WRITTEN QUESTION TO THE MINISTER FOR SOCIAL SECURITY
BY DEPUTY G.P. SOUTHERN OF ST. HELIER
ANSWER TO BE TABLED ON MONDAY 30th NOVEMBER 2020

Question

"Will the Minister advise when she expects to agree contracts for the delivery of the Jersey Care Model with G.P. representatives; and will she provide a detailed breakdown of the services to be delivered with the £6.6 million of additional investment required to fund the Jersey Care Model in 2021, especially for those vulnerable patient groups as identified in P.125/2019?"

Answer

As Minister for Social Security, I am currently responsible for discussions with GP representatives regarding a scheme which will improve access to GP services by reducing financial barriers for people with a low income. Discussions are on-going and progress is being made. This work will offer insight to the programmed implementation of the Jersey Care Model as new models of care and funding mechanisms are developed in the coming years. However, I am not involved in negotiations with GP representatives in respect of the delivery of the Jersey Care Model itself.

The £6.6 million of additional investment identified in the 2021 Government Plan falls under the responsibility of the Health and Social Services Minister.

The additional funding to support access to general practice for low income patients as proposed in the 2020 Government Plan, and re-iterated in the Assembly decision in respect of P.125/2019, does not form part of the £6.6 million identified in the 2021 Government Plan as part of the Jersey Care Model budget. This project will initially be funded from the Health Insurance Fund.

The Health and Social Services Minister has provided the following information on the £6.6 million of additional investment in 2021:

The detail of the investment is provided in the documentation of P.114/2020. Details of the financial case can be found on page 418 and 438, and for the annual detail of modelled recurrent expenditure, please refer to page 477 to 481 of the electronic proposition documentation. Below are extracts of the relevant tables.

Summary of additional re-current and non-recurrent expenditure:

Table 4.5b: Summary of cost and benefits for JCM

Description (£m)	2020	2021	2022	2023	2024	2025	Total
Additional non-recurrent revenue expenditure associated with the do something case	0.0	2.9	2.9	2.9	2.9	2.5	14.1
Additional capital expenditure associated with the do something case not captured above	0.0	1.3	0.8	0.5	0.4	0.0	3
Sub-total: Non-recurrent investment	***0.0***	***4.2***	***3.7***	***3.4***	***3.2***	***2.5***	**17**
Expenditure impact associated with the selected payment model option	0.0	0.0	0.0	0.0	0.0	0.0	0
Additional recurrent expenditure associated with the do something case	0.0	3.7	9.2	18.0	30.2	37.9	99
Benefits from the do something case	0.0	0.0	-3.8	-14.8	-29.0	-50.5	-98.1
Sub-total: Net recurrent benefits from the do something case	***0.0***	***3.7***	***5.4***	***3.2***	***1.3***	***-12.6***	**1**
Net recurrent and non-recurrent impact of the JCM	**0.0**	**7.9**	**9.1**	**6.6**	**4.5**	**-10.1**	**18**
Cumulative impact	**0.0**	**7.9**	**17.0**	**23.6**	**28.1**	**18.0**	**94.6**

In 2021, in addition to the recurrent investments contained within the ‘do something’ financial modelling (£3.7m), a number of non-recurrent investments are also required. These fall into two main categories, which are:

1. **Programme costs:** These are the costs associated with the transformation programme required in order to deliver the JCM (as described in the Management Case). It is expected that this transformation programme will operate over a five-year period and will include the following:

    a. **Programme Management Office (PMO) support** in order to plan and track delivery of the programme and manage risks and issues.
    b. **Organisational Development (OD) support** in order to design the new operating model associated with the JCM and embed the new ways of working that will be required.
    c. **Communications support** for both internal and external communications on the changes in the JCM.
    d. **Digital transformation subject matter expert(s)** in order to deliver those elements of the programme.

2. **Digital non-recurrent investments:** The JCM describes the requirement for several new digital tools for use across the health and care system. These include investment required for integrated care records and JCR, core record systems, hub and micro services, and analytics. These investments have been split between non-recurrent revenue and capital expenditure lines.

In addition to this, further non-recurrent expenditure has also been assumed to provide **contingency** for the programme.

The costs of each of these elements have been estimated at a high level based on similar examples from elsewhere (see section 4.2.3 for further details). The non-recurrent expenditure associated with these are shown in the table below.

Table 4.5a: Non-recurrent costs to deliver the JCM

Description (£m)	2020	2021	2022	2023	2024	2025	Total
Programme costs	-	2.1	2.1	2.1	2.2	2.2	**10.6**
Digital non-recurrent investment	-	0.3	0.3	0.3	0.3	-	**1.3**
Digital capital investment	-	1.3	0.8	0.5	0.4	-	**3.0**
Contingency	-	0.5	0.4	0.4	0.4	0.3	**2.0**
Total non-recurrent expenditure	-	**4.2**	**3.7**	**3.4**	**3.2**	**2.5**	**17.0**

The order of service delivery is described on p.174 of P.114/2020:

Implementation planning

In developing a realistic and achievable implementation plan we reviewed the deliverability of the JCM

In light of the emerging challenges the island is facing post COVID-19, phasing of the programme has been amended to allow stabilisation of the platform within Jersey and internationally.

HCS will still look to deliver the JCM as originally presented and reviewed within this report, however rollout of the programmes will be phased in three risk assessed tranches.

Assessment of deliverability	Tranche 1 (2021)	Tranche 2 (2022-2023)	Tranche 3 (2023-2025)
The ambition to the implementation has been reset recognising the need to: • Address the findings in the JCM and particular areas that are key risks e.g. having the right workforce ready and skilled • Learn lessons from COVID-19 in terms of the need of the model • Have capacity in the immediacy to respond to any potential Wave 2 COVID-19 and potential winter pressures • Focus on efficiencies in the acute to reduce bed numbers to support the 'Our Hospital' programme	• **Detailed planning** – assessment and modelling of need including supporting policy review • **Foundations** – establish the supports for the workforce to be successful (e.g. public health function, digital) • **Acute** – driving efficiencies as a part of GoJ requirements, best practice and Our Hospital build • **Community/Intermediate Care**- focus improving health & social care pathways through an enhanced single point of access and use of Tele-care • **Workforce** – creation of an island wide workforce plan to support implementation of system wide changes in tranche 2 and beyond • **Communications** – establishment of public, patient and wider stakeholder groups to inform design and delivery	• **Commissioning** – implement a commissioning framework with community and social care partners, building on the care at home initiative • **Acute staff** – community clinical team to support shift of model away from core acute, including nurse roles, etc. • **Community/Intermediate care** – launch schemes which involve co-designed services with external partners, including rapid access team and enhanced reablement services • **Detailed planning** – assessment, modelling and co-design of primary care framework, e.g. long-term condition management • **Staff training** – launch of long term staff training programme to ensure model of care delivery	• **Acute** – continued service improvement programme to support delivery of services in line with best clinical practice • **Primary care** – co-designed pathways for management of patients with long-term conditions to be rolled out • **Community/ Intermediate care** – fully implemented revised social and intermediate care model with a reduction in placement prevalence