There was consensus amongst stakeholders to adopt a similar independent Commission-led model to that implemented in Jersey, with clear recognition that the model should reflect and be proportionate to the Bailiwick's size. It is clear that regulatory standards should be introduced using a risk-based approach, prioritising the greatest area of risk first, identified as the domiciliary care sector and the unregistered workforce (e.g. Care Support Workers).
- 7.37 While the detailed proposals for the structure, governance and funding of the regulatory framework will be in a supplementary policy letter, the Committee believes that a pan Channel Islands' regulatory framework is not appropriate at this time, albeit any adopted framework should include capacity to move towards this in the future. This is due to the differing regulatory priorities in the two Bailiwicks at the current time, meaning that it would be difficult for the Islands to create a common approach in this initial implementation and development stage.
- 7.38 Reporting back to the Assembly on proposals for an appropriate health and care regulatory regime for the Bailiwick will be a priority for the Committee in 2018.

Health Ombudsman

- 7.39 The Committee notes that it has been suggested that Guernsey would benefit from an independent health ombudsman. Such an approach will be considered as part of the regulation workstream falling under the Transformation Programme to assess the potential cost and benefits of such a statutory post holder, whether a similar level of oversight could be achieved

as part of a single complaints policy across the Partnership of Purpose and the opportunities to work with other jurisdictions.

User Voice

- 7.40 Ultimately, a commitment to providing person-centred health and care services relies on having ordinary people at the heart of decision-making – not only the day-to-day decision-making about their care, which is done by GPs or nurses or teams of professionals, but also the senior, strategic decision-making about the whole shape of the health and care system, which is done by the Committee and the States, and at all levels in between. The regular States of Guernsey Community Survey may be one way in which the public will be able to contribute towards the future health and care vision on a routine basis.
- 7.41 It is particularly important to ensure that people whose voices might not be heard – because they are socially marginalised, disabled, or have diminished capacity – are able to access support and advocacy to get their views across and have their voices heard. This is an area where the Committee intends to work more closely with the voluntary sector to ensure such support is provided.
- 7.42 The Committee established a forum called CareWatch as part of its early transformation work, in order to ensure that voices representing diverse patient perspectives were heard and included throughout the process. Such a forum will continue to exist in the future, and that it is able and expected to have a voice in decision-making about health and care services, commissioning and governance.

Private Healthcare

- 7.43 In essence, there are two ways to reduce the cost of health and care to the public purse. One is to reduce the demand for services – which can be done by joining up services so that a person does not have to visit multiple providers in order to have their health and care needs met; by earlier interventions which ensure that health conditions are well-managed; and by effective health promotion, which maintains and improves the health and wellbeing of the general population. The other is to increase the level of income coming in.

- 7.44 At present, the States of Guernsey and MSG (along with other providers, on- and off-island) offer private health services. Having a good private healthcare service is important in terms of providing choice for islanders and it is also considered to be a significant economic enabler, in the broader sense, because it may be attractive to people considering relocation to the Bailiwick. However, many islanders with private health insurance do not choose to take advantage of this, and of those who do, a significant number choose to go off-island. Of course, the decision to utilise off island services should be recognised as a legitimate choice which some Islanders will always wish to exercise, however it should not be prompted by the perception that private services on island are inferior to those available elsewhere, and services provided by the States of Guernsey should be seen as a competitive alternative to off-island providers.
- 7.45 The current level of uptake of private healthcare is believed to be due, at least in part, to the fact that there is no meaningful differential between on-island private healthcare and its public equivalent. It is provided by the same people, to the same standards, and within the same facilities – indeed, the recently-built Brock and Carey Wards of the Princess Elizabeth Hospital offer a more attractive environment for patients than its private ward, Victoria Wing. An environment should be created which supports private and co-payment models in order to bridge the financial gap which is forecast to exist in the future. The Committee is keen the private offering should be seen in its broadest form and should not be seen as limited to that offered, in the hospital setting, on Victoria Wing but the full breadth of health and care services. Consideration should be paid as to how existing health and care facilities can be used innovatively to support a more comprehensive private offering in addition to the possible creation of new facilities.
- 7.46 The Committee is not prepared to reduce the quality or scope of public services in order to make private care seem more attractive. The Committee is strongly of the view that its primary duty is to ensure the provision of a good and equitable public system of health and care services. However, the Committee recognises that many of the elements that make private care attractive do not relate to the actual medical care, but to the environment in which care is provided – and there is considerable scope to improve that environment locally in order to make it more attractive to potential private patients.

- 7.47 In order to encourage people to choose on-island private care rather than going off-island, the Committee considers that these services should be managed, as far as possible, on a commercial basis. This requires high quality facilities and staff, offering competitive treatments at convenient times, proactive marketing of the offer and skilled commercial management. This is an important area where the Committee intends to return to the Assembly with practical proposals and an indication of possible funding mechanisms to bring its private facilities up to a competitive standard, and to manage and market them appropriately. The Committee envisages that this may include an application to the States of Guernsey Bond.

A Destination for Wellbeing

- 7.48 The Committee is keen to explore, with the Committee *for* Economic Development, whether the Bailiwick could position itself more actively as a “destination for health and wellbeing”, to the benefit of both residents and visitors.
- 7.49 Worldwide, there is a growing interest in travel for health and wellbeing. From 2012 to 2014, the European Commission funded a project, WelDest, which led to the publication of an online handbook on “Developing a Competitive Health and Well-being Destination”, including a self-assessment tool on whether a jurisdiction has the ability to flourish in this regard. Successful jurisdictions, it suggests, will have good endowed resources (natural assets, attractive scenery and environment, local culture and authenticity, and a good reputation); existing services to support health and wellbeing (from beauty therapy to meditation, healthy nutrition to exercise and fitness opportunities); good supporting services (including healthy food and beverages, accessible information and general accessibility); an existing tourism strategy and people with specific professional skills in health and wellbeing working in the destination.
- 7.50 The Bailiwick has an exceptional offer in many of these areas and, in taking a more coordinated approach towards them, could use this as a strong pillar of its tourism strategy. Developments here would also link with the work of the new Bailiwick Health and Wellbeing Commission, and the two could closely complement each other.

Recommendations

To affirm that the States, in all its policy decisions, should consider the impact of those decisions on health and wellbeing, and make use of any opportunities to improve health or reduce health inequalities, across all government policies;

To direct the Committee for Health & Social Care, working with other States' Committees and voluntary and private sector organisations, to establish a Bailiwick Health and Wellbeing Commission that shall be responsible for health promotion and health improvement activities within the Bailiwick;

To direct the Committee for Health & Social Care to report to the States in 2018 with proposals for the comprehensive regulation of health and care services and practitioners;

To direct the Committee for Health & Social Care to:-

- Develop, market and manage an attractive private offer in addition to its universal provision which should be run, as far as possible, on a commercial basis;*
- Investigate opportunities to incentivise people to use their private insurance where that option is available;*
- Work with the Committee for Economic Development, together with contracted partners and other interested private organisations, to explore whether the Bailiwick could develop and market itself as a “destination for health and wellbeing”;*

Section E: Alderney and Sark

Alderney

- 8.1 While this section specifically focuses on the implications of the proposals for Alderney, it must be highlighted that the proposals above are applicable across the Bailiwick. In delivering each of the proposals, steps will be taken to ensure that their benefits are felt in both Guernsey and Alderney.
- 8.2 Since the “1948 Agreement” was made between Guernsey and Alderney (by resolution of the States of Alderney on 27 October 1948 and the States of Guernsey on 5 November 1948), Guernsey has assumed financial and administrative responsibility for a number of ‘transferred’ services provided to Alderney, including health and care, in exchange for the ability to levy income and other taxes in Alderney. The States of Guernsey resolved in February 2016¹¹ that Committees should review the transferred services for which they are responsible, in order to reach appropriate, cost-effective and outcome-focused service level agreements with the States of Alderney in respect of their future provision. The Committee intends to discharge this resolution through its Transformation Programme.
- 8.3 The complexity of the health and care system in Guernsey is replicated in Alderney, compounded by the island’s smaller size. The Committee recognises that solutions that work for Guernsey may well need some adjustments in Alderney to reflect the demographic and logistical differences – a view that was reflected in both the recent Independent Review of Health and Social Care Need, Provision and Governance in Alderney (the “Wilson Report”), and the appended KPMG Report. This will be achieved both by ongoing discussions with the States of Alderney and its community, and the gathering of specific data relating to Alderney.
- 8.4 Service delivery in Alderney needs to reflect the community’s health and care needs, in a proportionate and responsive way. Alderney residents need to feel safe, secure and supported, and the proposed transformation provides further opportunity for the Committee to work with the Alderney community and the States of Alderney to rebuild confidence in health and care services. The “Community Hub” model proposed by the Committee offers a way of joining up the existing GP, hospital and care home

¹¹ Relationship with Alderney- Billet III, Art X 2016

environments, although in a bespoke form which takes consideration of Alderney's specific circumstances and more remote situation, potentially in the form of a Satellite Campus to that at the PEH.

- 8.5 Similarly, the profile of Alderney's health and care needs must be properly understood, and the comprehensive Population Needs Assessment described above will be conducted in Alderney, as well as in Guernsey. This will allow the Committee to make proposals which are based on reliable evidence about the community's needs. It will also mean that any health and care strategies can incorporate specific reference to Alderney and evidence-based initiatives targeted to the community's needs.
- 8.6 The Committee has shared a copy of this Policy Letter with the States of Alderney and was grateful for the opportunity to discuss the proposals with the Policy and Finance Committee. Both this discussion and its subsequent letter highlighted the importance of active engagement with Alderney health and care providers, the States of Alderney, civil service and community to ensure the solutions proposed for Alderney are bespoke to the island's needs. This will include creating, in conjunction with Alderney, an implementation timetable detailing tangible changes.

Sark

- 8.7 Sark's population currently fully fund their own health services. Most medications are subsidised by the Professor Charles Saint Medical Trust, which began in 1973 and is supported by ongoing fundraising.
- 8.8 While Sark's medical affairs are clearly a matter for Sark, the Committee recognises that there may be merit in a pan-Bailiwick approach, should this be of interest to Sark. The Committee considers that it is opportune, as part of the Transformation Programme, to discuss the health and care relationship between the islands, but recognises that such a proposal is more appropriately considered in the context of the Sark Liaison Group's portfolio of work.

Recommendations

To note that the Committee for Health & Social Care will continue to work with the Alderney community and the States of Alderney to rebuild confidence in health and care services, including those provided by the Satellite Campus, and ensure that they are proportionate and responsive to the needs of the island;

To direct the Policy & Resources Committee, as part of its ongoing work through the Sark Liaison Group, to engage with the Sark Authorities to establish the merits and cost implications of closer working in respect of health and care, and to report back to the States with recommendations;

Section F: Options, Risks and Benefits

Alternative Models Considered

- 9.1 The Committee commissioned KPMG, working in partnership with its in-house team, to assess the need for transformation of the health and care system, and to explore and recommend options for doing so. The conclusions of KPMG's work are appended to this policy letter. That report followed a previous benchmarking study carried out by BDO in 2015, and numerous internal and external studies and reports completed since 2010, when the States had adopted its Financial Transformation Programme and the HSSD of the time first began to build the case for system-wide transformation, as then set out in the "2020 Vision".
- 9.2 KPMG proposed three models for the future system, all of which would have resulted in a greater degree of integration and more person-centred care than in the present system. At least two of the models (options two and three) would have resulted in the whole health and care system having a greater degree of autonomy from government than the Committee believed the States would be prepared to accept, and would have led to significant organisational upheaval before the benefits of change could be realised.
- 9.3 The Committee's thinking has been closely informed by the recommendations from KPMG, taking into account the particular circumstances of Guernsey and Alderney. The proposals in this report seek to capture the strengths of KPMG's proposals – the closer integration and person-centred care – while allowing that integration to be achieved in an evolutionary manner, through service level agreements between organisations working within a Partnership of Purpose. However, should this approach fail to deliver good health and care for the people of the Bailiwick, on a more sustainable basis than at present, the Committee will not shrink from recommending more radical options to the States.
- 9.4 The Committee has considered more radical options, for example whether there are grounds for it to become a direct provider of health and care services currently provided by non-States organisations. Such an approach would undoubtedly be expensive and require complex negotiations, running the risk of damaging existing good practice. At the same time, there is not, at this stage, any evidence to suggest that such an approach would lead to

substantially better outcomes and, accordingly, the Committee has not progressed this further at this time.

- 9.5 The other option which must be considered is doing nothing. However, doing nothing now to change the system will simply result in a continuation in the inexorable rise of health and care costs. At the same time, there would be no meaningful improvement in the health and wellbeing of the Bailiwick's population whose life expectancy is rising, but who can expect a number of years of ill-health and disability towards the end of their lives if we don't do more to promote good health and wellbeing at every stage of the life course.

Summary of Preferred Model

- 9.6 The model recommended by the Committee is, in summary, as follows:

- Health and care services will be clustered in “Community Hubs” where people can show up and have a variety of needs met, through face-to-face and virtual services;
- The hubs will continue to be backed by the more specialist services which will be centralised at the Health and Care Campus on the PEH Campus and the Satellite Campus in Alderney;
- A ‘menu’ of the health and care services available to islanders (the Universal Offer), the timeframes and any user charges, will be constructed;
- Islanders will have their own Care Passport, making it clear what their entitlement to services is, which will be especially useful to those who may be entitled to services over and above the Universal Offer by reason of their risk profile or diagnosis;
- Qualifying organisations providing health and care will participate in a Partnership of Purpose, underpinned by service level agreements, which will deliver the Universal Offer;
- An independent Bailiwick Health and Wellbeing Commission will lead on physical and mental health for the Bailiwick, and encourage individuals to take more personal responsibility for their health and wellbeing;
- The regulation and commissioning of services will be separated from the provision of services to ensure good oversight of the Bailiwick's health and care system and high quality outcomes for patients and service users.

- 9.7 This will be a more integrated system, which allows people to experience consistent care from providers who work closely together, sharing information and making decisions jointly where appropriate. There will be an emphasis on improving health, both by providing person-centred care (which can lead to more timely and comprehensive interventions) and by health promotion initiatives which encourage islanders to manage their health and wellbeing, and make positive lifestyle choices which enhance their health outcomes.
- 9.8 This model shapes up well against the key aims of prevention, user-centred care, fair access to care, proportionate governance and regulation, direct access to services, effective community care, a focus on quality, a universal offering, and a partnership approach, with empowered providers and integrated teams. These are the core measures against which the Committee has assessed the acceptability of all options it has considered.

Risk and Benefit Analysis

- 9.9 The fundamental purpose of the Transformation Programme is to deliver tangible and recognisable benefits in terms of improving the affordability of the current model, its efficiency and its quality. In these three areas, the Committee commits to developing measurements which are capable of being benchmarked against other jurisdictions, in order that the benefits of the programme can be quantified and demonstrated. These will predominantly surround:-
- a. ensuring the consistent delivery of all health and care services against appropriate professional standards and service user/patient commitments;
 - b. enabling the system to cope with increasing demand on services by improving efficiency;
 - c. reducing the costs of individual services and interventions where possible, thereby releasing recurring savings capable of being re-invested to meet increasing demand or new or improved services.
- 9.10 One of the challenges for the Committee in terms of demonstrating the above is the information it currently has on islanders' health and wellbeing. At both a population and service user level, the information is not really adequate to allow it to formulate strategic goals in terms of how those health outcomes should change, or to measure the change. The solution to that is contained

within this Policy Letter: it is the conduct of comprehensive Population Needs Assessments, and the development of an Outcomes Framework. That is the work that will allow the success of the Transformation Programme to be quantified in respect of the Committee's core purpose – the health and wellbeing of the population.

- 9.11 The other core risks and benefits at this stage of the work are organisational, financial and cultural. The organisational risks have two distinct dimensions: the impact of transformation on organisations working within the health and care system, and the impact on the Committee of delivering this Transformation Programme.
- 9.12 In respect of the first point, the Committee's approach to this work has been to engage, as far as possible, with a wide range of health and care providers in the Bailiwick. The Committee is conscious that there are many pockets of excellent practice by public, commissioned and independent providers, and this should not be sacrificed for the sake of a more logical system unless the benefits to patient health and wellbeing, or the cost-effectiveness of the new model, are demonstrably greater than at present. As this has not yet been demonstrated, the Committee prefers to begin with an evolutionary approach, which allows patients to experience more integrated care without there being substantial organisational upheaval behind the scenes.
- 9.13 The second point relates to the Committee's own capacity to deliver on the transformation of the health and care system. The work leading to this Policy Letter was only ever going to be the first phase of what was expected to be a substantial and complex programme of reshaping the Bailiwick's approach to health and care. It ties in closely with other work being done, for example, across a number of States of Guernsey strategies and initiatives. Some of the workstreams arising from this policy letter, such as the development of a Universal Offer and the negotiations leading to a Partnership of Purpose, will be very large pieces of work, and the Committee will require funding and technical support from the Policy & Resources Committee, via the Transformation and Transition Fund.
- 9.14 As with the first phase of this work, the Committee believes that it is vital that the plans for transforming the health and care system are, fundamentally, owned by the Committee and, therefore, that as much work is done in-house as possible. However, the Committee will certainly require additional capacity,

and may well need to commission technical expertise in respect of some workstreams, in order to deliver.

- 9.15 In respect of the financial risk, the Committee does not at present envisage that the model outlined here will lead to such fundamental changes in the business model of any private health or care organisation as to render it unviable, and so has not factored in any costs that might be associated with stepping in to the breach. (The Committee does anticipate that the way users are charged for GP visits will likely change, but the total amount of funding going into that part of the system is unlikely to reduce – rather, it will be used to better support the Committee’s desired health outcomes.) The most fundamental financial risk is, therefore, if the proposals set out here fail to do enough to stop the ongoing rise in health and care costs over the coming decades. This is discussed further in the section below.
- 9.16 Finally, in respect of the cultural risk, as set out in the KPMG report, the proposals represent a significant change for both service providers and islanders in terms of their relationship with, and expectations of, the health and care system. The Committee truly believes that it is a genuine opportunity for the community to be a part of an integrated health and care system which transparently, collaboratively and innovatively delivers high quality care which is responsive to the needs of the public. However, it would be naïve to assume that, within an area as emotive as health and care, there will not be questions and concerns in respect of its practical implementation. For those providers and islanders who have found their needs to be comparatively well-served within the current structure, they will, understandably, need to be reassured as to the future approach.

Future Costs to the States and to Islanders

- 9.17 The cost to the States of health and care services is at least £183.8 million (in 2016). This includes the services directly provided by the Committee; the benefits paid by the Committee *for* Employment & Social Security which partially subsidise the cost of a primary care visit or a care home placement, as well as prescription items and travel for off-island care.
- 9.18 However, this figure does not include areas of health and care spending such as the amount spent by the Committee *for* Employment & Social Security on primary care for the islands’ poorest (people in receipt of Supplementary Benefit). Nor does it take into account the capital costs of providing health

and care facilities. Under the current model, the majority of the States' investment is in specialist and long-term care, rather than primary care and prevention.

- 9.19 Over the decade from 2006 to 2015, the expenditure of the Health & Social Services Department (now the Committee *for* Health & Social Care) increased at an average of 4% per year. (The actual increase profile was not steady, with 0 or 1% increases in several years, and a 14% increase in 2009.) Over the same period, the Social Security Department's (now the Committee *for* Employment & Social Security) Health Service Fund spending, which includes the cost of the secondary care contracts, increased by an average of 4% per year. The average increase in the Long-term Care Fund spending (which subsidises care home placements) over the last decade has been 7% per year.
- 9.20 KPMG have forecast that the States' spend on health and care will increase in real terms from £192.7m in 2017 to £214m in 2027, attributed to additional demand, particularly from greater numbers of older people. This figure would increase further to £267.6, if increases in medical costs (like drugs and competitive wages for medical staff) and general inflation were factored in.
- 9.21 The direct costs of health and care to islanders are not quantified. However, we know that the average person visits the GP four times a year. Assuming a cost of £48 per visit (after the States' subsidy), that amounts to £192 per person per year, plus the cost of prescriptions at £3.80 an item. For families with children, or people with long-term conditions who need to visit their GP more frequently and often have multiple prescriptions, the cost rapidly adds up.
- 9.22 People with long-term care needs who live in their own homes, and aren't eligible for financial support, have to pay for their own aids and adaptations (including things like wheelchairs and hoists). People who need to move into a care home must pay a weekly co-payment of £195 a week (over £10,000 a year) and most homes charge additional top-ups above that.
- 9.23 In other words, States' spending on health and care alone is around 10% of GDP (£2.36bn in 2015), and that percentage increases when the costs paid by the individual are added in. Delivering health and care is expensive:-
- a heart transplant can be up to £140,000;
 - a neonatal intensive care cot bed costs £3,500 per day;
 - a complex knee and hip operation can cost up to £20,000;
 - a pacemaker implant can cost £4,500;

- The average cost of a Day Patient Unit case, excluding Bowel screening, is approximately £955; and
- the average cost of an Oncology day case, for example the delivery of chemotherapy or bowel screening, is £1,176.

- 9.24 The Committee, the Policy & Resources Committee, and the States as a whole, have long recognised that this pattern of spending is unsustainable. A shift towards prevention and primary care is needed in order to slow down the rate at which health and care costs are climbing; and individual areas where public funding is used inefficiently or does not produce the best possible health results (such as those outlined in this policy letter) need to be changed.
- 9.25 KPMG estimate that a range of transformation initiatives could reduce the forecast future cost of health and care by between £8m and £17m over the next decade. BDO, in 2015, estimated that cost could be reduced by a similar range (£7m to £24m) over a five to ten year period. In both cases, these are whole-system cost reductions. In theory, the impact of those savings could be seen in the Committee *for* Employment & Social Security's budget but not the Committee's, or vice versa – it depends on exactly where the States focuses its transformation efforts.
- 9.26 Both BDO and KPMG recognise that there needs to be upfront investment in key services in order to deliver long-term cost reductions. For example, a large enough community care workforce to look after people well in their own homes will be needed in order to reduce the costs of caring for people in hospital or in care homes. This has also been accepted by the Committee and by the Policy & Resources Committee, who recognise that the Committee will need to invest in priority areas in order to reduce costs in the long term.
- 9.27 At this stage, the Committee cannot forecast, with any greater accuracy than these external consultants, the total financial impact of its Transformation Programme. As part of its annual submission to the Policy & Resource Plan, the Committee will report back to the Assembly, and consequently be held to account, on the total costs of health and care and the financial impact of the Transformation Programme so far.
- 9.28 It is important to emphasise that the cost reductions suggested by BDO and by KPMG slow down the rate at which health and care costs will increase. They **will not** result in the overall cost of health and care (in real terms) dropping any lower than it is today. The demographic shift makes that almost

impossible: for the next generation, at least, there will be more older people needing more care for multiple conditions. A sustained effort to improve the health and wellbeing of the population might reduce the scale or complexity of that demand in subsequent generations, but that will take time to work through. Meanwhile, the emphasis needs to be on earlier intervention and more joined-up care, to make the system as efficient as possible and reduce the significant individual and public cost of ill-health.

- 9.29 KPMG estimates that, without change, public spending on health and care will have risen from 45% of total public spending in 2017 to more than 55% of public spending by 2027. Under the current fiscal framework, this would put enormous pressure on the States to find savings from other budgets, or would require an increase in taxation to fill the gap. The more detailed financial analysis required as part of the next stage of implementation will improve the clarity surrounding the savings which can be achieved through the delivery of the proposals set out within this Policy Letter. This will subsequently allow any residual gap to be understood, including identifying whether it is necessary for the Policy & Resources Committee to look at other measures to ensure the long term sustainability of funding for these services and public services more broadly.
- 9.30 The process of establishing who should pay what for health and care will take place as part of this Transformation Programme, through the development of a Universal Offer. The question of how the States should raise and spend money on health and care is being explored, currently by the Policy & Resources Committee and the Committee *for* Employment & Social Security, and this is expected to report back to the States in 2018.
- 9.31 In the meantime, if the Committee, working together with its partners, can slow down that rate of increase by transforming health and care, it will not make the problem go away – but it will perhaps give the States enough time to work out solutions that are publicly acceptable and that distribute the increased costs fairly between individuals and the public purse.

Delivering Transformation

- 9.32 Since taking office in May 2016, the Committee has implemented a programme of system grip, seeking to improve the governance, processes and information driving decision-making across the organisation. This has improved the management and performance of day-to-day operational activities. In stabilising the financial position, the Committee has focused on

embedding a culture of cost and service improvement and focused evolution of health and care services.

- 9.33 The positive steps taken mean the Committee is confident of its ability to successfully progress the prioritised programme of reform set out within this Policy Letter, alongside continuous service improvement. The proposals are purposefully ambitious, but if they are to lead to sustainable, user-centred improvements these will best be delivered incrementally over time, taking our health and care partners with us.
- 9.34 In an ideal world, the Committee would wish to present to the Assembly in conjunction with this Policy Letter, a comprehensive action plan, setting out how and when all projects, workstreams and initiatives set out in this document will be achieved. This would serve as a framework for delivery over the next five to ten years and be a standard against which the Committee could clearly and unequivocally be held to account.
- 9.35 However, achieving this level of detail is simply not possible at this time. As a process of continued improvement and evolution, the proposals themselves are likely to develop over time and rapid advances in technology means continual adaptation will be a future reality. Accordingly, central to the delivery will be the need to continually review and assess proposals throughout implementation. Such an approach will mean that the Committee will be able to learn lessons and ensure that future implementation is informed by practical experience.
- 9.36 It is therefore essential that the Committee has a prioritised process of phased implementation which puts the essential structure in place first, before focusing on the more detailed aspects of the proposals. The Committee anticipates that the programme of work in this Policy Letter will take five to ten years to complete, acknowledging the need for substantial organisation and financial reform. While it is hoped that the most significant milestones will be in place in the next five years (the Universal Offer, the Partnership of Purpose and the start of a network of Community Hubs), future Committees will need to review and adapt the detail of current proposals in light of changing and competing priorities.
- 9.37 With this in mind, the Committee is keen to focus on the delivery of key outcomes both within the next twelve months and this term of office. The key initial priorities, and associated outcomes, have been identified so to lay a broad foundation for future development and are:-

- The development of the Partnership of Purpose to underpin the proposed new collaborative approach. While the Partnership will undoubtedly evolve over time, the key aims of this term are:-
 - to engage with core service providers across primary and secondary care with the view of creating Service Level Agreements;
 - to introduce Service Standards for the services and facilities directly provided by the Committee so as to enable their participation in the Partnership;
 - to establish the oversight group comprising direct or indirect representatives of the participating health and care providers, initially chaired by the Committee's Chief Secretary;
- The establishment of the Bailiwick Health and Wellbeing Commission, bringing together the private, public and third sectors. The Commission will initially develop and implement the Healthy Weight Strategy and Drug and Alcohol Strategy, but will have a longer term focus on driving wider community behaviour and wellbeing. Within the course of this term, the Committee would envisage the Commission's focus including:-
 - working with a broad range of partners to develop social prescribing options, and appropriate signposting opportunities;
 - ensuring a sustainable financial model, including securing external funding sources;
 - reviewing the synergies between public health strategies.
- Work with the Committee *for* Employment & Social Security and the Policy & Resources Committee to consider the reorganisation of grants, subsidies and funding;
- Work with the Committee *for* Employment & Social Security to develop the Universal Offer and commence work on the Care Passport;
- Commencement of the phased development and roll-out of the Partnership of Purpose digital application for the public, beginning with details of partners and services provided and to expand functionality to the development of the Care Passport;
- Development of proportionate proposals for the regulation of health and care in the Bailiwick, with the view to report back to the Assembly in 2018;

- Development of the physical and technical infrastructure, including:-
 - Commencement of the re-profiling of the hospital phase 1 project (for which capital funds are already allocated) which will include consideration of how the private offering can best be developed on the PEH Campus;
 - Development of a Principal Community Hub, potentially at the King Edward VII site;
 - Implementation of the Local Area Network infrastructure;
 - Implementation of the TRAK system upgrade;
 - A pilot project in respect of the use of technology within the community;
- Commencement of a programme of thematic Population Needs Assessments to inform health and care needs. The first theme identified for progression in 2018 will be Older People.

9.38 The Committee will translate the above, reflecting of the Assembly's discussions on the matter, into a detailed implementation plan. This will be presented to the Assembly as an appendix to its annual update to the Policy & Resource Plan, through which the Assembly can hold it to account. An initial version, setting out at a high level the priorities for next year, is attached as Appendix 3.

9.39 While the above sets out the work which the Committee wishes to undertake this term, the Committee has not had opportunity to calculate, with sufficient accuracy to make the required application for resources, the cost of delivery over the initial three year time frame. This further scoping and resourcing planning will be the first area which the Committee intends to focus on in the first quarter of 2018.

9.40 Accordingly, at this stage the Committee has focused on the resources for the workstreams that need to be commenced in 2018. It recommends that the Assembly provide additional delegated authority to the Policy & Resources Committee to approve funding from the Transformation and Transition Fund for the Transforming Health and Social Care Services programme of £2 million

to £3.5 million, noting that a request for further funding should be included in the 2019 Budget for the remainder of this term.

- 9.41 This initial funding will enable the creation of an internal programme team, engaging specific external expertise if, and when, necessary. It is anticipated that the internal team will bring with it a range of skills including programme and project management, technical expertise, change management, data analysis and core business functions. Additionally, the Committee is keen to utilise the practical expertise and experience of current staff by providing opportunity for operational managers to lead on core aspects of the Transformation Programme, and will facilitate this through appropriate backfilling.
- 9.42 As set out above, during the first quarter of next year, a core smaller team will focus on translating the decisions of the Assembly originating from this Policy Letter into a more defined, prioritised programme of delivery which will be reported to the Assembly as part of the Committee's Update to the Policy & Resource Plan in June and used to inform costings for 2019 and 2020, for submission in the next Annual Budget. At the same time, progress will continue in respect of discrete projects designed to deliver tactical, productivity and efficiency savings and beginning the most critical aspect of the strategic transformation. This will include a specific user-centred design project, using concentrated resources for a defined short period, to develop and accelerate improvements in both service user experience and efficiency, such as the process through which health and care appointments are made.
- 9.43 The Committee wishes to provide the Assembly with as full a picture of delivering transformation as possible, but cannot calculate with accuracy the full costs over the course of the programme at this stage.
- 9.44 It should also be remembered that, whilst the Committee is seeking approval from the Assembly in principle to spend £2 million in 2018, the practical release of funds at any given stage would be the decision of the Policy & Resources Committee, based on appropriate evidence-based business cases, thereby ensuring appropriate governance and rigour.
- 9.45 The benefits of the Transformation Programme will be both financial, primarily through cost avoidance, and improved health and care outcomes. In the short term these will be measured and reported through existing Key

Performance Indicators, representing the breadth of health and care services. Over time, these Key Performance Indicators will be refined and developed to ensure that the information is readily available to define need, guide decision making, set and prioritise goals and targets, and monitor progress. Updates will be provided to the Assembly through the annual updates to the Policy & Resource Plan.

Section G: Engagement and Consultation

- 10.1 In developing the proposals set out within the Policy Letter, the Committee has engaged with the public, health and care professionals, voluntary organisations, politicians and civil servants through a series of workshops, meetings and drop-in events. Continued involvement and engagement will be fundamental to the success of the proposals moving forward.
- 10.2 The Committee has formally consulted with the Policy & Resources Committee and the Committee for Employment & Social Security in respect of the full breadth of the Policy Letter. The Committee has further consulted with the remaining principal Committees and the States' Trading Supervisory Board to the extent that the proposals impact on their respective mandates. The responses received have been overwhelmingly positive, with any comments raised, addressed either through the Policy Letter or directly with the relevant party.
- 10.3 The Committee has additionally consulted with Alderney and Sark and was particularly pleased to have opportunity to discuss with the States of Alderney's Policy and Finance Committee the opportunities for Alderney. The Committee looks forward to developing this relationship further during the practical implementation of the Transformation Programme.
- 10.4 The Committee is committed to a culture of openness and honesty and has, throughout this political term, taken proactive steps to help the community understand its work. Central to this is the role of the representative forum, CareWatch, and the Committee looks forward to working closely with CareWatch in the delivery of the Transformation Programme.

Recommendations

To direct the Policy & Resources Committee to consider, as part of future budgets, what steps, if any, are required, over and above the transformation of health and care to ensure the sustainability of funding for health and care services;

To increase the authority delegated to the Policy & Resources Committee to approve funding from the Transformation and Transition Fund for Transforming Health and Social Care Services by £2,000,000 to £3,500,000.

Section H: Conclusion

- 11.1 There are significant challenges across the Bailiwick's health and care system. The current arrangements are complex, fragmented and confusing for islanders. It is reactive to demand, designed to respond to diseases, injuries, conditions or symptoms. It is not designed to prevent illness but instead primarily exists to provide diagnosis and treatment. This has created a system where:-
- There is a reliance on patients to contact the system when they have noticeable symptoms;
 - There is the greatest investment in acute care rather than prevention;
 - The focus is on immediate needs or symptoms and it risks viewing each interaction as an isolated encounter;
 - Patients may be seen as passive recipients, with the risk that interactions are symptom/treatment-focused as opposed to patient-centred;
 - Promoting a patient's overall health, preventing and delaying disease, and ensuring continuity of care across providers are not core aims of the delivery model; and
 - Planning and financial control is more difficult.
- 11.2 This approach to health and care is both expensive and ineffective in meeting the needs of today's population. The system has become stretched and lost its focus. These problems cannot be addressed by improving efficiency or in isolation. With consideration and investment, it is possible for the health and care system to change. Indeed, the health and care system has to change. The alternative, an increasingly unsustainable pattern of rising demand and increasing costs, is not a viable option.
- 11.3 The window for making the necessary change is narrowing, and without decisive action now, the health and care system will simply be unable to cope with the future pressures. Building on the Committee's three-fold purpose to protect, promote, and improve the health of Islanders, the proposals in this Policy Letter seek to change the landscape of health and care – physically, virtually and financially – to transform the current health and care system to one centred on care and able to respond to the challenges of the twenty-first century. It seeks to achieve a health and care system premised on an ever closer integration of care which places the user at its centre and provides a

greater focus on prevention and support and care in the community. The established key aims serve as a benchmark of how the success of transformation can be measured.

- 11.4 Spending on health and care will continue to rise. The growing prevalence of chronic diseases and an ageing population means that this is an unavoidable truth. However, it is possible for the States, by seizing the opportunity available for transformation, to set out a model which will deliver better value for money, by improving integration between services and promoting early intervention and promotion. Through focusing on outcomes, we can ensure that funding across the system is used to best effect, improving patients' overall wellbeing.
- 11.5 As acknowledged in the KPMG report, "the reform programme HSC is recommending will not deliver everything the States require immediately." This is undoubtedly true, the Assembly is being asked to commit to a medium to long term prioritised programme of reform which will, incrementally, deliver sustainable improvements to health and care services across the Bailiwick with the benefits being felt for decades.
- 11.6 Importantly, the benefits of this change will be felt in more than just the public purse. For islanders, they will be served by an integrated system where all providers understand the full range of options available to patients – possible treatments, delivery mechanisms, clinical and non-clinical implications - and are able to coordinate a seamless course of care. Individual providers will continue to exist, but through the Partnership of Purpose, they will be so thoroughly interlinked that they provide continuous care, centred around the needs of the patient. This seamless care will best be demonstrated within the Community Hubs, combining public, private and third sector organisations.
- 11.7 The Committee will ensure that there is equitable and affordable access to health and care for the whole population of the Bailiwick – through the development of a Universal Offer of services and a Care Passport that will set out individual entitlements. This information will ensure transparency across the system, enabling islanders to make informed choices about their health and care needs.

- 11.8 Through the greater use of technology in the home, electronic access to records and digital signposting through the use of Bailiwick-specific apps, care can be both personalised and improved. Rather than the current position where medical records are predominantly notes of consultations, diagnoses and treatments, this may be supplemented by data generated by patients themselves, for example from wearable monitors, fitness trackers, mood and symptom-tracking apps, video and sensor data, or genome data. This marks a shift from patients being seen as passive recipients to collaborative partners who have personal responsibility for their health and wellbeing.
- 11.9 Improved data will mean that we will be able to better understand the islands' needs. Valuable data isn't about processes or procedures, but about the outcomes that they deliver. To understand if health and care across the Bailiwick is delivering, we need to understand the impact that it is having on individual islanders. This requires both statistical evidence but also, clear opportunities for service users to provide feedback.
- 11.10 Rather than the current emphasis on the delivery of responsive services, a key focus for the future is that of prevention and early intervention. The Committee will create a Bailiwick Health and Wellbeing Commission, separate from the States and in partnership with community organisations, in order to raise awareness, deliver services, encourage healthy lifestyle choices and otherwise take steps to improve islanders' general health and wellbeing. This approach will be endorsed by the States, in considering health in all policies, and health and care providers, through the ethos of making every contact count.
- 11.11 The Committee is committed to delivering the above tangible improvements, and will report back to, and be held to account by, the Assembly on the progression of the Transformation Programme through submissions to the annual Policy & Resource Plan updates, in addition to the specific Policy Letters referenced throughout this Policy Letter.
- 11.12 By government, private sector, third sector and each and every one of us working together, over the coming years, it is possible to put in place a model of health and care that can truly help deliver the key vision of making the Bailiwick one of the happiest and healthiest communities in the world.

Propositions

12.1 The States are asked to decide whether, after consideration of this policy letter, they are of the opinion:

1. To reaffirm the States of Guernsey's commitment to a process of transformation of health and care services in the Bailiwick of Guernsey, based on the key aims of:
 - **Prevention:** supporting islanders to live healthier lives;
 - **User-centred care:** joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;
 - **Fair access to care:** ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs;
 - **Proportionate governance:** ensuring clear boundaries exist between commissioning, provision and regulation;
 - **Direct access to services:** enabling people to self-refer to services where appropriate;
 - **Effective community care:** improving out-of-hospital services through the development of Community Hubs for health and wellbeing, supported by a Health and Care Campus at the PEH site delivering integrated secondary care and a Satellite Campus in Alderney;
 - **Focus on quality:** measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience;
 - **A universal offering:** giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them;
 - **Partnership approach:** recognising the value of public, private and third sector organisations, and ensuring people can access the right provider; and
 - **Empowered providers and integrated teams:** supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.
2. To direct the Committee *for* Health & Social Care to develop a health and care system premised on a Partnership of Purpose bringing together

providers to deliver integrated care which places the user at its centre and provides greater focus on prevention, support and care in the community and makes every contact count;

3. To direct the Committee *for* Health & Social Care and the States' Trading Supervisory Board to work together to identify suitable sites for the development of Community Hubs;
4. To direct the Committee *for* Health & Social Care to work together with all health and care providers to produce a schedule of primary, secondary and tertiary health and care services that shall be publicly available as the Universal Offer either fully-subsidised or at an agreed rate;
5. To direct the Committee *for* Health & Social Care, the Committee *for* Employment & Social Security and the Policy & Resources Committee, together with any non-States' bodies affected, to consider how the current States' funding of health and care can be reorganised to support the Universal Offer and, if necessary, to report back to the States at the earliest opportunity;
6. To direct the Committee *for* Health & Social Care to work with:-
 - the Committee *for* Employment & Social Security to create a Care Passport for islanders, establishing their individual entitlement to health and care services and to explore how it could be linked with existing benefits or new opportunities to encourage individuals to save for their costs of care, in an individual Health Savings Account, a compulsory insurance scheme or otherwise;
 - the Policy & Resources Committee and representatives of the voluntary sector, to explore a scheme of "community credits" to incentivise more volunteering within the health and care system;
7. To agree that the Committee *for* Health & Social Care should investigate ways in which a technological interface could be developed that serves to create an aggregated service user record from the various patient records maintained across health and care providers;
8. To agree that, in line with the States of Guernsey's Digital Strategy, the Committee *for* Health & Social Care shall seek to provide user-friendly

online access to services, including providing service users with secure access to their own summary care record, where appropriate, their Care Passport and information on maintaining their own health and wellbeing;

9. To agree that the processing of health and care data should be premised on the equally important dual functions of protecting the integrity and confidentiality of such data and its sharing, where in the interests of the service user or the delivery of a public health function, and to direct the Committee *for* Health & Social Care and the Committee *for* Home Affairs to explore legal or practical mechanisms to achieve this;
10. To agree that the Committee *for* Health & Social Care shall be responsible, in accordance with its mandate, for:
 - Setting health and care policy for the Bailiwick;
 - Commissioning, or otherwise ensuring the provision of, health and care services, through the Partnership of Purpose;
 - Conducting a series of Health Needs Assessments, constituting a Comprehensive Health Needs Assessment for the Bailiwick, in order to plan ongoing service delivery with a view to improving health and wellbeing and reducing health inequalities;
 - Ensuring the good governance of health and care services;
 - Managing the public budget for health and care; and
 - Ensuring that there is effective regulation of health and care;
11. To agree that the Committee *for* Health & Social Care should report back to the States on the legislative changes needed to disband the roles of Medical Officer of Health and Chief Medical Officer and, where relevant, transfer their functions to existing services or statutory officials whilst exploring the potential for creating reciprocal arrangements for the independent challenge and peer review of respective health and care policy on a regular or ad hoc basis by other small jurisdictions;
12. To direct the Policy & Resources Committee to undertake a strategic review of the terms and conditions attached to nursing and midwifery professionals employed by the States of Guernsey, and to consider whether such a review may also be appropriate in respect of any other staff group;

13. To direct the Committee *for* Education, Sport & Culture, together with the Committee *for* Health & Social Care, to review the training and education provided by the Institute for Health and Social Care Studies to ensure that it continues to meet the health and care needs of the Bailiwick, and to explore options for supporting a wider range of on- and off-island training opportunities;

14. To agree that the Committee *for* Health & Social Care shall review the processes used to:-

- consider the merits of whether new drugs or medical treatments should be funded to ensure that a consistent approach is used across all decision-making bodies (including the Committee *for* Employment & Social Security's Prescribing Benefit Advisory Committee);
- determine access to child or adult social care services, along with reviewing the transition between the two;
- access long-term care in the community or in residential or nursing homes and work with the Committee *for* Employment & Social Security to produce a single assessment process in accordance with the resolutions of the Supported Living and Ageing Well Strategy;

and in so doing ensure that clear, user-friendly information about the processes and criteria shall be made publicly available;

15. To affirm that the States, in all its policy decisions, should consider the impact of those decisions on health and wellbeing, and make use of any opportunities to improve health or reduce health inequalities, across all government policies;

16. To direct the Committee *for* Health & Social Care, working with other States' Committees and voluntary and private sector organisations, to establish a Bailiwick Health and Wellbeing Commission that shall be responsible for health promotion and health improvement activities within the Bailiwick;

17. To direct the Committee *for* Health & Social Care to report to the States in 2018 with proposals for the comprehensive regulation of health and care services and practitioners;

18. To direct the Committee *for* Health & Social Care to :-
 - Develop, market and manage an attractive private offer in addition to its universal provision which should be run, as far as possible, on a commercial basis;
 - Investigate opportunities to incentivise people to use their private insurance where that option is available;
 - Work with the Committee *for* Economic Development and other interested parties to explore whether the Bailiwick could develop and market itself as a “destination for health and wellbeing”;
 19. To note that the Committee *for* Health & Social Care will continue to work with the Alderney community and the States of Alderney to rebuild confidence in health and care services, including those provided by the satellite campus, and ensure that they are proportionate and responsive to the needs of the island;
 20. To direct the Policy & Resources Committee, as part of its ongoing work through the Sark Liaison Group, to engage with the Sark Authorities to establish the merits and cost implications of closer working in respect of health and care, and to report back to the States with recommendations;
 21. To direct the Policy & Resources Committee to consider, as part of future budgets, what steps, if any, are required, over and above the transformation of health and care to ensure the sustainability of funding for health and care services;
 22. To increase the authority delegated to the Policy & Resources Committee to approve funding from the Transformation and Transition Fund for Transforming Health and Social Care Services by £2,000,000 to £3,500,000.
- 12.2 These Propositions have been submitted to Her Majesty’s Procureur for advice on any legal or constitutional implications in accordance with Rule 4(1) of the Rules of Procedure of the States of Deliberation and their Committees.

12.3 In accordance with Rule 4(4) of the Rules of Procedure of the States of Deliberation and their Committees, it is confirmed that the Propositions above have the unanimous support of the Committee.

Yours faithfully

H J R Soulsby
President

R H Tooley
Vice President

J I Mooney
R G Prow
E A Yerby

R H Allsopp OBE
Non States' Member

KEY AIMS

As detailed within the Policy Letter, the Committee has built upon the recommendations from the 2020 Vision, as well as through the various engagement events with health and care professionals and the wider community to develop key aims of the new model of care. Basically, the outcomes it wanted to see. The established key aims are:-

1. Prevention: supporting islanders to live healthier lives.

The aim is to move the emphasis of service delivery away from intervention and towards prevention. This means supporting programmes and initiatives which encourage beneficial change towards better health and social wellbeing. It emphasises the role of personal responsibility in achieving good health outcomes but also the cross committee role of the States of Guernsey, in conjunction with the private and third sectors, in ensuring that prevention and early intervention is central to policy. This might mean:-

- preventing people from becoming ill or frail in the first place;
- helping someone manage a condition as well as possible;
- preventing deterioration in existing conditions; and
- providing active support to help someone regain as much autonomy and independence as possible.

While prevention is key to the new model, it is recognised that its benefits will not be achieved overnight and embedding prevention is a longer term ambition.

2. User-centred care: joined up services where users are valued, listened to, informed, respected, and involved in their care throughout their health and care journey.

Rather than seeing a health and care need as an individual occurrence, any engagement with a health and care provider should be seen in the context of the user's entire health and care journey. This enables a user-centred response which sees that person as a true individual as opposed to simply a service user of a particular intervention or treatment. It recognises that throughout our lives, and in the course of individual illnesses and conditions, our requirements change and evolve and the importance of ensuring seamless service provision.

In this way, users are valued; they are listened to, informed, respected, and involved in their care and their wishes are, as far as is appropriate, honoured throughout their health and care journey. It recognises that a good outcome must be defined in terms of what is meaningful and valuable to the individual user.

Wherever possible, steps should be taken to strengthen the relationship between the user and their service provider, promote communication about things that matter and help users know more about their health.

3. Fair access to care: ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs.

At its most basic level, poor personal finances should not be a barrier to good health and there needs to be in place proportionate funding processes to ensure that access to the universal offering is fair and equitable. This will be informed by evidence and seek to achieve the best possible health and care outcomes across the Bailiwick. It is likely that the accessibility of certain treatments and interventions will apply equally across the population. However on occasion, to do so would be inequitable if it was likely to lead to worse health outcomes for a proportion of islanders, for example those with pre-existing chronic conditions.

4. Proportionate governance: ensuring clear boundaries exist between commissioning, provision and regulation.

There needs to be a clear distinction between respective roles in the governance of health and care services with the appropriate framework to incentivise the right behaviours. In a small jurisdiction, it is likely that there will always be some overlap between those who decide what kinds of services should be provided and how they should be paid for, those who provide these services and those who regulate the services to ensure their safety. However, there needs to be, in particular between commissioning and regulation, a framework which is proportionate to the size, resources and requirements of the Bailiwick, to ensure appropriate separation.

5. Direct access to services: enabling people to self-refer to services where appropriate.

People make choices and decisions every day about how to manage their lives and their health conditions. By facilitating this, and enabling direct access to certain care provision, it enables islanders, particularly those with long term conditions, to increase the control they have over their own lives and health and care needs. By allowing direct access to services, rather than via referrals, it will enable more expedient care.

6. Effective community care: improving out-of-hospital services through the development of Community Hubs for health and wellbeing, supported by a Health and Care Campus at the PEH site delivering integrated secondary care and a Satellite Campus in Alderney.

A prolonged stay in hospital can be counterproductive for individuals, particularly the elderly. Evidence shows that a healthy older person's mobility could age by up to 10 years if they are bed bound for just 10 days. There is therefore merit in reducing the amount of time that individuals spend in hospital. However, this needs to be complemented by post-discharge community based services. This will include the use of, but not reliance on, volunteers and the third sector.

Moving care closer to home is not about simply relocating services. It's about providing a model that works for the user. To simply move where care is delivered would be counterproductive if in practice it proved to be less convenient for that person, or led to a reduction in the quality of care. Instead it's about considering those individuals who previously would have been confined to hospital and seeking instead to develop multi-disciplinary teams (including social care, mental health and other service professionals) to provide holistic, high quality community care in response to their needs.

7. Focus on quality: measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience.

There is a clear need to focus on the outcomes of the health and care system, including looking at the effectiveness of steps taken, the experience of the service user and the system's safety. Within health and care, the three identified dimensions of quality have been established, based on the work of Avedis Donabedian, as:-

- Structure - the setting in which care is delivered and the resources available. This includes adequate facilities and equipment, the qualification of care providers, and administration structure;
- Process – how care has been provided in terms of appropriateness, acceptability, completeness or competency; and
- Outcome – changes in the patient's condition following treatment. Outcomes also include patient knowledge and satisfaction;

and the monitoring and reporting on these need to be embedded across the system.

While outcome metrics are, of course, important and will continue to be a way in which success is measured, it equally needs to be recognised that they are just one measure, and facts and figures alone are not a full indication of the “health” of the health and care system.

8. A universal offering: giving islanders clarity about the range of services they can expect to receive, and the criteria for accessing them.

There needs to be a clearly understood universal offering of health and care services which is, as far as possible, both socially just and financially sustainable. By ensuring that this information is readily available to the public, islanders will be best placed to make informed decisions in respect of their care.

9. Partnership approach: recognising the value of public, private and third sector organisations, and ensuring people can access the right provider.

The system needs to recognise the value that public, private and third sector organisations collectively bring to the health and care system as a whole and ensure that the most appropriate provider is used to deliver care.

10. Empowered providers and integrated teams: supporting staff to work collaboratively across organisational boundaries, with a focus on outcomes.

Through empowering staff, a culture can be created through which all providers are confident in their abilities to positively influence the health and care system as a whole. By sharing information, exchanging ideas and collaborating with other providers in an open manner, there will be support for whole health, care and wellbeing goals that could not be achieved within a disjointed system. Oversight needs to be proportionate so to ensure and maintain good practice without stifling staff innovation. By taking decisions at the lowest safest level, we continue to support the importance of personal responsibility by enabling islanders, in conjunction with their clinicians, to make informed decisions about their health and care needs.



Health and Social Care Target Operating Model for the Bailiwick of Guernsey

Summary Report

October 2017

APPENDIX 2



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Private and confidential

5 October 2017

The Office of the Committee for Health and Social Care (HSC)
Le Vauquierdor Office
Rue Mignot
Guernsey
GY6 8TW

Dear Sirs

Target Operating Model for Health and Social Care in the Bailiwick of Guernsey

In accordance with our signed contract for the provision of services and its attachments dated 3 April 2017 (the 'Engagement Letter'), we enclose our final report on the Target Operating Model for Health and Social Care. This report is designed to provide an independent summary of our findings in working with HSC to jointly develop a Target Operating Model for Health and Social Care in the Bailiwick of Guernsey.

As stated in our Engagement Letter, you have agreed that this final written report supersedes all previous oral, draft or interim advice, reports and presentations, and that no reliance will be placed by you on any such oral, draft or interim advice, reports or presentations other than at your own risk.

We understand that you may wish to make our report publically available. We will consent to it being made public on the basis that it is reproduced in its entirety. Our report should not be regarded as suitable to be used or relied on by any parties beyond the context and scope for which it was prepared.

The scope of work for this report has been agreed by the addressees and to the fullest extent permitted by law we will not accept responsibility or liability to any other party (including the addressees' legal and other professional advisers) in respect of our work or the report.

Yours faithfully

KPMG Channel Islands Limited

KPMG Channel Islands Limited

Important notice:

Our work commenced on 3 April 2017 and our fieldwork was completed on 29 September 2017. This report is based on factors and information up to that date. We have not undertaken to update our report for events or circumstances arising after that date. Any impact of future changes, including those related to economic, fiscal, and social policies, population statistics and projections have not been considered unless specifically noted within the report. Factual accuracy feedback was received on 5 October 2017.

In preparing our report, our primary sources have been information provided by The Office of the Committee for Health and Social Care (HSC) and the States of Guernsey. We do not accept responsibility for such information which remains the responsibility of HSC. Details of our principal information sources are set out within the document and we have satisfied ourselves, so far as possible, that the information presented in our report is consistent with other information which was made available to us in the course of our work in accordance with the terms of our Engagement Letter, and consistent with the work jointly undertaken by KPMG and HSC between April 2017 and August 2017. We have not, however, sought to establish the reliability of the sources by reference to other evidence. This engagement is not an assurance engagement conducted in accordance with any generally accepted assurance standards and consequently no assurance opinion is expressed.

The numerical data presented in our report may include minor rounding differences compared with other balances presented throughout this report.



Sources of information

The sources of information used are noted, wherever possible, in the report. We have not sought to establish the reliability of these sources by reference to evidence independent of the third party source. We have, however, reviewed the information produced and have satisfied ourselves, so far as possible, that the information presented is consistent with other information obtained by us during the course of our work.

Key sources of information include:

- Data provided by SoG;
- SoG publically available information;
- Discussions with industry stakeholders and health and care professionals across the Bailiwick;
- Desk top research;
- KPMG survey interviews carried out with stakeholders;
- KPMG benchmark information for other health and care jurisdictions.

Limitations of data

We draw your attention to the limitations in the information available to us. Our sources of data have been limited to those stated above. We have highlighted key data limitations within the report and where appropriate provided recommendations to improve the collection of this data.

Limited available data on health and social care costs and activity in both the public and private health and care market within the Bailiwick has limited the analysis we have been able to perform.

The financial modelling undertaken has been based on information provided by HSC. We do not accept responsibility for such information which remains the responsibility of HSC. Where appropriate, our recommendations have indicated the likely impacts on health and care costs and activity.

Where possible we have benchmarked Guernsey analysis against other jurisdictions. All health and care markets have varied characteristics and hence individual policies may cause differing results. In many cases, directly comparable data is not available or economic, fiscal, cultural or market differences exist and hence caution must be taken in interpreting the results.

The many factors affecting the health and care market mean that isolating impacts of specific factors or policies is often not possible or might yield inaccurate results. It is also difficult to accurately predict the future impact of individual policies.

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Glossary of terms

HSC	The Office of the Committee for Health and Social Care
SoG	States of Guernsey
Acute	The hospital setting
Primary	All first point of contact services including GPs, social care, community health and A&E
ESS	The Office of the Committee for Employment & Social Security
A&E	Accident and Emergency
TOM	Target operating model
MSG	Medical Specialist Group

Acknowledgement

Building upon the 2020 vision and in line with the Health and Social Care transformation programme KPMG were appointed to develop a target operating model for Health and Care in the Bailiwick. Whilst a collaborative approach was taken with HSC, this report comprises a summary of KPMG's professional recommendations and is designed to provide an easy to read overview of our findings and conclusions.

We would like to thank all of the parties who contributed to this engagement, in particular members of the public who participated in our engagement events and the HSC transformation team.

HSC Target Operating Model - Summary Report

1.1 The current state and do-nothing forecasts

The Bailiwick of Guernsey has a fantastic opportunity to enjoy genuinely world class health and care services; providing high quality care that people need, in the right place, at the right time and by the right person. The Bailiwick has a very good starting point in terms of the current quality of care, life expectancy and the outcomes that are delivered. Whilst there are pockets of clinical concern in areas such as cancer, obesity, alcohol consumption and increasingly dementia; overall people in the Bailiwick currently live longer and healthier lives than their English counterparts. This reflects well on the quality of care they currently receive.

However, without change the current system of health and care that Islanders enjoy is not sustainable and will not be able to continue as it is now, in terms of the services it provides to the public, its workforce or indeed financial position.

Like most developed countries, the current health and care services have grown organically over time and as such they are fragmented, the system is reactive to demand, there is little control over where patients access the system and little control or accountability for how patients are managed through the various providers within the system. People have multiple public and private entry points to access care and the system itself sometimes incentivises less favourable and more costly behaviours, such as seeing a specialist physician in the hospital when a community based professional would likely be a better option, to provide the same or better outcomes closer to home.

The reactive nature of the current system does little on the prevention of illnesses, health promotion and supporting people to self-manage with their conditions; which if invested in properly would reduce the need for health and care services. This combination of factors leads to a system that is very reliant on expensive acute, hospital based health and care services, with the forecast to be 46% of all health and care services deployed in the acute sector by 2027.

The biggest issue facing the world in relation to health and care provision is the increasing demand for health and care services being driven by the aging population. This issue is placing a significant additional burden on health and care systems across the globe as elderly people are living longer with multiple conditions and illnesses. In the Bailiwick this issue is compounded by the aging but relatively static overall population level, which means that the Bailiwick is projected to have one of the highest dependency ratios (ratio of dependent people to those who work and pay tax) in the developed world. Driven by the increasing proportion of elderly people, high public expectations and the over reliance on the acute sector, the total costs (public and private spend) for health and care within the Bailiwick will rise significantly over the next 10 to 20 years, and beyond, if nothing changes.

The current (2016 reconciled) public spend of the health and care system is £192.7m, by 2027 it is forecast to be £267.6m which is an increase of £74.9m. The £74.9m increase is made up of £54.3m for the inflationary impact of current costs (inflation on wages, existing contracts, drugs price increases, pensions, operational overheads etc.) plus £20.6m for the cost of treating increased demand (due to the change in demographic in the same period) from the elderly population. This includes the funding from the Committee for Health & Social Care (HSC) and the Committee for Employment & Social Security (ESS), but excludes private income.

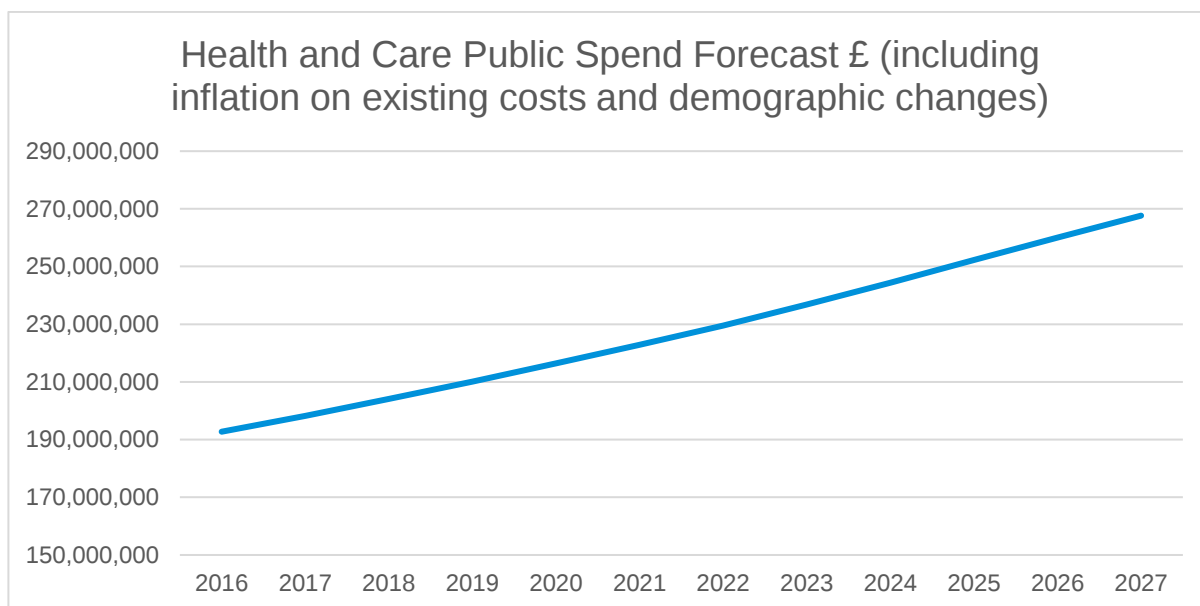


Figure 1: Health and Care Public Spend Forecast £ (including inflation on existing costs and the impact of demographic changes)

However, this is not simply a financial challenge. In a ‘do nothing’ scenario, the Bailiwick will require an additional 9,000 inpatient bed days (days where a hospital bed is required for patient use) per annum in Guernsey by 2027 and by 2037 this will rise to 19,000 bed days. At current occupancy rates this equates to approximately 29 additional full time inpatient hospital beds by 2027 which rises to 62 by 2037.

With similar growth predictions by 2027 in terms of hospital outpatients, day cases services and A&E attendances, 8,000 more hospital outpatient appointments will be needed annually as well as 2,000 more day case episodes (patients who are inpatients for less than 24 hours) and 1,000 more Emergency Department attendances. By 2037 these figures increase to a total of 13,000 more hospital outpatient appointments, 3,000 more day cases and 1,800 more A&E attendances. The ‘do nothing’ scenario not only increases running costs significantly but the forecast increased demand would also mean the need for a significantly enhanced and increased hospital facility in Guernsey to accommodate the rise in inpatients (29 additional hospital inpatient beds by 2027 and 62 by 2037), provide more hospital outpatient appointments and undertake more day case procedures.

Detailed plans and costs would need to be produced but a high level estimate is that a capital build extension would be needed to enhance and expand the hospital at a conservative estimate of £50 million. This extension and enhanced facility would need to be in place and operational by 2025 at the latest. Assuming depreciation of the extension over 25 years this would add a further cash investment of £50 million to the ‘do-nothing’ gap as well as an annual depreciation cost of £2 million (neither figure includes inflation).

Not only will the ‘do-nothing’ scenario increase costs significantly, and require considerable additional capital investment into buildings and supporting infrastructure, it will also require additional professional and support staff to deliver the activity levels and these staff do not currently exist within the Bailiwick. The table below provides our prediction of the required changes in Health and Social Care (HSC) staff in the ‘do nothing’ scenario:

HSC Employment Group	2017 Baseline	2027 Forecast	2037 Forecast
Full Time Equivalents (note: those that are permanently employed, not bank staff or agency staff)	2,113	2,284	2,448
Headcount (note: those that are permanently employed, not bank staff or agency staff)	1,951	2,110	2,261
Bank staff on payroll (note: that is not to say all work regularly)	496	536	575
Agency staff head count	39	42	45

By 2027, HSC will have to find 171 (8% increase) additional clinical and administrative resources to cater for the increases in demand. By 2037 this number will rise to 335 (16% increase). There is therefore a need to continue to recruit, train and retain staff in line with the transformation of the system and services.

The forecast increase in cost from a 'do-nothing' scenario is set against a backdrop of comparatively much lower increases in public funding which could be made available to support health and social care services (e.g. predicted change in general revenue taxation and social security contributions for the Bailiwick). Without change the proportion of Bailiwick wide general revenues and social security contributions that would be required for health and care rises from 45.3% to 57.7% between 2016 and 2027. This represents a 12.4% shift in spending from other public policy areas towards health and care over the next 10 years. This forecast also includes the current private contributions to the system, without these the shift in required funding would be greater and therefore this represents a best case scenario.

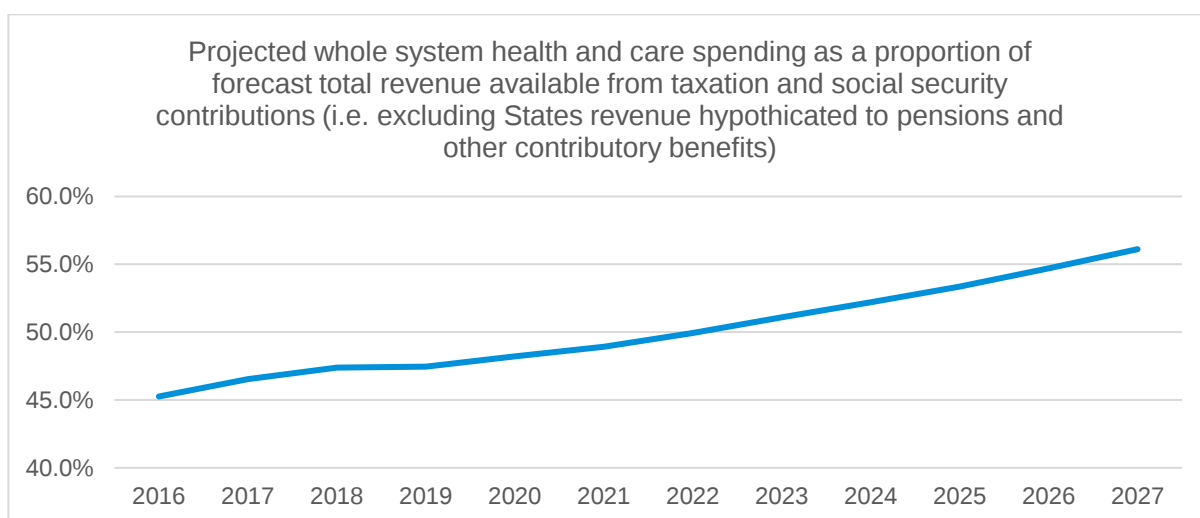


Figure 2: Whole system health and care spending (including private) versus forecast total revenue available

We believe that it is impossible for the current way of working to manage this serious financial challenge facing health and social care in the next decade. The challenge represents a circa 40% efficiency gain on the current delivery model and we know of no health and care economy that has delivered this level of efficiency without much wider transformation.

Whilst HSC has placed a significant emphasis on continuous improvement and stronger financial management of the current system, which will also provide longer term financial benefit and must continue, it is unrealistic to suggest that productivity savings alone could deal with this financial

challenge, nor could they mitigate for the need for significant additional staff. Therefore full scale transformation of the health and care system is required.

In summary, the 'do-nothing' scenario results in a serious financial challenge which could not be addressed without something akin to a 12.4% shift in wider public spending towards health and social care to compensate. It would also require significant additional capital investment in an enhanced hospital facility of circa £50 million by 2025 and approximately 171 additional staff by 2027. This position would exacerbate from 2027 to 2037 as population demographics continued to adversely impact the demand, capacity and hence costs of the system. As the rest of the developed world is realising, only major transformational change to our health and care systems will address the financial, capacity and staffing gaps which are being driven by increasing demand from the aging population.

The Bailiwick needs to make similar transformational changes to create a sustainable high quality health and care system for the future that deals specifically with these four key issues:

- **Demand Management** – The fragmented nature of the provider system, the lack of control over demand, perverse financial incentives and the over reliance on costly hospital based services means that the current health and care system will fail to manage future demand. There is also a lack of physical capacity and a lack of clinical and administrative staff to cope with this increased demand;
- **Finances** – Increasing demand, driven by the aging population, will create a gap of 12.4% between the funding required for health and care services and the public resources available. In addition to these figures there will be a further capital outlay of circa £50 million to enhance and expand hospital services. Productivity and efficiency improvements alone cannot bridge this gap;
- **Infrastructure and Staff** – By 2027 the system will require at least 29 additional beds and 171 additional full time equivalent staff to cope with the increase of 9,000 additional inpatient bed days, 8,000 additional hospital outpatient appointments, 2,000 additional day cases and 1,000 additional A&E attendances. By 2037 these figures would be an additional 62 beds, 335 full time equivalent staff, 19,000 inpatient bed days, 13,000 hospital outpatients, 3,000 day cases and 1,800 A&E attendances. To cope with this the system would require significant enhancements to the hospital and infrastructure in Guernsey at a capital outlay at a conservative estimate of circa £50 million.
- **Population needs** – The needs of the growing elderly population, who will have multiple conditions and illnesses, will be more complex and demanding than currently. The current system would see a large proportion of their care provided in an expensive hospital setting which is often not the best setting to give the optimum care and experience. There will be a need for a greater focus on prevention, as well as developing at home health and care support services that currently do not exist. These will need to be provided in an integrated way, moving care closer to home and proactively managing needs.

The future operating model for health and care must be efficient and avoid some of the significant additional costs which will be borne if delivery of services remains as in the current model, but it requires more than just good management. It requires genuine transformation in order to deliver affordable and high quality services for the people of the Bailiwick in the future. It also requires the ability to manage and control demand consistently, be more flexible from a workforce and financial perspective, utilising public funding to deliver universal services, as well as combining other funding sources within a consistent model of care for the public.

1.2 Transforming The Bailiwick of Guernsey's health and care system

The people of the Bailiwick understand the significant sustainability challenges facing health and social care and have been very positive in embracing the need for a fundamentally different target operating model (TOM). Through engagement with health and care providers and the public, HSC have developed a series of key aims for shaping the future health and care system. These key aims,

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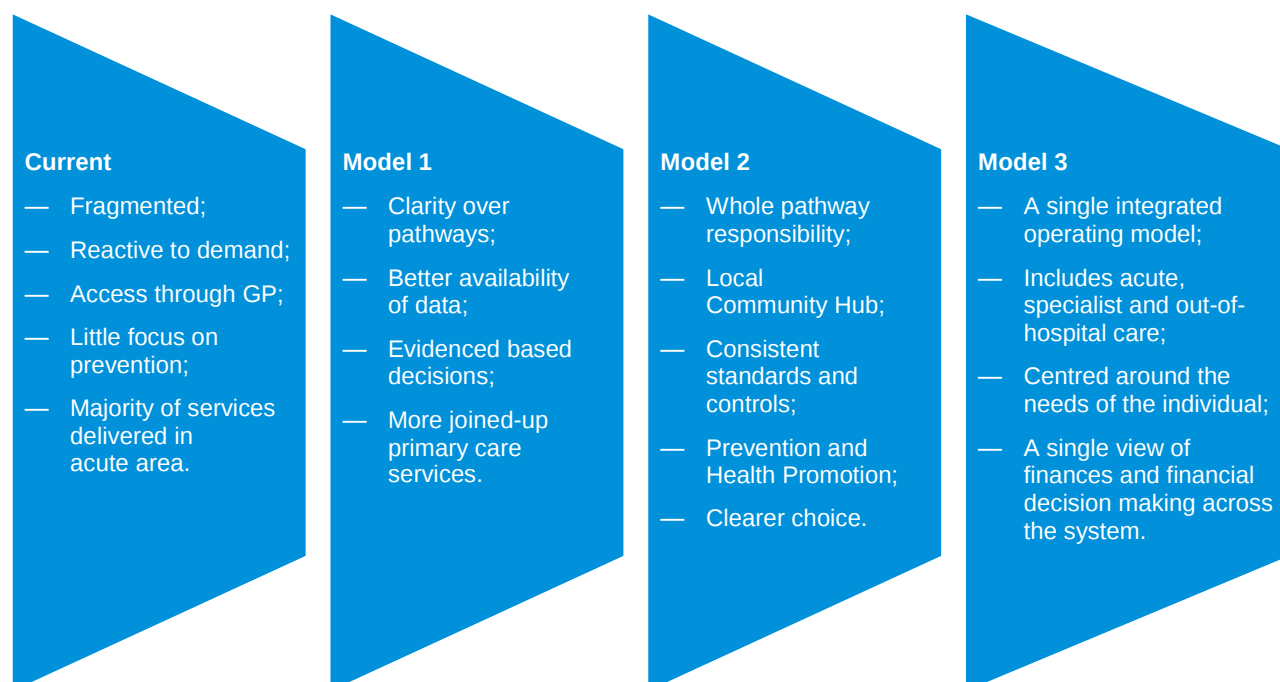
along with the sustainability challenges the Bailiwick faces, have been used to develop and appraise future target operating models for health and care within the Bailiwick.

Those Islanders that were engaged with have shown an ambition towards a comprehensive solution to our health and care challenges, through a model with key characteristics such as:

- Population health and care needs to be fully understood and services provided in line with those needs, including a much greater focus on prevention and supported self-management in the community;
- A unified customer services relationship with the public, where individuals experience 'one provider' for health and care services;
- All budgets (public and private) supporting that 'one provider' approach, with providers having financial flexibility between the use of public and private funds to deliver the right care for individuals;
- Public funds being protected for universal healthcare requirements (those that are not paid for privately) and to support those most vulnerable in society (reducing inequity);
- A much more transparent, open and honest relationship with the public where individuals are much clearer on what the public purse can and cannot afford versus what they are required to pay for.

The only way to achieve these characteristics is via multiple major transformational steps which would need to start now and be implemented over the next 10 years with the model then being in place for several decades.

The models proposed are described below:



As such KPMG recommend that the States of Guernsey embarks upon a prioritised programme of reform to begin to move towards the desired model (model 3, using models 1 and 2 as a stepping stone). The recommended reform programme will not deliver everything the Bailiwick requires immediately and HSC will need to prioritise the following initial changes within the next three years:

- **Out-of-hospital Reform** – Bringing together out-of-hospital services including GP practices, community health, social care and allied health services to create a new integrated care model. This priority area will target a reduction in the Bailiwick's dependency on acute services, directly reducing future hospital demand, eliminating the need for extended hospital capacity and extra staff and hence avoiding future increased costs through:
 - Alignment of the delivery and management of services in the out-of-hospital context;
 - Significantly improved control of demand in the primary setting, delivered through GP practices working in an integrated way with community hubs proactively managing the demand in the system consistently;
 - New clinical delivery models, including a greater focus on population management, prevention and supported self-management in home settings, delivered through much more integrated teams;
 - Much greater use of digital technology and communication, as well as an integrated patient record system and improved information provision to the public to help manage demand and coordinate care.
- **Finance and Accountability Reform** – Reforming the financial environment is absolutely crucial to create a sustainable and affordable health and care system for the Bailiwick. Financial reform is required to create transparency between public and private payment, increase provider accountability for delivering improved outcomes, create provider autonomy for delivering the required public services within the financial envelope available through tax and personal contributions, but also the flexibility to offer a growing range of services to the public on a private basis. This priority area will create the environment that will enable an integrated system to:
 - Clearly define the services that must be made available within an agreed public budget provided through taxation (universal services);
 - Define the rules through which health and care providers can charge the public, for example as private pay or co-payments, for services, over and above those that are funded through taxation;
 - Ensure transparency of payment for those individuals who have health and care insurance, and promoting the use of new payment models for some services;
 - Incentivise providers to control demand and manage the population in the most effective and outcomes orientated manner, stopping people from going to hospital who would be better looked after in other places.
- **Organisation and Governance Reform** – Clarifying the roles and responsibilities of the fragmented components of the current system. This priority area will target a reduction in the siloes in the system and improved governance through:
 - Clarifying the role of HSC as the organisation responsible for ensuring that best value is delivered for the available public finance;
 - Developing clearer standards and regulation for the health and care services enjoyed by Islanders;
 - Commissioning providers to become accountable, both in terms of outcomes, but also financially for the services they deliver to the public;
 - Supporting both existing and new providers to develop, come together as organisations and play their role as sustainable providers in the future system.
- **Technology Reform** – Maximising the use of technology to enable new care models, better understanding and targeting of needs as well as better management of the system. This priority area is the key enabler of the required transformation and will focus on:
 - Engaging the people of the Bailiwick in managing their own health and care through technology;
 - Joining up health and care data to enable providers, HSC and the public to better understand the needs of the population and develop services to meet those needs;

- Creating a joined up view of health and care records so that professionals can support patients to make the right choices in the most efficient way at the point of care;
- Provide improved management and financial information to providers, HSC and the States.

To deliver on the challenges health and social care in the States of Guernsey face, HSC believe that these initial reforms must be delivered in parallel, through a clearly led and well managed reform programme for the whole health and care system. This programme needs investment in detailed design, programme management and implementation and this work must commence now in order to deliver these initial reforms within the next three to five years.

1.3 What do these initial changes mean for islanders in the future?

For islanders this represents a significant change in terms of their relationship with and indeed expectations of the health and care system. It provides an opportunity for the public's care needs to be met more inclusively and in a genuinely joined up way. This will be a system that is transparent in its delivery of an agreed standard of care, with clarity in terms of what is available within a defined budget. Islanders will experience a significantly more joined-up system of health and care that works in an efficient way supporting them to manage their conditions out of hospital wherever possible. They will also have the choice to pay for services, over and above those that are available publically.

It will be necessary to create a relationship with the public where needs are clearly understood but also where expectations of what the system can and cannot offer are managed clearly. Within the Bailiwick system this means a much clearer and more transparent relationship around finance too, where the balance of public and private contribution to health and care is understood at an individual level.

Within the system there is opportunity for existing or indeed new provider organisations to integrate and offer a much wider variety of services to the public, as a joined up primary entry point to the system. Services integrated in the future will include GPs, community health, physiotherapy, urgent care, social care and specialists in the community. An integrated system for the Bailiwick provides the opportunity for the development of a much more joined up community hub tailored to the needs of Alderney's population as well.

In doing this, these organisations would also become the focal point for changing the relationship with the public from a financial perspective. They would have clarity on the available finance provided through taxation as well as the standards and rules through which the balance of private and public contribution can be managed.

Within the recommended model, the Medical Specialist Group (MSG) should see a reduction in non-acute, unnecessary referrals and consequently be able to incrementally free up capacity to focus on genuinely acute and specialist needs. MSG therefore has the opportunity to raise the standard and diversity of specialist care made available to the local population.

HSC's mandated role will remain the same, as the principal advisor to the States on matters of health and care. However, governance needs to be clearer, but also proportionate, and there is a need for separation of regulation, control and provision. In the future state there will be:

- A separate regulatory function;
- A clear role for HSC as the principal policy owner and payer of services on behalf of the public budget;
- Separate governance of provision.

There is the need for genuine strength in the role of HSC as a policy owner and principal payer. HSC will in effect be the main funder of an accountable provider managed system. It will need comprehensive population health management data to support critical decisions, such as:

- The menu and quality of services available to all through the public purse (i.e. the universal services);
- How to balance inequity in the system;
- The level of regulation required of both care and finance within the system;
- The need for competition;
- The barriers of entry to the market.

1.4 How will the changes enable the system to become sustainable?

The financial case for change is clear and the forecasted gap in public finances must be met in order for services to be sustainable in the future. Doing nothing also requires significant increases in hospital capacity and staff, both of which are unaffordable and unrealistic.

The changes KPMG are proposing address the forecast financial and capacity gap in two complementary ways;

- 1 The new integrated care model will proactively manage demand, move care closer to home and be more efficient in a multitude of ways to reduce the burden on hospital care and costs overall. These ways have been identified from both a bottom up and top down perspective and the impact of the schemes has been modelled to quantify the effect on future demand and cost.
- 2 The financial and accountability reforms, which need to run in parallel, are needed to create the environment, freedoms and incentives for:
 - Public spend on health and care to be agreed and capped in any one year, versus an agreed set of universal services;
 - Maximising the use of existing insurance schemes, through transparency;
 - Providers to find new ways of generating income such as charging the public for services over and above those that are universally available.

For the new integrated care model (model 3), KPMG has modelled a set of top down initiatives based on their extensive work across other health care jurisdictions to understand the holistic impact of a fully integrated health and care model, for both an optimistic and more realistic outcome.

In developing the top down 'optimistic' and 'realistic' transformation scenarios, we've developed a series of transformation schemes which are aligned to the direction being developed within the Bailiwick but are also supported by clear evidence from elsewhere. There are over 20 individual transformation schemes that have helped to create the forecasts, these include areas such as:

- 1 Improved access to primary care (evidenced through the U.K. Prime Minister's GP Challenge Fund);
- 2 Front end primary care streaming in A&E (evidenced through work at St. Georges, Kettering and Barts NHS Trusts);
- 3 Care home in reach (evidenced through the Airedale approach to telehealth within care homes);
- 4 Consistent system wide triage and control (evidenced through consistent GP and nurse led triage approaches in Peterborough and Cambridgeshire);
- 5 Greater community nursing and specialist nursing in the community (evidenced through the Neighbourhood Care model of care delivered in the Netherlands);
- 6 Third sector wrap around services (evidenced through the Rotherham Social prescribing Service).

By 2027, the top down initiatives reduce the forecast future costs by £17m on an optimistic basis and by £8m on a more realistic basis. The detailed design phase which will follow the agreement to this direction of travel will enable these schemes to be more accurately described and the impact quantified.

The £8m to £17m range generated by KPMG is comparable with the BDO high level estimate that £17m (before inflation) can be saved from major transformation of the provision of health and care. The KPMG top down initiatives reduce the impact on the required shift in SoG funding from other policy areas by between 2% (realistic) and 4% (optimistic) by 2027, implying a remaining 8.4% that must be found by other means.

The impact of these figures is shown in the graph below.

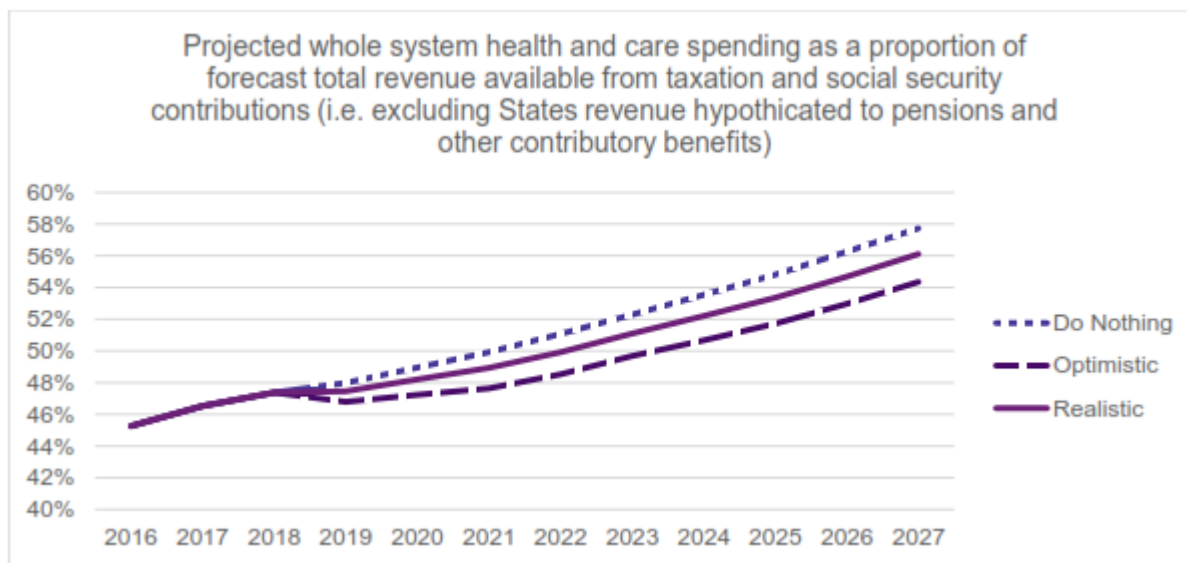


Figure 3: The impact of the new integrated care model on the relative requirements of health and care

The KPMG top down initiatives reduce the impact on the required shift in states funding from other policy areas by between 2% (realistic) and 4% (optimistic) by 2027. As can be seen from these figures, transforming the delivery model will make significant inroads into reducing the financial gap, however this alone will not fully bridge the gap and hence will not make the system financially sustainable. By 2027 the remaining gap is still 8.4% (in the most optimistic scenario) of the total revenue available to the States from taxation and social security contributions.

The financial and accountability reforms which run in parallel with the creation of a new integrated care model are therefore a crucial part of the transformation programme. These reforms will create the environment, freedoms and incentives for the future, where the system will either have to reduce the quality of existing services or find new ways to pay for services, for example via private or co-pay, to fully bridge the remaining gap and achieve financial sustainability. Transparency around the use of insurance and the ability for providers to charge for services beyond those that are universally made available are critical to the success of the Bailiwick's health and care system in the future.

1.5 Conclusion

The current (2016 reconciled without private income) public spend of the health and care system is £192.7m, by 2027 it is forecast to be £267.6m which is an increase of £74.9m (factoring increases in existing costs plus demographic changes).

If the current health and care operating model is left unchanged within the Bailiwick, the States will need to shift 12.4% of the forecasted available public finance from other public policy areas to focus

additional money on health and care (even with existing private payment factored). Without change our view is that the health and care system within the Bailiwick will fail, services will have to be reduced and the high quality health and care outcomes that Islanders currently enjoy will be a thing of the past.

The current system is fragmented, is over reliant on expensive hospital based care, has high structural costs and is forecast to have a considerable financial and capacity gap by 2027, which will continue to increase further if nothing changes. This gap cannot be bridged through productivity and efficiency savings alone, and the system requires transformation, both in terms of the delivery model and in terms of how it operates financially.

The initial reforms being put forward are a clear staging post en-route to a much more integrated and transparent system of health and care within the Bailiwick. They start the process of delivering the changes required within the system of health and care. They change the delivery of health and care in the out-of-hospital setting, create the opportunity for new entrants, greater involvement of voluntary sector organisations and a much clearer focus on prevention. The transformation of the delivery model creates an opportunity to reduce future costs by between £8m and £17m by 2027 which will reduce the required shift in funds from other public policy areas to 8.4% in the most optimistic scenario.

Beyond care model transformation, the reforms proposed critically provide a route to cap public spending on health and care at agreed levels each year and in parallel create the environment for new funding models, such as private and co-payment models, to co-exist with the public payment system – therefore creating an environment to bridge the remaining 8.4% gap through other funding means.

The changes require HSC to take a clearer role in determining universal services and indeed reducing inequity in the system, whilst creating the environment for greater levels of provider collaboration and accountability in addressing the needs of the whole population.

The reforms to the financial regime and accountability enable the system to deal with the remaining gap in new ways and create long term financial sustainability.

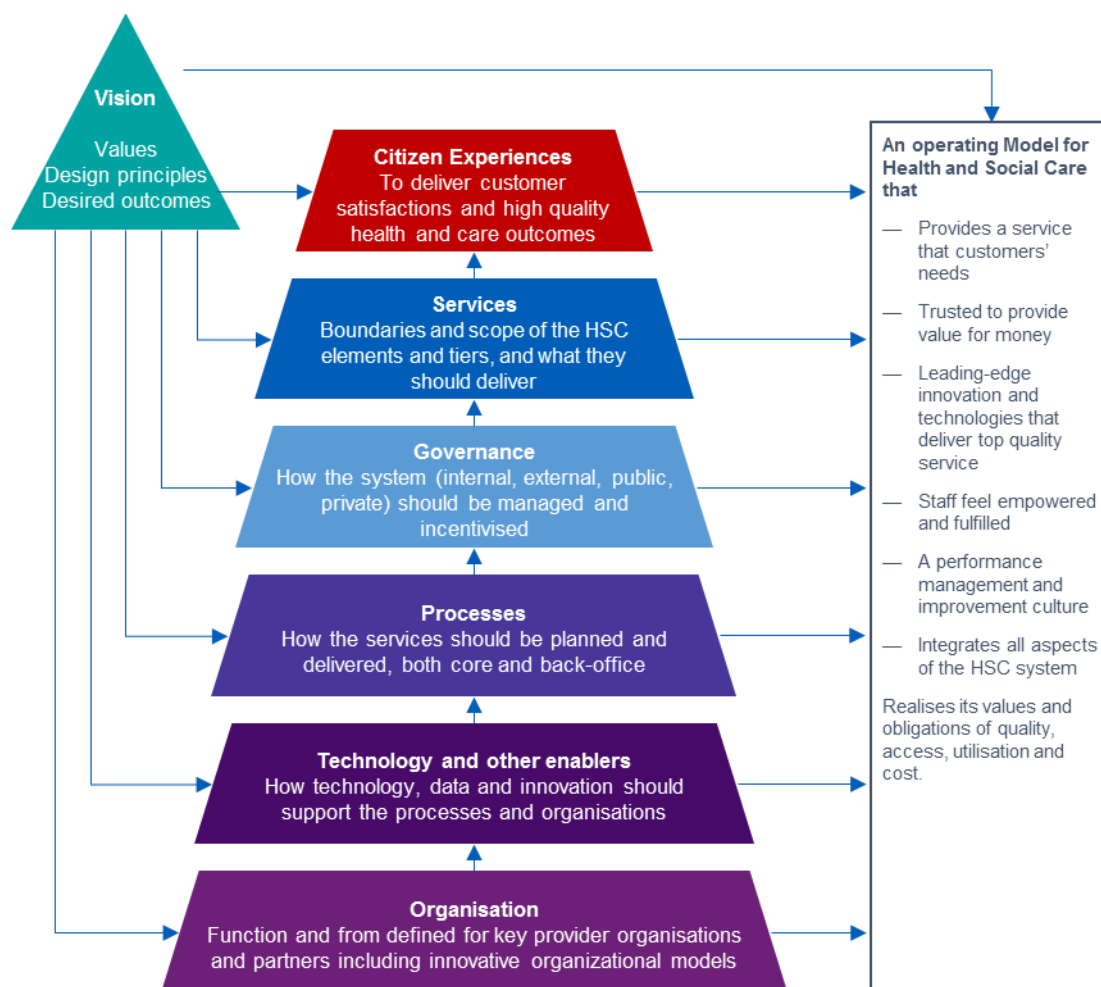
It is clear that the opportunities and benefits for a transformed health and care system are significant. However HSC should also acknowledge that the transformation to health and care alone is unlikely to tackle the financial gap fully. There is an ever increasing research base which looks at the social determinants of health. In order to create a fully sustainable health and care system the Bailiwick also needs to consider how the wider public service reforms can support this programme.

Whilst the change is significant, our engagement has shown that the public, politicians and health and social care providers support the change. KPMG are therefore recommending that HSC moves towards a next phase of iterative design and implementation for each of the priority reform areas that have been identified (section 1.2 above).

Appendix 1 - Developing a Target Operating Model

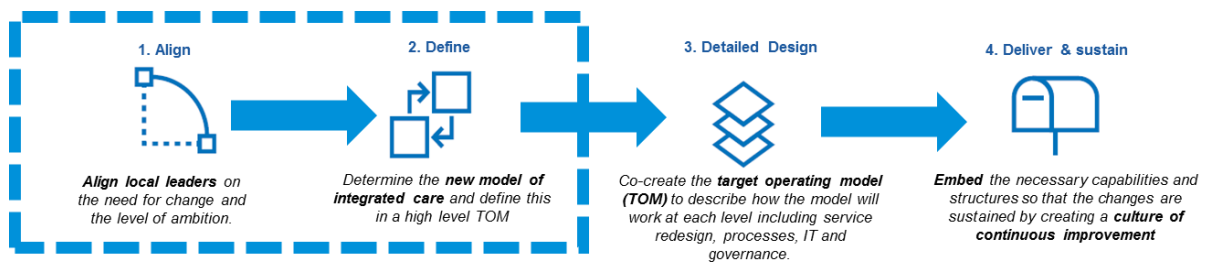
What is a Target Operating model (TOM)?

A Target Operating model is a description of the future way of delivering health and care for the Bailiwick. It is designed to be ambitious and represents a target for the current state. The operating model can be classified into layers which represent the relative flow of design. The sequential way for target operating model design stems from defining value from the vision and citizen experiences which consequently inform how services should be organised, how these services should be governed, the processes by which the services should be planned and delivered, the role and function of enabling factors such as technology in the new model and finally the organisation of partners in the system to optimally enable the new operating model. KPMG and HSC's work addressed each of these layers. The approach ensures that the vision, and how that will affect service users, is at the core of all design activities and that the requirements of each layer are informed by citizen experiences.

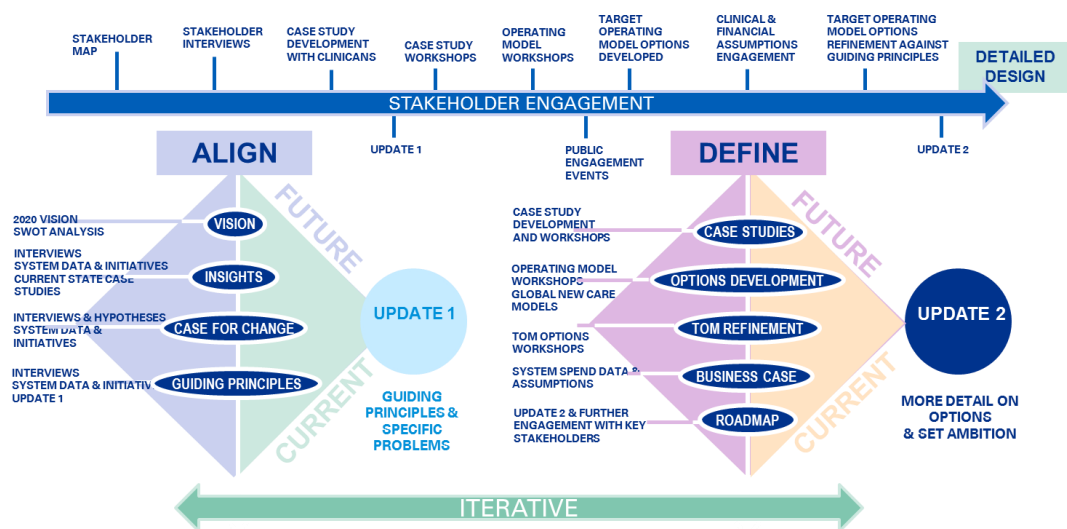


Transformation process

The transformation process follows a four stage sequence of 'Align', 'Define', 'Detailed Design' and 'Deliver and Sustain'. The work which has been performed to date has been within phases 'Align' and 'Define'. It is important that the high level TOM is agreed in order to provide a solid basis for the next stage: 'Detailed Design'.



The 'Align and Define' stages encompass the high level design of the TOM, and they fit with the double diamond transformation methodology already used by the States of Guernsey and HSC as shown in the diagram below. The 'Align' stage of the process was informed by the HSC 2020 Vision as well as a set of hypotheses describing the current problems. The 'Current and the 'Future' scenarios were understood and developed at the same time.



The approach to understand the current and future state detail is set out below. Outputs from each of these initial data gathering exercises fed into the options for the operating model. As shown in the double diamond diagram, models will be iterated and developed throughout the more 'Detailed Design' phase which is to follow.

The joint KPMG and HSC team used a variety of data gathering methods:

- *Research* - Interviews, research, questionnaires (engaging with around 100 people), global knowledge and to understand the 'As-Is' and requirements for the 'To-Be'.
- *Insights and Case Studies* – were gathered through analysis of the research and further engagement. Development of citizen case studies to drive further insights from a citizen/patient and frontline staff point of view.
- *Key aims* - were developed to check and refine the desired 'To-Be' state. These were developed from a combination of the 2020 vision, questionnaire and interview results and provide a reference for designing the TOM.
- *Hypotheses* – at this point hypotheses regarding what needed to change in the system had been developed and data was gathered to either prove or disprove them. These help to determine how the TOM options would address the specific issues currently present in the system.

This process supported the development of a short list of TOM options which aligned with the guiding principles. This was chosen over the process of developing a long list of options, which then needs to be refined and agreed by multiple stakeholders, as this reduces the time and effort required to reach consensus on a preferred option.

At this point a leadership workshop, 'Update 1', was held with around 30 of the senior health and care stakeholders. The key aims were refined and agreed by this group. The work aiming to define the model of the future state follows this in the 'Define' phase.

Islander experience

The experience of Islanders is at the heart of the process and TOM design. Therefore for the 'Align' and 'Define' phases where we align local leaders, and define the model for the future, six case studies were developed to represent a wide range of users, reflecting health and social care needs relevant to the population of the Bailiwick of Guernsey.

Building on the key aims, the case studies were used in a series of workshops. Service providers familiar with a broad range of service provision attended workshops to describe what an ideal future state would look like for the six case studies. This was not intended to replace public engagement, which is key to this process, but to use case studies to bring patient centred discussions to life.

Development of the TOM options

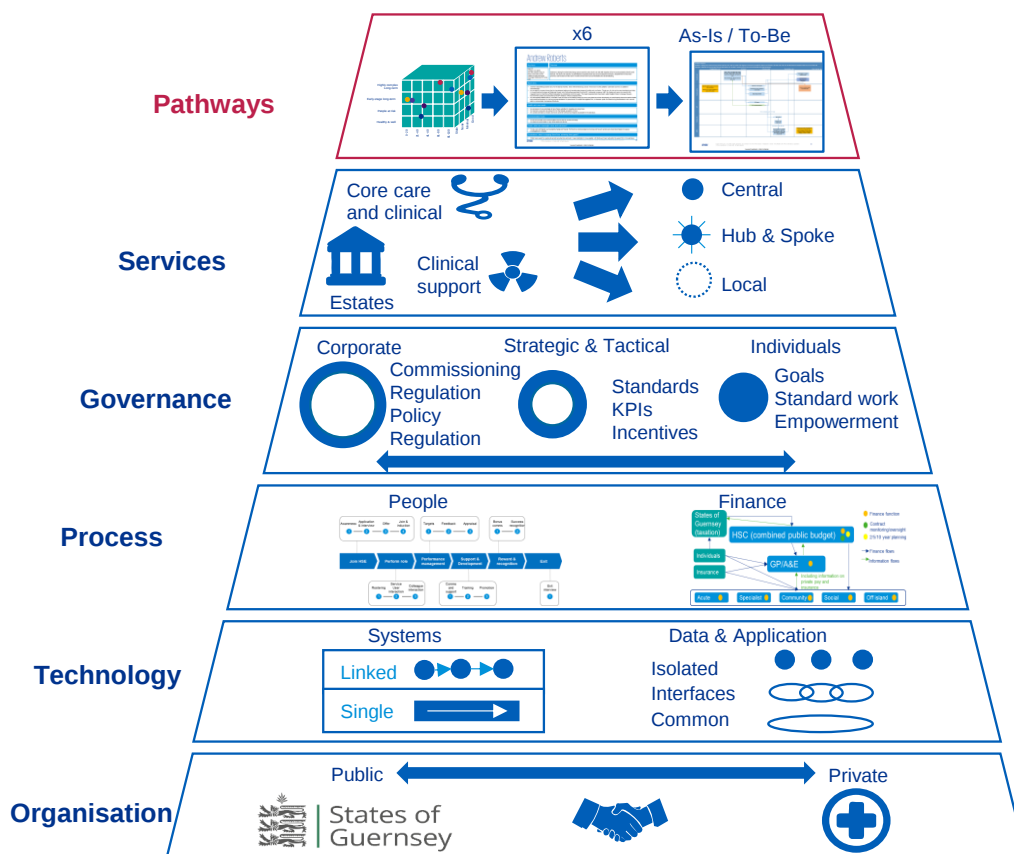
The future state case study stories supported the development of three high level service models, which had varying levels of adherence to the key aims.

These are three independent TOM models, but each could be seen as a development on the previous model. During 'Detailed Design' it is possible that the final operating model is a blend of a multiple of models, for example, model 2 and 3.

TOM Layers

Once the three models had been developed KPMG assessed, at a high level, what would be required for each layer of the operating model. These areas are indicated in the diagram below.

The requirements at each level are slightly different for each model and the relative benefits are discussed later in this report.



Engagement

In any major transformation it is important that the people who the transformation will affect are part of the process. As health and care affects everybody HSC understands the need to engage as widely as possible with islanders as well as service providers and other committees involved. At this stage engagement has started with a wide range of people involved. This engagement will continue and extend as the programme develops.

Through this phase there was engagement with over 380 people both individually and in groups. This has included Service users, staff, HSC management, MSG, GPs, and members of the public. Using both the HSC communication team & Orchard PR, an engagement and communications approach was developed to obtain the opinions and support of key influencers to ensure those affected by transformation were aware of the work being undertaken, understand the reasons why change is required, and understand the issues and challenges faced by health and social care in the Bailiwick and the proposed model for the future TOM.

The engagement process started with mapping out the key stakeholders. Once the key groups of people we needed to engage with had been identified we asked them to share information with us on how the system currently operates, their understanding of our vision for the future and how they thought we could get there. Involving these key groups early on in the process allows us to ensure the following:

- Our people own the solution(s) and are motivated to implement them;
- Our people are responsible for implementation are ready to deliver;
- Our people are impacted by the transformation, positively or negatively, and are kept informed through engagement of what is happening, so that they can prepare for change.

The joint team used several engagement methods covering a wide range of people. In addition to the meetings and workshops HSC have a Facebook page and website www.gov.gg which allowed the joint team to be open and transparent regarding the process HSC are going through.

Engagement Method		Purpose	Numbers attended
1	Survey 1 to 1 Group Interviews	To understand and capture the opportunities, issues and constraints of the current health and care system. The outputs were used in the development of the guiding principles.	CIRCA 100
The joint team created and sent a questionnaire before holding 1-2-1 and group interviews in the region of 100 of the most influential people including the Politicians and the HSC Transformation Board. These interviews captured opportunities, issues and constraints. Meeting with staff groups and providers, was crucial as the joint team needed their experience of other systems, opinions, feedback and ideas to progress and determine what the future care model should look like. This information fed into "Leadership Update 1" where KPMG facilitated the leadership to agree to a set of guiding principles and TOM options.			
2	Hypotheses Workshop	To understand the assumptions that different people understand to be the current state.	20
Designed to understand the key hypotheses (or assumptions) that different people within the health and care system understand to be the current (As-Is) state, both positive and negative, of the health and care system. Quantitative and qualitative evidence was then used to prove or disprove these hypotheses.			
3	Guiding Principles Workshop	To gain consensus on the ten guiding principles that will act as a filter for the TOM options.	20
From the questionnaires, interviews and input from over 200 people initial guiding principles were developed. At these workshops they were challenged and refined by the attendees in order to present at Update 1.			
4	Case Study Workshops	To develop the ideal future state for the user/patient journeys. The outputs of this were used to feed into the operating model workshops.	65
The case studies developed were used to support providers of care, i.e. clinicians, allied health professionals, nurses, pharmacists and paramedics to define a future 'ideal' state which then fed into the operating model workshops.			
5	Operating model Workshops	To define the requirements for each layer of the operating model in line with the guiding principles and the requirements of the future user journey as defined in the case study workshops.	51
The operating model service workshops enabled the joint team to engage with people about the programme approach, deliverables and methodology for care system redesign. Through group exercises the joint team were able to define the requirement for each layer of the operating model based on the guiding principles and the future ideal state as defined in the case study workshops. It also allowed the joint team to identify the changes and variations between the 'To Be' and 'As Is' service configuration.			
6	Staff Events (Drop In's)	To gain feedback on the challenges, opportunities and what staff felt they could contribute to the development of the current system.	68
Staff drop ins allowed the joint team to understand what HSC staff think. We asked three questions, what are the biggest challenges, what are the biggest opportunities and what can they do to support the guiding principles. Using a sliding scale the joint team wanted to understand what was important to staff in terms of accessibility, affordability and quality.			

17

This allowed HSC staff to give the joint team feedback on what was working currently and what must be changed in the future.

7	Public Events (Drop In's)	To gain an understanding of what the public preferred in terms of access to healthcare, affordability and quality. To also gain feedback on the challenges, opportunities and what the public felt they could contribute to improving the current system.	76
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Public engagement events were held which were facilitated by KPMG, HSC & Orchard PR, they enabled stakeholders such as patients, public, staff, local businesses, third sector and others to understand the case for change and feed in their ideas and concerns. These were advertised extensively on the radio, newspaper, through Facebook and by word of mouth. These events were open to all. Again, we asked three questions, what are the biggest challenges, what are the biggest opportunities and what can they do to support the guiding principles. Using a sliding scale the joint team wanted to understand what was important to them from accessibility, affordability and quality. The figure below shows that the majority of people asked wanted to be treated closer to home rather than going to hospital in the future.

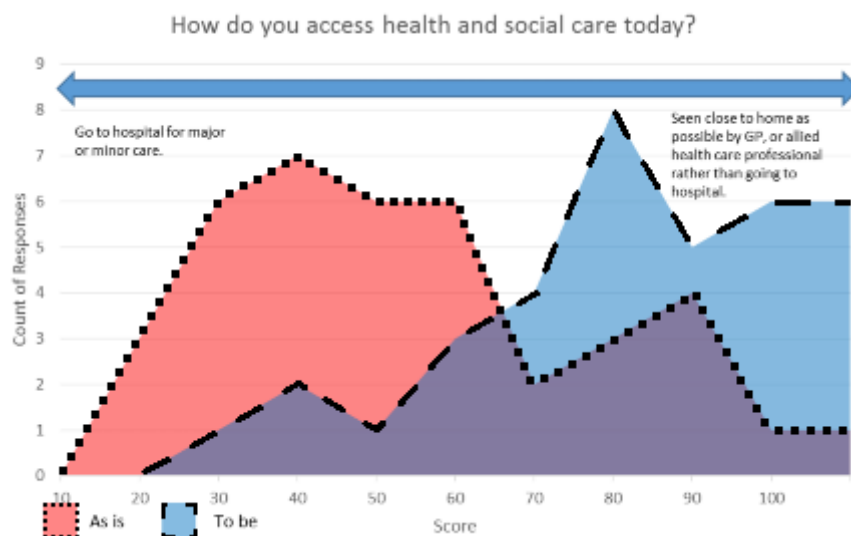


Fig 7. Responses from public engagement showing public perception on the 'As is' – where the majority of care is based in hospital and the desired 'To be' – showing how members of the public would prefer to be seen closer to home.

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TRANSFORMING HEALTH AND CARE IMPLEMENTATION PLAN

Outcome	Work Streams	Progress Milestones	Target Outcomes
Partnership of Purpose	Engagement with core service providers across primary and secondary care with the view of creating Service Level Agreements Introduction of Service Standards for the services and facilities directly provided by HSC Establishment of an oversight group comprising direct or indirect representatives of the participating health and care providers, initially chaired by the Committee's Chief Secretary	Commence discussions in Q1 with the view of having some SLAs in place by the end of Q4 Identification of the Service Standards required across HSC by the end of Q1, and agreement of the standard headings of the Service Standards by the end of Q2 Establishment of an oversight group, albeit in a shadow form, by Q4 recognising that membership will include representative of providers who have indicated their intention to join the Partnership of Purpose	Commencement of a collaborative and integrated approach with health and care providers Ability to hold HSC services to the same standard as external providers through the Partnership of Purpose Creation of key strategic leadership of the Partnership of Purpose and a mechanisms, from this it will be possible to explore common standards of quality and shared objectives
Bailiwick Health and Wellbeing Commission	Establishment of the Commission on a shadow basis, including the transfer of the relevant staff and resources	Q1, with a primary focus on Healthy Weight Strategy, Be Active and Drug & Alcohol Strategy	Bringing together the private, public and third sectors to drive wider community behaviour and wellbeing and inform the Commission's subsequent development

Outcome	Work Streams	Progress Milestones	Target Outcomes
Bailiwick Health and Wellbeing Commission (Cont....)	Production of a supplementary Policy Letter creating the Commission on a formal basis Commissioning from the Bailiwick Health and Wellbeing Commission key outcomes and deliverables for this term	Submission of Policy Letter for consideration during Q3 2018 Agreed programme in place for the period 2019-June 2020 by Q4 2018	Ensuring the Commission has the appropriate structure and governance Ensuring a programme of work is in place for the Commission which is in line with the States' direction as articulated through the Policy & Resource Plan
Universal Offer	Start of thematic Population Needs Assessments, starting with Older People Commencement of work with the Committee for Employment & Social Security and the Policy & Resources Committee to consider the reorganisation of grants, subsidies and funding and subsequent development of the universal offering	To commence arrangements by Q3 To agree, during Q1/Q2, with the involved Committees a detailed programme of delivery, including timescales	To ensure the universal offer is informed by evidence To ensure appropriate programme discipline and political ownership in respect of the most substantial aspect of the transformation
Regulation	Production of a comprehensive Policy Letter setting out proportionate proposals for the regulation of health and care in the Bailiwick	Submission of Policy Letter for consideration during Q4 2018	Clear policy direction of the Assembly in respect of the nature of future regulation and preparation of the necessary drafting instructions for the Law Officers

Outcome	Work Streams	Progress Milestones	Target Outcomes
Development of the physical and technical infrastructure	Commencement of the re-profiling of the hospital phase 1 project. This will include particular consideration of the development of the private offering and a walk in clinic	Evaluation during the course of Q1 of work undertaken to date to ensure that it is reflective of the States' decision	To maximise the Committee's real estate and ensure that it best meets the community's needs
	Development of a principal central Community Hub, potentially at the King Edward VII site	Commencement of discussions with States' Trading Supervisory Board in Q1	To deliver care closer to home and to house the current children and community services
	Implementation of the Local Area Network infrastructure	Commencement in Q1 with deployment completed across the whole HSC estate by end of Q3	To improve HSC's technical infrastructure so to support broader transformation
	Commencement of the TRAK system upgrade	Conclusion of a contract with appropriate schedules on deliverables, options to be adopted and programme approach by the end of Q1, with detailed programme planning to take place in Q2	To improve HSC's technical infrastructure so to support broader transformation
	A pilot project in respect of the use of technology within the community	Identification of appropriate pilot during Q1 with delivery anticipated for Q4	To evaluate the feasibility, cost and benefits of providing defined technology within the community