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Assemblée des États

Health and Social Security Scrutiny Panel

Jersey Care Model

Witness: The Minister for Health and Social Services

Thursday, 13th February 2020

Panel:

Deputy M.R. Le Hegarat of St. Helier (Chair)

Deputy K.G. Pamplin of St. Saviour (Vice-Chair)

Deputy C.S. Alves of St. Helier

Deputy T. Pointon of St. John

Deputy G.P. Southern of St. Helier

Mr. S. Coad, Adviser 1

Mr. P. O'Connor, Adviser 2

Witnesses:

Deputy R.J. Renouf of St. Ouen, The Minister for Health and Social Services

Mr. R. Sainsbury, Group Managing Director, Health and Community Services

Ms. C. Landon, Director General, Health and Community Services

Mr. P. Armstrong, Interim Group Medical Director, Health and Community Services

[10:06]

Deputy M.R. Le Hegarat of St. Helier (Chair):

Good morning, it is Thursday, 13th February. This is the first public hearing in relation to the Jersey Care Model with the Minister for Health and Social Services. We will all introduce ourselves. We are under the normal remit of being within the States Assembly and the normal rules apply. I am Deputy Mary Le Hegarat of St. Helier District 3 and 4 and I am the chair of this panel.

Deputy K.G. Pamplin of St. Saviour (Vice-Chair):

Deputy Kevin Pamplin, vice-chairman of this panel.

Deputy T. Pointon of St. John:

Deputy of St. John, Trevor Pointon, member of the panel.

Deputy C.S. Alves of St. Helier:

I am Deputy Carina Alves of St. Helier District 2 and a member of the panel.

Deputy G.P. Southern of St. Helier:

Geoff Southern, member of the panel.

Deputy M.R. Le Hegarat:

I will also ask the staff from Health to introduce themselves as well as the Minister but also to advise we have 2 advisers with us today as the Scrutiny Panel have obviously had a need to engage somebody to assist us with the scrutiny of this model.

The Minister for Health and Social Services:

I am Deputy Richard Renouf, Minister for Health and Community Services.

Director General, Health and Community Services:

I am Caroline Landon, director general, Health and Community Services.

Interim Group Medical Director, Health and Community Services:

Patrick Armstrong, interim group medical director for Health and Community Services.

Group Managing Director, Health and Community Services:

I am Rob Sainsbury, the group managing director for Health and Community Services.

Deputy M.R. Le Hegarat:

I will also ask the advisers to introduce themselves.

Adviser 1:

I am Struan Coad.

Adviser 2:

My name is Paul O'Connor.

Deputy M.R. Le Hegarat:

This morning we have a number of questions, which we are going to ask the Minister and we will start with Deputy Pamplin.

Deputy K.G. Pamplin:

What we are going to do in this is we have many questions to go through so Mary is literally going to chair and keep us on task and if we feel that we are dragging on she will promptly interject and move us along. We thought it would be fair to say, since we launched this review, what we have been doing. We have received a number of public submissions which were available on our Scrutiny website. We have had 2 hearings - one private, one public - and we have also had our advisers engaging with members of your team, Minister. So that is what we have been doing since we launched the review. So my first question is: what can you update us since we last met to advise us where you have progressed the Jersey Care Model up to this date?

The Minister for Health and Social Services:

We are in a position, Deputy, where we have the health planners who are working to validate the Jersey Care Model. They have established a series of focus groups drawn from service providers and all interested parties around 7 workstreams and those focus groups have begun to meet and inform the further deeper dive that needs to be done.

Deputy K.G. Pamplin:

As part of that is it also progressing with the structure of delivery of this future care model, presuming when the funding comes back when you lodged this, that some of that work has been done? So pre-empting decision-making on how it is going to be delivered. Can you give us some sort of indication on that?

The Minister for Health and Social Services:

All that is under examination, yes.

Deputy K.G. Pamplin:

Let us start then from the beginning, Minister. What was the driver for developing the care model?

The Minister for Health and Social Services:

I think a realisation that the model that has just evolved in Jersey is unsustainable in the long term due to ageing demographics and the increased care that rightly our population expects.

Deputy K.G. Pamplin:

How has this strategic case that we have been looking at for changing the healthcare model been developed since P.82?

The Minister for Health and Social Services:

P.82 set out a broad vision about delivering care in the community but for whatever reasons it did not seem to develop as quickly as necessary and I think this Jersey Care Model has got to grips with some of the detail that was needed, some of the hard questions that needed to be asked, and set out some ways in which we could achieve more rapidly that delivery of care in the community, which is now being stress tested.

Deputy K.G. Pamplin:

When was day one of the work put into this care model? When did that begin?

The Minister for Health and Social Services:

It began last summer, autumn, I think, is that fair to say? Can I ask officers to … you have probably been thinking about this for a very long time?

Deputy K.G. Pamplin:

Just before we do that, we did have an interim director general of health as well for a 6-month period as well. So just establishing timeline of when day one of the healthcare model, when it began and who was that? And then took over or has it worked?

The Minister for Health and Social Services:

I feel that is a difficult question for me to answer was there a day one. Because for me it was an evolution of thinking and planning and getting people in place to do the work. Perhaps I can ask officers when sort of the detailed planning …

Director General, Health and Community Services:

So we started thinking about this really … so I think as the Minister has alluded to, the health economy has been thinking about this since 2012 but we really started thinking about this when we started to look about the issues that we were having around our waits. So why does it, say, take so long to come into outpatients, why does it take so long to have your inpatient procedure and was the hospital empty most of the time, and we have still got significant waits? Why do we have challenges getting people out the back end of the hospital and why are we having so many admissions to nursing home and care home beds, which seemed disproportionate when we started to look at the information? We did not have the answers to any of that and we did not have any real solid information so one of the first things we did, and I think we really started to kick that off in the spring of last year, was start to look at our information. When we looked at our information it seemed

to suggest that we did not understand our demand, we did not understand our waiting list, which is like our order book. So we needed to think about what we could do differently and all the time in the background when we started to look at this, and I think Rob, you had done an awful lot of work in the preceding year around trying to manage our capacity, we had P.82, so I would think we kicked off when you started to address some of the capacity issues in the hospital but we really started motoring when we started to understand our information, which I would say was last spring.

Deputy K.G. Pamplin:

Just for clarification, your predecessor when he was in post, the interim, was there any work done at that stage that informed what you then just described picking up?

Director General, Health and Community Services:

I think the capacity where … did you want to elaborate on that more?

Group Managing Director, Health and Community Services:

The capacity work in terms of the day-to-day business and what the challenges we are facing, the only other piece of work that related to this is in the decision around the rescindment of the previous Future Hospital plans. A big part of the political review process that was happening around that decision focused on had we or had we not delivered P.82. Where were we? What was the success? What was the failure? What was in train? So we, as officers, then prior to Caroline's arrival, had a role in starting to look at what have we done with these community ambitions. Where have we got to? Did we achieve everything that we had set out? So that was the pre J.C.M. (Jersey Care Model) element that we had got to. Then we brought that together with the operational position we were in, which prompted the work we did in the summer last year.

Deputy K.G. Pamplin:

Going to jump forward a bit now. So how has the model been altered following the feedback you have received from the various workshops you have undertook and any public engagement that you have all been doing as well going round the Island?

The Minister for Health and Social Services:

The model is not finalised as yet. I think the public engagement around the Island added a number of thoughts and ideas to be investigated. At the moment they are all in the mix, if I may speak colloquially, and are being examined.

Deputy G.P. Southern:

Could you elucidate? What is in the mix now that was not there 6 months ago before you did your tour of the Parish Halls? Does anything spring to mind?

The Minister for Health and Social Services:
Through the Parish Halls we heard from carers and I think we needed to emphasise more what we provide for carers in the Jersey Care Model.

[10:15]

There is one very specific query that I remember. A lady came along and said: "Where is there reference to sexual health provision in this?" I think there was not. So that was taken in. But things like that, that is just one instance I remember. Respite was another one.

Director General, Health and Community Services:
We had not thought about respite clearly.

Deputy G.P. Southern:
Respite has been a bugbear that has been floating around. Nobody has ever addressed it for 10 years.

Director General, Health and Community Services:
The public sessions were really valuable because you get group think and we stood back from it now because it is being stress tested and that is right because we were heavily involved with the model, our clinicians, so as much as you … we want the best model we can deliver but we recognise that we have been looking at it and living it for 5 months. So we have stepped back now while the teams are examining it and while there is work going on in the background, the analytical work alongside the group work, so my understanding is from conversations that have been had with me from some of the team, particularly that group that keeps coming up with stuff that we had not thought of, is coming up with better ideas for some of the stuff we thought to, particularly around stepdown beds. The things we had not even thought about. Because the firm that is doing the stress testing is an international firm, they are also bringing some benchmarking information and ideas from other countries that we have not even looked at. So I think it seems to be being really beneficial but again we are not getting really close to it because we do not want to interfere with the process. So at the end of March it will be done, then we will get that report.

Deputy K.G. Pamplin:
Just on that point, that stress testing against other international areas, will some of them be small islands much like ours as opposed to just the UK or big national countries? Because that is a key, I would say.

Group Managing Director, Health and Community Services:

Yes, they are looking at population in similarities, they are looking at the demographics that could match Jersey from an Island perspective, they are looking at the systems that might be similar where you do not have separated commission or provision or lots of local authorities. They are doing multiple analysis across the UK and other jurisdictions to draw comparators.

Deputy G.P. Southern:

There is some interesting work going on in the Isle of Man I think. They have got a different structure but …

Director General, Health and Community Services:

And the Shetlands.

Deputy G.P. Southern:

They are seeing to the same problems that we are, a small island community.

Deputy K.G. Pamplin:

The last one from me before I hand over to Geoff: who was responsible for developing the model and can you provide us with the key personnel all the way through this? We have had a sense and we have seen a lot of change in the department and a lot of people shifting jobs for multiple reasons, we do not know. So can you definitively tell us today who is responsible and who is delivering this and also who are the team involved around it? If you cannot do all that today, provide it by all means please do in an email. That would just be really helpful at this stage to get an idea of who is being responsible for developing and leading this.

The Minister for Health and Social Services:

The development of the model has been the top management team, director general, managing director and medical director but with all the clinicians because we have now organised the department in care groups and all those care groups have contributed to the thinking behind it. Of course I have the political responsibility for presenting.

Deputy K.G. Pamplin:

So would you be able to deliver us a sort of diagram of who did what and who …

Director General, Health and Community Services:

We can do that.

Group Managing Director, Health and Community Services:

I think we probably provided that but we can send that again to you. We have a fully constituted tier 1 through to tier 4 arrangement as clinical and professional leadership from tier 2 down. So the main majority of people who inputted to the concept development of the Jersey Care Model were our associate medical directors, who are the lead doctors for all of our care groups, our lead nurses, our lead social workers, our lead therapists, and they were the key stakeholders that we involved to say: "What do you think, what do you see as the issues?" They helped us to develop the concept. Then we went out to wider stakeholders.

Deputy K.G. Pamplin:

I do remember the email you sent. It would just be really helpful to see small thorough throughline but then equally the delivery throughline, so how does that replicate delivery afterwards and who would be responsible for that?

Director General, Health and Community Services:

So I think that would be the implementation plan that is being worked up for us at the moment which we can share with you. That is quite iterative so we have had a few versions of that. I think as well as the delivery team once we had the model, the bones of the model, then we engage with external stakeholders. So you can argue should they have been involved right from the beginning but I think that we did significant engagement along the way of the summer talking to external stakeholders. We will share that with you.

Deputy K.G. Pamplin:

I think those throughlines are key so where we can see that. That is from me.

Deputy M.R. Le Hegarat:

Public health assessment, and as I said, Deputy Southern.

Deputy G.P. Southern:

The emphasis in this model is very much on preventative and early diagnosis, keeping our population healthy but we do not have any evidence at the moment that our public health initiatives are not working, that we need to do something about, and then the secondary question which you might want to take in with that is, and what do we do about it?

The Minister for Health and Social Services:

I would say there is no evidence that things we are doing are not working. I mean we have got a good vaccination programme, for example. But I think our public health vision has been too mellow and perhaps in recent years we have not given the proper emphasis to public health. So preventative care is about much more than just arranging vaccinations for school children and more

tests that are being carried out in a medical setting but it is about persuading people of the benefits of taking care of themselves and exercising regularly and having proper nutrition, that sort of thing. I have been pleased to be working recently on a health and well-being strategy which is soon going to be launched, which is going to drive a greater emphasis on all those things and go even further than sort of healthcare but talking about the determinants of health, which would be things like housing and education and ensuring that in those programmes that we think about people's well-being and how health improvements can arise as a result of that.

Deputy G.P. Southern:

Is there any concrete evidence? Are there any markers that you can look to and say: "We were there and we are now here"? Is it wellness that can encapsulate almost anything? How do you feel today? Well it is my birthday and I am still alive. I am very happy.

The Minister for Health and Social Services:

So you do need to measure it. The Government has a scheme which I think we recently attended presentations on a set of metrics that will be used to measure all sorts of progress against the aspirations of the Common Strategic Policy and the aims of the Government Plan.

Deputy G.P. Southern:

It seems to me that perhaps to some extent one branch is not talking to the other because what has happened, we have been told, is that the head of prevention programmes has recently left and her post has been replaced, I think it is 2 grades down. Does that auger well or is that deliberate? What is happening there?

Director General, Health and Community Services:

So that is a post that was voluntarily put forward by the department, by the head of the department, around a restructuring process that is taking place across family care and prevention. The intention to replace that post at a lower grade because of the bolstering up that has been done around that team.

Deputy G.P. Southern:

It just seems to me that where is the bolstering then? What is the initiative that is counterbalancing that because that goes against the thread of prevention is vital to what we are doing?

Group Managing Director, Health and Community Services:

Yes, it needs to be bigger. The plan around that team is much more than what the team previously would have been. If we are really going to start tackling the prevention agenda the previous structure would not have been big enough so in the revised structure for that team, which now comes under

a different care group, so it is a prevention primary and intermediate care group; it brings together more resource so you can properly develop our prevention agenda.

Deputy G.P. Southern:

Are you saying somebody has got a different care plan?

Group Managing Director, Health and Community Services:

No, I am saying we do not necessarily need so many people at the higher level. We need more people doing the work and the plan is we have more people developing these plans and implementing the development rather than senior heads of.

Director General, Health and Community Services:

That is a decision made by our senior commissioner in the area and supported by us. But you are absolutely right around public health and I am privileged to be working with the Minister on a workstream across Government because we have not given enough power to public health and our intention is to absolutely grow our public health function because, you are absolutely right, it is about prevention. But what we are very clear about is that that public health functionality when it is robust should not sit alongside H.C.S. (Health and Community Services) because there needs to be a multiplicity of voices around healthcare delivery on the Island, not just the H.C.S. voice. So we are really cognisant of the fact that public health is not where it needs to be and we are engaged in a workstream led by the Minister to build up that functionality because you are right, it is at the core of the care model around educative interventions for prevention.

Deputy G.P. Southern:

Okay, I will pay strict attention to that answer when it comes back from the transcript. Just part of the ongoing research: what evidence have you found that poor health is part of a poor income approach; the poor part literally, physically less wealth than the rest of us on the Island? Have we got evidence that that is an important factor? Because you were talking about working together with housing and other bodies thinking how about working with the Chief Minister on his initiative to reduce income inequality and how are we doing on that?

The Minister for Health and Social Services:

I believe there is evidence, as to precisely what evidence I am trying to think.

Interim Group Medical Director, Health and Community Services:

I am not an expert in this area but I think generally it is widely accepted there is a relationship between where you are socially and health and there is a connection between your income and your

access sometimes to well-being in healthcare. So there are higher rates of obesity and other chronic illnesses in people who are socially challenged.

Deputy G.P. Southern:

I was wondering where the progress in the J.C.M. ties in with stuff we are getting from the Stats Department and the Income Distribution Survey, which will be with us by the end of the year. I am wondering is there a clash there? Is there a timing issue in when we will find out about what is the level of quality in the Island, updated in the last 5 years, and the figures are 5 years old, and if so, can we respond to it?

The Minister for Health and Social Services:

You know, Deputy, because we have talked together, that we recognise the importance of primary care and delivering primary care to everybody without them feeling restricted because of the costs they have to pay, so we are working on that scheme that we have championed to bring forward a scheme whereby costs will no longer be a barrier to people whose income is stretched. So that is working alongside the care model and further details will come out later in the year.

Deputy G.P. Southern:

I will touch on timescale then. I set a timescale in my proposition that said by 1st January I want to see some people getting free healthcare or affordable healthcare. What about the multidisciplinary approach? Is that longer term or how are you progressing on that?

The Minister for Health and Social Services:

Let us be realistic, I do not think all G.P.s (general practitioners) are suddenly going to … it is not just G.P.s, but I do not think we are going to have those whole teams in place everywhere in a year. It is evolutionary and this will take longer than the year. But I think the direction is firmly in that direction.

Adviser 2:

Just to follow up on that, and appreciating totally that movements in public health are over long periods of time, they are not overnight things, but is it the intention of the health and well-being strategy to close the gap on health inequalities within the Island? Is that the overriding or an overriding intention?

The Minister for Health and Social Services:

It is an aim of the strategy. The principal purpose of the strategy I think is to prevent ill health and enhance the health and well-being of the whole population of the Island.

Adviser 2:

The purpose of my question was linking to the previous question on the links between poor health and poor income and therefore an appreciation that by reducing inequalities in one it implies a reduction in inequalities in the other.

[10:30]

The Minister for Health and Social Services:

Yes, I think that would occur. We can address the income inequality. People should be able to then access primary care when they feel ill and not just when they can afford it. We hope to improve nutrition through education programmes in schools, exercise also. There is a lot of work planned to go on in the education system but we also want to roll out initiatives to adults, to encourage more exercise, encourage cycling, other forms of transport.

Adviser 2:

Thank you.

Deputy M.R. Le Hegarat:

Thank you. We will now move on to clinical quality and that will be dealt with by Deputy Alves.

Deputy C.S. Alves:

Does the Minister have a sense of how well Jersey is doing in achieving the 3 elements of clinical quality?

The Minister for Health and Social Services:

Three elements?

Deputy C.S. Alves:

Yes; safety, patient experience and clinical outcomes.

The Minister for Health and Social Services:

How well Jersey is doing? I do not have a sense of in that I can compare very easily but I am not a clinician so can I pass over to the clinician?

Interim Group Medical Director, Health and Community Services:

I think the biggest step forward in terms of getting assurance around that is the introduction of the new care group structure and we are obviously looking at all those areas that you mentioned. The structure within H.C.S. now with departments feeding into care group leads, feeding into the quality

performance risks meeting and feeding into the health board and that sort of thread going through the whole organisation that are not sure has been as robust as it could have been in the past. So it is a development and it is improving and we are getting more and more information as time goes by. So the care group structure has done a lot to address that. It still needs to develop further. It still needs to embed further. But certainly it is a work in progress but we are getting there.

Deputy C.S. Alves:
How are you measuring the outcomes of that?

Interim Group Medical Director, Health and Community Services:
Within each care group, each group triumvirate, which is doctor, nurse and manager, will present to us as execs on a monthly basis with a dashboard around various metrics relating to their outcomes. We will be looking at incidents, serious incidents, we monitor our Datex, which is our reporting system and how many incidents that we are having and the outcomes that we are getting, we are now doing things like structured judgment reviews around any deaths that occur in the hospital to see if there is any learning. Each care group will have particular metrics that relate to that. For example, scheduled care would be looking at waiting lists for people who are waiting for operations and how long they are waiting for outpatients. Just a lot more intelligence now than I think we had in the past.

Adviser 1:
Can I just ask, sorry, has that already gone live those care groups and those reporting back to you on a monthly basis or is that going to happen?

Interim Group Medical Director, Health and Community Services:
Yes. That has been happening since …

Director General, Health and Community Services:
Since July of last year so it is dashboard from the ground up through to board, escalation through the committee structure and reported at board. So it is a standard N.H.S. (National Health Service) K.P.I. (key performance indicators) framework. We have Jersey-fied it a bit, on and off. It is a work in practice. We have only been doing it since July. We were not doing it previously. Again, it is iterative and we have just finished reviewing the care -- quality performance and risk committee predominantly around membership but predominantly around escalation to board. But we can share our dashboard … we might have already shared our dashboards.

Group Managing Director, Health and Community Services:
We already do, yes.

Director General, Health and Community Services:
It would be helpful.

Deputy C.S. Alves:
Okay, thank you. Regarding service changes, what would be your top priorities when delivering the Jersey Care Model?

The Minister for Health and Social Services:
I am struggling there. I am waiting to see what the Jersey Care Model work that has been done now will recommend. As a general rule we want to make the services more patient-centred. Delivery where patients lead, not dragging people into a huge building where that is unnecessary, and reserving our secondary care for appropriate cases and raising the standard of excellence in all aspects of care.

Interim Group Medical Director, Health and Community Services:
All care needs to be available in a timely fashion. It needs to be safe and it needs to be of high quality. I think those are the foundations upon any service that we provide.

Director General, Health and Community Services:
And not acute focused. I think we have a care model that is very much based around Gloucester Street and we do not think that … and I think we are already doing work because we demonstrably do processes within our hospital that in nearly every other jurisdiction is done external to the hospital. For us it is a model that is not so H.C.S. dominated but is a much more collaborative model whereby H.C.S. is one of a number of providers working to deliver health across the Island, and one of a number of voices determining the direction of health, which I think previously we have been the loudest and the voice with all the power. That is what we do not want going forward.

Adviser 2:
Just to follow up on that, it is sort of linking those last few questions really, when you look at the health of the Jersey population at the moment what are the key things that the care model is trying to address? I appreciate that stress testing is going on but where are your biggest concerns in terms of either outcomes or specific specialities or particular patient experience groups or whether there is a safety aspect? It cannot be trying to do everything for everyone all at the same time. Where are the big priorities in terms of clinical quality that need to be addressed by the Jersey Care Model?

Group Managing Director, Health and Community Services:

It is not just clinical and we need to be really clear about that; it is health and care. We are integrated with social care and at the heart of what we want to achieve with the Jersey Care Model we know when we look at our activity analysis, looking at our high-risk patients who are accessing our services frequently, they are being passed pillar to post around our health and care system. They are going between social care, between different physical specialities, between mental health and primary care, and they are not having continuity. They are having multiple assessments, multiple opinions, and they are not having good case management co-ordination, and their outcome is often leading to institutional focus care either in secondary care, in hospital, or within the care home environment. So we have set clear targets that we preserve the hospital to deal with those patients who absolutely need specialist, hospital focused intervention rather than having the hospital occupied by patients who are medically fit and do not need to be there. For the community part of our sector we really want that part to pick up and to manage patients to deliver more independent life where they do not have one choice only, which is predominantly to go into long-term institutional care. We want them to have more community care in their own usual place of residence.

Adviser 2:
If I may just try and encapsulate that, all you are describing at the moment is a poor experience for the recipients of care, and often as a result of that poor experience poor outcomes as well?

Group Managing Director, Health and Community Services:
Outcome, yes.

Adviser 2:
So the stress testing presumably will identify quantifiable improvements in both patient experience and outcomes for the population?

Group Managing Director, Health and Community Services:
Yes. In the other part of your question - we recognise we have some vulnerable specialities. We are an Island health economy so we need to preserve the specialist base that we have on the Island; we do not want to be fewer pathways that we can deliver within the hospital services here. In fact, if we can get hospital services configured in the right way we think that gives us an opportunity to do more on-Island to prevent some of our specialist activity going off-Island, which we think would gain a better outcome and experience for our patients here in Jersey. So our model really is about right place, right environment, at the right time for the person.

Adviser 1:
Can I ask one other question just on that? You talk a lot about high-risk patients; have you got a clear register of who they are and where they are?

Group Managing Director, Health and Community Services:

Yes, we have done patient-level costing, we have P.L.I.C.S. (Patient-Level Information and Costing Systems) and it tells us that our top 10 high utilisation patients can use up to £4.2 million worth of resource, and they are going around and around and around, 20 assessments, they end up in long-term care, they are not having good case co-ordination. We know in our analysis for mental health that we are not seeing good connectivity between physical and mental health services, and again they are high intensity, high cost, poor outcome patient groups that we need to target.

Director General, Health and Community Services:

Because it is so complex and muddled we do not have that clear line of sight to all our patients, so they leave our back door, they go home, they get packages of care - not necessarily the right packages of care because it is not patient determined - they go into a care home or a nursing home, and because the system is not co-ordinated we lose sight of those patients. We need to have sight of all of those patients, so even if you choose not to have care from us and you have capacity, but you are vulnerable, in most jurisdictions we still need to know you and have you on a caseload, even though we might not intervene. That is what we need to get to is that position of wrapping around all our patients, wherever they are, and working collaboratively with other providers, whereas at the moment we are all working in a bit of a melee.

Deputy G.P. Southern:

I am not quite sure yet how that is made easier by moving to a care in the community, close to home, multidisciplinary approach, by people - some of whom are not employees of ours, they are volunteers - so how is that made any easier by the approach that is contained in the J.C.M. to make sure that people are getting the right package? Because it seems to me that package is harder to organise almost.

Group Managing Director, Health and Community Services:

It is, but we are not seeking volunteers to co-ordinate this and I think there has been a confusion that in our aspiration under the voluntary sector that that means that we are expecting volunteers to co-ordinate care. We are commissioning services from voluntary providers with paid services that would be similar to in the U.K. (United Kingdom) context as a community trust. So we are not expecting these services to be delivered for free; we expect to invest within those community services, and those community services have more contact with our patients and clients than the hospital. They know the patient better, they see them on a more long-term basis. At the moment the system is weighted in a way that the hospital is making the decisions for patients, that it is only seeing for very short periods of time, rather than the consistent person who knows the patient, and that really should be the G.P. and a community service.

Director General, Health and Community Services:

That improved communication is through shared staff and through shared pool budgets and pooled staff. So at the moment one of the reasons why care is different is because we own the resource and we hold on to it, and a lot of our staff are keen to work outside the hospital - not all, and it is not going to be compulsory, as has been alluded to - but we have staff within the hospital who can provide that clear pathway management, who can go outside of Gloucester Street and work within the community, which enables us to maintain that line of sight which we do not have as well as we should at the moment because we are in our silos.

Deputy G.P. Southern:

Are you aware that over the past let us say 5 years there has been some deterioration in relation to the trust between the voluntary sector and …

Director General, Health and Community Services:

Yes.

Group Managing Director, Health and Community Services:

Absolutely, and that is what we want to change.

Director General, Health and Community Services:

With all our partners.

The Minister for Health and Social Services:

I believe we have begun to change. In speaking to voluntary sector bodies they tell me it is changing, they have greater engagement with the department, and they feel involved.

Deputy G.P. Southern:

I am probably out of order now …

Deputy M.H. Le Hegarat:

Yes, we will go back to Carina.

Deputy C.S. Alves:

Which almost brings me back to my next question: do you think the vision for community and out of hospital provision is too large for Jersey? While some services could be provided in the community, is there a danger that the vision is too ambitious?

The Minister for Health and Social Services:

Well the health planners will tell us that, I hope, if we are aiming too high. But I hope not. I do not want to be fearful and limit what we could do. I mean, I think the care model aligns perfectly with what I saw before I became the Minister, just as a States Deputy or even any member of the public. If we have lived in communities, as many of us have, for a lifetime or for decades we have seen them change and there are a lot more elderly people, those people are often frail but they are surviving a lot of illnesses and conditions and they are living in not good health and they are struggling, and often families get involved and there is a struggle for them to live.

[10:45]

You see them going into hospital for a week or so because something has gone wrong, and then they come out and then there is not a proper care package wrapped around them. We can do that better, and for a long time I have had that sense that we should be able to do that better, especially Jersey with its strong sense of community. So I think we can be ambitious.

Director General, Health and Community Services:

We welcome scrutiny; the more scrutiny the better. Great having a conversation with these guys. We do not want to be the team that got it wrong for patients in Jersey. So I think the planners … that is why we stood back from it, we want them to say: "Actually, you are mad, you have been way too ambitious, this is not going to work" or: "You have not been ambitious enough in this area" so that we get it right. Because this is a real chance for us to really build on all of that work that was done in P.82 really.

Adviser 2:

Just as a supplementary to that, when the planners are looking at this are they looking at specific numbers and very specific plans in terms of this will require this many community nurses, this many people doing this kind of thing in these different locations? Because when you talked about stress testing earlier it was very much about looking at models on other islands, but what you are describing now is stress testing quite specific plans with strong numbers against them.

Director General, Health and Community Services:

Well there is no jurisdiction in the world that will say: "Here is your health model, it requires this many nurses, this many doctors" I have yet to see one. But what it will do is it will give us clear recommendations around workforce, clear recommendations around economic determinants, and clear recommendations of how that will improve or maintain patient outcomes we want it to improve. What it will not do is say: "You need this many nurses and this many doctors in each care delivery

framework" but it will give us really strong recommendations around workforce, and indeed will tell us if we have the workforce available on-Island, either now or in the future, to be able to deliver it.

Group Managing Director, Health and Community Services:

So it will tell us about our caseload requirement for social care particularly, because we have clear indicators that we have a deficit market at the moment; we have an unfilled package of care position because the market just is not there. We know every week how many hours we would need to satisfy the requirement from the hospital and the community, so the planners are looking at that activity, they are saying: "To do that you would need a care provider to come in and provide this amount of hours, that would equate to this number of workers." But Caroline is right, for the other elements they are working on what we have already got and we are looking at how you would adjust that pathway to think about your community service provision.

Director General, Health and Community Services:

And future proof it. Because we have the same challenges as the U.K. around some recruitment, although we are not as challenged but there are still challenges. So one of the remits that we put through to the health planner was that chestnut, it is not what is on your badge, it is your competency, so how can we deliver care differently that does not necessarily have to be doctor-led care.

Group Managing Director, Health and Community Services:

But I guess in terms of thinking about the interrogation, to assure you that where the planners are looking in … you will have seen in the J.C.M. we have made some assumptions about our outpatient activity. So the planners are looking at those outpatient numbers, they are looking at the type of speciality, they are thinking: "Is that a realistic transfer of activity that could happen from secondary care into primary or community care; and if it did what would that need in terms of managing the activity? Is the workforce there/is it not there?" They are looking at that level of detail.

Director General, Health and Community Services:

I think some of the feedback that has come back is: "Some of your assumptions around outpatients we do not think are right, because when we have looked deeper into it the assumption you have made is perhaps erroneous. But we think you can do it differently, but you can do it more as a one-stop shop." So it might not be 60,000 out, as our analysis said, because they think maybe about 20,000 of those do need to stay in and we got it wrong, but you can probably do about 10,000 of them differently. That is going to be so valuable for us, I mean, the other value for us is that deeper interrogation of our data, because we are, as you know, not great on doing interrogation.

The Minister for Health and Social Services:

Yesterday I was speaking with 2 of the planners and I asked if they would be willing to meet the panel or your experts and they were very willing, so if you wish to meet them and drill down into some of the things they are doing …

Deputy G.P. Southern:
That is probably expert to expert.

The Minister for Health and Social Services:
It could be expert to expert, yes. They are certainly willing to do that.

Deputy M.H. Le Hegarat:
We will now move on. We have already touched very, very briefly on it, workforce, and we will move to Deputy Pointon.

The Deputy of St. John:
I have it in the back of my mind, and it is a bit of a concern, that we are here talking about a care model that, it has been said, will determine what type of hospital we are going to build.

The Minister for Health and Social Services:
Well, partly. It will contribute to that determination, I would say. It is not the only factor.

The Deputy of St. John:
So how far along the path are we and how quickly are we going to get this care model up and running so that you can then inform the hospital planners what type or size or version of a hospital we are going to need?

The Minister for Health and Social Services:
So the plan is that the planners report in late March or early April. I do not know exactly how they will set out their recommendation but that should give us an idea as to the number of beds that would be needed in the hospital; and we await that.

The Deputy of St. John:
So we then come on to how do we facilitate that hospital; that is, run it. Who do we engage and what numbers do we need to engage? I am wondering what work you have done on the demand and capacity analysis to try and establish what workforce needs are going to be in the hospital and community to deliver this model.

The Minister for Health and Social Services:

Again I believe that is within the remit we have given to the health planners, and frankly I am waiting for that next development because we recognise that is an important piece of work.

The Deputy of St. John:

So we have to wait quite some considerable time for a partial answer to that question?

The Minister for Health and Social Services:

What do you mean by that, Deputy?

The Deputy of St. John:

Well you must have some concept of what the needs are going to be and what the demands are going to be, and what numbers of staff you are going to need to engage in the community and also in the hospital.

The Minister for Health and Social Services:

I am sure we do, subject to the report that will come.

Group Managing Director, Health and Community Services:

We have a technical group that we have established as part of the Jersey Care Model that is tasked with looking at the enabling streams that we need to run the model, and a big part of that is workforce. So we are looking at the current workforce provision, what we have, and the technical group are mapping all of our specialities across the whole sector, what are our key areas of pressure, where is the supply market for those key posts, is it sustainable, does it need to be different. Patrick, I am sure, will talk about our doctor ambition and what we want to do there. But that group is doing that piece of work, and that is not isolated from the Our Hospital work either. So the group is thinking Jersey Care Model and it is also looking at how would you sustain the pathways within the hospital context as well, and what staff would you need to run those specialists services. It will be charged with looking at both; we are not doing it separately.

Director General, Health and Community Services:

The care model is influencing the hospital, because the hospital will not just be - I think is our aspiration - a deliverer of acute care; it is going to be an educative facility, and we are hoping it is going to be very much part of the community. It is one influence on the hospital build but I think what we are doing very differently this time is understanding from the clinical point of view what needs to be within those walls.

The Deputy of St. John:

Do you think the model is moving more towards a general hospital rather than the acute hospital that was previously talked about?

The Minister for Health and Social Services:

I made a mistake at Grouville Parish Hall and rapidly in answer to a question they asked me: "Is it acute or something else?" and I said: "No, acute." But it is much more than acute; it is maternity, it is E.D. (emergency department), it is what a hospital needs to be for the Island.

Group Managing Director, Health and Community Services:

We are not the N.H.S. and whether we call it a D.G.H. (district general hospital), a local hospital, or the Jersey General Hospital, we have been very, very clear that the hospital in Jersey will provide all of the services we currently have. There is no deficit in the current level of specialist services and diagnostics. We think it could provide more than what we currently have, including cancer services.

The Deputy of St. John:

So could you bring yourselves to talk about it as a general hospital?

Group Managing Director, Health and Community Services:

We do not care. We do not mind what it is called.

Deputy M.H. Le Hegarat:

Can we bring this all back on track and talk about the workforce and not the hospital please? Can I be explicit here; we are here to talk about the Jersey Care Model, not the hospital, and I am very minded that we have got a lot to get through and we want to finish on time, and we have got advisers who are here for the purpose of the Jersey Care Model, not whatever we put or do not put in a hospital I think. So let us stick with the Jersey Care Model.

Deputy G.P. Southern:

Can I just talk some concrete numbers at the moment? So where are we now? Where are the pinch points now, because we are bumbling on with our inefficient service, but we have got shortages of staff in several places. Where are the pinch points now, and are they going to be sustainable in the longer term to deliver the Jersey Care Model, or something else? Where are we in terms of staffing?

Group Managing Director, Health and Community Services:

They are similar to most areas. We know that we have got a staffing deficit within mental health services - that is across the nursing workforce and the medical workforce - that we are trying to address through our Government Plan. We have some pressures in obstetric services, on maternity

services. We have seen some recent difficulty with recruitment to A. and E. (Accident and Emergency), we are normally very successful in that area. Our general nursing recruitment is more favourable than the U.K. perspective. Then the other key area of workforce deficit is in the domiciliary care market. We believe that Jersey needs something different to that because low paid employment in this jurisdiction is difficult and we think that should not be low paid employment and we should be paying more for people providing personal care. So they are our current sort of pressure points. We have already horizon scanned and said we need different kinds of workers, we need more geriatricians, we need to preserve the specialists. We have got a good idea what we have got problems with now and we need to address, and where we need to go in terms of our future. The technical group is doing all of that work.

The Deputy of St. John:

Have you got the resources to be able to address these issues? Are they in place already or will there have to be a new vote at the end of this financial year to get the funds in place to be able to recruit the people want?

Group Managing Director, Health and Community Services:

We have definitely got the resources, particularly for mental health, we have had the resourcing for the way we would run that service differently. If you look at our pressures within maternity services, we think that we are able to look at the existing funding and change that into a different model, and we are working on that together. For domiciliary care that would require something different because we need to engage with the market to agree how we could incentivise that market to get it into a more robust position. That would involve pay conditions, continued professional development, a different arrangement to what it is now. The model is considering how we can do that. We have got a number of options that we are looking at around that, and that is probably not U.K. focused, we are looking more international for that.

Director General, Health and Community Services:

We want to be really different around that market. These are our most vulnerable population who generally are elderly, frail patients, and yet we are paying people below the living wage to look after our most vulnerable patients within their home and within care homes, and indeed within nursing homes. We do not believe that is a viable option for that demographic and we think that we need to be able to reward that demographic differently, and it is one of the challenges we have put into the planners: “How do we redistribute money in order to be able to fund that properly?”

Deputy G.P. Southern:

Can I ask whether you are going back on the decision some time ago by the previous Minister for Health and Social Services to scrap the subsidy for family nursing and to open it to the market? The

end result has been people paid peanuts to deliver vital services. Are you talking about going back on that decision? Is there some other way of subsidising those wages, those costs, or not?

Group Managing Director, Health and Community Services:
That is what we are looking at. It is not necessarily going back and just rescinding previous arrangements, we …

Deputy G.P. Southern:
No, no, but …

The Minister for Health and Social Services:
Or providing subsidies.

Group Managing Director, Health and Community Services:
No, we think this is a differently commissioned service that needs to deliver something different. If we see the objective around continuity of care, then we are thinking: "Do we have a community workforce that is able to carry out some of the things you would expect from a district nurse, that is also able to provide care co-ordination, that can perhaps do personal care, that can make sure that the person has got the equipment that they need, and is able to really support that person in a more intensive way?" Which will cost more, but we think would give a better outcome and stop so many different people working with them. We are looking at a number of international models that deliver that kind of workforce and way of working, and we think that might be something that Jersey would really benefit from because of our strong sense of community.

Deputy G.P. Southern:
When will that be ready, because I want to read it?

[11:00]

Group Managing Director, Health and Community Services:
That is part of the model; by the end of the review.

Deputy G.P. Southern:
Okay, and is there room for an ethical care charter in there?

The Minister for Health and Social Services:
I hope so, Deputy Southern.

Deputy G.P. Southern:

Because it deals with treatment of these very workers.

The Minister for Health and Social Services:

I just hope that standards will be improved and we will be able to direct how care is delivered.

Deputy G.P. Southern:

I look forward to our next conversation.

Deputy M.H. Le Hegarat:

We will come back to Deputy Pointon in a minute but I am aware that one of our advisers wants …

Adviser 2:

I just wanted to make sure there is clarity on when the technical group that you described will report on the gap between what the current workforce needs to be and what it is and, therefore, the plans to do anything about that; also what that different sort of gap will be between the current workforce and the workforce required by the J.C.M.

The Minister for Health and Social Services:

Yes, are the technical group reporting separately in any way?

Director General, Health and Community Services:

It is the end of March. End of March we will have the report from the planners detailing exactly where we are and those kind of metrics around workforce, around outcomes. It is quite comprehensive, is it not?

Group Managing Director, Health and Community Services:

Yes, so analysis of data assumptions, workforce requirement, where we are now, what we would need to do things differently in simple terms.

Adviser 2:

Because that feels as if it starts to define absolute priorities for major initial action as the kind of framework to help all this take off.

Group Managing Director, Health and Community Services:

It helps with our delivery plan. If we can set an understanding of our workforce requirements, the financial flow requirements, the pathway change requirements, we can then start to enact the model

over the next 5 years that is absolutely in place to coincide with the requirement of the Future Hospital. That is what we are trying to achieve.

Deputy K.G. Pamplin:

From a political point, where are we at then with bringing that to the Assembly for the debate and then the Appointed Day Act? How does that timeline shift along now? Because report in March, that work then goes in place; will we be debating this before the summer recess I guess is the obvious question?

The Minister for Health and Social Services:

Yes, I think that is presently the plan, June or early July. It partly depends on yourselves as well.

Deputy K.G. Pamplin:

Well, of course, and then an Appointed Day Act then I guess will be …

The Minister for Health and Social Services:

Well, it is not a law so …

Deputy K.G. Pamplin:

No, but are there aspects of it that will need any law changes, do you envision?

The Minister for Health and Social Services:

Well changes that we might want to make to the domiciliary care market …

Deputy K.G. Pamplin:

Yes, that is what I am thinking.

The Minister for Health and Social Services:

… would probably mean revamping the way we provide a long-term care scheme. That might take some time to work through because that is complex.

Deputy M.H. Le Hegarat:

I am conscious about …

Deputy G.P. Southern:

Can you explore that just a bit? Where is the overlap between the 2 and what are the issues?

The Minister for Health and Social Services:

That is just my sense of it at the moment, but it is subject to what the planners might tell us, how we can deliver. But obviously at the moment we have a long-term care scheme where Government has essentially put a fund in place, and so money is available but the Government has not in a sense gone out and regulated the market. It is just a free market out there. We need to have more consistency in the delivery of services.

Deputy G.P. Southern:
Is that funding largely directed at institutions, and is that part of the problem, rather than care in the home which is the new intention?

The Minister for Health and Social Services:
Yes, I think the sense is that we can keep people in their homes with better provision rather than sending them into care homes in many cases. So we would need to ensure that we have a well-functioning domiciliary care service that can keep people in their homes.

Director General, Health and Community Services:
The long-term care point is a fantastic thing in Jersey, but do we use it to incentivise delivery of care? So do we incentivise outcomes? I am not so sure we do.

Deputy M.H. Le Hegarat:
Okay, I would like to sort of move on with the workforce because I am conscious of the time.

The Deputy of St. John:
Yes, I would like to just pursue this business of, if you like, domiciliary partners. Obviously Family Nursing Service and Homecare are the obvious foundation, but what other partners do you have in your sights to collaborate with the care model?

The Minister for Health and Social Services:
For domiciliary care specifically?

The Deputy of St. John:
Yes.

The Minister for Health and Social Services:
Well there are some specific packages that are rolled out for people with learning difficulties, for example, that are delivered by others apart from Family Nursing. But in the field of domiciliary care I do not think we have any commissioning arrangements with others.

Group Managing Director, Health and Community Services:

All of them, we have engaged with all of them.

The Minister for Health and Social Services:

We have engaged with them, yes.

Group Managing Director, Health and Community Services:

Through the Care Federation we … it is a deficit market at the moment so they are all stakeholders that we need to talk to. They are the same organisations that also are responsible for the care home sector; we have engaged with them through the Jersey Care Model as well. They have come back and said: "Do not forget very specialist care that is required around dementia and around learning disabilities" which was helpful for us, so we have got that in our sights. But, in effect, all those providers on the Island that at the moment are major providers of domiciliary care or community healthcare, are partners within the J.C.M.

Director General, Health and Community Services:

We have had some howls of distress. So we went out on the road we met some very small private providers who were like: "Oh my God, we are here, listen to us. We are in people's homes. We can barely deliver. We do not get paid for travelling between their homes. If we get there and the traffic is bad and we have only got 15 minutes left of the 20-minute care provision we are staying for 25 minutes because we do not want to walk out, we want to deliver care. But that last 10 minutes we are not getting paid for." It is unregulated and that is the care market that is absolutely the soul I think of provision in a small community, and we have not invested in it. That is our intention.

Deputy G.P. Southern:

Who is going to regulate it? That is vital.

Group Managing Director, Health and Community Services:

The Care Commission. The Care Commission has a clear role with this and we have engaged with them. We had the Commission with us all morning yesterday looking at some of our intermediate care modelling which would incorporate the community services and some of the domiciliary care and reablement. We recognise that to make the changes we want to make personalisation is a big part of it, so that the person can say: "I do not want a carer coming in at 9.00 a.m. for 20 minutes, I want them there for 2 hours and I want them to do this, this and this, and I want to choose who I want." The Care Commission will have to adjust the way that it works in that regulated framework, so we are engaging with them as well. We have got a commissioning responsibility to make sure that if we are paying for the service we are assured that they are delivering the metrics, the outcomes

we are paying for. But the Commission has a regulatory responsibility to make sure that that service is delivering care to the required standards of the Commission in Jersey.

Director General, Health and Community Services:

To regulate us to ensure that the outcomes we are asking for from our contracts using public money are the right outcomes. It is not just what Rob and I are cooking up on the fourth floor; so it is that culture of regulation that we really want to work with Audrey to accelerate because it is what we need.

The Deputy of St. John:

Could I put in a practical example of the difficulties that are out there? You mentioned respite care, for example. I have a parishioner who has a small child, so this is not adult respite care. He is told that his child who needs respite care could be funded, there is plenty of money in the pot, but the difficulty is they cannot recruit the staff to deliver that care. Where are we at with that, because that is going to be an important factor, not just in relation to low-skilled people who, by the way, have to be highly skilled, but professionally qualified people. Are we going to make alterations to the Migration Policy Board? Are we going to make alterations to the current Housing laws, the current immigration laws and so on?

The Minister for Health and Social Services:

Yes, well I cannot say yes but that is all part of the picture. I think first of all when you look at what we could do locally, I think enhancing the pay and conditions of people who work as carers is crucial, and that hopefully would mean that it is a profession that is well respected locally and people will want to join. But I think there is also a case for saying that we will need to bring in some workforce from outside the Island. We made a submission to the Migration Policy Development Board to help them understand that we have to look at the social value of some of our workers and what they can deliver in terms of social care. Very crucial.

The Deputy of St. John:

Absolutely the foundation of the proposal you are making. Can we move on to G.P.s; what stage are you at in discussions with G.P.s to take on some of the work that is currently “performed in outpatients”?

The Minister for Health and Social Services:

I know there has been extensive engagement with G.P.s and G.P.s are sitting on the work streams and the focus groups that are now meeting. Yes, I am content that they are involved. Our managing director will know a lot more.

Group Managing Director, Health and Community Services:

We have had lots of engagement and discussion with G.P.s around this, and they are independent commercial providers in their own right and so there are different feelings and thoughts emerging from different practices. They are not a collective body. The primary care body represents a speaking voice for them but they are independent businesses. So we still are having good discussions with a number of the big providers around the potential for activity, that they need to understand the detail, they need to understand what is the mechanism for payment, how will they be supported so that they are not compromised with their access. That is critical for us because we do think their access is a key enabler as to why our acute care system is not overwhelmed at the moment, because you can see a G.P. really quickly if you can afford it. So we are working with them on that and that is a big part of the J.C.M., so we are still having that engagement to understand the activity, what would they need to support those pathways, how could we make it financially work is a core part of the scrutiny from the planners.

Director General, Health and Community Services:

We have not been a great partner to all our partners, and so there is an issue about building up trust. They have heard from H.C.S. before that we are going to do great things, and it kind of petered out. So it is about establishing that trust and, as Rob says, that detail, because recognising they are businesses and that they do need to generate an income, we support that; in fact, we want to enhance that. But they quite rightly want to see that detail and they want to see that we are going to deliver this time. So they are members of our delivery board, they are helping us around the development of the implementation plan, so that we can start to demonstrate to them that we want to work collegiately across the Island.

The Deputy of St. John:

I am introducing this question because we all know the latest news in relation to G.P. practices is not good news. Do you see any opportunities from the news that broke yesterday about the co-op medical practices?

Group Managing Director, Health and Community Services:

This is why we want to change the model. So we understand the pressures that the co-op is facing, with a different view about the recruitment element because our prevalence of G.P.s on the Island is much higher than anywhere in comparison to the United Kingdom. But we recognise that to make the current model of primary care sustainable for the future there needs to be a different arrangement in place. To target the patient grounds that we have identified, those vulnerable people, people with mental health, people with chronic conditions, they need a different funding arrangement and we need a different commissioning provision arrangement to what we have got at the moment. So we recognise why we might be where we are, and the Jersey Care Model is seeking to prevent the

situation that we have that was announced yesterday. That is what we are trying to prevent in our arrangement with primary care going forward, to make it more sustainable, more attractive, and a vital continued part of our healthcare system.

Director General, Health and Community Services:
To manage the funding streams in a different way, so not to be so reactive around funding. So absolutely supporting where you are coming from, we recognise that access to healthcare is a fundamental right, particularly for children and for vulnerable adults in our community, and it is at the heart of prevention. But if we just put money here how does it impact upon care in the acute, care in domiciliary? For us that is what we tried to do in the model this time is look at the whole picture and at how we can allocate funding in a way that brings therapeutic benefit but also long-term sustainability for the delivery of healthcare. So it feels slow but we are just trying to understand how we can allocate our money for the best effect.

[11:15]

Deputy K.G. Pamplin:
I think there is a key thing being missed here that when we talk about senior G.P.s we are talking about the hours of 9.00 a.m. to 6.00 p.m., but the bigger problem is out of hours so in the evening time suddenly those charges jump up to around £150 to see a G.P. So if I am a single mother with 3 children and one of my children gets suddenly sick and needs a G.P., she has to fork out £150 suddenly, or make the decision to cart all 3 children down to the general hospital.

Group Managing Director, Health and Community Services:
Yes, that is exactly what we want to change.

Deputy K.G. Pamplin:
So this is the point going back is that at the moment … and the weekend example, everything shuts up shop so we cannot see the primary care because it is closed. The only alternative is the hospital. So taking into consideration yesterday's model, it is all well and good trying to do things cheaper or free but are we talking more generalised here that people need access, especially mental health. It is not just a 9.00 am to 5.00 p.m. occurrence; we do not suddenly just need a G.P.: "Oh, it is 5.00 p.m., I do not need a G.P." So I am not hearing enough of that side of the model and how that is going to work?

Director General, Health and Community Services:
Can I just caveat, Deputy, we are not trying to do it cheaper, so we absolutely are not trying to deliver cheaper healthcare. We are trying to understand the allocation of funding of healthcare in order to

impact positively on outcomes. I agree, we fund J.D.O.C. (Jersey Doctors on Call), and we fund J.D.O.C. because there is no other alternative; but it is not the right answer or solution for our patients. You are absolutely right; it is healthcare dependent upon economic ability to pay. That is not what we want. Very clearly the Minister, when I came into post, one of the key tasks was about healthcare out of hours and making it safe, sustainable and affordable. That is one of the key precepts of the model.

Deputy K.G. Pamplin:

It is a U.N.C.R.C. (United Nations Convention on the Rights of the Child) right of children as well to have access to it.

Group Managing Director, Health and Community Services:

The model really clearly gives an ambition that we want 24/7 services, so for primary care we need a system that is accessible for people and affordable, and is responsive to people over a 24-hour period. So if we have a community services infrastructure - particularly intermediate care - that needs to have a medical model alignment, those nurses and those practitioners need to be able to speak to a G.P. or a geriatrician. So in looking in the modelling that we are doing we are absolutely saying it is 24/7 that does not have a 2-tier system of charging difference and it is consistent, and it provides a specification to support community services and general access. That is exactly what we are trying to achieve.

Deputy G.P. Southern:

That specific objective, is that in the plan that we will see in March, or is it already being developed? Is there a little group working on it and how far have you got with it? When can we see it?

Group Managing Director, Health and Community Services:

We have got a primary care group that met yesterday, and we have got a group specifically looking at that plan and what it will look like, and that is what we will present to you.

Deputy G.P. Southern:

Have you got the ferret in the corner that keeps saying: “This needs to be decided on now, not in 3 months’ time or 3 years down the line”?

Deputy M.H. Le Hegarat:

Can we just take a sort of final question because, as I say, I want to try and keep this on track, in relation to workforce because we do need to move on to the finances and the digital and everything else.

The Deputy of St. John:

On the periphery of all this are the informal care providers; there is a large, large number of charitable organisations that have a large, large number of volunteers. Where do they feature in this and how are they going to feature in providing care in people's homes, for example?

The Minister for Health and Social Services:

The voluntary sector have a critical role to play in the care model, I believe. They are a feature of Jersey's community and I would love our care system to enhance what they do. You are talking to us particularly about volunteers, I would love to see groups of people being received into homes of people who are isolated or vulnerable, not very mobile, and perhaps those people just need some social interaction, to have a talk with people or to help them with tasks, shopping or delivery of items in the house. We are talking about volunteers so they would not be a medical workforce or they would not be somebody involved in any specific care environments, but we all have a role to play as good neighbours and I think we need to enhance our community offering in that way.

Deputy M.H. Le Hegarat:

As I said, we need to sort of move on. We will now move on to digital.

Deputy C.S. Alves:

It was mentioned earlier on about there has been a lack of communication between the care that is provided in the community, if you like, in primary and how it is all interfacing with the secretary in the hospital. You have mentioned that staff could be a possible to solution to that; I think that was mentioned earlier as well. So does the digital side of things play any factor in enabling this communication because it just seems that the example that you gave about how people are not being provided with probably the best care and that communication is not happening, that maybe digital could help with that. Has that been looked at? Is there any plan for that?

The Minister for Health and Social Services:

There certainly is and it is certainly being studied. Digital is vital; I do not think we could deliver a care model with the digital services we have at the moment. We do need to improve those dramatically and have to if we want Family Nursing to be working with G.P.s, to be working with the department, they will need to be connected and there are plans. I cannot speak about them in detail but I know there is a programme of work that is mapped out to enhance our digital services. I do not know which of you might be able to give more detail.

Director General, Health and Community Services:

Can I just caveat, there is not a lack of communication between us and our patients and the community but it is not as robust, it is not where we want it to be or as responsive between us in the

organisations? Absolutely, we recognise that digital is our key risk around the care model. Our number one risk on our risk register. There is an incredible amount of work going on with our digital health team around how we can have one digital voice across the Island but we do not underestimate the challenge. Our infrastructure, Government-wide, is not robust. So while we have the money to invest and we have a great team of people leading with lots of different international companies about how we can deliver the best electronic patient record although it will still remain a challenge for us because of the challenges around our infrastructure. Again, that is one of the challenges we have put in with the health planners around identifying it as a risk, giving us recommendations but also how it caveats our implementation plan because we probably will not be able to go as quickly as all the jurisdictions but how can we go as quickly as we can. But, yes, it is integral to providing joined-up care. It is demonstrated in most health problems.

Deputy G.P. Southern:

What size budget, how much of the £32 million have we got on digital that is coming your way?

Director General, Health and Community Services:

It is not a defined envelope, which is great. It is about what we need so we are being enabled to be able to set exactly what our request is. I am not saying we will get it but there are no boundaries being put around that. It is very much the directive of what do we need to provide sustainable health for the next 20 years, recognising that there is a big digital ask in that.

Deputy C.S. Alves:

As technology is constantly being advanced, how well does the Jersey Care Model maximise the potential for ongoing implementation of digitally enabled care?

The Minister for Health and Social Services:

When you ask that question, what comes to mind for me is that in people's homes we can provide them with something that can take their blood pressure, can sense whether there is movement in the home or whether the person has remained in bed when we want them to be up. There are all sorts of home technology that I think can assist the people who are responsible for looking after frail and elderly in their homes.

Director General, Health and Community Services:

So we want to be able to prescribe without patients coming into hospital, we want to be able to see digital images without patients coming into hospital, we want to be able to share that information between clinicians. We want call and check systems that are digitally enabled that do not require people having to wear cumbersome objects around their neck and if they fall over and it falls out of reach. We are looking at all of the latest innovation around the delivery of healthcare and that is

what we want for Jersey. If I am talking from an acute perspective, and it was a big conversation yesterday, having been and seen some fantastic hospitals, we want a digitally-enabled hospital.

The Deputy of St. John:

You have been to Bristol, have you?

Group Managing Director, Health and Community Services:

No.

Deputy C.S. Alves:

This all sounds great and Deputy Southern mentioned funding but there are other resources, like skills of people, to realise the digital vision for the Jersey Care Model and over what timescale have these been defined?

Director General, Health and Community Services:

We have the skills and the people, absolutely. We do not have a deficit in that. A deficit is around our infrastructure. The modelling that we have asked for is around the implementation over the next 5 years, 3 to 5 years, of the model, if the model is approved. If the planners say that it has got legs, if the Assembly says, yes, we support this, then what we have asked for is an implementation side by side around the clinical and operational implementation with the digital implementation. They have to go hand in hand. But it is our key risk.

Deputy K.G. Pamplin:

That has to be resourced as well because as we have seen with the Tax Department introducing a new digital way of doing something, it is a way of life than has been done for many times put not only stress and pressure on the team trying to deliver that but the team trying to do the transition phase and dealing with the front end as well where customers are coming in highly stressed. So if that is not properly resourced then the mental health pressures that puts on the people delivering it, we just go back round and round in circles. If that is not fully resourced and funded, we create even more stress.

The Minister for Health and Social Services:

You are right, we have got to learn from that.

The Deputy of St. John:

How well developed are the discussions with the Justice and Home Affairs Department in relation to their aspiration to develop a digital patient record system for which they have been funded £667,000?

Group Managing Director, Health and Community Services:

The chief ambulance officer sits on our clinical and professional senate and they are a core part of our working groups. They particularly focus on the community part, intermediate care and on the primary care and on the front door of our hospital. So they are talking to us about how do we align our digital aspiration to make sure that there is interoperability, we can communicate between systems, there is continuity, there is no reverting back to separate strategies and separate papers, so we are trying align our ambition to make sure that it is consistent with the J.C.M.

The Minister for Health and Social Services:

Can you say something generally about the senate and what its role is?

Group Managing Director, Health and Community Services:

Yes, as part of the, I guess, scrutiny of the Jersey Care Model and what we envisage in any strategic change in Jersey in health and care, we have constituted a clinical and professional senate whereby our clinical and professional leaders will come together to look at the proposals put forward under the J.C.M. in a scrutiny perspective. So they are not thinking from an organisational perspective, they are thinking as a professional. "I am a lead doctor, I am a lead social worker, I am a lead O.T. (occupational therapist), physio. This is what I think about what I am seeing and this is my view about what we are proposing." That is part of our assurance and our assessment. Is it just Caroline and I and others who are group thinking in this and what do our actual clinical professional leaders think about our ideas?

Director General, Health and Community Services:

We can share that with you. So we very early on put in a governance structure so as Rob says, it is not the Caroline, Rob and Patrick, Rose and Minister show. We can share that with you. It shows the steps that we go through so that we have got some probity around decision making when we do come to make actual decisions.

The Deputy of St. John:

That is reassuring.

Deputy M.R. Le Hegarat:

Okay, we will move on to financial models now.

Deputy G.P. Southern:

I have got the indicative costs over the next 5 years, can you give us any more details apart from indicative costs, which is what we are going for? This apparently is extra to the Government Plan

and is it likely to be funded by the H.I.F. (Health Insurance Fund) in order to deliver in this transition period? Can you tell us any more about what the financial model is? How we are going to pay for this.

The Minister for Health and Social Services:

Again, I know all of that has been considered by the panel so I think you have said it. That is an aspiration, that is a thought of how this could be done, and we have asked the health planners to report back to us in detail on how funding can be arranged.

Deputy G.P. Southern:

But you must have given them a range of options. For example, if we are talking about free access to your G.P., are we talking about 30,000 people? Are we talking about a set of people who have particular long-term illnesses perhaps? Are we talking about the old or the young? Where are the parameters? You set them so that they can stress test it and say: "If you want to do this, this will cost you X."

[11:30]

The Minister for Health and Social Services:

Yes, we have not excluded any group. Whether you have said look at those on low income, look at those who have not been here 5 years and not eligible for benefits, look at children, look at those with long-term conditions. So all groups are under consideration.

Deputy G.P. Southern:

I am stuck with where to go with that. That is good. There was a follow-up in my brain, it may come to me yet. Overall, are you looking at spending more money basically is the question I wanted to ask because we know … you are saying we are inefficient at the moment, we are spending too much, and it is going to keep going up. Now it is going to keep going up because we are going to live older and hopefully healthier and there is a saving being made but is the overall package still going up is the question I want to ask.

The Minister for Health and Social Services:

I know when we went around the Parishes, our director general was saying that so much of the costs that are presently in hospital services could be released and be used to deliver care in the community. I would hope that that would be the case. But the health planners will tell us whether that is pie in the sky and give us a better idea of how these things can be costed.

The Deputy of St. John:

So if it is pie in the sky, what is your plan B?

The Minister for Health and Social Services:

To me it is obvious that there will be costs that could come out of the hospital. If we are delivering services differently and the hospital is not bringing people in that do not really need to be in that setting, then there are cost savings there. Ultimately, I believe for the longer term, surely the experience of health systems throughout the world that costs rise because people live longer. They have more treatments available and the expectations of populations from a health service. Quite rightly. So Governments just about everywhere in the western world I think have needed constantly to build their health budgets. I do not think Jersey will be in any different position in the longer term.

The Deputy of St. John:

That suggests that you do not realise significant transfer of funding into the community from presumably changes in direction for staff and for facilities that have moved into the community. If you do not achieve that transfer, have you got a backstop with additional funds or will you have to go through the process of the Government Plan?

The Minister for Health and Social Services:

We do not have a reserve.

The Deputy of St. John:

You have got the H.I.F. but once that is used that is used.

The Minister for Health and Social Services:

Yes, you are right but the H.I.F. is a substantial resource.

Deputy G.P. Southern:

You say in your document, I think, that £50 million out of £92 million surplus is acceptable but any more would have to be seriously looked at because you are then talking about running down the H.I.F. so it does not exist anymore. Are we back on the field of where is the health charge coming and when is it coming and how will that be structured? Because you are going to need to do something. If the H.I.F. fades out of the picture, then what next. Is that a plan?

The Minister for Health and Social Services:

There are no detailed plans of that but can I ask our director general perhaps to …

Director General, Health and Community Services:

So we have made some assumptions around the implementation of the model and we recognise that we will need additional funding because there will be double running because we will not be able to just turn on a switch. In order to deliver it safely we have to have that double running period, which is why we want to access the H.I.F. funding. Absolutely those figures are not particularly scientific. We are making an assumption and we have asked the health planners to stress that. But when I look at what we spend on care, for care that does not need to happen within our walls, you can see significant efficiencies. We delivered £5 million S.I.P. (service implementation plan) last year. We are on track to deliver £9 million S.I.P. this year. We have already delivered £5 million of it. That shows you that we are fairly inefficient around our delivery of care. But if we do not we think there are significant income generation opportunities. So echoing the Minister, if you look at all health economies, absolutely costs are rising but it is how you distribute those costs differently and how you generate income back into the economy. We have spent a significant amount of money on other providers outside of our borders that we think we can bring that work back. We also think that we are able to make a significant offer to other jurisdictions because once we have sorted out our waiting times, and we have committed that we will have proper substantive waiting lists by 1st April, we think we have capacity to offer diagnostic capacity to other jurisdictions, elective capacity to other jurisdictions and start to generate quite significant income. So we do think there are opportunities to utilise funding differently but we cannot sit here and say it is definitely not going to cost more. But that is the work of the health planners, to give us those assumptions around the economic framework.

The Deputy of St. John:

Do you have it in mind to expand the private offer so that people offshore might want to come into the Island.

Director General, Health and Community Services:

Absolutely. At the moment our offer is not fit for purpose. Our offer is based on wait and private offers should not be based on wait, it should be based on an environment of choice of surgeon, not because you can be seen quicker. Our aspiration, and we will have it in place this year, is that in the specialities where we are not compromised by recruiting surgeons, although we are looking for visiting surgeons for that, that our private and public offer will be similar. So you will not be forced to take the private option on this Island because your public wait is extreme. We aim to offer responsive care, that is the work we are doing through the management of our waiting lists so that we can understand how we are utilising our capacity. At the moment we are not doing that right but we are making significant inroads into that. We want to have a private offer that generates income to the state so that we can push that money back into public provision. At the moment we do not.

The Minister for Health and Social Services:

But I want to make sure that any private offer does not prejudice the local population.

Deputy G.P. Southern:

Can I suggest that G.P.s are more expensive in terms of employing doctors than people in hospital generally? Yet you are saying we can take people out of the hospital and deliver primary care to them through G.P.s who are more expensive. Also you are talking about we are too centric on … centred on the hospital and you are talking about having hubs through the Island and it seems to me, again, just in terms of the costs, if you go from one centre to 3, 4, 5 centres then you increase your overheads again. Have you thought those 2 issues through?

Director General, Health and Community Services:

Absolutely. Exactly what the Minister says. G.P.s are expensive on this Island because of the way we incentivise them. So I go in to see the G.P. and I have to have a plaster put on me, the G.P. has to put the plaster on me in order to get funded so there is no incentive for them to have a multidisciplinary team of a healthcare assistant and a nurse and a therapist. We have created that system and that is what we want the model to address by pushing our staff out. We are not looking to have multiple hubs. We were in the early days then we recognised, and you were very challenging about that, that we could not afford that. But we do have a lot of the G.P. surgeries, and Rob is more informed to this, are hubs in their own right, have fantastic facilities that in other jurisdiction would be considered a hub. We just need to enable them to deliver care. We need to commission differently.

Deputy G.P. Southern:

Okay, I hear what you are saying. That makes sense to me. Just briefly because I have noticed it, and we mentioned it, and again it is one of the groups of people that always get ignored that do not get noticed, the use of carers, the volunteer, family or neighbours, whatever, again their income and their permission to be a carer comes through Social Security. To what extent have you had proper dialogue with them about how can we include carers in our packages?

Group Managing Director, Health and Community Services:

It is one of our workstreams. We have had to engage the Care Commission as well because we are seeing some real conflict in our ambition around personalisation, and carers come into that because carers play a big part. At the moment it is really difficult to co-ordinate that through the rules that we have in commissioning through H.C.S., through the C.L.S. (Customer and Local Services) framework benefits and for long-term care fund and then the Jersey Care Commission around employment of carers or recognising those personalised offers. So we are working on that. That is part of our workstream to think about how could we do this differently, how do we incentivise personalisation and how do we recognise carers as part of that? Because we learned through

Parish visits that a lot of the support that people are getting through their informal and formal care network would constitute what we think is partly statutory provision, what we should be providing and we should be supporting. So we need to change the current to something that looks much more flexible, as much more oversight and is able to navigate through those 3 departments of Government.

Director General, Health and Community Services:

And a lot of care is provided by elderly people and a lot of volunteers are elderly people and we, as a government, cannot be sustainably dependent upon that. What really came out of the roadshows, which we had not thought about, was we had not thought enough about carers and it is because we do not measure it. It is that old adage, you do not measure it, you do not value it. But nearly every roadshow we had carers going: "I am doing this for free so you are talking big talk but what about me?" It is a real message we took away.

Adviser 2:

We have talked about cost and we have talked about the opportunity benefit, there is an awful lot that is done by volunteers on this Island. Turning that into a sort of value-for-money exercise, to what extent can the stress testing, particularly when comparing what we have here and what the plans are for the future here, against other similar populations and similar Island groups, to what extent can that tell you whether or not the aspiration offers good value for money for Jersey residents? Value for money being both cost and outcome and taking into account stress.

Group Managing Director, Health and Community Services:

We hope the stress testing says - we hope - is that at the moment we are going from zero to 100 really, really quickly. We are effectively going from an informal or formal care network that fails and then there is nothing that can stop it catapulting towards very expensive care, even in a hospital, or a care home or a very expensive package of care. What we hope that the J.C.M. will say is if you invest in something that is more robust at that lower level and is more targeted in its focus for patients and clients who are stratified better and you really start to co-ordinate the care better, you will have a better financial outcome because you are preventing that longer term very expensive situation happening. But you are also targeting investment in the area that recognises where that low-level support, that preventative action, is really needed. At the moment, most of our resources, we see it in mental health, it is set up at the point of crisis and the point of dealing with the crisis rather than how we stop the crisis happening. So we really hope the J.C.M. will say: "If you invest in this part of the pathway you will reap significant benefits in avoiding that really highly costly part at the end.

Adviser 2:

So what you are describing is an overall improvement in value for money. So putting costs to one side, describing an improvement in value for money …

Group Managing Director, Health and Community Services:
And outcome.

Adviser 2:
… in implementing the Jersey Care Model?

Group Managing Director, Health and Community Services:
Yes.

Director General, Health and Community Services:
Getting both ends right. We are really good at the fixing in the middle. We are just not so good at the other end and we think that is what it will help us to address.

Deputy M.R. Le Hegarat:
We will move into the final section now.

Deputy K.G. Pamplin:
We have got 15 minutes so we will see how many we can whistle through here. It is like doing my old job. The commissioning framework, which is part of this, in October the C.E.O. (chief executive officer) of the States told the Chamber of Commerce that outsourcing would not work in Jersey because there is not the market for it in such a small island. Response to that because that is very interesting?

The Minister for Health and Social Services:
Sorry, who made that statement?

Deputy K.G. Pamplin:
The C.E.O., the chief executive officer, I believe his name is …

The Minister for Health and Social Services:
Right, okay.

The Deputy of St. John:
Mr. Parker.

The Minister for Health and Social Services:

That outsourcing would not work in the Island.

Deputy K.G. Pamplin:

Just quoting him what he told the Chamber that outsourcing would not work in Jersey.

Director General, Health and Community Services:

Outsourcing healthcare?

Deputy K.G. Pamplin:

Just in general. He was talking about in all the projects by the looks of it, if you look at the transcript. But the point here is when the C.E.O. whether he means healthcare or if he means … he is saying something that is fundamentally part of what you are proposing. Do you not see whether that then creeps into the submissions that we are hearing that people are saying: "Hang on a minute, the big cheese has just said that that is not going to work" and I am just curious of what your view is and comment and your response to that? Looking at your faces it is telling me lots.

The Minister for Health and Social Services:

But I mean the healthcare in Jersey means G.P.s, it means hospice, it means family nursing.

[11:45]

It means so many of the voluntary groups that have been set up as well as government provided services. I do not want to change that at all. I think that is so valuable. Our community is invested in its health and it is invested … we invest in each other by the voluntary service we give. Absolutely we do not want a model where government is the sole provider.

Deputy G.P. Southern:

But if we talk about 24/7 care in the home, we already have to go to the U.K. companies to supply that. So in a sense we are already outsourcing that particular demand to a U.K. company rather than relying on our home-based resource.

Director General, Health and Community Services:

That is why we are proposing the model. I do not think we ever talk about outsourcing. We are share sourcing. It is exactly what the Minister said. We are partners. Islanders should not want us to be the dominant partner. It should not want government to be the dominant partner. It is a collaboration in partnership.

Deputy K.G. Pamplin:

That is good, thank you. Moving on. Will the financial model include service delivery costs for the care model and the potential costs of supporting the infrastructure?

The Minister for Health and Social Services:

I am sorry, again, I missed the first part of your …?

Deputy K.G. Pamplin:

Basically will the financial model that we are all waiting to see include the service delivery costs and the potential costs of the supporting infrastructure, that means digital …

The Minister for Health and Social Services:

Yes.

Deputy K.G. Pamplin:

Okay, thank you. Is there a clear programme plan in place for the development and the delivery of the care model or is that still in train?

Director General, Health and Community Services:

We are talking through various implementation plans but, yes.

Deputy K.G. Pamplin:

What is the timeline of the progress of that and when do you think it will be completed?

Director General, Health and Community Services:

It is the end of March. At the end of March, we will have one version of it.

Deputy K.G. Pamplin:

Sorry, Caroline, I am going to rattle through. Will you be able to provide us with that plan as soon as it is finished? Even confidentially?

Director General, Health and Community Services:

Yes.

Deputy K.G. Pamplin:

And we can expect that end of March?

Director General, Health and Community Services:

End of March we get the report and it will have to go through the various iterations so probably April but we are happy to share versions of what we are talking about now because we are looking at various versions of the implementation plan but they are not set in stone. The first one was rubbish. The second one a bit less rubbish. But we are happy to share them with you so you can look at them.

Deputy M.R. Le Hegarat:
That would be good.

Deputy G.P. Southern:
And something that is not rubbish.

Director General, Health and Community Services:
We will let you know. It is iterative so …

The Minister for Health and Social Services:
Please understand that, yes, they are still being worked on.

Deputy K.G. Pamplin:
What are the resourcing assumptions because we have heard a lot of assumptions being said today that have been made to ensure the ongoing delivery of healthcare as usual? There are points in there and I know you have touched on it. But also embark on the major transport programme that this is going to undertake. I know we have touched upon it but it is a very important point this. So what are those assumptions? We kind of need to start hearing those things now because it is the do or die this for me.

Director General, Health and Community Services:
So I am not sure what you are asking me sorry. Could you say it again?

Deputy K.G. Pamplin:
What are the resourcing assumptions that we keep saying we have made these assumptions, we have made these assumptions, these are the assumptions, these are the assumptions, what are they that have been made to ensure - to ensure - that this works? That the ongoing delivery of healthcare as it is at the moment continues. If there is a crisis, a virus suddenly overtakes you can manage that, manage the day to day, and embarking on a major transformation programme. Put the hospital to one side because that is another thing. But I have just heard over and over again there are assumptions, assumptions; we need to start hearing what they are.

Director General, Health and Community Services:

None of our assumptions will compromise the delivery of the healthcare. That is our main priority, that is what we are recruited and paid to do. The care model, the testing is almost happening separately now and we are carrying on with our delivery. The main assumption we have made is that we really need money and that is why we are going to petition to access the H.I.F. to do some double running but the whole point of doing that double running is maintaining safety and quality so that we do not just switch from one model to the next. So I think that will be one of the major frameworks that we have, to ensure that care continues as normal. But we are not going to see an instant reduction of capacity. We are not suddenly going to close the hospital. We have really robust business continuity plans that we have to enact almost daily predominantly because of our I.T. (information technology) issues. So we are more than confident that we can deal with any potential incident that would come on Island.

Deputy K.G. Pamplin:

That is the key thing that we need to see as part of this process is those plans.

Director General, Health and Community Services:

Absolutely.

Deputy K.G. Pamplin:

Those assumptions written down, diagrammed, explained, as well as the continued changes of governance in healthcare.

Director General, Health and Community Services:

That runs along the top of the implementation. So we are working through implementation plans and that is one of the mandates that we had with the organisation that is helping us, is as we drop each pathway out what is … what is the belt and braces around that to ensure that we can still deliver safe qualitative care.

Deputy K.G. Pamplin:

How is it going to be sustainable? How is all of this going to be sustainable? How can you sum all this up? How is it going to be sustainable?

Group Managing Director, Health and Community Services:

From a workforce perspective or a managerial?

Deputy K.G. Pamplin:

The whole thing.

Group Managing Director, Health and Community Services:

We are going to get a clear output that tells us this is what you need to deliver the model and this is what we need to run the model. So we might need to make some adjustments to our structure, our transformation, our modernisation team. We will adjust as to what the delivery plan is telling us we need to. But we have got to keep the B.A.U. (business as usual) going as normal and we have got to transition ourselves into the different stages of the care model ambition if it is approved. So we need to look at the outcome of the stress testing and consider then how we constitute ourselves to deliver the B.A.U. moving forward.

Director General, Health and Community Services:

It is a journey. So I think the care model that if it is agreed and delivered in 5 years will be really different to what we are talking about today because it will progress and it will be an iterative process. So the real clear mandate they have been given is this has to be sustainable for Jersey because if we are going to invest money then we need to invest in public money wisely and safely. It is a real key metric of the stress testing. Will it be sustainable and robust?

Deputy K.G. Pamplin:

You touched on something there. How do we retain the uniqueness for Jersey? How did this become a Jersey healthcare model? Because that, at the heart of it, is really critical. We are an Island. We are not the N.H.S. We have what we have and it seemingly works in some areas. There are some areas which we know it does not, so how do we … we are assured that this is not going to un-Jersify the system that we have had in place that we do not want to lose and go down a privatisation route or a N.H.S. route or an American route or whatever route you want to pull out of the sky, but how are we going to retain and make this Jersey-fied?

The Minister for Health and Social Services:

Because this has not been modelled just by a small group, that there has been engagement across the board with everyone involved in the healthcare sector. That is what Jersey-fied means, if you like. Please remember that our clinicians are heavily involved perhaps unlike in the past. They will tell us if we are compromising care because they are involved in it. As the managing director said, they are the stress testers, they are doing the scrutiny, they are on the senate that has just recently been set up. They will tell us if it is not fit for purpose.

Group Managing Director, Health and Community Services:

That is why we want to make sure that the partnership of purpose across the health and care system in the Island reflects the D.N.A. of the Island. So we do not want the voluntary sector to be seen as a state provided arm. They are the voluntary sector and this is what they deliver and these are the

services that they deliver within a long-term framework with funding recognised for government provided services and funding that they do for charitable purposes. The Parish-based system enabled to deliver what it wants to deliver with its objectives and then our statutory provision clearly understanding what it needs to do. Primary care system specified to what it needs to do but this is not about changing the provision commissioning function within the Island drastically to fit another jurisdiction. We would keep and retain what we think is the unique Jersey element.

Director General, Health and Community Services:
And the ethos. I know it is not the U.K. but I have worked all over the U.K., what is so unique here is time to care across all the sectors; is that in Jersey clinicians have time to care. Precious.

Deputy K.G. Pamplin:
Final question would surprise you, it touches on mental health from me. Last year we released our review, you accepted most of our recommendations. It has been almost a year since then, how does the success or otherwise of the mental health implementation informs with lessons learned for taking the broader care model forward to full implementation? Surely that is going to inform. Can you give us some insight to that?

The Minister for Health and Social Services:
To use the phrase there is no health without mental health. It is a key part; it must be treated equally with …

Deputy K.G. Pamplin:
No, I am talking about plans that we started last year when we said: "Here you go, 21 recommendations." You fully accepted them, we put all that funding in the Government Plan, what I am saying is the transformation that is needed to turn that service around, how are you going to learn the lessons from that as an ideal for this care model?

Group Managing Director, Health and Community Services:
We already are.

Deputy K.G. Pamplin:
Because there are problems we are encountering with mental health still. The issue of improvement, the building infrastructures, capacities …

Group Managing Director, Health and Community Services:
The model, the concept for mental health and what we submitted in the Government Plan is absolutely a precursor for what we thought the J.C.M. would look like because it is about prevention

and intervention being right and it is about all of the community facing aspects that stop hospitalisation in mental health. So the remit is consistent with physical health. There is a distinct difference though in that the physical health component or healthcare is in a different place of stabilisation to the mental health. So the concept is consistent but we cannot judge the year one of the mental health improvement plan as the barometer of how the physical part of our system is going to be changed. They are at different places.

Deputy K.G. Pamplin:

But it will give you indications of what the possibilities will probably be.

Group Managing Director, Health and Community Services:

The plans and aspirations are consistent. Multi-professional co-ordination linking in housing, employment, the wider fabric of community about how you help someone because that often prevents ill health; physical or mental. It is all very consistent. Community out-of-hospital care, very consistent. But we are starting in a very different place of mental health services. This is the first year that we have parity of esteem and that we are able to say that there is no health without mental health and we have tracked that with funding mainly because of the support we have received but they are at different staring places we must say.

Adviser 1:

In terms of the actual implementation of that work though how are you capturing the way that is being rolled out practically on the ground by the actual resources both programme management wise and dealing with service users?

Group Managing Director, Health and Community Services:

We already are. We are at stage one of that. So we have already established part one of the crisis prevention intervention service, so we are monitoring all the activity within our Listening Lounge, which is very much about that prevention. What activity they are seeing. We have adjusted the pathway for the Listening Lounge so that they are being diverted to psychological therapies better. We are about to look at how we can get stage 2 with the street triage, which we think will make a big difference to the States of Jersey Police intervention. By quarter 3, which we have set within our plan, which we have shared with Scrutiny, we want to deliver the more robust community crisis prevention and intervention service where the liaison function of our community team will deliver something different. So we are already looking at caseload, how do we adjust, how do we start to stratify patients better? So that is all within our 2020 plan. We have already started monitoring that change in the way we will deliver those services.

Director General, Health and Community Services:

There is a real clear programme management approach which is that we have an overarching mental health improvement plan but underneath that, we have task and finish groups. We had a task and finish plan which pulls down aspects of the mental health improvement plan that are not accelerating at the pace we want to. Have really clear outcomes, really clear measures for our deliverables. Rob meets with that team every week, I meet with them every month with the Assistant Minister, Steve Pallett, and hold the service lines to account and also support them to deliver. So we have really learned from the conversations we have had with Scrutiny around some of the conversations you had before about: "Where is the plan, where is the plan, you are talking the good talk, where is the plan?" That is the methodology that we very much wanting to use around the rollout of the healthcare. So having an overarching plan but underneath that we are going to have to have significant programmes of work with clear outcomes and clear deliverables that we monitor and that we share with Scrutiny so that we can get more challenge back around that.

Adviser 2:
Given the scale and accepting mental health and physical health, very different starting points and everything else, but the scale of the 2 things are completely different. What is that telling you about the skills that are currently within your team of people, your departments, to do the delivery?

Director General, Health and Community Services:
We absolutely recognise that we will need a partner to help us bring delivery. This is a huge programme of transformative work. We do not have the workforce to do what -- the challenge is run business as usual and do this huge piece of transformation. So we recognise that as part of that implementation plan, and that will be part of the cost, that we will need a team to help us deliver.

Group Managing Director, Health and Community Services:
And we need to model what we have constituted within that area. So it is telling us that we needed to have what we have now, which is a psychiatrist as part of the core service delivery, not an ophthalmologist, that we needed a lead social worker, we needed a lead nurse. You need professional and clinical leadership that was able to deliver the care that is required in the transformation that is required and so we will need that across all of our physical health pathways as well. So it is good learning.

Director General, Health and Community Services:
But we need proper programme management.

Group Managing Director, Health and Community Services:
And programme management.

Director General, Health and Community Services:

So we have got a programme manager over mental health, a proper programme manager, because we are health but we are not programme managers. For this we will need a team in order to be able to ensure that we are delivering according to timelines and that we are on track around outcomes really. That is what we need to be tight on and we need that with …

[12:00]

Deputy G.P. Southern:

Can the offer to take a look at the latest version of the graph in confidence, can you release that?

Director General, Health and Community Services:

In confidence, yes, certainly.

Deputy G.P. Southern:

Whatever it is, 1.3.7 point whatever. That would be great because that would be useful now.

Director General, Health and Community Services:

Yes. Like show you the latest version of the implementation plan but if we can have that confidentiality that would be good.

Deputy M.R. Le Hegarat:

Perfect. I think that has brought us to a conclusion and we look forward to the second brief in relation to the Jersey Care Model. I would like to thank all the people around the room really for having attended and for those who are listening to us on livestreaming and the members of the public that have come in today. Hopefully people will begin to have maybe a better understanding of where we think that the Jersey Care Model will take us. Thank you very much.

The Minister for Health and Social Services:

Thank you, Chair. We value the opportunity and we look forward to your reports.

[12:01]