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Health and Social Security Scrutiny Panel

Jersey Care Model

Witness: The Minister for Health and Social Services

Tuesday, 29th September 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

Deputy H.C. Raymond of Trinity, Assistant Minister for Health and Social Services (1)

Senator S.W. Pallett, Assistant Minister for Health and Social Services (2)

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

Ms. R. Naylor, Chief Nurse, Health and Community Services

Ms. J. Poynter, Associate Managing Director, Modernisation, Health and Community Services

Dr. P. Armstrong, Medical Director, Health and Community Services

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

Mr. S. Mair, Treasury and Exchequer

[12:02]

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

... of our public hearings being done virtually. Hopefully the public will be able to hear the whole panel meeting. We are meeting for a public hearing of the Health and Social Security Scrutiny Panel. This afternoon we are meeting with the Minister for Health and Social Services and I will ask the panel to introduce themselves and then I would ask the Health Department to introduce whoever is going to contribute to this afternoon's proceedings. Thank you.

The Minister for Health and Social Services:

Thank you, Chair. We have got some of our team around this table and others are online, but if I can introduce myself, I am Deputy Richard Renouf, the Minister for Health and Social Services and if I can turn now online to my Assistant Minister.

Assistant Minister for Health and Social Services (1):

Good afternoon. Hugh Raymond, Assistant Minister for Health as well. Thank you, Richard.

Assistant Minister for Health and Social Services (2):

Senator Steve Pallett, Assistant Minister for Health and Community Services. Hello.

The Minister for Health and Social Services:

Okay, so around the table here, can I ask Rob to start?

Group Managing Director, Health and Community Services:

Rob Sainsbury, Group Managing Director.

Chief Nurse, Health and Community Services:

Rose Naylor, Chief Nurse.

Associate Managing Director, Modernisation, Health and Community Services:

Jo Poynter, Associate Managing Director.

The Minister for Health and Social Services:

We are about to be joined by Patrick Armstrong, our Medical Director. The team online, Caroline, can you introduce yourself?

Director General, Health and Community Services:

Hi, Caroline Landon, Director General, Health and Community Services.

Mr. S. Mair, Treasury and Exchequer:

Stephen Mair from Treasury and Exchequer. Good afternoon.

The Minister for Health and Social Services:

Have we got anyone else?

Director General, Health and Community Services:

No, just here at Broad Street, thank you.

The Minister for Health and Social Services:

Okay, many thanks.

Deputy M.R. Le Hegarat:

Perfect, and I should have introduced, Deputy Mary Le Hegarat, the chair of this panel and Deputy for Districts 3 and 4 of St. Helier.

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

Good afternoon, everybody. Deputy Kevin Pamplin of St. Saviour and the vice-chair of this panel.

Deputy C.S. Alves of St. Helier:

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

Deputy G.P. Southern of St. Helier:

Geoff Southern, St. Helier No. 2 District, member of the panel.

Deputy T. Pointon of St. John:

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

Deputy M.R. Le Hegarat:

Thank you and welcome to everybody that is going to contribute to this afternoon. We will start off with Deputy Pointon who will start with questions in relation to enablers. Thank you.

The Deputy of St. John:

Good afternoon to you all. As Deputy Le Hegarat says, these questions are about enablers and we want to ask what specific progress have you made on 2 of the most obvious enablers, that is digital and workforce, in the last 12 months?

The Minister for Health and Social Services:

Yes, I agree, Deputy Pointon, very significant programmes. There has been progress and you will see in the Government Plan a significant amount of money that has been spent and will be spent next year on digital. Rose, are you in a position to talk more about digital? Jo, yes, of course, sorry.

Associate Managing Director, Modernisation, Health and Community Services:

So specifically in the last year we have introduced the electronic pharmacy management discharge arrangements, so the E.P.M.A. (Electronic Prescribing and Medicines Administration) is up and running. We are currently undergoing the process of the G.P. (General Practitioner) Order Comms for the radiology and working around each of the G.P. practices. They are the 2 specific pieces of work that we have managed to do. There has been lots of other work that you will see from the reports through the COVID process and some of the things that we have had to do rapidly. A lot of electronic systems put in place so that we can do remote consultations, things that we would ...

The Deputy of St. John:

May I intervene there? When we last met it was clear that your aspiration was to have digital systems in place by 2021 and that you would have an electronic patient record in place by 2022. How far down the road are you on those aspirations?

Associate Managing Director, Modernisation, Health and Community Services:

So the E.P.R. (Electronic Patient Record) is out within a procurement process and we still want to hit that deadline of 2022. That is the process that is happening at the moment. Remind me of the first system that you requested information on?

The Deputy of St. John:

You were expecting to be fully digital by 2021.

Associate Managing Director, Modernisation, Health and Community Services:

There is a digital strategy, I do not think it concludes in 2021, that sets out the whole digitisation process. So fully digital is an interesting ambition because it is something that is constantly changing and modern technologies and new systems are coming forward, but we are following that strategy. We have made some great leaps this year as I say around the E.P.M.A. which is the discharge process of ordering digitally through the G.P. systems and we are rolling that work out now as we speak.

The Deputy of St. John:

Okay, thanks for that. Let us move on to the workforce. The J.C.M. (Jersey Care Model) envisages moving a lot of the workload into the community but currently it is not apparent whether there is a comparable workforce in the community to deal with the workload.

The Minister for Health and Social Services:

Deputy, I do not think this will necessarily be an additional workforce but we can use some of our team that presently work in other locations in the community and we can engage with third party providers, perhaps in the charitable sector and commission services from them. This year of course there has been considerable disruption to workforce, but we have also learned some useful lessons and I think we have seen how flexible and fleet of foot a workforce can be when required. I think that bodes well for the future that we can reorganise ourselves. As for the detail, if I may pass over to Rob Sainsbury.

Group Managing Director, Health and Community Services:

In the year one implementation plan under the J.C.M. the workforce baseline analysis and future needs assessment is the main priority for that piece of work. That does not mean that we are not in the process of establishing that now, so we are actively doing that. Our data and systems are not great here around workforce indicators.

The Deputy of St. John:

May I interrupt you, Rob, and ask what are you actively doing now?

Group Managing Director, Health and Community Services:

We are undertaking a baseline assessment as best we can now, so where are we with our current workforce establishments across all of our professional disciplines? Where are the gaps? Where is the targeted recruitment and what do we need to change? If we have got a particular problem around recruitment in one profession are we able to transition that into a different role? That work is being undertaken now. I would say mental health and adult social care are doing quite well in their baseline assessment, so they are well-placed going into 2021. A lot of work is happening within nursing I will ask the Chief Nurse to update on. Our medical staffing is undergoing the same process as well. It is a key part of our implementation plan for the J.C.M. in 2021 to future-proof that workforce requirement.

Chief Nurse, Health and Community Services:

I was just going to add to what Rob said, to say that despite the interruption of COVID to some of our plans this year it has given us an opportunity to stress-test some of the fundamental principles of the J.C.M. so we have had staff working quite differently, as has the N.H.S. (National Health Service) so we are not unique in that regard, but we have continued with the programmes, continued

to recruit into the pre-registration programmes to develop resources on-Island and to do as much as we can do this year with a view that we expand those programmes next year as well, so we start to increase our steady flow of on-Island delivery in terms of new registrants coming into the workforce.

The Deputy of St. John:

Yes, and what actions are you taking to train this new workforce, not the qualified workforce but those people who will have to deliver care on the ground at, perhaps, a lower professional level? What are you doing to ensure that you are home-growing those people?

Chief Nurse, Health and Community Services:

So again through the COVID experience as you will be aware we did recruit over 200 people to our bank and we put them through some specific training, so we did have people who were ready to step up if need be to support the Nightingale if that had needed to be used at that time. A number of those staff are now working on the Test and Trace programme out in the community, but again that has enabled us to look at the initial training programmes for that particular workforce, but also to make sure that our R.Q.F. (Regulated Qualifications Framework) programmes, which are the new vocational training qualifications, are fit-for-purpose in relation to our ambition as set out in the J.C.M. So we do run programmes here locally that will support this particular workforce going forward and we run them up to level 5, which is a registered manager programme. So we can flex those up and down and, as I said, we have tested our ability to do that through COVID.

The Deputy of St. John:

You are running these programmes in-house, are you?

Chief Nurse, Health and Community Services:

Yes, we work with Edexcel, so it is a nationally accredited programme that we run locally in Jersey.

[12:15]

The Minister for Health and Social Services:

Can I just add, Deputy, thinking about mental health workers, that we now have a community crisis team that is working among people, so that is an example of taking our workforce and using them differently. They are trying to address needs within the community before they become acute and we also have the Listening Lounge, which is a commission service, they have recruited staff to address people with lower level needs and are doing so successfully. I think that is also something that is a good pointer to how things might work in the future.

Deputy G.P. Southern:

Can I ask the Minister 2 questions? One, what conversations have you had with H.A.W.A.G. (Housing and Work Advisory Group) or the S.E.B. (States Employment Board) in terms of making sure that you have numbers to fill the posts that you require, and secondly what target do you have to be able to digitally cover G.P.s, district nurses and the hospital? What target have you got to get that in a single system where you can talk to everybody concerned about a patient? How close are you?

The Minister for Health and Social Services:

On the first question, we made a submission to the Migration Policy Development Board, which of course is reporting or has reported and we are due to have that debate in the States imminently.

Deputy G.P. Southern:

Can we see that letter, Minister?

The Minister for Health and Social Services:

I believe it has been provided to the panel on a previous occasion. We can resend it but it will be among your records. As to a complete number for the whole workforce, I think this is going to have to be planned and developed and that is envisaged by the J.C.M. that we will move towards a comprehensive workforce plan.

Deputy G.P. Southern:

But moving towards a comprehensive plan does not enable the J.C.M. to progress, does it? Are we talking phase 1, 2 or 3?

Group Managing Director, Health and Community Services:

It is phase 1. We have clearly outlined in phase 1 of the J.C.M. we will be taking forward the key deficits within the system, so we already have a great deal of this information in relation to what the workforce gaps are, so district nursing overnight, 24/7 community nursing, night-sitters, there are deficits within the domiciliary care market, we need more reablement workers and we already have an understanding of where we have got key professional appointments. That is all targeted within phase 1, but in 2021 we have got to future-proof that. So for the training that we need on-Island for future nurses, future physios, future carers, we have got to build that into our educational offer, our system support offer and to grow and develop and attract that workforce if we do need it externally. That is why we have targeted that as the very first thing that we need to do with the J.C.M. phase 1.

Deputy G.P. Southern:

Where are we with digital communication across the board?

Associate Managing Director, Modernisation, Health and Community Services:

The ambition remains the Jersey Care Record. We are in the process and in the strategy the first bit is to design the links and that is what I was talking about, putting the links across the different systems, across primary care and the hospital secondary care and other services within the system. We are in the process of ensuring we have got the updated equipment and part of the Government Plan is to make sure that we have got the funding for the digital equipment that comes into the new hospital and we are creating those frameworks. We need the framework in place to be able to then focus on having that Jersey Care Record for each Islander. So that is a longer piece of work but we are currently making those links across the systems.

Deputy M.R. Le Hegarat:

Okay, we need to move on. I am conscious that Carina has got a quick question and then we have got an adviser that is going to ask a question.

Deputy C.S. Alves:

Do you accept that as enablers digital in the workforce need robust plans early in the process prior to the implementation of major parts of the plan and, if so, why have you not prioritised to at least use the baseline to inform the financial and implementation planning?

Group Managing Director, Health and Community Services:

I can in part answer that and if there is more detail in relation to the finance, I can refer to Steve Mairto support. We are using the baseline assessment to inform our plan, so we already have an understanding of some of the deficit gaps within the system. We would not wait for the J.C.M. in entirety to address those gaps because we fundamentally believe that we require 24/7 community nursing to keep our system safe and to support Islanders more prominently than now, to support palliative care and wider care needs. That is a firm part of our implementation plan for phase 1, but we recognise that for the future-proofing of the model and to guarantee that we have a sustainable workforce we need much more longer-term workforce projection planning, and that is why we have targeted 2021. In our first phase we are looking at direct investment and workforce enhancement into those clear areas in out-of-hospital services and in the community. That is why we have prioritised those in year one in 2021.

Deputy M.R. Le Hegarat:

I would like to ask one of our advisers, Paul, if he would like to ask his question, please.

Adviser 1:

It is going to be Struan Coad asking the question.

Deputy M.R. Le Hegarat:
My apologies.

Adviser 1:
That is okay. In the business case you have provided you have talked about capital expenditure and talked regarding community estates and you have stated in there that there is no capital expenditure required, and then later on you have said you have not done the estates profile and gap analysis. Is that not quite a big financial risk, if you are saying you do not think there is any capital required for estates development in those community aspects, because clearly estates can be a very significant enabler for the Jersey Care Model? How is that being managed and how are you confident that there will be no estate requiring funding going forward?

Director General, Health and Community Services:
So it is Caroline here, Director General. Apologies, Chair, my camera does not work. So we know that there is already significant high quality estate out in the community which we are fortunate to have, both through our primary care partners and other arm's-length bodies that we work with. We also have significant estate, not all of it in such good working order but we do have some fit-for-purpose estate out there. We need to understand how we are going to prioritise the utilisation of that, and those are the conversations that we will be having next year if the Assembly agrees to go forward with the Jersey Care Model. Steve, did you want to answer anything around the money?

Mr. S. Mair, Treasury and Exchequer:
So just around that, there are obviously the benefits to the J.C.M. process of the work being done on the hospital, which is also looking at the estate across the piece as well, so just to supplement what Caroline has said.

Deputy M.R. Le Hegarat:
Can I have a follow-up to that please? You say estate which is not ours. Can you please give a couple of examples of what you are talking about?

Director General, Health and Community Services:
I think we recognise that the work that we do within the hospital can be re-provisioned across other providers on-Island, whether that be primary care provision or through our charitable sector or through our arm's-length organisations that we work with. Therefore we would want to work with those partners to understand what that looked like and how we could transfer costs that we are currently spending provisioning that care within our environment to that other environment.

The Minister for Health and Social Services:

As a concrete example there are services that have been delivered at Communicare in recent months and I know there is an eastern hub that has been considered as well. Closer to Home has gone to Samarès and other venues as well.

Deputy M.R. Le Hegarat:

Do you have a follow-up to that, Struan?

Adviser 1:

It is all right. I will leave it for now, thank you, Chair.

Deputy M.R. Le Hegarat:

Okay, thank you. I will revert back to Deputy Pointon in relation to question 4. Thank you.

The Deputy of St. John:

That very nicely brings us into community hubs. Of course community hubs are fundamental to the success of the Jersey Care Model but there is no detail about them in the report. Have these changed to becoming community multidisciplinary teams?

The Minister for Health and Social Services:

Yes. Deputy, I do not think the J.C.M. directs that there shall be health centres dotted around the Island. The J.C.M. is not that dictatorial. It is a framework and it will evolve, so much care will be delivered in people's homes. There will also be a lot of care in G.P. surgeries, which themselves can act as a hub for all sorts of professionals and where appropriate it may be that a hall will be hired for an afternoon to do some physiotherapy or podiatry or something like that. All that is in the mix and I envisage would evolve as we roll out services within the communities.

The Deputy of St. John:

So, Minister, are you talking to staff teams about this migration into the community and if you are what are the respondents saying to you?

The Minister for Health and Social Services:

I can give a practical example from St. Ouen, which immediately prior to COVID was running a weekly physiotherapy session for not necessarily residents of St. Ouen but people were referred to St. Ouen parish hall for their physiotherapy. This was received well by those who were attending but also the staff thought it was a really good idea and the people attending seemed to be more relaxed and it was easier for them to reach the venue and they seemed to be able to spend more time or pay more attention to people's needs in that setting.

The Deputy of St. John:

That is one example, Minister, but there are an awful lot of other professionals delivering care in the hospital, some of whom you suggest will be moving into the community. Are you consulting with those people and outlining your ideas and proposals?

The Minister for Health and Social Services:

We have consulted, spoken to them at significant length about the Jersey Care Model and what it contains, but if I can ask Rose and Rob to add to that.

Chief Nurse, Health and Community Services:

Yes, so just in relation to the conversations prior to COVID obviously we did very formal road shows, not just out in the parishes but also to our workforce which formed part of the presentation that we had done on the Jersey Care Model, but I think it is fair to say since that time there probably is not a conversation that goes by with our staff where they do not mention the J.C.M. So they talk about the Jersey Care Model in relation to the plans for their service development. A good example was we had the respiratory nursing team came to the H.C.S. (Health and Community Services) board and did a presentation around the work they are doing to support people in the community and how they envisage through expansion of that team and through bringing more services out into the community we can support people better and prevent them from coming into hospital. Now we know that is just one other example but there are lots of examples like that from cardiology, from conversations with diabetes, particularly with the specialist areas, but also the conversations do happen with the general ward staff as well. Again this was very evident when we did some of the parish road shows and some ward teams attended those road shows and talked from an audience perspective about their frustrations when they see patients still in hospital who they think could be cared for at home had we got the infrastructure in place at the time. I just want to reassure you and members of the public that this is very much high profile in the department.

The Deputy of St. John:

Okay. We are still on community hubs but could you detail for us how many of these hubs that you might envisage existing in the Island eventually?

Director General, Health and Community Services:

It is Caroline Landon here. I think perhaps we caused confusion, because in the early assumptions we made a year ago around the J.C.M. we made an assumption around having community hubs, one in the east, one in the west, in order to improve access for patients. I think we then learned through our engagement with various stakeholders and partners that those hubs already existed but

in multiple forms, through primary care, through facilities provision by family nursing, Jersey Hospice et cetera.

[12:30]

We did not need to build hubs. What we needed to do was to maximise the estate and the services and the skills that we had already available. We do not have a number around hubs. What we are looking at is re-provisioning care where it can be best delivered for patients, so delivering the right care at the right time and in the right place. We have multiple places to do that across the Island and it is just about understanding that, which we plan to start doing our first year. We are already having ongoing conversations. Rose yesterday appointed a joint role with one of our stakeholders who is going to work across both our organisations. We are talking with primary care about services that we think would be more responsibly provisioned outside of the hospital, so it is about utilising the facilities that we already have. That is also why we do not envisage that there will be significant capital outlay, because what we will do is transfer the spend that we are spending already out into those other facilities.

The Deputy of St. John:
So what you are describing to me is a hub that is more or less a virtual hub in that different services would be provided by different organisations at different locations around the Island. Is that correct?

Director General, Health and Community Services:
Absolutely and that is why we need to get the digital system right because we need to have that digital map of the Island. At our trust board, which is on YouTube, we had a presentation by our Chief Clinical Information Officer that demonstrated that digital map and the work that we are doing to get there. So while it is challenging we have the infrastructure in place. The biggest challenge for us is getting multiple systems to talk to each other and that is what the digital team is working on. This is about Islanders being able to access care closer to home, in effect.

The Deputy of St. John:
So you have a person with multiple conditions, one of which is being provided for by a G.P. practice perhaps in a town, another condition that is perhaps being provided for by MIND Jersey, some distance away, and another that is being provided by family nursing and home care. Does that mean now that the individual has to shuttle between these various establishments to find the care they need?

Director General, Health and Community Services:

That is what they currently have to do, Deputy, but the vision of the Jersey Care Model is that they will not have to do that because we will co-ordinate their care, so like a care passport, really, I am sure from your career in the early 1990s, what we will work to do is have a care co-ordinator that manages that care so that we have oversight of what a patient's journey is. At the moment patients are doing exactly that and we think we can improve upon that.

The Deputy of St. John:

Right. From a transport point of view are you going to be providing inter-centre transport for people who need different care on the same day?

Director General, Health and Community Services:

I cannot answer that, Deputy. I think that is the work that we need to do. We would hope not to get into a shuttle bus system, because I think that would create more bureaucracy than the benefit it would deliver. The work we are currently doing is about understanding the diverse care pathways that we offer and how they interlink with different providers and how we can join up to deliver that more seamlessly. We are looking at some examples that I personally have worked in Epsom where we have visiting clinicians that co-ordinate care and go to people's G.P. surgeries or, as Rob has said, town halls or indeed even their home, depending on the acuity of illness.

The Deputy of St. John:

Thanks very much for that. I will pass you on to Deputy Alves.

Deputy C.S. Alves:

Thank you.

Deputy M.R. Le Hegarat:

Apologies. Struan wants a question before Deputy Alves comes in.

Adviser 1:

Thank you, Chair. I just wanted to ask a follow-up question around the community approach and in terms you talk about the care co-ordinator role. How much has that been developed in terms of the role, the number of people you might need, the skill set and also how much have you worked through over the 3 tranches which pathways or which care groups will be influenced or be dealt with in those tranches in terms of rolling out this model? Is it clear yet which cohorts of the population you will be serving through the community model, however that is, virtual or in existing facilities?

Director General, Health and Community Services:

I think we have been clear in previous answers that the workforce plan will take part in the first tranche and we have detailed that in the submission. Around what care delivery will look like and what those care providers will be that is work that we are currently doing and we would be doing regardless of the J.C.M. and even if the Assembly rejects the J.C.M. we still will be looking at what care pathways we deliver and how they are either duplicated or cross over with other care that is delivered across-Island. So it is an ongoing piece of work. I am unable to give you a number; I think it would be spurious of me to do so because we are working to understand our current care delivery mode.

Deputy M.R. Le Hegarat:

Thank you. I will move on to Deputy Alves.

Deputy C.S. Alves:

I am going to be asking some questions about care in the community, so my first question is the Strategic Outline Case states that care in the community will be enhanced by increasing support to carers. Can you tell us how you intend doing this?

Group Managing Director, Health and Community Services:

Shall I start? We saw this in the road shows, that there are some real gaps at the moment, so robust offer of things like respite services is a space that we know we need to have much more responsiveness around, and we need to schedule that into our care co-ordination and understanding through the key worker where are we seeing that we need more targeted support for people around respite services? There is something as well around more formal support for carers and how we tie carers into the care co-ordination role. Like most health and care jurisdictions, we see some tension between personalisation, what family want in terms of care and what we offer. We have got quite a way to go to shift our services so that they are more personalised. Social care and mental health are looking at how we start to drive so that the patient and their family are more in control of the services that they need. We think that will be a critical part of how we help to support carers, because we know that that can be quite difficult for them to navigate at the moment.

Director General, Health and Community Services:

We are very green field, Deputy Alves. We have not even successfully delivered the carer strategy, but that is a piece of work that we are absolutely focused on and we are planning to bring that through the Jersey Care Model steering group, if it is approved. If it is not approved then it is a piece of work that we are hoping to get external support around because we recognise that we are not where we need to be and in order for the Jersey Care Model to be successful we absolutely need to understand the needs of carers and start to address those.

Deputy C.S. Alves:

Okay, thank you. I see that Deputy Southern has a question but I am just going to ask this one first and then I will allow him to ask his. The social care market strategy, reference is made to using market forces to alter the use of social care providers to more home-based solutions, so how will this be achieved? What levers do you have to influence the current market?

Group Managing Director, Health and Community Services:

I can answer that. So we have quite an immature approach to our commissioning strategy in the social care domain. What the information and what the data at the moment is telling us is that we need to work with the provision sector to gear up more robust offers for care at home, because often we get to the point of requiring care in a home, such as a residential care nursing home, because of the absence of robust care at home. So the particular area that we want to develop with the market is around the reablement offer and we think that domiciliary care provided in conjunction with our sectors like F.N.H.C. (Family Nursing and Home Care) for example could really start to mould and shape how we could make a difference within that. Our strategy is going to look at targeting how we start to shift domiciliary care and reablement care into a more robust out-of-hospital community team. That then will start to shape the market differently. In terms of the care home sector we are talking to them about how we can also think about a more intermediate care offer within some of our residential and nursing care homes, do we have step-up and step-down and where we might have short-term utilisation of bed-based care if we need to. Again that is something where we are looking to shape the market to have a slightly different offer. At the moment it is a very black and white market in terms of domiciliary care, care within a facility as in a building. We need much more of something in the middle of that, and that is what the whole intermediate care strategy is about and commissioning strategy for social care.

Deputy C.S. Alves:

Okay, Deputy Southern. I think you might be muted, Deputy.

Deputy G.P. Southern:

Again? Okay, is that now clear?

Deputy C.S. Alves:

Yes, we can hear you.

Deputy G.P. Southern:

Stay. You mentioned respite care and I wish you good luck with that because we have had problems with respite care for the past decade and report after report saying we must do something about it and nothing has ever happened. Good luck with that. My main point is what is the timeline on

getting extra help to carers? Unless you tie in voluntary carers, family carers as well, then I cannot see how your package in the home is going to be made to work. What is your timeline on involving those people and improving their condition?

Director General, Health and Community Services:

Hello, Deputy Southern. I have been having conversations currently with various stakeholders around how we can launch this piece of work this side of Christmas, and we are just working through that so that we can get a strategy because, quite rightly, we are being challenged that we do not have one, and then we can start working to that next year. I am at the beginning of a piece of work working with various stakeholders to involve them so that we can kick off some engagement with carers on the Island and do that before Christmas this year.

Group Managing Director, Health and Community Services:

We must state that in 2021 our key actions around service changes should absolutely support carers. We know from our evidence that where we see the likely breakdown of care at home is usually in the evening and at night, particularly where we see deterioration in a person at home. That is why we want to target that evening and overnight care, because if you know you have got that additional support, you have got that community nurse that you can contact, they can visit, they can assess, you can wrap that into night-sitting support, that makes a big difference to carers. At the moment the only option they have is to call an ambulance and for those clients to be transferred into the acute hospital. We should start to see these changes within the implementation of the model change in 2021. That is why we have targeted overnight care in particular, because we know that is an issue for carers.

Director General, Health and Community Services:

The engagement events that we gave Deputy Southern were revealing for all of us in the amount of people that came up and talked to us about the informal care that is delivered. After that some of the feedback that we have had about the sheer volume of it and how those carers in the main, the ones that spoke to us, did not feel supported. So it is an absolutely integral part of our work plan.

Deputy M.R. Le Hegarat:

Okay, thank you. I will move back to Deputy Alves.

Deputy C.S. Alves:

We as a panel commissioned our own survey of the G.P.s and it is showing us results that are not consistent with what we are hearing, so much is expected of the G.P.s in terms of changing the way in which they work, their clinical responsibilities and their method and level of payments. However, our survey results show you have not got the level of understanding or support from them to make

these changes successful. What will you do differently to get them on board and how can you be confident that their support will change favourably?

[12:45]

Director General, Health and Community Services:
Do you want me to take that, Minister?

The Minister for Health and Social Services:
Yes, please, Caroline.

Director General, Health and Community Services:
We have absolutely recognised that challenge, Deputy Alves, and we recognise that we absolutely need primary care to be on this journey with us and they are integral to delivering care. Indeed, they deliver the majority of care on the Island, so that is why as part of the tranching up we have done of the care model we have moved some of the significant changes around primary care later into one of the final tranches so that we have time, particularly over the next year, to work closely with primary care colleagues to co-create what the model of care would look like so that they do feel more engaged. I think we have done significant engagement with G.P.s. Rob last summer visited every G.P. practice. We held 3 events in the town hall and we are in regular dialogue with the Primary Care Board, but we recognise that dialogue needs to be ongoing and that the support of primary care is integral to the delivery of the model and we intend to be working much more closely than we have been with them over the next one to 3 years.

Deputy C.S. Alves:
Okay, thank you. Sorry, I think the Chair, did you want to step in there?

Deputy M.R. Le Hegarat:
Yes. It was just really that in relation to the G.P.s, we have had some feedback from them and it is of real concern for us and I think probably it would be within the community as well that there has been a lack of communication, which I think you have identified yourselves. Can you give us some indications as to what you are going to be doing moving forward in relation to this?

Director General, Health and Community Services:
I believe we have communicated with G.P.s and I think we have had regular engagement. We have the Chair of the P.C.B. (Primary Care Board) on our board and I have listed our previous engagements and I know that Rob has regular meetings. However, we recognise you can never engage enough. Also we have a member of the G.P.s on the J.C.M. steering group, so I think we

have communicated but our conversations around if the Assembly agrees the J.C.M. and the work that we need to do next year is that we absolutely need to have even greater engagement with the G.P.s around what that integrated care offer can look like particularly around intermediate care and domiciliary care, which is what we are focusing on next year. Deputy Le Hegarat, we value the G.P.s, we recognise they deliver most of the care on this Island, not H.C.S. and so we are committed to working closely with them.

Deputy M.R. Le Hegarat:

To follow up on that, with the G.P.s that you have communicated with, what is their feedback to you in relation to whether they are confident that the J.C.M. as it is proposed can be delivered?

Director General, Health and Community Services:

I think they have varying levels of confidence, as do many stakeholders. I think they are concerned around the funding model and what that looks like and how the volume of work will be managed and dealt with and how that will be supported not just by funding but by staff. They want to be very much involved in the workforce planning. They recognise that we have never had a feasible Island-wide workforce plan, and that is what we need to do and that is what Rose and Patrick are going to be leading on with all of our stakeholders. I think they were concerned that the J.C.M. was going to be an attempt to nationalise primary care and to take away the many benefits that the Island has around access and continuity of care. That absolutely is not the purpose of the J.C.M. and we have really strived to reassure them of that. I think as we work more closely on the work streams they will start to gain more assurance. We want the J.C.M. to be a co-creation, not an H.C.S.-driven framework. I do not know if Rob wanted to add more, because I know he has had significant communications with the G.P.s.

Group Managing Director, Health and Community Services:

Yes, even recently the dialogue I have had with G.P.s is that we have got a lot of common ground. So it is G.P.s who are highlighting to us the issues that we have overnight and through our out-of-hours provision that they are supporting, the kind of issues and deficits they face so when they do not have somebody that they can contact they are doing an assessment that they do not need to that can be undertaken by other professionals. All of that is consistent with the J.C.M. so we agree on much of the principles of the J.C.M. Where we need more work is around what is the mechanism as Caroline outlined around funding. Is it a capitation model? There has been some positive angle towards that, but it needs more work. That is why we need this additional time. We have been really clear that the clinical senate and the steering group need to drive that. That is not going to be an H.C.S.-dictated model. It needs to be, as Caroline said, a co-created model working with G.P.s. That does not disrupt our implementation of our objectives, particularly in our phasing approach for

the J.C.M. G.P.s are just one part of the system. The J.C.M. is about much more than just medical care.

Deputy M.R. Le Hegarat:

Can I just finish? I just want to finish off on this and then I notice that Carina has asked a question and then there is Geoff as well. I wanted to come back and say from the perspective of us as politicians if we are not getting the sort of feeling that G.P.s are confident in the delivery of the plan and you are then going to ask us to vote to be supportive of this, what my concern is that we need to be confident certainly as a panel that there will be support of the G.P.s. It is our view that if this does not happen then this is not going to be delivered and we certainly would not want to support something that would be undeliverable. What can you do to build the confidence of both the panel and G.P.s that they will be supported and that this plan will be workable with them in order that we can support you?

Deputy C.S. Alves:

To add to what the Chair has just said there and to make you aware, of the 106 G.P.s we had 74 that responded and 55 completed the survey. Not one of the total 55 G.P.s felt that they were confident or very confident that the G.P. would be adequately supported under the J.C.M. Just to make you aware of the kind of statistics that we are seeing and the kind of things that we are hearing from the G.P. This was a survey that was just recently conducted.

The Minister for Health and Social Services:

Okay. Can we have the results of that survey? Can you share it with us and we will respond?

Deputy C.S. Alves:

Yes, I believe that will be shared with you.

The Minister for Health and Social Services:

I take on board what you said. I regard G.P.s as a crucial part of the delivery of the Jersey Care Model and we will redouble our efforts. We will get back to you on exactly how we will engage with the G.P.s to an even greater extent and give you that confidence you need.

Deputy C.S. Alves:

Okay, thank you. I think Deputy Southern is next.

Deputy G.P. Southern:

Let us go to the bottom line. Let us talk money. The proposals have identified a specific net saving of £23 million, £90 million savings minus £67 million additional costs but we do not see specific

details that support this level of specificity. Where are the assumptions listed that enable such precise financials, a £23 million saving?

Medical Director, Health and Community Services:

The model is based on 3 main assumptions. Firstly it includes inflation of some 3 per cent per annum. It is based on activity growth which is related to population increases. That comes from the Government's S.P.P.P. (Strategic Policy, Planning and Performance) population data and then it is based on a changing demographic, again modelled from population increases. Obviously as everyone will appreciate an ageing population can tip more people into certain case mixes et cetera. That is what the model is based on, so it is largely driven by information from the Government of Jersey and also people's knowledge from elsewhere.

Deputy G.P. Southern:

Where are the assumptions in addition to those 3 things which just load up that it is going to cost more, where are the assumptions about the detail of how much more it is going to cost in which areas? I do not see that anywhere.

Medical Director, Health and Community Services:

The model does analyse out by area. It analyses out the additional costs. It analyses out any consequential savings. It also analyses out the one-off investment that is needed that is subject to the Government Plan and subject to consideration by the States will see investment through the first years and possibly through the H.I.F. (Health Insurance Fund) as well. It is all in the model and the outcome then appears in slides I believe that have been circulated to the members of the panel.

Deputy G.P. Southern:

They were in the presentation, the yearly presentation.

Medical Director, Health and Community Services:

They are in a presentation, yes. I assume you have got that there.

Deputy G.P. Southern:

And in the appendix in the back, presumably. I just need to spend more time ploughing through that, then. In particular, let us be specific, if you are going to save £23 million using this model for example what is the specific hospital bed reduction assumed in the projected savings? Okay, we know there is a link with the hospital and we are talking about how many beds. How many beds have been lost through this method?

Medical Director, Health and Community Services:

I cannot answer that detail as to exactly the change in beds. Whether any have been lost I think is a different issue but colleagues might be able to give that. Alternatively I am sure we will be able to research the fine grain of the model and come back later. Sorry, I do not have that degree of activity in my head at the moment.

Deputy G.P. Southern:

Is there anyone there who can enlighten me?

The Minister for Health and Social Services:

Deputy Southern, it is not about bed losses. It is about having the means to treat patients in the best location, so that might be in their home or it might be in hospital. Numbers of beds in the hospital will vary, so it varies between wintertime to summertime. There is planning behind the new hospital but flexibility is the key to be able to meet whatever a health service needs to meet. I learned recently it is not about the number of beds; it is about bed heads. In your buildings you have got to have the required electrical points, oxygen outlets and things like that and you can just roll up a bed against those when you need it, but when you do not need it you can use that space for something else. It is about flexibility and not a single number that lasts for years and years.

Deputy G.P. Southern:

Okay, then. Let us talk about how we fund this new model for primary care. How much support did you have from G.P.s on the proposed capitation plus model and can you tell us about the capitation plus model? What exactly does that mean?

The Minister for Health and Social Services:

So remember side-by-side with the engagement that H.C.S. has with G.P.s C.L.S. (Customer and Local Services) is also talking to G.P.s and I understand from C.L.S. that in those conversations the G.P.s have agreed that the capitation plus model is the most appropriate means of funding primary care in future years. So that is that a G.P. surgery will receive an annual lump sum for taking care of a patient, but the “plus” part of it means that they will in addition receive a payment each time that they would see a patient. I think as far as Government are concerned that is a good method. It takes us away from the current fee-for-service model which is not ideal in this day and age and means that the G.P.s take responsibility for a cohort of patients, and that is the way, by taking responsibility, they will receive that income to keep their practices afloat. Does that answer your question?

Deputy G.P. Southern:

That goes some way to answering my question.

Deputy M.R. Le Hegarat:

Geoff, I am just conscious that Struan may wish to come in with a supplementary on that.

Adviser 1:

Sorry, I just wanted to come back to the previous question. You talked about there is a very detailed model which is great and we understand that. What we are really interested in is the assumptions that go into that model around what savings will be made. So in appendix 4 of the business case there is a really good detail of year-by-year across which areas those savings will be made and the percentages and the annual impact. Are you able to share what assumptions have been made to inform those savings and costs? We are not worried about bed reduction but what assumptions have been made about what savings will be made and how can you share them with us to give a sense that those are informed by what is planned over the next 3 to 5 years? At the moment it is not clear how those decisions or those changes have been made. Is there any clarity on that you can provide, please?

[13:00]

The Minister for Health and Social Services:

Steve, are you able to share that with Struan and also speak to him and search out what information is needed?

Mr. S. Mair, Treasury and Exchequer:

I am sure we could arrange a separate briefing session if that would be helpful. It is rather a long and involved model but, yes, I am sure we could do that at an appropriate time.

Adviser 1:

Thank you. That would be very helpful. I appreciate it would be quite complex, but those sort of details are really important to understand how and also to inform. Part of the reason that this question is so helpful is to understand what your assumptions had been about what service changes will take place between secondary care and obviously we have not seen part of the hospital development because that is not relevant to this but it is relevant to understand what the transfer of activity will be from secondary care into the community and to primary care. Clearly some assumptions will have been made, which is great, but it would be useful for us to be able to understand those. Thank you.

The Minister for Health and Social Services:

Yes, we will get all that information to you, Struan. Thank you.

Deputy M.R. Le Hegarat:

Okay, back to Deputy Southern.

Deputy G.P. Southern:

A final one from me, I think, for the moment. On page 5 of the business case we see the statement: "While a residual affordability challenge of £153 million remains following implementation of the J.C.M. efficiencies of around 1.8 per cent per year will be required to be financially sustainable above implementation of the J.C.M." Can you justify efficiencies of 1.8 per cent on each and every year of the 16 years that you are covered? Is that not a difficult thing to do?

Mr. S. Mair, Treasury and Exchequer:

Efficiencies at that level, no, are not difficult to do. As you will appreciate 1.8 per cent is a small figure. The other thing to remember of course is this is a model and the amount of efficiencies needed will be dependent on the outcomes of the other works. It will vary, as I am sure we will all appreciate as we go through the next 16 years, but, no, 1.6 per cent is not a difficult number at all in budgets of this scale.

Deputy G.P. Southern:

I am glad you think so. Thank you.

Deputy M.R. Le Hegarat:

Thank you. Hopefully, Deputy Pamplin is still with us and he is going to talk about commissioning.

Deputy K.G. Pamplin of St. Saviour:

I am definitely still with you all, meaning technical problems and nothing more serious. Just a couple of quick questions from me at this stage. How are you confident there is a market for procurement as you have outlined here in Jersey?

The Minister for Health and Social Services:

So I think that is about the independence in people's homes and the domiciliary care. Is that about domiciliary care, Kevin? Which part of the States did you mean, Deputy Pamplin? Sorry, Deputy Pamplin, we had difficulty hearing you. How confident are we that there is a procurement market in Jersey?

The Deputy St. Saviour:

Yes.

The Minister for Health and Social Services:

Do you mean in the context of how responsive the market would be to procuring services to be delivered?

The Deputy St. Saviour:
That is one part of it, yes, for sure.

The Minister for Health and Social Services:
So we already have that situation in place at the moment within Jersey. It is quite a complex commissioning function here but it is not a particularly strategically co-ordinated commissioning strategy. So what we hear from the sector is that we believe there is room for all but there is absolute duplication overlay and, at times, there is some confusion about which provider is doing what and what they are absolutely asking for is longer term certainty so longer term contracting. I think most parts of the sector would be responsive to a procurement commissioning strategy providing that they can see they have the certainty around assured long-term interface with funding around commissioned services. So that is what we hear that the sector wants, whether that is domiciliary care, the voluntary sector and G.P.s (General Practitioners) were also saying the same thing. They want to understand long-term security and sustainability with the model.

The Deputy St. Saviour:
How is it sustainable, just outlining what you are hearing and picking up, with the 2 major factors of this year; the global pandemic which has caused economic unsustainability and Brexit which is the great unknown in all of this. So, again, I repeat, how confident are you that this is going to be enabling for the future of this care model as it is present as of now?

The Minister for Health and Social Services:
Well, I imagine Brexit will throw up its challenges in terms of workforce and we do not know the precise outcome of that yet but that should not prevent us from planning. If we think of how much of our health economy lies outside the sphere of government, then there is obviously a market there and government needs to ensure that health services are delivered to Islanders. Therefore, it needs to be instrumental in procuring those services from the many independent providers we have and that begins with G.P.s. So going back to my talk about capitation, well, that is a procurement, is it not? We say to them: "We would like you to look after an Islander and, for that, we will pay you a lump sum per annum" and then that is then in all other areas, among the charitable bodies and among the commercial players. We will procure services rather than nationalise the whole of a Health Service which we do not want to do. It is not the Jersey way of doing things, would not be popular and I do not want to go down that line and so ...

The Deputy St. Saviour:

Sorry, Minister. Go ahead.

The Minister for Health and Social Services:

Yes. No, please go on because I think I have said what I have wanted to say.

The Deputy St. Saviour:

So just picking up on one area so can you clarify what are the services and all services under consideration suitable for procurement?

The Minister for Health and Social Services:

Well, I think they are wide areas. So Rob has spoken about enhancing our reablement service for which a candidate would be family nursing and homecare but they might not be the only one. There are other providers who are in the market to provide that and we have seen the market grow in the last 6 or 7 years from a situation where there were few independent providers to a situation now where there is a number of companies. Sure, in the main, domiciliary care but they are also offering services to our community with learning difficulties or mental health difficulties so all of those services have been and are being commissioned.

The Deputy St. Saviour:

You are describing improved contracting and partnershiping, which I think we would all support, so can you be more specific at this point about what might be procured? It is just so we are clear because this is a huge document that all States Members are requested to read and we are doing our work. The public need to understand it but what we are doing at this very late stage of the process is looking for detail and looking for specifics and what can you point to? Again, I repeat the 2 major new changes of this care model are the effects of the pandemic economically and infrastructure wise and Brexit, the unknown. So could you just point more specifically on those areas of contracting and partnership for us and how confident you are they will be there?

Associate Managing Director, Modernisation, Health and Community Services:

So one example would be where we have been through this pandemic situation and we know there have been increased issues around Mental Health Services. We have worked in partnership to procure better ways of working as well as more access to talking therapies. We have opened up who is doing assessments, there is a really good partnership agreement between 4 or 5 of the different providers including H.C.S. to deliver this growing need. So it is one good example of where we have provision, how we bring it together, we make it more efficient procuring it in a different way to deliver to meet the needs of a certain sector of people within a time when there has been a pandemic and a shortage and things being affected. So that would be one example. There are other areas around reablement and providing care at night that Rob has just talked about that we

do not have the detail on and that is our first part of next year's work which is to look at how we commission things. I think we talk very much about a partnership of purpose and our local providers, of which there are many of, coming together to deliver the services that need around patients and around individuals to deliver that care. The work that we have done across the Mental Health Service is a really good example and we have had some good feedback on how that is working for people of how we would procure and commission things differently as part of the Jersey Care Model.

The Deputy St. Saviour:

You are pushing my buttons there on the Mental Health Service and I cannot let that go because obviously we discussed this in other areas. The issue is we are talking therapies. It is historic and it has been systematic for a long period of time. There is a backlog waiting list. That is still dealing with a historic problem so, again, we are still looking for specific partnerships. You are quite right to point at areas in the mental health area where we have worked, thank goodness, with others who have stepped forward but I do not want to go down that road because I will lose track. So I am going to bring in Struan who wants to just add on an extra question to the area of commissioning. Struan.

Adviser 1:

Thank you. I just wanted to check, in terms of commissioning, throughout the documentation, you have talked a lot about the model in England around commissioning. Clearly, there is a lot of work going on in England where commissioning is becoming less and less around potentially divisive procurement and more around integration. I know you have mentioned more in respect of care and domiciliary care earlier on but I just want to understand a bit more about how far are you planning to go in terms of the English model and understanding about how much procurement, which tends to be quite divisive in many cases? How far do you plan to go around that and how can you try to prevent it becoming too divisive in Jersey? You have talked a lot about good partnership but how will you balance the partnership versus procurement dilemma?

Group Managing Director, Health and Community Services:

We need to be really, really clear. The model that we are implementing in Jersey absolutely does not replicate the N.H.S. England model of commissioning. That is not the arrangement that we have here in Jersey and we do not think that that commissioning function either at a strategic level by N.H.S. England or a local level by C.C.G.s (Clinical Commissioning Groups) is applicable here. We have procurement limitations around certain services that we have to engage with the market around under procurement law but that is not to the extent of the way that we would envisage care provision going forward. The situation in mental health has absolutely demonstrated to us that there is room for all within that market space and there is capability for individual providers that is catered to those specific providers. How we co-ordinate that into a provision strategy is part of the partnership of purpose. So we have to go through a contractual process that could be around elements of

accountable care, that could be around direct S.L.A.s (Service Level Agreements). The thing that we want is to be really clear about the role that the Commission Service and the partner plays and how they operate within an intergraded service delivery but we absolutely do not want a divisive procured system of care that sees our Island of Jersey coming into competition with itself. We want clarity but we do not want to create that kind of a system here. It is not the intention of the model.

Adviser 1:
Thank you. That is incredibly clear, thank you.

The Deputy St. Saviour:
Yes, thank you, Rob. Deputy Alves is going to chip in with a couple of questions here.

Deputy C.S. Alves:
Thank you. Yes, I just wanted to go back to something that Deputy Southern said when he was asking some questions about the funding model for primary care and I do not believe the Minister really answered the question about how much support did you have from the G.P.s on the proposed capitation plus model?

[13:15]

The Minister for Health and Social Services:
The G.P.s and government are agreed that that would be the appropriate model to discuss further. There is detail around it but my understanding is we are not still discussing what model it might be. So capitation plus has been agreed as the way forward and then we have to get into the detail because all sorts of questions arise.

Group Managing Director, Health and Community Services:
G.P.s want more work on capitation plus. So they recognise the benefit of that kind of a model but they believe that it needs much more work and the detail that they are asking for is what are the wider service elements that would support the model? So what community services will be wrapped around this model to ensure that our G.P. practices are not having too much activity and that affects our access? We also need to be mindful that the time when we were discussing capitation plus was at the time of the pandemic. The G.P.s were under contract and so there were multiple elements that that timing has thrown up and that is why the new P.C.B. have asked for more work to be undertaken because our discussions were very much with the old P.C.B. and so we recognise we need to do more work in this space. It might mean capitation plus plus but capitation is the model that I think we broadly believe we are going in. It just does require more work.

Deputy C.S. Alves:

So can I ask then what engagement is there with the wider G.P.s beyond the P.C.B.? I see you have mentioned that, obviously, you were engaging with the previous P.C.B. but did you engage with the wider G.P.s about the different models that were being considered by P.w.C. (PricewaterhouseCoopers) and can you provide reasons why, for example, the hybrid model that was proposed by the G.P.s as their preferred model was not considered by P.w.C.? Thank you.

Group Managing Director, Health and Community Services:

So I think what we have learnt from this summer is that we absolutely need a different mechanism of engagement, as Caroline outlined. We have assumed that the P.C.B. is the voice of primary care in Jersey but we need to recognise that each of those G.P. practices are sovereign organisations with their own business plans and their own commercial offer. What we are coming to realise is that we have to have engagement beyond the P.C.B. The P.C.B. is a good collective to have broad representation but we now need to make sure that we get hundreds of people involved. There needs to be more engagement individually with these individual practitioners and their practices respectfully and that is where I think that work is required on the capitation plus. They want to see more detail; they want to understand the risks and they want to understand how it would be rolled out more effectively. We are hearing that from them.

Deputy C.S. Alves:

Thank you. So I am going to move onto future efficiencies and given the massive change programme to deliver the Jersey Care Model, it only delivers a net of £23 million saving. How can you be confident that you can find a further £153 million efficiencies to close the funding gap?

Group Managing Director, Health and Community Services:

I think, first of all, that number is obviously over a very long period of time. Secondly, the service has a very good demonstrable record of tacking the efficiencies programme. I think, thirdly, the Government as a whole has a good record of tackling efficiencies and, no doubt, we will see that come through the Government Plan and the end of year accounts as we come to it. I know there are a number of colleagues with a lot of experience of doing this and the percentage the Deputy quoted is not a large percentage in the scale of the budgets that we are dealing with.

Deputy C.S. Alves:

Thank you for that. So moving on to risk management, for such an ambitious change programme, the risks identified are scored quite low. Can you talk us through the major risks and why you feel so confident in their mitigation? Thank you.

Group Managing Director, Health and Community Services:

Is Caroline able to speak to the risks?

Director General, Health and Community Services:

I am afraid I do not have the document in front of me. Rob, do you have it there? I know we have identified risks around workforce but I do not have the risk register in front of me. Do you have it there, Rob?

Group Managing Director, Health and Community Services:

I have not but I do understand the different elements I think that we might need to focus on. I think we have covered off workforce, digital and some of the key enabling elements that we need to address. I think that some of the changes that we are proposing within the care model, as Caroline outlined at the very beginning, we would be wanting to pursue anyway. So I guess that ambition is variable depending on what we want to do so we are always going to try to tackle our secondary care productivity and our theatre utilisation. We were always going to look to try to reduce our volume of outpatient appointments because they are too high and we were always going to try to push out of hospital care. In terms of our confidence in delivery and mitigating the risks, I think that builds on what Steve Mair just described around our financial delivery. We have delivered some of the changes that we have made and COVID particularly has demonstrated to us that we can do things differently. So we are able to have more virtual appointments and we are able to engage digital in a more prominent way. Our workforce is able to work across the hospital and the community and we have seen that throughout COVID and we see it post COVID as well. So that has given us confidence that the big risks that we face around workforce, around digital and around cultural change that is required, we can collectively start to tackle. We just need to bring the system together and the steering group and the clinical senate has a key role to address that, I would say. Is there something you want to add to that, Rose?

Chief Nurse, Health and Community Services:

No.

Deputy C.S. Alves:

Thank you. So the final question from me on engagement. You undertook a wide engagement process last year. How confident are you that key stakeholders, not least the public and the workforce, are aware of the developments of the Jersey Care Model and support it? Thank you.

The Minister for Health and Social Services:

I know that in the work done to stress test the model, staff members were involved and other partners within the health economy and we are intending - we have not worked out exactly how - to go back into the community and engage with people after the States debate, assuming the States adopt the

model. We will go out to explain the changes that people might be seeing in the days ahead. Thank you, Carina. Can anyone else add about engagement with our staff and with partners?

Chief Nurse, Health and Community Services:

Yes. I am happy to add. So it just goes back to what I said at the beginning that the J.C.M. probably features in nearly every conversation we have with staff because the underlying principles are still the same. So whether the tranching of the model coming in over a phased period is slightly altered or not, the key principle that we set out at the beginning remains unchanged. I think one of the challenges we have definitely had this year has been that missed opportunity of face-to-face communication on a scale that we were previously able to do pre- COVID. So we have been extremely limited in our opportunities to bring large cohorts of individuals together for what is always a much better way to communicate which is face-to-face. So we do know, even though we have relied on other methods to communicate information to our workforce and beyond during the pandemic, that it reaches limited numbers of people. So we are working across a different sort of platform in relation to how we engage with people going forward and using lots of different mechanisms to get that communication across to the wider healthcare community. So it has been challenging and we do continue to have those conversations at every opportunity but the landscape has changed so significantly in terms of the numbers of opportunity to get people together and in a room so that has been quite difficult for us but things are getting a little bit easier in that regard.

Deputy C.S. Alves:

So can I just ask, because you have mentioned a lot about staff and the workforce, what about the wider public?

The Minister for Health and Social Services:

Caroline, your thoughts on that please?

Director General, Health and Community Services:

I think we did our going around the parishes and talking to people and I think the plan is ... I met with our comms head at the beginning of this week and it was to start thinking about how we do that again. But if the Assembly does say that the model is approved, then what is it that we do and what that looks like taking onboard Rose's point that we may not be able to do the parish hall piece again because of social distancing? There is a lot of stuff that we can do in small groups of people who are not able to access electronic means of comms but there is an awful lot of stuff that we can do virtually as well. So we are working on that plan currently in anticipation of the debate in November.

Deputy C.S. Alves:

Thank you. I will handover to Deputy Pamplin.

The Deputy St. Saviour:

I cannot let this area of engagement go. It would not surprise you for me to pick up on this. Can I just be clear what was just said by the Director General there? Caroline, you just said you had a meeting with the Director General of Communications this week about plans to communicate the care model. Is that right?

Director General, Health and Community Services:

Yes, around the campaign that we are going to launch if the Assembly agrees with the model.

The Deputy St. Saviour:

So it begs the question - and, again, I hold up that it has been a very busy 6 months - what continued conversations have been going on in the areas of engagement with the Director General of Communications? Also, could you confirm who wrote and published the care model in its final guise? Was it also the Director of Communications as well who had the final signoff?

Director General, Health and Community Services:

So I have not been liaising with the Director of Communications. I have been liaising with the Health and Community Services head of comms who sits with us in H.C.S. and leads all our comms work for us and so we have not been having conversations with the Director of Communications about it. We have been talking with Martin about what we need to do to go back out to people. If the Assembly decides not to support the model and to talk to people about: "Okay, this is what we are doing in healthcare currently post COVID and what we plan to do during the winter probably in December, January" so that was what I working up with Martin, what that would look like.

The Deputy St. Saviour:

I will come back to that.

The Minister for Health and Social Services:

Can I say, Kevin, it sounds as if you are sceptical. I think that is the right way to proceed. At the beginning going back to last year, we had this gem of an idea. We wrote something down and then we went out to the parish halls to engage with Islanders to see what they felt about their care and what was needed and, in large parts, our ideas were reinforced and we were able to add things. Then we went to the stress testing and it is not a consultation process. We are not developing a prescriptive programme here. It is very much a broad framework so I think the next step is to go and get the States Assembly approval to our direction of travel rather than go to the public at this stage, which I think is what you were perhaps suggesting. We will go to the public to engage with

them to explain to them if States Members think this is the right way, they wish health to be delivered in the Island and, that way, we have undertaken a process and everyone has been involved.

The Deputy St. Saviour:

Yes, the point I was more making is communication is a 2-way process and in the eyes of the public, as you have just demonstrated, there were these road shows which I have here back listed in November of 2019 and then December and then nothing and then of course the pandemic and then of course 6 months of time moves on and now, suddenly, it has come back on the agenda. As we all know, sat around this virtual room, the healthcare system in Jersey already is confusing. That is why this needs to be worked. Patient pathways are confusing. Rob illustrated it brilliantly earlier. So it is crystal clear that the communication of what this is, who came up with it, how it is being funded, who is engaged and how that is going to be communicated and adapted with the public is really clear. I was trying to understand the consistent through line of that process over the last few months which was where I was aiming for. You are also right on what you said but I want to quickly move on. The radical programme of changes required to deliver the care model is not just justified primarily by finance, which seems to be the thing we are hooked on here, because it only reduces costs by about £23 million, still leaving a remaining funding gap of £153 million, the efficiencies. So therefore, it must be presumably justified by quantitative improvements. So what level of quality improvements will be delivered in the terms of the user experience, so ie their safety and their outcomes medically, and is equality reduced and, if so, how does this care model adjust that as well? In pure simplest terms, how are people better and how are people going to live longer? Is it because of this care model? I know it is many questions for you to unpick there but there you are.

[13:30]

Group Managing Director, Health and Community Services:

So it is a really good point because the analysis that we have looked at is identifying many of the issues that we currently face because our services are very much geared up to the stated crisis, that is in physical health, mental health, and adult social care. So what we are seeing is that at the expense and the focus of the service delivery often then becomes targeted towards bed based care, long-term institutional care, and a high level of dependency needed in either in or out of hospital settings. That is the thing we are trying to change in the model because we believe if we start to invest differently in preventative services, in independence focussed services and in functions that prevent people having to only pick up care at the point of crisis, then we see better quality and better outcomes for the patients and the clients and we see those pathways changed. We see the services reconfigured to provide care in a more targeted way and we see less reliance on our most expensive part of the care system which is the beds. It is the beds which is really, really costly, it is buildings and it often is not the right setting of care for people. So that is why we are trying to change and

that is how we are trying to align the quality of the care model and the outputs and outcomes. They also do have a financial impact but we have to refocus and invest into the services upfront to change that model and that will take time.

The Deputy St. Saviour:

The inequality issue, Rob, is really important. How is this going to provide a care model for generations with healthcare access for all, with the outcome that it is there for everybody no matter how rich or poor you are and it is accessible? What can you point to me in this care model at this stage that identifies those key issues of the current state of healthcare on the Island right now?

Director General, Health and Community Services:

I do not think we can, Deputy. It is a healthcare model, it is a transformational framework, it is not anticipated to cure all ills and challenges. But what we will do through co-design with partners and with patients and with clients is seek to address those issues of inequality so that we are building care from the bottom up, which in itself will help us to determine qualitative outcomes; and quality care is generally more efficient care.

Deputy K.G. Pamplin:

Page 89 lists some very basic major elements to be included - tranche one - if these are yet to be identified in details, as you explained because it is not going to happen until next year, how have you costed this Jersey Care Model?

Mr. S. Mair, Treasury and Exchequer:

It has been costed as we have previously described based upon the assumptions that we said in the detail that is in the model, so the growth, the change in demographics, the inflation assumptions, and working with colleagues as to when they think that the activities will take place.

Deputy K.G. Pamplin:

So the cost of the Care Model is based on presumptions; that is the answer, is it not?

Mr. S. Mair, Treasury and Exchequer:

The cost of every model is based on presumptions because it is a model. But they are well-informed presumptions by using experts like P.w.C. who have the expertise in H.C.S. You will not find a model anywhere that does not have any presumptions in it because it is a model.

Deputy K.G. Pamplin:

Arguably the States Assembly are going to be asked to vote for a fundamental change that could save a lot of money, or it could be a decision we have to make, and we have to be based on exactly

what we are voting for. One of the key areas that we have discussed in all of this journey is we have always asked is how are you costing: "It is being stress tested." Is that the answer at this stage?

Mr. S. Mair, Treasury and Exchequer:

It has. It is a full model that we have described previously and we are going to meet separately and take colleagues through the more detailed assumptions. It is a very involved model based upon the costs of the existing service, based upon costs of knowledge elsewhere; it is an extremely good and detailed piece of work. It is, nonetheless, a model. Everything is a model; things will change over the next 16 years but you have to make a decision based on the best information you have got and this is the best information with everybody's feedback into it. It is not just financially driven, sorry, not my area, it is driven by the need to improve the quality of care.

Deputy K.G. Pamplin:

This is good because I think we are getting somewhere. This is what people want to hear is what we are looking for in terms of the basis of this because what we have also heard is work will start on this next year. So I think we have to be really clear what everything is being based on, where we have asked previous questions of: "How are you basing this?" "It is being stress tested." It comes back: "We are working on next year." We have to be really clear on the detail for our final report as well so that was really helpful, thank you. But of course tranche 1 starts and finishes in 2021 so how will you know it has been successful? So again, what specific targets need to be achieved in terms of the main listed components of tranche 1, so for example planning, policy, workforce planning, improved pathways, all of it. So how will you know and what can you just point to me are the specific targets that will be measured as success?

Group Managing Director, Health and Community Services:

So in terms of the first year in tranche one there are some specific outcomes that we would expect to be delivered. We have clearly said that we want to target intermediate care and we want to look at night sitting and we want to look at 24/7 community nursing and attach that to a more robust out of hospital system. So the indicators that we would be looking at are, are we seeing the same volume of people coming into the hospital at night at a point of crisis, are the ambulance service experiencing the same level of call out, are we seeing the same number of unfilled hours in our reablement, in our domiciliary care services, and are we seeing the same prevalence of volume of activity coming in through our front door in these key demographic and key areas. So there are some specific things that we will be looking out for as we implement the changes. We know that intermediate care can have a positive impact on reducing the need for more intensive packages of care; we know it can also start to slow down and delay the length of time it might take before somebody needs to go into a longer term care facility, and we know it also has a good impact on preventing admission to hospital if you can support patients more prominently in that care at home

sector. So they are all the things that we will be monitoring and they are all the indicators that we will look at to say: "Is this working? What parts are successful? What do we need to change? What do we need to adjust? Where are seeing benefits and where are we seeing some challenges still?" So they will be the kind of things that we would share with the panel and with the public about our year one impact and what we have seen from the changes we have made.

Deputy K.G. Pamplin:

It is also important to pick out what will the public see in their lives as an impact at the end of tranche one, and could you just pinpoint the date roughly of the end of that period as well?

Group Managing Director, Health and Community Services:

We are targeting the changes in tranche one for 2021 and it is a really good point, Deputy, because one of the things we would like the public to understand by the end of next year is to have more reassurance and more confidence around some of those services. So I mentioned to you that where we often see a breakdown in care continuity and where we start to see a dependency on the hospital based system is often where the patient or their relatives are becoming scared and where they do not understand, whether or not they have got somebody they can call, somebody will come in to support them, and what services are available to them. So we would like to see by the end of 2021 that people recognise there are services wrapped around them that can support them. We would like people to start to say they are starting to understand what a care co-ordinator is. We would like people to understand reablement services better and we would like people to understand how we are wrapping around that community service to them to help them when they are deteriorating and they are needing more intensive care. We see that in feedback at the moment from our rapid response service. We really want to build on that and it is a key test of our assessing patient experience and public experience that we want to monitor that and learn from it, because it will be evolutionary, we will need to adjust it, we will need to identify where we need to adjust it throughout the year. But by the end of 2021 we hope that people will understand those services a bit better.

Deputy K.G. Pamplin:

Rob, thank you, and appreciate all of your answers. It is challenging because we are dealing with something so comprehensive, but I appreciate you all understand that. One final point before I hand over back to everybody else to Director General, I just need to go back to the issue of communication between director generals and especially the head of communication. Just so I am clear, who finalised the final Care Model as presented, like the Government Plan; who wrote that? Who took all the elements and finalised the final presentation? Who was that?

Director General, Health and Community Services:

Just to be clear, Deputy Pamplin, I have not been talking to any other director general. I have been talking to the head of coms for H.C.S. who sits within my team and who is a tier 3. It is not a director general or the Director of Coms; the Director of Coms is Dirk. The covering paper was written by Rob and is a great piece of work. The Care Model originally was written by us as a H.C.S. team, and the report on the Care Model is written by P.w.C.

Deputy K.G. Pamplin:

Just so I am clear on it, it was not published or overseen by the Director of Communications for the Government of Jersey; is that correct?

Director General, Health and Community Services:

No.

Unknown Speaker:

No, definitely no.

Director General, Health and Community Services:

No, there has been no input around any of that.

Deputy K.G. Pamplin:

That is it from me, thank you very much, I am sure you will be all relieved to hear. Deputy Pointon, back to St. John we go.

The Deputy of St. John:

Thank you very much, Deputy Pamplin. I want to talk a little bit about the proposal itself and how you are going to manage the service if it is accepted by the States. If it is able to be developed you are going to need people to manage the service, but we do not see anything in this proposal about training managers on-Island to deliver the proposal.

Director General, Health and Community Services:

We have a service improvement team and we have recently appointed a Director of Innovation and Improvement, a substantive role because we have had interims in post for the last couple of years. She has been working closely with us during her handover period and she is very much minded to grow expertise on-Island. We have a significant management resource across provider organisations across the Island who have expressed interest in being invested in delivering the model. So I think while we recognise that we may require some external support it is not the level of support that we envisaged at the beginning, and what we do not want is to be bringing people on and them doing the implementation; we want to have skills transfer for our own people to be able to

do it. So that is very much the plan that is being worked up by our incoming director who is Anuschka Muller, who is currently the Strategy Director for Government. Jo, I do not know if you wanted to elaborate, because I know you have been working with Anuschka around the potential resource requirement for implementation?

Associate Managing Director, Modernisation, Health and Community Services:
Yes, so we have been doing exactly that, looking at how there will be oversight, who we need in working groups, what the task and finished pieces of work are and how we resource that as part of the plan. So that is a piece of work that Anuschka and I have been looking at and how we make sure that reports comes back to executive and back to our ministerial team. The training of managing the services; we have got managers in services and as things change, we will be developing our local managers, whether they are ward managers or community managers, and part of the programme will also be developing the local people here that are in management roles. But those roles - I am saying inevitably - those roles will change as we develop and implement the Jersey Care Model; so they are the plans that we are looking at currently.

The Deputy of St. John:
So what sort of levels of expenditure do you expect to be required to fund external consultancy?

Mr. S. Mair, Treasury and Exchequer:
The model makes provision for some one-off expenditure over a period of 4 years for programme management, whether that be internal brought in by the Director General or whether that be consultants. That is provided for in the model.

Director General, Health and Community Services:
Deputy Pointon, I think that as a team who work close to the model we perhaps have had the assumption that we would need significant external support and it has been very valuable having Anuschka join our team and bring in new eyes and, as I have said, she is very confident - I mean, ask me again in 6 months - but she is very confident that we have the resource on-Island.

[13:45]

Transformation is about bringing people with us and utilising the skills we already have, so that is the model that she is looking to work up when she starts with us next Monday, but which I know she has already been working through the bones of with Jo. So while there is provision in the model for external support - and I think we recognise we will have to bring in subject experts - our thinking has moved away from having a consultancy firm come in and support us wholescale.

The Deputy of St. John:

Thank you for that.

Deputy M.R. Le Hegarat:

Just finally we have one final question from Deputy Southern and then we have got one final question in relation to deliverability from the adviser, because I am conscious of timings, thank you.

Deputy G.P. Southern:

The funding of primary care at the moment is very dependent on the Health Insurance Fund. There was talk about double running the H.I.F. and a new method of paying for our health service. What is the timeline in terms of one to 3 years for the H.I.F. and what you see as the way forward?

Mr. S. Mair, Treasury and Exchequer:

The Government Plan which comes out on 12th October, as I presume you know, Deputy Southern, will outline where the funding is coming from for the proposals within the J.C.M. Anything broader on the H.I.F. in isolation I think will be a separate piece of work that we would have to come back on.

Deputy G.P. Southern:

I look forward to seeing it.

Deputy M.R. Le Hegarat:

Thank you. Final question coming from, as I said, one of our advisers in relation to deliverability.

Adviser 1:

We have had a lot of detail that we have requested over the last months and all have been said would be forthcoming after the stress test that we have not received yet. Now, following the change in the implementation plan, there is quite a few more details that we are keen to understand such as specific metrics we asked about in terms of metrics against tranche one and what will be different, so what is the baseline today and what will be different in 12 months as a result of tranche one. How confident can we be and can other members be that you will be able to deliver business as usual, all the follow up that is ongoing around COVID-19, and implement the J.C.M.? Clearly you have recruited someone substantive which is great but still there is a very large programme of work for the team. How confident can everybody be that you will be able to deliver the level of work that needs to be done to deliver J.C.M., because already quite a lot has been pushed into tranche one that was going to have been in this year. So I just want to understand a bit more around that implementation confidence.

Director General, Health and Community Services:

I think we are very clear that we cannot deliver it on our own. The reason that implementation has been delayed I think is fairly self-evident. So we are confident that working with other provider organisations we can deliver the change in care that we wish to deliver in year one. However, there has been significant work happening across H.C.S. as a provider organisation for the past 2 years in order to be able to develop performance framework, qualitative frameworks, the standard delivery metrics that you see in organisations that we did not have before. So we are now able to measure both qualitatively and quantitatively the care that we deliver. We have already got some of the levers in place and established within the organisation that we currently share with the public, which will enable us to measure the work that we are doing and the outcomes that we wish to deliver. But I need to emphasise it is not just the H.C.S. model because if it is it will not work; it is about us working collaboratively with all partners to implement next year, and that is why we have all partners on our steering group, why we have representatives on our board, why we have our Deputy Ministers holding us to account on our assurance committees to ensure that there are multiple eyes on delivery and not just the H.C.S. exec team.

Deputy M.R. Le Hegarat:

Is there further from you, Struan?

Adviser 1:

I do understand this year has been unusual but what is to say it is not going to continue through for the next 6 months and how are you going to ensure that tranche one does deliver what it needs to deliver. Because, yes, you have brought some people on board and that is great and you have got more collaboration across the partners, but it still needs to be driven by yourselves as an exec team. If things progress over this winter how are you going to make sure that the J.C.M. development progresses and does not ... because if we look back to 2012 there was a lot of progress and a lot of intention around delivery, but clearly there will be a concern across the public and other Members about what did and did not deliver. How do you assure people that will not be a similar scenario now, especially with the unknowns around COVID?

Director General, Health and Community Services:

I think for the first 3 months of the pandemic our business as usual was indeed not paralysed but it was certainly significantly impacted upon, although we did try to continue to deliver care for our most acutely unwell presentations. But we have learnt from that and we have done significant planning so that we can continue the measures that we put in place during the initial 3 months in order to ensure that if we do have a second wave we are better positioned in order to be able to continue our business as usual and our transformation project. We have the Nightingale Hospital; we have had significant changes around our pathways within our own organisation and indeed with partner

organisations across social care and mental health. So I am confident we are in a much more robust position to deal with both the pandemic and transformation. I disagree with you; I do not think it is the role of the H.C.S. executive team to deliver this transformation programme. I think that has been some of the challenges within the current healthcare model that H.C.S. is the holder of all the money and all of the power and that drives a health economy that is - as Deputy Pamplin has alluded to - unequal. That is why we have set up a steering group so that delivery is driven from a team of people from all organisations that need to be invested in that delivery.

Adviser 1:
Can I ask one final question? So who is accountable for delivery of this model?

Director General, Health and Community Services:
Ultimately me, as the Director General.

Adviser 1:
Okay, thank you.

Deputy K.G. Pamplin:
Struan just took the words literally out of our mouth, which shows how we are very grateful for their work on this, Minister, equally for you, we are dealing with a care model to adjust and bring improvements for the working status of the healthcare situation but, as the Director General has outlined herself, that the pressure is put on everybody. So how this is achievable is who takes responsibility and who is day-to-day delivering it; who is going to be that person and who is ultimately responsible, Minister?

The Minister for Health and Social Services:
I would hold political accountability for its delivery and it was my wish to bring it to the States Assembly to demonstrate that, I suppose, and to seek the views of the Assembly, well knowing that the Assembly will hold me accountable following any decision to adopt it.

Deputy K.G. Pamplin:
The day-to-day delivery, Minister, we cannot expect - as the Director General has just outlined - she cannot be doing that on everything else that she is responsible for. Mr. Sainsbury, with the greatest respect, is one of the busiest men on this Island and so are many other people. So how do you identify without burdening the risk even further that somebody has got this every single day and is delivering this without burdening the workload with on top possible outlining issues of Brexit and COVID?

The Minister for Health and Social Services:

Yes, well we will have to cascade that down through our care groups and make sure that they are all in receipt of the vision of this care model and working to it and putting patients at the centre of care, working with all other professionals in teams rather than the silo working we have seen in the past. In the same way any service would run the people at the top would be accountable and would have to make sure that the programme is delivered as it cascades down the organisation.

Director General, Health and Community Services:

I am the ultimate accountable officer from a civil servant point of view, but the accountable director will be Anuschka Muller who will be working with her service improvement team which is a significant number of people, probably about 15 but Jo will correct me, and a lot of work they have been doing is work that you would see within any healthcare model around transformation. It will her job to harness and rationalise that and then to use that team through the care groups and through the community in order to deliver the model. Now, absolutely, her aspiration is not to bring in lots of external folk to do this but to do it from the ground up - but I cannot guarantee that she will not need to bring external people in to help around implementation - but she will be the person who will be absolutely leading this programme on behalf of H.C.S. We are going to be working with partner organisations to have similar people within their organisations who because they are smaller than us certainly cannot carry that level of accountability, but absolutely will be sat at the same table as Anuschka.

Deputy M.R. Le Hegarat:

I am conscious of time. Thank you all very much for your participation. It has, I am sure, been invaluable for us to have had this public hearing this morning, so thank you all very much and have a good day.

[13:55]