STATES OF JERSEY

JERSEY CARE MODEL

Lodged au Greffe on 22nd September 2020
by the Minister for Health and Social Services

STATES GREFFE

PROPOSITION

THE STATES are asked to decide whether they are of opinion −

1. To receive the Jersey Care Model (JCM) (as set out in Appendix 1 to the report accompanying this proposition), the Jersey Care Model Review (as set out in Appendix 2 to the report accompanying this proposition) and JCM Strategic Outline Business Case (as set out in Appendix 3 to the report accompanying this proposition), and to approve the strategic objectives of the Jersey Care Model set out on page 4 of the report accompanying this proposition.

2. To note that Ministers intend to bring forward proposals for investment in the Jersey Care Model in the Government Plan 2021-24, and subject to that investment being approved, to:

    a. approve the proposals to move to the next stage of the programme, to progress to the detailed design and phased implementation of the Jersey Care Model, as defined in the Strategic Outline Business Case and summarised on page 28 of the report accompanying this proposition; and

    b. to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval proposals for a sustainable funding model for health and social care, to be operational by the end of 2025.

MINISTER FOR HEALTH AND SOCIAL SERVICES

HEALTH AND COMMUNITY SERVICES

JERSEY CARE MODEL

Proposition Report

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INTRODUCTION

The Minister for Health and Social Services believes the adoption of the Jersey Care Model (JCM) is an important development for the whole community and should have Assembly endorsement. Therefore, the Minister is seeking the Assembly's endorsement of the overall concept of the Jersey Care Model and its objectives, and is seeking the Assembly's approval to move into the next stages recommended by PWC, the Executive Management Team of the Health and Community Services Department (HCS) and the Council of Ministers.

States Members' input into the strategic direction is valued at this stage before a move into detailed design at a service level.

The Minister and the HCS Executive Management Team recognise that past operating environments have been difficult ones in which to implement change. However, we have recently seen successes in moves towards less reliance on bed-based care, resulting in lower occupancy at the Hospital. There has also been good progress on social care discharge pathways, and community outreach projects in both mental and physical health have shown positive results in preventing admissions. The journey through COVID-19 in the first half of 2020 has given all providers a much better practical understanding of the interconnections and the strong and weak points of our system, putting us in a much better position to develop good practice. We feel there is public support for ensuring that healthcare services are configured to be delivered resiliently, sustainably, safely and, in many cases, out of hospital. This is the ideal opportunity to make a coordinated, positive change to the Island's healthcare system.

THE JERSEY CARE MODEL

A care model is a conceptual framework which calls for an organised and planned approach to improving patient health. It sets out the high-level design for services, incorporating all elements of the health and care system, as a guide to improve services holistically. The care model helps create a consistent narrative by which all elements of the system can understand the direction of travel and coordinate integration. Healthcare by its nature is complex and never static. HCS has not stopped evolving services outside of this programme as it has reacted to changing environments. The Jersey Care Model (JCM) will inform a delivery programme which will develop and deliver integrated services that will be designed and delivered as an evolution rather than a revolution, using the care model as it's reference point.

The overarching aim of the Jersey Care Model is to transform health and social care, in order to improve Islanders' physical and mental health and wellbeing. To achieve this, it proposes adopting a patient-centred approach whereby care is financially sustainable, safe and accessible, being provided in the places where people need it the most.

This also aligns closely with the Government of Jersey's Common Strategic Policy – in particular to improve Islanders' wellbeing and mental and physical health, whilst preparing for more Islanders living longer. Indeed, without the JCM, analysis suggests that the current health system would be overwhelmed as a result of the ageing population demographics and disease prevalence on the Island.[1]

Care will be enhanced in the community and decentralised from the hospital by strengthening public health, prevention and community services to reduce the dependency on secondary care. Care will be proactive rather than reactive and will put individuals at the centre of their own care. Technology will also be fully utilised to allow people to manage their own health. A strong partnership model will be developed with valued service providers across the public, private and community sectors.

JERSEY CARE MODEL STRATEGIC OBJECTIVES

The JCM has three overarching objectives, which are aligned with the Government strategic ambitions[2]. These are to:

1. Ensure care is person-centred with a focus on prevention and self-care, for both physical and mental health

2. Reduce dependency on secondary care services by expanding primary and community services, working closely with all partners, in order to deliver more care in the community and at home

3. Redesign health and community services so that they are structured to meet the current and future needs of Islanders

[1] https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R%20DiseaseProjections2016-2036%20140917%20PH.pdf

[2] JCM Strategic Outline Business case – Page 3

HOW DOES THIS ALIGN WITH GOVERNMENT STRATEGY?

Over the last decade, a series of papers and publications have set out the vision for health and care services in Jersey and developed the JCM to achieve this vision.

In 2011, Health and Social Services published the Green Paper 'Caring for each other, caring for ourselves[3]'. This set out a 30-year vision and a ten-year plan for health and care services on the island, including how health and care services would be modernised and expanded in the community to deliver more round-the-clock care with a view to reducing admissions.

It set out a desire to move towards a less medicalised and paternalistic approach to care and mirrored aspirations elsewhere in the world to better integrate services to provide a more joined-up approach. The intention was to support people to remain independent for as long as possible, reduce unnecessary hospital emergency visits and only admit people to hospital when they needed to be. This would reduce pressure on the acute hospital as our community's demographic changed. The Green Paper also acknowledged the need for a new hospital and, within this context, for the new care model to facilitate a shift to a more community-focused model of care at the point at which a new hospital was built. In 2012, this was developed into a White Paper[4] which developed the ten-year plan in more detail.

Following the publication of the White Paper, the Government of Jersey published 'Health and Social Services: a new way forward' (P82)[5]. This set out a clear case for change in the way services should be delivered in order to be sustainable. This White Paper has set the foundation for the strategic direction of health and social care on the Island.

The JCM builds on the foundations and principles of P82/2012 but brings it up to date with reference to modern practices and international best practice.

As highlighted in the PWC Review of the JCM[6], the Jersey Care Model is aligned with internationally recognised best practice examples and addresses issues in the current care model, with a fundamental shift to the provision of sustainable, affordable, safe and high-quality services. The JCM outlines a strong, person-centred approach to delivering healthcare in Jersey, in line with current trends in healthcare worldwide. The proposed integrated care

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[3] https://statesassembly.gov.je/assemblyreports/2012/r.082-2012.pdf

[4]https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R2%20New%20System%20for%20HSSD%20main%20doc.pdf

[5]https://statesassembly.gov.je/Pages/Propositions.aspx?ref=P.82/2012&refurl=%2FPages%2FPropositions.aspx%3Fdocumentref%3DP.82%2F2012

[6] JCM Review Paper_20200528_Final_Draft_incl Addendum, page 13

model is likely to deliver enhanced service user experience and care by streamlining services and workforce resources.

WHY DOES JERSEY NEED THE JCM?

Health and care are continuously evolving, and the practice of today isn't always practice for tomorrow. Hospital interventions, community capabilities and digital innovation are all shaping the way health and care is delivered now and for the future. Jersey will need to adapt to these changes in order to attract the many professionals needed to provide care on the Island. The Global Pandemic in 2020 has shifted focus onto the resilience of health and care systems, and for Jersey has outlined that care out of hospital is as important as care in hospital.

International organisations[7] including the World Health Organisation (WHO), Organisation for Economic Cooperation and Development (OECD) and World Economic Forum (WEF), together with the EU Parliament[8] and British Medical Journal[9], have recently identified significant challenges to the long-term durability, performance and sustainability of healthcare systems. Ageing populations, increasing rates of chronic and complex disease, growing cost pressures from new medical technologies and medicines, wasteful spending on low-value care, inefficiencies due to system fragmentation and limited use of data and evidence to support reform have been identified as threats to health system performance and sustainability. Jersey is facing the same threats as the rest of the world in this respect. The cost of health care is also rising by around 4-10%pa[10] , which places a challenge on sustainability. Health and care systems are being forced to think differently about how to meet those challenges.

Whilst many health and care services in Jersey are performing well currently, there is room to improve and modernise in many areas; and services are not future proofed. The Island expects its population to grow by 13% between 2019 and 2030[11], with a growing proportion in age groups that have greater health and care needs. By 2036, around one in five of the population will be 65 or over. The result of this demographic change is likely to be a significant growth in those accessing services, particularly when the prevalence of long-term conditions in this group is taken into account (more than half of Islanders aged over 60 have

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6340467/

[8] https://www.europarl.europa.eu/RegData/etudes/IDAN/2018/619029/IPOL_IDA(2018)619029_EN.pdf

[9] https://www.bmj.com/content/358/bmj.j3895

[10] https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

[11] https://www.gov.je/Government/JerseyInFigures/Population/Pages/PopulationProjections.aspx

two or more long-term conditions[12]). It is therefore imperative that Jersey adapts to this demographic challenge by ensuring health and care on the Island is co-ordinated and directed to meet the care needs of Islanders.

With an ageing population, the cost associated with treating these diseases in Jersey is due to rise to unsustainable levels. Statistics Jersey's Disease Projections Report[13] predicts that a 'do nothing' approach will result in the following by 2036:

* Diabetes to increase by 42%

* Stroke to increase by 64%

* Dementia to double

* Chronic kidney disease to increase by 74%

* Chronic Obstructive Pulmonary Disease to increase by 50%

* Mental health conditions to increase by 29%.

As an island we are also an outlier compared to UK comparable regions in our high use of residential care, highlighting our lack of 24/7 community care to support independent living[14].

The current health and social care model is hospital-focused and based on an institutionalised model, with a high level of referrals to specialists leading to dependency on secondary hospital care for the provision of services. This was also recognised in P82/2012. This is evidenced by approximately 30,000 visits to the Emergency Department in 2018 that were not classified as emergencies requiring Hospital care and over 200,000 outpatient appointments per annum. Many patients and families describe the existing system of care as 'fragmented', with little continuity in care leading to multiple reviews by many professionals.

In addition to this inefficiency, there are further acknowledged issues with the current model, including[15]:

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[12]https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R%20DiseaseProjections2016-2036%20140917%20PH.pdf

[13]https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R%20DiseaseProjections2016-2036%20140917%20PH.pdf

[14] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/current/delaying-and-reducing-the-need-for-care-and-support/2a-long-term-support-needs-met-by-admission-to-residential-and-nursing-care-homes

[15] JCM Review Paper_20200528_Final_Draft_incl Addendum, page 18

- Limitations in preventative care on the Island
- Lack of co-ordination between Primary and Secondary Care services and external partners can lead to transactional care for patients evidenced in multiple referrals and repetitive consultations
- Mental health services are not fully integrated with physical health and social care services
- Absence of 24/7 help and care for people to access, in particular overnight community nursing and carers who can provide a 'night sitting' service.

The JCM offers an opportunity to address these gaps and coordinate services across all parts of the system for an improved service user and care experience, and to invest in preventative services which will support Islanders in staying healthier for longer.

Given the rising cost of care, it is important for Jersey to make efficiencies to ensure public services offer good value and quality for Islanders. By 2036, the JCM is forecast to avoid £23m of recurrent annual expenditure growth for the health and care system[16]. Over the 16-year period modelled, the net present value saving associated with the JCM is estimated to be £118m.

[16] JCM Strategic Outline Case_09092020 – Page 4

HOW WILL IT DIFFER FROM THE PRESENT SYSTEM OF CARE?

CURRENT SYSTEM

The development of the Jersey Care Model has identified several gaps within the current system of care which include;

Secondary Hospital Care Focused Model

- *The Hospital is the centre of care for the island. There is evidence of extended Hospital length of stay for people who are medically fit and require care out of hospital and there is concern the current model focuses on institutionalised bed-based care.*
- *Emergency Department (ED) attendances – there is a high rate of attendance at ED with relatively low acuity which demonstrates that many attendances could be avoided – this is evidenced by the low conversion rate of admission to hospital when seen in the Emergency Department*
- *The Hospital is currently underutilising its operating theatres, both in terms of scheduling and use of day case theatre – this has been re-set due to COVID but there is still opportunity for improvement*
- *Rehabilitation / length of stay – there are long length of stays in rehab inpatient services which are also Hospital-based and there is a high flow rate into residential care direct from Hospital as a result of no alternative care being available*
- *Outpatients – the 'new to follow-up' ratio is high in comparison to benchmarks – suggesting that secondary care is not discharging into primary care and patients are having to continue to attend the Hospital outpatients for follow-up care*
- *Rapid response (a service to prevent people going into Hospital and help them to leave hospital when able) could be more optimised. This was a key part of P82 but the JCM has identified this service requires more investment*
- *Reablement to support rehabilitation services is limited due to the size of the service and it is not standard practice to assist people to live independently*
- *The current system is heavily reliant on beds, particularly for older demographic care which presents high risk of hospital-acquired infection, falls and long-term institutional care*
- *Mental Health – services are not integrated with physical health and social care*
- *Lack of positive risk taking in the current service configuration, risk assessment and planning for people to achieve their goals*

Prevention, Primary, Community

- *There are limitations in the services offered due to funding and the payment framework and this is driving activity towards hospital care*
- *Payment model does not incentivise self-care, collaboration or innovation*
- *Pharmacy, Nursing, Dental and Optometry are under-utilised*
- *Deskilled workforce in primary care due to secondary care- focused model*
- *Long-term condition management is typically run in secondary care e.g. Diabetes, where most of the service could be primary care-delivered*
- *Lack of formal approach to how conditions are managed across care settings*

Community, Social Care and External Partners

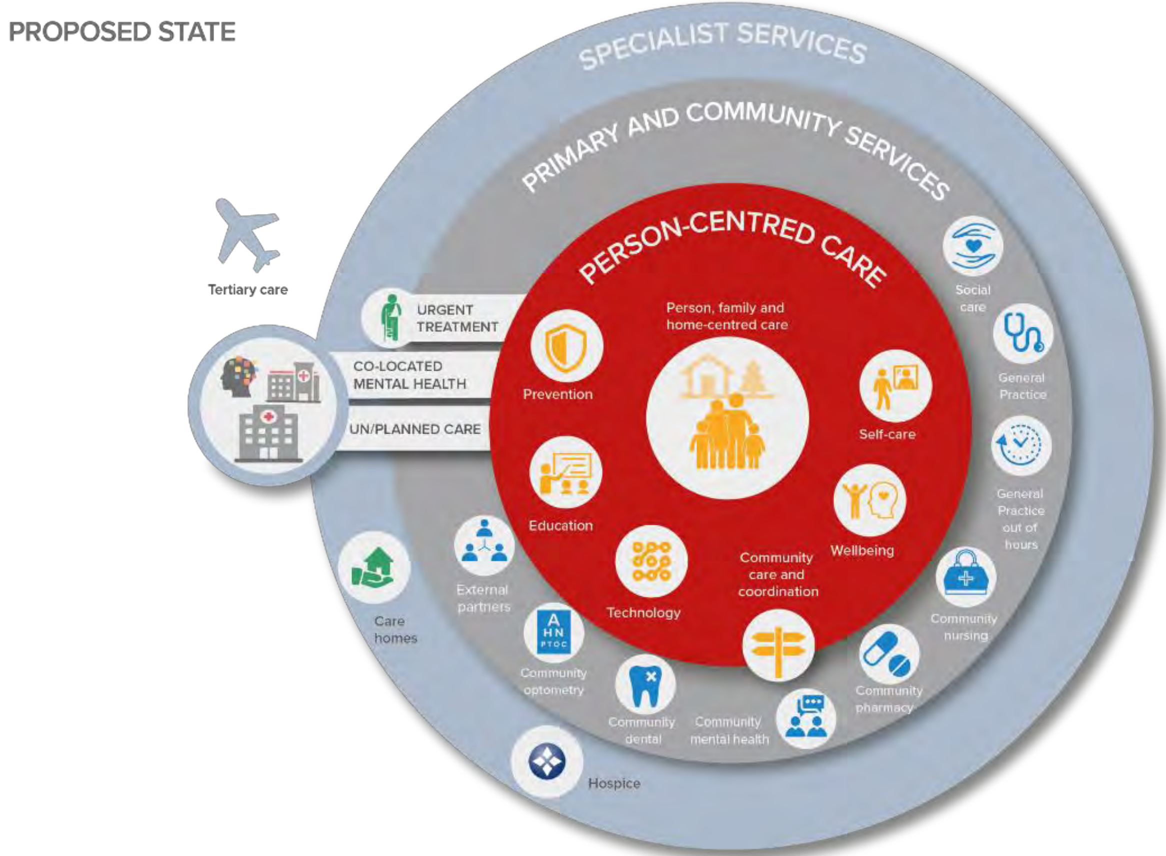
- *24/7 community nursing not in place*
- *Services are not optimally commissioned and managed with care providers having short-term contracts and no long-term commitments*
- *Social Care model is over-reliant on high-cost / dependency residential care*
- *Limited options for Long-Term Care other than residential care*
- *Community mental health offering over-subscribed and needs development*
- *There is a very strong voluntary sector and social care market, but it could be better coordinated and is difficult to navigate, especially in times of crisis*
- *£18m commissioned services and approved providers, although not through coordinated commissioning*
- *Duplication of services and back office functions*
- *Lack of public understanding of services available and signposting to services*
- *Careers are not adequately supported by the current system as many are supported by the voluntary sector and Parishes*

FUTURE CARE

Building on the foundations of P82, the care model has been developed as a clinically and professionally-led model for how health and care services are delivered across all sectors on the Island. The model seeks to move away from the unsustainable institutional-based model into a more modern community-based model, putting patients, their family and home at the centre of care.

The model is based around these components:

I. Person-centred Care
II. Primary and Community Services
III. Specialist Services



Person-centred Care

- *A new model for healthcare, focusing on prevention and community partnership*
- *Ensure care and support are person-centred: personalised, coordinated and empowering*
- *Develop self-care and patient education programmes to enable people to look after themselves better*
- *Improve health outcomes by ensuring that care from different providers is not delivered in silos*
- *Develop partnership of purpose with community sector and improve signposting and coordination*
- *Lead in the use of technology to empower people to manage their health and care*

Primary and Community Care

- *Make full use of breadth and depth of primary care resources including General Practice, Pharmacy, Dental, Ophthalmology*
- *Support Primary Care to manage long term conditions*
- *Enhance Primary Care with knowledge transfer and support from specialist services in Secondary Care*
- *Improve rapid access to diagnostic services and specialist advice and guidance to help people stay within primary care*
- *Rapid response and reablement as default options - delivered in patients' homes, care homes or hospital*
- *Positive risk taking; risk assessment and planning for people to achieve their goals*
- *Person centred planning; maximise independence, confidence and resilience*
- *Focus on crisis response and home-based reablement / care*
- *24/7 Community Nursing will be introduced to ensure that nursing cover supports people at home overnight*
- *Mental Health crisis prevention services to be established*
- *Support independence through bespoke care packages that incorporate assistive technology*
- *There will be an increase in personal choice and working with external partners to reduce the key pressures that an ageing population presents*
- *Increase support to parents/carers*
- *Government will establish a scalable commissioning model developed in partnership with external providers*
- *Develop a Partnership of Purpose for wider external provider network to help steer the market where appropriate and support pathways of care*

- *Establish a care coordination and signposting function to help all navigate the available options*

Specialist Hospital Services

- *Hospital front door becomes an Emergency Care Centre which incorporates an Urgent Care service, paediatric, mental health and ambulatory assessment*
- *Mental health acute services provided on the same site as physical hospital services*
- *Theatre utilisation and flow will be optimised, with more day surgery to reduce demand for inpatient beds*
- *Hospital will be preserved for hospital care, meaning patients requiring care that can only be delivered in hospital will have more timely access*
- *Hospital services such as diagnostics and specialist treatments will be sustained*

EXAMPLES OF THE JCM IN PRACTICE

The following section highlights stories from different sections of the care system. (The names have been changed.) The services covered are not exclusive, and are often in their infancy, but demonstrate alignment to the direction of travel for the care model.

JERSEY CASE STUDY EXAMPLES OF SERVICES THAT NEED TO BE EXPANDED AS A CORE OFFERING

PRIMARY CARE MENTAL HEALTH & SOCIAL PRESCRIBING

Bob said that working with the primary care mental health and social prescribing practitioner was a huge help with managing stress and working through issues that had been holding him back, both professionally and personally, without having to wait several months or longer, which would have taken a massive toll. He could not thank the service enough for its help and support through some very difficult times and hopes that more people are able to access this fantastic support, which is very much needed in Jersey. Being able to talk to someone face to face and work together on how to manage difficult situations, in a timely manner, has really been incredibly beneficial.

MENTAL HEALTH – COMMUNITY OUTREACH

Home treatment team / admission avoidance / early discharge

Esme is a 42-year-old woman with a long-standing diagnosis of schizophrenia. She has had multiple admissions in the past to Orchard House due to disengagement with services and discontinuation of treatment. Historically Esme's mental state would deteriorate in the community and she would be detained by the police under Article 36 then subsequently be detained under Article 22 of the Mental Health (Jersey) Law. Historically, it would often take several months for Esme to recover from an acute episode and deterioration in mental health and she would have to be treated against her wishes.

Esme is seen regularly by her community consultant psychiatrist and care co-ordinator. It was noted that Esme was showing signs of deterioration which would normally result in hospital admission. However, before there was further deterioration, she was referred to the newly established Home Treatment Team which immediately began to engage with Esme on a daily basis. They supported her care in the community by assessing and monitoring her mental state and they engaged with her around her medication to check she was taking it properly. The Home Treatment Team

remained actively involved for over three weeks until her mental state stabilised, and her care could be transferred back to her community team. Mental Health services were able to avoid inpatient admission and Esme did not suffer a relapse of her illness.

COMMUNITY RESPIRATORY TEAM

Outreach to community to prevent admissions

David is a patient with End Stage COPD on maximum dose of medications and other non-medical treatments. He lives in a residential care home. In 2019 he had around eight Hospital admissions to the Intensive Care Unit (ICU) with Respiratory Failure Type II and he required non-invasive ventilation. ICU admissions with Respiratory Failure Type II on COPD patients increase the mortality in more than 50% of cases. In 2019, David had an estimated secondary care cost of around £160k.

David's case was switched to a community model where he came under the caseload of the Respiratory Specialist Nurses Team. A multidisciplinary approach was taken with David and all stakeholders (Home Manager, Social Services, Long- Term Care Nurses, GP, Respiratory Nurse). First-line and second-line responses were provided in the community by a joint team (GP/ Respiratory Nurses / Rapid Response Team).

Since January 2020, David's hospital admissions have been reduced by 100%. Being able to work together and have the resources in the community on how to manage difficult acute exacerbations, in a timely manner, has been incredibly beneficial to David.

RAPID RESPONSE

Service user: 'When my Doctor told me I was on the verge of going into hospital for my chest infection, I asked if I could have the Rapid Response Team, and within 1 ½ hours from leaving the surgery they were treating me with intravenous antibiotics and they came for five days. They are a lovely team and so friendly - long may this service continue.'

CLOSER TO HOME

Jersey Library Outreach - "Thank you so much for the books you lent my husband – just what he needed. We used to go to the library in town all the time but now I don't drive I find it too difficult to carry the books"

Jersey Sport - "The exercise sessions we have delivered at Communicare have been some of the best that we have been able to deliver. This is due to the help of the staff at Communicare, the opportunity to have a coffee after the session, but most

importantly it has been a welcoming environment. All participants who took part had never been to Communicare before but really enjoyed it and have said they will be bringing a friend next week. There is a much better community feel about the sessions and we believe this will grow considerably in a short space of time."

Social Work - "I have received a referral from Call & Check for a gentleman who requires social care assessment. This was taken at Communicare, which was key as the referral may not have been spotted this early in the person's set of circumstances if services were not available close to his home. This referral will lead to early intervention and prevention work."

"As a result of a social worker being present at Communicare at the same time as Call & Check, networking opportunities have led to an invite for Call & Check to attend the social work team meeting to provide a presentation to the Adult Social Care Team."

UK CASE STUDYEXAMPLES OF SERVICES THAT NEED TO BE DEVELOPED AS A CORE OFFERING

SOCIAL CARE – PERSONAL BUDGETS

Gordon, 54. My mother was already in a care home, and the services my father was getting at home just weren't working. They would come and give him breakfast and lunch, but they were too rushed to talk to him so didn't know if he ever ate it. The microwave meals were piling up and he was living on crisps and biscuits. He was deteriorating and becoming isolated.

So I rang social services and they told me about individual budgets. We wrote a very detailed support plan tailored to his needs and were awarded a budget. This was great because it provided for respite care to enable us to go on looking after my father. He used to go to my mother's care home for six hours a week, plus some overnights. My father improved physically and used to come out for walks with the family. It was a huge improvement on the previous situation.

SOCIAL CARE - REABLEMENT / FRAILTY

Marjorie received an individualised programme that was cost-saving and allowed her to remain at home. Two months away from her 103rd birthday, after suffering a fall which left Marjorie with a badly injured shoulder and leg, she was admitted to hospital. Following a progressive recovery, it was felt that the best aid towards Marjorie regaining her independence was through the Reablement service.

Over the six-week programme, Marjorie developed the strength and confidence to start caring for herself and was soon able

to walk around the house unaccompanied. Marjorie's recovery didn't come without its challenges. With partial sight and hearing impairments, even the smallest task presented difficulties. Marjorie explained: "A simple thing such as listening to the carer or hearing the doorbell ring when they arrived was a struggle. It just makes everything that little bit harder not being able to see and hear, especially when you're as old as me!"

However, Marjorie fought every obstacle thrown her way and nine weeks after her accident she is living at home independently.

Marjorie said: "If it was not for the wonderful people from the Reablement team I would not be back in my own home looking after myself. I felt from the very first day, I knew them. They made me feel so cared for and that it was possible to take my life back into my own hands."

SOCIAL CARE - REABLEMENT / STROKE

Barry was referred to the Reablement Team after suffering a stroke that had debilitated his left-hand side and inflicted memory loss. At the time of the stroke, Barry was supporting his wife who was undergoing treatment after recently discovering she had breast cancer.

Due to his poor mobility and memory loss, Barry was left feeling vulnerable and anxious at the prospect of caring for both his wife and himself. However, with the help of the Reablement team, they were able to assess the level of intervention needed and what equipment Barry required to allow for an easier recovery.

Barry initially received four daily visits and small pieces of equipment such as grab rails, toilet surrounds and a showering stool were put in place to allow more independence with personal tasks. Due to Barry's memory loss, blister packs were given to ensure that he was taking the correct medication which helped with building the confidence needed to take care of himself.

Over the six weeks, Barry was able to reduce his calls and began to take control of his life. He began Reablement worried that he wouldn't be able to cope with his recovery whilst caring for his wife, but the support offered allowed him to get back on his feet. Barry is now independent and has the confidence that if his wife was to be admitted to hospital, he would be able to manage independently at home.

DIFFERENT WAYS OF WORKING WITH PRIMARY CARE, EXAMPLES (NOT ACTUAL PATIENT STORIES)

LONG-TERM CONDITIONS MANAGEMENT E.G. DIABETES

Jo was a regular attender at the specialist diabetes clinic, but also at his GP practice due to other health conditions. In the new integrated system, Jo is supported to manage his own care through better education programmes and technology. He checks in with his GP for his annual checks at the same time as his other appointments. The GP occasionally checks in with the Diabetes centre via the same IT system if there is a specialist problem to discuss. Jo is now making good progress through improved ownership of his lifestyle.

RAPID ACCESS TO COMMUNITY SERVICES

Barbara, 46, had a sore shoulder that for months had been deteriorating. Rather than having to wait for a specialist referral to secondary care, she accessed her local primary care physiotherapy service after a brief consultation with her GP. She is now on the road to recovery.

HOW CAN WE KNOW IT WILL WORK?

A key commitment to Islanders was that this model would be externally 'stress tested' to provide an objective assessment of the validity, feasibility and deliverability of the model with a focus on:

- The proposed model's attributes and features, particularly those that represent changes from current service model delivery against an agreed assessment framework
- Interdependencies between areas of care
- Enablers that will support the delivery of care.

The HealthCare team at PWC were engaged to help review / stress test / develop the model from an independent viewpoint (the Jersey Care Model Review). A programme of review was established which saw each of the nine main workstreams comprehensively reviewed with relevant stakeholders (internal and external) from across the system. A financial analysis was also conducted to establish the costs and benefits of the model. The report[17] of this is appended to this report, as is the strategic outline business case[18] which sets out the investment requirements and benefits profile for the model.

Following completion of the Jersey Care Model Review, an addendum to the Review has been inserted at the request of the Council of Ministers. This request asked for updates to provide revised implementation and financial information following further assessment of the JCM considering COVID-19 and associated impacts on deliverability.

PWC METHODOLOGY AND APPROACH

An independent review was completed over an 11-week period by the PWC Healthcare Team.

The findings outlined in the PWC report were developed through adopting an iterative, clinically-led approach. Working with key clinical stakeholders in Jersey, a five-stage approach was adopted (see Figure 1 below).

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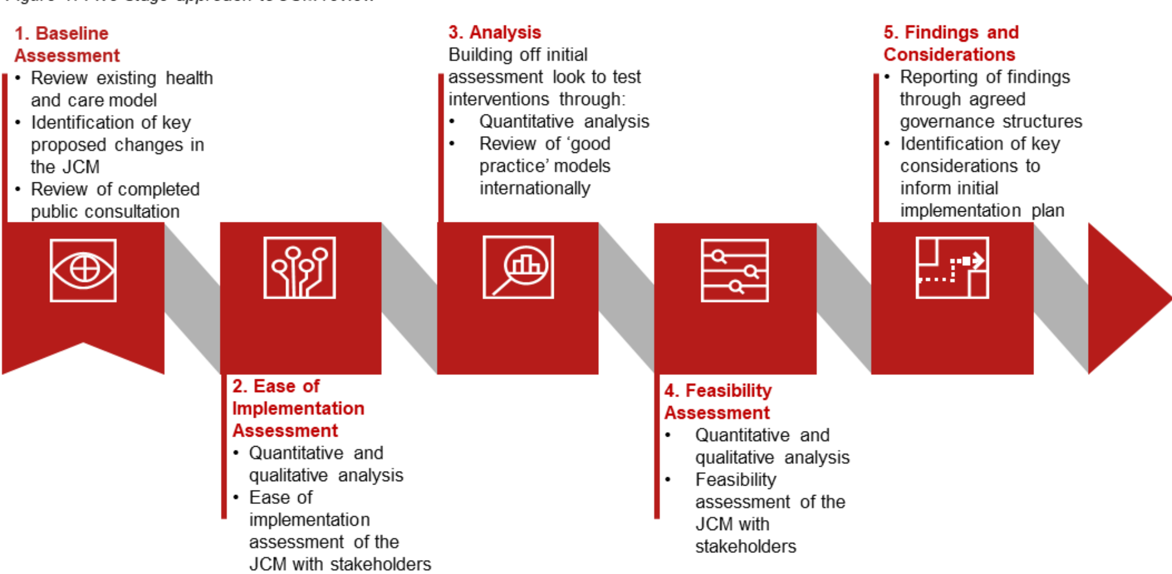
[17] JCM Review Paper_20200528_Final_Draft_incl Addendum-Appendix 2

[18] JCM Strategic Outline Case_09092020 -Appendix 3

Figure 1: Five stage approach to JCM review



To structure the analysis, an assessment framework was applied to the model (see page 20, JCM Review) which was agreed with the respective groups that provided governance over the JCM review.

Over 150 stakeholders were engaged across the Jersey health and community care system as part of the review.

Whilst an independent review, it was imperative to have strong clinical engagement to provide context, feedback and oversight of the programme, which is outlined in Figure 2. Detail on the Clinical Engagement performed for the review can be found in Appendix 8 of the JCM Review.

Figure 2: Overview of engagement for the JCM Review

FINDINGS OF THE JCM REVIEW[19]

Overarching model and workstreams

- The review found that overall the **model is in line with good practice for integrated care** and when implemented will enhance quality, safe and timely care; **benefits can start to be realised immediately**
- Some areas of the JCM are misaligned with its ambition and require further work and detail

JCM enablers

- The model is financially sustainable and will not cost more to the service users if resource allocation, funding models and commissioning arrangements are amended
- Feasibility of the JCM rests on an appropriate and enough workforce and digital capabilities

Further JCM enhancements

- The shift to preventative, service user-centred care and self-care is fundamental to JCM; however, how this will be systemically delivered is still unclear
- To realise real benefit, a Population Health Management[20] approach should be adopted
- To be a leading model globally, the JCM will need to expand the care model beyond traditional settings and workforce

Assumptions and limitations

- The level of alignment and commitment across partners will be imperative
- The JCM will only be achieved through a decentralised care model

Public Perception[21]

- The JCM assumes that all Islanders will be supportive of service changes; this is broadly in line with the findings from the review
- Through the extensive public consultation meetings in Parishes, it is clear that the health care system in Jersey is important to Islanders. While there is a strong

[19] JCM Review Paper_20200528_Final_Draft_incl Addendum, Page 25

[20] JCM Review Paper_20200528_Final_Draft_incl Addendum, Page 39

[21] JCM Review Paper_20200528_Final_Draft_incl Addendum, Page 51

viewpoint provided, overall, there is recognition from Islanders that a change is required, and a health and care system that is integrated and sustainable is important and needed for Jersey.

PWC's view of the top ten benefits of the JCM[22]:

- Supporting people to live independently at home by offering integrated, community services
- Developing and strengthening partnerships between primary and secondary care with external partners to prevent duplication of services. Additionally, developing partnerships off-island to provide joint specialist services
- Innovative care delivery through digital solutions and services
- Repurposing existing estates and forming strategic partnerships with parishes
- Streamlining current pathways and processes, particularly in relation to referral management for long-term conditions
- Removing barriers to access for vulnerable service users through re-modelling funding structure
- Reducing and delaying people's need for care, through investment in preventative services
- Developing new ways of providing services, for example, development of an Urgent Care Centre, and where possible, exploring the expansion of existing services
- Expanding existing crisis response services to lower avoidable inpatient admissions
- Improving children's health through several initiatives supported by Public Health

[22] JCM Review Paper_20200528_Final_Draft_incl Addendum, page 25

BENEFITS / COSTS AS VALIDATED BY PWC

As validated by PWC, the JCM is financially sustainable[23] and will not cost more to the service users. This is provided that resource allocation, funding models and commissioning arrangements are amended. After investments, the JCM is forecast to avoid £23m per year by 2036 of the expected expenditure growth for Jersey's health and care system.

In order to deliver the JCM and realise the expected benefits, investment of £28.1m over this government plan (2021-23) is required, before the model could deliver a net financial benefit from 2025. £17m of non-recurrent investment over a five-year period is required in order to deliver the savings (included within the £28.1m).

Non-recurrent investment requirement

Non-recurrent investment is expected to fall across two main categories:

- Programme costs: These are the costs associated with the transformation programme required to deliver the JCM. It is expected this programme would operate over a five-year period. The costs associated with this would cover PMO support, organisational development support, communications support and digital transformation subject matter expert(s).
- Digital non-recurrent investment: The JCM describes the requirement for several new digital tools for use across the health and care system. These include investment required for integrated care records and Jersey care record, core record systems, hub and micro services, and analytics. These investments have been split between non-recurrent revenue and capital expenditure lines.

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

Further details on the breakdown of this non-recurrent investment requirement can be found in sections 4.2.3 and 4.3.4 of the JCM Strategic Outline Business Case[24].

Recurrent investment requirement

In addition to the non-recurrent investment, the JCM requires the implementation of a number of new services and the expansion of some existing out of hospital services. Over the 16 years to 2036, these have been estimated to cost a total of £679m.

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[23] JCM Review Paper_20200528_Final_Draft_incl Addendum, page 26

[24] JCM Strategic Outline Business Case_09092020

The new services required through the JCM primarily relate to out of hospital provision of health and care services that avoid hospital care (inpatient or outpatient) or long-term care placements.

These have been assumed to ramp up from 2021 and, by 2036, they will cost £67m per year. An element of double running has been assumed between the new services coming online and benefits being achieved. In particular, unless otherwise identified through the implementation plan, it has been assumed that changes will take 12 months from the implementation of the new service before the impacts of the JCM are fully delivered (leading to an initial net recurrent investment in 2021 to 2024).

Further details on this recurrent investment requirement can be found in sections 4.2.3 and 4.3.3 of the JCM Strategic Outline Business Case.

'Do nothing' scenario

In the 'do nothing' scenario, where provision remains predominantly provided by the acute sector, but demand and activity increase due to a growing and ageing population, the service will face a significant affordability challenge driven by an increase in activity. In the 'do nothing' scenario, there is a predicted growth in cost across the system of 112%. This would see the total expenditure on health and care services rise from £378m to £716m by 2036.

Population growth and demand and capacity

The 'do nothing' growth assumptions are based on data from the latest demographic growth scenarios provided by Statistics Jersey. Several assumptions have been made in modelling population change, demographic change and associated demand and capacity. See the strategic Outline Business Case, Financial Case for full details of these assumptions.

In a 'do nothing' scenario, there is projected to be increased demand across all areas, with up to a 35% increase in activity in non-elective in-hospital care by 2036.

'Do something' scenario

Analysis of the financial benefits for the 'do something' case suggest that there will be a 'do something' gross impact of £90m per annum by 2036. When accounting for the recurrent costs of re-provision of new services, net cost reductions of around £23m per annum are expected by 2036. See the JCM Strategic Outline Business Case section 4.3.4 for full details of these assumptions.

In total, the JCM is forecast to avoid just under £23m per annum of expenditure growth for the health and care system by 2036.

For each of the changes proposed in the JCM, PWC estimated how patient flows will be impacted and then modelled an appropriate change in forecast expenditure. This includes both areas where activity will reduce (i.e. removing patients from in hospital settings) and where they will increase (i.e. provision of new services to enable the change).

Through implementing the changes proposed in the JCM, the financial sustainability of Jersey's health and care system will be significantly improved.

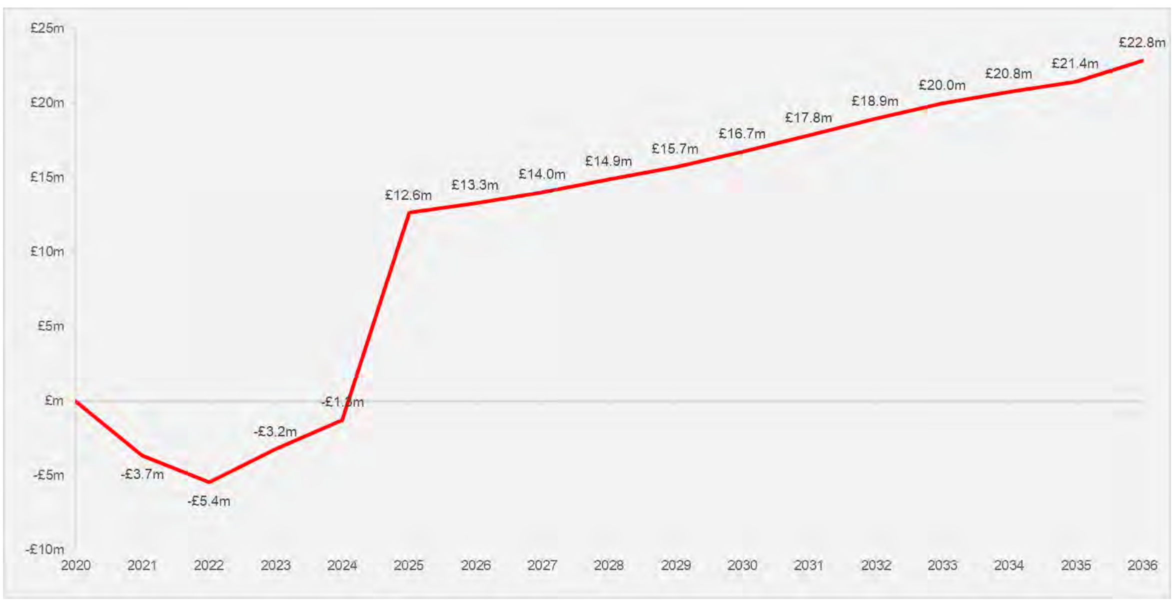
In addition to the non-recurrent investment, the JCM requires the implementation of several new services and expansion of some existing out of hospital services. Over the 16 years to 2036, these have been estimated to cost a total of £679m.

As a result of these investments, over 16 years, the JCM is forecast to avoid a total of £874m in expenditure growth compared to the 'do nothing' scenario (where no changes are made to the health and care system). Net of the recurrent investment requirement, there is a total forecast reduction in expenditure growth of £195m compared to the 'do nothing' scenario, which falls to an impact of £178m once non-recurrent investment has also been removed.

The JCM will avoid expenditure growth and particularly improve the financial position of the Long-Term Care fund.

As a result of the JCM, sustainability of Jersey's health and care system is forecast to significantly improve. From 2025 onwards, the savings associated with the JCM start to exceed the investments.

Figure 2: 'Do something' net benefits from delivery of the JCM



LONGER TERM FUNDING & BUDGET STRUCTURES

To integrate the health and social care system, a different approach will be needed to funding and financial management across the system. A one system, one budget approach will need to be taken to truly integrate services. Currently, there are several funding sources e.g. from tax, social security, user payments, and insurance; these often create inefficiencies in the system. A full review of the system financial sources, process and structures will be required over the next four years to create a sustainable, efficient model for health and care on the Island.

COVID – IMPACT AND LATEST POSITION WITH GENERAL PRACTICE

Health and Community Services and General Practice, via the Primary Care Body (PCB), have been in dialogue about the future funding model for general practice. Pre-COVID, a set of sessions was held to evaluate potential options to support various projects e.g. P125/2020 Access for the financially vulnerable to GPs. PWC also helped to assess and work up cost models for various options of payment and incentivisation, as presented in the JCM Business Case. The PCB has also submitted proposals for a hybrid funding model post-COVID for the longer term which has the broad support of General Practice.

During the pandemic in early 2020, HCS and the PCB worked together to ensure the continuity of general practice during this period. A temporary employment contract was put in place for four months, with GPs directly employed by HCS during that time. That contract ended in August 2020, with practices returning to their usual operations at that time.

Exploratory work was undertaken towards the end of the contract period looking at options for potentially extending the contract, or putting in place a new version, to accelerate ambitions for changing the model on a more permanent basis. The review determined that further work and analysis was required in order to negotiate the right arrangement for all parties and that it should not be rushed.

All parties are committed to developing a funding model via the JCM that helps take the health and care system forwards. General Practice through the PCB continues to engage with the Government of Jersey to explore care models in conjunction with funding models consistent with the principles of the Jersey Care Model. The PCB supports a transition to an evolved care model and looks forward to continued engagement along with Health, CLS and other stakeholders.

IMPLEMENTATION

Following the review of the JCM, a multi-year implementation plan has been developed with key projects prioritised in tranches[25].

Taking on board the finding of the JCM review, and through internal planning, it is been determined that the implementation of the JCM will be completed in three tranches. The emphasis of the first tranche will be on detailed planning, particularly around workforce and change management, to be able to support our health and care professionals to deliver in the new model, establishing the necessary foundations to deliver on the new model, and driving care delivery through enhancing intermediate care. Implementation will need to be phased, to be able to shift to the new model, while being responsive to any immediate needs on the system, including COVID-19.

In developing a realistic and achievable implementation plan, the deliverability of the JCM was reviewed. Considering the emerging challenges the Island is facing post-COVID-19, the phasing of the programme has been amended to allow stabilisation of the platform within Jersey with the roll-out of the programme phased in three tranches outlined in Figure 3.

[25] JCM Strategic Outline Business Case, Section 5, Page 83

Figure 3: JCM prioritisation framework for implementation

Assessment of deliverability

The ambition to the implementation has been reset recognising the need to:

- Address the findings in the JCM and particular areas that are key risks e.g. having the right workforce ready and skilled
- Learn lessons from COVID-19 in terms of the need of the model
- Have capacity in the immediacy to respond to any potential Wave 2 COVID-19 and potential winter pressures
- Focus on efficiencies in the acute to reduce bed numbers to support the 'Our Hospital' programme

Tranche 1 (2021)

- **Detailed planning** – assessment and modelling of need including supporting policy review
- **Foundations** – establish the supports for the workforce to be successful (e.g. public health function, digital)
- **Acute** – driving efficiencies as a part of GoJ requirements, best practice and Our Hospital build
- **Community/Intermediate Care-** focus improving health & social care pathways through an enhanced single point of access and use of Tele-care
- **Workforce** – creation of an island wide workforce plan to support implementation of system wide changes in tranche 2 and beyond
- **Communications** – establishment of public, patient and wider stakeholder groups to inform design and delivery

Tranche 2 (2022-2023)

- **Commissioning** – implement a commissioning framework with community and social care partners, building on the care at home initiative
- **Acute staff** – community clinical team to support shift of model away from core acute, including nurse roles, etc.
- **Community/Intermediate care** – launch schemes which involve co-designed services with external partners, including rapid access team and enhanced reablement services
- **Detailed planning** – assessment, modelling and co-design of primary care framework, e.g. long-term condition management
- **Staff training** – launch of long term staff training programme to ensure model of care delivery

Tranche 3 (2023-2025)

- **Acute** – continued service improvement programme to support delivery of services in line with best clinical practice
- **Primary care** – co-designed pathways for management of patients with long-term conditions to be rolled out
- **Community/ Intermediate care** – fully implemented revised social and intermediate care model with a reduction in placement prevalence

Delivery plans will be presented as part of the GP 2022 and beyond to access funding required for tranches 2 and 3.

These tranches are still in line with the key areas as identified within the PWC review. An initial summary of key areas of focus is outlined in Table 5.3 in the JCM Business Case[26]. As noted, the areas of focus upfront are targeted on detailed planning to establish the foundations of the JCM, and clear communication of the programme progress and changes to Islanders and staff.

[26] JCM Strategic Outline Business Case, page 89

JCM IMPLEMENTATION GOVERNANCE[27]

Governance has been established to provide oversight (including clinical oversight) over the JCM review and this will continue through implementation.

Three key oversight groups were established as part of the JCM Review programme to provide input, review, challenge and oversight:

- Integrated Care System Leadership Team (formerly the JCM Steering Committee): formed to provide strategic leadership, direction and overall decision-making capability for the JCM review.
- Clinical and Professional Senate: provided strategic oversight and recommendations on the outputs of the JCM review. It is proposed that the Senate will continue to make decisions regarding the implementation and delivery of the JCM beyond the completion of the review.
- Technical Group: created to oversee data analytics, modelling and provide decision-making capability in relation to quantitative analysis.

These groups will continue as part of the implementation of the programme.

External assurance arrangements will also be established during programme mobilisation.

[27] JCM Strategic Management Business Case, Management Case, Page 82

PWC FINDINGS OF FURTHER OPPORTUNITIES IDENTIFIED IN STRESS TEST

PWC identified several areas where the Jersey Care Model could potentially be enhanced[28]:

The prevention agenda should not be limited to the list provided. There are other opportunities for preventative measures throughout workstreams, for example, in Women's Health, Children's Health and Mental Health. Working with Public Health will support benefits realisation, whilst helping deliver on government policy.

Embedding preventative health in the future JCM will prove challenging as it will require significant financial investment. Despite these high costs, preventative health is widely regarded as a cost-effective means of improving population health.

Jersey could consider an alternative payment mechanism to support the shift to preventative care. If Jersey was to move to a different system in primary care, including for community pharmacy, this could incentivise prevention, in turn keeping healthcare costs down and supporting the integration of care.

Building on the prevention agenda, there is further opportunity for the JCM to achieve real gains through a **focus on driving service user-centred and led care**. This is encouraged by the ageing population and increasing prevalence of long-term conditions.

Digitising the system can help realise the full benefit of self-care in Jersey. In health and care systems where self-care is prominent, digital front doors *(i.e. an online point of access for information and, signposting and possibly referral)* help redirect service users who would traditionally present to primary or secondary care services to self-care models. For Jersey, a digital front door could not only reduce unnecessary attendances but also address the issues regarding staffing.

To realise the full benefit of the JCM, a **Population Health Management** (PHM) approach should be adopted

PHM is an approach to using data from across the health and care system to segment the population according to their risk profile, and to proactively identify where interventions may prevent that level of risk escalating. Rather than taking a disease-focused view (e.g. identifying those with diabetes in the over-65 age group), PHM allows a more nuanced view of risk as it considers a wider selection of data points.

Jersey has made some progress on moving towards a PHM-enabled model, although there is more to be done. Jersey can make real progress with PHM, due to the way in which data

[28] JCM Review Paper_20200528_Final_Draft_incl Addendum, Page 35

sets are collected and managed in Jersey already. The Jersey health system is more of a 'closed system' than many NHS systems as there is less patient flow across boundaries of the health system, except for some specialised services. In addition, the implementation of the JCM will create a longitudinal data set *(i.e. a set of data/records over time)*, which would provide a useful foundation for population health analytics.

To be a leading model globally, the JCM will need to **expand the care model beyond traditional settings and workforce**. Leading integrated models extend the delivery of health beyond social care to incorporate non-traditional healthcare providers

While advanced systems aim to integrate their health and social care services, leading systems look to integrate these more traditional models with the wider components in their system, including schools and government agencies. This type of whole system integration can impact on broader population wellbeing.

While the JCM identifies the importance of pharmacies, dental and ophthalmology services in the Island's future integrated model, there are numerous other services that could be considered to achieve leading edge good practice. These services are accessed across the life of a service user from infancy to older age and are reflected in all aspects of living within a society. These include:

- Schools – can improve health literacy, create healthy habits and lifestyles
- Businesses – to provide mental and physical health checks and programmes, promote healthy alternatives
- Clubs and societies – to promote health discussions, encourage social interaction and mental health
- Government agencies – to provide incentives for healthy living, including financial benefits for healthy lifestyles
- Urban planning – redesigning public spaces and amenities, as well as planned housing to promote an increase in healthy lifestyles.

In addition, the **provision of health and care does not always need to involve trained professionals.**

The JCM will require a workforce different to that currently seen in Jersey. The model will need to look to an alternative workforce that expands from clinical to a wider range of staffing groups. This would not necessarily mean a substitution of the workforce, but additional service users who can enhance a culture of health and wellbeing on the Island.

FREQUENTLY ASKED QUESTIONS

It is important to highlight what the Jersey Care Model is **not** proposing in order to avoid misconceptions of the changes being proposed.

What the JCM is not:

1. The JCM is not nationalisation of GP and community services. GPs play an important role in the delivery of healthcare provision within the Island and it is accepted that many of the valued system benefits of the GP service must be retained in future care models, such as continuity of care for patients by GPs and direct access in a timely fashion.

   Whilst the JCM seeks to empower and equip GPs to support additional services in the community, this cannot be undertaken to the detriment of ease of access and continuity in care and any proposed changes will require negotiation with GP partners.

   There is commitment to ensure, however, that access is available to all, and in particular, vulnerable persons.

   Community provision through the many third-sector organisations on the Island would continue under the Jersey Care Model with longer term contracts in place and more clarity in service specification.

2. The JCM does not replicate the NHS and it is recognised that health and care services are different within Jersey and must be tailored to the requirements of Jersey. It must be borne in mind that most of our health and care professional workforce are trained and educated within the UK healthcare system, but this does not mean the NHS approach is required.

   The UK NHS system provides nationalised Hospital, GP, Community & Primary care services that are Government-led under a constitution of care. Under the JCM proposals, the Jersey Government retains the provision of core Hospital, Community, Mental Health and Social Care services. GPs, community pharmacy, dentistry and ophthalmologists remain independent service providers and community organisations such as Family Nursing and Homecare, Jersey Hospice Care, Mind

Jersey and others remain sovereign bodies that are commissioned by Government to provide key services.

Pathways proposed under the JCM have and will continue to be developed with all system partners.

3. The JCM has an important role with the development of the new Hospital, but it is important to note distinct differences between the two initiatives.

   The specification of services for the new Hospital in Jersey has been developed by clinicians through the clinical brief process of the Our Hospital Programme. We have committed that all the current services provided at Jersey General Hospital will be provided in the new Hospital facility and the process for designing and planning clinical functions and adjacencies sits outside the remit of the JCM.

   The JCM has explored pathways that transition in and out of hospital and it is in this area where there is connectivity between the two programmes. It is important to note the JCM is a transformation programme and that regardless of the Our Hospital programme, the health and care system would still be required to implement many of the proposed changes in order to meet the demographic challenges outlined.

   The JCM seeks to co-ordinate the Island response to those challenges and this will enhance the function of the Hospital, but it will not determine that function. We anticipate benefits such as robust out of hospital care will impact upon patient flow through the Hospital, but these initiatives would be pursued with or without the JCM transformation programme.

4. The JCM is not seeking to stop Residential and Nursing Care provision on the Island. Whilst the JCM has identified heavy reliance on this sector of care within Jersey, it does not seek to prevent Residential and Nursing Care being available for Islanders who wish to access it. The JCM seeks to provide Islanders with a choice of future care both at home and within other longer-term care settings such as care homes.

   The COVID-19 pandemic has outlined how important this part of our health and care system is and how vital it is to sustain these services. In addition, it is anticipated new care provision being provided within Jersey supporting people with Dementia

such as Extra Care 'village' concepts and specialist services such as Learning Disabilities.

5. The JCM is not a financial strategy. The model was designed by clinicians and health professionals and the financial impact and benefits realisation of the JCM has been determined through internal and external review. Best practice in high quality care delivery is evidenced to often be more financially efficient and this approach provides an opportunity to re-purpose workforce and investment across the system of healthcare.

APPEDICIES

Appendix 1 – JCM Briefing Paper (pp.38-169)
Appendix 2 – JCM Review Paper (pp.170-355)
Appendix 3 - JCM Strategic Business Case 2020 (pp. 356-493)

END

APPENDIX 1

HEALTH AND COMMUNITY SERVICES

JERSEY CARE MODEL

Produced by Jersey Health and Community Services, October 2019. V1.1

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VERSION HISTORY

Version	Issued	Author	Changes
V0.1 – Draft	14 June 2019	Caroline Landon	Minor CP OB
V0.2 - Draft	12 July 2019	Stephen Bull	Development of work streams
V0.3 - Draft	20/09/2019	Stephen Bull	Update following engagement process
V0.4 - Draft	27/09/2019	Stephen Bull	Update following review
V0.5 - Draft	02/10/2019	Stephen Bull	Update following review
V1.0 – Issued to POG	02/10/2019	Stephen Bull	Final Print Version
V1.1	07/10/2019	Stephen Bull	Authors table added

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Term	Definition
Prevention	There are three types of prevention activities that can benefit populations, termed primary, secondary and tertiary prevention: **Primary prevention** aims to promote population health and well-being and prevent disease and harm before it occurs – seen as an "upstream approach". **Secondary prevention** aims to detect disease and identify risk factors before they become harmful to health (e.g. screening). **Tertiary prevention** treats disease with cost-effective interventions to slow or reverse disease progression; it includes rehabilitation for disability – seen as a "downstream approach". Source: Adapted from Donaldson LJ, Donaldson RJ (2003). Essential public health, second edition. Abingdon: Radcliffe Publishing. In Jersey, primary, secondary and tertiary prevention is facilitated by a range of public and private providers in a variety of settings.
Self-care	Self-care techniques and general lifestyle changes can help manage the symptoms of many mental and physical health problems. They may also help prevent some problems from developing or getting worse
Primary Care	Primary Care is the first place people most often go to when they have a health problem and includes a wide range of professionals, e.g., GPs, dentists, pharmacists and optometrists
Secondary Care	Secondary Care simply means being taken care of by someone who has particular expertise in whatever problem a patient is having. It's where most people go when they have a health problem that can't be dealt with in Primary Care because it needs more specialised knowledge, skill or equipment than the GP has. Specialists focus either on a specific system of the body or a specific disease or condition. For example, cardiologists focus on the heart and its pumping system. Endocrinologists focus on hormone systems and some specialise in diseases like diabetes or thyroid disease. Oncologists have a specialty in treating cancers and many focus on a specific type of cancer. Secondary Care can either be planned (elective) care such as a hip replacement or cataract operation, or urgent/emergency care (unplanned) such as treatment for sepsis, heart attacks or broken bones.
Tertiary care	Tertiary care refers to highly specialised treatment such as neurosurgery, organ transplantation, complex cancer care and secure forensic mental health services and is not available on Island

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	A smaller number of hospitals in the UK provide what is called 'tertiary care', which means the third level of care. This is where hospitals, such as Great Ormond Street for children, and Southampton Neurological Centre, look after patients sent to them by other hospitals for highly specialised care. Jersey sends patients typically to the UK for most tertiary care.
Social Care	Care across the Island provided by either Government of Jersey, commissioned charities or private companies for those Islanders, who need additional support and assistance in order to live comfortably, for example help with washing or eating, respite services, and End of life Care.

HEALTH AND COMMUNITY SERVICES AMBITION AND VISION

Our ambition is aligned to the Government of Jersey strategic priority (Common Strategic Policy 2019) to improve Islanders wellbeing and Mental and Physical Health.

To achieve our ambition, we will

- Put Children First
- Support Islanders to prevent ill-health and adopt self-care as part of our shared commitment with Islanders to maintaining a healthy lifestyle
- Ensure services provided by HCS and external partners are: high quality, efficient and effective, working to professional standards shared by professionals and volunteers across the delivery of Health and Social care
- Harness the experience, ambitions and insights of professionals and volunteers involved in delivering care and our service users when planning and organising services around our service user's needs and circumstances
- Make the best use of resources available for the development and delivery of publicly funded services and help to support service users to secure Value for Money (VFM) when paying for services
- Ensure HCS is business like in the ways it works, encouraging staff to exhibit the values and behaviours that underpin the Team Jersey culture.

Health and Community Services Vision

Our vision for Health and Community Services is to create a healthy Island with safe, high quality, outcome focussed, affordable care that is accessible when and where our service users need it.

Building on our strengths

Jersey has many strengths across our health economy and we need to build on them when designing change.

Among our strengths are:

- Our committed workforce
- The breadth and depth of our services, despite the small size of our population
- Timeliness of services compared with many jurisdictions
- Our Parish system and wider community assets
- Our carers in the community
- Access to investment in health remains a strong political priority

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- Our long-term care benefit scheme
- Our resilient Primary Care and the prevalence of GP’s in the Island
- The unique blend of Primary and Secondary Care
- A strong culture of voluntary work

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OUR PROPOSED CARE MODEL

To deliver truly patient focussed, outcome-based care, a OneIsland, OneGovernment approach, we need a clear idea of the building blocks integral to meeting Jersey's overall Health and Care system needs.

At the centre of the model are the core provisions included in any Health and Care system:

- Prevention and Self-Care – includes the actions that people take to look after, treat and manage their own health, either independently or with the support of the Health and Care system
- Primary Care – Usually the first point of contact for people in need of Health and Care services e.g. GP's, Nurses, Dentists, Pharmacists and others
- Intermediate Care – Services that provide support for a short time to help people prevent problems from getting worse, recover from an episode of care or increase independence
- Secondary Care – Specialist treatment for a defined period of time for a more acute serious illness, injury, mental health crisis or other health condition
- Tertiary Care – Highly specialised treatment which for Jersey is provided off Island

The Care Model identifies a number of principles to improve our Health and Care services:

- There is **no health without Mental Health**. Mental Health is just as important as Physical Health
- We must **support people of all ages**, from family planning to bereavement services
- We must **treat all people equally** and ensure equal access to services regardless of Gender, identified Gender, Sexuality, identified Sexuality, Nationality, Ethic Origin, Age, Disability, Language or Presenting Illness
- **Social Care and Safeguarding services** must underpin our Health and Community Services
- Community services, education, employment and housing are fundamental as **it isn't just Health services that keep people healthy**
- Our services must be built on platforms that **enable efficient working and evidence-based decision making**, supported by **technology and information**
- Our services must be built on **robust governance and risk management frameworks**
- Our services must involve the **voices of our service users**
- There must be **smooth transitions and hand offs** when service users transition from one type of care to another
- There must be smooth interaction in the way each component of the health and care system **communicates with each other** and how we **communicate with our service users**
- Services must be designed and available **according to need**
- We must work within available budgets and ensure the delivery of **Value for Money, outcome-based care.**

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Secondary Care Focused Model

- *The Hospital is the centre of care for the island. People are institutionalised via provision of central services*
- *ED attendances – we see a high rate of low acuity cases – also evidenced by our low conversion rate from ED to main hospital*
- *We are currently underutilising our theatres both in terms of scheduling and use of day case theatre*
- *Rehabilitation / length of stay – we have a long length of stay in rehab and high flow rate into Long Term Care (residential)*
- *Out patients - new to follow up ratio is high in comparison to benchmarks – suggesting that Secondary Care is not discharging back into primary care*
- *Rapid response could be optimised to keep people out of hospital – very limited service currently*
- *Reablement services are limited and not standard to assist people staying or going home*
- *Our system is too reliant on beds, particularly for older demographic care*
- *Mental Health – services are not integrated with physical health*

Intermediate and Ambulatory Care

- *Rapid response and reablement not delivered consistently and to their full potential to help people remain at home*
- *Lack of positive risk taking in the current service configuration; risk assessment and planning for people to achieve their goals*
- *The current teams are not configured to manage higher risk patients due to lack of 24/7 cover and skills mix*
- *We have an institutionalised model where patients are brought in to hospital as the default option*
- *Lack of 24/7 Community Nursing means that there is no nursing cover to support people at home overnight*
- *Mental Health Crisis prevention service requires development to support increased demand*

Prevention, Primary, Community

- *There are limitations in the services offered due to funding and payment framework*
- *Payment model does not incentivise self-care, collaboration or innovation*
- *Pharmacy, Nursing, Dental and Optometry under-utilised and can't be funded*
- *Deskilled workforce in primary care due to secondary care focused model*
- *Long term condition management is typically run in secondary care, e.g. Diabetes*
- *Lack of formal approach to how conditions are managed across care settings*

Community Care

- *24/7 community nursing not in place*
- *Services are not optimally commissioned and managed*
- *Social Care model is over-reliant on high cost / dependency residential care*
- *Limited options for Long Term Care other than residential care*
- *Community mental health offering over-subscribed and needs development*

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Direct access services

- *Primary care services such as Pharmacy, Dental and Ophthalmology are not empowered to play as big a role as they could*
- *Funding mechanisms not in place to allow extended services to be provided*
- *Most services are accessed / paid for directly by the public, e.g. Dental and Ophthalmology*
- *Technology and information sharing are sometimes a barrier to joined up service provision*

Social Care and External Partners

- *We have a very strong voluntary sector and social care market, but could be better coordinated and difficult to navigate, especially in times of crisis*
- *Over £80m is raised annually, 1 in 8 adults on the island are volunteering*
- *£18m commissioned services and approved providers, although not through coordinated commissioning*
- *Duplication of services and back office functions*
- *Lack of understanding and signposting of all services*
- *Carers are not adequately supported by the current system as many are supported by the voluntary sector and Parishes*

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Jersey Care Model

Building on the foundations of P82, we have developed a clinically led model for how health and care services are delivered across all sectors on the island. The model seeks to move away from the unsustainable institutional-based model into a more modern community-based model; putting people, their family and home at the centre.

The model is based around these components:

I. Person-centred Care
II. Primary and Community Services
III. Specialist Services

Person-centred Care

PROPOSED STATE

- *A new model for healthcare, focusing on prevention and community partnership*
- *We will ensure care and support are person-centred: personalised, coordinated and empowering*
- *Develop self-care and patient education programmes to enable people to look after themselves better*
- *Improve health outcomes by ensuring that care from different providers is not delivered in silos*
- *Develop partnership of purpose with community sector and improve signposting and coordination*
- *We will lead in the use of technology to empower people to manage their health and care*

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Primary and Community Care

PROPOSED STATE

Primary Care

- *Make full use of breadth and depth of primary care resources including General Practice, Pharmacy, Dental, Ophthalmology*
- *Support Primary Care to manage long term conditions*
- *Upskill Primary Care with knowledge transfer and support from specialist services in Secondary Care*
- *Access to diagnostics and specialist advice and guidance*

Intermediate and Ambulatory Care

- *Rapid response and reablement as default options - delivered in patients' homes, care homes or hospital*
- *Positive risk taking; risk assessment and planning for people to achieve their goals*
- *Person centred planning; maximise independence, confidence and resilience*
- *Focus on crisis response and home base reablement / care*
- *24/7 Community Nursing will be introduced to ensure that nursing cover supports people at home overnight*
- *Mental Health crisis prevention*

Social Care and External Partners

- *Support independence through bespoke care packages that incorporate assistive technology*
- *There will be an increase in personal choice and working with external partners to reduce the key pressures that an ageing population presents*
- *Increased support to the parent/carer forum*
- *Scalable commissioning model developed in partnership with external providers*
- *Partnership of Purpose for wider external provider network*
- *Care coordination and signposting function to help all navigate the available options*

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Specialist Services

- *Front door becomes an Emergency Care Centre which incorporates an Urgent Care service, paediatric, mental health and ambulatory assessment.*
- *Mental health acute services provided on same campus as hospital*
- *Optimise theatres utilization and flow, more day surgery to reduce demand for inpatient beds*
- *Rehab – make better use of community, improve access to social care*
- *Partnership model with primary care for Long Term Conditions, with services provided out of the hospital*
- *Tertiary care will remain but increased opportunity for repatriation and closer working with Guernsey. We think there is a strong commercial opportunity here.*

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- The Hospital may be **circa 200 beds which is 80 less beds (subject to detailed validation)** than the previous FH Plan. We will see greater activity in the community, building on the '**closer to home**' initiative
- The **Hospital will focus on Acute treatment** and pathways, ensuring diagnostic, ambulatory, day case and intervention focussed services are prioritised. Critical and Specialist care areas including Special Care Baby Unit (SCBU) and Maternity will be in place
- No **Westaway Court concept** - Long term conditions will be more managed in Primary Care. This approach will replace traditional outpatient services. Up to 40,000 contacts have already been identified through Top 5 speciality analysis (Diabetes, Dermatology, Cardio-Respiratory etc)
- The front door of the Hospital will be **smaller (Acute & Emergency Floor model) with a co-located Urgent Treatment Centre** hosted by HCS but connected to the Primary Care system. A high proportion of ED activity can be diverted to the UTC (circa 30,000) patient episodes
- We will see a **shift in settings of care** for our workforce within a **virtual hub** across many professions with Secondary Sare Dr's providing specialist advice and guidance to GP's who are able to work to the top of their clinical licence
- **Mental Health services will be co-located** to the new Hospital and focus on crisis prevention and community intervention
- The **Social Care Market Strategy** will shape the sector into an independence focussed model building on care at home shifting away from institutional residential and nursing care. Reablement will be a default offer before long term care is provided
- There will be a more comprehensive **Community Service offer which will run 7 days a week** with enhanced intermediate care that is part of a Community Independence Service incorporating Frailty
- We will focus on **Connecting Care for Children** by enhancing the community and preventative offer which is aligned to the CYPES strategy
- Tertiary pathways will be strengthened but we will **aim to repatriate activity where possible** (bariatrics and cancer care in particular) through closer working with Guernsey
- Services like Drugs and Alcohol can be **provided through external partners**
- The prevention agenda will have greater focus for our service strategies **away from Secondary Care and into Primary, Prevention and Intermediate Care** which will be our biggest Care Group

Which services could transfer out to community?

- Long term conditions: Obesity, Asthma, Diabetes, Renal, Heart Diseases, COPD, End of Life Care
- Community Mental Health services, e.g. Listening Lounge
- Paediatric consultations
- Drugs and Alcohol
- Frailty
- Rehabilitation
- Physiotherapy
- Dermatology
- Dressing clinics
- Midwife lead maternity services
- Build on Care Closer to Home initiative around community services provision and signposting

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HOW WILL WE MAKE THIS HAPPEN?

A multi-year programme of work will be required to transform services from secondary focussed services to community provision. Services must be transitioned prior to the new hospital facility being available in order to ensure that the model can accommodate the size / shape and function of the new hospital. Key areas for development are:

- A Commissioning Framework for Primary Care and external partners to support the shift in activity **–** The HIF needs to be re-purposed.
- A workforce strategy that shifts settings of care for key roles
- A profoundly revised provision offers in the Community
- Mental health will need greater investment as identified in the Government Plan – Parity of Esteem for the future
- Social Care will require investment to deliver a revised Market Strategy and Personalisation
- A Partnership of Purpose with external partners is required to coordinate partners
- The Jersey Care Model strategy and Future Hospital must be digitally enabled beyond previous ambition
- Transparency re commercial strategy for secondary care (Public v Private)
- Revised contractual framework for Tertiary Care
- A cross-government prevention initiative is required
- Access for vulnerable groups, children and free dental care
- Culture and Risk tolerance will need to be tackled

HCS ORGANISATIONAL STRUCTURE

Our Government structure for the overall Jersey Health and Care system is built around five groups with four cross cutting services (Figure 1).

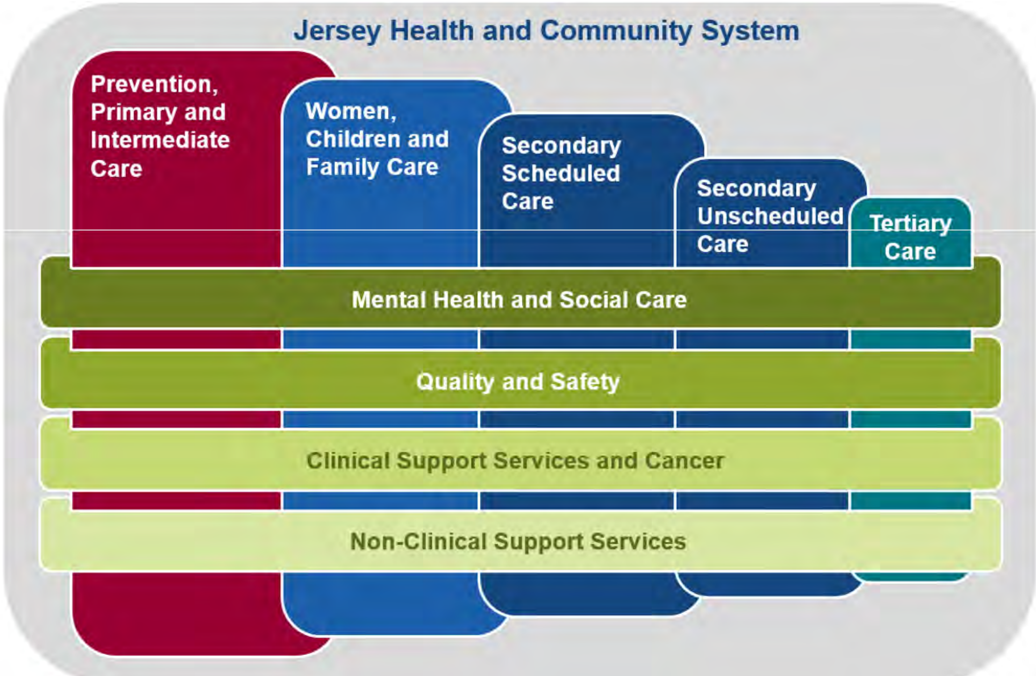

Figure 1: Jersey Health and Community Services Care Model Structure

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The new organisation design will support delivery of the Jersey Care Model via focussed care groups which are clinically-led. The new structure also enables:

- Engagement with our patients and service users to ensure the Islands Health and Care system meets their needs and is transparent in enacting the delivery of care that is Safe, Sustainable, Measurable and Value for Money
- Engagement with clinical and non-clinical staff across HCS
- Engagement and collaboration with partner organisations, Primary Care and the Voluntary Sector to ensure our health and care system meets the current and future needs of our island
- Transparency and efficiency in Risk Management and Governance structures with clear accountability
- A modernisation function that will bring together transformation and digital teams across organisations to support and deliver technological change across the Island Health economy.

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WORK STREAM DETAILS

The following sections outline the proposed direction of travel for each main work stream of the Jersey Care Model. They present an overview of our current state and highlight opportunities to develop our model of care in order to support the current and anticipated needs of islanders and to support the requirements analysis for Our Hospital. Consideration has been given to: existing strategies, analysis of activity, a review of delivery against strategy, and opportunities to deliver services in a different way to ensure that we have a truly integrated healthcare service across Jersey.

Work streams:

- Prevention & Primary Care
- Intermediate Care
- Secondary Care
- Mental Health
- Children's Health
- Adults Social Care
- External Partners

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PREVENTION & PRIMARY CARE INTRODUCTION

Our Government has set out the priorities for all Islanders in the 2018 Common Strategic Policy (CSP) which sets the strategic intent around putting children first, improving wellbeing, both mental and physical health, reducing income inequality and improving the standard of living [1]. Just one extract states;

"While prevention is key, mental and physical health and care services must be fit for purpose, support equitable access and be more integrated around the needs of Islanders. Care must be provided when and where it is needed most, and closer to people's homes. To do this, we must evolve our health and care system to meet patients' needs, particularly as more Islanders live longer. This will include testing new approaches to the delivery of primary health care, with more support within the community and Parishes, through multidisciplinary teams, community hubs, and excellent acute care within a new hospital."

The CSP states that in order to achieve our desired outcomes, we shall utilise the system of Primary Care;

1. *Actively engage GPs and other health professionals in developing and testing new models of health care delivery.*
2. *Improve access for vulnerable people, including children and an aging population, to all primary care services, including dentistry, and make it easier and more affordable to use.*
3. *Create the conditions, which, over the long term, will reduce the most common diseases and preventable death, supporting Islanders to live healthier, active, longer lives.*

Furthermore, the shared vision for a healthy Island delivered in most cases in our community mirrors the vision of the World Health Organisation (WHO). Primary Care in Jersey consists of general practice services, community pharmacy, dentistry and optometry. Primary Care plays a crucial role in delivering core health care services whilst having responsibility for referrals to help patients gain access to a large range of other healthcare providers.

> *"Primary Health Care (PHC) is a whole-of-society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people's needs and preferences (both as individuals and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.*
>
> *With its emphasis on promotion and prevention, addressing determinants, and a people-centred approach, PHC has proven to be a highly effective and efficient way to address the main causes of, and risk factors for, poor health, as well as for handling the emerging challenges that may threaten health in the future."*
> **WHO Vision for Primary Health Care 2018**

OUR FUTURE CARE MODEL – STRATEGIC AIMS FOR PRIMARY CARE

As we look to deliver Our Hospital as part of a Jersey Care Model, remodelling our Primary Care is imperative so that we can achieve the goals of the CSP. We intend to;

1. Innovate and promote resources that help citizens with **self-care** for themselves, their families and loved ones to improve health outcomes
2. Expand and enhance **prevention and screening** to identify and treat risk factors, pre-cursors and disease as early as possible (Appendix 4)
3. Improve and remove potential barriers to **access** for patients who are financially, clinically and socially vulnerable
4. Maintain the existing excellent rapid access to Primary Care services

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5. Re-purpose existing Secondary Care **resources** into preventative and Primary Care services, thus reducing current over-reliance on our Secondary Care services
6. Provide and support high quality multidisciplinary care, **24 hours a day, 365 days a year** – with the right care in the right place at the right time

Our strategic aims require a Primary Care sustainable Island workforce model, educational and training strategy, and 'joined-up' digital strategy, which interfaces with all other health and care provision. There is also a requirement for enhanced support for carers and inclusion of the future External Partner and Secondary Models to ensure equity and efficiency of care.

IMPROVING ACCESS TO SPECIFIC PRIMARY CARE SERVICES FOR SPECIFIC GROUPS

We will consider all opportunities for expanding access to Primary Care for those who are financially, clinically and socially vulnerable. This may be achieved by a combination of financial support, education, cultural champions and availability of services in alternative locations.

Financially vulnerable

- Support for those who are unable to afford the service user co-payment (in the short or long term) by expansion of the income support system (use of Primary Care Medical Cards etc.)

Clinically vulnerable

- Review of the current system for providing dental services for children in Jersey, to look at other potential models of care which could provide more timely access for all children
- Developing clinical pathways for long term conditions such as Diabetes, COPD, Cardiovascular Disease, Depression, Epilepsy and End-of-Life Care (Appendix D)

Socially vulnerable

- Support for specific age groups, e.g. all under 5s, all children, teenagers with specific conditions or the over 85s
- Vulnerable adults – access to a range of primary care services via a multidisciplinary clinic based at the Shelter and other similar External Partner facilities

Alternatively, a 24/7 hospital based Primary Care service could provide specific Primary Care services for those otherwise unable to access care (Salaried GPs, Urgent Care Centre, Clinical Practitioners) and provide support for all other 24/7 services – Acute Floor, Ambulance, Talking Therapies etc.

PREVENTION AND SCREENING

Identifying disease earlier, and managing health and care better, means healthier, longer lives for the population. For every £1 spent on prevention, £1.90 could be saved that would otherwise have had to be spent on treatment.

Opportunities for expanding prevention and screening include:

- Pneumococcal Vaccination programme
- Expansion of smoking cessation programme to practice nurses
- Dental caries prevention for children
- Five yearly Health Check for all those aged 40-74 including screening for alcohol and tobacco use, hypertension, obesity, cholesterol, diabetes, depression with appropriate follow up
- Make Every Contact Count (MECC) using every interaction to promote the benefits of healthy living

Prevention services should be provided by a **range of disciplines in a range of settings** in a **clinically and cost-effective way**.

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To achieve real and sustained action on prevention, **activities need to be co-ordinated** and collaborative working with the Strategic Public Health Unit is essential.

DEVELOPING THE MULTIDISCIPLINARY WORKFORCE

Jersey has long been reliant on the General Practitioner as the main provider in Primary Care. Whilst continuing to value our GP workforce we will move away from this outdated model to a multidisciplinary approach, with the patient at its heart.

We will consider expanded roles including:

- **Pharmacists** – non-medical prescribing, supporting GP practices and Care Homes, funded Medication Use Reviews, preventative services
- **Nursing** – expand use of Practice Nurses, non-medical prescribing, long-term conditions management and intermediate care, prevention
- **Physiotherapy** – we will assess the viability of direct access physiotherapy for musculoskeletal conditions, increase community exercise programmes (e.g. frailty), consider non-medical prescribing if appropriate
- **Mental Health workers** – 'There is no health without mental health' and primary mental health care needs to be as accessible as any other – we will review primary mental health care, explore use of Primary Care mental health workers in practices, encourage mental health first-aid at work training, and develop online cognitive behavioural therapy (CBT) delivery (GP cluster work ongoing)
- **Social prescribing** – linked with the **Closer to Home** initiative – we will build a network of community support resources, with a single point of access to multiple services based in community hubs advising on resources available – e.g. walking groups, community groups, exercise as medicine initiatives (exercise referral scheme). This will also improve support for carers.

We will **move Secondary Care services into the community**, through the development of Primary Care Practitioners with Special Interests, e.g. Dermatology. We will provide high quality multidisciplinary care, **24 hours a day** – with the right care in the right place at the right time. We will address the current **funding mechanism** to facilitate expansion of these services – including review of the potential to expand the use of the Health Insurance Fund to allow increased funding for a range of providers.

FUTURE FUNDING MODELS FOR PRIMARY CARE

There is agreement across the Island that the current funding model for Primary Care will not allow our strategic intent to be deliverable. Previous reviews (Deloitte, KPMG) have identified inequity and barriers to transformation of care within Jersey and we only have limited government financial levers (JQIF) available to improve outcomes, allow more care to be delivered closer to home and encourage self-care. There are a multitude of international models to assist our deliberations, ranging from;

- NHS Care (majority is free at point of access, e.g. GP services), salaried GPs.
- Social health funds, Household Medical Accounts, Universal Medical Cards.
- Private / public health insurance schemes (Holland as an example)
- Blended models (the majority), whereby there is a mixture of 'user pays', capitation (payment for list size or special groups), fee for service payments and various Performance Related Framework payments from central government (JQIF)

Funding for Primary Care services in Jersey is sourced from a combination of; service user co-payments, payments from the Health Insurance Fund (HIF), and payments from Health and Community Services (paid for

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by general taxation)[1]. Increased provision of Primary Care services is likely to require extra funding, repurposing of current budgets or reducing the spend on Secondary Care into the future;

Reconfiguration of current funding streams

- Moving funds and resources from secondary to primary care with concomitant activity changes
- Combination/redistribution of the HIF and HCS budgets
- Ring fenced budget for prevention and screening

Potential new funding streams

- Expand public contributions to social security or general taxation/indirect taxes/charges
- Prescription charges for some medicines

It should be noted that there is the potential to access funds from the HIF on a one-off basis in order to offset double running costs in primary and secondary care during a period of transition.

CONCLUSIONS

Significant work is still required to achieve sustainable implementation of our strategic objectives. In particular early work is required for the development of a clinical forum and clinical pathway design process, and a combined strategic needs analysis. A pan-island workforce planning exercise is required to develop a comprehensive business plan for the provision of 24-hour multidisciplinary primary care, 365 days a year.

We also need to ensure our Primary Care Strategy aligns and supports the wider Jersey Model of Care to allow the CSP vision to be fully realised.

Political direction and robust financial modelling are essential in order to make informed decisions about the future of funding and access for prevention and Primary Care in Jersey.

PREVENTION & PRIMARY CARE APPENDICES

Prevention & Primary Care Appendix A: The Common Strategic Policy re Primary and Prevention

Prevention & Primary Care Appendix B: Definitions

Prevention & Primary Care Appendix C: Population demographics and multi-morbidity projections

Prevention & Primary Care Appendix D: Long-term Conditions

Prevention & Primary Care Appendix E: Strategic Aims – more details

Prevention & Primary Care Appendix F: Enabling the Strategy

Prevention & Primary Care Appendix G: Notes on Intermediate Care

Prevention & Primary Care Appendix H: Current Funding Sources

Prevention & Primary Care Appendix I: The Future of Funding for Prevention and Primary Care

Prevention & Primary Care Appendix J: Primary care pharmacists - example of value opportunity

[1] For more details of the current funding sources please see Appendix J

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INTERMEDIATE CARE

INTERMEDIATE CARE INTRODUCTION

Intermediate care is a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care. It is critical in supporting the patient to avoid Secondary Care admissions or long lengths of stay in acute bed, which are costly and not the best course of action for the patient.

CURRENT POSITON

The current position on the island is as follows;

- Intermediate care offer is delivered in partnership with FNHC
- The current specification and offer are not an optimal solution when considering other models and the needs of a re-shaped hospital
- In 2018 the Rapid Response and Reablement Service averaged around 300 referrals per quarter
- The Top five conditions reported (2016) were wound infection, orthopaedic, falls, urinary infections and reduced mobility
- Current service has been hampered by gaps in the workforce
- The most common destination for onward referral was GPs in 2018
- The most common equipment provided was washing and dressing aids

High level data from our service provider demonstrates that majority of our services are delivered to those with the highest need and there is room for expansion to support more people in their own homes. In 2018 the following total care days were provided:

- 4,126 level 3 (General Inpatient Care)
- 801 level 2 (Continuous Home Care)
- 971 level 1 (Routine Home Care)
- 1,482 community mental health

FUTURE STATE

A high functioning intermediate care offer is imperative to delivering a health and social care system that is firmly embedded in the community. To deliver such an improvement will require a detailed specification which includes the following NICE guidance. A specification tailored to Jersey will be developed on this framework, significantly enhancing the level and frequency of service provision in this area

Key Service Attributes for Jersey

We will establish a Community Independence focussed Intermediate Care function which incorporates Frailty and Older Person's Rapid Access.

The service is proposed to be available 7 days a week with a minimum 8am-8pm function but connected to a core overnight community function.

We expect the service to provide;

➢ Urgent Rapid Response (Nursing Assessment and Support - Intervention)

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- Urgent Social Care Assessment and Support – Care direction
- Urgent Therapy Assessment and Support (Physio and / or Occupational therapist) – equipment and support
- Rapid deployment of Reablement support or enhanced care at home
- Integrated liaison to the Mental Health Crisis Prevention Service
- Night sitting deployment
- Integrated Medical support to broaden the intermediate care scope

The service would be made up of Nurses, Social Workers, Therapists, Reablement workers, Mental Health staff and connected to but not driven by a medical model which incorporates Primary Care and Care of the Elderly specialist opinion.

The service would have rapid access to Secondary Care diagnostics, step up-down provision and home facing enabler services (handyman and parish-based offer etc)

The service will be connected to a broader community services specification to support 24/7 care needs including end of life care. The service will work with the Closer to Home initiative.

This service will help support the changes in the social and long-term care sector (residential and nursing) from bed based to home faced care provision around a personalisation agenda.

Key Expectations of the Service

- Improved Quality of care delivered in the right setting by the right professionals
- A reduction in admissions to the Acute sector for target groups (Ageing Demographics and Chronic conditions)
- Early facilitated discharge from the Secondary Care setting which improves Length of Stay (LoS) and drives a Discharge to Assess model
- A reduction in intensive and high cost packages of care
- A reduction in placement prevalence (Nursing and Residential)
- Reduced professional contacts and duplication
- Reduced Mental Health crisis activity
- Reduction in adverse safeguarding outcomes
- Reduction in interdisciplinary and inter-provider related incidents
- Improved service user experience and outcomes

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INTERMEDIATE CARE APPENDICES:

Intermediate Care Appendix 1: Intermediate care service definition (NICE)

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SECONDARY CARE

SECONDARY CARE INTRODUCTION

In order to meet the long-term care needs of the Island the Department of Health and Community (HCS) will need to ensure there is an effective Acute Services Strategy (for hospital services) in place. The department has already undertaken significant work in this area and 'The Acute Service Strategy' 2015-2024 detailed a high-level direction of travel for the core acute service at Jersey General Hospital.

The case for change for the previous Future Hospital scheme also outlined many of the same issues to address in order to sustain acute hospital services. The population of Jersey is growing relatively slowly but is ageing rapidly. Between 2010 and 2040 there will be a 95% increase in the over 65 population, with a 35% increase by 2020. This growth in the older adult population will create a challenging increase in demand for Health and Community Services. Subsequently, the Acute Service Strategy 2015-2024 predicted that current services could not accommodate this increase in demand and the island will run out of capacity in key service areas (E.G Theatres, In-Patient Wards) in the next five to ten years.

The previous Future Hospital proposal was for significant expansion of Acute Hospital capacity in order to ensure the needs of the people of Jersey can be met in the future.

The Executive team are in the process of reviewing the Acute Services Strategy and previous Future Hospital Outline Business Case (OBC), and, there are clear considerations for a change in direction in the way we establish future hospital Secondary Care services.

CURRENT STATE AND KEY ISSUES

There are many factors that need to be considered in determining the future hospital Secondary Care requirement, and, it is important to note that healthcare is a continually evolving service, which requires flexibility and innovation. There are many issues to note in relation to the current state and 'as is' position;

- The current acute hospital/Secondary Care system cannot be sustained in the existing hospital building, and, there is clear recognition that the original 'Case for Change' for a new hospital remains.
- The current service reflects that of a small 'District General Hospital' which doesn't necessarily match the demographic pressures the Island faces. The previous OBC for the Future Hospital determined more beds would be required to meet the needs of the ageing demographic, but, modern health and care strategy would determine that institutional bed-based services are not always the best solution for these pressures. We believe the future model of Secondary Care should not mirror the NHS District Hospital specification and should reflect more modern and international concepts for Hospital services.
- The model of care for the Island is currently over reliant on 'beds' both in and out of hospital.
- The current service has workforce and operational challenges.
- The system is not digitally optimised.
- Mental Health has not been considered to be in scope previously, but we believe it is integral to the future state.
- Optimising truly integrated physical, mental and social care services has not been considered enough in future physical capacity requirements of the new hospital. In determining future hospital needs there must be interrogation across the entirety of the health and care system and its strategic capability.

The clinical and professional leadership teams across HCS believe the model of care delivery in Jersey needs to change. In essence our system of healthcare has focussed on an over reliance of bed-based care within

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institutional care settings from Hospital to Residential and Nursing care. Given the most significant demographic of health care utilisation is amongst our older population it is therefore important that our system of care reflects this need.

FUTURE STATE: SECONDARY CARE MODEL

The Executive and newly formed senior clinical and professional leadership team have been considering the future care model requirements for the Secondary Care system (Acute General Hospital). Key conclusions include;

- The **Front Door of the Hospital** will require an Emergency Care Centre that provides all of the existing Urgent and Unscheduled Care access. Appendix B outlines the current and projected Emergency Care Capacity requirements and proposed future pathways in more detail.

  On reviewing the existing data and future projected need there is an opportunity to change the Accident & Emergency service into an Emergency Care department. HCS believes the future model of care must ensure the Emergency Care department maintains the ability to manage urgent, very urgent and resuscitation patient activity with a specialist medically led model of Emergency Care. The Emergency Care department will also need close connectivity to the proposed Acute Floor Model concept. An **Acute Paediatric Assessment Unit** should be provided in a co-located Emergency Care setting, this should include shared care facilities for CAMHS (Child & Adolescent Mental Health Services) patient pathways.

  Non-urgent and standard activity which is a significant part of the current volume of patients could be managed within an urgent care centre that is closely connected to the Emergency Care department. The Urgent Care Centre (UCC) will need careful consideration in relation to policy as a high volume of the activity could be considered to be minor illness that can be managed by Primary Care. Further analysis will be needed in relation to charging consideration and the role of Primary Care in managing this volume of patient activity.

- **Ambulatory Assessment** needs to be more prominent and this particularly includes Older Person's Rapid Access to multi professional services outside the Hospital.

- **Inpatient capacity** (the number of beds) need to be set to trajectories of need based on effective integrated care pathways. Our initial evaluation indicates that there should be no increase in bed base beyond the current position. We are anticipating a range of 150-210 beds, but further modelling is required. This is a smaller bed base than the previous scheme at circa 280 beds (Appendix C). The clear rationale for this change is that the demographic growth outlined in the previous OBC should have targeted Out of Hospital services as an alternative to bed-based care. The assumptions in Appendix B also identified the existing and future hospital bed base can be further optimised by an improvement in Length of Stay and more focus on Ambulatory assessment and admission avoidance schemes.

  We believe that specialist functions and inpatient capacity will still be required as identified within the previous OBC for Women and Children's services, Neonates and Critical Care. Further analysis is required to determine the specific volumes of activity anticipated.

  Infection Prevention and Control compliance with isolation capacity will need to be maintained and we believe the previous concept of adaptable wards to ensure sufficient cubicle capacity that includes flexibility to open bays is the best option for the new Secondary Care facility. **Specialist functions** such as theatres, cardiology, renal, pain services etc. will be set to effective clinical pathways based on

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island need and so we would anticipate **increased day surgery and endoscopy capacity** based on current disease prevalence analysis. **Appendix E** outlines the opportunity to improve day case utilisation and theatre efficiency in the Secondary Care system.

- **An Integrated Care Hub** model will ensure the continuity of care required within the health and care system. This will ensure we have efficient planned care services that connect Primary and Secondary Care and so replacing traditional outpatient services. **Appendix D** considers the existing outpatient activity for the Secondary care system.

  Our new approach would see a transformation of the way outpatient services would run with an aim to connect care for adults and children between Primary and Secondary Care. Early results from similar schemes indicate reductions of up to 40% in outpatient activity with alternative processes set up to ensure immediate specialist advice and guidance for GP's is available. This approach reduces unnecessary waits for patients and ensures the secondary care system is able to focus on the more specialist and acute care needs for the Hospital.

- **Clinical Support and Cancer Services:** Clinical support services will be needed including increased clinical Investigations capacity, MRI and CT scanning capability as well as mobile equipment functions. Pathology and Wider Radiology is broadly expected to be in line with previous scheme expectations but with increased connectivity to Primary Care and more 'near testing' capability. **Cancer services** need to be prominent and the department needs to develop a cancer strategy for the Island.

- We anticipate that the new Secondary Care hospital system will have **Co-located mental health services** for inpatient beds along with enhanced community services focussed on crisis prevention and intervention. The Hospital care environment needs to be **dementia and cognitive impaired** friendly.

- **Connectivity to tertiary and specialist services** via a Jersey Emergency Transfer Service is required as well as planned tertiary care services. We anticipate more patient activity can be repatriated to Jersey in a modern Hospital facility and there is significant opportunity of working more closely with Guernsey. **Critical Care** and Outreach will need to be in place.

- **The Hospital must be Digitally Optimised.**

- The health and care system needs to establish a more comprehensive **intermediate and community care model** so that hospital capacity is protected for acutely unwell patients and to meet the demographic needs of the Island.

KEY DIFFERENCES TO PREVIOUS FUTURE HOSPITAL PLAN

We anticipate the future Secondary Care (Acute General Hospital) system should provide many of the existing and previously planned functions. There are however some different characteristics envisaged to the current Hospital, and, proposed changes when compared to the previous OBC for the Future Hospital. In essence, we believe the future hospital should be smaller in scale than originally proposed.

Key Differences;

- The bed base of the Hospital would remain a similar level to current state and be circa 80 beds less than proposed in the previous OBC.
- Services such as Physiotherapy, Podiatry, Long Term Condition Management and those outlined in Appendix G can be partially or fully provided in an alternative care setting outside the Hospital

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including home focussed community care. Any re-provision outside the future hospital would need to ensure the de minimus of the hospital isn't compromised so that the facility is able to run in the most efficient way.

- The Outpatient service is proposed to operate in a different way by adopting virtual Hubs for specialist advice and guidance and continuity in care that connects the entirety of the health and care system. The new approach for planned care management and in particular chronic disease management would see the previous 'Westaway Court' concept removed from future plans. The activity planned within the Westaway court concept is believed to be adaptable and more appropriate for Primary Care services with close connectivity to specialist Secondary Care via a 'virtual Hub' concept, with Secondary Care clinicians providing advice and guidance to Primary Care.
- Capacity in the future building should be modular in nature so that clinical environments can be adapted to reflect demographic pressure areas such as gastroenterology, renal or cancer services for example where increased capacity may be needed. The environment should also be flexible enough to adapt to future care innovation for increased day surgery and non-invasive procedures, which can result in requiring fewer inpatient beds.
- The new facility should be co-located with a small inpatient mental health unit (Campus model) so that services can be closer integrated. This will ensure clinical and non-clinical support services are concentrated in one campus rather than spread across the Island as they are currently.
- The new facility needs greater ambition for digital optimisation than the previous scheme, which is again anticipated to impact on the physical scale and requirements of the Hospital.
- The new facility needs to operate with confidence that out of hospital primary, community, social and intermediate care services are managing increased activity, therefore protecting the Acute Hospital capacity for true hospital-based care need.

SECONDARY CARE CONCLUSION

The Future Care model for secondary services is one part of a wider health and community system. It should be noted that most health and care needs to happen outside the Secondary Care setting. The Government Plan in line with all health and care strategies across modern jurisdictions focusses on greater prominence for prevention, early help services so that over reliance on secondary healthcare systems is mitigated.

The revised Acute Services Strategy would envisage;

- More responsive service for islanders with quick access to hospital services both planned and unplanned
- An improved quality of services for islanders with enhanced environments of care and better-connected health and care services.
- More care outside the hospital
- A more comprehensive community and out of hospital system
- A revised social care system which reflects the needs of the island
- An attractive workplace for key professional groups in an innovative and creative environment
- A long-term sustainable health and care system for Jersey
- The potential to repatriate off-island activity and provide care pathways closer to home
- A more productive and efficient health and care system to ensure the 'Jersey pound' is well spent

With a revised ambition we believe the future Secondary Care system in Jersey can be a beacon of innovation, working as a centre of excellence for care which will sustain the long-term provision of Secondary Care on the Island. The services can attract a workforce of the highest calibre and is able to match the economic enterprise and opportunity of the Island's wider services such as financial services.

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SECONDARY CARE APPENDICES

Secondary Care Appendix A: Emergency Care

Secondary Care Appendix B: Bed Base

Secondary Care Appendix C: Planned Care

Secondary Care Appendix D: Day Surgery-Theatre Utilisation

Secondary Care Appendix E: Step Down & Intermediate Care

Secondary Care Appendix F: Hospital Services Analysis

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MENTAL HEALTH

MENTAL HEALTH INTRODUCTION

The following statement gives a high-level overview of the strategic improvement agenda and vision for mental health services. It builds on the Jersey Mental Health Strategy 2016-20 as well as more recent assessments such as the Health and Social Care Scrutiny review of mental health care on the Island. It reflects and summarises the response to the scrutiny findings and recommendations and other relevant external reviews of the Islands mental health services. It outlines an ambition to deliver a good mental health service in Jersey starting with the mission and vision we have for the service and the underpinning values that will guide our work.

Our mission is to improve the mental health and wellbeing of Islanders (Objective 2 Common Strategic Policy) through services which are recovery focused, person centred, and integrated incorporating legal safeguards and practices that facilitate community partnership and social inclusion.

VISION

Our vision is for an island that is humane, socially just, caring and responsive to those who are mentally ill and those who experience issues impacting upon their mental health and wellbeing; a place where individual rights are upheld, and all aspects of Island life enable the opportunity for those experiencing mental illness and/or distress to recover and restore their lives free from discrimination, stigma and prejudice.

KEY ISSUES

The challenges facing our Mental Health Services are well known and some elements are consistent with most health and care jurisdictions. Key issues;

- We face a recruitment challenge for key skilled roles such as Registered Mental Health Nurses, Medical Staff and Allied Health Professionals.
- Our mental Health Estate doesn't provide a therapeutic environment of care
- We are seeing increased activity in Mental Health services
- There is a lack of care co-ordination and over reliance on the voluntary sector
- The wider system of Government such as Housing and Economic prosperity need to be linked to our strategic plans for mental health

PLANS

We believe mental wellbeing is essential to personal aspiration and development. All stakeholders have a role in supporting and enabling people who experience mental ill health to live meaningful and productive lives.

Over the next 5 years we will:

- ✓ Review and manage our capacity and demand for care by redesigning our mental health care system
- ✓ Develop community-based alternatives to hospital-based care and offer timely integrated crisis care and support over a 24-hour period.
- ✓ Significantly improve the safety and effectiveness of services using data and evidence to drive quality improvement and optimal performance
- ✓ Invest in Primary Care led mental health and focus on preventing mental ill health as well as intervening early to give people the best chance of recovery

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- ✓ Work with local communities and a range of partners to promote social justice and expand capacity for recovery-oriented care and support (e.g. housing, employment, social support)
- ✓ Invest in digital solutions which can transform the care experience and bring therapeutic benefits to all ages and complexities
- ✓ Stabilise our workforce by investing in people with relevant experience, knowledge, skills and competence who are committed to Jersey and can work together to make the best use of the talent and resources available on the Island
- ✓ Enhance the fabric and design of our facilities
- ✓ Listen to and value the experience of those with lived experience and work with them to improve our mental health system through co production and service evaluation
- ✓ Embed an organisational culture that embraces all of the above values in the systems, processes and institutions within our island community

TRANSFORMING OUR CARE OFFER

It is our belief that transforming the mental health care system in Jersey will only be achieved if the need for better mental health care on the Island is fully recognised and demonstrated by our collective commitment to the mental health goals identified within the Common Strategic policy. As a Government we are serious about and fully understand our responsibilities to deliver this requirement and involving all Government departments.

Person centred care, shaped (importantly) by the experience of those who live with mental illness is at the heart of this transformative process and is the means by which people are helped and supported as an equal partner in their own care to recover and regain their usual life. We know better outcomes are achieved when services are community based, recovery oriented, integrated and evidence based and when the system of care embraces the principle of co-production[2] and partnership.

We know individual and community resilience is possible when all community assets are engaged in working together to promote positive mental health and wellbeing and social justice and that mental ill health can be prevented by providing early intervention and high-quality treatment and support services. Our ambition is to strengthen the quality of delivery by supporting and facilitating Primary and Secondary Care services, External Partners and all government departments to work together, collaboratively and productively to achieve this outcome.

By working with local communities, colleagues in other Government departments e.g. Primary Care, housing, education, criminal justice and home affairs, and employers and local businesses we believe people of all ages with mental health needs will benefit from a model of care that provides the right care at the right time in the right way by the right people. We call upon all stakeholders to embrace and adopt 'person centred recovery' as the model of care in Jersey. Our purpose is to bring hope and offer choice to individual islanders who can define for themselves what it means to live a fulfilling and productive life. We know this approach positively changes lives.

STRATEGIC AND IMPROVEMENT OBJECTIVES

The Mental Health Improvement Board has approved 5 high level objectives to secure improvements in mental health services:

[2] Co-Production: *When an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered (Care Act 2014 – Department of Health UK)*

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(A) STABLE AND HIGH PERFORMING WORKFORCE

"Our workforce is skilled, motivated, resilient, and committed to delivering excellent services to people with mental health needs. They are confident and feel supported make decisions, assess and hold risk and to develop and create innovative solutions".

(B) IMPROVING THE EXPERIENCE FOR PEOPLE WITH MENTAL HEALTH NEEDS

"Our recovery focused service offer is person centred and rights based providing the right intervention at the right time in the right way through the delivery of an integrated service that starts with prevention through to specialist support".

(C) PREVENTION AND EARLY INTERVENTION

"We intervene early to prevent deterioration in mental health and wellbeing to enable individuals to flourish and remain as active citizens so that they can continue to lead a usual life.

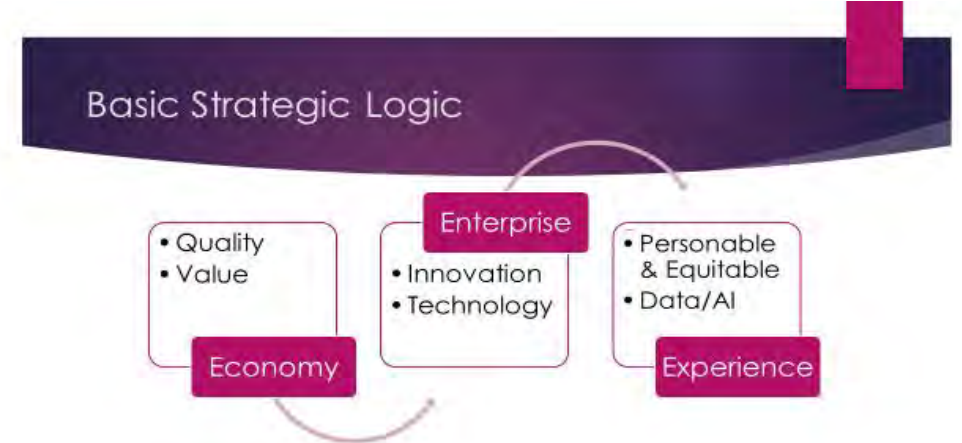
(D) APPROPRIATE ENVIRONMENT AND FACILITIES

"People are supported in a person centred and least restrictive way. Wherever possible this will be at home or in the community but when they cannot remain at home, they will have access to services and facilities that are of high quality in facilities that address their immediate need and support their recovery; accessing a wide range of therapeutic services will ensure they have the best opportunity to recover and flourish".

(E) CUSTOMER FOCUSED DELIVERY

"Our services are outcome driven and we are clear about the impact we are having on people's lives. The mental health outcomes achieved demonstrate we are providing a high performing service".

The following strategic framework proposes a basic logic that we will apply in pursuit of these objectives and associated outcomes. It is a simple logic based on shifting our current pattern of service to that which is more aligned to prevention, early detection and early intervention.



We plan to shape the economy of our resources and transition these in ways that remove inefficiency and ineffectiveness to deliver real improvement in the quality and value of the service we offer. We will be enterprising and constantly seeking new ways of working to improve our productivity and deliver good care. Our ambition is to deliver a care experience that is timely, personable and equitable, shaped, informed and

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influenced by advances in technology and innovation, relevant evidence and the experience of those who use services. The dimensions of our work will include;

(a) Redesigning the model of care and support
(b) Improvement activity
(c) Commissioning and Strategy and policy development

INPATIENT SERVICES

The latest bed analysis for inpatient Mental Health services indicates the bed ratio is broadly in line with the UK. The recent appointment of new medical staffing has also had a positive impact on reducing Length of Stay and Occupancy across all 3 units. Going forward the impact of the Crisis Prevention and Intervention service will also have an impact on the number of beds required for mental health services. A Mental Health steering group is reviewing this position and a co-located inpatient service within the main hospital is the preferred option at this stage, but it should be noted the full impact of the 24/7 Crisis Prevention and Intervention service will have significant impact for inpatient configuration.

MENTAL HEALTH CONCLUSION

The statement "Without mental health there can be no true physical health" [3] was made by the first Director General of the WHO over half a century ago. In 2011 the UK Government adopted "no health without mental health" as the starting position to develop their strategic ambition to mainstream mental health care in England. A change never seen before was evident in this strategy - the focus on outcomes and the importance of public health and social justice as the cornerstones of better mental health. In Jersey, we have set out our own immediate outcomes and pursuing these until we start the refresh our strategic ambition from 2020 and beyond.

By proactively tackling the wider underlying causes of mental ill health, increasing access to preventative care and support, treating people quickly and effectively, promoting their rights and addressing social injustice we will be successful in helping people regain their hope and choice for the future not only for themselves and their families but for our One Island community.

The Our Hospital programme will need to consider the long-term requirements of Mental Health services as part of the a ONE HCS strategy that encompasses the entirety of the Health and Community estate across the Island.

In essence, HCS has concluded that we will require;

- A new Hospital facility that embraces Physical and Mental Health services with consideration for shared care needs and dementia friendly environments for older adults.
- A co-located physical and mental health facility is favoured at this stage – as a campus style facility.
- Outpatient support will need to be part of the integrated hub model of care as outlined in the secondary care model.
- Increased support of Mental Health in Primary Care and Community services will be required.
- Tertiary Pathways for specialist care will be required off island. The department will consider provider options in partnership with Guernsey.
- Child and Adolescent Mental Health support will remain a community focussed service delivered in partnership between CYPES and HCS. Inpatient facilities will be required for shared care purposes

[3] *No Health without Mental Health* UK: a cross government mental health outcomes strategy for people of all ages (Department of Health, February 2011)

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within the new Hospital and the Island should explore the potential for on island specialist provision (an off-site facility), again in partnership with Guernsey.

- Full benefits realisation of all Government Plan schemes is required;
    - Full roll out of the Crisis Prevention and Intervention service
    - Full implementation of the Complex Trauma Pathway
    - The Listening Lounge and Place of Safety schemes
    - A clear strategy for Dementia and Suicide prevention
    - A Partnership of Purpose between the Government of Jersey and External Partners.

Our analysis (Mental Health Appendix A and B) demonstrates there is increased opportunity to have a small inpatient bed base for mental health care along with an enhanced community offer to address the increasing needs. The system of care will need to consider longer term specialist activity which is managed off island at present and consider if there is a case for change for more repatriation of this activity back to Jersey rather than using UK based providers. Further feasibility reviews and assessments are needed in this area.

The Child and Adolescent Mental Health service also requires further review with collaboration from the departments Health and Community Services (HCS) and Children, Young People, Education & Skills (CYPES) as it is clear that on and off island care pathways need to be re-designed.

As part of the Government Plan HCS has submitted a number of business cases outlining strategic intent for adult, child and adolescent mental health services which can be found in Appendix C.

MENTAL HEALTH APPENDICES

Mental Health Appendix A: Inpatient Activity

Mental Health Appendix B: Community Based Activity

Mental Health Appendix C: Government Plan Business Cases for Mental Health

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CHILDRENS’ HEALTH

Children and Young People's Plan

The Children and Young People's Plan 2019 to 2023 is a fundamental new plan for Jersey’s children, young people and families, which aims to make sure Jersey is the best place to grow up and also improves everyday lives. The Government of Jersey has developed the plan to achieve better outcomes for children and young people so that they have the brightest futures possible.

For the next four years, everyone who works with children and young people across the Government will use the Children and Young People’s Plan to help them decide what they need to do to ensure that all children and young people:

- grow up safely
- live healthy lives
- learn and achieve
- are valued and involved

Developing and implementing a new Children’s Plan for Jersey was recommended by The Independent Jersey Care Inquiry panel in its findings on 3 July 2017.

Health and Community Services - All children in Jersey Live Healthy Lives

Ambition

We want children to be heard, valued and involved in the decisions that affect their everyday lives, regardless of where they live or the school they go to.

Why?

Good health is an essential foundation for children’s quality of life. Often healthy behaviours (e.g. a balanced diet, regular exercise avoidance of tobacco and alcohol) established in childhood can last into adulthood and reduce the chances of developing a chronic condition later in life. There can be no health without mental health, yet demand for child mental health services are continuing to increase. Timely access to health services is important in securing a healthy start to life. In addition, wider factors such as good quality housing, active transport, and access to parks and countryside are recognised as having a key role to play in supporting healthy childhoods.

Key Policy Areas

• Public Health Strategies

• Mental Health Strategy

• Disability Strategy

• Sustainable Transport Policy

• St Helier Masterplan

• Primary Care Strategy

• Open Space Strategy

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• Culture Strategy

HOW WE WANT TO MAKE A DIFFERENCE	KEY INSIGHTS
Increase the number of Year 6 pupils who are a healthy weight	• Average BMI has stayed the same since 2011 but hides variations • Cost of fresh food is higher than processed alternatives - impacting low incomes families • High employment rates challenge family and work-life balance • Variation in exercise and fresh food consumption can be shown according to ethnicity and school • Rates of breastfeeding initiation are lower than European average but similar to England's average
Increase the number of two-year olds who reach their developmental milestones in all domains	• Percentage of 2 year olds reaching their developmental milestone is already good • Delay in communication domains are the most common factor in a child not reaching their milestones locally • Parenting and home learning environment critical to achieving developmental goals • The new Early Years Quality Framework was introduced in September 2018
Reduce the number of under 18s who require a dental extraction	• Increasing number of children in the Community Dental Service seen for teeth extraction • Timely access to the Community Dental Service is a key issue • Children who attend States primary schools, are of Portuguese ethnicity or who live in single parent households were least likely to have visited a dentist in the previous year
Increase the number of pupils who report they have a good quality of life	• Jersey children's 'Health Related Quality of Life' score is slightly lower than European average • Increasing trend over years on low levels of self-esteem among young people • 13% of Jersey children lived in households below relative low-income threshold. 44% of single-parent households find it difficult to cope. • Access to communal spaces and social/recreational activities likely to be key factors in reporting a good quality life.

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Connecting Care for Children

We aim to deliver an integrated care model which will improve continuity of care for our children in Jersey. This will address the high rates of paediatric A&E and paediatric outpatient attendances at the General Hospital and enable our GP's and community services partners to provide many of the services currently offered within the General Hospital. In order to achieve this we will be working with local GPs, community partner leads and our social care partners in children's services.

Our model will have key components:

- Public and patient engagement - enabling primary, secondary and community care professionals to work cohesively with islanders. We aim to ensure the public are clear of services offered and how to access them.
- Specialist advice and guidance – we aim to transfer specialist knowledge from the hospital to the community. Hospital paediatricians will work closely with GPs so that children receive the best possible advice and care within home and community settings.
- Open access - making the expertise of paediatricians in hospitals much more widely available. We will establish direct access to specialist advice and guidance which, primary and community healthcare professionals can access when they need specialist support.

At the core of the model we support healthcare education and training. We ensure primary and community healthcare professionals have the information they need to provide care at home. We will also increase education events for patients and families so that they can learn how to stay healthy and what health care services are available to them.

We will also work closely with our partners in Children, Young People Education and Skills (CYPES) to support the wider Government agenda on delivering preventative services. This will build on our 'Early Help' approach and will ensure that our functions and services are closely aligned to the wider children's services across the Island. A key area of focus for HCS and CYPES will be to improve care and support for Child and Adolescent Mental Health services in Jersey and both departments have a role to play in driving better early intervention and improved access for services.

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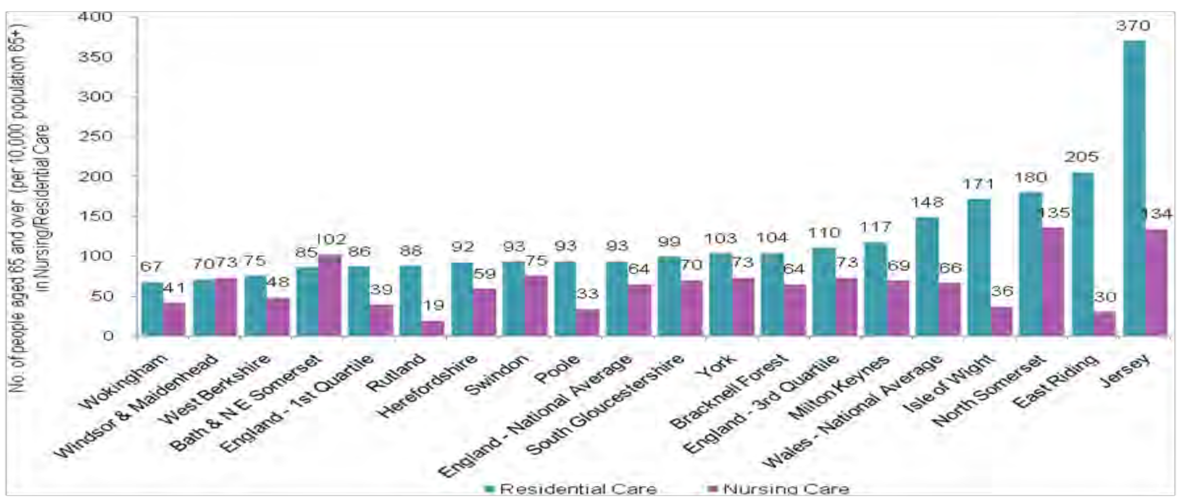
ADULTS SOCIAL CARE

Health spending has risen steadily over the past three decades and has accelerated since the turn of the century to average 8.8[4]% of Gross Domestic Product (GDP) for countries that were members of the Organisation for Economic Co-production and Development (OECD). It is anticipated that if no specific policies are employed to move away from current trends the health sector spending is projected to rise to nearly 14% of GDP by 2060[5].

Although people are living longer than in the past, the functionality of the human body inevitably declines over time, thereby increasing demand for health and social care products and services.

Jersey has an ageing population like many jurisdictions and to support people we need to be innovative and change our current model of delivery which is not sustainable. If we consider the below diagram we can see that our use of residential beds has been significantly higher than anywhere in the UK. Unless we change direction, these pressures will impact the entire Jersey economy.[6]



We will need to work in partnership with Customer and Local Services (CLS) to reduce the pressure on the Long Term Care (LTC) fund to develop the introduction of personal budgets which will increase the range of services available to support people in the community as well as increasing the number of people who can be paid carers. £46.97m paid to support 1,320 people in long term care. 85 people were supported each month (on average) to continue living at home with a domiciliary care package, where the individual needs are particularly complex, and costs exceed the Long Term Care Benefit. HCS also spend around £5.8m annually on packages of care and respite that do not meet the criteria for the Long Term Care fund.

SOCIAL CARE PERSONALISATION

A different adult social care model is required to achieve sustainable services for adults who need care, and sufficient choice for adults with varying needs which may change over time. Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support.

[4] http://www.oecd.org/els/health-systems/health-data.htm

[5] https://www.oecd.org/economy/health-spending.pdf

[6] July 2019 -1002 residential and nursing beds – 3% capacity

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The traditional service-led approach has often meant that people have not been able to shape the kind of support they need or received the right help. Personalised approaches like self-directed support and personal budgets involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives. People need access to information, advocacy and advice so they can make informed decisions.

Personalisation is also about making sure there is an integrated, community-based approach for everyone. This involves building community capacity and local strategic commissioning so that people have a good choice of support, including that provided by user-led organisations. It means ensuring people can access universal services such as transport, leisure, education, housing, health and employment opportunities. All systems, processes, staff and services need to put people at the centre.

- Personalisation is not just about personal budgets, but about achieving choice and control in many ways and in different settings, including basic needs such as being able to access public transport if you are disabled.
- Personalisation is about the dignity and well-being of the individual.
- Delivering personalised services will mean different things to different people – it's about self-determination and self-directed care.
- The relationship between social workers/PAs and service users should be based on respect and a recognition of equality.

Personalisation is a social care approach that enables every person who receives support, whether provided by statutory services or funded by themselves, to have choice and control over the shape of that support in all care settings.

While it is often associated with direct payments and personal budgets, under which service users can choose the services that they receive, personalisation also entails that services are tailored to the needs of every individual, rather than delivered in a one-size-fits-all fashion.

It also encompasses the provision of improved information and advice on care and support for families, investment in preventive services to reduce or delay people's need for care and the promotion of independence and self-reliance among individuals and communities. As such, personalisation has significant implications for everyone involved in the social care sector.

Personalisation and service users and carers

The key test of personalisation's success is the extent to which it improves the lives of service users and their carers. Users should assess their own needs, with or without support, play a full part in drawing up a wide-ranging support plan, rather than a narrower care plan, and directly purchase or choose the services they want. Personalisation in other societies is having a significant impact on the roles of social care professionals. The core functions of care management – assessing service users, drawing up a care plan and purchasing services to meet needs – are all transformed through personalised care. This will call upon other professionals of course in determining more complex needs and in assessing and supporting those needs.

Instead of purchasing services in bulk from available providers and fitting eligible service users into those that best meet their needs, commissioners must shape the social care market to promote the availability of a diverse range of high-quality services from which service users can choose.

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EXTERNAL PARTNERS

EXTERNAL PARTNERS INTRODUCTION

The development of a new hospital for Jersey is well documented and as the project considers a new approach it enables discussions to focus on the size and function of a new facility and crucially what community provision will be needed to support a sustainable health and social care system for Jersey.

Like the rest of the developed world Jersey faces similar challenges such as an ageing population, increased pressure from long term conditions at a time where resources, while still superior to other countries, are rightly under scrutiny. The challenge we have is to spend the Jersey health pound wisely and maximise our current partnerships to deliver the best outcomes for the community.

While central to this is the development of a new hospital, this alone will not provide a sustainable system of healthcare. *The new hospital needs to be part of the health and social care system, but it needs to be fully supported by high quality community provision* delivered in partnership where people can easily access care and support. Key to delivering a sustainable and quality care system is strong partnerships with the voluntary sector, social care providers, private providers and social enterprises based on achieving shared outcomes.

CURRENT POSITION

We are fortunate to have a strong voluntary sector, that is intrinsically motivated and a social care market that is looking to expand. While this is a strength we lack a clinically led commissioning framework that builds on the partnership approach, built around outcomes. In terms of the local landscape, The Charity Commissioner has received 450 applications for charity registration and the Association of Jersey Charities has around 330 members.

A KPMG report in 2016: *The Jersey Charity Survey* [7]highlighted the following;

- £80m is raised annually within the sector
- The largest 4% of organisations raised £48m accounting for 62% of all income in the sector
- 1 in 8 adults on the island are volunteering
- Advancement of health was the joint top aim of organisations surveyed and was top of generating income based on organisations aims
- 2/3 organisations operate without any paid staff
- Those 34% with paid full-time staff have the biggest incomes
- 70% of all organisations agree that they rely on regular volunteers but 35% struggle with retention

There is a great opportunity in Jersey to create a different system wide approach that builds on the strengths of this sector through a transparent partnership approach to drive improvement in health and social care across the whole population. The case for change is clear and the need to direct people's attention to what's important without introducing complexity into the system will require a different relationship. However, there are a number of areas that can be developed to improve how we support people across the community, such as;

- Develop and implement Adults Social Care Strategy
- Improved intermediate care across the system
- Support carers through the Carers Partnership Forum
- Increased care at home

[7] https://www.jerseycommunitypartnership.org/media/1022/survey-final.pdf

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- Market development based on current and future needs
- Introduction of personal budgets
- Increased use of technology to support the delivery of services
- Delivering services where people live using the Parish system
- Workforce development/availability of carers

OPPORTUNITIES

Our partner organisations are ideally placed to support a new and innovative system of health and social care. From supporting homeless people who are 60 times more likely to visit the Emergency Department in a year compared to the general population[8] to access the support they need through to reducing the unnecessary length of stay for some patients in hospital by providing care and support in people's homes through an agile intermediate care offer.

There are a number of opportunities for a partnership approach, to build on the services currently delivered across the island by a range of organisations to improve outcomes for people, make the best use of the resources available and make the Jersey system of health and social care sustainable for generations to come. The implementation of an Adults Social Care Strategy will need to include suitable housing provision for extra care housing and sheltered accommodation to support people's independence in the community for longer.

CARE CLOSER TO HOME

The Health Modernisation Team (HMT) as well as Customer and Local Services (CLS) have started to map a local offer of services that could initially include dementia, mental health, loneliness, social prescribing, and developing a Good Gym model.

This approach includes negotiating the flexible use of local community buildings including schools, Parish and community halls for the provision of activities. It is envisaged that this local offer will be extended to all Parishes based on demographic need and delivering a seasonal offer.

It is proposed that the appropriate redirection of existing resources to a more local, community setting will both have a positive impact on service delivery and will reduce inappropriate referrals to emergency and acute services through a preventative approach. The vision is for services to be delivered closer to or in people's homes.

Closer to home builds on existing strengths and supports self-care and prevention, key components of the Jersey Care Model.

The approach also seeks to work with all age groups, not just older, vulnerable residents. Fundamentally the approach is not only about delivering more accessible services but is also about providing more preventative services which will ensure long term efficiencies for the Government through keeping people in their home for longer and avoiding costly care provision reducing both GP and hospital visits and stays.

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[8] https://www.theguardian.com/society/2019/jul/02/homeless-people-60-times-more-likely-visit-ae-study?CMP=share_btn_link

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This model is an asset-based approach rather than a traditional needs-based approach, whereby services are provided to individuals based on their whole needs of individual support rather than their symptomatic problems. An asset-based approach builds on the strengths of communities and existing services. This approach should lead to increased independence and self-care for individuals in the community and create a menu of services and support that can be universal or part of bespoke packages of care.

To consider an asset-based methodology in providing a range of services in Jersey across all ages, members of the HMT have met with representatives of the Community and Voluntary Sector, Jersey Sport, Children, Young People, Education and Skills (CYPES), mental health services and with the Comité des Connetablés.

A pilot hub has been developed in the west of the island at the Communicare community facility which is situated in a central location within the Parish of St Brelade. Communicare provides a wide range of community activities which successfully attracts a large number of residents accessing the existing offer. The activities include a mother and toddler group, after school club, nursery, youth club, and luncheon club as well as a wide range of other community uses. Both its central location and use by all age groups in large numbers make it an ideal facility to build on. Colleagues from HCS, CLS and CYPES have worked together with staff at Communicare to determine additional services that are offered from the centre.

A steering group has been formed and now includes the local Connetablé of St Brelade, who was selected by the Comité des Connetablés, to oversee the delivery of a rota-based system of services from various providers that is delivered at the Communicare centre and, therefore, closer to peoples' home.

The rota of additional services could in the future include health services such as mental health, chiropody, diabetes clinics and smoking cessation groups, as well as a range of Children's Services such as parenting and family support sessions. Other services such as Social Security drop-ins, Police advice surgeries, and voluntary sector services including Jersey Citizen's Advice Bureau, Mind Jersey are currently delivered there. To maximise the use of a facility that is already incredibly well used a rota system has been developed that publicises the range of services on offer and when they will be available. The "Closer to Home" pilot commenced at the beginning of March with a soft launch and was formally launched in July 2019.

The initial rota has services delivered by the following organisations: Age Concern Jersey, Brook, Jersey Sport, Citizens Advice Jersey, Mind Jersey, Adult Community Services, Library Service, Call and Check, Youth Service, FNHC and Community Police Officers. It is anticipated that this offer will grow and that the steering group will flex and change.

Work has started to look at existing facilities in the east, the condition and capacity of each facility, the services being provided from them and the potential to expand the use of each facility. This should help to develop an appropriate community hub offer in the east of the island. It is anticipated that the "Closer to Home" service will reach across all Parishes working with Connetablés and Parishioners to identify and meet needs.

Initial Feedback

Jersey Library - Children's session:

"Just one more..." multiple pleas to Mum to be allowed to stay for just one more story (they stayed for about an hour!)

"I didn't know you did e-magazines, that's really useful, I'll have a look"

"Fantastic idea having you here"

Jersey Library - Adult Session:

"Thank you so much for the books you lent my husband – just what he needed"

"We used to go to the library in town all the time but now I don't drive I find it too difficult to carry the books"

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Citizens Advice Jersey
"This is fantastic! I can now get this sorted without having to go to town, thanks for the advice"

Jersey Sport, David Kennedy (General Manager)

"The exercise sessions we have delivered at Communicare have been some of the best that we have been able to deliver. This is due to the help of the staff at Communicare, the opportunity to have a coffee after the session, but most importantly it has been a welcoming environment unlike the gym-based sessions. All participants who took part had never been to Communicare before but really enjoyed it and have said they will be bringing a friend next week. There is a much better community feel about the sessions and we believe this will grow considerably in a short space of time."

Social Work, Kate Profitt (Social Worker)

"I have received a referral from Call & Check for a gentleman who requires social care assessment. This was taken at Communicare, which was key as the referral may not have been spotted this early in the persons set of circumstances if services were not available close to this person's home. This referral will lead to early intervention and prevention work."

"As a result of a social worker being present at Communicare at the same time as Call & Check, networking opportunities have led to an invite for Call & Check to attend the social work team meeting to provide a presentation for Adult Social Care Team."

COMISSIONING FRAMEWORK

As we further develop an integrated health and social care system in Jersey it is vital that our partnerships with providers are open and transparent and our purposes are aligned. There are a number of models that can be considered. It is proposed that a new framework is considered that provides assurance around the quality of services, that the funding model doesn't distract and drive the wrong behaviour, more so it supports the system to deliver the type of care we would all want for our own relatives.

Our relationship with contracted services should be built around a common purpose working in partnership, using payment to support the delivery of care, sharing resources, collaborative working and delivering in the community with clear outcomes. Working to a common purpose across the whole system with all sectors aligned to the new system of care will create an approach to support the most vulnerable in our communities and promote the use of resources in a different way. This will require not only a different approach to commissioning but ongoing work with providers and funders who are not commissioned through Government of Jersey (GoJ) to move to a place where budgets are aggregated as a pool of resource for services to deliver against a common purpose.

Delivering services to an agreed common purpose will require the development and commitment of organisations to work to an overarching *Partnership of Purpose* this would be the core to all areas of service delivery and would provide the focus and structure for a framework. This in turn would be supported by an outcome-based commissioning approach in addition to developing personalisation on the island. This would see services commissioned for health and social care outcomes not simply measuring throughput of a service.

Using a co-production model for service development involving both customers and providers, data and trends would be analysed in order to support market development. A centralised commissioning function with clarity for accountability in the model and strong governance arrangements to assure delivery against the Partnership of Purpose could be introduced alongside longer term contracts. Jersey has a diverse health and social care economy and one format of commissioning will not deliver the results required to improve islander's health, mental health and wellbeing.

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A hybrid and blended approach will be adopted to ensure proportionality and a focus on outcomes. Our approach will underpin the delivery of the Jersey Care Model by focusing on current and future needs based on evidence while developing partnerships.

Our model will stimulate market development and reward positive outcomes for patients/clients through sharing rewards. The overarching theme of our approach will be place-based systems of care in which HCS work together with partners to improve health and care for the population. This means organisations collaborating to manage the common resources available to them.

The approach taken to developing systems of care will be determined by HCS and partners, based on a set of design principles. These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

HCS will work to remove the barriers that get in the way of working in place-based systems of care and will work in a co-ordinated way to support the development of these systems. This includes creating stronger incentives for systems of care to evolve to tackle current and future challenges.

Commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. This will enable organisations to plan and develop while underpinning strong partnership working.

Individuals and organisations cannot solve the problems facing today's society on their own. Instead, we must design new ways in which individuals can work together in teams and across systems to make the best use of collective skills and knowledge.

EXTERNAL PARTNERS CONCLUSION

To deliver a new and sustainable system of health and social care requires a new way of working through developing services in the community.

The Jersey system of health and social care will be delivered by a wide range of partners across the island delivered where people live. The reach of the system will extend beyond GoJ services into Parishes, supporting self-care, prevention and early intervention. Partners will deliver services that were traditionally delivered in secondary health and social care settings in the community using hubs at strategic locations on the island.

The system will see parity across mental health, physical health and social care and will ensure that we deliver the Common Strategic Policy priorities of *We will put Children first and we will improve Islanders well-being, mental and physical health.*

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To conclude we can't continue to deliver health and social care as we currently do, and we need to develop a modern system that improves outcomes for patients that is sustainable for future generations. GoJ cannot achieve this in isolation and we need a cross sector approach to developing and owning a new system of health and social care for Jersey that is firmly embedded in the community.

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EXTERNAL PARTNERS APPENDICES

External Partners Appendix A: Introduction

External Partners Appendix B: Partnership framework

External Partners Appendix C: Commissioning Framework Outline

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PRIMARY CARE APPENDICES

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PREVENTION & PRIMARY CARE APPENDIX A: THE COMMON STRATEGIC POLICY RE PRIMARY AND PREVENTION

The Common Strategic Policy published in 2018 was a statement from the Council of Ministers regarding the shared ambitions to “make the positive difference for Jersey that the electorate has demanded”.

Five strategic priorities were identified

- We will put children first
- We will improve Islanders’ wellbeing and mental and physical health
- We will create a sustainable, vibrant economy and skilled local workforce for the future
- We will reduce income inequality and improve the standard of living
- We will protect and value our environment

While all of these will have an impact on health, the three highlighted directly inform the strategy for prevention and primary care.

PREVENTION & PRIMARY CARE APPENDIX B: DEFINITIONS

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Prevention: There are three types of prevention activities that can benefit populations, termed primary, secondary and tertiary prevention:

Primary prevention aims to promote population health and well-being and prevent disease and harm before it occurs – seen as an "upstream approach".

Secondary prevention aims to detect disease and identify risk factors before they become harmful to health (e.g. screening).

Tertiary prevention treats disease with cost-effective interventions to slow or reverse disease progression; it includes rehabilitation for disability – seen as a "downstream approach".

Source: Adapted from Donaldson LJ, Donaldson RJ (2003). Essential public health, second edition. Abingdon: Radcliffe Publishing.

In Jersey, primary, secondary and tertiary prevention is facilitated by a range of public and private providers in a variety of settings.

Primary Care: Primary care in Jersey consists of general practice services, community pharmacy, dentistry and optometry. Primary care plays a crucial role in delivering core health care services whilst having responsibility for referrals to help patients gain access to a large range of other healthcare providers.

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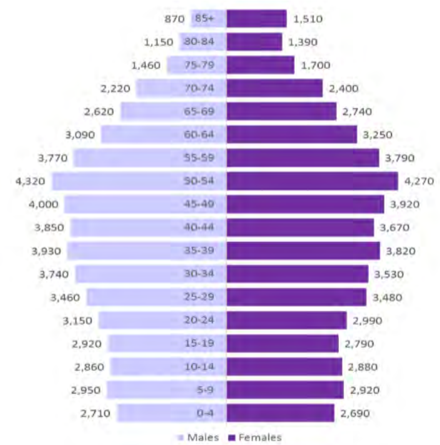
>>> Click here to return to Primary Care section

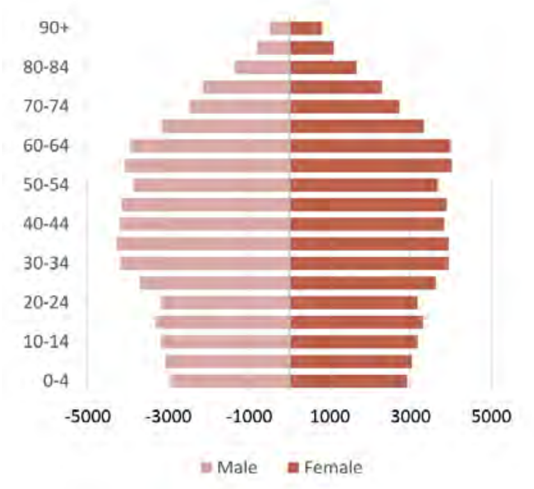
In the next decade Jersey will face a growing and ageing population, a rising tide of chronic illness, higher expectations of care from the next generation, and the availability of new treatments and technologies.

The resident population of Jersey at year-end 2018 is estimated as 106,800.

Estimates of the distribution of people in each age and gender group is demonstrated as follows:



Jersey Resident Population 2018 Estimate, SJ



Jersey Resident Population 2026 Estimate, SOJ

In 2026, the projected population is 117,100, an overall increase of 12%. The proportion of those aged 65 or over is projected to increase from around 17% in 2018 to 19% in 2026.

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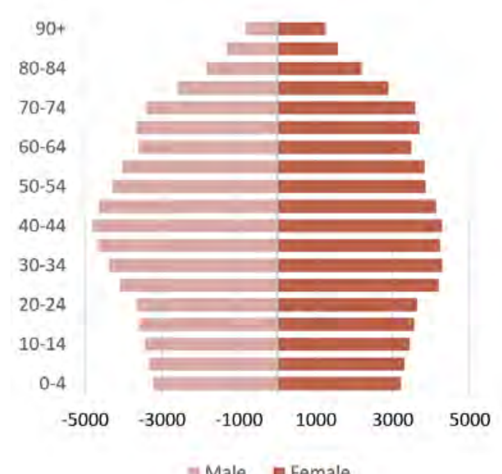
By 2036, the population increases by another 11%, to 130,000.

Around one in five (22%) of the population would be aged 65 or over.



Population Projections 2016-2036 PHSU, SOJ

Having a larger population of those aged 65 or over has implications for the health service, especially if these individuals have accumulated morbidities over their lifetime.

The projected increase in population size and change in its age profile will be reflected in an increase in GP consultations:

- It is estimated that there will be an additional 70,000 GP consultations each year by 2026, bringing the total to 502,000 (an increase of 16%)
- by 2036, it is estimated there will be an additional 143,000 consultations compared to 2016 (an increase of 33%) bringing the number of consultations to 575,000 per year[9]

Figures from the General Practitioner Central Server (GPCS) showed 105,490 people as registered with a Jersey GP and active on 31 December 2017. An analysis of the numbers of patients with 13 identified long-term conditions was conducted by Statistics Jersey, including the 12 long-term conditions recorded as part of the Jersey Quality Improvement Framework (JQIF) and cancer (with the exception of non-melanoma skin cancer).

Of people registered with a Jersey GP at the end of 2017, 75,020 (71%) had none of the 13 long-term conditions considered; 17,765 (17%) had a single long-term condition and 12,705 (12%) had two or more long-term conditions.

[9] Disease Projections 2016-2036 PHSU, SOJ

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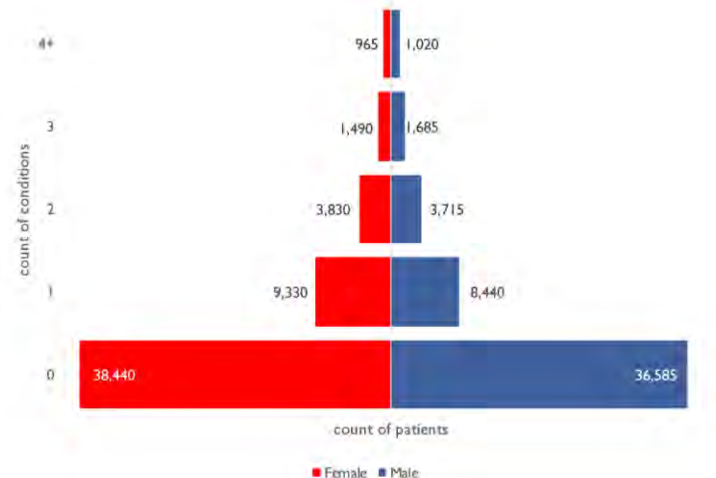
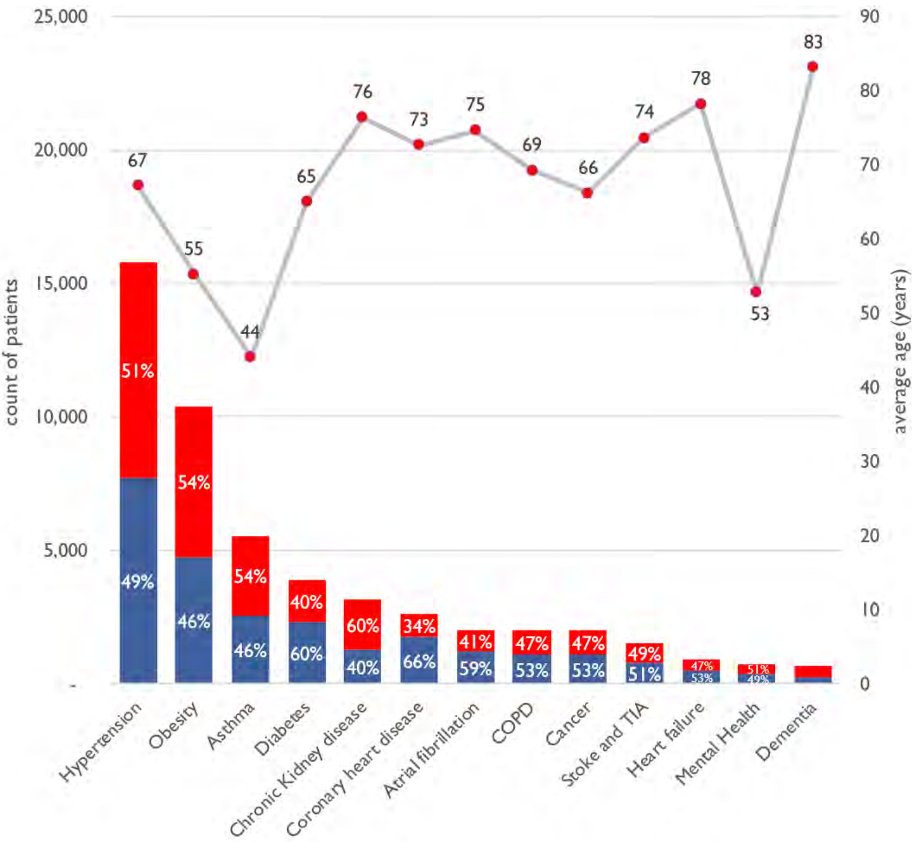


Progressively fewer patients had a higher number of the conditions:

- 17,765 (17% of all patients) had a single condition
- 7,545 (7%) 2 conditions
- 3,175 (3%) 3 conditions and
- 1,985 (2%) had 4 or more conditions.

Prevalence of health conditions in Jersey and their multi-morbidity, SJ 2018

The below graph shows the count and average age of Jersey GP patients with each type of morbidity (note: patients with multi-morbidity are linked to more than one condition)[10]:



[10] Prevalence of health conditions in Jersey and their multi-morbidity, SJ 2018

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By 2026 and 2036 there are significant projected increases in patient numbers for many of these conditions[11]:

Patients in 2016 | Increase by 2026 | Increase by 2036

Changes to numbers of patients with specific conditions

Heart Failure: 800 | +400 | Up 75% by 2036
Stroke/TIA: 1,400 | +400 | +500 | Up 64% by 2036
COPD: 1,800 | +500 | +500 | Up 50% by 2036
Atrial Fibrillation: 1,800 | +500 | +600 | Up 67% by 2036
Coronary heart disease: 2,400 | +700 | +800 | Up 63% by 2036
Chronic Kidney disease: 2,700 | +900 | +1,100 | Up 74% by 2036
Diabetes: 3,600 | +700 | +800 | Up 42% by 2036
Asthma: 5,200 | +700 | +700 | Up 25% by 2036
Obesity: 9,400 | +1,400 | +1,200 | Up 28% by 2036

- 2,000 4,000 6,000 8,000 10,000 12,000
Numbers of patients

[11] Disease Projections 2016-2036, SJ 2016

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PREVENTION & PRIMARY CARE APPENDIX D: LONG-TERM CONDITIONS

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Minimising costly secondary care admissions though improved primary care management and self-care of long-term conditions, results in lower health costs and improved health outcomes. HCS has recognised the need to move management of long-term conditions into the community, with well-structured clinical pathways and handovers. Self-care and joint care planning (e.g. expert patient programme, patient education) should also play a significant role.

We will develop a Multidisciplinary Clinical Forum to manage and agree pathways across primary/secondary care, including (but not limited to) – Diabetes, COPD, Heart Failure, Depression, Epilepsy, End of Life Care. Pilots have been completed for Diabetes and COPD care, and this work now needs rapid expansion and roll-out.

Funding mechanisms as previously discussed will be required in order to transfer funds from secondary to primary care, considering a number of options (individually or in combination):

1) Bundled payments (for service user and HIF+/-HCS)
2) Expansion of JQIF quality measures to drive provider behaviour change
3) Funding a long-term conditions care co-ordinator role (expansion of year of care pilot areas)
4) Commissioning Framework

PREVENTION & PRIMARY CARE APPENDIX E: STRATEGIC AIMS – MORE DETAILS

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Improve health outcomes and improve population health – identifying disease earlier, and managing health and care better, means healthier, longer lives for the population.

Improve health system efficiency and health equity – minimising costly secondary care admissions though improved primary care management, particularly of long-term conditions, results in lower health costs. Supporting financially vulnerable, clinically vulnerable and socially vulnerable groups improves welfare and reduces overall costs.

Improve workforce utilisation with care closer to home – maximising use of appropriate primary-care and community resources releases capacity from specialist hospital resources, saving money and leading to improved satisfaction for all providers.

Support the island's economy – supporting an increasingly aging population to remain healthy and stay in work reduces the load on Social Security benefits, increases tax revenues, and ensures that the health and care system and wider economy are more sustainable.

Self-care - develop and promote resources that help citizens with self-care for themselves, their families and loved ones.

Expand prevention and screening - increase access to safe, cost-effective screening services, in line with international best practice, to identify and treat risk factors, pre-cursors and disease as early as possible.

Improve access – for patients who are financially, clinically and socially vulnerable.

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Shift resources – staff and money – into preventative and primary care services and reduce reliance on secondary care services. Include community-based professionals (including GPs, pharmacists and others) in designing care pathways.

Intermediate care – urgently expand intermediate care services, both in terms of the types of services offered and the capacity of those services – deliver care as close to home as possible.

Support carers and the community – identify and implement opportunities to increase the support provided to carers with their own needs and those of the people they look after.

PREVENTION & PRIMARY CARE APPENDIX F: ENABLING THE STRATEGY

>>> Click here to return to Primary Care section

DIGITAL CARE

In order for people to access services more efficiently Jersey's Primary Care System needs to be supported by a number of digital initiatives, aiming for **'Digital First'** access in-line with Government of Jersey's CSP. Projects will include:

- Developing validated self-help resources
- Encouraging self-care/management via patient facing applications
- Monitoring of long-term conditions using IoT Devices
- Development of the Jersey Care Record – allowing access to appropriate information in different settings
- Widening access to booking appointments for patients and professionals, checking results, and exploring the use of video consultations and virtual wards
- Improving links with secondary care through: E-prescribing, E-discharge, GP Order comms

WORKFORCE PLANNING, EDUCATION AND TRAINING

The Primary Care strategy will be supported by the development of a Primary Care People Strategy, in-line with wider Health initiatives, to ensure we have the right people, with the right skills, in the right place, at the right time.

As a significant number of staff involved in the provision of prevention and primary care are not directly employed by Health & Community Services **special consideration** should be given as to how best address this issue.

We will move towards a collaborative approach to workforce planning, education and training which incorporates all primary and secondary care.

GOVERNANCE

Moving care from secondary to primary care will require expansion of primary care governance and assurance structures, particularly if behaviour change is driven by expansion of JQIF. This needs to be explored and costed.

PREVENTION & PRIMARY CARE APPENDIX G: NOTES ON INTERMEDIATE CARE

Improving care of long-term conditions will keep people healthy, their conditions stable, and reduce the need for admission. However, when people do need more advance levels of care we plan to **offer this care as close to home as possible** with expansion of the size and scope of our intermediate care offering, including:

Expand our hospital-at-home/Rapid Response service

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- Prevent admission – care at home (IV therapy – antibiotics/diuretics), patient monitoring
- Faster discharge
- Expand team, capacity and skillset – more community nurse prescribers, expand service to new conditions; 24 hour community nursing
- Increase use of digital solutions to bring the hospital to the home

Utilise the island's non-acute bed-base: Acute hospital wards are not where patients should wait for a care package – improve flow to community facilities/nursing home beds/Silver Springs/home

Expand our re-enablement/frailty service

- Increase access to physiotherapy/occupational therapy/community exercise programmes
- Community geriatrician and multidisciplinary intermediate care team to facilitate standardised in-reach programmes

Primary Care will have a role to play in developing and delivering the specification for Intermediate Care.

PREVENTION & PRIMARY CARE APPENDIX H: CURRENT FUNDING SOURCES

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Health and Community Services - **£209m** (2018) funded by general taxation

Health Insurance Fund - £39.2m income, **£31.9m** expenditure (2017) funded from social security contributions

- Prescriptions **£20m** (£13m drugs, £7m dispensing fees)
- Pharmacy flu vaccines £0.1m
- GPs **£8.8m** (£6.9m medical benefit - £20.28/visit, £1.6m JQIF, £0.3m flu vaccines)
- £0.9m blood tests to Pathology, HCS
- Gluten free products **£0.5m**
- Admin **£1.8m** (inc. primary care governance, pharmaceutical advisors, CLS costs/processes, administration of law etc.)

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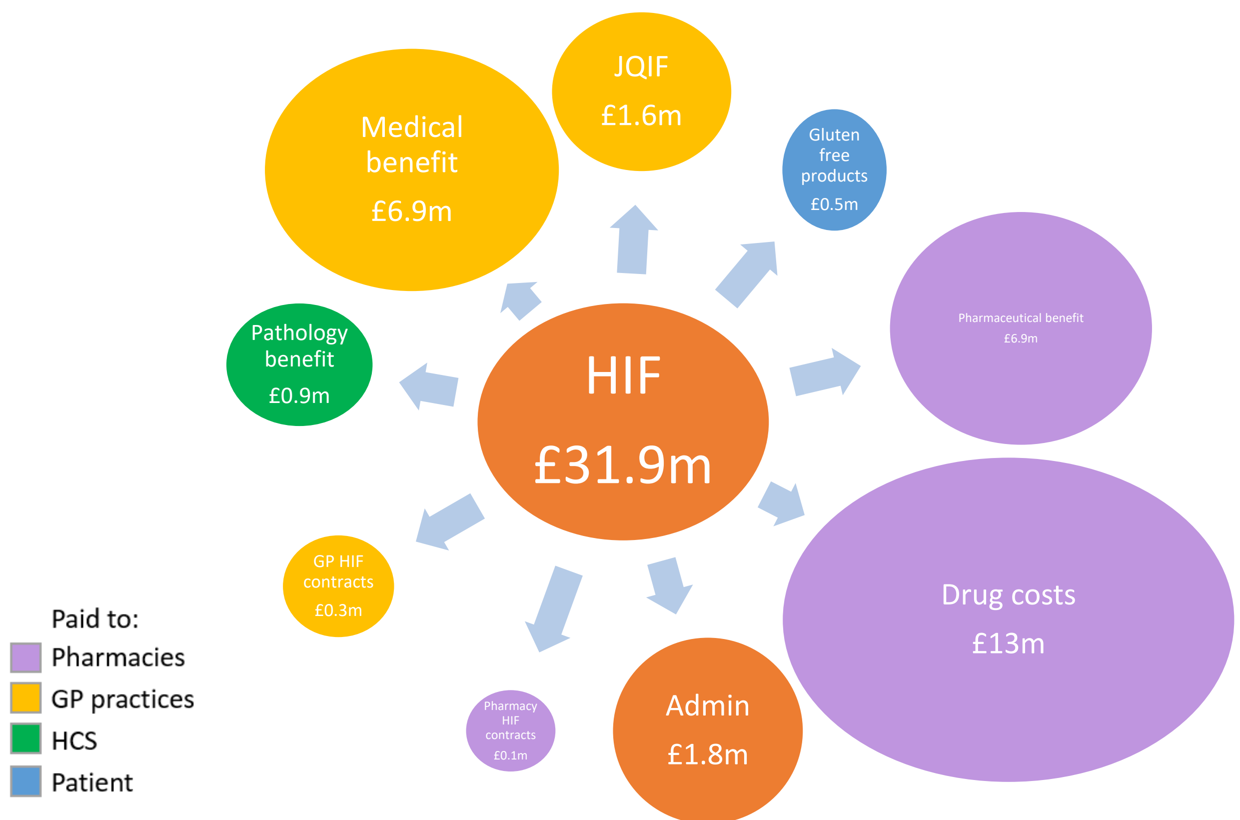

Patient payment – estimated contribution from the public for all General Practice Services is **£10m**

In 2017 a total of **£36.1m** was spent on Incapacity Benefits (LTIA, STIA, DB) – if we improve access to primary care and improve population health potential savings could be made, but more importantly there are significant benefits for society in general.

PREVENTION & PRIMARY CARE APPENDIX I: THE FUTURE OF FUNDING FOR PREVENTION AND PRIMARY CARE

>>> Click here to return to Primary Care section

Under the current state GoJ have only limited financial levers (JQIF) available to improve outcomes, drive care into the community, encourage self-care and achieve the aspirations of the Prevention and Primary Care Strategy. In order to frame the discussion around the future of funding for prevention and primary care there are three questions to be addressed and modelled.

1) WHAT TO FUND?

There are three approaches for consideration either in isolation or in combination.

- **Free general practice services[12] for all**. The estimated contribution from the public for all general practice services is **£10m**. Consideration could be given to replacing this contribution with central funding, making general practice accessible to all.
- **Specific Primary Care services for specific groups**

[12] general practice services refers to services provided within a GP medical practice, which may be delivered by a range of professionals including GPs, practice nurses, primary care pharmacists, healthcare assistants etc.

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- Financially vulnerable (those who are unable to afford the required GP consultations, either in the short or long term)
- Clinically vulnerable (dental care for children, long-term conditions, mental health conditions)
- Socially vulnerable (0-5y, all children, teenagers, elderly, vulnerable adults)

• **Address specific inequalities/perverse incentives**:

This refers to the current disparity in service user payments for similar services delivered in different environments. Resolving these inequities may help increase access in the shorter term. Some examples include – dressings and subsidised products, diabetes supplies, imaging & pathology, primary care presentations to ED

2) MECHANISMS FOR PAYMENT AND WHO TO PAY?

There are several mechanisms for payments for provision of prevention and primary care services. Again, any solution is likely to incorporate part or all of each mechanism.

Mechanism	**Current State and Future options**
Expand current fee-for-service (FFS) payments system (Volume driven)	Currently only paid to GPs (per consultation) & pharmacists (dispensing fees) Options to expand system include: • Payments to other staff– e.g. practice nurses, HCAs, physiotherapists, pharmacy assistants, counsellors etc. • payments for other services
Expand pay for performance framework (Quality driven)	Currently only JQIF paid to GPs Options to expand system to include: • incentives for primary care management of long-term conditions • delivery of enhanced services by pharmacist
Bundled/contracted payments	Contracts exist with both GPs and pharmacists to deliver 'flu vaccinations, and with GPs to provide cervical smear tests. Maternity bundled payments provide a prescribed range of services for a defined service user fee. Both contracts and bundled payments systems could be expanded to deliver care for particular services, conditions or patient groups in exchange for a negotiated fee. For each, a decision would have to made regarding the amount of charge incurred by the service user.
Capitated payment	No services are currently provided on a capitated basis. A full or partly capitated system could be introduced. • **Full capitation:** All general practice services provided at no cost to the service user, payment to providers based on the number of patients registered to the medical practice. • **Part capitation** – either: 1] general practice services provided at no cost to the service user for certain groups within the population e.g. under 5s, over 85s, certain conditions 2] the payment made from GoJ for general practice services could be delivered using a capitated model rather than a fee for service model, while the service user payment remains on a FFS basis *NB 2] is unlikely to significantly change provider behaviour without an additional change to the fee-for-service service user co-payment which will continue to encourage activity over quality*

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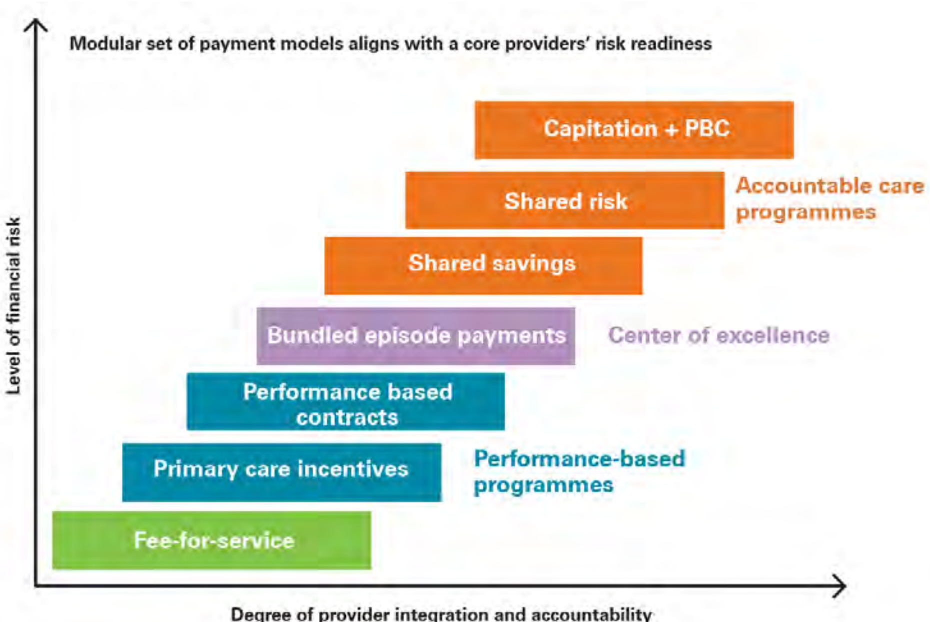
Direct employment of primary care staff	Currently one primary care pharmacist is employed directly. Options for the future include direct employment of some or all primary care staff (GPs, pharmacists, practice nurses etc.)
Social Insurance Scheme/Expansion of HMAs	Not currently in use, although those in receipt of income support may choose to make a regular payment into a Household Medical Account (HMA) to pay for general practice services. Future options could include: • expansion of HMA to all individuals in receipt of income support • a universal social insurance scheme for all service users to pay for access to primary care

The below diagram illustrates how the widely used fee for service payment mechanism, with a low level of accountability and financial risk for the provider may lead to sub-optimal outcomes. Instead, the system should move towards payment mechanisms that create accountability and incentivise correct behaviours[13].



Value based payment continuum

3) WHAT ARE THE SOURCES OF INCOME?

Funding for primary care services is currently provided from a combination of service user payments, payments from the Health Insurance Fund (HIF), and payments from Health and Community Services paid for by general taxation)[14]. Increased provision of prevention and primary care services is likely to require extra funding. This can be addressed in two ways:

Reconfiguration of current funding streams

- Moving funds and resources from secondary to primary care
- Combination/redistribution of the HIF and HCS funding

[13] Key Issues in healthcare: Island Healthcare Perspective, KPMG, 2015

[14] For more details of the current funding sources please see Appendix 8

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- Ring fenced budget for prevention & screening

Potential new funding streams

- Expand contributions from social security or general taxation
- Prescription charges

It should be noted that there is the potential to access funds from the HIF on a one off basis in order to offset double running costs in primary and secondary care during a period of transition.

PREVENTION & PRIMARY CARE APPENDIX J: PRIMARY CARE PHARMACISTS - EXAMPLE OF VALUE OPPORTUNITY

Pharmacist-led Information Technology Intervention for Medication Errors (PINCER)

PINCER involves using a computer programme to extract information from GP systems. Pharmacists use this information to identify patients at potential risk from their prescribed medicines. An action plan is then produced in conjunction with GP practice colleagues to carry out targeted reviews, resolve the issues identified and prevent future recurrence. Having a pharmacist available to identify the root cause of any prescribing problems, provide feedback, give educational outreach, and dedicated support for the GP practice makes a real differences to patient safety.

Potentially hazardous prescribing is identified by searching patient records for 'prescribing indicators'. An example of an indicator is;

Prescription of an oral non-steroidal anti-inflammatory drug (NSAID), without co-prescription of an ulcer healing drug, to a patient aged ≥65 years

The biggest impact in reduction in unsafe prescribing can be seen by indicators linked to a risk of gastrointestinal bleeding, heart failure, and kidney injury.

It is highly likely that PINCER will cut hospital admissions and would be a great way to meet the World Health Organization's Global Patient Safety Challenge of reducing the level of severe, avoidable harm related to medicines by 50% over the next five years.

By merging the PINCER indications with an electronic patient record, it is possible to develop a real-time health dashboard that flags up problems in a 'live' system rather than having to periodically run an audit.

The implementation of GP pharmacists is a vital part of making PINCER a success. Being able to access the information from GP systems is not enough the pharmacist is needed to make sense of the intervention, engage others and ensure changes are sustained in everyday practice.

References

Avery AJ, Rodgers S, Cantrill JA ET AL. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. THE LANCET 2012:9823;1310–1319. Available at; https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0140673611618175?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0140673611618175%3Fshowall%3Dtrue&referrer=https:%2F%2Fwww.pharmaceutical-journal.com%2Fnews-and-analysis%2Ffeatures%2Fthe-gp-pharmacists-leading-a-life-saving-medicines-safety-project%2F20206119.article%3FfirstPass%3Dfalse

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https://www.health.org.uk/improvement-projects/scale-up-replication-and-licensing-of-the-pincer-intervention

>>> Click here to return to Primary Care section

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INTERMEDIATE CARE APPENDIX A: INTERMEDIATE CARE SERVICE DEFINITION - HIGH LEVEL

>>> Click here to return to Intermediate Care section

Key Service Attributes for Jersey

We will establish a Community Independence focussed Intermediate Care function which incorporates Frailty and Older Person's Rapid Access.

The service is proposed to run 7 days a week with a minimum 8am-8pm function but connected to a core overnight community function.

We expect the service to provide;

- Urgent Rapid Response (Nursing Assessment and Support - Intervention)
- Urgent Social Care Assessment & Support – Care direction
- Urgent Therapy Assessment & Support (Physio & or OT) – equipment and support
- Rapid deployment of Reablement support or enhanced care @ home
- Integrated liaison to the Mental Health Crisis Prevention Service
- Night sitting deployment
- Integrated Medical support to broaden the intermediate care scope

The service would be made up of Nurses, Social Workers, Therapists, Reablement workers, Mental Health staff and connected to but not driven by a medical model which incorporates Primary Care and Care of the Elderly specialist opinion.

The service would have rapid access to secondary care diagnostics, step up-down provision and home facing enabler services (handyman & parish based offer etc)

The service will be connected to a broader community services specification to support 24/7 care needs including end of life care. The service will work closely with the Closer to Home initiative.

This service will help support the changes in the social and long term care sector (residential & nursing) from bed based to home faced care provision around a personalisation agenda.

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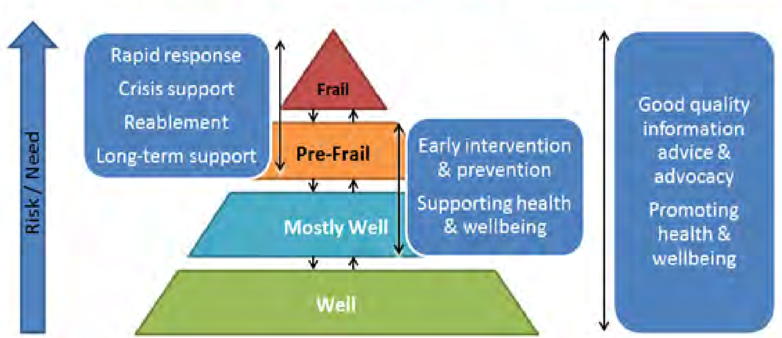

Key Expectations of the Service

- Improved Quality of care delivered in the right setting by the right professionals
- A reduction in admissions to the Acute sector for target groups (Ageing Demographics and Chronic conditions)
- Early facilitated discharge from the secondary care setting which improves LOS and drives a Discharge to Assess model
- A reduction in intensive & high cost packages of care
- A reduction in placement prevalence (Nursing and Residential)
- Reduced professional contacts & duplication as evidenced through PLICS
- Reduced Mental Health crisis activity
- Reduction in adverse safeguarding outcomes
- Reduction in interdisciplinary and inter-provider related incidents
- Improved service user experience and outcomes

NICE Definition (for reference)

Intermediate care is defined by NICE as follows; HCS would seek to develop a similar comprehensive offer tailored to Jersey needs.

Intermediate care

A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

Bed-based intermediate care

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Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, Government facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Crisis response

Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home-based intermediate care

Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Home care

Care provided in a person's own home by paid care workers which helps them with their daily life. It is also known as domiciliary care. Home care workers are usually employed by an independent agency, and the service may be arranged by the local council or by the person receiving home care (or someone acting on their behalf).

Person-centred approach

An approach that puts the person at the centre of their support and goal planning. It is based around the person's strengths, needs, preferences and priorities. It involves treating them as an equal partner and considering whether they may benefit from intermediate care, regardless of their living arrangements, socioeconomic status or health conditions.

Positive risk taking

This involves balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether.

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Reablement

Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

Core principles of intermediate care, including reablement

Ensure that intermediate care practitioners:

- develop goals in a collaborative way that optimises independence and wellbeing
- adopt a person-centred approach, taking into account cultural differences and preferences.

At all stages of assessment and delivery, ensure good communication between intermediate care practitioners and:

- other agencies
- people using the service and their families and carers.

Intermediate care practitioners should:

- work in partnership with the person to find out what they want to achieve and understand what motivates them
- focus on the person's own strengths and help them realise their potential to regain independence
- build the person's knowledge, skills, resilience and confidence
- learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack
- support positive risk taking.

Ensure that the person using intermediate care and their family and carers know who to speak to if they have any questions or concerns about the service, and how to contact them.

Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats, for example:

- verbally
- in written format (in plain English)
- in other accessible formats, such as braille or Easy Read
- translated into other languages
- provided by a trained, qualified interpreter.

>>> Click here to return to Intermediate Care section

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SECONDARY CARE APPENDICES

SECONDARY CARE APPENDIX A: EMERGENCY CARE

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The Emergency Department(ED) currently treats 119 (Average Last 12 Weeks) patients per day with a conversion rate to inpatient of 14.3% (Average last 12 Weeks). The conversion rate is greater than best practice as is the time to first assessment (70% of patients starting treatment within 60 minutes of arrival) demonstrating that we are delivering responsive care in the department.

When analysing ED activity over the past 5 years (Figure 1) there is a small pattern of growth emerging. 2014 – 2016 saw a period of growth equating to an increase of 6-7 patients attending ED per day. However 2017 saw a decrease in activity when compared to 2016. 2018 saw the greatest number of ED attendances to date, slightly greater than 2016, but growth between these two periods when extrapolated down into daily figures is 1 patient per day.

FIGURE 1: JERSEY GENERAL HOSPITAL EMERGENCY DEPARTMENT ATTENDANCES: LAST 5 YEARS (2014-2018) SPLIT BY ACUITY

TRIAGE CATEGORY	2014	2015	2016	2017	2018
P1: Resus	154	187	147	136	155
P2: Very Urgent	1435	1732	1745	1816	1666
P3: Urgent	10833	11862	13027	13009	12762
P4: Standard	23007	22432	22932	22345	22595
P5:Non-Urgent	1061	1025	1047	1236	1991
Blank	265	231	266	235	323
TOTAL	36755	37469	39164	38777	39492
GROWTH	N/A	714	1695	-387	715
% CHANGE	N/A	1.90%	4.50%	-1.00%	1.80%

Perhaps what is most striking about the ED attendances is the case mix. Figure 1B demonstrates the acuity of ED attendances (by Manchester triage category – Figure 1A) at JGH in 2018. Grouping all P1, 2 and 3 attendances as 'majors' and all other activity as 'minors' demonstrates as 63% Minor: 37% Major split in acuity. When compared to the NHS type 1 Emergency Departments the split is 62% Major: 38% minor.

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FIGURE 1A: MANCHESTER TRIAGE CATEGORIES

1	Immediate resuscitation	Patient in need of immediate treatment for preservation of life
2	Very urgent	Seriously ill or injured patients whose lives are not in immediate danger
3	Urgent	Patients with serious problems, but apparently stable condition
4	Standard	Standard cases without immediate danger or distress
5	Non-urgent	Patients whose conditions are not true accidents or emergencies

FIGURE 1B: JGH ACUITY BREAKDOWN (LEFT) Vs NHS TYPICAL ACUITY BREAKDWON (RIGHT)

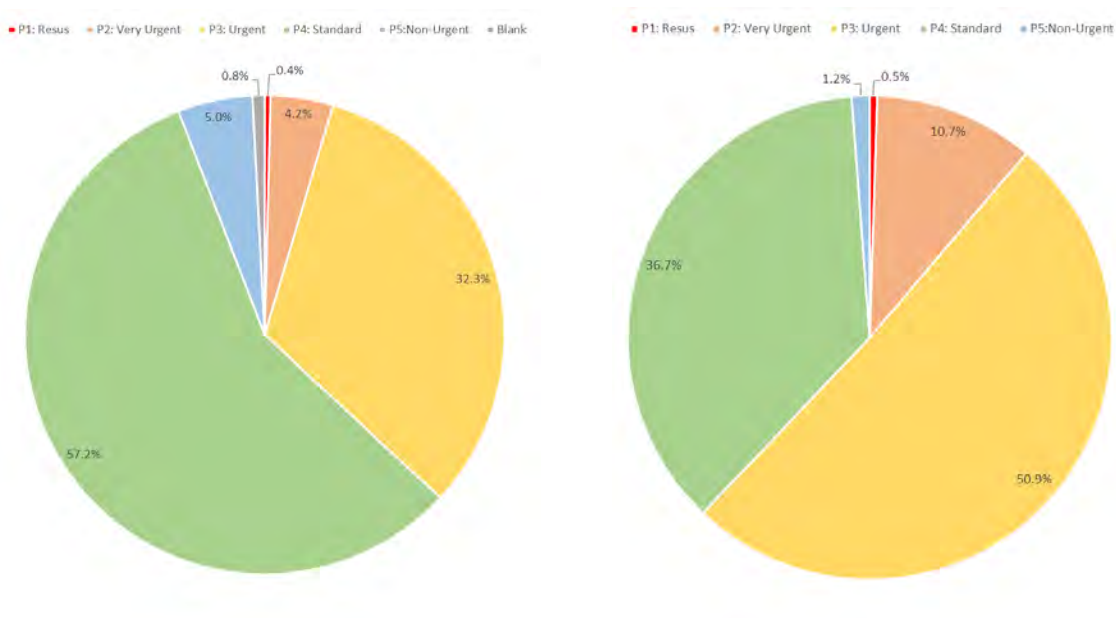
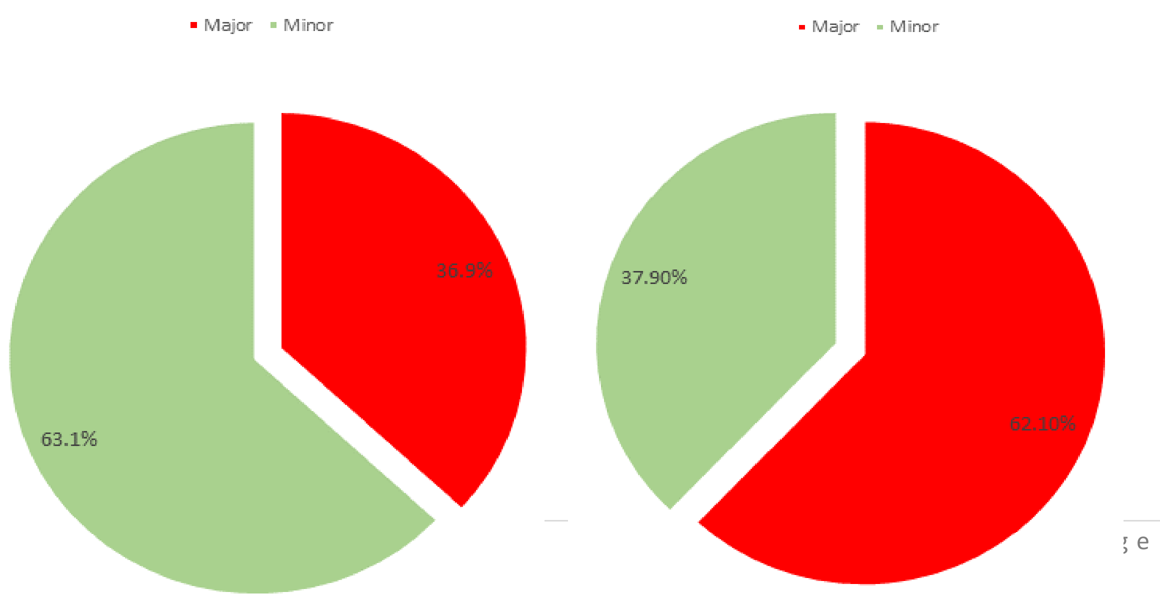


FIGURE 1C: JGH MAJOR/MINOR BREAKDOWN (LEFT) Vs NHS TYPICAL MAJOR/MINOR BREAKDWON (RIGHT)



Therefore is a classic Emergency Department necessary for the increased minor illness and injury presentation experienced in JGH. Would an Urgent Treatment Centre be more suitable for the majority of this activity?

FUTURE MODEL CONSIDERATIONS

On reviewing the existing data and future projected need there is an opportunity to change the Accident & Emergency service into an Emergency Care department. HCS believes the future model of care must ensure the Emergency Care department maintains the ability to manage urgent, very urgent and resuscitation patient activity with a specialist medically led model of Emergency Care. The Emergency Care department needs close connectivity to the proposed Acute Floor Model concept.

Non-urgent and standard activity which is a significant part of the current volume of patients could be managed within an urgent care centre that is closely connected to the Emergency Care department. The Urgent Care Centre (UCC) will need careful consideration in relation to policy as a high volume of the activity could be considered to be minor illness that can be managed by Primary care. Further analysis will be needed in relation to charging consideration and the role of Primary care in managing this volume of patient activity.

In terms of workforce requirements, we would envisage;

- The need for specialist A&E medical staffing
- A stronger emphasis on Emergency Nurse Practitioners and enhanced Reregistered Nurse roles
- A stronger emphasis on Multi-Professional teams such as Physio's, Social Workers and Occupational Therapists
- GP's and Acute Care Physicians should be considered for part of the model, particularly GP's for the UCC element
- Care of the Elderly physicians are needed to support the high volume of older demographic activity
- Near testing and diagnostic support staff will be needed
- Mental Health liaison practitioners – Medical and Nursing will be required
- The role of the Health Care Assistant in Emergency Care needs to be expanded and optimise

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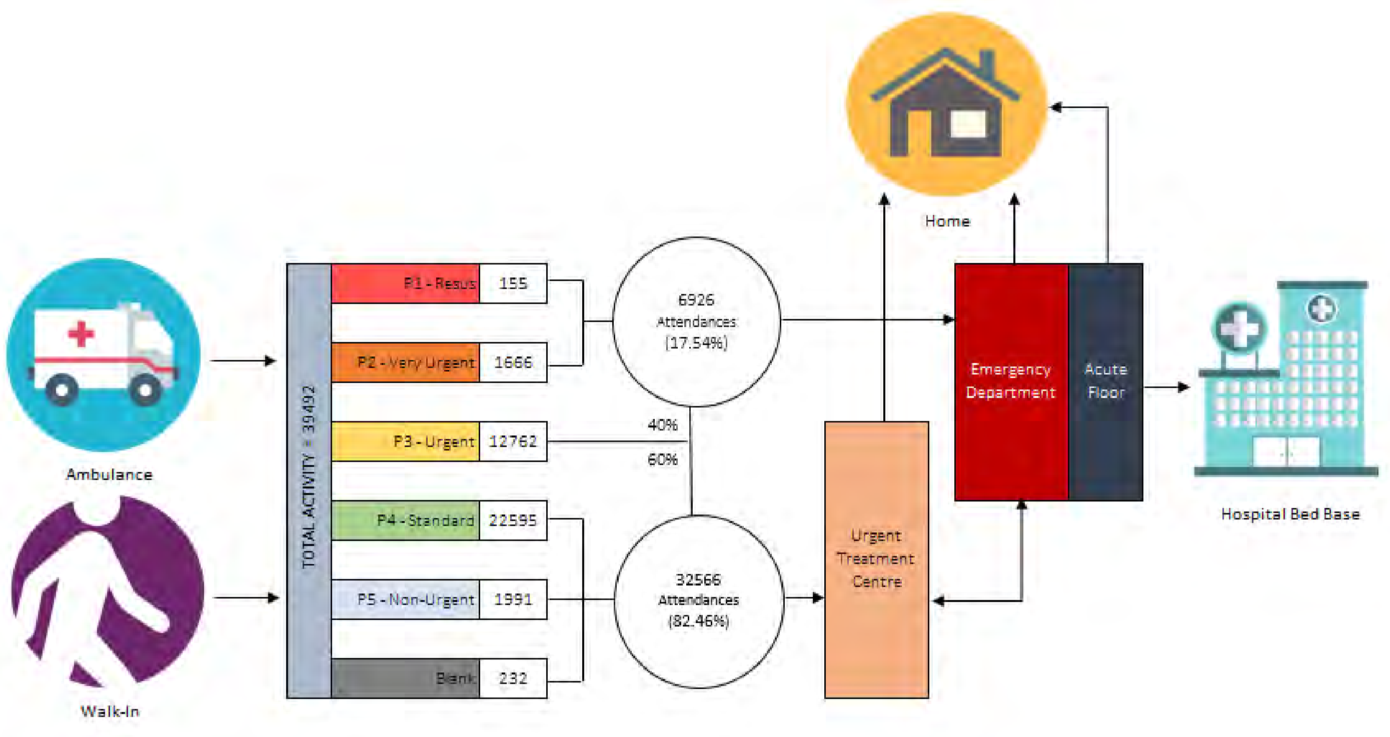
FIGURE 1D: EMERGENCY DEPARTMENT > URGENT CARE CENTE ACTIVITY RE-CONFIGURATION (2018)



Jersey Care Model

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SECONDARY CARE APPENDIX B: BED BASE

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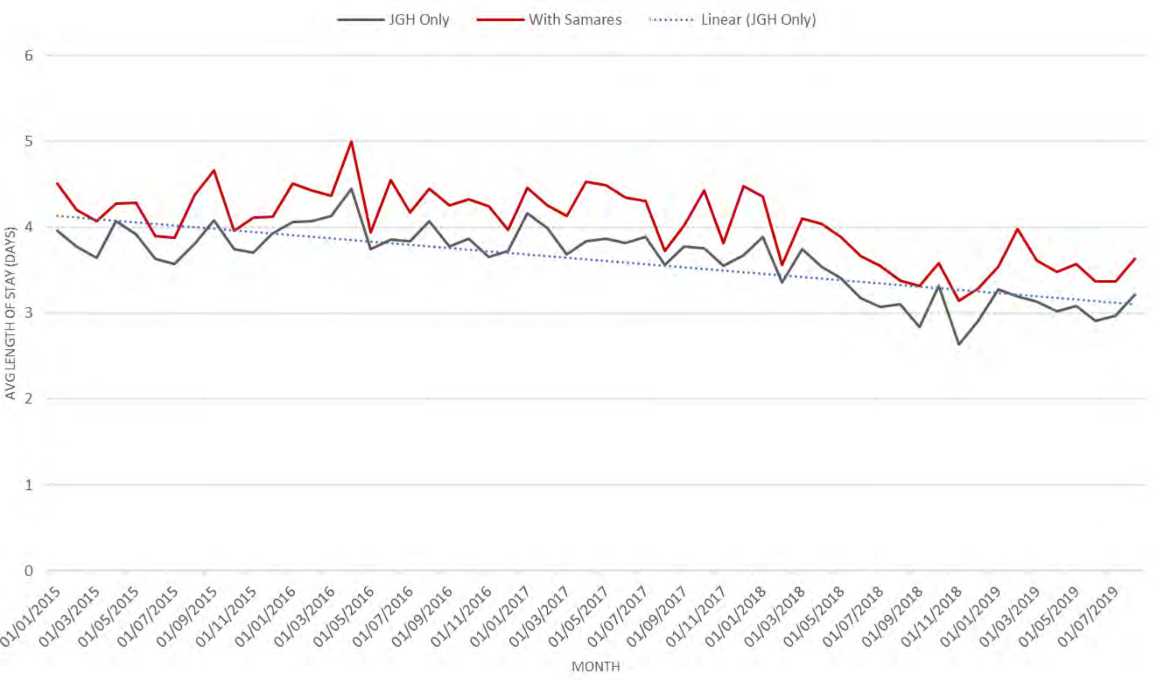
There has been an improvement in length of stay over the past 12 months; this has been the result of focussed attention on stranded patients and review of discharge processes. Subsequently our occupancy rates have also improved significantly in the past 12 months as we manage our capacity differently in order to mothball capacity and review patient pathways. Contrary to the acute service strategy, 2015-2024 inpatient bed availability has not run out of capacity due to improvements in length of stay. Therefore, is the future care model focussed around minimal bedded capacity if we move to increased day case procedures? If we understand and address our conversion rates in ED? If we remodel our rehabilitation services and we manage our bedded capacity proactively.

FIGURE 2: JERSEY GENERAL HOSPITAL (WITH/WITHOUT SAMARES) LENGTH OF STAY SINCE 2015



Planning for the impact of population and demographic change is critical to the size and functional composition of any hospital. The population of Jersey is growing relatively slow, but is ageing rapidly. Between 2010 and 2040 there will be a 95% increase in the over 65 population, with a 35% increase by 2020. This growth in the older adult population will create a challenging increase in demand for Health and Community Services. Extensive demand modelling has been completed by Ernst & Young (EY) based on the population figures obtained from the report 'Jersey population projections 2016 release '(produced by the States of Jersey Statistics Unit on the +700 migration scenario). The following demographic growth rates (below –Table 1) were applied to forecast future activity up to 2065 (Below – Table 2).

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FIGURE 2A: DEMOGRAPHIC GROWTH RATES 2017 – 2065

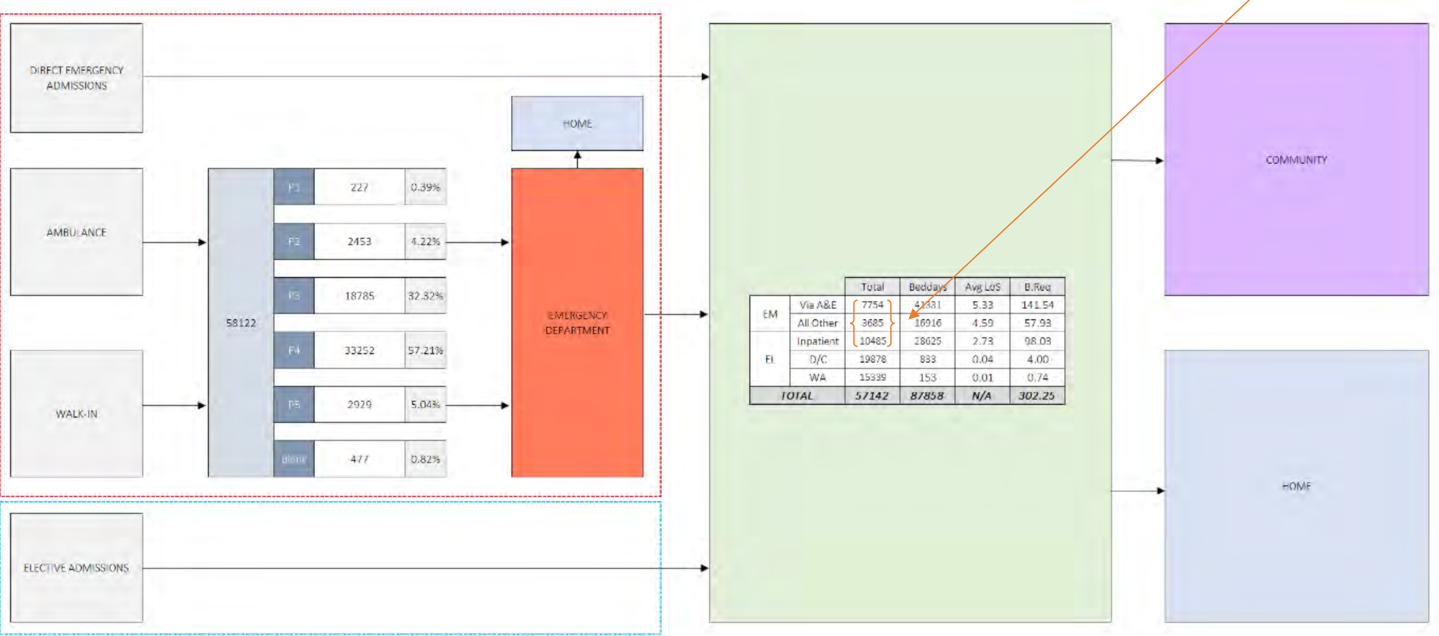
Age Group	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027-2036	2037-2046	2047-2056	2057-2065
0-4	-1.0%	0.5%	1.4%	0.8%	0.2%	0.3%	0.3%	0.4%	0.4%	0.5%	6.2%	8.0%	4.5%	4.0%
5-17	1.7%	1.4%	0.7%	1.2%	0.9%	1.0%	1.0%	0.7%	0.6%	0.5%	4.1%	5.9%	6.5%	3.9%
18-64	0.5%	0.5%	0.5%	0.5%	0.5%	0.4%	0.3%	0.4%	0.4%	0.4%	2.8%	5.7%	5.5%	4.7%
65-79	2.4%	2.2%	2.3%	2.0%	3.2%	3.2%	3.2%	2.3%	2.7%	1.8%	22.1%	-2.4%	2.6%	6.3%
80+	3.1%	3.2%	3.0%	3.3%	1.6%	1.8%	2.8%	3.9%	2.8%	5.3%	43.9%	38.5%	13.3%	6.3%

FIGURE 2B: ESTIMATED ACTIVITY FROM BASELINE YEAR 2016 TO 2065

Activity	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027-2036	2037-2046	2047-2056	2057-2065
Inpatient Episodes (EL & NEL)	13104	13283	13468	13653	13825	14001	14200	14414	14616	14863	17226	19350	20784	21925
Daycase	13215	13367	13525	13678	13847	14015	14191	14364	14540	14719	16501	17781	18870	19878
Regular Attender	9562	9698	9839	9973	10134	10295	10467	10630	10800	10967	12698	13686	14519	15339
ED Attendances	39551	39960	40382	40801	41180	41562	41966	42392	42798	43257	47620	51954	55327	58122

Based on the activity in Table 2 and applying current Length of Stay from 2015 at 80% occupancy the bed requirement in 2065 would be 302.25. However, Length of Stay since 2015 has improved significantly between when compared to 2018/19.

FIGURE 2C: 2065 activity with 2015 baseline length of stay bed requirement



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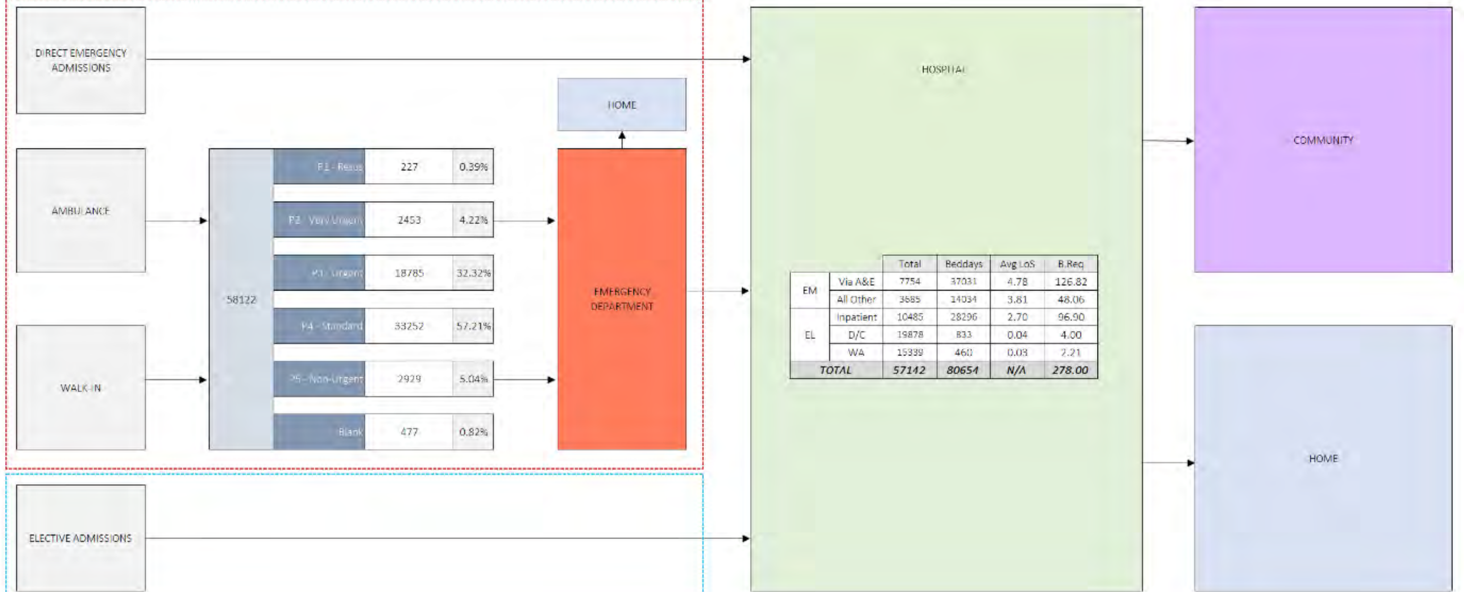
When applying the current Length of Stay to the projected 2065 activity the bed requirement reduces to 278 as shown in Figure 2 () length of stay bed requirement

FIGURE 2D: 2065 Activity with 2018 Length of Stay



		Total	Beddays	Avg LoS	B.Req
EM	Via A&E	7754	37031	4.78	126.82
	All Other	3685	14034	3.81	48.06
EL	Inpatient	10485	28296	2.70	96.90
	D/C	19878	833	0.04	4.00
	WA	15339	460	0.03	2.21
TOTAL		***57142***	***80654***	***N/A***	***278.00***

Subsequently there are two significant areas of focus affecting the size of the bed base managing urgent, emergency and planned activity

1. Admission avoidance
2. Length of stay reduction

Admission avoidance

The previous OBC modelled bed base based on population growth and the acute hospital bed base expanding in line to deal with the ageing demographic. Current healthcare professional view is that an acute hospital is not the right environment for dealing with frail/elderly people. Older people are frequent users of the unplanned care pathway and experience a higher level of hospital based harm (falls, etc) and have high re-admission rates.

We would develop a much stronger community-based offer to manage geriatric care, which means that fewer older people would come into the acute hospital.

Intermediate care also needs to play a much more predominate role in responding to the need of people in the community. Whether that is in the form of Rapid Response; which delivers specialist nursing care in people's place of residence, supported by a medical team and an 24/7 community nursing offer, or via Reablement; which helps people to remain in their home for longer by providing intensive support to help people recover skills and confidence and maximise their independence.

Introduction of a frailty / Older Personals Rapid Access liaison service – a multi-professional service at the hospital or at a step up - down facility which is connected to a community independence service. The older persons rapid access service would complement the community with direct access to diagnostics, geriatrician-specialist advice and the wider MDT.

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Length of stay reduction

For those admission that are unavoidable, there are a number of options for reducing the length of stay that a patient has in the hospital (whilst still delivering high quality care). Those options include:

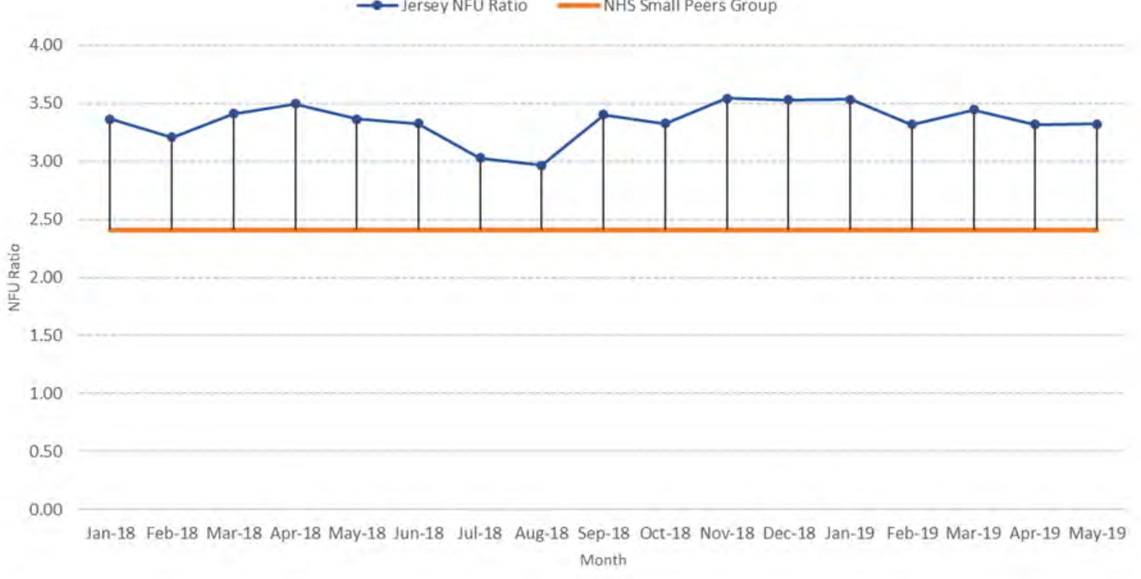
- Greater use of day case surgery i.e. in and out on same day;
- Greater use of ambulatory care – i.e. deal with patients outside of a bedded environment with the aim to send home if safe on the same day;
- Reablement services to help people get back home quicker and be safe in their own home;
- Community-based rehabilitation i.e. deliver service like physio in homes or community facilities rather than keep people in hospital wards

SECONDARY CARE APPENDIX C: PLANNED / SCHEDULED CARE

>>> Click here to return to Secondary Care section

Our Outpatient new to follow-up ratio (NFU) is significantly challenged when benchmarked against a recognised standard of 1:2.4 (GIRFT 2018). If Jersey achieved the 1:2.4 benchmark in 2018 then 47236 Follow-up appointments would have been saved = 22.69% reduction in total outpatient activity.

FIGURE 2: NEW TO FOLLOW-UP RATIO 2018-2019 (YTD) VS NHS SMALL PEER GROUP



FUTURE MODEL CONSIDERATIONS

Recognising that patients require different pathways dependent upon different presenting conditions or patients living with long term conditions, there is no standardised delivery model across outpatients and the data suggests we are not servicing our patients according to need and outcomes.

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The vision is that, similarly to the service delivery model presented at La Motte Street, islanders would be serviced by a variety of 'health providers', these health providers would consist of GP's, Nurses, health advisors, social workers, healthcare assistants, alternative therapists, counsellors, support workers and access to consultant assessment if required. Virtual hubs would enable access to secondary care expertise if required but in a way that utilised our consultant expertise more flexibly utilising the specialty consultant of the week model, covering the ward and responding to hub referrals as required.

The concept of specialist advice and guidance needs to be established to ensure there is less transactional care between Primary and Secondary care and we would envisage GP's having more seamless and direct access to specialists that doesn't result in outpatient appointments. In terms of workforce & operational requirements, we believe that;

- We will continue to need Consultant specialist expertise
- Specialist Nursing has an increasing role
- GP's are essential in supporting HUB based activity
- Multi-Professional teams will be needed including Social Workers, Physiotherapists, Occupational; Therapists etc.
- Mental Health practitioners will be needed
- CAMHS support
- Access to diagnostics and virtual support

Further analysis is needed to determine the volume of long-term conditions that can be managed within the Primary Care settings and revised policy and payment mechanisms may be required in doing this.

SECONDARY CARE APPENDIX D: DAY SURGERY THEATRE UTILISATION

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Analysis of 2017 data suggests that we are not maximising the opportunity to perform day case procedures. In 2017, 1824 out of 2792 procedures were completed as a day case; this equates to 65%. The overall BADS target for day case surgery is 86%. It is recognised that where clinically appropriate, patient experience and outcome is enhanced when surgical procedures are delivered as day case wherever possible, reducing patient's length of stay and exposure to Hospital acquired infections.

THEATRE UTLISATION:

Our theatre utilisation data suggests our utilisation hovers at between 60-70%, our starts and finishes are erratic (Appendix B) and our turnaround time is not standardised.

FIGURE 3: JERSEY THEATRE UTILISATIONS VS NHS AVERAGE (2018)

Jersey NHS

80.00% 78.00% 76.00% 74.00% 72.00% 70.00% 68.00% 66.00% 64.00% 62.00% 60.00%

CORE THEATRE UTILISATION

May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19

MONTH

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If we address our scheduling, list management and utilisation challenges in theatres then there will be the opportunity to repatriate work that we are currently outsourcing back to Island and look at how we incentivise utilisation of our capacity to generate PP income or offer ‘procedure packages’ to challenged acute providers within the UK.

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FIGURE 3A: % LATE STARTS JERSEY VS NHS AVERAGE (2018)

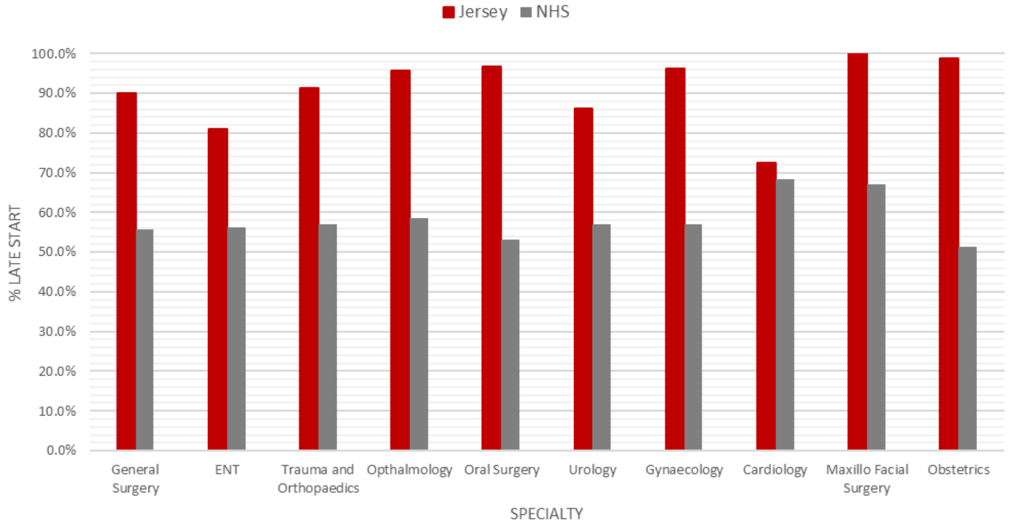
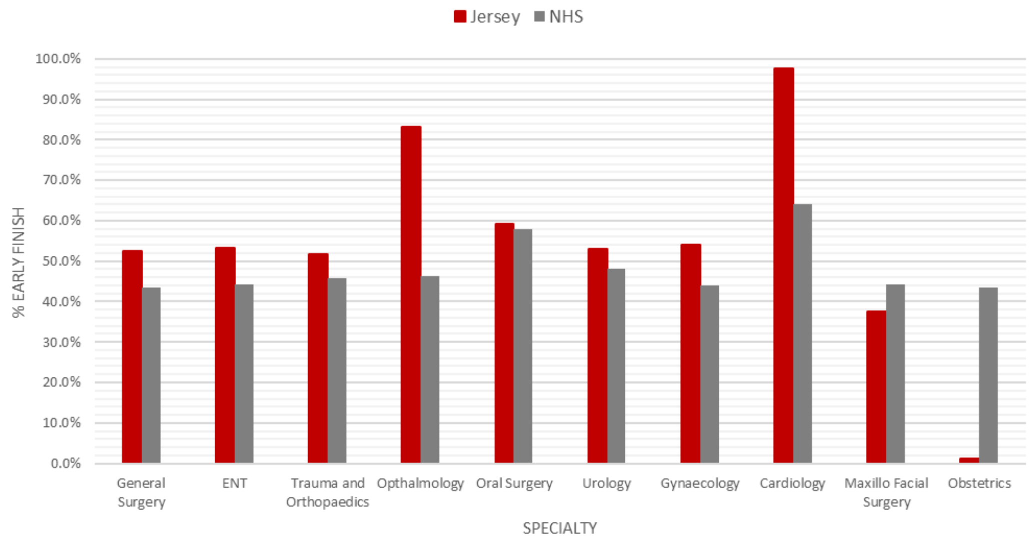


FIGURE 3B: % EARLY FINISHES JERSEY VS NHS AVERAGE (2018)



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SECONDARY CARE APPENDIX E: STEP DOWN CARE & INTERMEDIATE CARE

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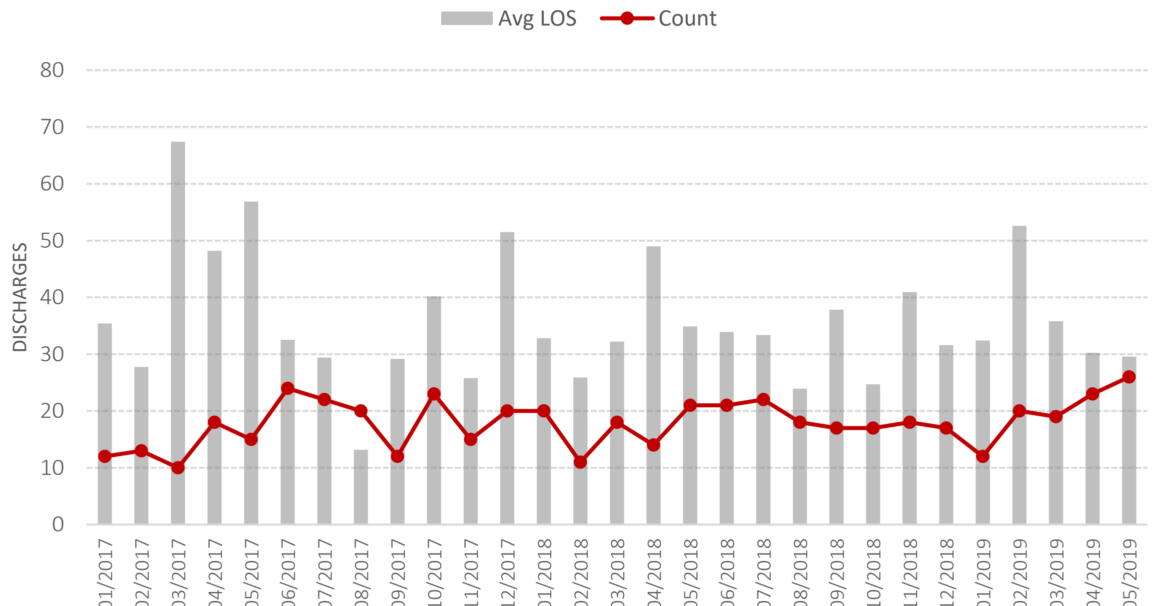
Analysis of Samares ward has been completed for the period 2012-2018. In 2017, Samares discharged 204 patients with an average LOS of 37.1 days at a cost of £5,868,757.52 (average cost per discharge = £28,768.42). Our rehabilitation resource across therapies is significant but care is predominantly protocol driven and patients are treated according to rota treatment, not necessarily need. The significant resource available for therapeutic rehabilitation does not seem to result in a corresponding reduction in length of stay as a result of therapeutic input.

FIGURE 4: SAMARES WARD DISCHARGES AND AVERAGE LENGTH OF STAY: 2017 -2019 (YTD)



SECONDARY CARE APPENDIX F: HOSPITAL SERVICE ANALYSIS

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INTRODUCTION

The Jersey Care Model recognises that Secondary care provides a comprehensive service to the island population but is not utilising its valuable resources as efficiently as it could. This paper aims to highlight and where possible quantify the opportunity to work more efficiently by reviewing aspects of current service delivery.

Figure 1 below demonstrates this activity spilt by specialty.

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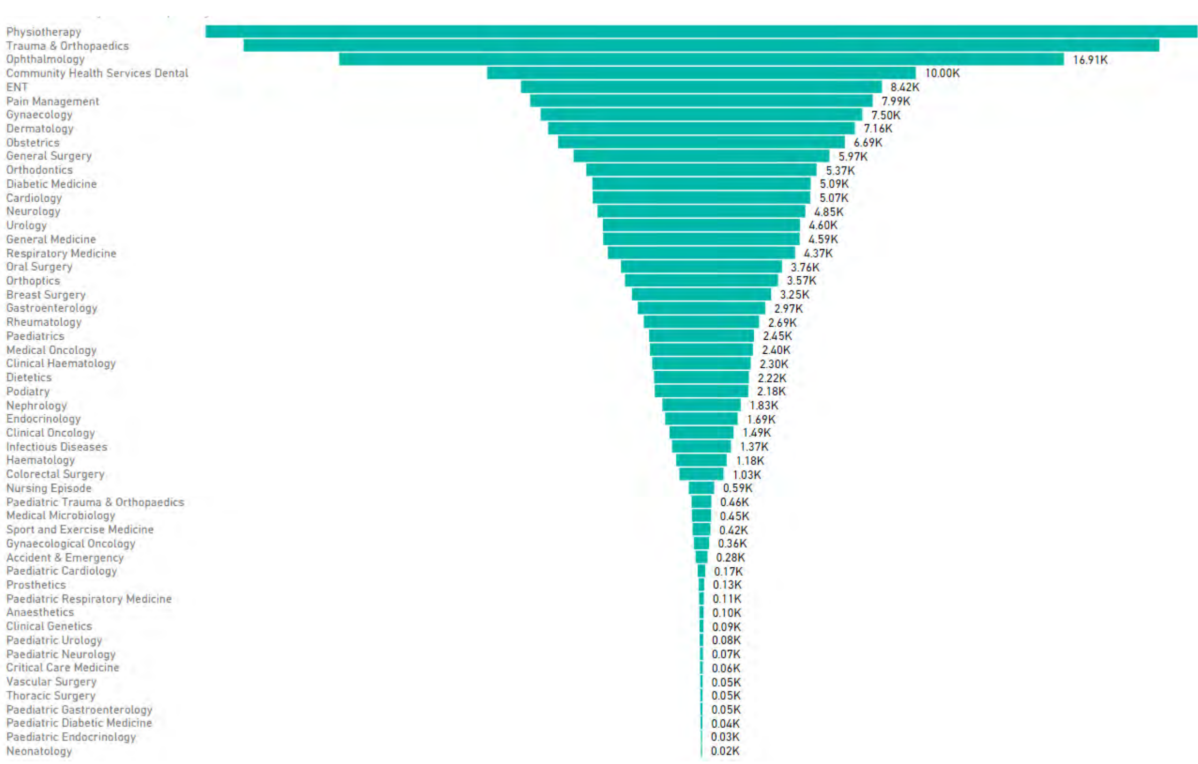
Figure 1: 2018 Total Outpatient Activity at JCH & Overdale Split by Specialty



Physiotherapy, Trauma & Orthopaedics, Ophthalmology, Community Health Services Dental and Ear, Nose & Throat account for 79,850 (42%) of all this activity. In 2017 these specialties were also the top 5 specialties in terms of volume of activity. The Patient Level Information and Costing System (PLICS) costed this activity at £8,493,479.00 in 2017. For 2018 (with inflation at 3%) this cost would be approximately £8,897,1245.29.

Figure 2: 2017 PLICS Costing with 2018 adjustment for top 5 specialties

	2017 Activity	Cost	Average Cost Per Appointment	2018 Adjustment (+3%)	2018 Activity	Estimated Cost
Physiotherapy	21415	£1,466,288.00	£68.47	£70.52	23145	£1,632,283.58
Trauma & Othopaedics	22689	£2,169,405.00	£95.61	£98.48	21373	£2,104,883.15
Opthalmology	16381	£2,208,396.00	£134.81	£138.86	16912	£2,348,381.96
Community Health Services Dental	9830	£1,446,097.00	£147.11	£151.52	10000	£1,515,238.97
Ear, Nose & Throat	8050	£1,203,293.00	£149.48	£153.96	8420	£1,296,357.62
TOTAL	**78365**	**£8,493,479.00**	**N/A**	**N/A**	**79850**	**£8,897,145.29**

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TOP 5 SERVICE REVIEW

A review of the top 5 specialties (by volume) took place with the associate medical director for each specialty. Where possible the opportunity has been quantified using the breakdown of services and clinics of each specialty within the outpatient dataset.

Physiotherapy: Physiotherapy represents 12.24% of all outpatient activity with 23,145 attendances in 2018. The review of the activity with the AMD and service leads demonstrated that all of the outpatient activity can take place in an alternative setting to the hospital. The Hospital would still require a core inpatient function but there is significant opportunity for the profession to lead a community focussed model of care which is closely aligned to a reablement/independence service that is offered in the community and closer to home.

The current outpatient service is delivering 23,145 appointment at an estimated cost of £1,632,283.58 with the average cost of an appointment £70.52, similar to the cost of non face to face clinics due to the use of group therapy sessions in gym based environments.

Trauma & Orthopaedics: Trauma & Orthopaedics (T&O) represents 11.3% of all outpatient activity with 21,373 attendances in 2018.

- At present 3,288 appointments within T&O are for routine post-operative dressing changes; at least 75% can be managed within primary care (2466 appointment / £242,859.00). There is also opportunity in general surgery for the post-operative dressing clinics to be managed in primary care (194 Appointments)
- At present 1,512 appointments are for pre-admission clinics taking place in addition to a consultation where the decision to proceed to surgery was made. A one-stop pre-assessment would see 90% (1361 Appointments / £134,035.74) of the current pre-admission clinics negated as Pre-assessment would take place directly after the previous consultation. It is estimated that 10% of current activity in pre-assessment clinics would remain for complex patients/patient requiring further investigations.
- At present 3171 appointments within T&O are in the ED referral fracture clinic for following an attendance at the Emergency Department. Patients do not necessarily need to attend hospital for this to take place. In a virtual fracture clinic, clinicians will look at x-rays alongside medical notes and the patient is called to discuss further treatment or management. Following the call, the patient may be discharged by phone or if they require further specialist input will be referred to clinic. The estimated impact is a 50% reduction in the ED referral fracture clinic (1103 appointments in 2018 / £108,627.00).

Overall the opportunity above would see a 23.1% reduction in T&O outpatient activity totalling 4,929 appointments. The approximate cost of this activity is £485,522.57.

Ophthalmology: Ophthalmology represents 8.94% of all outpatient activity with 16,912 attendances in 2018.

- Similarly, to T&O Ophthalmology has a pre-admissions clinic which could be converted to a one-stop clinic. This would see 90% of this activity converted into a one-stop clinic equating to 522 appointments (£72,484.35).
- At present Eye Screening is completed in an eye screening clinic which saw 730 appointments in 2018. There is also more activity within screening E.G Retinal & Diabetic screening which could work in partnership with community ophthalmology as long term conditions such as Diabetes require annual review currently undertaken in the acute setting.
- Our initial modelling also suggests that a further proportion of this specialty can be supported by community ophthalmologists; further analysis of the data for activity assumptions is required.

Community Health Services Dental: Community Health Services Dental represents 5.3% of all outpatient activity with 10,000 appointment in 2018. The bulk of this activity is routine dental appointments and procedures for

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children aged 12 or below. The review of this activity with the AMD demonstrated that 90% of all the outpatient activity can be provided by community dental practice outside of the hospital setting. The estimated cost of this activity was £1,515,238.97 in 2018.

Ear, Nose and Throat: ENT represents 4.6% of all outpatient activity with 8,420 attendances in 2018.

- Similarly, to other specialties ENT has a number or pre-assessment clinics which could be converted to a one-stop clinic. This would see 90% of this activity converted into one-stop equating to 189 appointments.
- The ENT Micro suction clinic could be completed in general practice resulting in 790 appointments moving into primary care.
- Our initial modelling also suggests that a further proportion on ENT activity can be supported by primary care with improved access to specialist advice and guidance from secondary care clinicians. Further analysis of the data for activity assumptions is required.

In summary 21.28% (40,232 appointments) of all outpatient activity has been identified as either moving to primary care, community partners and/or being reduced by service optimisation. A visual summary of this activity breakdown is found below.

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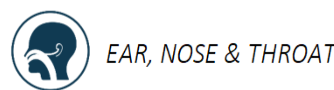
TRAUMA & ORTHOPAEDICS

TOTAL ACTIVITY		21373 / 189071 (11.3%)
SERVICE TO MOVE OUT		
1. DRESSING CLINICS	**TOTAL**	**75%**
Orthopaedic Dressings Clinic	740	555
Orthopaedic Dressings	1358	1019
A&E Nurse Led Dressings Clinic	1190	893
	3288	2466
SERVICE OPTOMISATION		
1. PRE-ASSESSMENT (One Stop)	**TOTAL**	**90%**
Orthopaedic Pre-Admission Clinic	1271	1144
DSU Orthopaedic Pre-Admission Clinic	241	217
2. VIRTUAL FRACTRURE CLINIC	**TOTAL**	**50%**
ED Referral Fracture Clinic	2205	1103
	3717	**2463**
Grand Total	**7005**	**4929.3 (23.1%)**

COMMUNITY HEALTH SERVICES DENTAL

TOTAL ACTIVITY		10,000 / 189071 (5.3%)
SERVICE TO MOVE OUT		
1.DENTAL SERVICE	**TOTAL**	**90%**
90% of all outpaitent activity	10,000	9,000
	10,000	9000



EAR, NOSE & THROAT

TOTAL ACTIVITY		8,420 / 189071 (4.6%)
SERVICE TO MOVE OUT		
1. Suction Clinic	**TOTAL**	**100%**
ENT Microsuction Clinic	790	790
	790	790
SERVICE OPTOMISATION		
1. PRE-ASSESSMENT (One Stop)	**TOTAL**	**90%**
Nurse Led ENT Pre-assessment Clinic	117	105
ENT Nurse Pre-Op Assessment Clinic	80	72
ENT Pre-Admission Clinic	13	12
	210	189
Grand Total	**1000**	**979 (11.6%)**

GENERAL SURGERY

TOTAL ACTIVITY		5969 / 189071 (3.2%)
SERVICE TO MOVE OUT		
1. DRESSING CLINICS	**TOTAL**	**75%**
Nurse led wound dressing clinic	258	194
	258	194
SERVICE OPTOMISATION	**TOTAL**	**90%**
1. PRE-ASSESSMENT (One Stop)	814	733
	814	733
Grand Total	**1072**	**927 (15.5%)**

OPHTHALMOLOGY

TOTAL ACTIVITY		16912 / 189071 (8.94%)
SERVICE TO MOVE OUT		
1. SCREENING	**TOTAL**	**100%**
Eye Screening Clinic	730	730
	730	**730**
SERVICE OPTOMISATION		
1. PRE-ASSESSMENT (One Stop)	**TOTAL**	**90%**
Ophthalmology Pre-Admission Clinic	580	522
	580	**522**
Grand Total	**1310**	**1252 (7.4%)**

PHYSIOTHERAPY

TOTAL ACTIVITY	23145 / 189071 (12.2%)
SERVICE TO MOVE OUT	

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MEDICINE SERVICE REVIEW

In addition to the review of the top 5 specialties by volume, the medical specialities, led by the Associate Medical Director Dr Effie Liakopoulou offered their thoughts, concepts and analysis of current service provision to inform the future proposals within the Jersey Care Model.

Each specialty presented guided by the following format:

1. An appraisal of current services and provision within the specialty
2. An analytical review of current activity and performance metrics
3. Future proposals / changes to current service delivery in support of the Jersey Care Model.

This paper draws upon the key messages and recommendations from the medical specialities.

PATHWAY DESIGN, REFERRAL MANAGEMENT AND EDUCATION WITH GENERAL PRACTICE

The biggest opportunity within current service delivery across Medicine focused upon **pathway development** with **improved referral management** between Primary and Secondary **facilitated by education for general practice** aiming to increase confidence to manage chronic conditions outside of the acute setting.

Gastroenterology identified Dyspepsia, Reflux, Change of Bowel Habit and Irritable Bowel Syndrome as the top referred conditions within the service. The Wolverhampton NHS Trust introduced a clinical triage of all patients referred into the Gastroenterology service in 2014 which saw a 27% reduction in new outpatient attendances. Based on that model, the Gastroenterology service at Jersey General Hospital has identified this practice as an area for development estimating a more conservative 15-20% however realistic reduction in referrals by adopting this scheme. In 2018, there were 1927 referrals into the Gastroenterology Service, the estimated impact would be a reduction of at least 290-385 referrals per annum.

Dermatology completed an audit on their urgent referrals of which only 10 resulted in a cancer diagnosis of 42 (the rest were discharged). G.P Education, virtual clinics and quarterly MDT's with G.P's could reduce the number of referrals by 20%. This is significant when comparing the prevalence of dermatology speciality referral with the UK. In the UK 31 referrals per 1,000 of the population per week are made into the specialist; in Jersey its it 50 referrals per 1,000 of the population per week.

Similarly, Cardiology (Hypertension and Lipid Management), Respiratory (Chronic Obstructive Pulmonary Disease) and Endocrine (Diabetes, foot and retinal screening, prevention and remission) all identified opportunities within referral management and the education of General Practitioners to manage long term and chronic conditions outside of the acute setting. The extent as to how much activity can be managed in an alternative setting is yet to be confirmed and fully worked up by the division. Regulated access to modern diagnostics (blood sciences, molecular and different forms of imaging is essential for the success of this approach.

Figure 4: Shows the current (2018) level of outpatient activity Medical Specialities.

Figure 4: 2018 Medical Division outpatient activity

FREQUENCY OF PHARMACY/PRESCRIPTIONS AND DIAGNOSTICS

Almost all specialties treating long term/chronic conditions identified the frequency of prescriptions as a reason for following up patients more frequently than expected as the hospital represents a free service for repeat testing (e.g. Bloods) informing prescription of medication when compared to primary care. There would be an estimated 5-8% reduction in follow-up appointments across Medicine if the catalysts driving this behaviour between Primary and Secondary Care were overcome. A 5-8% reduction in follow-up appointments would see an estimated 1980 – 3170 reduction in follow-up attendances across all medical specialties.

In addition to this maximising the digital opportunity via integrated reporting systems and modern technology could impact on services in the future even reducing the activity & cost of off-island activity. For example efficient use of currently existing equipment (PCR, other analysers), Calprotectin (biochemistry) in Gastroenterology and confocal imaging (vivascope) reducing the number of samples going off island and improving turnaround times for diagnostics.

ACCESS TO SPECIALIST ADVICE AND GUIDANCE

Initial modelling suggests that a proportion of this division can be supported by Primary Care with improved access to specialist advice and guidance from specialist, secondary care clinicians. Further analysis of the data for activity assumptions is required. Specialties identified as having the biggest impact are dermatology, gastroenterology and diabetes/endocrinology.

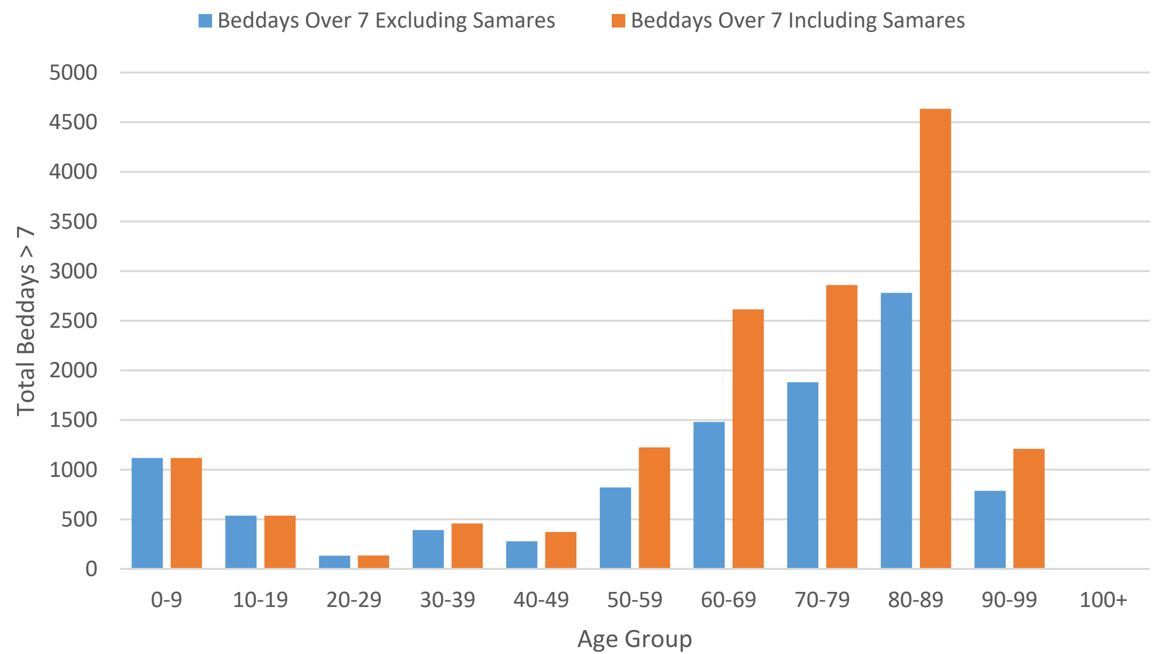
MEDICAL SUPPORT FOR RAPID RESPONSE (In Reach)

Area of opportunity to keep patient care closer to home in the community, avoid unnecessary referrals and readmissions.

CARE OF THE ELDERLY AND FRAILTY

The Division of Medicine proposes to define the remits of this specialist activity within a 'whole island' context. The aim of Care of the Elderly is to support patients in living independently, preferably in their own homes. At present Care of the Elderly is predominantly an inpatient function and the current care model has a significant impact on the effectiveness of the service. Figure 5 below highlights the stranded patients (patient with a length of Stay > 7 days) and the associated bed days in hospital > 7 days; this demonstrates the current models in ability to move patients out of the acute as predominantly the only option is waiting for space in another institutionalised care setting.

Figure 5: Total Beddays > 7 split by Age group (2018)



Therefore the shared vision of the Care of the Elderly Team in support of the Jersey care model is to:

- Operate as an umbrella specialty spanning across all secondary and Social Care in relation with Primary Care
- Secure an appropriate balance between hospital and community based services within local health economies
- Introduce the concept of frailty ward for inpatient care in successfully targeting a specific patient group aiming to reduce inpatient occupancy
- Continue the expansion and evaluation of intermediate care as a way of working that is designed to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge, maximise independent living and improve the quality of assessment of long-term health and social care needs
- In co-operation with the independent sector, expand the use of supported living, domiciliary care, day care and assistive technologies as alternatives to residential accommodation, focusing on rehabilitation and independent living
- Focus on rehabilitation in tandem with assessment of long term care needs to avoid unnecessary reliance on residential and nursing home care.

At present the >60 years of age total bed days occupied by stranded patients (beddays > 7) has a bed requirement of 38.8 beds.

MENTAL HEALTH APPENDICES

>>> Click here to return to Mental Health section

The following data presents an overview of activity across mental health services looking at inpatient length of stay.

MENTAL HEALTH APPENDIX A: DATA ANALYSIS

INPATIENT - ORCHARD HOUSE

- Data Range Jan 2015 – May 2019
- GIRFT Length of Stay Benchmark = Average Length of Stay (LoS) 2017/18
- Increase in admissions in 2018

FIGURE 1: Orchard House Admissions & Length of Stay 2015 - 2018

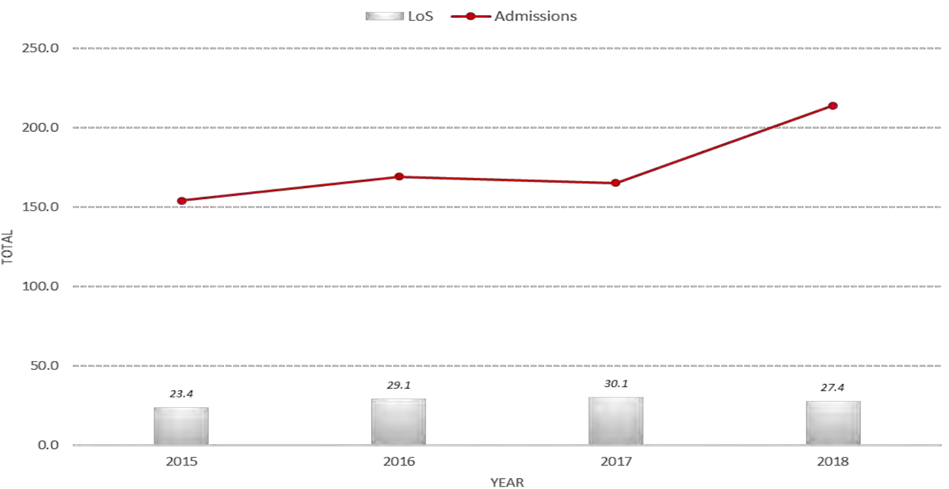


FIGURE 2: Orchard House Admissions & Length of Stay 2018 -2019 (YTD) Split by Month

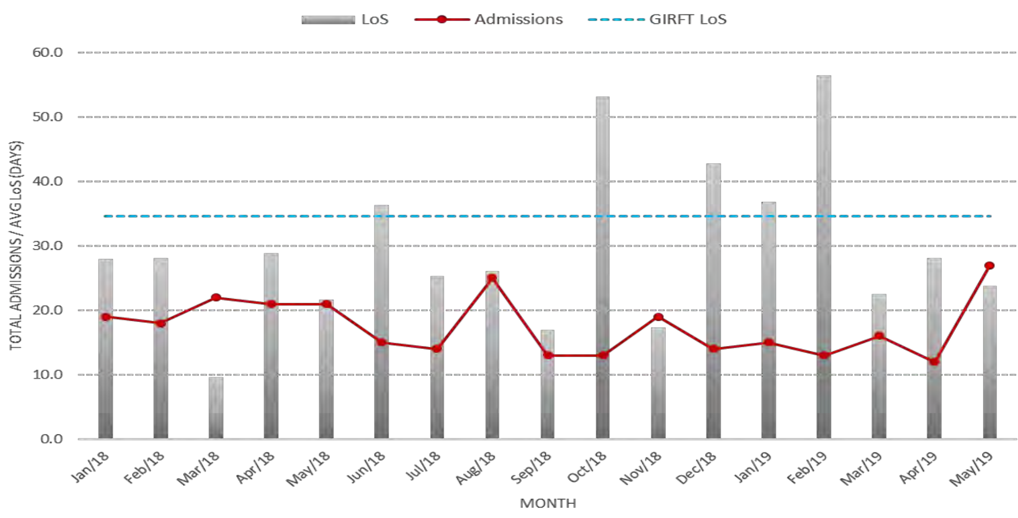
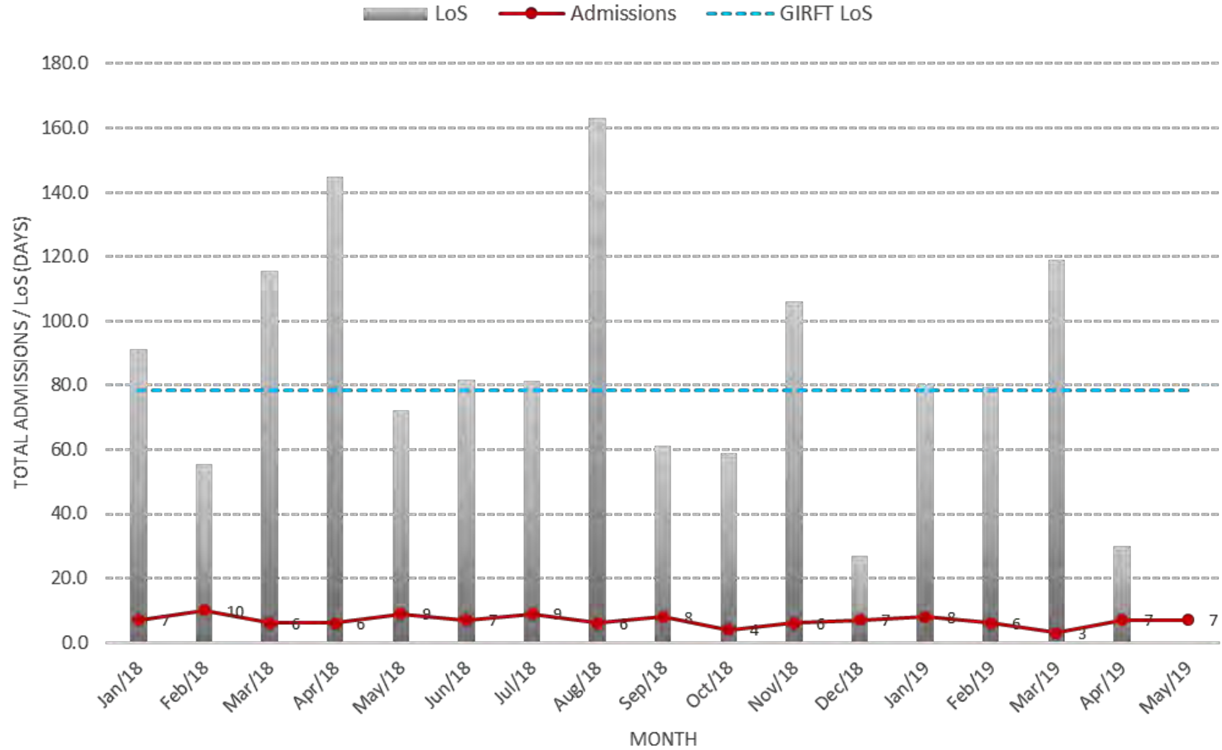


FIGURE 3: Beech & Cedar ward admissions and Length of Stay 2018 – 2019 (YTD) split by month

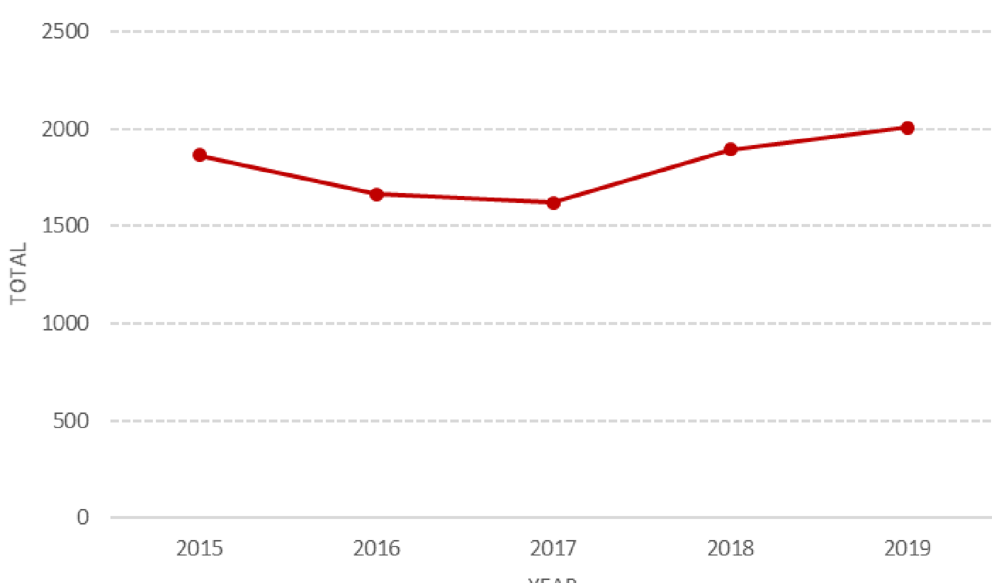


MENTAL HEALTH APPENDIX B: COMMUNITY MENTAL HEALTH TEAM CASELOAD / CONTACTS

>>> Click here to return to Mental Health section

The following data presents an overview of activity across mental health services looking at community -facing services.

FIGURE 4: Community Mental Health Team Caseload 2015 – 2019 (YTD – April)



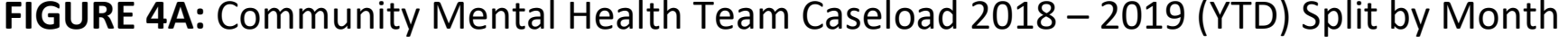


FIGURE 4A: Community Mental Health Team Caseload 2018 – 2019 (YTD) Split by Month

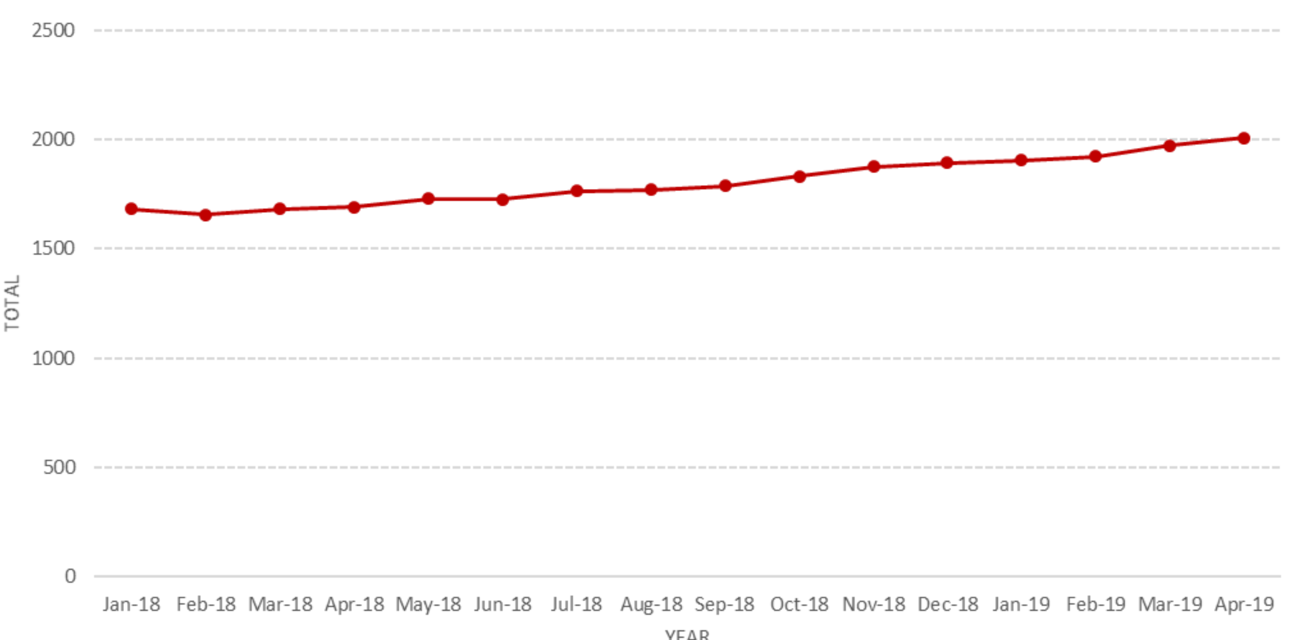


FIGURE 5: Total Community Contacts per 100,000 Population 2015 - 2018

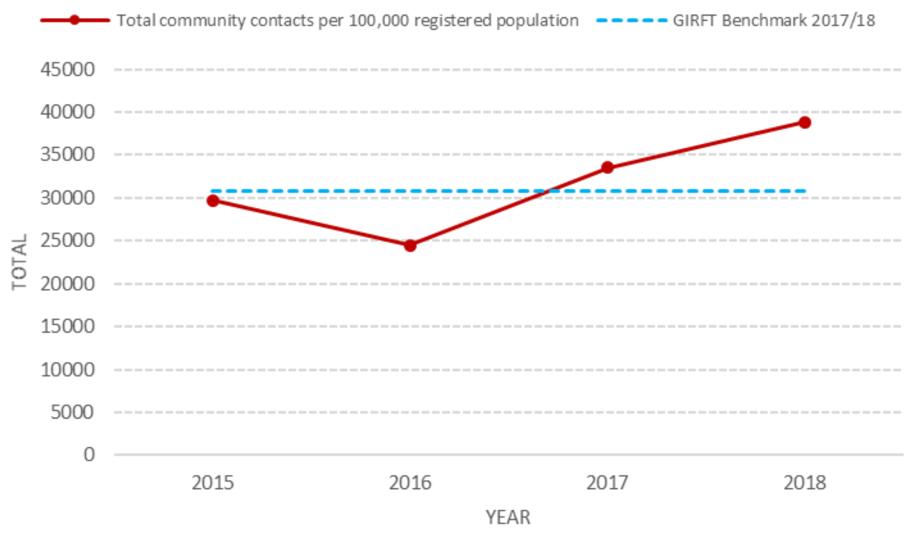
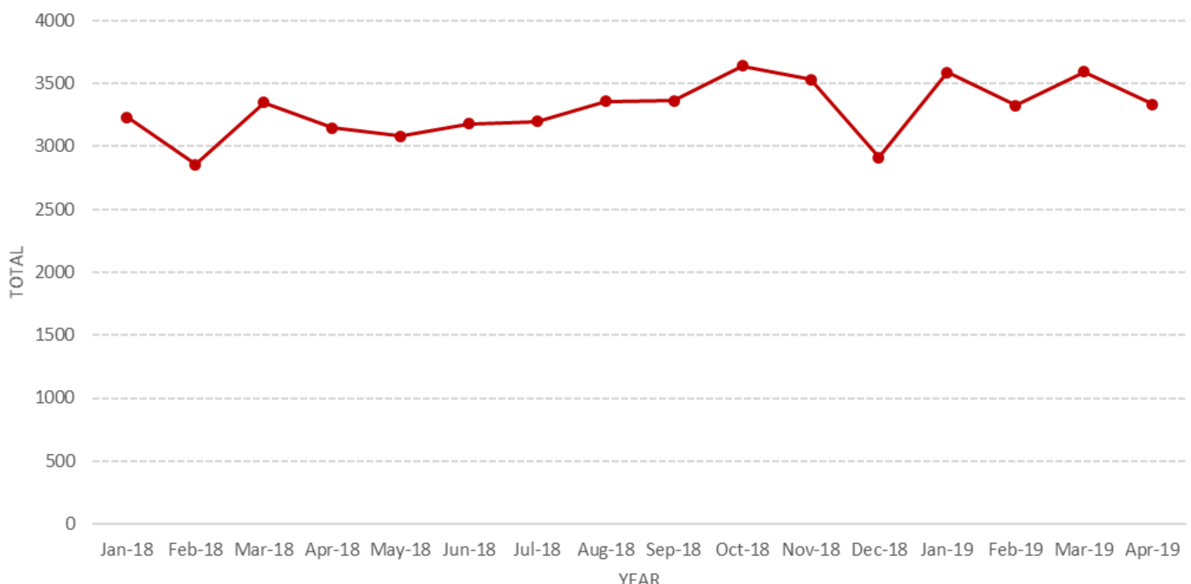


FIGURE 5A: Total Community Contacts per 100,000 Population 2018-2019 (YTD) Split by Month



MENTAL HEALTH APPENDIX C: GOVERNMENT PLAN 2020-2023 BUSINESS CASES

The following business cases were approved at Mental Health Improvement Board in April 2019 and submitted for consideration in the Government plan 2020-23.

- Crisis Prevention and Intervention service
- The Listening Lounge and Place of Safety schemes
- Complex Trauma Pathway
- CAMHS
- Mental Health Law

SUMMARY OF BUSINESS CASES

CRISIS PREVENTION & INTERVENTION SERVICE

Crisis teams deal with people who are either experiencing a first episode or a relapse of mental illness or showing signs of severe psychological distress and these symptoms often (but not exclusively) arise in the context of social problems such as relationship issues, trauma, substance misuse, housing difficulties, unemployment, Is it possible to ameliorate and resolve these problems without admission to hospital but on occasions to protect a person's safety or for the protection of others it may be necessary to admit them to hospital with or without detention under the mental health act.

The advantages of having a crisis team as part of a comprehensive mental health services are as follows:

- It reduces the need for hospital treatment and this has clinical and economic benefits for an individual and wider society (Care provided by a crisis team has been shown to cost less than inpatient care of which 30% of costs relate to non-clinical care e.g. building maintenance/capital hotel services etc..)
- It can respond quickly which reduces risk and increases the chance of early recovery
- It allows people to receive treatment in settings that are closer to home which reduces disruption and stigma and helps with recovery

It increases the resilience of the whole mental health service by:

- strengthening the out of hours response and reduces disruption to planned care
- preventing the collapse of community arrangement
- Improves overall safety by reducing the number of serious incidents
- It prevents the breakdown of community support
- It can facilitate safe discharge from hospital particularly for those who are not attached or known to the CMHT
- It acts as a buffer between the CMHT and the population experiencing mental illness which means the CMHT can focus on those with enduring ill health and not those with short term problems
- It reassures and supports carers who know who to ring particularly during out of hours

Most people are willing to accept treatment at home if they know there is a service that can immediately respond to them (particularly during the night) when they feel most alone.

A crisis team must therefore operate 24/7 and remains involved until the crisis has resolved and ensures that links with other appropriate services with responsibility for supporting ongoing care needs are in place. An outcome for a crisis team is crisis resolution.

The size and structure of the crisis team has been based around a population size of 150,000. While Jerseys population is 105,500 the unique circumstances of the Islands location and availability of workforce resource

to sustain quality and effectiveness during period of sickness, holidays, training leave needs to be scaled up to ensure services remain wrapped around the individual and sustainable so that the outcome of crisis resolution is achieved.

Sustainability relies on a service model that reduces activity related to bed use and admission, ensuring the right staffing and skill set/expertise is in place, being responsive and supportive to the individual involved, their families and carers.

A crisis team needs effective team working and leadership, liaison and cooperation with the wider mental health service and other stakeholders.

THE LISTENING LOUNGE AND PLACE OF SAFETY SCHEMES

During an extensive consultation exercise with service users (via a citizens panel), staff working in mental health services and a range of external stakeholders a body of evidence emerged that showed people experiencing a mental health crisis had limited options for timely and relevant support which as a result exacerbated the crisis situation and resulted in contact with the emergency services (including contact with the emergency department). Evidence gathered relating to activity at the Emergency Department and Police service showed that some of the support needs could not be met at these locations or otherwise due to a lack of alternative 24/7 support. Contact with these services was often inappropriate to address need and could have been avoided if a more effective, proportionate and responsive support model was available at the time.

The Mental Health Strategy (2016-20) outlined a new direction of travel for mental health services which included plans for (i) developing prevention and early intervention based mental health services, (ii) improving access to mental health support over a 24/7 period and(iii) optimising opportunities for recovery, all of which are underpinned by a model of coproduction and redesign. The proposal contributes to defining 'what good looks like' and draws comparisons with other similar UK based developments to present the case for need.

Other than the Samaritans which offer a 24/7 helpline – (including calls which are diverted to UK call handlers) out of hours options for support with mental health issues are limited for residents of Jersey.

COMPLEX TRAUMA PATHWAY

The Jersey Care Enquiry came about from historic disclosures of physical and sexual abuse in Jersey's Care system for vulnerable children. The abuse dates back to the 1940's and as more and more victims in Jersey's care system came forward to disclose, cases were brought against many individuals responsible for the abuse of these children.

Many of the children of the historic abuse enquiry are still living on the Island and as adults had suppressed the traumatic memories of their childhood experiences. The prosecution of the perpetrators meant that many survivors were contacted by police to help with the cases being investigated. This re-opened the trauma for these clients and they struggled with the psychological symptoms they were now experiencing.

In the Independent Jersey Care Enquiry Frances Oldham QC (Rec 8.4) stated that Jersey needed to respond by further developing accessible services that meet the different recovery needs of survivors.

The development of a trauma informed pathway is one of a range of responses designed to meet the mental health needs of complex trauma clients in support of their recovery.

CAMHS

In the Target Operating Model of the Government of Jersey the Child development centre and CAMHS are to transfer from Health and Community Services into the Children and Young people's services.

This aim is to achieve a fully integrated children's system with clear and effective pathway that work for children and their families.

A memorandum of understanding will be agreed between HCS and C&YPS which includes but is not limited to:

- Performance and Outcomes
- Handover arrangements relating to staffing and workforce management; clinical governance & data protection; records management; health & safety and pathways and referrals.

The programme of transition is devised in 2 phases over one year and will require dedicated project management support

A fully integrated children's system is possible to achieve and will be measured against a set of management arrangements for the service that encompass delivery objectives that can be measured.

MENTAL HEALTH LAW

Jersey has undertaken an ambitious plan of introducing two new pieces of legislation, with statutory obligations, key benefits and safeguards for citizens who are often vulnerable. This case proposes new arrangements for the operational delivery of the Mental Health (Jersey) Law 2016 [MHL] and the Capacity and Self-Determination (Jersey) Law 2016 [CSDL].

The recommendation is made with consideration of:

(a) projected analysis of need

(b) review of current provision

(c) provision mapping to identified need

(d) reorganising/funding to meet identified need

As both pieces of legislation are new, annual review of any agreed proposal is recommended until 2022. The proposal is built utilising the proposed 4 full time equivalent (FTE) Approved Officer (AO) model as this has been agreed as a minimum requirement to provide a 24/7-365 out of hours (OOH) AO service, also minimising the diseconomy of scale risk in the AO and AO OOH roles.

>>> Click here to return to Mental Health section

EXTERNAL PARTNERS APPENDICES

>>> Click here to return to Social Care and External Partner section

EXTERNAL PARTNERS APPENDIX A: INTRODUCTION / BACKGROUND / CONTEXT FURTHER DETAIL

Introduction/background/context

The development of a new hospital for Jersey is well documented and as the project considers a new approach it enables discussions to focus on the size and function of a new facility and crucially what community provision will be needed to support a sustainable health and social care system for Jersey.

Like the rest of the developed world Jersey faces similar challenges such as an ageing population, increased pressure from long term conditions at a time where resources while still superior to other countries are rightly under scrutiny. The challenge we have is to spend the Jersey health pound wisely and maximise our current partnerships to deliver the best outcomes for the community.

While central to this is the development of a new hospital, this alone will not provide a sustainable system of healthcare. The new hospital needs to be *part* of the health and social care system but it needs to be fully supported by high quality community provision delivered in partnership where people can easily access care and support. Central to delivering a sustainable and quality care system is strong partnerships with the voluntary sector, social care providers, private providers and social enterprises based on achieving shared outcomes

Part of the remit of the P82 programme was to develop services in the community including the voluntary sector. While some progress was made not all of the potential benefits were realised. Work has been undertaken to further develop relationships with the sector and the sector is keen to work in partnership with GoJ as part of delivering services across the community.

GoJ needs to rebuild the trust and goodwill that was in some cases eroded by the previous interaction/relationship with the sector.

The work of the Closer to Home project has demonstrated that shared assets and resources can support the successful delivery of services in the community and this needs to be firmly embedded across the sector.

The development of an Adult Social Care Strategy has commenced and this is focused on a tiered approach to service delivery delivered by a number of partners from across all sectors, enabling personalisation and utilising technology.

When considering a new system of health and social care and the role the voluntary sector and social care providers could play we need to consider the following;

- Keeping people out of hospital will require increased community services and a new system of health and social care for the 21st century
- System to move from an acute focus to one embedded in the community delivered in partnership with the voluntary sector and the private sector with a focus on self-help and prevention
- Reduce preventable disease where possible
- Support carers through the Carers Partnership Forum
- Current system is not sustainable when considering pressures on budgets and the workforce
- Delivery of intermediate care
- Developing services for Children and Young People with Complex Needs

- Delivery of community Mental Health services
- System to embrace technology to support the delivery of quality services

Current state assessment (positive/negative)

We are fortunate to have a strong voluntary sector, that is intrinsically motivated and a social care market that is looking to expand. While this is a strength we lack a clinically led commissioning framework that builds on the partnership approach, built around outcomes. In terms of the local landscape, The Charity Commissioner has received 450 applications for charity registration and the Association of Jersey Charities has around 330 members.

A KPMG report in 2016: *The Jersey Charity Survey* [15]highlighted the following;

- £80m is raised annually within the sector
- 1 in 8 adults on the island are volunteering
- Advancement of health was the joint top aim of organisations surveyed and was top of generating income based on organisations aims
- 2/3rds of organisations operate without any paid staff
- Those 34% with paid full time staff have the biggest incomes
- The vast majority report a constant and increased level of volunteers of which it is estimated there are 11,000
- Most volunteers are between 25 and 55 years old
- 70% of all organisations agree that the relay on regular volunteers but 35% struggle with retention
- The largest 4% of organisations raised £48m accounting for 62% of all income in the sector
- The most common income bracket (50% of responding organisations) was 10-25k for organisations
- 81% of all funding applications made were successful – however 50% had not made applications in the previous 2 years
- 44% were not aware of how to tender for public services
- Most organisations feel their work is valued and respected but they don't feel informed and involved appropriately by the GoJ

There is a great opportunity in Jersey to create a different system wide approach that builds on the strengths of this sector through a transparent partnership approach to drive improvement in health and social care across the whole population.

The case for change is clear and the need to direct people's attention to what's important without introducing complexity into the system will require a different relationship. However, there are a number of areas that can be developed to improve how we support people across the community, such as;

- Develop and implement Adults Social Care Strategy
- Improved intermediate care across the system
- Increased support for carers
- Increased care at home
- Market development based on current and future needs
- Introduction of personal budgets
- Increased use of technology to support the delivery of services
- Delivering services where people live using the Parish system
- Workforce development/availability of carers

[15] 197 Organisations participated

The future system of a seamless health and social care system for Jersey must be built around partnerships, quality outcomes and a focus away from acute care where practicable. It will rely on a skilled and enthused workforce with an engaged patient voice central to policy developments and governance.

To deliver this vision will require a change from all sectors to work in a collaborative manner where the patient experience is at the heart of every decision made.

For HCS it will require delivering on the agreed system of care working in partnership across all sectors working to a shared goal with shared accountability and governance. It will require working to deliver outcomes with external partners and supporting them to develop as an equal partner.

It will see some traditional HCS services moved away from the hospital setting and delivered in Parish locations, using Parish knowledge to support early identification and prevention.

For external providers it will mean closer working relationships in cluster type arrangements across the care groups to maximise resource and focus on service delivery using existing assets. It will see clearer commissioning through co-production of specifications focused on outcomes and will see longer term partnerships developed through business planning and regular training opportunities as well as an ongoing relationship where the sector is an equal partner.

It will see opportunities for the private sector to help support the digital transformation and supporting people to live longer and safely in their homes.

Key Issues

While the sector has a number of strengths there are areas that need to be address to maximise the undoubted potential there is to build upon. The following is a snapshot of key issues;

- Duplication of offer across sector and wider health economy without joined working
- Duplication of back office functionality across sector and health economy
- Funding pressures across sector
- Care regulations and the possible reduction in service delivery
- Workforce challenges and future proofing sector
- Workforce models
- Modes of care delivery
- Organised representation of sector and collaborative agendas
- Value for money, outcomes against investment
- Governance and risk frameworks
- Access to training
- Discrepancy in fund raising and retention of volunteers
- Lack of a JSNA, data and statistics does not lead to good commissioning

Objectives for Community Services

The key objectives are as follows;

- Reduced reliance on acute services
- Services delivered closer to people's home
- Increased choice and control for customers
- Increase in providers sharing resources/assets
- Reduction in the use of the residential estate

- Ensuring value for money
- Aligned strategy and funding
- Robust commissioning framework
- Increased use of technology in service delivery
- Improve/introduce market development and evidence based decision making
- Improved communications and relationships with the sector
- Labour market planning across the model

EXTERNAL PARTNERS APPENDIX B: FRAMEWORK FOR PARTNERSHIPS WITH THE VOLUNTARY SECTOR, PRIVATE SECTOR AND SOCIAL ENTERPRISES

>>> Click here to return to Social Care and External Partner section

Overview

As we develop an integrated Health and Social Care system in Jersey it is vital that our partnerships with providers are robust and our purposes are aligned. There are a number of models that can be considered, and it is proposed that a new framework is considered to enable assurance around the quality of services and that we are maximising the Jersey health pound.

Our contracted services should focus on partnerships, sharing resources, collaborative working and delivering in the community with clear outcomes. We need to also engage the wider sector to deliver services based around agreed principles and aligned to the new model of care. This will require not only a different approach to commissioning but ongoing work with providers and funders who are not commissioned through Government of Jersey (GoJ). These developments will focus on joint working and maximising the impact of the money that comes into the sector.

We will need to work in partnership with Customer and Local Services (CLS) to reduce the pressure on the Long Term Care (LTC) fund develop through the introduction of personal budgets which will increase the range of services available to support people in the community as well as increasing the number of people who can be paid carers. The following framework model should be explored.

Framework

As we further develop an integrated health and social care system in Jersey it is vital that our partnerships with providers are open and transparent and our purposes are aligned. There are a number of models that can be considered and it is proposed that a new framework is considered that provides assurance around the quality of services, that the funding model doesn't distract and drive the wrong behaviour, more so it supports the system to deliver the type of care we would all want for our own relatives.

Our relationship with contracted services should be built around a common purpose working in partnership, using payment to support the delivery of care, sharing resources, collaborative working and delivering in the community with clear outcomes. Working to a common purpose across the whole system with all sectors aligned to the new system of care will create an approach to support the most vulnerable in our communities and promote the use of resources in a different way. This will require not only a different approach to commissioning but ongoing work with providers and funders who are not commissioned through Government of Jersey (GoJ) to move to a place where budgets are aggregated as a pool of resource for services to deliver against a common purpose.

Delivering services to an agreed common purpose will require the development and commitment of organisations to work to an overarching *Partnership of Purpose* this would be the core to all areas of service delivery and would provide the focus and structure for a framework. This in turn would be supported by an outcome based commissioning approach in addition to developing personalisation on the island. This would see services commissioned for health and social care outcomes not simply measuring throughput of a service.

Using a co-production model for service development involving both customers and providers, data and trends would be analysed in order to support market development. A centralised commissioning function with clarity for accountability in the model and strong governance arrangements to assure delivery against the Partnership of Purpose could be introduced alongside longer term contracts.

A Partnership of Purpose

HCS will develop a Partnership of Purpose which would be an agreement between all parties delivering services directly or indirectly linked to the care model. The following principles provides an overview of what could be developed[16];

Prevention: supporting islanders to live longer and healthier lives;

User-centred care: joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey;

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

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

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

Effective community care: improving out-of-hospital services through the development of Community Hubs for health and wellbeing complementing the community offer through Closer to Home,

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

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

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[16] https://www.gov.gg/article/162629/A-Partnership-of-Purpose-Transforming-Health-and-Care

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

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

The Partnership of Purpose would underpin all relationships both internally and externally as a framework committed to delivering the CSP objectives. As well as providing a framework for services such as intermediate care it would also be recognised and agreed across OneGov ensuring that the physical and mental health of islanders is considered in all relevant policy and legislative developments.

Traditional outcomes-based commissioning

We will need to design an outcomes based commissioning framework that focuses on activity aligned to our strategy. Our contracts should be used to both modernise service delivery and ensure providers are working in partnership to increase efficiency and maximise the impact of resources.

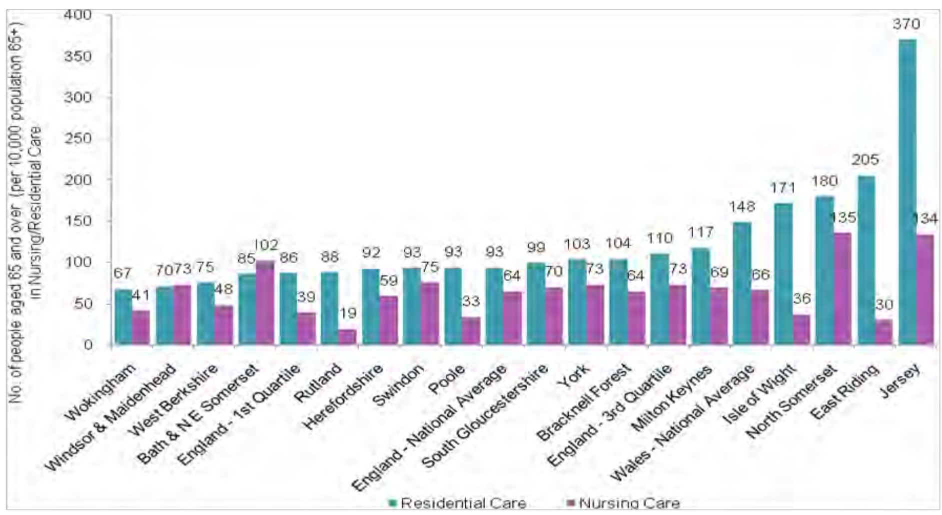
To support this model we will require a commissioning function which follows a clear cycle;

- Needs assessment
- Annual planning
- Design and contracting services
- Shaping the structure of supply/market
- Managing performance
- Evaluation

Personalisation

Personalisation refers to the process by which people with long-term illnesses or conditions receive support that is tailored to their individual needs and wishes. It means that everyone eligible for support is empowered to shape their own lives and the services they receive.

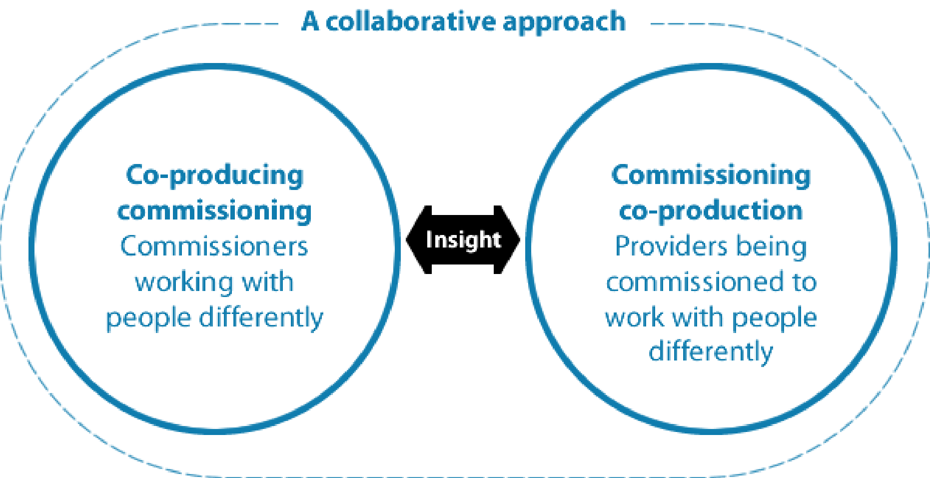
The lack of personalisation in Jersey contributes to the high levels of occupancy in the residential estate (below) which is far higher that other jurisdictions. Personal budgets can be used to support independence and safely support people in their own homes whilst crucially developing a wider market place for providers of services and making better use of technology.



Co – production

The 2014 Joint sector review by the Department of Health, Public Health and NHS England recommended that, commissioners *should co-produce their health and care systems with local people, using VCSE (Voluntary, Charitable, Social Enterprise) organisations as partners to do this, particularly in engaging overlooked groups and communities.*

Co-production – sitting down with organisations as partners and equals – requires strong and mature relationships both within the sector and between the sector and commissioners. These relationships require time and attention to develop and maintain, and leaders of commissioning organisations need to be clearer about the need to invest in relationship-building. The development of Closer to Home in Jersey is an example of co-production and this model will support joint working and alignment of resources. As well as involving organisations we must also engage service users as part of a collaborative approach.



Governance and Funding

To support the framework a dedicated resource would be required to effectively monitor delivery by providers, ensure that the Partnership of Purpose was embedded across the system as well as the day to day managing of relationships.

More focus is required on measuring impacts and in some cases both providers and the GoJ need to hold each other to account.

Multiyear funding should be available for providers to enable them to plan and develop as well as influencing wider funding from the Lottery and foundations to align with the Partnership of Purpose.

Market Development

A market development strategy needs to be developed to strengthen the offer that can be delivered in the community. To maximise the Jersey health pound we need to focus not just on traditional providers but also influence other developments, such as housing, which is key to supporting independence.

We will need to develop a market position statement and use data more strategically to map and plan services.

A rolling cycle of events will enable a continued dialogue with organisations and will improve partnerships and meaningful engagement. This cycle should have a OneGov approach to maximise opportunities to improve islanders mental and physical health.

EXTERNAL PARTNERS APPENDIX C: COMMISSIONING FRAMEWORK OUTLINE

This document outlines a commissioning framework for HCS. It is based on advice from UK Home Office, NHS CCGs and other national commissioning organisations. A final version will need to be tailored further to local requirements.

Purpose

The clinically led Jersey Care Model has been developed to demonstrate how health and care services are delivered across all sectors on the island. The model seeks to move away from the unsustainable institutional-based model into a more modern community-based model; putting people, their family and home at the centre.

This Commissioning Framework has been developed as a simple, easy to use document to support the Jersey Care system leaders commissioning the Jersey Care Model.

Commissioning is the continual process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

The framework is designed to support system leaders to work in a collaborative way, encouraging open and transparent discussions with providers and other partners in the wider care system to achieve the best outcomes for patients and individuals accessing care services.

We are committed to working in partnership with external providers including the voluntary sector and a strategic approach to commissioning will reduce duplication, maximise current expertise and resource to improve the health, mental health and wellbeing of Islanders.

The framework will also identify commercial opportunities both locally and from overseas to increase income generation for service developments and sustainability.

How should it be used?

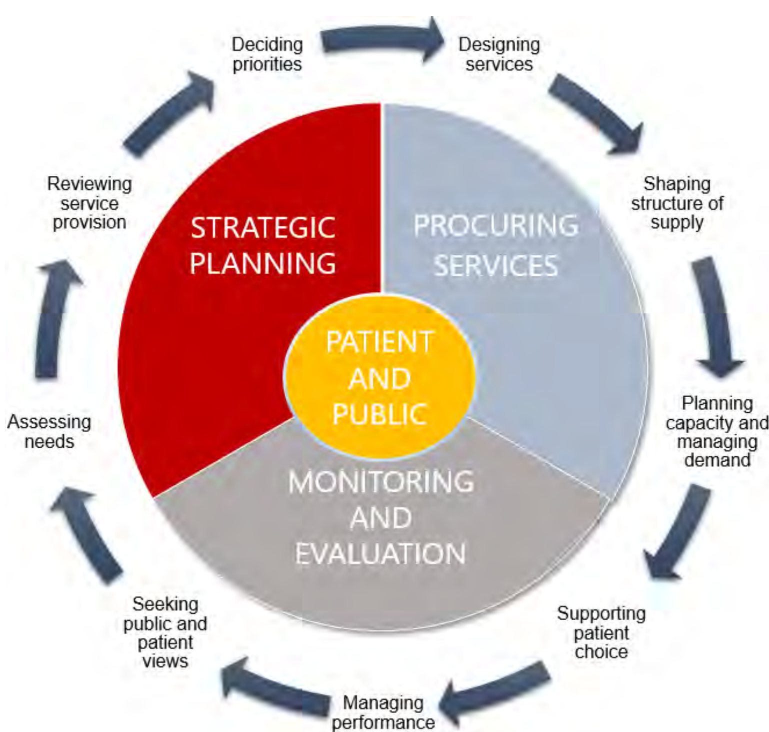
The framework should be used by commissioners/senior managers to provide overarching guidance and support for navigating the commissioning environment for the Jersey Care Model. It should be read prior to making commissioning decisions and when formulating commissioning plans strategies.

This framework highlights the key issues commissioners/senior managers need to consider when commissioning support services and should help to achieve smarter, more effective and innovative commissioning.

The framework will provide guidance for all partners of commissioning intentions, the principles behind these and the Partnership of Purpose that underpins partnership working in the delivery of the Jersey Care model

Commissioning cycle

It is best practice for commissioners/senior managers to follow the commissioning cycle, which underpins this framework.



Types of commissioning

Commissioning models:

Outcomes-based commissioning not only involves a focus on outcomes rather than outputs but also the use of a population approach, metrics and learning, payments and incentives, and co-ordinated delivery across providers; it places a greater focus on the strategic and planning elements of commissioning, leading to changes in the commissioning cycle as well as engagement of experts by experience and providers

Personal Care Commissioning health and social care budgets given to an individual from which they can commission their own services

Partnership of Purpose will bring together health and care providers to collectively develop and deliver health and care with shared outcomes. The Partnership will be open to all health and care providers fulfilling set criteria and they will work towards common standards of customer service and quality.

Principle 1 - Commission services according to need

Assess need through analysis of robust evidence as demonstrated within the care model.

Commissioning decisions must be based on a good understanding both of the current and future health and care needs and where those needs can be best met.

Principle 2 – Commission services closer to home

Develop an understanding of all provider's roles and aligned strategies. Ensure best use of resources to build capacity and achieve the highest quality of services. Understand the provider's role in local provision. Consider also the pathway for typical individuals and how each service can refer to another as seamlessly as possible.

A good understanding of the local landscape and market position is needed to ensure services are co-ordinated, existing resources are utilised, best practice is shared and individuals are provided as seamless a service as possible. This should also include the transition between child and adult services.

Principle 3 – Commission services to put the person at the centre of delivery

The individual requiring care will be at the centre of the commissioning process. Individuals will be seen as a whole person and commissioning will reflect this.

Each person has different experiences and needs. Commissioners/senior managers should ensure that services are flexible and responsive to the experience of the individual and their family where appropriate.

Principle 4 – Commission services to work in collaboration across OneGov and the wider community to deliver best care

Improve partnership working. Involve, engage and empower the community to seek, design and deliver services. Look to commission services which work across OneGov and the wider community. Talk to sector experts not just as bidders but as providers of knowledge and crucially to experts by experience, families and customers to support the development of locally appropriate services.

Principle 5 – Assess the value of services by measuring outcomes rather than activity

Measure success according to the result of the care provided. Outcomes should include patient and individual care outcomes and establish improved emotional and physical wellbeing.

Outcome-based commissioning is about defining and establishing the outcomes which need to be achieved. It is important to be ambitious and seek best practice to achieve the desired result. This approach is important for tracking the progress of individuals, improving the quality of the service and providing evidence of the service's impact.

PARTNERSHIP OF PURPOSE

To support organisations to work to an agreed common purpose a Partnership of Purpose will underpin the strategic and operational delivery of services. Having a common set of standards will strengthen the current relationship across OneGov as well as with our external partners.

The Partnership of Purpose will ensure parity across the health and social care economy with the system focused on the patient/customer experience and quality outcomes for Islanders.

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

COMMISSIONING PRACTICE: COLLABORATIVE WORKING

A key ambition is to encourage integrated, outcomes focussed commissioning and service provision

It is important for a collaborative approach to be taken to:

- provide consistency of provision
- encourage more joined-up services
- provide a cost-effective approach for both commissioners and service providers

Responsibilities, governance and partnership

Commissioners should look for opportunities to jointly commission services. For joint commissioning to work, there needs to be clear responsibilities and robust governance. When exploring commissioning options, effective leadership must be established to ensure services are responsive to the needs of individuals. The following are key components to achieve this:

Form a joint HCS commissioning committee > Identify the right people, bring commissioning across HCS together and meet on a regular basis to agree priorities, service needs, discuss budgets reporting to GoJ Chief Operating Office.

Agree terms of reference for the committee > These should clearly set out the objectives of the committee.

Create joint commissioning agreements > These will be required to formally implement joint working between commissioning bodies/GoJ departments. This should include interoperability protocols for joint working with clear lines of reporting and must set out clear policies for information sharing, risk management and risk sharing.

Mapping local structures

Mapping the key agencies and local structures relevant to commissioning will allow commissioners to identify the right contacts. At a minimum, commissioners should have a collective understanding of every partner with a stake in local service provision or a formal role to play. This will also help to develop appropriate governance structures for joint working. This mapping should include key information on what role organisations perform, what operational policies they have in place and what role they play in assessing risks and, where relevant, delivering services to individuals.

Joint strategy

Commissioning departments should work towards producing a joint OneGov strategy, setting clear responsibilities and goals aligned to the Government Plan. The process of producing joint commissioning strategies is a key platform for exploring health and care issues and has been emphasised as an effective way for commissioners to help consolidate joint working.

Other relevant strategic plans from across Government Departments should be considered. These include;

- Customer and Local Services
- Children, Young People, Education and Skills
- Justice and Home Affairs,
- Treasury and Exchequer
- Growth, Housing and Environment
- Strategic Policy, Performance and Population
- Chief Operating Office

Pooling Government of Jersey budgets

Commissioners should aim to pool budgets and funding sources. Having a number of different funding streams contributes to the complex commissioning landscape and makes it harder for service providers to know where to bid to. Pooling budgets will promote integrated services, prevent duplication of effort and increase efficiency. It allows organisations to align services against agreed outcomes and facilitates and promotes joint commissioning.

Resources and management structures can be integrated and functions can be reallocated between partners. Commissioners should also encourage, where possible, working collaboratively across the GoJ to achieve economy of scales.

Advisory group

It is important for commissioners to consider relationships with key stakeholders beyond commissioning colleagues to build local networks and capacity. An advisory group to inform joint commissioning decisions is a way to involve other professionals, service providers, and experts by experience in decision making, drawing on frontline expertise and experience. It is anticipated that this could build on the Cluster structure which has been established across the Voluntary Sector as well as partners delivering Closer to Home.

An advisory group should create proactive and constructive links and ensure that people are at the centre of service delivery. The importance of the involvement of experts by experience in making commissioning decisions is highlighted as one of the fundamental commissioning principles and an advisory group can be an effective method to implement this.

Assessing need

Services must be commissioned according to need, ensuring individuals receiving support are at the centre of delivery. Commissioners must understand the need to directly inform future service specification and delivery. The following provides guidance for the method of undertaking a comprehensive and effective needs assessment for services.

Compile existing sources of information

The following are examples of the types of data sources commissioners should use when assessing need:

- Jersey prevalence statistics
- Patient/customer feedback
- Caseload and waiting lists of existing services
- Primary care data
- Jersey Needs Assessment (JNA)
- CAMHS transformation plans
- Joint commissioning strategy for mental health services or children's services
- Serious case reviews
- Service provider activity data
- Performance data
- Health and Community services data

Map existing services against need

Mapping which services are currently available from public, private and external providers can be helpful to understand the local environment and assist joint working. Although good services should be re-commissioned, it is important that a mapping exercise does not prevent a full consideration of need and which services are required to meet this.

Key tips for mapping services

- Map current services provided by all sectors
- Undertake a gap analysis of services, considering location and service types and identify elements of the pathway that are missing
- Estimate the existing capacity in service providers
- Estimate the current demand for services from activity data and local audits
- As far as possible, consider future demand looking at local trends and the impact of preventative services, such as awareness raising

Involve experts by experience and service providers in the process

The views and experiences of those accessing services and frontline organisations are essential to having an informed and comprehensive understanding of local need. It is also important to understand whether there are any barriers to accessing support. An advisory group can be an effective way to engage experts by experience in the commissioning process.

Analysis and interpretation

Time must be taken to understand and analyse the information gathered, which will allow the identification of gaps, establish priorities and indicate which services are required.

The following provides a checklist for commissioners to identify if they are conducting an effective needs assessment:

- Have you engaged directly with experts by experience, service providers and others to gain an understanding of the needs of individuals and their families and the types of services, which might best meet those needs? Engaging with experts by experience and providers will help to understand a wide range of views, and how this may alter the services required.
- Have you considered associated issues? Relationships with other relevant commissioning bodies/funders or joint commissioning relationships will help to make better links between relevant services, and consider how these may cross over, or work together.
- Do you understand local demography sufficiently? What particular groups exist in the area? Which social demographics and ethnicities are represented? How are these populations changing and what does that mean for service need?
- Do you understand the likely issues of groups identified in the Islands demography and of other general groups?
- As far as possible, have you identified the likely prevalence of the condition/need/service to be commissioned? Use demographic data as well as other sources, such as local data and international research.
- Have you considered groups or communities that find it hard to access support?
- Are you aware of the eight categories of need: mental and physical health; shelter and accommodation; family, friends and children; education, skills and employment; substance misuse;

finance and benefits; outlook and attitudes; and social interaction? Services should be targeted in line with these, recognising that they are likely to cover more than one category.

Is there any prevention work ongoing, or planned, in your area? Prevention activity can lead to an increase in identification; spikes in demand can, to a degree, be anticipated and should be robustly planned for in terms of increased referrals to existing services.

Transition pathways

It is important for commissioners to note that the transition from children's to adult's and from working age adults to retirees services can be an extremely vulnerable time, as the entitlement to, and availability of, a range of support services, changes significantly in a short space of time. Commissioners should consider what is best for the individual when considering the transition.

Outcomes

Outcome measures are vital to allow commissioners to understand the impact of services to align funding to services which achieve the greatest impact. While outcome focused commissioning can be challenging, commissioners should encourage services to focus on outcomes as:

It ensures that services focus on the benefit for individuals accessing the service rather than only on process and outputs.

It encourages services to develop monitoring and evaluation processes and embed outcomes measurement within their work.

Health and Care services and the outcomes they seek to achieve are diverse. Commissioners are encouraged to use a range of appropriate outcome measures. These measures should be tailored to the needs of the individuals requiring the service.

It is important for commissioners to avoid imposing either outcomes or measurement tools on services. Where possible individuals accessing the service should be consulted in the process of developing outcome measures and service design.

Commissioners should aim to include service improvements and continuous learning as part of any monitoring and evaluation process. There should also be feedback loops in place to ensure mangers and practitioners have access to information that enables them to make improvements.

The following provides key points for commissioners to remember when considering outcome measures:

- A collaborative approach must be taken to establish outcome measures, with communication between commissioners, service providers and experts by experience
- Outcome measures should be reviewed on an ongoing basis to ensure they adequately reflect an ever-changing Health and Care environment
- Consider a range of measures and indicators, including individuals reported outcomes, staff-reported outcomes, and qualitative outcomes
- Ensure the measures are tailored to the level of funding, type of service and size of the organisation, ensuring measures are not onerous
- Ensure outcome measures encourage sustainability of support provision to reflect the long-term process of recovery for victims and survivors

Commissioners must continually review the impact of individual services commissioned using appropriate outcome measures and outputs. In addition, there has to be an overarching review of whether the system as a whole is appropriately responding to experts by experience in line with the needs assessment for the area.

To do this, commissioners must:

- continually listen to the concerns and issues of experts by experience and their families and service providers through advisory groups such as the Clusters
- be alert to developments and emerging trends in the commissioned service area through the service providers, other commissioning bodies and agencies, the media and Government
- continue dialogue and joint working with commissioners in the area to keep mapping of services up to date

This framework is intended to encourage a more joined up approach to commissioning of health and care in Jersey, ensure delivery is tailored to the needs of individuals and to share best practice.

HCS is keen to ensure this framework has been utilised by commissioners and has had a positive effect on the commissioning environment.

The publication is intended to be a living document which can continue to be used for the future, developing in line with the sector.

HCS will commit to:

- implementing a review of the framework after 18 months of publication
- seek feedback and understand what has worked, what has not worked and how the approach could be improved
- support the sharing of best practice, working with others to develop thinking about the role of the GoJ in facilitating the sharing of best practice across the sector
- work together with partners across Government to ensure alignment with other relevant work streams.

Commissioning intentions describe to providers how we as an organisation intend to shape local health and care services. They will describe what services we want to commission and the health and care outcomes we wish to achieve for our population. They demonstrate how we will respond to health needs and local clinical priorities.

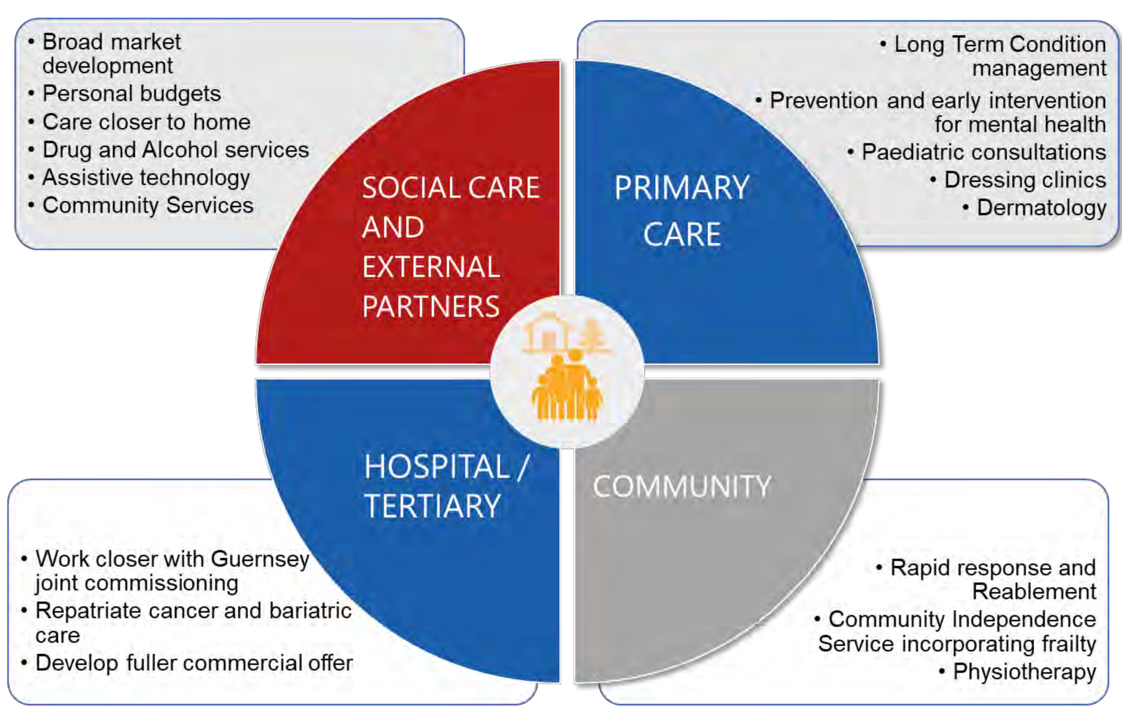


Figure 3 - Jersey Care Model Commissioning intentions (outline)

Jersey has a diverse health and social care economy and one format of commissioning will not deliver the results required to improve islander's health, mental health and wellbeing.

A hybrid and blended approach will be adopted to ensure proportionality and a focus on outcomes. Our approach will underpin the delivery of the Jersey Care Model by focusing on current and future needs based on evidence while developing partnerships.

Our model will stimulate market development and reward positive outcomes for patients/customers through sharing rewards. The overarching theme of our approach will be place-based systems[17] of care in which HCS work together with partners to improve health and care for the population. This means organisations collaborating to manage the common resources available to them.

The approach taken to developing systems of care will be determined by HCS and partners, based on a set of design principles. These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

HCS will work to remove the barriers that get in the way of working in place-based systems of care and will work in a co-ordinated way to support the development of these systems. This includes creating stronger incentives for systems of care to evolve to tackle current and future challenges.

Commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. This will enable organisations to plan and develop while underpinning strong partnership working.

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[17] https://www.kingsfund.org.uk/publications/place-based-systems-care

Individuals and organisations cannot solve the problems facing today's society on their own. Instead, we must design new ways in which individuals can work together in teams and across systems to make the best use of collective skills and knowledge.

The following design principles will be considered when developing services;

- Define the population group served and the boundaries of the system.
- Identify the right partners and services that need to be involved.
- Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.
- Develop an appropriate governance structure, which must meaningfully involve patients and the public in decision-making.
- Identify the right leaders to be involved in managing the system and develop a new form of system leadership.
- Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.
- Develop a sustainable financing model for the system across three different levels:
- The combined resources available to achieve the aims of the system
- The way resources will flow to providers
- How these resources are allocated between providers and the way that costs, risks and rewards will be shared
- Develop a single set of measures to understand progress and use for improvement.

To support the Jersey Model of Care the following approaches will be adopted.

Transactional

This approach will see HCS commission providers to deliver a specific area of service delivery based upon volume, outcomes and results.

It is anticipated that this approach will be adopted for smaller services who deliver specific activity in the community as well as a tool to incentivise Primary Care to deliver services that will be delivered in the community and not in acute settings.

This approach will also allow HCS to commission bespoke services targeted at specific groups for a finite period of time.

Strategic partnerships (SP)

To deliver the Jersey model of care will require organisations to work in partnership to deliver key services such as intermediate care for example. To endear the transformational change required to deliver a quality and sustainable model of care will in practice mean different parts of the health and social care system working together to provide more co-ordinated services to patients – for example, by GPs working more closely with hospital specialists, district nurses and social workers to improve care for people with long-term conditions.

It is anticipated that HCS will work with partner organisations to develop SP which will blend traditional commissioning with accountable organisations agreements to share rewards and risks. This approach can also be adopted with Primary Care providers as well as all external providers. Services such as intermediate care could be developed and delivered through SP.

SP will be responsible for improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services.

SP will be central to driving a change in behaviours, improving quality, access and affordability of services.

Collaborative commissioning of bespoke services

HCS has a number of bespoke services targeted at vulnerable groups. While these arrangements do have a health and social care component, customers and providers would benefit from a cross OneGov approach. For these services HCS will work collaboratively to jointly develop and fund services to ensure optimising outcomes.

In addition to this HCS does have a number of specialist off-island placements and we will work with other jurisdictions such as Guernsey to explore potential joint commissioning.

Joint or integrated commissioning at a local level

Jersey has a unique Parish system that is central to island life. Each Parish has its own individuality and to meet Parishioners needs a flexible approach to commissioning and delivering services is required. HCS will work in partnership to commission services at a micro level with partners to meet current and emerging needs. This will link with the Closer to Home agenda as well as specific local evidence based commissioning.

Personalisation

To support choice and control for individuals, HCS will work with partners to develop personalisation. This will see individual budgets based on an assessment, allow people to have control over their care and provide a real alternative to institutional care.

APPENDICES

Appendix 1 Definitions, Acronyms and Abbreviations

Term	**Definition**
Agreement	A document that describes a formal understanding between two or more parties
Escalation	An activity that obtains additional resources when these are needed to meet service level targets or customer expectations
HCS	Health and Community Services
Impact	A measure of the effect of an incident, problem or change on business processes
Incident	An unplanned interruption to a service or reduction in the quality of a service
Priority	A category used to identify the relative importance of an incident, problem or change.
Process	A structured set of activities designed to accomplish a specific objective.
Resolution	Action taken to repair the root cause of an incident or problem, or to implement a workaround.
Role	A set of responsibilities, activities and authorities assigned to a person or team
Service Hours	An agreed time period when a particular service should be available
Service Level	Measured and reported achievement against one or more service level targets
Service Level Agreement (SLA)	An agreement between a service provider and a customer
Service Level Target	A commitment that is documented in a service level agreement.
TOM	Target Operating Model

HEALTH SYSTEMS COMPARISON REPORT

INTRODUCTION

This report has been produced in order to support the development of the Government of Jersey's health and social care strategy. This strategy is intended to design and implement plans which improve the quality of health and social care services in order to improve the health of the population. The report examines how two countries (England and France) deliver their health services and their performance levels against a range of indicators. These two comparative countries have been selected as they are regularly used as benchmarks for the Government of Jersey and are geographically proximate.

The report provides a description of the main features of the three countries' systems and sets out available data against a range of aspects of practice and performance. Where possible, relevant data relating to the performance of the Government of Jersey services have been included. Data has been collated from a number of sources and does not always relate to the same point in time. Data has been mainly drawn from the OECD for England (UK) and France and the "Jersey Health Profile 2016" for the Government of Jersey.

This briefing is also intended to establish how best to determine where GoJ patients are transferred for treatment which cannot be undertaken within the states. This paper includes a section on current practice and sets out the main considerations which could be taken into account when establishing international patient flows.

The report concludes with a set of observations based on the evaluation which has been undertaken and a conclusion with suggested areas for further work.

FURTHER ANALYSIS AND EVALUATION

Performance data

This report gives a snapshot comparison of the health care services in UK/England and France. Where possible data from GoJ has been included, although this is relatively light and as a result only broad observations can be made in terms of how this comparison relates to GoJ.

Areas of further analysis could include:

- Given the significant difference in population size of GoJ compared to England/ UK undertake a comparison with a similar county/region within the UK rather than the country as a whole
- Define, review and compare any issues with access in GoJ and how these are managed
- Look at areas of concern/high demand within the health care system of GoJ and do a more in depth comparative analysis of that area (for example access to cancer services)
- Compare different care pathways (for example stroke management) within all three countries, to identify similarities/ differences and points of learning
- Review GoJ workforce profile and potentially undertake a training needs analysis given available population health information and data
- Undertake further comparative analysis, allowing for Island Health economy specific issues with regard to access, transport, resources etc.

- Include available GoJ data to compare with that recorded for England/UK and France in the report to produce a more comprehensive comparative picture.

International activity data

In order to review current international activity and model future international care requirements, the following data is needed in terms of the type of care provided by each of the current international partners (total numbers, percentage and percentage spend):

- Complex care cases
- Simple care cases
- Trauma
- Mental health
- Adult
- Paediatric
- Mutual aid emergency planning.

Benchmarking with a comparable English healthcare economy region

It is proposed that a comparable English healthcare economy region is selected in order to evaluate in greater detail how GoJ is performing. The following indicators could be used to undertake this comparison.

Area	**Outcome**	**Outcome indicators**
Quality	Safety	• Deaths and severe harm attributable to problems in healthcare (can include metrics such as inpatient hip fractures, hospital acquired infections, category 2,3,4 pressure ulcers) • Proportion using services who say services make them feel safe and secure
	Outcomes and effectiveness	• Mortality rate from causes considered preventable (can include lifestyle related cancers, access to services, long-term condition management) • Proportion of people reporting good health/social care related quality of life • Proportion of people who feel they have control over their daily life • Proportion of people who feel supported to manage their long-term condition • Smoking prevalence in adults aged under 18 • Proportion of adults with excess weight • Avoidable admissions • Permanent care home admissions • Reablement effectiveness • Risk standardised all-condition readmission rate
Experience	Citizen	Experience of integrated care (based on comparable data collected in both services)
	Carer	Measure of carer experience of care (maybe carer quality of life)
	Staff	Friends and family test (or other metrics from staff surveys)
Cost		• Activity measures relevant to GoJ (for example A and E attendance, length of hospital stay, transfer costs) • Per capita cost

		• Total cost and cost growth

OVERVIEW OF THE HEALTH AND SOCIAL CARE SYSTEMS

FRANCE

France has a population of 66 million with an average life expectancy of over 82 years. In 2016, expenses related to the healthcare system in France represented 11.5% of the country's GDP and almost 25% of GDP for social care.

The French healthcare system was named by the World Health Organization in 2008 as the best performing system in the world in terms of availability and organisation of health care providers. However, in 2017 The Commonwealth Fund report ranking developed-country healthcare systems ranked France as 10th out of the top eleven global healthcare systems against 5 key performance indicators (annex 1)

France has a universal health care system. It features a mix of public and private services, relatively high expenditure, high patient success rates and low mortality rates, and high consumer satisfaction. Its aims are to combine low cost with flexibility of patient choice as well as doctors' autonomy.

Public health finances come from taxes and compulsory social health insurance contributions from employers and employees. The Sickness Insurance Funds cover 99% of the population and people have no choice of insurer. They are automatically affiliated to a health insurance scheme on the basis of their professional status and place of residence. Mutual Insurance Funds provide supplementary, voluntary insurance to cover cost-sharing arrangements and extra billings. Salaried workers purchase voluntary insurance from their employers, but this can be purchased on an individual basis. The mutual funds cover 80 per cent of the population, which means that for most of the population, 100 per cent of the cost of the majority of normal medical procedures is reimbursed.

There are patient contributions for ambulatory care (around 30 per cent for GP and specialist visits), drugs (between 35 per cent and 65 per cent depending on the therapeutic value) and 40 per cent for laboratory tests. Out of pocket payments account for 10% of health care expenditure.

The rising cost of the system has been a source of concern, as has the lack of emergency service in some areas. In 2004, the system underwent a number of reforms, including introduction of the *Carte Vitale or* smart card system, improved treatment of patients with rare diseases, and efforts aimed at reducing medical fraud.

While private medical care exists in France, the 75% of doctors who are in the national program provide care free to the patient, with costs being reimbursed from government funds. Like most countries, France faces problems of rising costs of prescription medication, increasing unemployment, and a large aging population.

ENGLAND (AND THE UK)

Despite there being separate health services for each country within the UK, the performance of the National Health Service (NHS) across the UK as a whole is usually measured for the purpose of making international comparisons. In this report, where there is England specific data available that will be cited, otherwise all data refers to the UK.

England has a population of 56 million. The UK the population is 66 million, with an average life expectancy of just under 82 years.

In 2016, expenses related to the healthcare system in the UK represented 9.8% of the country's GDP and 20% of GDP for social care.

The United Kingdom's healthcare system is predominately public sector with the majority of the funds coming from general taxation and some from national insurance contributions. About 11.5% of the population have

supplementary private medical insurance, usually for reasons of faster access. NHS care is free at the point of delivery, but charges are levied on prescription drugs, ophthalmic services and dental services. There are exemptions, for example, for children, elderly, and the unemployed and 85% of prescriptions are exempt from the charge.

In the 2017 report by the Commonwealth Fund ranking developed-country healthcare systems, the United Kingdom was ranked the best healthcare system in the world overall (annex 1). The UK system was also ranked the best in the world overall in the previous three reports by the Commonwealth Fund in 2007, 2010 and 2014. The UK's palliative care has also been ranked as the best in the world by the Economist Intelligence Unit. On the other hand, in 2005-09 cancer survival rates lagged ten years behind the rest of Europe, although survival rates continue to increase.

The majority of healthcare in England is provided by NHS England, which accounts for most of the Department of Health and Social Care's budget (£122.5 billion in 2017-18). It is free at the point of use and paid for from taxation.

In April 2013, under the terms of the Health and Social Care Act 2012, a reorganisation of the NHS took place regarding the administration of the NHS. Clinical commissioning Groups (CCGs) were introduced to commission most of the hospital and community NHS services in the local areas for which they are responsible. The CCGs are overseen by NHS England, which was established on 1 October 2012 as an executive non-departmental public body. Services commissioned include general practice physician services (most of whom are private businesses working under contract to the NHS), community nursing, local clinics and mental health services. The organisation of health services is undergoing substantial changes within the limits of the 2012 legislation.

The NHS is the world's largest health service and the world's fourth-largest employer; only the Chinese People's Liberation Army, Indian Railways, and Wal-Mart employ more people directly.

In parallel with France and other countries it faces the challenges of an ageing population, with chronic and long-term conditions, with increasingly complex co-morbidities.

PERFORMANCE DATA

This section gives more detail on comparative recorded performance data. Again, where possible, metrics for England have been used but in most cases UK data is only available and this is annotated in the tables by (UK). In addition, as the data sources were varied, all metrics used for comparison were recorded within three years of each other.

Where metrics are available for GoJ they have also been included in the tables for comparison.

A full list of data sources is given in annex B.

FUNDING AND EXPENDITURE

Table 1: Funding and expenditure

Measure	England (UK)	France	GoJ
Health care spending as % GDP	9.8 (UK)	11.5	*
Total spend per capita	4070 (UK)	4965	*
Spending per capita by source of funding ($)			*
• Public	3341 (UK)	4068	*
• Private	223 (UK)	351	*
• Out of pocket	630 (UK)	466	*
Long term care spending (% of total health spend)	18.54 (UK)	14.83	*

* Total health care spending is not currently calculated by Statistics Jersey. While GoJ departments spending gives some indication of healthcare spending, it would need a line by line analysis of each budget to give an accurate calculation for GoJ. The total spend would also include spending by external partners and personal healthcare which is not all readily available. It is understood that Statistics Jersey are looking at producing the health care spending figure in future and will be reviewed during the next phase of analysis.

Health spending measures the final consumption of health care goods and services including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration) but excluding spending on investments. Health care is financed through a mix of financing arrangements including government spending and compulsory health insurance (Public) as well as voluntary health insurance, NGOs, private corporations and private funds (Private) and households' out-of-pocket payments (Out of pocket).

Long term care spend is included as chronic and complex illnesses are an increasing requirement in health care provision. GoJ long-term care is funded through a ring-fenced proportion of tax.

RESOURCE SUPPLY AND WORKFORCE

Table 2: Resource supply and workforce

Measure	England (UK)	France	GoJ
Doctors per 1000 population	2.8 (UK)	5.1	1.1
GPs per 1000 population	0.6	3.3	0.9
Nurses per 1000 population	7.8 (UK)	10.8	6.3
Practice nurses per 1000 population	0.8	No comparable data	0.5
Acute care hospital beds per 1000 population	2.1(UK)	3.1	2.5
Bed occupancy (%)	90	80	66 – 71 (adult; male – female)
MRI units per 1,000,000 population	7.2 (UK) (Hospital only)	14.8 (6.4 ambulatory and 8.4 hospitals)	18.9

Doctors and nurses are defined as "practising" – that is providing direct care to patients. However, it should be noted for France they correspond to "professionally active" doctors and nurses, including those working in the health sector as managers, educators, researchers, etc. (which it is estimated to add another 5-10% to overall numbers for each profession).

Acute care hospital beds provides a measure of the resources available for delivering services to inpatients in hospitals in terms of number of beds that are maintained, staffed and immediately available for use and together with bed occupancy is a good indicator of access and efficiency. The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.

The number of MRI units relates to those in hospitals and ambulatory care (outpatient facilities). It is an important metric for access and efficiency when taken with the number of MRIs examinations performed (see section 3.4)

EDUCATION AND TRAINING

Table 3: Medical and nursing graduates

Measure	England (UK)	France	GoJ
Medical Graduates per 100,000 inhabitants	12.9 (UK)	9.5	0
Nursing Graduates per 100,000 inhabitants	31 (UK)	41	11

Medical graduates are defined as the number of students who have graduated from medical schools or similar institutions in a given year. Dental, public health and epidemiology graduates are excluded.

Nursing graduates refer to the number of students who have obtained a recognised qualification required to become a licensed or registered nurse. They include graduates from both higher level and lower level nursing programmes. They exclude graduates from Masters or PhD degrees in nursing to avoid double-counting nurses acquiring further qualifications.

ACCESS, UTILISATION AND QUALITY PERFORMANCE

Table 4: Access, utilisation and performance

Measure	England (UK)	France	GoJ
Doctor consultations per capita	5 (UK)	6.1	4.1
A and E conversion rate (%)	27		14
Average length of hospital stay (days)	5.9 (UK)	5.6	4.6
Hospital discharge rates per 100,000 inhabitants	12.4 (UK)	18.6	Equivalent not available
MRI exams per 1,000 population	62 (UK) (hospital only)	114 (49 hospital, 65 ambulatory care)	81.7

Doctor consultations represent the number of consultations patients have with doctors in a given year and are seen as an indicator of access. Consultations with doctors can take place in doctors' offices or clinics, in hospital outpatient departments or, in some cases, in patients' own homes.

The Accident and Emergency conversion rate is the percentage of unscheduled attendees who are then subsequently admitted to the hospital for further treatment and/or investigation. The numbers are significantly impacted by the availability of out of hospital services (that is patients unnecessarily having to be admitted because of lack of community/ tertiary care) coupled the increasing numbers of elderly patients with complex conditions. No comparable statistics were available for France.

The average length of stay in hospitals (ALOS) is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. The ALOS refers to the average number of days that patients spend in hospital. It is generally measured by dividing the total number of days stayed by all inpatients during a year by the number of admissions or discharges. Day cases are excluded.

Hospital discharge rates measure the number of patients who leave a hospital after staying at least one night. Together with the average length of stay, they are important indicators of hospital activities. Hospital activities are affected by a number of factors, including the capacity of hospitals to treat patients, the ability of the primary care sector to prevent avoidable hospital admissions, and the availability of post-acute care settings to provide rehabilitative and long-term care.

The number of MRI exams gives an indication of both care process and access. At the time of measurement all UK MRIs were undertaken in a hospital setting, whereas France has access to MRI in ambulatory care. Private MRIs are not included in this metric.

HEALTH OUTCOMES

PREVENTION AND POPULATION HEALTH

Table 5: Public health

Measure	England (UK)	France	GoJ
Life expectancy at birth (years)	83.1 (f) (UK) 79.5 (m)	85.6 (f) 79.6 (m)	84.9.6 (f) 80.6 (m)
Potential years of life lost per 100,000 inhabitants aged 0-69	4168 (UK)	4167	5910 (m) 3410 (f)
Smoking rate (% population >15 years)	17.2	22.4	15
Overweight or obese (% population >15 years)	64.3 (UK)	49	48
Flu immunisations (%) aged >65 years	72.6 (UK)	49.7	60

Life expectancy at birth is defined as how long, on average, a newborn can expect to live, if current death rates do not change. Gains in life expectancy at birth can be attributed to a number of factors, including rising living standards, improved lifestyle and better education, as well as greater access to quality health services.

The infant mortality rate is defined as the number of deaths of children under one year of age and is used as in indicator for the quality of pre-, peri- and post-natal care.

Both smoking and obesity rates reflect on public health education and preventative health care measures.

Potential years of life lost is an important indicator as it is a summary measure of premature mortality, providing an explicit way of weighting deaths occurring at younger ages, which may be preventable.

Influenza vaccination rates for those over the age of 65 gives a good indicator of public health investment in prevention and awareness.

MORTALITY RATES

Table 6: Mortality rates

Measure	England (UK)	France	GoJ
Infant mortality (per 1,000 live births	3.9 (UK)	3.8	3.1

Total deaths from cancers (per 100,000 of the population)	216 (UK)	198	146
Breast	28.2 (UK)	27.1	17
Cervical	2.3 (UK)	1.9	n/a
Colorectal	21.7 (UK)	20.5	14
Ischaemic heart disease mortality (per 100,000 of the population)	116 (UK)	49	29
Stroke mortality (per 100,000 of the population)	67 (UK)	46	10

There are over 100 different cancers recorded for the total number of deaths attributable to the disease. The OECD uses mortality and survival rates for three cancers – breast, cervical and colorectal – as indicators of the quality of the healthcare system (e.g. prevention, early detection and treatment).

Circulatory diseases are the largest group of illnesses contributing deaths across Europe. The numbers give an indication of both public health and prevention, together with access to appropriate treatment and aftercare.

PRINCIPAL OBSERVATIONS

There are a number of variables that can influence and impact the metrics detailed above, in particular the method of data collection and interpretation in the two countries, and by third parties undertaking research. Wherever possible, sources – such as the OECD, Nuffield Health and Commonwealth Fund have been used as they standardise results, which allows for a more level playing field for comparison.

France spends more than the UK on health care and has a marginally higher life expectancy for both men and women. As the baby boom population ages, more people in both countries are living with age-related disabilities and chronic disease, placing pressure on health care systems to respond. Compared to France, the UK spends almost 4% more of their total health spend on long term conditions, which suggests a focus on this increasing burden. With a population of 102,700, life expectancy in GoJ is in line with that of both countries, being 81.1years (male) and 85.3 years (female).

Even allowing for data variances, in terms of clinicians (both doctors and nurses) France exceeds the number per 1,000 of the population than the UK in both. Significantly the number of GPs per 1,000 is over three times that in England which undoubtedly impacts the increased number of doctor consultations reported for France and may also have a positive effect on health outcomes due to earlier intervention and disease management. In addition, total nursing numbers are higher in France than the UK (10.8 compared to 7.8). With a proportionally reduced number of clinical staff, access and efficiency may be affected.

There is Europe-wide concern about the need for additional clinical staff in the face of the increased burden on healthcare systems due to a larger ageing population and more complex co-morbidities and long-term conditions. Both France and the UK exercise some form of control over medical school intakes, often by limiting the number of available training places. As it takes about ten years to train a doctor, there is a lag time to see an impact in increasing qualified doctor numbers and therefore robust workforce planning is required.

The proportionally higher number of medical graduates in the UK compared to France (12.9 compared to 9.5) shows advance planning and investment in anticipation of this need.

However, the nursing statistics do not follow this trend, with over 20% fewer graduating in the UK than France. This may be in part caused by the relatively new UK requirement for all nursing students to have a degree, which adds both personal expense and time to qualify (now averaging 5 years, including degree). Given there is already a nursing shortage in the UK, this will only compound matters in the future if nurses cannot be recruited from elsewhere.

From available figures, GoJ has just over one doctor and 6.3 nurses per 1,000 population. Furthermore, the number of practice (or primary care) nurses in GoJ is just 0.5 per 1,000 population compared to 0.8 in England. Appropriately skilled practice nurses are an invaluable resource in primary care, releasing GP time for more complex cases. This is especially relevant when it comes to managing long term conditions such as diabetes and circulatory diseases, which are shown to have better outcomes when treated through specialist nursing clinics in the community. These statistics underpin the need for detailed population health information and associated training needs analysis in order to train and recruit the right number and profile of clinical staff.

The UK also has proportionally fewer acute care beds available to the population than France and this is reflected in the bed occupancy rate which has been greater than the internationally recognised safe level of 85% for several years.

Interestingly, France has a 50% higher hospital discharge rate compared to the UK which, coupled with their lower occupancy rate, suggests a more efficient hospital patient pathway from admission to discharge. This is supported by a reduced average length of stay compared to the UK.

The adult bed occupancy rate in GoJ varies from 66% (male) to 71% (female). This is substantially lower than the suggested optimal rate of 85%. The extra capacity can in part be explained by the fact that GoJ is an Island Health economy - it does not have a network of hospitals to rely on should there be a spike in demand (such as a winter flu epidemic) and therefore needs to have a proportionally larger buffer to mitigate this risk. In order to safely increase the bed occupancy (have the appropriate number of hospital beds and community care services), modelling already undertaken as part of the Our Hospital Project should be reviewed in tandem with exploring the potential for off shore health networks to provide the capacity and specialist care required.

France has over double the number of MRI units compared to the UK, and this is largely due to the fact that France also has units within ambulatory care settings – whereas in the UK they are only hospital based. The number of MRI examinations reflects this, with almost twice the number being undertaken in France per 1,000 population compared to the UK. Timely access to diagnostics is crucial when it comes to diagnosis and management of some key health outcomes indicators.

Public health education and prevention programmes are crucial to help optimise individuals' health opportunities and lifestyle choices. This is especially important with increasing life expectancy. Key indicators including obesity and smoking rates vary between the two countries, with France having a higher smoking rate but the UK having a higher proportion of the population being overweight or obese. Both of these indicators are known to be significant contributors to the two groups of diseases that contribute to the top causes of mortality – namely cancers and cardiovascular disease. GoJ has a relatively lower smoking rate but with 50% of the population overweight or obese could be facing an increased burden in terms of these diseases. Cancer already accounts for one in 3 deaths in GoJ.

Being previously rated poorly in terms of cancer care and mortality rates, the UK has invested in this specialty – and the mortality rates, whilst still slightly higher than that of France for breast and colorectal cancers have a <2% variation. The higher rate of cervical cancer mortality rate in the UK may be due to a later introduction of the HPV vaccination programme, but also may be attributable to late diagnosis.

Cardiovascular outcomes, however, show a significant gap in terms of mortality. The UK has a mortality rate of 116 per 100,000 population for ischaemic heart disease, whilst it is only 49 in France. Likewise for stroke, mortality rate is almost 50% higher in the UK, with 67 per 100,000 population as opposed to 46 in France. As both countries have risk factors in terms of smoking and obesity, the conclusion may be drawn that rapid access to appropriate specialists and treatment are key to explaining the difference in outcomes.

Finally, it is widely appreciated that patient experience is a very good indicator of the underlying robustness and overall performance of a health care system.

The percentage of the populations rating health as 'good' or 'very good' is as follows:

- Jersey = 80%
- UK = 70%
- France = 68.1%

INTERNATIONAL HEALTH CARE EXPENDITURE AND ACTIVITY

The tables below give a summary of the overall GoJ planned international spend for acute and mental health services for 2018/9 and the proportion of overall spend represented by each acute care provider.

Table 7: International spend on acute services

NHS Provider	2018/19 Plan	Proportion
Addenbrookes	£671,000	7.6%
BOSS (spinal)	£360,000	4.1%
GOSH	£149,000	1.7%
Guys and St Thomas'	£300,408	3.4%
Marsden	£176,173	2.0%
Moorfields	£17,651	0.2%
Oxford Radcliffe	£1,175,050	13.3%
Portsmouth	£262,142	3.0%
Royal Bournemouth	£237,053	2.7%
Royal Free	£263,448	3.0%
Salisbury	£119,000	1.3%
UCLH	£780,000	8.8%
University Hospital Southampton	£4,343,000	49.1%
Total	**£8,853,985**	

Year to date actual spend (M6) = £5,905,475 – with a FYE forecast of £11,114,788

Table 8: International spend on mental health

Provider	2018/19 Plan	Proportion
Essex Partnership Trust	£1,065,379	71.2%
St Andrews	£380,188	25.4%
Bramley Health	0	0.0%
Kent and Medway NHS Trust	0	0.0%
Cygnet	0	0.0%
Tavistock	0	0.0%
SLAM	£50,000	3.3%
Total	£1,495,567	

Year to date actual spend (M6) = £860,912 – with a FYE forecast of £1,833,107

This diagram gives a breakdown of international cases by specialty, where the percentage for the specialty is >1% of total activity.

Diagram 1: International cases by specialty – 2018/19 (YTD M4)

Vascular 1%
Bariatrics 1%
Cardiology 13%
Dermatology 1%
Diagnostics 15%
Endocrinology 1%
ENT 2%
Gastroenterology 4%
General Surgery 4%
Gynaecology 2%
Haematology 1%
Mental Health 1%
Neonatal / SCBU 1%
Neuro Sciences 4%
Obstetrics 3%
Oncology 12%
Ophthalmology 2%
Paediatrics 9%
Respiratory 7%
Trauma and Orthopaedics 8%
Urology 8%

Below is the list of specialities with <1% of overseas case activity:

- Dental
- General Medicine
- Genetics
- Hepatobiliary
- Microbiology
- Neurology
- Neurosurgery
- Pain Management
- Palliative Medicine
- Plastic Surgery
- Renal
- Rheumatology
- Surgical Outpatients
- Thoracics

CRITERIA FOR SELECTING INTERNATIONAL PROVIDER PARTNERS

The following list gives some proposed criteria to consider when selecting international health care provider partners.

i. **International level contracting:** whether to seek an overarching framework with the country. This option may give greater economies of scale, but less potential for contracting tailored to specialist need.
ii. **Patient information and data:** the process managing transfer given confidentiality requirements and system compatibility. Consideration needs to be given to both electronic and paper-based notes as the majority of providers still use a mix of both.
iii. **Safeguarding:** managing adequate safeguarding for vulnerable patients, with clear lines of accountability.
iv. **Patient consent:** managing patient consent to international diagnosis, treatment and rehabilitation.
v. **Information and guidance:** producing relevant advice and guidance for patients and those involved in international care.
vi. **Clinical practice reconciliation:** managing differences in practice and protocols between the health care providers.
vii. **Clinical relations:** managing inter-professional connections and communications, ensuring clear and open multidisciplinary team working throughout the patient pathway
viii. **Clinical incidents:** having clear and agreed systems and processes for investigating and managing clinical incidents (including reporting, investigation and changes to practice)
ix. **Indemnity and liability:** having clear definitions, agreements and processes in terms of accountability and responsibility for handling and covering inadequate outcomes.
x. **Pricing:** setting prices for services.
xi. **Payment:** organising payment arrangements, especially as France does not accept the Jersey Pound.
xii. **Pre-transfer activity:** managing what needs to be done to organise pre-transfer stabilisation and preparation.
xiii. **Travel arrangements:** organising safe and appropriate travel for the patient and professional/personal escorts, noting that access to France requires a passport and just ID to England.

xiv. **Clinical considerations during transfer:** managing clinical issues such as infection control, intravenous, oxygen therapy, tissue viability, moving and handling, and pharmacy (where French drugs do not require information in English).

xv. **Immigration:** handling matters relating to the immigration status of patients (and escorts).

xvi. **Equipment:** handling availability of equipment transferred with the patient.

xvii. **Training, education and guidance:** providing training and production of guidance for staff involved.

xviii. **Flight accessibility:** implications of: limited number of direct flights to France out of season, and only intermittent in season; travel to and from airports; and cost consequences as flights to France considered 'international' and to England as 'domestic'.

xix. **Cultural matters:** main language used is English.

CONCLUSION

Performance data

Of all the metrics above, the measure of potential years of life lost per 100,000 inhabitants is an important one to consider in this report. It is a summary measure of premature mortality, providing an explicit way of weighting deaths occurring at younger ages, which may be preventable. For this indicator, the UK and France are only a point apart at 4168 and 4167 respectively. So, whilst we see considerable variation in the indicators for spending, resources, workforce, access and utilisation and health outcomes, a possible conclusion is that whilst both systems have strengths and weaknesses, these are balanced out by overall population education, prevention and health care in each country.

The data set used in this report is based on key indicators used by the OECD and only the most up to date recorded information available was used. For a more in depth comparison, historical data and trends analysis would need to be used.

International activity data

The report only sets out the current baseline regarding international treatment and expenditure and more work needs to be done in order inform future commissioning requirements and arrangements.

ANNEX A

The Commonwealth Fund report 'Mirror, Mirror: 2017. International comparison reflects flaws and opportunities for better US health care'

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

Source: Commonwealth Fund analysis.

E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror: How the U.S. Health Care System Compares Internationally at a Time of Radical Change*, The Commonwealth Fund, July 2017.

Notes:

Care Process encompasses four subdomains relevant to health care for the general population: PREVENTIVE CARE, SAFE CARE, COORDINATED CARE, and ENGAGEMENT AND PATIENT PREFERENCES.

Access encompasses two subdomains: AFFORDABILITY and TIMELINESS. The six measures of affordability include patient reports of avoiding medical care or dental care because of cost, having high out-of-pocket expenses, facing insurance shortfalls, or having problems paying medical bills. One measure reflects primary care doctors' views of the difficulty patients face in paying for care. Timeliness includes nine measures (three of which are reported by primary care clinicians) summarizing how quickly patients can obtain information, make appointments, and obtain urgent care after hours. It also addresses the length of time needed to obtain specialty and elective non-emergency surgery.

Administrative Efficiency includes seven measures. Four measures evaluate barriers to care experienced by patients, such as limited availability of the regular doctor, medical records, or test results. Three indicators measure patients' and primary care clinicians' reports of time and effort spent dealing with paperwork, as well as disputes related to documentation requirements of insurance plans and government agencies.

Equity compares performance for higher- and lower-income individuals within each country, using 11 selected survey measures from the Care Process and Access domains.

The Health Care Outcomes domain includes nine measures of the health of populations. Taken together, they are intended to reflect outcomes that are attributable to the performance of the countries' health care delivery systems. The measures fall into three categories: population health outcomes (i.e., those that reflect the chronic disease and mortality of populations, regardless of whether they have received health care), mortality amenable to health care (i.e., deaths under age 75 from specific causes that are considered preventable in the presence of timely and effective health care), and disease-specific health outcomes measures (i.e., mortality rates following stroke or heart attack and the duration of survival after a cancer diagnosis).

ANNEX B

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GoJ research: Pre-Feasibility Bed Numbers in Future Hospital

Jersey Future Hospital Site Option Report – C0004. Gleeds 2015

https://www.gov.je/sitecollectiondocuments/health%20and%20wellbeing/new%20general%20hospital%20change%20request%20004%20appendix-9-soj-relevant-activity-data.pdf

Statistics Jersey 2018

Life Expectancy and Healthy Life Expectancy 2015-17

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Jersey Residential Population – Estimate 2018

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Avoidable Mortality 2016

Jersey Opinions and Lifestyle 2017

Jersey Opinions and Lifestyle 2018

Measuring Jersey's Economy GVA + GDP 2017

KPMG

A Proposed New System for Jersey 2011

GoJ

A New Governance Model for Health and Social Care 2017

Paper on projected international health spend 2018/19

GoJ staff involved in the production of the paper:

- Dr Duncan Gibaut
- Caroline Landon
- Robert Sainsbury
- John McInerney
- Anne Homer
- Bernard Place
- Rachel Williams
- Gary Kynman
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END

APPENDIX 2

APPENDIX 2

Jersey Care Model review

Date: 28/08/20

	Version	Date	Reviewer
Version:	Final Draft - Addendum added*	28 August 2020	• Provided to Health and Community Services (HCS) Executive Team
	Final Draft	14 May 2020	• Provided to HCS Executive Team
		11 May 2020	• Provided to HCS Executive Team
		7 May 2020	• Provided to HCS Executive Team
	V3.0	18 April 2020	• Provided to HCS Executive Team
	V2.0	10 April 2020	• Provided to HCS Executive Team
		7 April 2020	• Provided to Hilary Lucas
		30 March 2020	• Detailed consolidated comments received from Executive Team • Detailed comments received from Programme Clinical Chair - Patrick Armstrong
	V1.0	24 March 2020	• Provided to HCS Executive Team
	V0.6	23 March 2020	• Provided to Hilary Lucas

Please note: The HCS Executive Team is made up of:

- Caroline Landon
- Rob Sainsbury
- Patrick Armstrong
- Rose Naylor
- Darren Skinner
- Hilary Lucas

Addendum

Following completion of the Jersey Care Model Review, an addendum to the Review has been inserted at the request of the Council of Ministers at their meeting on 26 August 2020. This request asked for updates to provide revised implementation and financial information following further assessment of the JCM in light of COVID-19 and associated impacts on deliverability.

No other changes (with the exception of updating referenced page numbers) have been made to the Final Draft of the Review as provided on 14 May 2020.

Addendum

Implementation planning

Following the Review, there have significant inroads to embed the Jersey Care Model (JCM) in response to COVID-19

COVID-19 presented the Government of Jersey (GoJ) with an opportunity to accelerate key aspects of the JCM as there has been a need to change the way we support Islanders and deliver care.

There have been a number of changes that have been seen in how care has been provided on the island.

Business Area	Change
Public Health	• Business case drafted for expansion of the team to support implementation of public health policy.
Prevention	• At risk groups were identified and contacted by primary care clinicians in order to assess state, level of support required, and update any medications needed. • Public have been asked to work at home and take daily exercise. • Software to support self-care / telecare / telemedicine are in the process of being deployed to support patients to learn about their conditions, better understand their medicines and devices and track their progress, supported by clinicians receiving the data.
Community Care	• Services have been enhanced with Meals on Wheels being expanded. • Charitable and voluntary groups mobilised to support vulnerable groups.
Primary Care	• Access to primary care has been changed, barriers lowered through changes to the GP payment model, consultation fees lowered, and an urgent treatment centre established in conjunction with the secondary care, staffed by GPs.
Intermediate Care	• Care Homes being used for step down capacity. • Out of hospital care is being more proactively managed. • A call centre has been established, which is the start of a care coordination or care hub that could be further developed. Enhancement with more clinical staff provide additional services.
Ambulance	• Admissions avoidance is being targeted, with patients either being treated at home, or turned around quickly if brought to the Emergency Department (ED). • GPs now being part of the response team both at base and in the car, enabling prescriptions to be provided on site.
Unplanned Care	• The urgent treatment centre established in the hospital to treat ambulatory GP referrals, minor injuries and illnesses. • The ED is now streamed.
Women Children's and Family Care	• Obstetrics and Gynaecology are operating reasonably normally, with modifications to timetables to minimise risk to clients. • An on-island Category 4 Children and Adolescent Mental Health Services (CAMHS) unit has been established to manage older adolescent mental health patients on island as UK services are closed.

Addendum

Impact of COVID-19 cont.

Business Area	Change
Planned Care	• A pause on electives has seen enhanced discharge process, with limited delays and no backlog; waiting lists in all areas are having a thorough review by clinicians for revalidation. • Advice and guidance given to GPs on various pathways, but particularly for immunosuppressed patients. A new cross-organisation pathways site has been established. • A re-set of the theatres lists seen a review of how theatres can operative more effectively as we ramp back up post-pandemic.
Tertiary Care	• Repatriation – as there have been no visiting consultants, services have been taken up by Jersey clinicians. Cancellation of elective surgery has created this capacity. Some of this activity will now stay in Jersey.
Mental Health	• Local in-patient services for high acuity CAMHS patient are now being delivered on island as the UK are no longer taking new referrals.
Social Care	• Whilst face to face community mental health services are operating differently (many are now on the telephone), it has give the opportunity to restructure the department to deliver a more effecting Liaison service with ED and Police, and re-define the referrals process. • Improvements in our multi-agency safeguarding work, which much improved processes and communications. • Strength based practice is being deployed more effectively, keeping people in home, keep people out of care, enabling people to maintain independence. This is been mostly be via calls, tapping into private providers, volunteers. Need more resources in the community to make this sustainable . • All assessments from hospital are now up-to-date with zero-backlog. Samaree ward is empty. • There are now much stronger links with community providers and we have a much improved awareness of staffing and capacity in this sector, with improved collaborative working. • The crisis has further highlighted the lack of home care workforce available, but some resources from other industry sectors are now being trained to provide these services. We need to ensure they stay in the sector post-pandemic. • Some people are wanting to take parents out of care homes as they now want to care for them at home. A few instances have seen people withdrawn from homes back into family care. There may be a shift in thinking about the use of residential care.
Digital	• Tele & video consultations has increased. Tele-consultations have has the most traction as people get used to new ways of working. • Professionally, the use of video conferencing through Office 365 has helps connect staff in different locations.

Addendum

Implementation planning

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

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

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

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

Addendum

Financial Impact of the JCM (replaces page 119)

An assessment of the financial impact associated with the changes proposed in the JCM has been undertaken

This has considered the patient flows around the Jersey health and care system, and the impacts that these have in terms of income and expenditure for the system. The following areas have been considered in scope for the analysis:

1. All income and expenditure associated with the Health and Community Services Department
2. The Health Insurance Fund (HIF) and Long Term Care (LTC) fund, which sit within the Customer and Local Services department
3. Income and expenditure associated with Child and Adolescent Mental Health Services (CAMHS) within the Children, Young People, Education and Skills Department
4. Additional expenditure associated with Public Health changes proposed in the JCM, within the Strategic Policy, Planning and Performance Department.
5. Individual contributions to General Practice.

Our financial modelling has considered two main scenarios:

1. The 'do nothing' scenario, i.e. the forecast income and expenditure impacts associated with continuing with the existing model of care
2. The 'do something' scenario, i.e. the forecast income and expenditure impacts associated with implementing the Jersey Care Model as well as understanding the one-off costs required

Within the 'do something' scenario we have split out our analysis into each of the individual interventions contained within the JCM (noting that some interventions occur in multiple focus groups). For each of these interventions, our analysis shows both the avoided cost growth/savings associated with implementing the proposed change and also the addition costs required in the new care setting (reprovision costs).

Failure to change the model of care will lead to significant financial pressures for health and care services

While GoJ has made significant investments into health and care services in recent years (and has projected to continue to do so in the Government Plan), health and care expenditure is forecast to outstrip these investments due to a number of factors including:

- **Growing population:** The population of Jersey is forecast to grow by over 19% by 2036.
- **Increased health needs:** Demand for healthcare services forecast to grow by a faster rate than the growth in population, primarily due to an aging population with increasingly complex health needs. For example, through looking at current usage of hospital beds and how patient groups are going to change over time, demand for hospital beds has been estimated to grow by over 31% by 2036.
- **Cost of healthcare is increasing:** Inflation in the healthcare sector is typically higher than other parts of the economy. It has been assumed that healthcare costs will increase by an average of 3% per year.

We have forecast that, without making changes to the care model, expenditure on the HCS department will grow from £234m in 2020 (not including emergency expenditure in response to COVID-19) to £288m in 2025 and £457m by 2036. This will create a £125m funding pressure by 2036 even if GoJ continues to increase HCS allocations in line with projections in the Government Plan.

There are also likely to be similar pressures in other departments including on the following relevant areas:

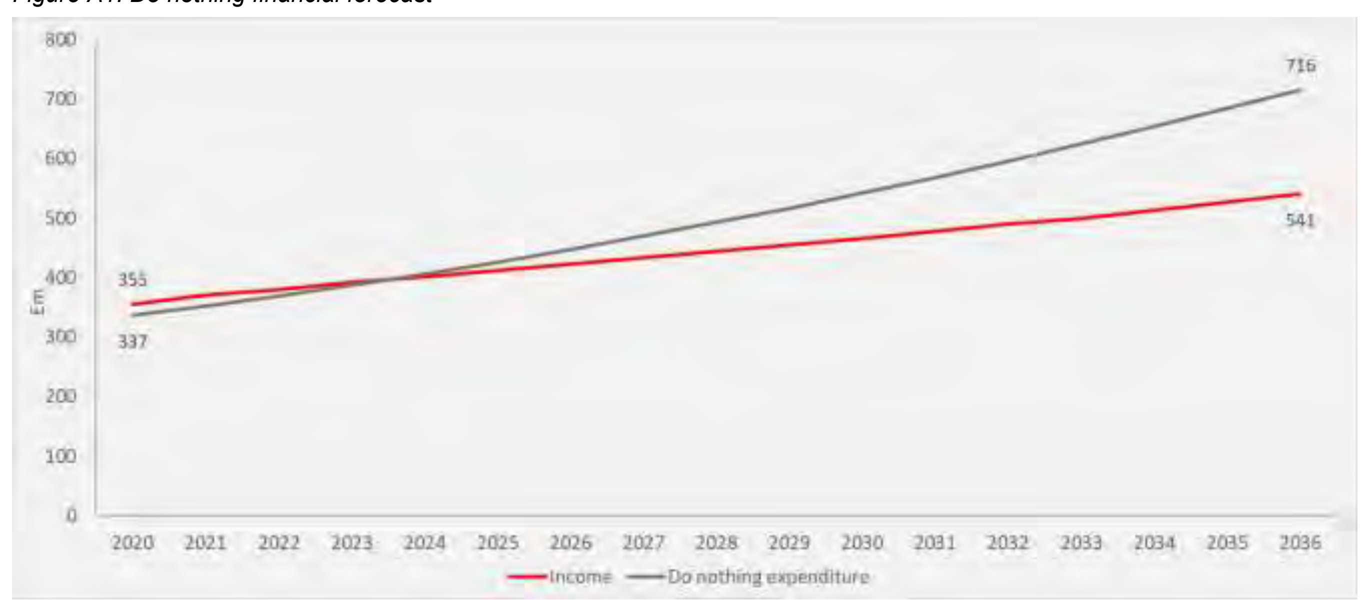
- **Customer and Local Services:** The Long Term Care (LTC) fund and, to a lesser extent, the Health Insurance Fund (HIF) are forecast to face financial pressures as expenditure grows faster than income.
- **Children, Young People, Education and Skills:** Child and Adolescent Mental Health Services are forecast to have a financial pressure of just under £2.5m by 2036.

Addendum

Financial Impact of the JCM (replaces page 120)

Do nothing financial forecast

Figure A1: Do nothing financial forecast



Do nothing financial forecast

Table A1: Do nothing financial forecast

(Income)/expenditure (£m)	2020	2036
Health and Community Services	(234)	(333)
Customer and Local Services	(107)	(182)
Children, Young People, Education and Skills	(4)	(4)
Strategic Policy, Planning and Performance	-	-
Patient/User Contributions	(11)	(21)
Total income	**(355)**	**(541)**
Health and Community Services	234	457
Customer and Local Services	89	230
Children, Young People, Education and Skills	3	7
Strategic Policy, Planning and Performance	-	-
Patient/User Contributions	11	21
Total expenditure	**337**	**716**
Income (over)/under expenditure	**(18)**	**175**

Addendum

Financial Impact of the JCM (replaces page 121)

In total the JCM is forecast to avoid just under £23m of expenditure growth in total for the health and care system by 2036

For each of the changes proposed in the JCM, we have estimated how patient flows will be impacted and then modelled an appropriate change in forecast expenditure.

This includes both areas where activity will reduce (i.e. removing patients from in hospital settings) and where they will increase (i.e. provision of new services to enable the change). On the following pages we will refer to the first of these as 'gross financial savings' and the second as 're-provision costs'. The combination of these two will give the 'net financial savings'.

This approach is summarised in the flow diagram below.

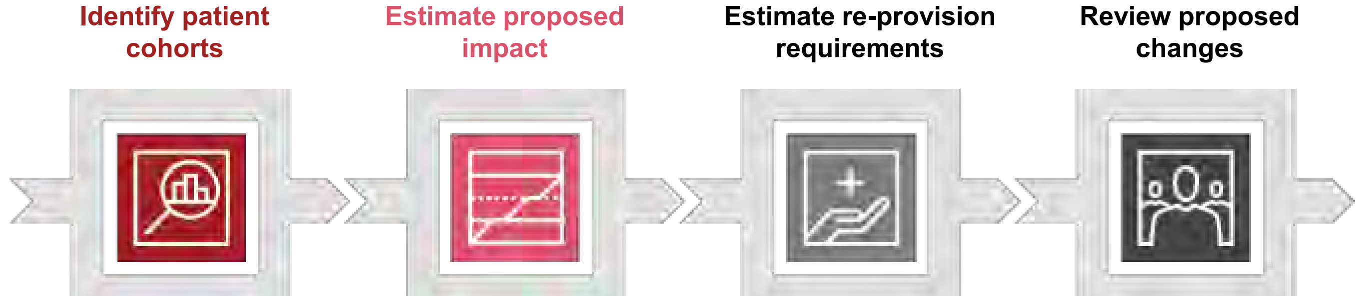
Assumptions associated with each of the proposed interventions

The assumed impacts across all on activity within current care settings are described in table 5.

Table A2: Assumed impact on hospital activity on care areas

Area	Assumed impact on hospital activity
ED	Reduce total ED attendances by 10%
ED	Reduce ED attendances age 65+ by 18%
ED	65% of remaining ED attendances go to the UCC, taken from non-urgent and standard activity
Inpatient	Reduce hospital admission rates by 17%
Inpatient	Reduce length of stay for stranded patients by up to 25 beds
Inpatient	Reduce mental health bed days by 27%
Outpatient	Move Trauma & Orthopaedics (23%), ENT (12%), Ophthalmology (7%), Community Dental Services (90%), Gastroenterology (20%), Podiatry (50%) out of hospital
Outpatient	Move Dermatology (12%), Cardiology (32%), Neurology (30%), General Medicine (35%), Respiratory Medicine (50%) follow-ups out of hospital
Social care	Move residential care placements by 70% and nursing care placements by 46%

Figure A2: Summary of approach



Each change in the JCM was reviewed and an impacted patient cohort (i.e. over 65s) was identified.

Bespoke analyses were then undertaken for each change, estimate the proposed impact in the current care setting. These were reviewed by the Technical Group.

Based on the amount of activity impacted by a change, a reprovision requirement in terms of the new care setting could also be estimated.

The impacts modelled were then reviewed within the relevant Pod focus groups, iterating for feedback where required.

Addendum

Financial Impact of the JCM (replaces page 122)

Estimating the net savings

Through applying the activity change assumptions, making allowances for the fact that some costs are fixed and will not move as activity increases or decreases, we have been able to estimate net savings associated with the proposed changes in the JCM.

These savings are summarised, by tranche (see page 5), in the table below. Overall the changes are forecast to reduce expenditure by £90m per year by 2036 as compared with the 'do nothing' scenario. However, £67m per year of re-provision costs have been estimated to be required in order to deliver these savings. As a result, the net savings associated with the JCM are estimated to be c. £23m per year by 2036.

Non-recurrent investments of £17m (spread over five years from 2021) are required to deliver these savings.

Through implementing the changes proposed in the JCM, the financial sustainability of Jersey's health and care system will be significantly improved

By combining the impacts shown above with the 'do nothing' scenario, we are able to estimate a 'do something' scenario including the impacts of the JCM.

In this scenario, expenditure in the health and care system will be c. £23m lower by 2036. This significantly reduces the affordability challenge in that year to c. £153m. Assuming the system addresses this challenge, system-wide efficiencies of c. 1.8% per year will be required to be financially sustainable. This is in line with the levels delivered in other similar health and care economies.

Table A3: Net (saving)/investment associated with proposed change in 2036

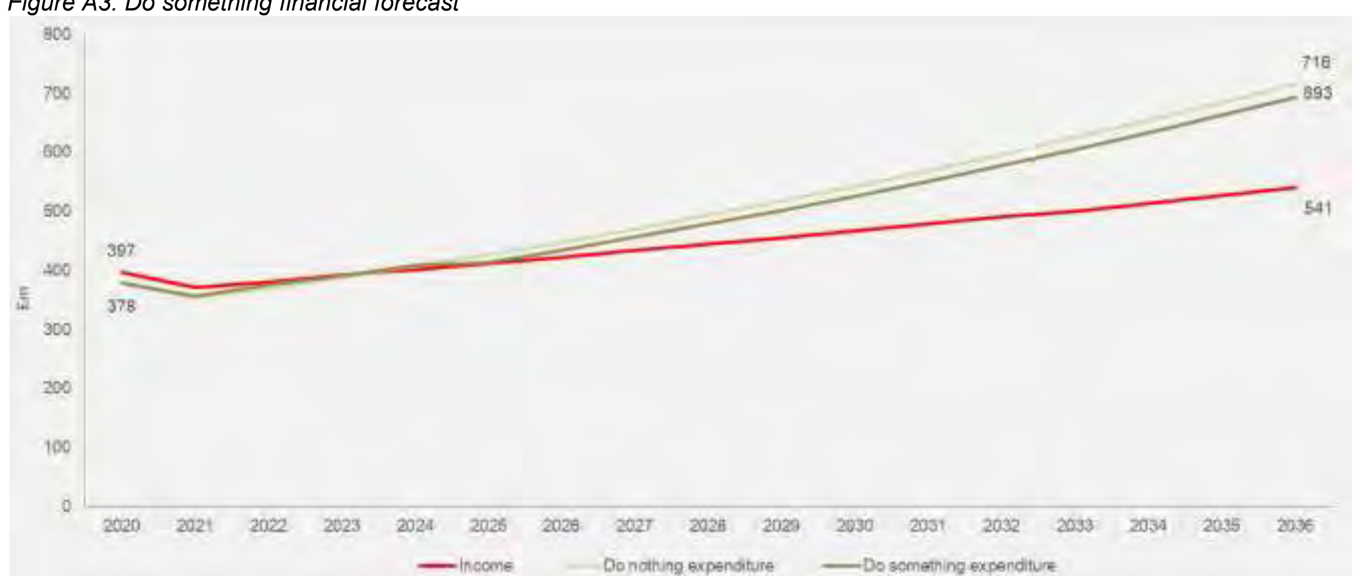
Tranche	Assumed impact on hospital activity	Net (saving)/investment in 2036 (£m)
1	Reduce length of stay for stranded patients over 60 years old by 65%	(6)
	Reduce mental health bed days by 27%	(3)
	Other investments required by tranche 1 of the JCM	2
	Tranche 1 sub-total	**(7)**
2	Reduce ED attendances age 65+ by 18%	-
	Reduce hospital admission rates by 17%	(14)
	Move residential and nursing care placements by 70% and 46% respectively	(9)
	Other investments required by tranche 2 of the JCM	9
	Tranche 2 sub-total	**(14)**
3	Reduce total ED attendances by 10%	<(1)
	65% of remaining non-urgent/standard ED attendances go to the UCC	(1)
	Move Physiotherapy (100%), Trauma & Orthopaedics (23%), ENT (12%), Ophthalmology (7%), Community Dental Services (90%), Gastroenterology (20%), Podiatry (50%) outpatients out of hospital	-
	Move Dermatology (12%), Cardiology (32%), Neurology (30%), General Medicine (35%), Respiratory Medicine (50%) follow-ups out of hospital	(1)
	Tranche 3 sub-total	**(2)**
	Total impact of the proposed changes	**(23)**

Addendum

Financial Impact of the JCM (replaces page 123)

Do something financial forecast

Figure A3: Do something financial forecast



Do something financial forecast

Table A4: Do nothing financial forecast

(Income)/expenditure (£m)	2020	2036
Health and Community Services	(234)	(333)
Customer and Local Services	(107)	(182)
Children, Young People, Education and Skills	(4)	(4)
Strategic Policy, Planning and Performance	-	-
Patient/User Contributions	(11)	(21)
Total income	**(355)**	**(541)**
Health and Community Services	234	438
Customer and Local Services	89	226
Children, Young People, Education and Skills	3	7
Strategic Policy, Planning and Performance	-	1
Patient/User Contributions	11	21
Total expenditure	**337**	**693**
Income (over)/under expenditure	**(18)**	**153**

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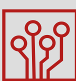
Executive Summary

Executive Summary

Executive Summary (1/4)

The Jersey Care Model is an ambitious new model of health and community care which will support Jersey's future transformation

The Jersey Care Model (JCM) is aligned with internationally recognised best practice examples and addresses issues in the current care model with a fundamental shift to the provision of affordable, safe and high-quality services.



Impact of COVID-19

In the face of the pandemic, out of necessity many of the proposed changes in the JCM have been implemented already demonstrating improved integrated working. Further prioritisation of next steps should be considered in the light of immediate need. As the pandemic occurred as this Review was being finalised, amendments to the engagement process were required as agreed with the Programme Lead.

The JCM review produced a range of findings, which have been considered through four lenses:

1 Overarching model and workstreams

The model reflects international best practice and will form the basis of the future transformation of Jersey's health and community care

- **Overall the model is in line with internationally acknowledged best practice for integrated care**, there are opportunities to build out the proposed changes in the JCM with greater alignment of resources and payment models to support care being handed back to service user
- **There are opportunities to develop areas in the model with further detail,** this includes opportunities across a number of workstreams outlined in the JCM, and integrating additional areas not currently detailed in the JCM, such as Private Care
- **There were some areas identified that need to be repositioned and developed** in further detail to fully implement the change outlined, for example, cancer services repatriation

2 Further JCM enhancements

Further enhancements to the JCM could include preventative care, expansion to alternative settings and Population Health Management (PHM)

- To fully realise the benefits of the JCM, a **PHM approach should be adopted as a key feature** of the prevention agenda, through a risk-focussed approach to care for service users
- The shift to **preventative, patient-centred care and self-care will require significant** investment to realise the benefits of savings, efficiencies and improved health outcomes
- To be a leading model globally, the **JCM will need to expand the care model beyond traditional settings and workforce**, within schools, businesses and urban planning and alternative wellness models can incorporate a wider workforce

Executive Summary

Executive Summary (2/4)

3 JCM enablers

The JCM will avoid expenditure growth and improve the financial position of the Long Term Care fund

- **The JCM is financially sustainable and will not cost more to the consumer.** This is provided that resource allocation, funding models and commissioning arrangements are amended.
- **After investments, the JCM is forecast to avoid £23m per year by 2036 of the expected expenditure growth** for Jersey's health and care system.
- **Feasibility of the JCM rests on an appropriate and sufficient workforce**; a key challenge for the workforce is recruitment and retention across the system, this could be supported by training and development, multi-disciplinary teams, workforce culture and external partners.
- There are further dependencies on a number of capital enablers to realise its benefits, including **digitally enabling a full system transformation.**
- **The model would be further supported by closer working with Guernsey.** In particular by developing shared systems for digital and workforce, key to this will be interoperability of digital systems.

External partners and transition models can help support the decentralised model outlined in the JCM

- The **level of alignment**, commitment across partners will be imperative to achieve the benefits along with a strong cultural shift not only from the health service, but Islanders as well.
- As part of **implementation** planning there is a need to focus on **transition models** while key enablers and new models are being developed and implemented.
- The JCM will only be achieved through progressing a **decentralised care model.** This shift in balance between centralised to decentralised care will be enabled by transformation in digital technology, adequate provision and estates, and importantly, an adequate workforce profile to deliver transformed care.

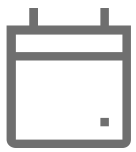
Executive Summary

Executive Summary (3/4)

Building on existing progress there is an opportunity to move rapidly to implementation, with some immediate quick wins

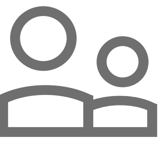
To maintain momentum and implement the JCM at pace, it is recommended that there is a focus on the following 4 key activities:

Implementation planning across workstreams

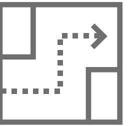


Detailed design planning for clinical services

Establish governance and processes

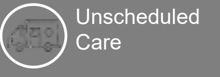


Establish a formalised PMO and processes



Further detail on key considerations, next steps, prioritising and focusing resources can be found in the Implementation Plan. A range of quick wins activities, listed below, can be implemented immediately. To support closer working with Guernsey these could be considered simultaneously across both systems.

Quick wins have been identified across workstream areas:

	Potential 'quick win' areas (1/2)
Mental Health	• Further refine the definition of the Crisis Prevention and Intervention service and undertake further analysis to quantify the full expected impact of the service on inpatient bed configuration. • Consider options for initiatives to reduce ED attendances by high intensity users, reviewing examples of good practice.
External Partners	• Continue to develop the Partnership of Purpose to provide the structure and focus for a new commissioning framework.
Adult Social Care	• Further develop the prevention approach, considering international good practice and successful initiatives from elsewhere. • Explore the potential for partnerships with digital and telecoms providers to provide the assistive technology referred to in the JCM.
Scheduled Care	• Develop implementation plans for increasing day case surgery, reducing procedures of limited clinical effectiveness and undertake further assessment of areas of growth according to island need.
 Unscheduled Care	• Further consider the proposed acute floor model changes when designing a new hospital estate to optimise the delivery of Unscheduled Care services.

Executive Summary

Executive Summary (4/4)

	Potential 'quick win' areas (2/2)
Clinical Support Services	• Further develop a cancer strategy to assess what cancer services can be provided on-island. • Further refine and develop implementation plans to delineate what services, such as physiotherapy services, could be fully provided in the community.
Intermediate Care	• Implement the identified key changes that focus on providing bed-based care, crisis response, home-based care, and reablement services.
Women and Children's Services	• Set out a detailed vision of the future care model for Women and Children's services, in particular working up operational plans to support the proposed changes for women's health. • Work with colleagues in CYPES and Public Health to develop a plan for how HCS, CYPES and Public Health will work together to deliver the changes proposed in the JCM.
Primary Care and Prevention	• Explore broader public health management opportunities with a view to targeting the wider determinants of health.

In conclusion, the JCM is recommended as a suitable model for Jersey, with additional next steps to realise the benefits of implementation

- **The JCM outlines a strong, person-centred approach** to delivering healthcare in Jersey, in line with current trends in healthcare worldwide
- **The proposed integrated care model is likely to deliver enhanced service user experience** and care by streamlining services and workforce resources
- **The model includes a number of priority actions for implementation across the system**, a number of identified key areas will require further development, to facilitate full system implementation of the model

Introduction

Strategic context of the JCM review

- Jersey faces significant health and financial **challenges**
- The **JCM created to tackle these challenges** by **transforming** health and community care through a **patient-centred** approach to care
- A key commitment to Islanders was that this model would be externally 'stress tested'

JCM review approach

- The findings outlined in this report were developed through adopting an **iterative, clinically led approach**
- To structure the review an **Assessment Framework** was used that sought to answer 3 key questions

Outline of assessment approach

- To 'stress test' the JCM, the review sought to answer 3 key questions:
  1. Can the JCM be easily **implemented**?
  2. How **feasible** are the proposed changes proposed by the JCM?
  3. How does the JCM affect the **system** as a **whole**?

Assumptions and limitations

- The overarching objective of this work was to provide an **external perspective** on the **validity** of the JCM
- The review is **not a redesign** of the JCM or development of specific service, hospital or systems strategy

Introduction

Strategic context of the Jersey Care Model Review

The Jersey Care Model addresses the need to transform health and community care in Jersey

In the spring of 2019, the Government of Jersey released a briefing paper outlining a new and ambitious model for the delivery of health and community care in line with leading global practice, the 'Jersey Care Model' (JCM).

Like countries across the world, Jersey faces significant challenges in improving the availability of high quality health and community care within a financially affordable sum. As an island, Jersey faces some unique challenges including diseconomies of scale that create workforce pressures, clinical viability and cost pressures.

Jersey residents are living longer today than ever before. New medicines, better ways of diagnosing and treating illnesses such as cancer, and other advances have improved the life expectancy of Jersey population. But it also means that many islanders require health and care services for longer. In addition to this, 29% of the population have a long-term condition and will require more treatment and care throughout their lives.

The current health and community care model is hospital focused, with a dependency on secondary care for the provision of services. This is evidenced by approximately 30,000 visits to the Emergency Department in 2018 that were not classified emergencies(1). In addition to this inefficiency, there are further acknowledged issues with the current model, including:

- Lack of co-ordination between Primary and Secondary Care services and External Partners
- Limitations in preventative care
- Mental health services are not integrated with physical health services
- Absence of 24/7 help / care for people to access

There is opportunity for Jersey to adapt the delivery of care in order to support the population and future demographic changes

The JCM aims to transform health and community care in order to improve islander's physical and mental health and wellbeing. To achieve this, it proposes adopting a patient-centred approach whereby care is affordable, safe and accessible, being provided in the places where people need it the most.

Under this model, care will be decentralised by expanding primary services and strengthening care based in the community to reduce the dependency on secondary care to develop. Care will be proactive rather than reactive and will put service users at the centre of their own care, directing and providing their care where possible. Technology will also be fully utilised to allow people to manage their own health.

This report outlines the external review, also referred to as a 'stress test' of the JCM; the Review assessed the feasibility of the model

Following the release of the JCM, thirteen public consultation events were held throughout November and December 2019 for residents to find out more about the JCM, voice concerns and ask questions.

A key commitment to Islanders was that this model would be externally 'stress tested' to provide an objective assessment of the validity, feasibility and deliverability of the model with a focus on:

- The proposed model attributes and features, particularly those that represent changes from current service model delivery against an agreed assessment framework
- Interdependencies between areas of care
- Enablers that will support the delivery of care.

This report outlines this review (the Review).

Introduction

Jersey Care Model Review approach

This independent review was completed over an 11 week period

The findings outlined in this report were developed through adopting an iterative, clinically led approach. Working with key clinical stakeholders in Jersey, a five stage approach was adopted (see Figure 1).

To structure our analysis an Assessment framework was applied to the model (see page 20) that was agreed with the respective groups that provided governance over the JCM.

Over 150 key stakeholders were engaged across the Jersey health and community care system as part of the review

Whilst an independent review, it was imperative to have strong clinical engagement to provide context, feedback and oversight of the programme, which is outlined in Figure 2. For more detail on the Clinical Engagement performed for the review see Appendix 8.

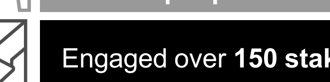
Engagement with local health and care stakeholders was key to this review as they:

- Understand the proposed model and the context within which care is, and will be provided
- Will play a vital role in maintaining momentum towards future implementation of the JCM

Figure 2: Overview of engagement for the JCM Review

Engaged with **representatives** from:
- Government of Jersey
- GPs and Primary Care
- Secondary Care clinicians
- Voluntary and third sector organisations (e.g. Jersey Hospice and Les Amis)

Held **13 workshops** with a positive response and **137 people attending** in total



Engaged over **150 stakeholders** altogether

Figure 1: Five stage approach to JCM review

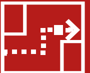
1. Baseline Assessment
- Review existing health and care model
- Identification of key proposed changes in the JCM
- Review of completed public consultation

2. Ease of Implementation Assessment
- Quantitative and qualitative analysis
- Ease of implementation assessment of the JCM with stakeholders

3. Analysis
Building off initial assessment look to test interventions through:
- Quantitative analysis
- Review of 'good practice' models internationally

4. Feasibility Assessment
- Quantitative and qualitative analysis
- Feasibility assessment of the JCM with stakeholders

5. Findings and Considerations
- Reporting of findings through agreed governance structures
- Identification of key considerations to inform initial implementation plan



Note: The five stage approach was tested and approved by external stakeholders through the review's Clinical and Professional Senate and Steering Group

Introduction

Outline of assessment approach

Quantitative and qualitative analysis was undertaken to test the changes proposed in the JCM

The review was structured around the workstreams set out in the JCM. To 'stress test' the JCM, this review sought to address the following key points:

(1) To test the ease of implementing the new model

- How will current service provision have to change to implement this model? What affect will this have on digital, estate, workforce, finance and pathways?
- How significant is this proposed change?

(2) To test how feasible the changes proposed in the JCM are

- Is the model feasible with current service structure? Do we have the capability? Is it acceptable to do so?
- How safe is the model? What is its impact on service user experience and operational efficiencies?

(3) Collation of findings for a whole system review

- Do the workstreams collectively work together?
- Does literature show alternative models that are preferred over that outlined in the JCM?

To help answer these questions, the review has employed quantitative analysis that uses:

- Existing datasets relating to the current and forecast Jersey health and care system (activity, financial, performance)
- Benchmarking from comparable health and care economies
- Bespoke analysis based on specific interventions in the JCM

To answer Question 1, initial analysis was presented to key workstream stakeholders who then agreed on areas where further analysis should be required to help assess the JCM to answer Questions 2 and 3. The results of these analyses are presented in this report.

Figure 3: JCM testing framework, including ease of implementation and feasibility assessment frameworks

JCM workstreams
Mental Health
External Partners
Adult Social Care
Scheduled Care
Unscheduled Care
Clinical Support Services
Intermediate Care
Women and Children's Services
Primary Care and Prevention

Ease of implementation assessment

Focus
Digital
Estates
Workforce
Finance
Pathways and processes

Feasibility assessment

Focus	Description
Capability	Is there capability to implement this recommendation?
Safety	Is this recommendation safe?
Operational Efficiency	Will this recommendation deliver operational efficiencies?
Acceptable	Is this recommendation likely to be acceptable to service users?
Patient Experience	Will this recommendation improve our service user experience?

Assessment against international good practice

Introduction

Assumptions and limitations

Scope of work

The overarching objective of this work was to provide an external perspective on the validity of the JCM.

In scope for this review was:

- Assessment of the JCM in terms of the impact of the proposed changes on current service provision, the feasibility of the model and the necessary requirements to deliver the JCM
- Review of the financial impact of the JCM and the cost of the new model for a service user, as such service users were considered at the centre of the assessment

Exclusions outside the scope of the JCM review

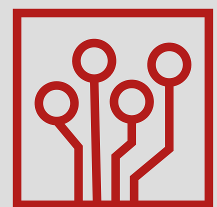
The review of the JCM is not:

- A redesign of the JCM or design of areas that were identified as having potential to be added to the JCM
- The development of specific service, hospital and system strategies (for example cancer, dementia, suicide and adult social care)
- A review of current and proposed care at a service level or the associated development of system or service level implementation plan(s)
- The development of full operational / governance policies that extend beyond the information required to develop the draft Functional Brief
- A business case for potential services to be brought on Island (for example radiotherapy)

Introduction

Assumptions and limitations

Impact of COVID-19



During the finalisation of the review, the COVID-19 pandemic occurred.

Outcomes

A number of key initiatives have already been implemented in response to the pandemic. These have seen a shift to better leverage digital, improve patient access to primary care and minimise reliance on acute services where safe and appropriate to do so.

Project impact

Where possible, measures were taken to minimise the impact on the review and still maintain the integrity of the review. The decision was made to prioritise clinical and management effort to support the COVID-19 response.

Therefore the following measure were taken:

- JCM Workstream Pod Focus Group 2 - Feasibility assessments were undertaken with Pod Leads. Feedback had been received by a broader group of stakeholders in the first round of Focus Groups, and Pod Leads were encouraged prior to the 1 to 1 interviews to speak with colleagues.
- Finalisation of the report was completed with the Programme Sponsor and Chair of the Clinical and Professional Senate, along with the HSC Leads

Examples of key interventions from the JCM that have been implemented in the face of the pandemic:

Primary Care

General Practice

- Pro-active checking of at risk groups underway
- Tele-consultations / Video-consultations underway
- Urgent Treatment Centre (UTC) in Gwyneth Hewlin established
- Workforce models, including single GP practice, to respond to pandemic, and potential GP recruitment on HCS staff contracts being reviewed
- Open book accounting is in place
- Pro-active rescue pack review and re-issue, with wider issue of rescue packs for wider organisations such as Care Homes, and those individuals with different conditions

Pharmacy

- Pharmacies are delivering prescriptions directly to users along with the Jersey Post service

Intermediate Care

- Digital front door through a single number call centre established with CLS services with handoff to HCS if necessary - the equipment and infrastructure is in place.
- Rapid Response delivery with FNHC
- GP lead Community Response team in place to respond to COVID
- Step up and step down preparations have been made, including repurposing Samnow for non-COVID-19 cases

Ambulance Service

- GPs and ambulance service are collaborating for admission prevention, with further equipment and digital setup to be delivered
- Exploring the potential for ED video-calling capabilities

Introduction

Assumptions and limitations

Examples of key interventions from the JCM that have been implemented in the face of the pandemic (cont.):

Unscheduled Care

- UTC operating with pathways established to ED
- ED access redirected via ambulance and UTC only

Scheduled Care

- Elective activity paused with an ongoing review of waiting lists, outpatients and theatres
- Discharge pathways have been enhanced

Women, Children's and Family Care

- Children's Mental Health unit is planned for opening Greenfield
- iPads have been requested for remote antenatal clinics

Tertiary Care

- Unplanned care will proceed only in an emergency

Mental Health

- Changes to liaison service, with community triaging occurring through liaison
- JTT has closed and currently only service users in secondary care
- Listening lounge service provided through telephone and video, with wider video consultations being explored
- Recovery college webinar for whole island is ongoing

Social Care

- Introduction and roll out of new Telecare system
- Enhanced use and coordination of the 3rd/voluntary sector
- Multi-agency safeguarding hub – helpline with some virtual consultations
- Discharge planning seeing more individuals returning to usual place of residence than care homes
- Exploring opportunity to enhance domiciliary care to offer more family/hospitality care
- Investigating CLS personalisation of budgets
- Extension of some voluntary sector services e.g. meals on wheels

Informatics

- Using real time dashboards for key data, Trak, Omni – for test results, care home beds availability and Primary care data

Workforce

- E-rostering, and bank office in HCS to manage all nursing bank/agency staff, and potentially doctors, across the island

3rd Sector

- Increased data capture on workforce, capacity and resource to support additional staffing needs

Overarching findings from the review

Overarching model and workstreams

- The review found that overall the **model is in line with good practice for integrated care** and when implemented, will enhance quality safe and timely care; **benefits can start to be realised immediately**
- Some areas of the JCM are misaligned with its ambition and require further work and detail

JCM enablers

- The model is **financially sustainable** and **will not cost more to the consumer** if **resource allocation**, funding models and commissioning arrangements are amended
- Feasibility of the JCM rests on an **appropriate and sufficient workforce and digital capabilities**

Further JCM enhancements

- The shift to **preventative, service user centred care and self care** is fundamental to JCM, however how this will be systemically delivered is still unclear
- To realise real benefit, a **PHM approach** should be adopted
- To be a leading model globally, the JCM will need to **expand** the care model **beyond traditional settings and workforce**

Assumptions and limitations

- The **level of alignment**, commitment across partners will be imperative
- The JCM will only be achieved through a **decentralised care model**

Overview of the Jersey Care Model

Overall aims of the Jersey Care Model

Objective of the Jersey Care Model

The Jersey Care Model seeks to transform health and community care, delivering affordable, safe and accessible services to people. The model describes the changes to what care should be provided, how and where it should be provided, and by whom.

These changes fall within the aim of delivering on the Health and Community Services' vision:

> *To create a healthy Island with safe, high-quality, outcome-focused, affordable care that is accessible when and where our service users need it.*

The new model looks to move away from the unsustainable institutional-based model towards a more modern community-based system that puts people, their family and home at the centre. This represents a shift to a personalised, coordinated and empowering model of care.

There are three overarching objectives of the Jersey Care Model, which are aligned to the Government of Jersey's strategic priority:

- Focus on prevention and self-care through primary care initiatives
- Reduce dependency on secondary care through expanding primary and secondary care services
- Redesigning health and social care to meet current and Jersey's future needs through community partnerships

In order to achieve patient-centred care, there will be an increased focus on primary care and community partnerships alongside preventative care. This will be supported by self-care and education initiatives which will utilise technology to enable people to look after themselves more effectively.

To deliver patient-centred care the model aims to expand primary and community services with the intent of refocusing service delivery models and support sustainable secondary care services. Where possible services currently within the hospital will evolve to be more community focussed.

Additionally, the model will redesign Health and Community services so that they are structured to meet the current and future needs of Jersey's population. There will be a focus on community partnerships, an improvement in signposting and coordination between services. Furthermore, tertiary services will be developed to provide specialised treatment for Jersey. Ultimately, through effective collaboration across the system as outlined in the JCM, rather than across silos, it is anticipated that health outcomes will improve.

Top 10 benefits of the JCM that were identified through the Review:

1. Supporting people to live independently at home by offering integrated, community services
2. Developing and strengthening partnerships between primary and secondary care with External Partners to prevent duplication of services. Additionally, developing partnerships off-island to provide joint specialist services
3. Innovative care delivery through digital solutions and services
4. Repurposing existing estates and form strategic partnerships with parishes
5. Streamlining current pathways and processes, particularly in relation to referral management for long-term conditions
6. Removing barriers to access for vulnerable service users through re-modelling funding structure
7. Reducing and delaying people's need for care, through investment in preventative services
8. Developing new ways of providing services, for example, development of an Urgent Care Centre, and where possible, exploring the expansion of existing services
9. Expanding existing crisis-response services to lower avoidable inpatient admissions
10. Improving children's health through a number of initiatives supported by public health

Key findings of the JCM review

Overarching findings

There are 12 key findings from our review

The JCM review was conducted through four lenses:

- **Test the workstreams as outlined within the JCM** – this was carried out using the JCM testing framework (see page 20) to assess ease of implementation and feasibility with key stakeholders, supported by quantitative analysis
- **Assess the enablers supporting the model** – review cross-cutting themes relating to the infrastructure, resources and supports that sit across all workstreams e.g. digital, workforce, estates
- **Assess challenges and enhancements** – identify opportunities to develop the JCM
- **Identify recommendations for implementation** – define key features and changes required to progress the JCM to implementation

Key finding from the JCM review:

- Overall the model is in line with good practice for integrated care and will improve the quality of care and health outcomes; these benefits can be realised immediately after implementation
- The review outlines a series of recommendations to progress the development of key workstreams in the JCM, further detail for which can be found in the body of the report

1 – Overarching model and workstreams

1. Overall the **model is in line with good practice for integrated care** and when implemented, will enhance quality safe and timely care; **benefits can start to be realised immediately**
2. There were some areas identified that were **misaligned with the ambition** sought and may need to be repositioned
3. There is still **further work** required to **detail the model** within a number of workstreams

2 – Further JCM enhancements

4. The shift to **preventative, service user centred care and self care** is fundamental to JCM, however how this will be systemically delivered is still unclear; it will **require significant investment**
5. To realise real benefit, a **PHM approach** should be adopted
6. To be a leading model globally, the JCM will need to **expand** the care model **beyond traditional settings and workforce**

3 – JCM Enablers

7. The model is **financially sustainable** and **will not cost more to the consumer** if **resource allocation**, funding models and commissioning arrangements are amended
8. Feasibility of the JCM rests on an **appropriate and sufficient workforce**; enabling the JCM may require significant changes
9. There are further dependencies on a number of **capital enablers to realise its benefits**, including **digitising full system transformation**

4 – Progressing to implementation

10. The **level of alignment**, commitment across partners will be imperative to achieve the benefits along with a strong cultural shift not only from the health service, but Jersey inhabitants
11. As part of **implementation** planning there is a need to focus on **transition models** while key enablers and new models are being developed and implemented
12. The JCM will only be achieved through a **decentralised care model**

Key findings of the JCM review

1. Overarching model and workstream

Key findings

1. Overall the model is in line with good practice for integrated care and when implemented, will enhance quality safe and timely care; benefits can start to be realised immediately

Increasingly across the globe, health and care economies are shifting to integrated care models

Integrated care is defined as a care model that combines processes, methods and tools across a number of disciplines and/or agencies. There are many exemplars that can be cited to demonstrate the strong benefits of clinical, quality and financial sustainability, as well as improvement in service user experience of health and care.

Integrated care models come in a range of shapes and sizes. The Kings Fund (2010)[2] outlines four different forms of integration (see table 1).

	Typographies of integration
Organisational	• Integration of organisations are brought together formally by mergers or through 'collectives' and/or virtually through coordinated provider networks
Functional	• Integration of non-clinical support and back-office functions, such as electronic patient records
Service	• Integration of different clinical services at an organisational level, such as through teams of MDTs
Clinical	• Integration of care delivered by professional and providers to patients into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols

Table 1: Four different forms of integration, The King's Fund

In addition, integration can be seen as horizontal (with peer or like services) or vertical (with services that connect with others as a part of a service user pathway).

The Jersey Care model is aligned with internationally recognised good practice by adopting similar principles that underpin the model

With such international variation, it is difficult to call out one or multiple exemplars against which the JCM model can be assessed. As found in benchmarking for this review, Jersey is unique in its size and the support that is in place.

To this end, it is important that the integrated model adopted for Jersey is not a copy of another model but is instead tailored to the environment it will operate within. Examples of health system's adapting integrated care delivery to their environment can be found below:

- **Demographic** – the make up of the population, its size and age. The UK Integrated Care Systems have adopted sub-structures within an integrated model to respond to the large size of populations, which differs to Jersey and the size of its Parishes
- **Political** – the structure of the political system and decision making. For example, the local government in the Spanish Alzira model had the ability to direct a new service model across a discrete geography, unlike in Australia where there is a three tier government system responsible for policy over different parts of the health and care system creating variation between States
- **Funding models** – how health and care is paid for. Models such as those in the US and Scandinavia reflect the insurance payment models, unlike those in the UK, which is public
- **Geographical** – climate, geography and workforce mandate different models. For example, models in Canterbury New Zealand will differ to those that are appropriate in The Netherlands

Key findings of the JCM review

1. Overarching model and workstream

Key findings

The key underlying principles for the best practice identified by the literature are in line with the JCM

The JCM review identified core principles that should underpin a good integrated model using learnings from different systems (see Figure 4). The JCM ambition, principles and proposed state are aligned with these features.

The JCM outlines a shift in care delivery so that the service user is at the centre of the new model. This is in line with internationally recognised good practice that is held as the baseline for integrated care models. This is shown in Figure 5, where integrated care aims to focus its attention on the service user as seen in the JCM.

The JCM should place greater emphasis on the need to align resources to support the shift in care delivery back to the service user

The starting position in the JCM should be to encourage self-care. To do so, resources and support services will need to be re-positioned to promote self-care. If this is not possible then peers, family/ carers and the community should be empowered to support service users promote care. When necessary the next level of support will be through primary care, escalating to enhanced community care as needed. Acute and bed-based care should be seen as the last option where the alternatives have been exhausted.

Where a higher level of acuity is required there should always be a consistent focus on re-assessing alternative step-down options where appropriate. Therefore, recognising a person's needs and level of support will be dynamic. Ultimately, the focus will always be on moving the service user back down the levels of acuity where possible.

Whilst this model feature is implicit in the JCM (i.e. the focus on reducing inpatient stay), detailed design should not lose sight of its importance in radically shifting the allocation of resources as set out in the aims of the JCM. This will prove significant in the ultimate implementation of the JCM.

Figure 4: Integrated care principles

Integrated Care Principles
6 levers seen in optimal integrated care models

Manage the flow of people to the right resources
Understand and actively manage the population
Multiple conditions and complex needs supported by multiagency teams
Support community professionals with resources from the acute
Actively diverting people to the most effective & efficient access points
Actively promoting self care, self service and developing community assets

The integrated care model outlined in the JCM is in line with international best practice, where the services user is at the centre of the model.

Figure 5: Service user at the centre of care model

Self Care
Community Care
Bed Based Care
Promoting & managing health & wellbeing
Community empowerment & reintegration
Planned care
Urgent response & unplanned care
Maintaining independence at home
Enhanced services away from home
Enhanced primary &community care

Key findings of the JCM review

1. Overarching model and workstream

Key findings

From our review and engagement with stakeholders it is clear that this is the optimal model to deliver care

As a part of our review, we worked with stakeholders within the workstreams to assess the ease of implementation and feasibility of the JCM across the 69 'interventions' or changes that are proposed. As Table 2 shows, in our feasibility assessment of the JCM, there were strong results regarding the appropriateness of the model on:

- **Safety** – is this safe
- **Operational efficiency** – will this deliver efficiencies
- **Patient experience** – will this improve the service user's experience of care

Low / *Moderate* / *High*	Safety	Operational efficiency	Patient experience
Mental Health*	-	-	-
Adult Social Care	*Moderate*	*High*	*High*
Scheduled Care*	-	-	-
Unscheduled Care*	-	-	-
Clinical Support Services	*Moderate*	*Moderate*	*Moderate*
Intermediate Care	*Moderate*	*Moderate*	*High*
Women and Children's Services	*High*	*High*	*High*
Primary Care and Prevention	*High*	*High*	*High*

** Assessment was completed by intervention or change overall not by each attribute, therefore result not able to be put into the model in this form*

Table 2: Feasibility assessment framework

Overall it was felt that there was a high and positive impact on these key areas; moderate scorings were often the result of:

- Concern over the workforce or other resources required to facilitate the new model
- Expectation that the change is so significant that service users may not, in the initial stages respond well to the change

Further analysis completed within this review showed that through these models there will be improved timely access to care and ultimately, the JCM will achieve financial return.

Barriers should not preclude progressing with implementation, as a number of areas could start transitioning to the new model immediately

While this model represents full system change, there can be some trepidation on where to begin the change.

From our experience working with other integrated systems we know that it is important to 'double run':

- Identify areas that present 'quick wins' to kickstart the transition to the JCM and build confidence in the model through positive outcomes
- Start immediately on the systemic changes, infrastructure and investment in resources that may take time

The JCM highlights a number of key activities relating to strategies and further planning that is required. While this is important, stakeholders also identified a number of key initiatives, or 'quick wins' as outlined in Table 3.

To continue the momentum, it is recommended that an agile prioritisation and programme management approach is adopted to support clinical teams to continue the momentum and move at pace.

The JCM represents the optimal model to deliver healthcare in Jersey and there are a number of areas that could start transitioning to the new model immediately.

Key findings of the JCM review

1. Overarching model and workstream

Key findings

	Potential 'quick win' areas
Mental Health	• Further refine the definition of the Crisis Prevention and Intervention service and undertake further analysis to quantify the full expected impact of the service on inpatient bed configuration • Consider options for initiatives to reduce ED attendances by high intensity users, reviewing examples of good practice
External Partners	• Continue to develop the Partnership of Purpose to provide the structure and focus for a new commissioning framework
Adult Social Care	• Further develop the prevention approach, considering international good practice and successful initiatives from elsewhere • Explore the potential for partnerships with digital and telecoms providers to provide the assistive technology referred to in the JCM
Scheduled Care	• Develop implementation plans for increasing day case surgery, reducing procedures of limited clinical effectiveness and undertake further assessment of areas of growth according to island need.
Unscheduled Care	• Further consider the proposed acute floor model changes when designing a new hospital estate to optimise the delivery of Unscheduled Care services.
Clinical Support Services	• Further develop a cancer strategy to assess what cancer services can be provided on-island • Further refine and develop implementation plans to delineate what services, such as physiotherapy services, could be fully provided in the community
Intermediate Care	• Implement the identified key changes that focus on providing bed-based care, crisis response, home-based care, and reablement services
Women and Children's Services	• Set out a detailed vision of the future care model for Women and Children's services, in particular working up operational plans to support the proposed changes for women's health • Work with colleagues in CYPES and Public Health to develop a plan for how HCS, CYPES and Public Health will work together to deliver the changes proposed in the JCM
Primary Care and Prevention	• Explore broader public health management opportunities with a view to targeting the wider determinants of health

Table 3: Potential 'quick win' areas

Key findings of the JCM review

1. Overarching model and workstream

Key findings

2. The review identified some areas of the JCM that were misaligned with Jersey's ambition for health and community care

As part of the Review, the changes within the delivery of care were assessed against the overarching principles of the JCM. In several instances, there were misalignments between the outcome of the identified change and the aims set by the JCM.

Increasing cancer services on-island will need further development to understand the impact on efficiencies and workforce.

The JCM outlines the aim to strengthen the connection to tertiary specialist services, with the aim of repatriating activity in a range of services, including cancer care. The JCM additionally outlines that cancer services need to be more prominent on-island, and a cancer strategy needs to be developed.

The cancer strategy development, indicated as needed in the JCM, is currently in progress, with development of governance structures to oversee the set-up. Stakeholders from focus groups identified that the development of the cancer strategy may include bringing services back on-Island, as opposed to the current provision of cancer care with multiple specialist hospitals in the UK.

There was a mixed outcome in the assessment of the feasibility of this change based on the divergence in opinion of the potential to realise operational efficiencies and the potential impact on service user experience. In particular, the review highlighted that repatriation of cancer services will require:

- A corresponding specialist workforce to deliver these services
- Significant public engagement to evaluate the described change

There were challenges identified as to which cancer services could be repatriated.

Benefits and challenges related to the repatriation of cancer services:

Potential benefit of increasing the repatriation of on-island cancer care
Bringing cancer services back on island could potentially support service user experience, such as improving the ability to provide personal care closer to home.

Potential challenge of repatriating cancer care
Currently, paediatric oncology cases are sent to Southampton General Hospital, part of the Wessex Children's Cancer Network. Evidence suggests that cancer treatment performed in a network of dedicated providers for cancer care has better quality of care, along with the benefit of peer support through treatment in a network.

Moving forward, to develop the JCM, further analysis should be completed on the model of repatriating cancer activity to Jersey and expanding the range of services delivered on island.

There is a risk to service user quality and safety, service user experience and financial sustainability of the model if activity levels result from diseconomies of scale. It is highly recommended to develop a cancer strategy that has a comprehensive assessment of the profile of services that could be made available on-island, supported by an adequate specialist workforce.

More detail on the assessment of cancer services is available in the Clinical Support Services review

Key findings of the JCM review

1. Overarching model and workstream

Key findings

3. Whilst the vision of the JCM aligns with international good practice, there is still further work required to detail the model within a number of workstreams

While the principles and ambition of the JCM are in alignment with good practice models seen internationally, there is still further work required to explain how this model will work in practice.

Ultimately the 'devil is in the detail'; the feasibility and deliverability of the JCM is in the finer detail of the model. Many health and care economies have struggled to clearly articulate how their models will work. This has led to poor implementation of these models as it can result in misalignment, inappropriate resource allocation, and competition that result in overspend and underachievement of outcomes.

It is not expected that the JCM would be able to articulate every component part of the model; this would create a significantly complex and unmanageable model that would not be able to sufficiently flex to new practice, technologies or external changes.

However, there are some areas within the model in which we would suggest further work is completed.

Integrated care hubs

The future model of scheduled care is predicated on the existence of integrated care hubs, however a clear definition of what an integrated care hub model would look like in Jersey is absent from the JCM.

It is important to provide further clarity on the integrated care hub model as it represents a substantial change from current service delivery, but without a clear definition, it is difficult to assess whether it is financially or operationally practicable, or what the impact on service user experience may be.

Further clarity is required in a number of areas:

- A specification of which services will be provided through the hubs is needed
- A clear vision of how service user pathways will be reconfigured from the existing centralised model
- Further consideration should also be given to the potential impact on staff productivity of a decentralised model and implications on workforce requirements.

A review of potential funding models is needed, as significant changes to the existing model will be required to incentivise outpatient care in community settings and support integrated working between primary and secondary care.

Urgent care centre

The creation of an urgent care centre (UCC) is central to the envisaged future state of secondary care in Jersey, however it is not clearly articulated what exactly an UCC would entail, beyond the fact it would manage non-urgent and standard activity.

Further modelling is needed to ascertain a realistic view of how many Emergency Department (ED) attendances could be redirected to an UCC. The proportion of ED attenders who could be redirected to an UCC is dependent not only on case acuity patterns in Jersey, but on the proposed staffing model and size of the UCC, both of which also require further definition.

Future funding and payment models should also be considered as a significant restructure of funding mechanisms is needed to support the redirection of a proportion of low acuity activity to primary care. The current funding model incentivises ED attendance over primary care, in particular for clinically, financially or socially vulnerable service users.

Key findings of the JCM review

1. Overarching model and workstream

Key findings

Stakeholders also highlighted that further consideration should be given to the development of effective triage processes, onwards pathways to other services, and 24/7 access to diagnostics, in order to effectively implement this change to the secondary care model.

Women and Children's services

A substantial amount of further detail is required in order to understand the proposed future model of care for Women and Children's services.

Currently, there are no changes set out which are specific to women's health services. Stakeholders had a number of proposals for the future state of the model, such as:

- Providing more gynaecology care in the community
- Improving ambulatory care to reduce acute admissions.

Further detail is needed to clearly articulate what the future model looks like, how it will work in practice, and what the implications are for enabling factors such as workforce, estates and pathways and processes.

The JCM contains slightly more detail around children's health services. High level references are given to the need for integrated primary and secondary care, the development of transition pathways, and timely access to mental health services. However, the only specific ambitions outlined for children's health are four targets taken from the Children's and Young People's Plan.

As with women's health, much more detail is needed to understand what the ambition is for the future delivery of paediatric services, as well as a clear articulation of how this will work in practice.

Primary Care and Prevention

The JCM highlights self-care as central to the Government of Jersey strategic priority to improve the population's mental and physical wellbeing. It is referred to frequently across multiple JCM workstreams, and particularly in Primary Care and Prevention. Whilst a glossary definition of self-care is given, a clear articulation of what self-care initiatives might be implemented and what this looks like in practice, is missing from the JCM.

Further consideration needs to be given to the most appropriate payment model to incentivise prevention and self-care, as this is not incentivised currently.

The JCM sets out a strategic aim to promote resources that help citizens with self-care. However, a significant culture shift is needed to encourage people to self-care and self-manage their health rather than rely on clinical intervention, and how this will be addressed is not set out in detail in the JCM. This is vital, as public health education and culture change will play a key part in promoting self-care.

Clinical Support Services

The JCM sets out a broad ambition for future clinical support services to include increased clinical investigations capacity and more 'near testing' capability. It also states that cancer services need to be prominent and a cancer strategy for the island is needed.

The ambitions set out for clinical support services and cancer are broad and lack detail on what the operational implications are for the future model.

Analysis is required to understand current clinical investigations capacity, as well as what the projected future need will be, given wider changes to the model of care in Jersey. Current workforce capacity limitations are well-known within the service, and

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1. Overarching model and workstream

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difficulties with recruitment and retention are limiting factors to the expansion of the service. The investment required for procuring more high-cost equipment is also substantial.

Further detail is required on what the model would look like, beyond the suggestion that more cancer services could be repatriated to Jersey in the future. Without a supporting cancer strategy, understanding what is feasible, achievable and recommendable in terms of cancer provision on the island is extremely difficult. It is understood from the review process that work is underway to develop a cancer strategy, which is due for publication in November 2020.

Integrating opportunities identified in public health and private service user services

In the review a number of opportunities to support the JCM were identified in both public health and private service user services. Further work and collaboration with the public health team and private service user committee is recommended to integrate the proposed recommendations and initiatives into the JCM.

Consideration should be given to whether all of the recommendations are appropriate for Jersey, and where they are deemed to be appropriate, how best to operationalise and implement them.

The recommendations for private service users are set out at a high level below:

- The model should incorporate private care services – this would provide an opportunity to realise financial benefits and create efficiencies through reducing demand on public services
- This would require significant culture change as private services are not widely accepted by the general public, and opportunities for attracting new private business are not well developed
- Consider opportunities to use private beds for ED service users, rather than ring-fencing exclusively for surgical procedures
- Review opportunities to expand private service user income, such as: engagement with insurance companies; expand market offerings for short procedures; embrace technological advances such as confocal imaging; offer one-stop clinics; offer a general wellness package for Government; offer women's health packages
- Key workforce could open up revenue opportunities in both public and private healthcare – for example, hiring a radiographer could facilitate expansion of cardiac CT, and offer a new cardiac MRI service.

A summary of the recommendations from the public health team can be found in the following pages on prevention and public health.

The JCM outlines a number of key opportunities to improve the health and care experience of Jersey's population, for these to be realised more detail is required to progress to implementation

The vision set by the JCM is to deliver safe, high quality care that is outcome-focused and accessible at the point of need. The changes proposed by the JCM offer a means of achieving this vision through implementing measures, such as an integrated care hub and an Urgent Care Centre, as well as strengthening services, such as Women and Children's and Primary Care and Prevention. Whilst promising, to be successful through to execution these measures will require more detail on their specific implementation needs including, but not limited to, their workforce, estates and financial resource requirements.

> The JCM outlines a number of opportunities that could positively impact on service efficiencies and outcomes, however for these benefits to be realised further work is needed to detail the requirements for these opportunities to be made a reality.

Key findings of the JCM review

2. Further JCM enhancements

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4. The shift to preventative care is fundamental to the JCM, however how this will be systemically delivered is still unclear; it will require significant investment

Leading health and community care models have a key focus on prevention with the intent that 'prevention is better than cure'. The 'Prevention First' approach can affect healthcare spend and population health outcomes by lowering the need for services. It is internationally recognised as cost-effective and has been evidenced in other systems (Figure 6)[3].

Figure 6: Resilient Together[3] is a 3-year community building project developed and delivered by Cambridgeshire, Peterborough and South Lincolnshire Mind. It focused on two communities in Cambridge with the aim of improving wellbeing and resilience. Resilient Together used an asset-based community development (ABCD) approach to bring people together using their existing knowledge, skills and lived experience to achieve positive change. Initiatives included resident-led activities, community groups, community based mental health awareness stalls and the formation of a national network of ABCD practitioners. The project empowered people to get involved with their community, and evaluation showed a statistically significant improvement in levels of wellbeing and resilience amongst participants.

The JCM sets out a priority for preventative services, which aligns with broader Government policy

Preventative healthcare is a priority for Jersey as outlined in the Government Plan, which brings a new focus on wellbeing through the 'Health and Wellbeing Policy Framework'. This Framework focuses on sustainable wellbeing; a holistic, integrated approach to measuring how Jersey is performing across three domains:

- community wellbeing
- environmental wellbeing
- economic wellbeing

Whilst the shift to preventative care outlines a huge opportunity for Jersey, the Framework outlined in the JCM is not consistently embedded in each workstream

As it stands there is no one workstream dedicated to prevention, instead it sits within the Primary Care and Prevention workstream. Whilst primary care will play an important role in driving the prevention agenda, it would be too simplistic to align prevention solely to the Primary Care workstream. To do this would ignore the broader opportunities for prevention initiatives outside of health and care system in Jersey. For example, initiatives that target social inequalities and the wider determinants of health and wellbeing. To achieve this, a whole-island, system-wide approach needs to be taken to enable joined-up thinking about preventative measures.

In addition to the identified considerations, the prevention programmes listed in the JCM are predominantly medicalised and are not exhaustive (Figure 7). While these programmes are commonly seen in other systems, there is limited information within the JCM as to why these programmes were selected or prioritised over others and, except for MECC, how they would be implemented.

Figure 7: Key prevention activities outlined in the JCM

- Pneumococcal Vaccination programme
- Expand smoking cessation to practice nurses
- Dental caries prevention for children
- Five yearly Health Check for all those aged 40-74 including screening for alcohol and tobacco use, hypertension, obesity, cholesterol, diabetes, depression with appropriate follow up
- Make Every Contact Count (MECC) using every interaction to promote healthy living

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The prevention agenda should not be limited to the list provided. There are other opportunities for preventative measures throughout workstreams, for example:

- **Women's Health**: Establish a pre-conception service for service users with pre-existing conditions – to reduce and prevent health complications for mother and child during pregnancy and beyond
- **Children's Health:** Establish nutrition education initiatives to support children to maintain a healthy weight – to reduce childhood obesity and prevent health complications in later life such as cardiovascular disease and diabetes, both of which are prevalent in Jersey
- **Mental Health:** Establish a 24/7 Crisis Prevention and Intervention service – to provide more support in the community, reduce the number of people reaching crisis point, reduce risk and increase the chance of early recovery for those in distress

Working with public health will support benefits realisation, whilst helping deliver on government policy

In discussions with the HSC public health team, a number of additional opportunities regarding preventative health measures were identified. These should be further considered in the development of the JCM, and include:

- Embedding brief intervention as part of triaging assessment and sign posting which could be included as part of the generic health assessment
- Developing health literacy before, after and during care, to promote service user understanding of and planning for their own needs and how to stay well
- Increasing access to primary care for the financially vulnerable, aligned with preventative approaches, would reduce pre-disease risk factors that escalate to more costly complicated disease outcomes
- Embedding the principle of recovery and hope through personalisation of care supported by social prescribing and digital support
- Developing a more pro-active offer of key protective factors combined with services and community support to get ahead of mental health problems developing and / or escalating
- Directing some health visiting and school nursing capacity to support existing strategic commitments, particularly around preventative early years programmes such as nutrition and dental health

Embedding preventative health in the future JCM will prove challenge as it will require significant financial investment

Moving to a preventative model will require significant upfront investment in both preventative initiatives and their associated engagement and public to support high uptake of the programmes and healthy behaviours. Adding to the cost of implementation is the necessary investment in digital solutions to support integration of preventative health across the whole system. Despite these high costs, preventative health is widely regarded as a cost-effective means of improving population health. Ultimately, Jersey will need to consider funding options and cost-benefit before implementation.

Outside of funding, Jersey could consider an alternative payment mechanism to support the shift to preventative care. The current GP payment mechanism is volume driven. If Jersey were to move to a capitated system and expand fee for service activities to community pharmacy, this can incentivise prevention, in turn keeping healthcare costs down and supporting the integration of care.

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Building on the prevention agenda, there is further a opportunity for the JCM to achieve real gains through a focus on driving service user centred and led care. This is encouraged by the ageing population and increasing prevalence of long term conditions.

Self-care is defined by the World Health Organization (WHO) as "the ability of service users, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider". It is a broad concept which encompasses hygiene, nutrition, lifestyle, environmental factors, socioeconomic factors and self-medication[4].

Self-care operates across the continuum of health care management, from wellness to maintenance of a long term condition. In doing so, it supports the redirection of care delivery away from traditional settings of primary and secondary care and into service users' homes.

To successfully empower a service user to improve their health through self-care requires:

- Education to build health literacy
- Support with alternative technology and devices

Figure 8: WHO conceptual framework for self-care[5]

This is guided by the WHO's conceptual framework for self-care, which sets out a number of layers that must be in place to establish effective self-care (Figure 8). These include:

- **Places of access** – both physical and digital
- **An enabling environment** – e.g. a trained health workforce, supporting laws and policies
- **Accountability** – health sector, private sector, government, social and service user

The WHO also states that "meaningful community engagement where self-care is championed and advocated by service user groups is also an essential factor in the success of linkage to care".

In the Jersey context, digital access, community engagement and supporting policies will be key to effectively implementing a self-care led, preventative model. Jersey is well positioned to capitalise on its digital capabilities but a whole-system, innovative approach is needed to truly harness this opportunity.

Community engagement will be key to success, as encouraging independence and moving away from a reliance on traditional health and care structures requires significant culture change.

As previously mentioned, appropriate funding mechanisms will need to be in place to incentivise preventative health, and the associated supporting laws and policies will first need to be in place to allow this.

Whilst self-care is placed at the heart of the JCM, how it will be delivered is not detailed

In the workstreams, self-care is mentioned at a high level as seen below. Detail on how this will be delivered, or the expected outcomes, is missing.

- **Primary Care**: Innovate and promote resources that help citizens with self-care; secondary care admissions will be minimised through self-care of long-term conditions; self-care will be encouraged through service user facing applications

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- **External Partners**: The 'Closer to Home' initiative builds on existing strengths and supports self-care and prevention
- **Adult Social Care**: Personal budgets can be used to support independence and support people in their own homes
- **Mental Health**: Person-centred care is at the heart of the transformative process and is the means by which people are helped and supported as an equal partner in their own care to recover and regain their usual life
- **Children's Health**: We will increase education events for service users and families so that they can learn how to stay healthy

Digitising the system can help realise the full benefit of self-care in Jersey

In health and care systems where self-care is prominent, digital front doors help redirect service users who would traditionally present to primary or secondary care services to self-care models.

A digital front door is defined as a "digital platform that enables access to end-to-end healthcare services, from initial contact to diagnosis and treatment, by providing services such as digital consultations, managed prescriptions and a personal health record"[(6)].

For Jersey, a digital front door could not only reduce unnecessary attendances but also address the issues regarding staffing.

Implementing a digital front door can deliver a number of benefits to a health and care system, including:

- A secure and accessible platform for an ecosystem of partners to support health innovations
- Supported decision making for service users including self reporting and home monitoring
- Potential access to medical records for citizens to support self-care strategies
- A greater data source for targeted interventions to improve health across populations.

There are a number of digital tools and models that can support self-care in Jersey

The examples of good practice below are not exhaustive, and further consideration should be given to the most effective and feasible model for Jersey.

Improving health literacy through digital mechanisms:

In West Wakefield, a **care navigation app**[(7)] provides a logical decision tree to help people find the most appropriate service based on their answers and self-evaluations. This has reduced the number of unnecessary GP appointments and increased use of other initiatives, such as Physio First.

In Victoria, Australia, the **Better Health Channel**[(8)] is an easy to use health portal that can direct to healthy lifestyle advice, answer questions and redirect to other services.

Health monitoring through digital mechanisms:

Vitality Life UK[(9)] is a health insurance provider who offer clients incentives for making healthier choices. Activity trackers log daily exercise and help clients to earn points that can be redeemed for prizes. Customers are also offered discounts on gym memberships and exercise equipment.

Self-management rehabilitation:

The **Holland Orthopaedic & Arthritic Centre app**[(10)] is a mobile app used to self-manage recovery and rehabilitation following a hip or knee replacement. It gives reminders leading up to surgery and a daily check in to track progress after surgery, as well as access to exercise videos. The centre uses data to gain insight on how people recover to help them continuously improve the service.

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5. To realise the full benefit of the JCM, a Population Health Management (PHM) approach should be adopted

Population Health Management (PHM) is an approach to using data from across the health and care system to segment the population according to their risk profile, and proactively identify where interventions may prevent that level of risk escalating.

Rather than taking a disease focussed view (e.g. identifying those with diabetes in the over 65 age group), PHM allows a more nuanced view of risk as it takes into account a wider selection of data points.

In order to implement a PHM approach across the system, there are three areas that should be considered: infrastructure; intelligence and interventions.

- **Infrastructure** includes getting the correct leadership, governance, strategy and vision in place; building the correct data infrastructure, understanding information governance requirements; and assessing local capability and capacity
- **Intelligence** includes segmenting the population into distinct but manageable groups; stratifying the population; impact modelling; using analytical techniques to identify groups to target; developing an approach to data analytics for planning as well as interventions
- **Interventions** aspect includes both identifying clinically sound intervention for targeted groups, but also implementing a change management approach across Jersey which allows for clinicians to use and understand continuous quality improvement approaches based on data. This should also involve service user activation approaches, coaching and support for carers

Jersey has made some progress towards moving towards a PHM enabled model, although there is more to be done

The Island's 2015 Sustainable Primary Care Strategy identifies the need to stratify the population's risk based on Kaiser Permanente's model, which uses cost (and so utilisation of health services) as a proxy for risk. It also goes some way to identify the prevalence of multi-morbidities and the importance of a differentiated approach to long term condition management based on current risk.

In addition, the Jersey Digital Health and Care Strategy sets out the intention to move towards a Jersey Integrated Care Record, which would collate information about the service user across multiple settings and in real time. In addition, there is an aspiration to supplement the Jersey Care Record with additional data and insight that service users can provide, e.g. via wearables. While this is some way off, it demonstrates the aspiration of the system to bring together a comprehensive data set.

Jersey is in a position to make real progress with PHM, due to the way in which data sets are collected and managed in Jersey already

The Jersey health system is more of a 'closed system' than many NHS systems, as there is less patient flow across boundaries of the health system, with the exception of some specialised services. In addition, the implementation of the JCM will create a longitudinal data set, which would provide a useful foundation for population health analytics.

To progress, there should be:

- **Further work on a strategy for PHM in Jersey** which would bring together a shared vision and understanding; set out the governance requirements; set out a data strategy; and agree an approach to continuous quality improvement

Key findings of the JCM review

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- **Better understanding of the population health.** While there is good work being done as part of the Jersey Performance Framework to understand health and wellbeing outcomes in a holistic way, there is more to do to understand the combination of factors that lead to service users becoming rising risk
- **Ability to identify rising risk service users as well as those who are currently high users of services.** An assessment should be done as to whether Jersey has the analytical capabilities - e.g. in longitudinal analysis, segmentation, stratification, actuarial capabilities, impact modelling etc., to move forward with PHM, and whether some of these capabilities should be developed or bought

Population health management should be a whole population approach that continuously identifies those with rising risk and high users of services

The aim of population health management should be to identify those in key cohorts who are at risk of needing more intervention in the future, and acting proactively.

This should take into account a combination of factors including co-morbidities, wider determinants of health, and any changes to the way a service user is accessing services (e.g. increasingly accessing care in an unplanned way; or, conversely, not attending planned appointments).

Jersey is in a position to make real progress with PHM given the success that has already been achieved with the Island's Sustainable Primary Care Strategy (2015) and Digital Health and Care Strategy. There is an opportunity to build on this progress through the development of the JCM. Moving forward, more work could be done to detail the potential PHM approach in the JCM to help Jersey realise the full benefits of a prevention first approach.

Figure 9: Lancashire and South Cumbria's PHM strategy allows granular identification of risk and targeted interventions[11]

Using a PHM approach means that Lancashire and South Cumbria can delve into **place-level data** (30-50k people), so that GPs can explore **the personal circumstances that may be fuelling someone's ill health or their use of health and care services**, and therefore analyse how to best help them. To do this, they:

- Collaborated over a **network of organisations**, including GPs, data analysts, local authorities, the voluntary sector, care providers, faith groups, and community members
- Formed a **local data sharing agreement**
- Developed a **single shared health record** that MDTs can read and write into
- Improved **risk stratification**

Furthermore, in Blackpool they have found in one neighbourhood, by cross referencing the housing department information, that **almost 10% of the GPs' list were living in poor quality houses in multiple occupation (HMOs)** - sharing often dilapidated kitchen and bathroom facilities. This type of accommodation is proving to be a major driver of poor physical and mental health. Cross sector neighbourhood teams are now developing targeted interventions to get ahead of the curve.

Key findings of the JCM review

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6. To be a leading model globally, the JCM will need to expand the care model beyond traditional settings and workforce

There are real opportunities to fully integrate health and community care through the JCM

Leading integrated care models look beyond the integration of health care services with the intent of optimising the health and wellbeing of the respective communities.

In other systems, such as the UK, integration between health and community care is often hindered by poor co-terminus boundaries. These barriers do not exist in Jersey, which presents a significant opportunity for the JCM to achieve what other systems have not been able to.

In the JCM there is a significant reliance on social care to support the redirection of service users out of secondary care to keep them within their homes where possible. The models proposed, particularly those focussed on personalisation and case management, are aligned with good practice and could impact outcomes whilst delivering a strong model for collaborative working across public and private sectors.

Leading integrated models extend the delivery of health beyond social care to incorporate non-traditional healthcare providers

Whilst advanced systems aim to integrate their health and social care services, leading systems look to integrate these more traditional models with the wider components in their system, including schools and government agencies. This type of whole system integration can impact on broader population wellbeing.

While the JCM identifies the importance of pharmacies, dental and ophthalmology services in Jersey's future integrated model, there are numerous other services that could be considered to achieve the described leading good practice. These services are accessed across the life of a service user from infancy to older age and is reflected in all aspects of living within a society. These include:

- **Schools** – can improve health literacy, create healthy habits and lifestyles
- **Businesses** – to provide mental and physical health checks and programmes, promote healthy alternatives
- **Clubs and societies** – to promote health discussions, encourage social interaction and mental health
- **Government agencies** – to provide incentives for healthy living, including financial benefits for healthy lifestyles
- **Urban planning** – redesigning public spaces and amenities, as well as planned housing to promote increase healthy lifestyles (see Figure 10).

Figure 10: Active Design[12]

- Public Health England in partnership with Sport England developed an urban planning guide spanning public spaces, housing and sport fields
- The focus of many of these initiatives is on promoting passive health and wellbeing based on the design created
- For example, the Sheffield Gold Route that looks to connect major parts of the city and promote walking and cycling through its design

In addition, the provision of health and care does not always need to involve trained professionals

The JCM will require a workforce greater than that currently seen in Jersey. The model will need to look to an alternative workforce that expands from clinical to a wider range of staffing groups. This would not necessarily mean a substitution of the workforce, but additional service users who can enhance a culture of health and wellbeing on the Island.

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The alternative workforce may be in any part of the care continuum, for example:

- **Prevention** – neighbours, friends and colleagues providing support to each other and promote health lifestyles (see Figure 11)
- **Acute care** – community navigators who are volunteers that support social prescribing (see Figure 12)
- **Rehabilitation** – while Jersey already has a strong, albeit ageing volunteer sector, further education, support and resources could be given to empower carers to take a more active role in care
- **Maintaining health and wellness** – support programmes and networks can help service users with long term conditions to keep well (see Figure 13).

Community education across Jersey, pilot programmes within parishes and existing groups, clubs and forums could be leveraged to further support developing a health and wellness culture across the Island.

Given the features of Jersey as a self-governing island with a distinct population, that there are significant opportunities to leverage these alternative wellness models

The success of many of the models above rests on access to resources and education, as well as the goodwill shown within communities. As the latter can take time, there is often a need for Governments to put appropriate incentives in place while a cultural change occurs.

This may include financial benefits, or rewards, for example. subsidised healthy goods, produce or equipment. Further consideration should be made of models that may be appropriate in Jersey based on a gap analysis of existing programmes and initiatives that may not be outlined in the JCM.

Figure 11: Elder Watch, Village of Allouez, United States[13]

- Under a **'neighbours helping neighbours' programme,** community volunteers are paired with an older person - this programme includes weekly check-ins for the elderly

Figure 12: Community Navigation, Age NI[14]

- Community Navigation is a s**ocial prescribing service** of trained volunteers with previous experience of supporting people
- They work with a person to help them **identify** and **access** the **right local groups** and **services**
- Navigators can also facilitate onwards referrals by making arrangements on the person's behalf as needed, filling in forms, making appointments and following up

Figure 13: University of California San Francisco Peer Support Programme for Cancer[15]

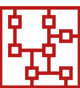
- The programme **matches volunteers with people** based on criteria such as diagnosis, cancer stage, age, gender, or preference of the service user. The programme facilitates conversations between cancer service users and a support between persons who have experienced a similar diagnosis.

In addition, building on the existing health policy, GoJ should continue to think of the role that they can take in adopting policies and mechanisms to nudge and encourage these non-traditional care and workforce models. The JCM should look to further explore these opportunities.

The integrated care model outlined in the JCM is aligned with international good practice. However, to be a leading model globally Jersey needs to consider integration outside of traditional health and social care settings and towards broader community services.

Key findings of the JCM review

3. JCM enablers



Key findings

7. The model is financially sustainable and will not cost more to the service user if resource allocation, funding models and commissioning arrangements are amended

One of the concerns of stakeholders was that the model, while supported, would be at a greater cost to Jersey's population. Through the review's technical group and Pod focus groups, the analysis supporting the review tested key assumptions and estimated the impact of the proposed JCM changes to the current system as a result of implementation.

Failure to change the model of care will lead to significant financial pressures for health and care services

There is a financial imperative for changing the model of care. While GoJ has made significant investments into health and care services in recent years (and has projected to continue to do so in the Government Plan), health and care expenditure is forecast to outstrip these investments.

This is due to a number of factors, including:

- **Growing population:** The population of Jersey is forecast to grow by over 19% by 2036.
- **Increased health needs:** Demand for healthcare services forecast to grow by a faster rate than the growth in population, primarily due to an aging population with increasingly complex health needs. For example, through looking at current usage of hospital beds and how patient groups are going to change over time, demand for hospital beds has been estimated to grow by over 31% by 2036.
- **Cost of healthcare is increasing:** Inflation in the healthcare sector is typically higher than other parts of the economy. It has been assumed that healthcare costs will increase by an average of 3% per year.

As a result of these factors, we have forecast that, without making changes to the care model or other efficiencies, expenditure on the Health and Care Services department will grow from £234m in 2020 to £288m in 2025 and £457m by 2036. This will create a £125m funding pressure by 2036 even if GoJ continues to increase HCS allocations in line with projections in the Government Plan

There are also likely to be similar pressures in other departments including on the following relevant areas:

- **Customer and Local Services:** The Long Term Care (LTC) fund and, to a lesser extent, the Health Insurance Fund (HIF) are forecast to face financial pressures as expenditure grows at a faster rate than income
- **Children, Young People, Education and Skills:** Child and Adolescent Mental Health Services (alongside other children's services) are forecast to have a financial pressure of just under £2.5m by 2036 (requiring a 50% reduction in the expenditure of the service to be sustainable)

Implementing the JCM has the potential to reduce the growth in expenditure to sustainable levels

Through implementing the JCM, growth in expenditure would be significantly lower than current projections.

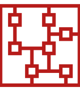
By 2036, the JCM is forecast to avoid £23m of expenditure growth for the Jersey health and care system, leaving a residual financial challenge of £153m to be achieved through other efficiencies.

From 2026 (after implementation of the JCM, efficiencies will need to reduce expenditure by c.2% per year, which is in line with the levels delivered in other similar health and care economies.

The JCM has the potential to reduce the growth in expenditure to sustainable levels and failure to implement this model will lead to significant financial pressures.

Key findings of the JCM review

3. JCM enablers



Key findings

Shifting primary care into the community could be a risk if funding models do not change

There is a risk that the current funding structures are leading to health behaviours driven by cost, rather than person-centred care. There is a financial incentive for Islanders to seek care in secondary care, where it is free at the point of use. There is also a financial disincentive for general practice to move towards more efficient models of delivery, e.g. virtual or telephone consultations, or to fully make use of the range of primary care available in other models, e.g. pharmacy or practice nursing.

The developing experience with COVID-19 has highlighted that the current model for primary care does not provide the resilience that Jersey needs; in particular, the requirement for GPs to see service users face to face, combined with the fee for service model is not suitable for the situation that we are facing.

There is an urgent need to change primary care payment mechanisms in the short term, with an opportunity to update them in the longer term.

Given the reliance on primary care to support and redirect services our analysis shows that the model will only be feasible if it is amended if there are changes to the funding model.

Four different options have been proposed beyond do nothing which can be considered in isolation or in combination. The range from expanding the fee for service to community pharmacy and nurse consultations, to a part- or full-capitated scheme for vulnerable groups or the whole population to a GP salaried model.

Do nothing: In this scenario, funding for general practice would continue via a combination of fee for service, Jersey Quality Improvement Framework (JQIF) and the HIF.

Option 1: Do minimum: Expanding the current fee for service approach to allow services to be delivered in other settings (e.g. community pharmacy), combined with JQIF or an alternative outcomes-based incentives mechanism (e.g. PharmOutcomes) and HIF.

Option 2: Capitation with some co-payment (for vulnerable groups or universally): This would include capitated lump sum funding for vulnerable groups (financially vulnerable (those who are unable to afford the required GP consultations, either in the short or long term, identified by those on income support); clinically vulnerable (those with one or more long term conditions); or socially vulnerable (identified as those below the age of 9, adolescents between 10-19 years, people aged 70 or older and pregnant women) combined with a smaller co-payment, and JQIF. This could be expanded to the total population.

Option 3: Capitation with no co-payment (for vulnerable groups or universally): This would include capitated lump sum funding for vulnerable groups (financially vulnerable(those who are unable to afford the required GP consultations, either in the short or long term, identified by those on income support); clinically vulnerable (those with one or more long term conditions); or socially vulnerable (identified as those below the age of 9, adolescents between 10-19 years, people aged 70 or older and pregnant women) which completely covers the cost of care for these groups, and JQIF. This could be expanded to the total population.

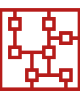
Option 4: Salaried model with pay for performance for all GPs: All GPs would be employed directly by the Government of Jersey.

The Capitation+ model (Option 2) is the preferred option for either vulnerable groups or with universal coverage

The total cost this option with universal coverage would be c. £14.5m per year (approximately £7.5m more than current payments via the HIF).

Key findings of the JCM review

3. JCM enablers



Key findings

There is also a need to change the associated commissioning framework

The JCM acknowledges for the new service to be feasible the commissioning framework needs to change. The Review supported this assumption.

The Commissioned Service Review identified many of the organisations HCS works alongside should be re-commissioned with an extended contract duration.

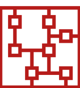
Many services are reliant on funding, and provisions are often above and beyond their original contract agreement. Organisations noted the need for an open and functioning relationship with the GoJ and to work in close partnership with Health and Community services.

The strength of the sector gives an opportunity to create a system wide approach that builds on this strength through a transparent partnership to improve health and community care across the whole population. Continued relationships with external partners will be needed to direct people's attention to what's important without introducing complexity into the system.

Moving forward there is a need to help develop the marketplace, link organisations and develop further a volunteers' network. There is also a need to move away from short term contracts to enable organisations to plan more effectively.

Key findings of the JCM review

3. JCM enablers



Key findings

8. Feasibility of the JCM rests on an appropriate and sufficient workforce; enabling the JCM may require significant changes

Throughout the JCM review, key stakeholders identified the provision of adequate workforce numbers as the greatest barrier to delivering on the JCM. More specifically, for the ease of implementation assessment the JCM was seen to have the greatest impact on workforce.

Recruitment and retention strategies stand as overarching considerations for implementing the JCM

Key themes emerged from the JCM review, in particular the current challenges with recruitment and retention of workforce and the need to overcome these challenges to adapt the current workforce to reflect the changes outlined in the JCM. Stakeholders also highlighted the need to increase staff numbers across the services. It was noted that this need will vary by providers, with an increasing focus on community care.

The workforce profile will flex and evolve to meet changes in service provision

In addition to recruitment and retention, the profile of the workforce will evolve to underpin the increased provision of community services. Using new workforce models to incorporate multi-disciplinary teams (MDTs) to increase care in the community and provide specialist knowledge whilst keeping service users out of hospital, may mean that staff will work with different colleagues, in different teams and locations compared to current services.

Following the changes to the workforce profile, training and development will play a significant factor in realising the changes provided in the JCM.

The JCM outlines additional options to develop and optimise the workforce in order to coalesce with the themes and changes outlined for the healthcare system. These are broadly represented in Figure 14.

Figure 14: Themes for development of the workforce

- **Integrated care** – working across Primary and Secondary care in effective channels supporting patient pathways and processes
- **MDTs** –to deliver better care in the community and avoid attendance at hospitals
- **Training and development** – to upskill the current workforce to deliver better care
- **Financial funding** – a review of the funding model to incentivise working across channels
- **External Partners** – develop relationships and co-ordinate care across external partners
- **Culture change** – transforming the workforce culture to adapt to new ways of working

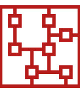
More detail on these themes is available in the workforce section

Further consideration as to how the workforce can provide effective services could be realised through leveraging digital technologies to optimise the integration of services, through record sharing for MDTs across services and conferencing technology to connect staff across multiple locations.

These options outlined in the JCM align with other similar economies, however, further consideration and comfort is required to make sure necessary workforce is in place.

Key findings of the JCM review

3. JCM enablers



Key findings

9. There are further dependencies on a number of capital enablers to realise the benefits of the JCM, including digitally enabling system-wide transformation

Full system digitisation is key to the new model of care

The JCM describes a future care system and Hospital that are digitally enabled and optimised. This builds on the 2018 Digital Skills Strategy(16) to provide an educational roadmap to a successful digital-tech workforce, and its vision for Jersey to be:

'A digitally world class health and care system that used technology everywhere to deliver accessible, joined-up, person-centred care that is safe, effective and efficient, where data is used intelligently to improve ever aspect of care and where innovation flourishes.'

Full system digitisation presents a real opportunity to realise the key aims of the JCM including:

- **Supporting PHM** through interoperable digital systems and robust data management
- **Supporting patient-centred care** by putting service users in control of their care
- **Improving service user and staff experience** through greater choice in care provision and supported self management
- **Improving value and supporting sustainable service delivery models,** through delivering services more efficiently at a lower cost with reduced need for capital investment in physical estate development
- **Enabling the system to respond at pace** to unexpected situations, through infrastructure for remote consultations

This is in line with shifts in healthcare in the UK and internationally

Digital disruption is having a significant impact on many industries globally, and has the potential to transform the delivery of physical and mental health care. This has been a key focus of health systems globally; the UK Department of Health policy has developed a strategy and a new unit, NHSX, to oversee digital transformation, with similar models in many countries, including Sweden and Australia.

There are a number of components of digitising the system specified in the JCM; these need to be costed and expanded

Key points that have been specified include:

- Access to devices and WiFi
- Improved training and education
- Integrated reporting systems to reduce off-island activity and associated costs

The components identified need to be further developed to prioritise initial activities, interoperability and partnership models. The review also identified key areas of focus to inform required investment:

- Assessing the available digital estate across providers
- Planning for digital interoperability across the system and to harness new technologies
- Developing partnership models with other systems such as Guernsey and France

Assessment of the available digital estate across providers will provide the foundation for full system digitisation. In order to achieve integrated care and PHM an assessment is needed across existing digital estates to provide a clear view of initial priorities alongside opportunities to include emerging technologies such as personalised medicine and wearable devices.

Key findings of the JCM review

4. Progressing to implementation

Key findings

Digital interoperability across the system and harnessing new technologies must be core to the new model of care

This will support developments such as digitally enabled tertiary pathways, telemedicine clinics and links to off-site specialists. Interoperable systems could also be used to detect high risk service users as a part of the wider prevention agenda.

Additional considerations not currently detailed in the JCM include:

Self-management: wearables and the Internet of Things can be leveraged to allow people to monitor and manage their conditions in both hospital and community settings.

Triage and assessment: AI can be used to augment the skills of the existing workforce, including using smart speakers and voice recognition to screen service uses at risk of self harm.

Advances in the use of big data: predictive analytics could be used with AI to make strategic decisions about population health and prevention.

Precision medicine: advances in precision medicine will mean a greater range of tailored treatments, reducing polypharmacy and medication errors

Telemedicine and virtual consultations: can be used to create different models of service delivery, allowing service users more choice and convenience over how they access health services.

Both interoperability and investment in new technologies should be considered in terms of investment required alongside the potential financial benefits which could be realised such as reduction in admissions and reduction in physical estate requirements.

Opportunities to develop partnership models with other systems such as Guernsey and France were identified

Shared systems will open up opportunities to develop partnerships with other systems such as Guernsey and France. Developing interoperable systems to support partnerships may require initial capital investment, however this has the potential to generate revenue for Jersey alongside opportunities to drive efficiencies such as through sharing of back and middle office functions.

Digitising the full system has the potential to support specific service areas across the system in line with other enablers was highlighted

The review identified the significance of digital in supporting the expansion of community services, the paid carer workforce and home care services. This was identified to be particularly significant for Women's and Child Health, as well as Mental Health.

Digitising full system transformation is a key finding from the review. It is recommended that the JCM be further developed to expand upon this including the opportunities this presents, investment required and priorities for implementation.

The JCM already outlines its ambition for digital initiatives in Primary Care and Prevention and the digital optimisation of the new Hospital. Taking this further, the JCM could advocate whole system digitisation. In doing so, Jersey could realise the full benefits of the JCM, including supporting specific service areas across the system and driving a patient-centred approach to care.

Key findings of the JCM review

4. Progressing to implementation

Key findings

10. The level of alignment across partners supported by a culture shift in service provision will support Jersey in realising the benefits of the JCM

Some aspects of the JCM represents a significant change to the current model

Most immediately, the JCM will change what type of care is provided and where care. These changes will include:

- **New secondary care facilities to divert care** – e.g. Urgent Care Centre
- **Shifting care from secondary care to primary care and the community** – e.g. physiotherapy, rapid response and reablement
- **Shifting care from the community into the home** – e.g. enhanced social care markets and personalised budgets

The JCM will also represent a material change to who provides care and how. For example:

__Virtually__ – through hubs and devices

__Multidisciplinary teams__ – Greater reliance on MDTs to work collaboratively to plan and manage care, similar to the model in La Motte Street

__Carers and voluntary sector__ – who will be provided with greater support

__Self care__ – Strengthening the resilience of service users to manage health and well-being, particularly in the case of long term conditions

Achieving this significant change in service provision is dependent on a series of factors, including alignment across partners

The review identified a series of factors required to support the implementation of the identified changes:

- **Alignment:** strategic alignment of all health and care partners on the JCM and its ambition
- **Commitment to change:** buy-in from partners in many cases to commit, to new roles, workforce and delivery models as the JCM requires:
  - Greater reliance on the external partners to deliver adult social care
  - New market entrants who are willing and able to deliver primary and secondary care
- **The right operating model:** funding, commissioning, data governance and HR processes needed to transition to the new model

This notion is supported by the World Health Organisation who cites the prerequisites for a successful integrated care model as outlined by the University of Birmingham's framework[17]:

01	**Common cause –** understanding the need to change from a population health perspective, often driven by a 'burning platform'
02	**Common vision and strategy** – which is a process inclusive of all agencies to develop clear aspirations, measurable goals and time-scales
03	**Joint funding and planning –** clear focus on shared outcomes and deliverables, resource/reward agreements linked to group performance
04	**Joint delivery –** strong leadership, high trust, clear governance arrangements, effective and dedicated managerial resources phased over time
05	**Evaluation –** outcomes can be assessed to see if goals are being met
06	**Quality improvement** – developing a learning culture using data / information to support reviews of performance and instigate changes and decisions

Figure 15: Prerequisites and common features of integrated care

Key findings of the JCM review

4. Progressing to implementation

Key findings

The review tested the JCM against the features of successful integrated care models; the JCM performed well in this assessment, however opportunities for improvement were identified

The JCM review has made considerable acknowledgement to the tools and processes needed to overcome the risks and issues with the JCM. Further work needs to be done to understand how these will be implemented and embedded in Jersey's future health and care model.

The framework outlined by the WHO from the University of Birmingham[17] emphasises the importance of the behaviours and incentives of delivering integrated care services. The JCM was tested against the framework as outlined below.

Assessment against the features of successful integrated models

01 **Common cause**	• **The JCM clearly articulates a common cause** on evaluating public consultation feedback, and through the review itself it is apparent that there is agreement on the need for a new model of care
02 **Common vision and strategy**	• **The JCM provides a clear ambition, principles and outcomes for the programme** • While interviews and focus groups with stakeholders demonstrated broad alignment to the aims of the JCM, this cannot be assumed. Ultimately, the JCM has been developed with the ambition of improving health and wellbeing, not of commercial returns. Given the reliance on a range of partners who may have other ambitions, there is the potential for misalignment • This caution is reflected in the JCM's 'Partnership of Purpose', which outlines a commitment for partnerships to 10 principles (e.g. universal offering, partnership approach, focus on quality etc.). On review, it sets a strong foundation and recognises the need to set up functions to enact and monitor these principles. Further consideration should be made to the governance and planning mechanisms in place to support ongoing alignment
03 **Joint funding and planning**	• **The JCM outlines the supporting commissioning framework**. The aims, approach and model for commissioning is in alignment with good practice models, in particular: the focus on joint planning needs assessments at local (Parish) and system (Jersey) level; pooling budgets between government agencies; joining data sets; setting outcome measures within contracting; multi-year funding; and Strategic Partnerships • However, the JCM lacks detail surrounding how outcomes-based, capitated contracting will occur, or how personalised budgets will be managed • In addition to this, whilst Strategic Partnerships with risk and reward mechanisms are in alignment with other integrated models, the JCM lacks detail of how these would be established and managed • Furthermore, more work is required to transform the role of the commissioner from a traditional contract relationship to a strategic commissioning one as this will be important to support commissioning to oversee outcomes rather than set activity • The JCM is lacking on the approach for poor performance, or financial challenges relating to a provider – this is particularly an issue where external partners are engaged

Key findings of the JCM review

4. Progressing to implementation

Key findings

Assessment cont.

04 **Joint delivery (Gover-nance)**	• In line with other good practice models, the JCM outlines the intent to deliver at different levels – local (Parish) and system (Jersey). • While this allows for local needs to be identified, unlike other models internationally, the population of Jersey as a whole is considerably smaller. In many other jurisdictions, local structures would have a population much larger than that for Jersey. • Careful consideration is needed on what roles and delegations would be at each level particularly in planning and delivery to be able to adequately respond to local Parish needs, while preventing diseconomies of scale, inefficiencies and duplication.
05 **Evaluat-ion**	• In terms of care delivery, evaluation is limited explicitly to an acknowledgement of a need for mental health and intermediate care service evaluation. Evaluation processes should be extended to all parts of the JCM and be embedded in how care is planned, designed and delivered. • The commissioning framework proposed outlines 'evaluation' as a part of the model. This is in line with standard commissioning models and is assessed as appropriate for the JCM • The framework also highlights that having outcomes within contracts should "encourage" services to implement evaluation processes. It is suggested that this is a requirements so that a culture of learning is supported, while the measures used, as outlined in the JCM, may need to vary. • To this end, it will be important to focus having the appropriate evaluation models established upfront, so that the impact of the changes in the JCM can be captured and learning can be taken to effect refinements to the care model.
06 **Quality improve-ement**	• There is an absence of detail on quality improvement processes that are proposed for the JCM. • While a number of areas acknowledge the need in the JCM to drive quality improvement (e.g. mental health) this is not consistently articulated. • The commissioning frameworks, including 'Partnerships of Purpose' acknowledge the need for quality outcomes and evaluation processes but do not emphasise explicitly quality improvement.

The JCM makes the assumption that all Islanders will be supportive of service changes; this is broadly in line with the findings from the review

Through the extensive public consultation meetings in Parishes, it is clear that the health care system in Jersey is important to Islanders. While there is a strong viewpoints provided, overall, there is recognition from Islanders that a change is required, and a health and care system that is integrated and sustainable is important and needed for Jersey.

While there is support for the JCM as a whole, it is difficult to gauge acceptability of the model.

As a part of the review's assessment framework, the acceptability of changes, defined as 'whether the change is likely to be acceptable to service users', was tested with key stakeholders.

It was found that across the board, most interventions scored as 'high'. Where there were low scores, the rationale was related to:

- The significant change attached to care delivery
- Where there may be a perceived lack of quality or safety (note – these were scored by clinical staff as low on the believed risk to patient safety)

Testing the JCM against key features of successful integrated care models shows that the JCM is broadly in line with these features. This is further supported by the acceptability assessment performed by the review. However, further detail on how these features will be embedded in care delivery is required.

Key findings of the JCM review

4. Progressing to implementation

Key findings

While the acceptability is high overall, these results do provide caution. While it may be the 'right' model in line with good practice, if service users receiving the care do not support it, it may result in poor health outcomes, poor patient experience and financial and operational inefficiency as service users look to receive care in alternative ways and locations.

It is encouraged that ongoing engagement is undertaken with service users and the broader community on the JCM, any refinements and detailed design to encourage maximum buy-in and support.

Even with optimal models and buy-in, the JCM will need to respond to the behaviours of individual service users

People are generally viewed through the lens of their specific illness, and individual characteristics are not considered when services are designed or delivered.

The Commonwealth Fund, among others, have started to consider behavioural segmentation in health in the design and delivery of services (see Figure 16)[18] . Behavioural segmentation involves identifying different groups of people based on the way they interact with a health and social care system regardless of their demographics or health status.

The JCM outlined personalised budgets and co-commissioning of services. However this will not be possible or appropriate in all cases. Further acknowledgement of factors that impact on how care is accessed and used, particularly behavioural segmentation is absent (along with social determinants of health).

Further work should be considered through the process of detailed design of care models to include these factors, when designing care models for high and rising risk service users.

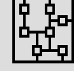
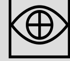
13%	*18%*	*27%*	*18%*	*24%*
Direction Takers	**Balance Seekers**	**Wilful Endurers**	**Priority Jugglers**	**Self Achievers**
View physicians as the most credible source of information and look to them for direction and guidance Likely to go to the doctor at the first sign of a health concern Tend to ignore medical advice only when it is difficult to work recommend-ations into their routines 	Dedicated to their health and wellness but don't pay as much attention as do Direction Takers when it comes to what doctors tell them Prefer to come to their own conclusions about what success looks like after seeking treatment information via the internet and friends and family	Live for the here and now and put current pleasures over future health Resistant to changing habits Only visit the doctor when they absolutely must 	So busy with other responsibilities, they invest less in health and wellness, but are proactive about the health of their loved ones Put off dealing with their own health issues until problems are too big to ignore or interfere with their responsibilities	The most proactive about health and wellness but more likely than Balance Seekers to prioritise doctors' advice Very task-orientated and will stay on top of health issues with medical check-ups Willing to tackle challenges if given measurable goals
They are looking for and are happy to follow doctors' orders	*They need to be presented with options and choices, while stressing the consequences of each*	*As the toughest groups to work with, they need simple steps and immediate gratification*	*Appealing to their sense of duty and responsibility by pointing out that others depend on their health*	*They need to be provided with education and tasks along with baseline measures and tracking tools to reinforce progress*

Figure 16: Behavioural segmentation in health

Key findings of the JCM review

4. Progressing to implementation

Key findings

11. As part of implementation planning there is a need to focus on transition models while key enablers and new models are being developed and implemented

The JCM reflects the greatest change that Jersey will see in delivering health and community care

It is an exciting opportunity to impact on the health and wellbeing of Islanders, and improve the clinical and financial sustainability of the health and care model. It will see significant changes across the system as both health and social service partners and recipients will change how, where and what care is provided.

The JCM has identified a number of areas of focus for further work, but is absent on a broad implementation programme

The JCM acknowledges the significant work required to achieve sustainable implementation of the strategic objectives.

The JCM highlights the following as priority areas for further work:

- Development of a clinical forum (note – this was setup as a part of undertaking this review)
- Development of a clinical pathway design process
- Completion of a combined strategic needs analysis
- A pan-island workforce planning exercise
- Alignment of the sub-strategies that sit underneath the JCM (e.g. Primary Care Strategy)
- Robust financial modelling to make informed decisions about the future of funding and access for prevention and Primary Care in Jersey (note – commenced as a part of this review).

On assessment, these are key areas, however they are missing a number of priority areas. Our suggestion would be to focus on the 14 priority areas as outlined in Figure 17 below.

Note – the groupings will be dependent on the existing and proposed structures / teams in place and are provided for illustrative purposes.

Figure 17: Priority areas proposed by the JCM review

Priority areas proposed by the JCM review

Key findings of the JCM review

4. Progressing to implementation

Key findings

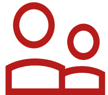
For the JCM to be successful lessons can be taken from other systems - a phased transition is proposed given the scale of change

The JCM should take further consideration of approach to implementation of the model. At present, the JCM lacks detail on this approach.

While there is a strong momentum behind the model at present, limited focus on implementation could see the model poorly adopted, inefficiencies and various levels of access to services.

Building on the experience of other models, it is recommended that detailed implementation planning is completed that focuses on change management, education and development, infrastructure and finance, workforce, and resource design as illustrated below– literature shows that a phased or transition approach to the new model is seen to be more successful.

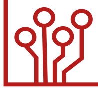
The rationale to adopting this approach is outlined in Figure 18 below, which represents an example of an internationally renowned model that started small.



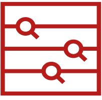
Change management – This represents a significant change, which will take some adjustment in 'hearts and minds'. Seeing small successes and benefits should increase confidence in the model and promote further buy-in.

Infrastructure and finance – There is significant infrastructure and resource requirements to realise the full benefit; funding models in the immediacy need to support the new models, with digital and data to be able to facilitate.

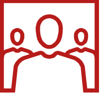
Education and development – Service users and staff will both need to be skilled and aware of the new care models and requirements – some service users will be faced with a lot of differences which may be overwhelming to process.



Limited resource to design – the change requires significant detailed design and the number of people to complete is insufficient given the size of the Jersey health and care economy. Starting small will allow progress to be made quickly.



Build from learnings (scale and expand) – Pilots are often leveraged as they allow new models to be tested. A test and scale approach should be adopted with care models, with different Parishes trialling new models where appropriate.



Ability to deliver (workforce) – Like the ability to design, the JCM acknowledges the lack of resources. Implementation must be safe and not compromise care. Shifting to a new model should be done over time when the necessary workforce is in place.

Figure 18: Buurtzorg: Dutch model of neighbourhood care[19]

- In 2006, a small group of nurses set up a social enterprise in Almelo, The Netherlands called Buurtzorg in which a small team of self-managing/governing nurses look after people in their own home. In this model the nurses acted as health coaches emphasising self management and improvements to the quality of life
- They developed a small scalable unit and while care was more expensive per person, only half the amount of care was now required with an estimated potential cost saving of 40%[20]
- This model is now adopted in 950 teams in The Netherlands and across the globe, in the US, UK, Asia and Scandinavia. Being small allowed them to refine the model and establish the necessary infrastructure.

Key findings of the JCM review

4. Progressing to implementation

Key findings

12. The JCM will only be achieved through a decentralised care model

The JCM outlines that currently there is a secondary care focussed model of healthcare service. The majority of activity on Jersey is in an acute hospital setting with a centralised provision of services. However, the current system is not optimised and may have further unsustainable pressures in the future, relating to increases in the elderly population and higher presence of long-term conditions.

Decentralisation of services has been recommended to deliver patient-focussed care, provided in the community and closer to home. The anticipated benefits of providing care in the community on patient outcomes as well as developing the clinical sustainability for the future of services across the healthcare system.

To realise the vision of the JCM care will need to be delivered through a decentralised model

Care in the community
Through providing services closer to home, service users may enjoy the flexibility provided by services, and feel empowered to remain longer in their communities

Activity provided in the hospital
Decreasing the current activity provided in the hospital will alleviate strains on capacity, and may offer the opportunity to expand services that would otherwise be limited by capacity constraints

Interdependencies between workforce, digital and estates are crucial to developing the future decentralised services

In order for decentralised care to be feasible for Jersey, a number of interdependencies lie within supporting enablers to be able to realise the benefits of this model. Namely:

1. **An adequate and sustainable workforce to adapt to decentralised services and work in the community**

Public feedback on the decentralisation of services revolved around concerns of adequate workforce in the community whilst maintain the specialist expertise in the hospital. These supporting views aligns with the perspectives outlined in the JCM review, where the workforce will play a crucial role in realising the benefits of the JCM.

2. **Digital technologies to leverage the benefits of integrated platforms for record sharing**

Digital technologies have been described by stakeholders as crucial to effectively deliver services in a decentralised model. In particular, interoperable systems to allow sharing of patient records will greatly enhance the effectiveness to which the workforce will be able to deliver services in out of hospital settings, and in multi-disciplinary teams.

3. **Adequate community estates in order to provide the services in the community**

Adequate estates in the community enable the ability of the workforce to provide services in the community, and will require the digital infrastructure to provide these services.

Workstream analysis

Overview

- **Workstreams** outlined in the JCM have been **tested** for **validity** as part of the JCM review
- The proposed changes were **assessed for feasibility and ease of implementation** against **five key areas** to understand any potential nuances in implementing these changes to the JCM
- This was supported with **quantitative analysis** and **evidence of good practice** from the health literature

Summary of findings from JCM testing

- During the ease of implementation testing, **Women and Children's services** were **scored** to be the **easiest** to implement – this is opposed to **Clinical Support Services** and **Adult Social Care** who demonstrated the **lowest** ease of implementation
- As for impact on current service provisions, the testing identified the implementation of the JCM would have the **greatest impact** on **workforce** and the **lowest impact** on **estates**
- The feasibility assessment of the JCM demonstrated a **high feasibility across service areas** with respect to safety, operational efficiency and patient experience

Detailed impact assessment findings

- The review presents detailed impact assessment findings from which the following takeaways can be identified:
  - Further consider the proposed **acute floor model** changes when designing a new hospital estate
  - **Optimise acute bed base** to reflect need
  - Establish **Emergency Care Centre**
  - Implement key changes that focus on providing bed-based care, crisis response, home-based care and **reablement** services
  - Explore broader **population health management** opportunities

Recommendations

- Based on the workstream assessment and accompanying analysis, the **JCM** was **recommended** as **suitable** for Jersey
- **Additional next steps** are outlined later in the review – these represent priority actions for **enhancing the value** of implementing the **JCM**

Workstream analysis

Overview

Workstreams outlined in the JCM have been tested for validity as part of the JCM review

The workstreams set out in the JCM detail specific changes according to their respective areas of care. Testing of these workstreams as part of the JCM review allowed a deep-dive into areas to understand the relative impact of changes in the JCM on the current service provision.

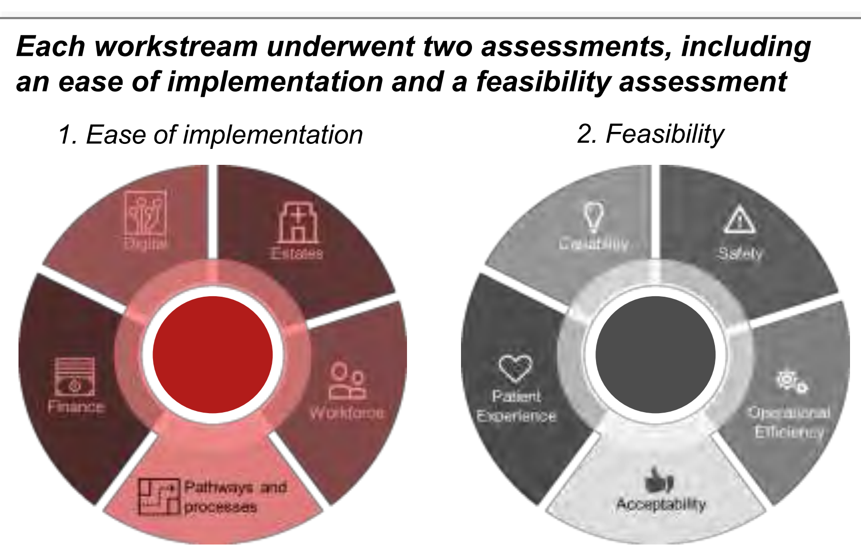
The testing approach of the JCM review investigated the ease of implementation and feasibility of changes

The testing approach incorporated engagement with stakeholders from each workstream to understand the key areas of impact pertinent to each service.

The proposed changes were then assessed for ease of implementation and feasibility against five key areas to understand any potential nuances in implementing these changes to the JCM.

Changes were scored and assessments were collated, with key findings, challenges and opportunities highlighted in the workstream review sections.

Figure 19: Testing approach of the JCM review



Ease of implementation scoring		
0	Low impact	Implementation of proposed change is achievable within the current structure and available resource profile
1	Moderate impact	Proposed change requires additional resource and service change compared to current provision, but does not require substantial transformation
2	High impact	Proposed change requires substantial transformation from current structure and resource profile, radically changing the way care is provided through the area of focus

Feasibility scoring		
0	High feasibility	This change is feasible given existing requirements for the respective focus area
1	Moderately feasible	The proposed change is moderately feasible given the considerations discussed
2	Low feasibility	This change is unlikely to be feasible given the considerations discussed

Workstream analysis

1. Mental Health

Summary of findings from JCM testing

12	proposed JCM changes reviewed
0	additional JCM changes identified
12	stakeholders engaged

The JCM sets out a vision for increased community-based care including crisis prevention and intervention. The key changes from current service provision are:

1. Develop **co-located mental health services** with physical health services on a new hospital site
2. Focus on **24-hour, community-based crisis prevention and response**, by fully rolling out the Crisis Prevention and Intervention service. Expand community-based capacity for recovery-oriented, person-centred care and support
3. Invest **in primary care-led mental health care** with a focus on prevention and early intervention

Further consideration should be given to the **estates requirements** associated with co-located services, **a workforce strategy** which addresses the recruitment challenge for key skilled roles, such as mental health nurses, and alternative **payment mechanisms** to incentivise the use of primary and community care over ED attendance.

1.6 *Average ease of implementation score*

N/A *Average feasibility score*

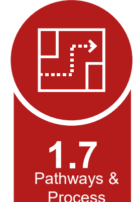
Average ease of implementation score by enabler

1.7 Digital

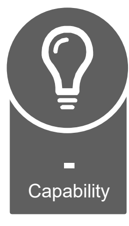
1.4 Estates

1.7 Workforce

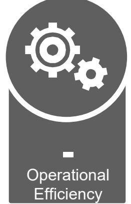
1.5 Finance


1.7 Pathways & Process

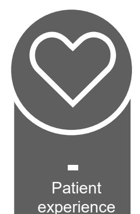
Average feasibility score by change area


- Capability

- Safety


- Operational Efficiency

- Acceptability


- Patient experience

Note that due to COVID-19 pandemic, feasibility scoring was unable to be completed; discussions on feasibility were completed with Pod Chair

"There needs to be better interfaces and integration between physical and mental health"

"Good community estates means less demand for beds in wards"

"We should be looking at people's wellbeing holistically – mental, physical and social wellbeing"

Workstream analysis

1. Mental Health

Detailed impact assessment findings

Community-based mental health care, including crisis prevention and intervention, may reduce acute admissions and support people's capacity for recovery

Mental health care in Jersey is provided largely in acute settings. There are a number of acute inpatient units, including acute admissions units, recovery units and continuing care wards. Services are provided across the life continuum from children to older adults. Care provision is supported by a number of third sector and voluntary organisations across the island.

The new care model will see more care delivered in community and home settings, with a focus on crisis prevention and early intervention

The JCM states that mental health care will be recovery-oriented, integrated, evidence-based and centred around the service user. During testing, stakeholders strongly emphasised that a whole system approach is required, to consider people's health and wellbeing holistically, covering physical, mental, social and emotional health.

The JCM outlines key changes to mental health care including co-located mental health services and establishing a Crisis Prevention and Intervention service

1. Develop co-located mental health services
2. Focus on 24-hour, community-based crisis prevention and response, by fully rolling out the Crisis Prevention and Intervention service. Expand community-based capacity for recovery-oriented, person-centred care and support
3. Invest in primary care-led mental health care with a focus on prevention and early intervention

Opportunities and challenges

Opportunity to **decommission** existing mental health **estates**

Challenges with **recruitment** and **retention** of workforce in Jersey

Demand on emergency and inpatient care for mental health service users may be eased by co-locating mental and physical health services on a new hospital site

Currently mental health services are provided in a number of locations, increasing the rate of transfers. Increasing co-located services could enable service users to have their physical and mental health needs addressed more holistically, in the same location, and by a joined-up team.

Many patients receiving mental health treatment also have significant physical comorbidities. In 2017, 47% of patients with a mental health problem were recorded as having also had at least one additional long-term condition (Figures 20 and 21). 36% of patients who had an inpatient episode at the mental health hospital in 2019 also had an inpatient episode at JGH for something other than psychiatric treatment.

Figure 20: Service users with mental health problems who also had other selected long term conditions

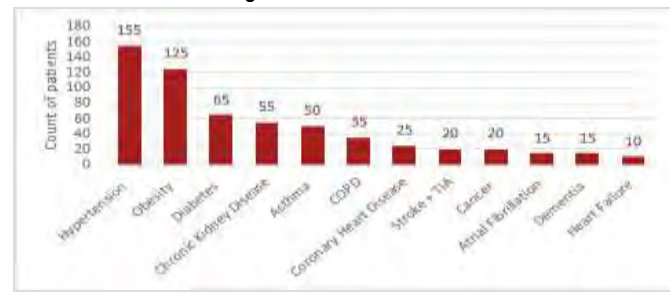
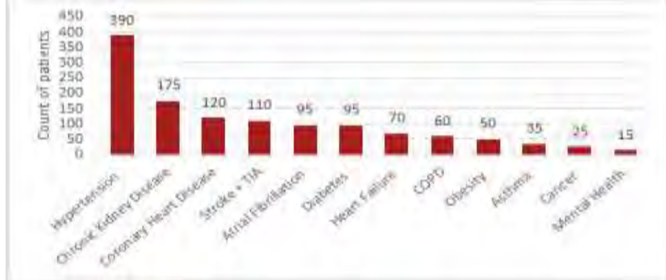


Figure 21: Service users with dementia who also had other selected long term conditions



1. Mental Health

Detailed impact assessment findings

This suggests that service users, especially those with dementia, may benefit from co-located mental health services and multidisciplinary teams, as such a model would allow for mental and physical healthcare professionals to access service users more quickly, and to work collaboratively to deliver holistic care.

Access to a co-located mental health unit is also likely to drive a reduction in ED attendances and length of stay, as service users with complex needs would have more timely access to both physical and mental health professionals. Additionally, the improved availability and accessibility of both physical and mental health services may result in reduced demand for outpatient appointments driven by a reduction in duplication. Reduced ED attendances, length of stay, and outpatient appointments would deliver financial benefits, operational efficiencies, and improved patient experience.

Given the prevalence of service users with co-existing mental health problems and physical conditions in Jersey, the proposed co-location of physical and mental health services is appropriate for Jersey.

When it comes to implementing this change, further consideration should be given to the opportunity to decommission existing mental health estates and the associated financial impact. Additionally, a mental health workforce strategy is required to address the recruitment challenge for key skilled roles such as mental health nurses.

"Significant investment will be required to co-locate services, but this is the right thing for mental health services." Mental Health Stakeholder

Acute and inpatient admissions may be further reduced by expanding community capacity, and fully rolling out the 24-hour Crisis Prevention and Intervention service

There is not currently 24-hour community mental health provision in Jersey, and people in crisis often end up being seen in the ED. An exact definition of the Crisis Prevention and Intervention service is not given in the JCM, but it is stated that the planned service would allow people to receive treatment in settings that are closer to home, which reduces disruption and supports recovery.

Such a service would strengthen the out of hours response and reduce disruption to planned care, as well as reducing the estates need associated with treating people in acute settings, as identified by stakeholders during the review. The benefits of a robust crisis response service on reducing admission rates to mental health wards and reducing ED attendances [21] have been evidenced in England (Figure 22).

Figure 22: The First Response Service in Bradford provides a collaborative multi-agency approach to out of hours mental health crisis services. It is a 24/7 telephone line for those in need of urgent mental health support, where a coach assesses a person's needs, decides if urgent support is required and can request a first responder to visit the person's home. The scheme has saved over £1.8m so far, due to reduced admission rates and A&E attendances.

Evidence from the above health literature supports the claim in the JCM that the crisis prevention service will have a significant impact on mental health inpatient configuration, however, further analysis is required to quantify the full expected impact and understand the subsequent changes to bed requirements.

In light of the evidence from literature that demonstrates that the provision of 24-hour crisis prevention and response services reduces the pressure on mental health inpatient wards and emergency departments, the proposal to expand community capacity and roll out the 24-hour Crisis Prevention and Intervention service is appropriate and recommended.

Workstream analysis

1. Mental Health

Detailed impact assessment findings

Further consideration should be given to the workforce requirements associated with this model. There is well-documented challenge around recruitment and retention of the workforce in Jersey, in particular those with specialist skillsets such as mental health workers. Therefore a robust workforce strategy should be in place to enable the implementation of this model.

Investing in primary care-led mental health care with a focus on prevention and early intervention may reduce or delay people's need for care

At present, a significant proportion of mental health care in Jersey is hospital-based, and there is little by way of prevention initiatives in place. Prevention and early intervention are central to the Jersey Care Model across all health and care areas, and mental health care is no exception. It is stated in the JCM that over the next five years, there will be investment in primary care-led mental health and a focus on prevention and early intervention to give people the best chance of recovery.

It is widely recognised that investment in prevention initiatives reduces demand on acute and urgent services further downstream. In southwest Yorkshire, there is evidence [22] that integrating mental health therapy into primary care supported improved recovery rates for service users with long term conditions, and led to a reduction in follow-up appointments (Figure 23)[23] .

Figure 23: The Improving Access to Psychological Therapies (IAPT) – Long Term Conditions (LTC) pathway provides a holistic approach to service user care by providing IAPT services at local GP surgeries. By embedding IAPT input in GP surgeries, it was hoped that service users would see talking therapy as part of the management of their condition, rather than being 'passed on' to another service.

Additionally, Nuffield Trust states that the extent to which people with mental ill health use unplanned or emergency care "suggests that there is the potential for better […] preventative care for long-term physical health conditions in those with mental ill health"[24].

The evidence in health literature, then, supports the idea that prevention and early intervention would reduce the instances of people with mental health conditions presenting in acute settings.

This is particularly relevant for Jersey, where 2.4% of ED attendances are for reasons related to mental ill health (Figure 24).

Figure 24: 2019 ED activity by diagnosis category

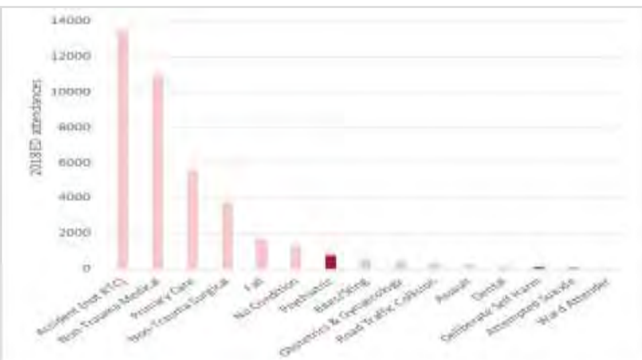


Figure 25: The Bristol high intensity user project sought to reduce ED attendances by high impact users (largely people with mental health and/or drug and alcohol usage and/or homelessness). Interventions included: individual service user support plans, risk assessments, crisis planning and a proactive community support scheme. ED attendances and admissions were reduced by up to 80% in the high impact user group.

Anecdotal evidence received during the review highlighted that the homeless population are frequent ED attenders (data to substantiate this point was not analysed during this review). Initiatives implemented in other health and care systems [25] have demonstrated that it is possible to significantly reduce the number of attendances by high intensity ED users by implementing preventative measures (Figure 25).

Workstream analysis

1. Mental Health

Detailed impact assessment findings

Taking into account the supporting evidence from other health systems, and the identified impact of avoidable ED attendances and admissions by people with mental health needs, the proposal to invest in primary-care led mental health care with a focus on prevention and early intervention is appropriate for Jersey, and recommended for implementation.

Further consideration should be given to wider social determinants of health such as housing, education and social security, as identified by stakeholders during ease of implementation testing. Assessment should also be undertaken as part of the development of a mental health workforce strategy in order to quantify the potential need for an expanded GP workforce. Payment mechanisms and funding flows are also a key consideration in the implementation of this model, as existing payment mechanisms incentivise ED attendance over accessing primary care, particularly for vulnerable service users.

"We should be building a community that looks at a person's wellbeing holistically – physical, mental, psychological and social health together."
Stakeholder – Mental Health Stakeholder

Additional changes for Mental Health services:

Stakeholders identified no additional changes beyond those outlined in the JCM. However, in the course of further developing and operationalising the planned changes set out in the JCM, additional changes to the care model may be identified.

Key recommendations for Mental Health services

1. Review the estates requirements associated with co-locating physical and mental health services at the future hospital, considering opportunities to decommission existing estates and the associated financial impact.
2. Develop a robust mental health workforce strategy, including training and recruitment needs to develop a multidisciplinary workforce and how to address the recruitment challenge for key skilled roles such as mental health nurses
3. Undertake further analysis to quantify the full expected impact of the Crisis Prevention and Intervention service on inpatient bed configuration.
4. Review existing payment mechanisms and consider alternative options that would incentivise use of primary and community care over ED attendance.

Workstream analysis

2. External Partners

Detailed impact assessment findings

Central to delivering a sustainable and quality care system is strong partnerships with external partners

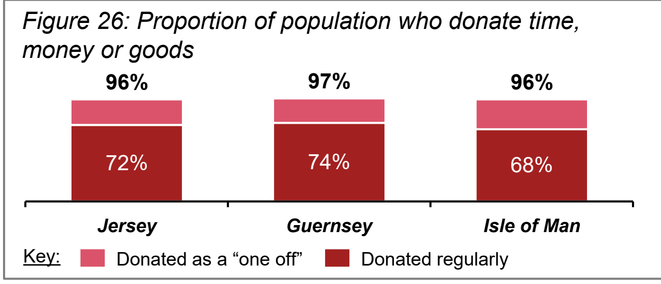
Jersey currently delivers many of its services in partnership with external partners, including voluntary organisations, social care providers, private providers, and social enterprises. These partners provide a range of services across the different HCS workstreams, most notably in Adult Social Care, Mental Health and Intermediate Care, with the biggest organisations including Shelter Jersey, Autism Jersey and Silkworth Jersey. Their contribution is so integrated into the delivery of care services in Jersey that they receive ring-fenced budgets from the Government of Jersey every year.

£10m | of Government budget is spent on external partners

89% | of residents thought charities made an **important / very important** contribution

The significance of this contribution is also recognised by the wider public. This is reflected in the high proportion of the population who regularly contribute time, money or goods to these services, which is mirrored in other Channel Islands' spending patterns suggesting shared behaviors (Figure 26).

Figure 26: Proportion of population who donate time, money or goods



Despite this, Jersey lacks a strategic commissioning framework to commission these services and formalise the partnership with these providers. This represents an opportunity for the future of partnerships in the JCM.

The JCM outlines key opportunities for external partners to engage with health and care challenges

The JCM emphasises the significance of external partners in supporting the delivery of a sustainable and quality care system for the future. Moving forward, their role will be formalised through an outcome-based commissioning framework.

In doing so, Jersey recognises the unique position of external partners in offering more holistic services and additional support in areas where HCS is lacking the workforce and financial resource, for example, in the community. To this end, the JCM outlines a number of opportunities for future partnerships, including developing an Adult Social Care strategy; improving Intermediate Care; supporting carers; increasing care at home; and developing technology to support the delivery of services. These could be pursued through the following types of partnerships:

1. **Networked partnerships:** establishing a community hub that provides a single point of access to a network of external partner-led community services
2. **Commissioned partnerships:** establishing a single partnership for the provision of a unique service by an external-partner on an outcomes-based commissioning contract

Evaluating these partnerships against quantitative and qualitative analysis saw them recognised as moderately easy to pursue with some barriers to implementation. These barriers include limited transparency over existing partnerships, poor digital interoperability and limited resources.

Opportunities and challenges:

Opportunity to **link community services provided by external partners** to core HCS functions to support the JCM's vision

Challenges with **workforce and digital,** which represent barriers to partnerships

2. External Partners

Detailed impact assessment findings

The review identified an opportunity to strengthen the multi-disciplinary workforce through partnerships

Jersey's demographic changes present a challenge to the current structure of service provision. More specifically, the population is ageing and presents complex health challenges. The evidence supporting the review suggests that by 2035 this challenge will have increased in size as the proportion of the population over 65 will have increased from 17% to 22% and the prevalence of chronic conditions will have increased substantially. For example heart failure, COPD and obesity are expected to increase by 75%, 50%, and 28% respectively.

The current structure of service provision is not adapted to meet this need. Here, service users are largely treated in acute settings. Moving forward, service users would be better served in the community by a multi-disciplinary team that reflects their diverse service user needs. This presents an opportunity for external partners to support inter-agency working and provide the varied workforce to support this opportunity. This is supported by the evidence from Living Well[26], where partnerships with charities supported people with chronic conditions (Figure 27).

Figure 27: Living Well offered an integrated wellness service that worked with a variety of volunteers and social workers from a mix of local charities and agencies to help support people **over 50 with chronic conditions.** Volunteers helped train people to better manage their own condition by connecting them with local resources, including stop smoking and weight management services.

The evidence highlights the potential benefits successful partnerships can bring. Most significantly, the authors reflected on the importance of networked working to bring together multiple health professionals to meet the complex needs of their service users. For Jersey, this could be achieved through creating community hubs as outlined in the JCM.

"We should take a holistic and multidisciplinary approach when considering a person's needs" – External Partners Stakeholder

The opportunity for community hubs was tested during the JCM review and was scored as moderately easy to implement. This decision was supported by the current direction service provision is taking broader Parish involvement and initiatives such as Closer to Home[27], which delivers a broad range of health and social services through monthly roadshows. This type of initiative lays the foundations for the type of networked and collaborative working outlined in the JCM. Further to this, it could support Jersey in realising the aspiration for Primary and Intermediate care outlined in the JCM, which is to shift care into the community.

Figure 28: The **Closer to Home** initiative has **partnered** with a selection **of Jersey's third sector organisations**, including Family Nursing & Home Care, Call and Check, Mind Jersey, St John's Ambulance and more, to deliver a selection of services across the island in the form of Roadshows at different Parishes. These roadshows deliver health check, social activities, physical activities, support and advice, as well as craft and culture. This model represents an **asset-based approach** rather than a traditional needs-based approach, whereby **services are provided** based on service users **whole needs** rather than their symptomatic problems.

Whilst the evidence outlines the importance of networked working with multi-disciplinary teams, the JCM overlooks the broader opportunity to use these types of services to support high-risk populations. These types of community hubs, working in collaboration with health and social care providers, could identify at-risk service users and tailor services to meet their needs as a part of the broader prevention agenda. This opportunity is overlooked by the JCM and could be further explored to realise the total value of the identified community hubs.

Workstream analysis

2. External Partners

Detailed impact assessment findings

Testing the JCM identified an opportunity for outcomes-based commissioning to support partners

External partners have a track record for supporting the wider delivery of Jersey's health and community care services (Figure 29)[28]. However, this support has never been formalised through specific commissioning activities. As such, there is a lack of transparency in Jersey's current system surrounding the wide range of services available to its population. This represents an opportunity to implement a commissioning framework for external partners, as outlined by the JCM.

Figure 29: Mind Jersey can provide support service users with **mental health conditions**, as well as their families and carers. This includes information services, residential care, peer support and sign-posting.

The JCM review acknowledged the necessity for a commissioning framework. This is encouraged by its ability to formalise partnerships, stimulate market development and, in the instance of an outcomes-based framework, drive innovation in care delivery. However, the review identified Jersey's lack of experience commissioning external partner's services. Given this, it would be advised that Jersey explores more traditional commissioning frameworks first so that Jersey can develop the foundational skills and capabilities required before moving to outcomes-based contracting. This is recommended to support the future sustainability of these partnerships.

To realise the benefits of the identified opportunities, key challenges with digital and workforce need to be tackled. The JCM identified key challenges with external partner's digital and workforce capabilities, which could affect the implementation of the described opportunities.

More specifically, when testing the JCM with key stakeholders they identified a key challenge with digital interoperability between external partner and HCS provider systems. These stakeholders reflected that this affected the ability to integrate with HCS providers through partnership, as well as impacting on the broader service user experience by limiting continuity of care. This challenge could negate the functionality of the previously described community care hubs. To overcome this challenge, Jersey could develop an overarching digital strategy that covers an estates assessment of the available digital tools and systems across both HCS and external partners and sets out a strategy to integrated those identified.

"Currently IT systems are disjointed and would be unable to support the changes proposed in the JCM" – External Partners Stakeholder

In addition to this, stakeholders highlighted challenges specific to their External partners' workforce, particularly in relation to recruitment and retention. This was thought to be a result of poor incentives, such as pay and training. This represents a particular challenge moving forward, given the aspiration of the JCM is to increase its reliance on external partners for delivering services in the community. Looking ahead, a future workforce strategy would be required to assess the available workforce across the system.

"Limited workforce due to poor retention, training and financial incentives, which affects consistency of services" – External Partners Stakeholder

To conclude, to realise the value of future partnerships through networked working in community-hubs or single services using outcomes-based commissioning then Jersey would need to consider developing a comprehensive digital and workforce strategy that assess the resources available to both HCS and external partners.

Workstream analysis

2. External Partners

Detailed impact assessment findings

Stakeholders acknowledged the significance of partnerships and therefore the need to tackle the identified **challenges with workforce and digital**. This was supported across the review, where the need to partner with external partners was raised numerous times.

In addition to the changes outlined in the JCM, External Partners identified others that will be crucial to transformation.

As well as testing the changes proposed in the JCM, through discussions in focus groups, stakeholders identified a number of additional changes to support the new care model, which could be further developed in future iterations of the JCM:

1. Social prescribing should be offered in primary and secondary care services
2. Create care hubs, either virtual or physical, with spokes into each Parish or district
3. Decentralise care through a community-based support model
4. Improve primary care access to vulnerable people
5. Upskill GPs on domestic abuse and identification of vulnerabilities and other safeguarding issues
6. Create and publish a detailed commissioning framework to overcome fragmentation in commissioning

Additional changes for External Partners:

Reflecting on the JCM, key stakeholders felt that the JCM was missing a focus on **care hub development** and a clear **commissioning** framework.

The JCM review identified key opportunities for partnerships in line with vision for the JCM

The JCM review demonstrated an alignment between External partners and the aims of the JCM. It highlighted External partners as being uniquely placed to tackle some of the challenges faced by Jersey's current system to support the implementation of the future JCM. This is because External partners present a more holistic and non-traditional service offering, as well as offering the resource in areas where HCS is lacking, such as in the community. Whilst External partners may present more holistic offerings outside of the traditional HCS service, these providers still face the same challenges as HCS – poor digital and workforce capabilities.

Therefore, to set realistic expectations for the role of External partners in the future JCM, Jersey will need to develop a detailed digital and workforce estates assessment and strategy to understand exactly how External partners can support on the implementation of the JCM.

Key recommendations for External Partners

1. To successfully implement the JCM, there needs to be a clear, system-wide workforce strategy that covers external providers and HCS and establishes the workforce needs for the JCM
2. This could be complimented by a digital estates assessment and strategy to support integration and interoperability of digital tools, solutions and systems between external partners and HCS
3. Explore future partnerships through networked working with community hubs or single service provision supported by a traditional commissioning model
4. Use the more holistic and non-traditional services offered by external partners to support the prevention agenda by target high-risk populations

Workstream analysis

3. Adult Social Care

Summary of findings from JCM testing

8 proposed JCM changes reviewed

1 additional JCM change identified

10 stakeholders engaged

The JCM sets out a vision for an integrated, community-based model for Adult Social Care, based on a personalised approach. The key changes from current service provision set out are:

1. Develop an **integrated, community-based approach to social care** supported by **increased community capacity** and local strategic commissioning
2. Invest in **preventative services** to reduce or delay people's need for care
3. Enable people to **make their own choices** about how they are supported by developing personalised approaches like self-directed support and personal budgets

The changes are underpinned by the **need to develop and implement an Adult Social Care strategy.** This will need to link with the Intermediate Care and External Partners offerings. Further consideration should be given to the funding mechanisms required to support personal budgets, and a strategy to support a stable workforce.

1.6 *Average ease of implementation score*

0.8 *Average feasibility score*

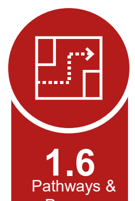
Average ease of implementation score by enabler

1.5 Digital

1.5 Estates

2 Workforce

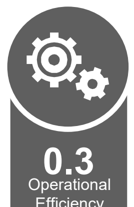
1.4 Finance


1.6 Pathways & Process

Average feasibility score by change area

0.8 Capability

1.3 Safety


0.3 Operational Efficiency

1.3 Acceptability

0.3 Patient experience

"We should be developing a strengths-based practice"

"For training to be successful, we should consider pursuing a whole system approach"

"Funding to intermediate care services will have a large impact on the potential success of ASC changes"

Workstream analysis

3. Adult Social Care

Detailed impact assessment findings

An integrated, community-based model for Adult Social Care based on a personalised approach may support independence and a better quality of care

Adult Social Care (ASC) services in Jersey are delivered through a combination of community and home settings. Social care for adults is largely provided in residential or nursing homes, or through domiciliary care packages. Residential care is typically supplied by private providers, while domiciliary care is largely provided by unpaid carers and the third sector. Eligible Islanders receive financial support for care from the Long Term Care (LTC) fund.

The JCM outlines key changes for Adult Social Care that focus on providing personalised care

1. Develop an integrated, community-based approach to social care supported by increased community capacity and local strategic commissioning
2. Invest in preventative services to reduce or delay people's need for care
3. Enable people to make their own choices about how they are supported by developing personalised approaches self-directed support and personal budgets

All of the above changes are underpinned by the need identified in the JCM to further develop and implement an Adult Social Care strategy. Due to the nature of services provided, the Adult Social Care model should be considered closely alongside the Intermediate Care and External Partners offerings.

Testing demonstrated that the proposed changes to ASC may be moderately difficult to implement as the proposed model is substantially different from the current state. Analysis and review of international good practice suggest that the proposed changes to ASC, whilst potentially challenging to implement, would ultimately offer a much improved service user experience, reduce demand on secondary care for older adults, and enable people to live independently in their own home for longer.

The proposed model of care is therefore recommendable, but in order for it to work for Jersey, further consideration should be given to funding mechanisms and supporting workforce stability.

Opportunities and challenges:

Opportunity for **community** services, strategic **commissioning** and **preventative** care

Challenges **shifting culture**

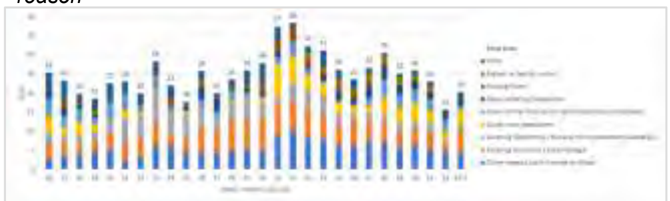
There is an opportunity to enable people to live independently in their own homes for longer

This can be achieved by developing an integrated, community-based approach to social care supported by increased community capacity and local strategic commissioning. Care options in Jersey are currently somewhat limited to traditional care settings such as residential homes, and relatively standardised care packages. This model lends itself to care based on the services available, rather than on service user need.

An integrated, community-based approach would see more people cared for either in their own homes, or accessing care in accessible community settings close to their home. Links between primary, community and secondary care would be strengthened, allowing people to receive the right care for them, in the right place, at the right time, and reducing the pressure on acute beds that is seen on the island.

The JCM highlights that at present, the total bed days occupied by stranded service users over the age of 60 equates to a bed requirement of 38.8 beds per year. Analysis has shown that across the second half of 2019, an average of 25 hospital beds were being used each week by service users who were medically fit for discharge, but delayed for another reason. 11 of these beds were occupied by people awaiting a domiciliary care package, awaiting a residential or nursing home placement, or a social work assessment (Figure 30).

Figure 30: Beds used for medically fit service users with delays, by reason



Workstream analysis

3. Adult Social Care

Detailed impact assessment findings

The analysis suggests that increased community social care capacity may free up to 11 beds, where people are waiting for care packages, placements or assessment, and would likely reduce pressure on acute beds.

Evidence from Norway[29] supports the case for developing an integrated model with increased community capacity (Figure 31).

Figure 31: Norway's SUSTAIN project aimed to improve care for the elderly at home who have multiple care needs. A Holistic Patient Care at Home pathway was introduced to support service users after hospital discharge, and Everyday Mastery Training was implemented to encourage independence. The initiatives enabled older people to live safely at home and reduced reliance on care homes.

The SUSTAIN project provided rehabilitation services at home, as well as expanding day centre access, and encouraging shared decision-making, all of which improved the ability for older people with multiple medical and social care needs to live at home. Given the opportunity highlighted in the analysis to reduce pressure on acute beds and support people to return home or into care by increasing community capacity, it is recommended that the proposed new model is implemented.

It may be beneficial to consider the learnings from health literature around methods of supporting independent living after discharge from hospital, in particular the Holistic Patient Care at Home pathway.

There is a further opportunity to reduce or delay people's need for care by investing in preventative services

At present the ASC offering does not incorporate prevention initiatives, and the provision of care is consequently relatively reactive. Furthermore, the ageing population presents a challenge as the demand for services will substantially increase over time. Providing ongoing care is costly, and reducing or delaying people's need for care offers a significant financial benefit. Indeed, the JCM states that for every £1 spent on prevention, £1.90 could be saved that would otherwise have had to be spent on treatment.

The JCM identifies a number of opportunities for prevention initiatives, including a five yearly health check for all those aged 40-74 with screening for a number of conditions. During the review, stakeholders also suggested there is an opportunity for parishes to coordinate prevention initiatives such as social prescribing, an approach which has delivered good outcomes [30] in other health and care systems (Figure 32).

Figure 32: A social prescriber role was introduced in a GP practice in Liverpool. They specialised in supporting service users with non-clinical issues and referring service users into community schemes. The result was an increased uptake of community care, a reduction in social isolation and reduced demand for GP appointments for non-clinical issues.

The evidence from the case study suggests that social prescribing can support the prevention agenda and reduce demand for GP appointments, as well as reducing social isolation. Given the likely improvement in service user experience offered by such prevention initiatives, as well as the substantial financial savings set out in the JCM, investment in preventative services should be a key pillar of the new care model.

Consideration should be given to how to most effectively invest in prevention initiatives. Collaboration with public health, primary care and intermediate care is recommended to support this.

Self-directed support and personal budgets may enable people to make their own choices about how they are supported

The current model of care has a traditional service-led approach, with a limited range of services and providers available to people. This can mean that people are not able to shape the kind of support that they as a service user require.

Workstream analysis

3. Adult Social Care

Detailed impact assessment findings

Under a personalisation approach, service users are enabled to identify their own needs and make choices about how and when they are supported to live their lives [31]. This is underpinned by ready access to information, advocacy and advice to support them to make informed decisions.

The benefits of a personalised approach to social care are widely documented in health and social care literature. In Cornwall, Age UK's personalised integrated care pathway [32] supports older people to manage their long term conditions while maintaining or improving their overall health and wellbeing (Figure 33).

Figure 33: Age UK's personalised integrated care pathway sees Age UK staff and volunteers becoming members of primary care led multidisciplinary teams, developing tailored care plans and providing essential support in the community. This has been shown to improve older people's wellbeing, prevent unplanned hospital admissions and reduce the costs of social care.

Working with a multidisciplinary team including primary care staff and volunteers, Age UK works with the relevant organisations to co-design and co-produce a combination of medical and non-medical support that draws out the goals the older person identifies as most important to them. The service has been shown to deliver a 23% average improvement in mental wellbeing and a 30% reduction in non-elective hospital admissions. Early findings also showed a potential to save up to £4 for every pound spent for the local health and care system.

Such an approach would not only be likely to improve people's wellbeing and enhance their independence, but is also likely to reduce the financial and operational strain caused by a heavy reliance on care homes in Jersey, as people may be able to live independently in their own homes for longer.

The JCM states that Jersey's use of residential beds is significantly higher than anywhere in the UK (370 people and 134 people per 10,000 population aged over 65 in residential and nursing care respectively).

Analysis has shown that reducing care home use to the England upper quartile would mean a reduction of 70% of residential care placements and 46% of nursing care placements for people aged over 65. Some reduction in hospital admissions and length of stay would also be expected as people would have support services in place closer to home, preventing admission or allowing for an earlier discharge home.

Evidence from North Staffordshire [33] suggests that an integrated, personalised approach does indeed support people to receive care in their own homes and reduce acute admissions (Figure 34).

Figure 34: The Older Adults Outreach service in North Staffordshire saw community psychiatric nurses meet with the A&E triage team to assess service users' needs. The nurses suggested alternatives to inpatient admission for many service users, and where admission was necessary, facilitated earlier discharge. This approach saw a reduction in the use of 24-hour care as a first option and a reduction in delayed discharges.

Analysis has shown that Jersey would benefit from reducing over-reliance on care homes, and evidence from England demonstrated that personalised approaches not only improve people's experience and support independence, but materially reduce acute attendances and admissions.

Developing a personalised approach to social care is therefore a recommended model. Further consideration should be given to how digital tools can be used to support independence in the home, and to how personal budgets will be allocated and managed, given existing funding mechanisms. It should also be noted that stakeholders highlighted the significant challenge associated with driving a culture shift away from reliance on care homes, both in terms of service user expectations and workforce culture.

"A shift in culture will be needed, to support a no blame culture and to support the workforce in adopting innovative new ways of working."
Stakeholder – Adult Social Care Stakeholder

Jersey Care Model

Workstream analysis

3. Adult Social Care

Detailed impact assessment findings

Additional changes for Adult Social Care services:

Reflecting on the JCM, key stakeholders felt that a **social prescriber model** may be appropriate for Jersey. This would enable a **holistic approach** to people's wellbeing, connecting them to community groups and statutory services for p**ractical and emotional support**. This approach would need to involve **primary care and GPs**, and would require a cultural shift as people acclimatised to accessing less medicalised, more community-based care.

Key recommendations for Adult Social Care services

1. Review existing commissioning arrangements and explore the funding structures required to support the establishment of personal budgets
2. Assess existing digital infrastructure and future digital capability needs to support the use of assistive technology in delivering care packages
3. Develop a workforce strategy to address increasing demand for social care provision in the community, considering initiatives and potential policy requirements to recruit and retain social care workers, as well as how best to work with external partners and the voluntary workforce
4. Further develop the prevention approach, considering international good practice and successful initiatives from elsewhere

Workstream analysis

4a. Scheduled Care

Summary of findings from JCM testing

6	proposed JCM changes reviewed
3	additional JCM changes identified
21	stakeholders engaged

The JCM outlines a **shift in activity to an out of hospital setting** for Scheduled Care, leveraging an **integrated care model.** The proposed model for Scheduled Care presents some opportunities and challenges:

- The **current acute bed base presents an opportunity** to be reconfigured to provide extra capacity, through greater use of day case surgery. There is also an **opportunity for greater efficiency** of these services, for example, by stopping procedures of limited clinical effectiveness.
- Challenges in the development of an integrated care hub and transformation of outpatient services arise when **considering the transformation from traditional ways of working to integrated care across services.**

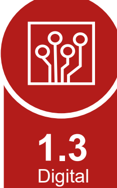
Additional considerations include **further integration** across workstreams such as Unscheduled Care and Mental Health, to aid delivery of the integrated care model.

Development of workforce strategies and **revision of the funding model** to incorporate Primary and Secondary care will also need to be considered.

1.5 *Average ease of implementation score*

N/A *Average feasibility score*

Average ease of implementation score by enabler

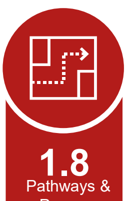


1.3 Digital

1.4 Estates

1.6 Workforce

1.5 Finance

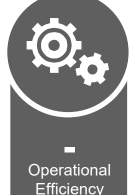


1.8 Pathways & Process

Average feasibility score by change area

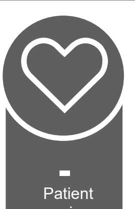
- Capability

- Safety



- Operational Efficiency

- Acceptability



- Patient experience

"**The Digital Journey** has started but there is a long way to go"

"More space is required for services to **grow and future proof**"

"**Funding options** should be considered to support care in the community"

Note that due to COVID-19 pandemic, feasibility scoring was unable to be completed; discussions on feasibility were completed with Pod Chair

4a. Scheduled Care

Detailed impact assessment findings

The transformation of Scheduled Care reflects the aim to decentralise services

Scheduled Care currently represents the centralised care provision for Jersey. The changes outlined in the JCM for Scheduled Care signify the transformation towards decentralised care, leveraging an integrated care model. In response to growing demand for acute services, these changes aim to allow for additional capacity to respond to the future needs of Jersey.

The key changes are summarised below:

1. Optimisation of the acute bed base, such as increasing discharge and reducing length of stay, by leveraging initiatives such as increasing use of day surgery and reducing procedures of limited clinical effectiveness (PoLCE) to allow repatriation of planned activity from tertiary and specialist services.
2. Development of an integrated care hub to strengthen the connection between Primary and Secondary Care and improve referral management, with the transformation of traditional outpatients services.

These key changes were assessed to be moderately easy to implement. Specifically, discussions around whether optimisation of the acute bed base and supporting evidence showed this change as an opportunity to pursue for implementation, with design of new pathways and processes to increase day surgery. Challenges were noted for the development of an integrated care hub and transformation of outpatients services across a broad range of areas, requiring further developments with a workforce and culture strategy to transform traditional ways of working.

Opportunities and challenges:

Efficiency opportunities through optimisation of **acute bed base** to reflect need through reducing utilisation of beds and redesigning current services

Challenges with **workforce** and **culture** strategy to transform ways of working.

Optimisation of the acute bed base to reflect changing island need can realise significant efficiencies for Scheduled Care

The JCM highlights that the new model of care will reduce the utilisation of beds, by incorporating more day surgery, ambulatory care and reablement services. There are also further opportunities to improve efficiency within scheduled care, for example by reducing the numbers of procedures of limited clinical effectiveness.

In reducing the utilisation of beds, the JCM outlines the opportunities to develop the connectivity of services to tertiary hospitals, and repatriate some activity, such as bariatrics. This overall optimisation of the acute bed base aims to allow future hospital capacity to be protected for acutely unwell service users and to meet the demographic needs of the Island, whilst improving efficiencies within Scheduled Care services.

Supporting analysis highlights the higher than average current levels of admissions in acute care settings (Figure 35) and anticipated increases in demand on the services. Further analysis shows an estimated increase faster than the rise in population numbers in specialties such as endoscopy, whereby clinical pathways will need to be designed to manage an increase of at least 67% in endoscopy episodes by 2065. This increase in demand presents an opportunity to redesign current services in order to encourage a decrease in length of stay for service users and provide extra capacity for services that need it. The JCM additionally highlights efficiency opportunities for theatre utilisation and in outpatient new to follow-up ratio (NFU).

Another approach to improving efficiency of Scheduled Care services involves stopping procedures of limited clinical effectiveness (PoLCE). Work undertaken by EY in 2018 identified 856 procedures that could be considered within this category across a range of care areas with an estimated cost of £1.1m in 2020 prices. Further details on this opportunity can be found in Figure 36.

Workstream analysis

4a. Scheduled Care

Detailed impact assessment findings

Efficiency opportunities for Scheduled Care:

1. **Reduction in hospital admissions** for general and acute services
2. **Reduce numbers of procedures of limited clinical effectiveness** through regular reviews of Jersey's PoLCE policy and procedures that have been recently undertaken
3. **Reduce the utilisation of beds** by optimising the current bed base to reflect the needs of the Island
4. **Improved discharge into the community** through ambulatory assessments and reablement services
5. **Improve theatre utilisation and NFU ratios** by transformation of inpatient/ outpatient services

Initially, investigating the impact of reducing utilisation of bed capacity with stakeholders highlighted the need to design new pathways and processes for redirecting some inpatient activity to day case surgery. However, this change was considered to have minimal transformation needed for the current estates and workforce, as well as low financial impact.

Increasing ambulatory care and reablement services will help reduce activity staying in acute care settings

Ambulatory care and reablement services are increasingly used as initiatives to reduce activity within acute care settings (Figure 37). Analysis additionally shows opportunities to improve the discharge of stranded service users to the community services in Jersey (Figure 38), with initiatives seen in the UK to improve reablement services to reduce delays in stranded service users[38].

A redesign of pathway and processes, to leverage better use of services outside of the hospital to release stranded service users should be considered, alongside an increase in workforce in order to facilitate the effective management of these processes. These changes are in line with discussions outlined in Unscheduled Care for ambulatory care, and Intermediate care for reablement services.

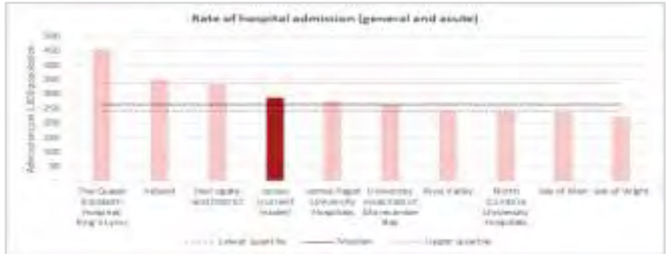
Operational efficiencies need to be realised before repatriation of tertiary services is possible as to provide safe and effective care

In optimising the acute bed base, the JCM outlines the opportunity to repatriate activity from tertiary care, particularly outlining bariatrics in terms of Scheduled Care services. This is reflected in aligning with the JCM aim of anticipating future demand on services. Whilst additional activity to be repatriated should be considered based on island need, space and staffing considerations for the repatriation of activity should additionally be developed before implementing this change.

In conclusion, analysis has supported the aim to optimise the acute bed base. Increasing the use of day case surgery has been recommended to improve cost-saving and service user experience through shorter lengths of stay[35] [36].

Ambulatory care initiatives are also being explored in Unscheduled Care, the use of these initiatives to optimise the acute bed base may realise benefits for acute care in Jersey and enable space for repatriation of tertiary activity.

Figure 35: Rate of hospital admissions for general and acute services in comparison to Peer trusts (see appendix for peer selection criteria)



4a. Scheduled Care

Detailed impact assessment findings

Figure 36: Procedures of limited clinical effectiveness (PoLCE)

Analysis undertaken by EY in 2018, identified that 856 procedures of limited clinical effectiveness had been carried out, which would have an estimated cost of £1.1m in 2020 prices. These included the following:

- Therapeutic facet joint injections: 135 procedures
- Surgical removal of wisdom teeth: 180 procedures
- Carpal tunnel release: 126 procedures
- Tonsillectomies: 48 procedures

Regular review of Jersey's PoLCE policy in light of latest clinical guidance may identify further opportunities to avoid undertaking activity that has limited clinical benefits.

Efficiency Opportunity:

- *Review Jersey PoLCE policy against latest clinical guidance and undertake regular reviews of procedures undertaken.*

Figure 37: Ambulatory programme to reduce waiting times

Nottingham University Hospitals NHS Trust (NUH) led a new ambulatory care programme. They identified that service users should not have to wait longer than 30 minutes to have their blood taken and launched a three step approach to achieve this. Following the three month pilot, 3988 service users had their bloods taken, 33% service users were seen within 30 minute goal and average waiting time was 29 minutes 13 seconds. This compares to October 2017 where average waiting time almost halved to 15 minutes 27 seconds.

Efficiency Opportunity:

- *Reducing waiting time for service users by identifying improvement areas for patient flow*

Overall, optimising of the acute bed base may realise efficiency opportunities across Scheduled Care, which may in turn realise benefits across the healthcare system by improved capacity and resources.

Integrated care between Primary and Secondary Care requires substantial transformation across Scheduled Care

The JCM outlines the development of an 'integrated care hub', connecting Primary and Secondary care to provide efficient planned care services with the use of virtual hubs. Whilst examples of integrated care hubs exist [38], the current broad outline of this change for Scheduled Care will need to be further developed to delineate what services will be provided through integrated care, in order to define and direct the implementation of this change across Primary and Secondary Care (for commentary from a Primary Care perspective, please refer to the Primary Care section).

The JCM also describes the improvement of referral management between Primary and Secondary care and transformation of outpatient services, including providing outpatient activity in an out of hospital setting.

These changes are outlined in the JCM to remove activity from the hospital setting, and relieve pressure on acute services. This transformation aims to reduce the number of referrals to the acute hospital setting (Figure 39), and improve service user experience[39].

> "Developing the pathways and processes should include a review of processes to support effective management of service users in hospital and when discharged" – Scheduled Care Stakeholder

Stakeholders assessed these changes, and indicated the aims outlined in the JCM would be a substantial transformation from current service provision. In particular, the dependency of the workforce capacity, standardisation of pathways and processes, and financial impact were considered to be dependent on the availability of appropriate estates to provide integrated care and reformed outpatient activity.

Workstream analysis

4a. Scheduled Care

Detailed impact assessment findings

Figure 38: Delays in discharge from acute beds

Analysis shows that in 2018, service users who were deemed medically fit to be discharge, but were stranded in acute beds, were delayed the most due to:

- Awaiting domiciliary care package (including adult and EMI): average of **5.3 beds**
- Awaiting residential/nursing home placement availability: average of **3.8 beds**
- Social work assessment: average of **2.5 beds**
- Awaiting further non acute H&SS healthcare (i.e. Samares): average of **2.3 beds.**

These trends are in line with delays in discharge seen in the UK[37]

Figure 39: Clinical Assessment Service for GI referrals [40]

In the Royal Wolverhampton NHS Trust, between 2012 to 2013, there was a 25% increase in new outpatient gastroenterology (GI) referrals. Referrals were sourced to the hospital via three routes. Hence, a Clinical Assessment Service was introduced in 2014. GPs used a standard referral letter which GI consultants evaluated, and then directed service users on to the most appropriate care.

Following the two year pilot, new outpatient attendances decreased by 27%. Moreover, in 2014, waiting times dropped from 53.8 to 32.2 days for outpatient GI appointments, with the service now continuing and expanded to the renal department.

Efficiency Opportunity:

- *Standardising referrals and increasing GP education can reduce outpatient appointments*

Current funding and ways of working will need to transform to realise the full benefits of integrated care

When considering the aim to work in an integrated care model, working practices need to shift to realise effective integrated care. Currently, stakeholders identified that there would be a substantial change needed in working practices to realise the benefits of integrated care. Additional considerations for the impact on staff productivity in moving away from a decentralised model and investment in training.

A review of the financial implications for providing out of hospital outpatient activity recommended that significant changes to the current funding model would be required. Specific considerations include a review of commissioning support/relationship management of agreements between Primary and Secondary Care providers.

This change presents an opportunity to reform current ways of working, with supporting successful examples from the UK through standardised referrals (see Figure 39) and leveraging digital technologies (see Figure 40).

Overall, whilst integration between primary and secondary care is a key aim of the JCM, in the context of current service provision in Jersey, substantial transformation would need to happen to realise the benefits of this change.

Workstream analysis

4a. Scheduled Care

Detailed impact assessment findings

Figure 40: E-clinics for renal referrals(41)
Barts Health NHS Trust has one of the largest renal services in London, with 220,000 dialysis sessions a year. However, in 2017, there was a waiting time between 55 and 84 days for outpatient appointments. To address this a pilot e-clinic was introduced in 2017 to allow GPs to send questions to consultants about renal service users, enabling more service users to be seen in a non-acute setting. This has reduced both the number of outpatient appointments by a fifth and the waiting times for these appointments has fallen to five days.

Efficiency Opportunity:

- *Integrated care can reduce the waiting times and number of traditional outpatient appointments*

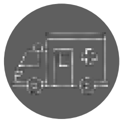
Beyond optimising the acute bed base, there will need to be consideration of further changes

1. Closer integration of Scheduled Care with other services, particularly Unscheduled Care and Mental Health services, needs to be recognised across all focus areas in order to realise the benefits of integrated care.
2. Increase the earlier connection of physiotherapy services to service users who are deemed “at risk”, by working more closely with GP services to standardise processes for referrals.
3. Integrate recruitment and retention strategies as part of the overall workforce strategy, key for developing a community-based workforce.
4. Continue the development of a service-user centred approach to care, empowering users to determine the most suitable care provision whilst leveraging the integrated care model.

Key recommendations for Scheduled Care services; reflecting on the changes outlined in the JCM, key operational efficiencies can be realised, in order to provide effective care for service users.

1. Increasing day case surgery capacity should be further explored as a viable option, and further analysis into other suitable areas to increase day case surgery should also be investigated
2. Regular reviews should be undertaken of Jersey’s PoLCE policy and the numbers of procedures undertaken that are covered by this
3. Provision of ambulatory care and reablement services will require further refining and development for the design of pathways and processes
4. The development of the ‘Integrated Care Hub’ will need extensive assessments across all areas to define what services will be provided and appropriate estates to be used
5. Development of a workforce strategy with consideration for transformation of traditional ways of working is required
6. A review of the funding model in co-ordination with integration with Primary Care providers will need to be pursued.

Workstream analysis



4b. Unscheduled Care

Summary of findings from JCM testing

5 proposed JCM changes reviewed

8 additional JCM changes identified

10 stakeholders engaged

Unscheduled care is looking to transform the current acute and emergency care, namely from an **ED department to an Emergency Care Centre (ECC)** with a redesign of the acute floor model, to **increase bed capacity** through robust admission process and improved discharge.

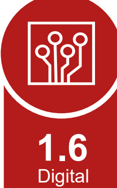
- The **development or redesign of estates** to support the proposed floor model for Unscheduled Care will provide the opportunity to establish the ECC model
- Challenges to transform from current service provision to incorporate more **ambulatory assessments** into Unscheduled Care will need to be addressed in order to realise benefits seen elsewhere

Further considerations for Unscheduled Care include a **review of the funding and charging models** due to proposed closer integration with Primary Care and further development of **emergency transfer service plans.**

1.5 *Average ease of implementation score*

N/A *Average feasibility score*

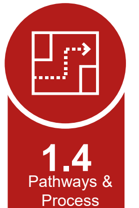
Average ease of implementation score by enabler


1.6 Digital

1.3 Estates

1.7 Workforce

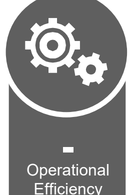
1.6 Finance


1.4 Pathways & Process

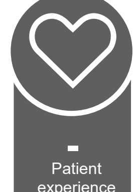
Average feasibility score by change area

- Capability

- Safety


- Operational Efficiency

- Acceptability


- Patient experience

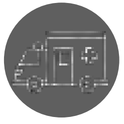
Note that due to COVID-19 pandemic, feasibility scoring was unable to be completed; discussions on feasibility were completed with Pod Chair

> "Developing **information sharing capability** will be key to effectively manage patient care across pathways"

> "A financial exercise to **investigate and assess workforce and estates** would be needed"

> "**Workforce links to other hospitals** should continue to be developed"

4b. Unscheduled Care



Detailed impact assessment findings

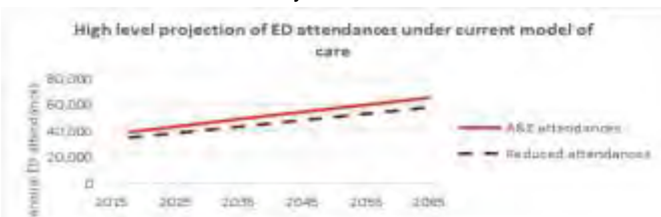
Transformation of Unscheduled Care aims to reduce activity in emergency care setting

Unscheduled Care in Jersey is defined as urgent/ emergency care. The outlined changes in the JCM seek to maintain the clinical sustainability of services, focussing on increasing bed capacity by a robust admissions process and improved discharge, to mitigate potential strains in capacity as a results of rising attendances in the Emergency Department (ED) (Figure 41).

The key changes summarised below were tested as part of the JCM review:

1. The front door of the Hospital will require an Emergency Care Centre (ECC). The Emergency Care department will be co-located to the proposed Acute Floor Model concept, with an Urgent Care Centre (UCC) to manage non-urgent and standard activity
2. Development of more prominent ambulatory assessment capability, including Older Person's rapid access
3. Development of the connectivity to tertiary and specialist services for Unscheduled Care

Figure 41: Estimation of the increase in ED attendances under the current model of care for Jersey



These changes were assessed to be moderately easy to implement overall. The review considers establishment of an ECC and the redirection of urgent care activity as an opportunity to implement, with the optimal design dependent on the redesign of estates.

A review of developing more prominent ambulatory assessment highlighted challenges with this change for Jersey, particularly the substantial change to current service provision that would be needed. Whilst this change has similar areas to address as the development of the UCC, when considering implementation, the relative impact of changes across the focus areas were regarded as harder to implement, with workforce, estates, and integration with community health services integral to this change.

Opportunities and challenges:

Opportunity to establish an ECC

Challenge in lack of **digital** platform and requirement of supporting **workforce**

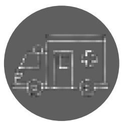
A redesign of estates is considered a minimum in order to establish the ECC

The transformation of A&E to an Emergency Care department, co-located to the Acute Floor Model, is outlined in the JCM. The Acute Floor Model, although not fully described in the JCM, commonly refers to the concept of co- or proximally-located integrated acute and emergency services. With the high rate of low acuity cases, and low conversion rate from ED to hospital, the JCM additionally outlined the opportunity to redirect 60% of urgent care, with non-urgent and standard activity, from the current ED to a UCC (Figure 42), with further investigation into activity moving to a Primary Care setting, to transfer activity away from emergency care services.

Transforming urgent and emergency care by establishing a co-located UCC to emergency departments has been highlighted as a good model of care to reduce crowding in emergency care settings[42]. This presents an opportunity in Jersey to maximise the effectiveness of urgent and emergency care. The benefits of implementing a UCC have been seen elsewhere [43] [44], including one of the benchmarking sites on the Isle of Wight, whereby an increase in the proportion of service users seen within four hours in the ED was realised within four months of establishment (Figure 44).

Workstream analysis

4b. Unscheduled Care



Detailed impact assessment findings

When assessing this change in the context of Jersey, stakeholders highlighted that a reconfiguration of current estates, or the development of new estates, is a minimum to achieve this change. A new hospital for Jersey therefore presents a key opportunity for Unscheduled Care.

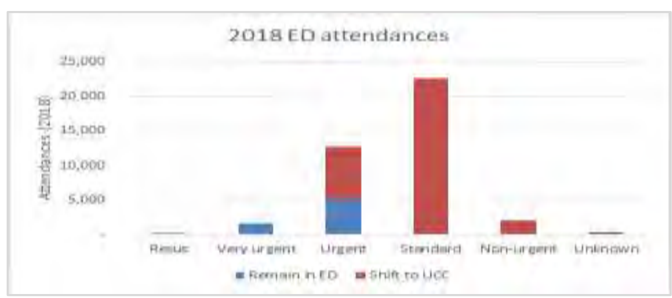
Stakeholders also noted that the existing workforce could be used to deliver this model of care, with considerations for recruitment of more specialists needed when further developing this change for implementation.

In practice, the JCM highlights that the Emergency Care department would maintain the ability to manage very urgent and resuscitation service user activity, with some urgent activity. Considerations towards the redesign of current pathways and processes was considered substantial by stakeholders, with the following noted to effectively implement this change:

- Development of effective triage processes
- Development of onwards pathways to other services
- 24/7 access to diagnostics

> "A phased approach to implementing new pathways and processes could be used to initiate changes, whilst waiting for a new Hospital build" – Unscheduled Care Stakeholder

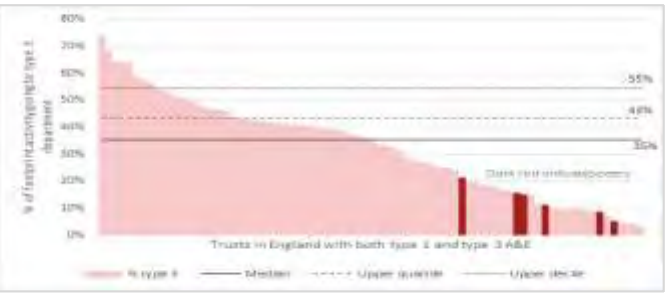
Figure 42: Proportion of 2018 ED attendances proposed to move to the UCC



Analysis on moving activity to a UCC and Primary Care

The JCM outlined the opportunity to redirect 60% of urgent care, with non-urgent and standard activity from the ED to a UCC (Figure 42). Whilst the JCM outlined that further consideration to direct minor illness activity to Primary Care is required, additional analysis from benchmarking studies has recommended that **45-55% of ED activity moves to the UCC**, with an additional **10% of activity moving to Primary Care**.

Figure 43: Proportions of activity going to Type 3 departments (UCC) as, in trusts in England that have both Type 1 (A&E) and Type 3 departments

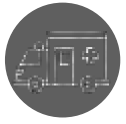


Additional analysis on the activity moving to a UCC recommends that a portion of activity should move to Primary Care (Figure 43). As a consequence, a review of the funding and costing models to investigate the cost to the service user for this move in activity needs to be investigated if funding models were not to change.

Establishment of an emergency care department with a co-located UCC has been supported by evidence from other providers. Whilst the effectiveness of this change for Jersey is dependent on the redesign of estates. Additional considerations should be outlined for the integration of Primary Care to manage some activity, with benefits from Primary Care integration for acute and emergency care outlined by providers in the NHS.[45]

Workstream analysis

4b. Unscheduled Care



Detailed impact assessment findings

Overall, establishment of this change would be considered a good model for urgent and emergency care in Jersey, based on examples from other providers. Learnings from analysis recommends further delineation of the proportion of emergency and acute activity provided within units and services will be needed, with further investigation into the funding/ payment models if activity is to be moved to a Primary Care setting.

Figure 44[46] : A new Urgent Treatment Centre on the Isle of Wight
In the Emergency Department, 70.9% service users at St Mary's hospital were seen within four hours in October 2019. Hence, in November 2019, the hospital built an Urgent Treatment Centre. As a result, in January 2020, **74.8% service users in the emergency department were seen within four hours**, with **all 2,594 service users seen within 4 hours in the Urgent Care Centre.**

More prominent ambulatory assessment was determined as requiring substantial transformation

Additional improvements to the decreasing length of stay and occupancy rates of secondary care beds can realised through more prominent ambulatory assessments. The JCM additionally outlines that this would include Older Person's rapid access. This change was developed in more detail with stakeholders, describing the incorporation of a defined pathway/process for elderly and/or frail service users, known as the Geriatric Emergency Medical Service (GEMS).

This change has been outlined in order to address the rate of admissions and further improve the length of stay in the hospital, with a particular focus of care for the elderly.

When considering whether this change is right for Jersey, stakeholders in Unscheduled Care described challenges across areas, specifically:

- The integration of digital platforms across primary, secondary and third sectors was considered high impact to transform
- Additional consideration for the commissioning structure needed to align the third sector and secondary care to implement this change
- An additional facility within an emergency care setting would be required to facilitate this change
- A community geriatrician and supporting workforce would also be required to deliver effective care for Older People

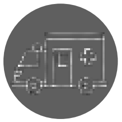
"The impact on pathways and processes is dependant on other factors, as they are not considered to be the limiting factor for this change. The development of these will enable the delivery of the model" – Unscheduled Care Stakeholder

The benefits of ambulatory care has been seen through multiple providers in the UK[47], Ireland[48] and worldwide[49] . Importantly, some of these examples centre around the development of a specific ambulatory assessment unit, co-located to emergency care settings. Whilst the JCM outlines the incorporation of ambulatory care assessment into the ECC, it has not specified the introduction of a unit. Key stakeholders have outlined a potential consideration to incorporate a unit, which will need further development to implement in future iterations of the JCM.

Overall, despite coalescing with practice developed worldwide, the context of Jersey presents a challenge when considering the ease of implementation of this change. This change may produce benefits in decreasing admissions and length of stay, but primarily will need to address some of the challenges around digital, workforce and facilities for implementation in Jersey.

Workstream analysis

4b. Unscheduled Care



Detailed impact assessment findings

Development of connectivity to specialty and tertiary services could be broader than originally outlined in the JCM

Development of the connectivity to tertiary and specialist services via Jersey Emergency Transfer Service (JETS) was described in the JCM.

"This change incorporates the "streamlining of current processes to give access to tertiary services in a timely manner." – Unscheduled Care Stakeholder

This change has been broadly outlined in the JCM, with limited detail as to what this would entail. In assessing this change compared to current service provision, it was assessed as moderate impact. Broadly, digital tools were recommended to improve this service and investment in workforce was highlighted through impact on finance and workforce. Specific impacts on pathways and processes were noted around robust contracting and accountability of tertiary hospitals.

Risks were also identified due to the time-critical nature of the services associated with this change, for example, access to diagnostics.

Further considerations for the service user experience of transfer should also be considered when developing these considerations further(50). Overall, considerations of how the JCM will prevent admissions to an acute care setting will intertwine with the changing requirements of the emergency transfer services, therefore, the move to care in the community may lead to the need for bespoke emergency transfer service plan.

This review of the JCM recommends that further details needs to be provided to adequately assess this change, with discussions with stakeholders highlighted some additional changes to be considered.

Additional changes for Unscheduled Care were discussed by stakeholders

1. Development of acute care services in close co-ordination with Mental Health acute care
2. Development of pathways for rapid access to diagnostics at weekends and evenings
3. Increase the dedicated access of services to community beds
4. Further development of model to include HDU/ITU and development of an outreach team
5. Development of closer connections with justice department and home affairs to improve integration with wider services for effective, holistic care
6. Further development of the community emergency care model is needed, including development of ambulance/advanced paramedic roles to assess service users in the community to prevent admission in Hospital
7. A service user transport service review needs to be undertaken, with consideration of ambulance escort capacity with expansion of JETS

Key recommendations for Unscheduled Care services

1. The provision of adequate estates for the acute floor model is central to developing an optimised emergency and urgent care setting
2. With analysis recommending moving some activity to Primary Care, a review of funding and charging models will be required
3. Capacity requirements for the PAU should be taken into account when co-locating to the Paediatric ward
4. A comprehensive workforce strategy is required to underpin provision for Unscheduled Care
5. More prominent ambulatory assessment will require further development with Intermediate Care to understand the limitations and challenges with the proposed service
6. Further design of emergency services to provide adequate care in a timely manner

Workstream analysis

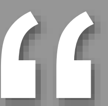
4c. Clinical Support Services

Summary of findings from JCM testing

5 proposed JCM changes reviewed

6 additional JCM changes identified

24 stakeholders engaged



The JCM recognises the critical role that Clinical Support Services has in all areas of healthcare. The key changes outlined in the JCM outline the expansion of services, including community services, and incorporation in the MDT workforce.

- The provision of services in the community will be leveraged by a workforce strategy
- Delineation of cancer services will also be leveraged by a **cancer** strategy
- Clinical Support services will be challenged to increase **capacity** and provide '**near testing**' with the current workforce and infrastructure

Additional considerations include further development of service specific plans to complement further development of changes from the JCM.

"Resources are currently scarce and difficulty in recruitment may exacerbate this"

"Community focussed pathways require significant change to the current model, especially as the current model is very centralised"

"Explore the opportunity for off site reporting (home working, other sites, etc.)"

1.7 *Average ease of implementation score*

1.4 *Average feasibility score*

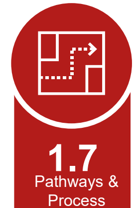
Average ease of implementation score by enabler

1.8 Digital

1.6 Estates

1.8 Workforce

1.8 Finance


1.7 Pathways & Process

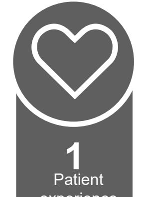
Average feasibility score by change area

1.7 Capability

1.3 Safety

1.8 Operational Efficiency

1 Acceptability


1 Patient experience

Note that due to COVID-19 pandemic, feasibility scoring was only able to be completed with Pod Chair

4c. Clinical Support Services

Detailed impact assessment findings

Integration of Clinical Support Services across healthcare services is becoming more prominent

Clinical Support Services in Jersey comprises of testing and diagnostic services, therapies, pharmacy and cancer care.

The JCM recognises the critical role that Clinical Support Services has across the healthcare system in Jersey. Thus, transformation of Clinical Support services from a centralised service to adapt to system-wide changes has been outlined in the JCM, and will need to evolve as its own entity to reflect innovations in service provision. The JCM has outlined the following key changes for Clinical Support Services:

1. Provide services such as physiotherapy in an out of hospital setting, and expanding roles of Clinical Support Services workforce
2. Developing the prominence of cancer services on-island
3. Increase the capacity of Clinical Support services
4. Improve the connectivity of Clinical Support services to Primary Care, including ‘near testing’.

Assessment of the changes with stakeholders identified that overall, these changes would be moderately easy to implement, and moderately feasible.

Opportunities for provision of services in the community, supported by MDT’s, support the key aims of the JCM, will require development of the workforce to support this change. Development of a cancer strategy will also realise the opportunities to provide more prominent cancer services on island.

Challenges have been outlined with increasing the capacity of services, due to current workforce capacity, and introducing ‘near testing’ for pathology and wider radiology, which may not realise the operational efficiencies or quality of testing that would be provided in a centralised model.

A number of additional recommendations for Clinical Support services include comprehensive workforce and digital strategies to maximise capacity and capability of the services.

Opportunities and challenges

Opportunity to increase **community-based** services to provide care in a **non-acute** setting

Challenges in the provision of an adequate **workforce**

A key opportunity for Clinical Support Services lies in community-based service provision

The JCM outlines the aim for some services to be partially or fully provided in an alternative care setting outside the hospital. The JCM highlights physiotherapy as a key example, with the highest proportion of outpatients activity currently provided in the hospital, and outlines that it could be lead through a community-focussed model of care. This service, as proposed in the JCM, would be closely aligned to a reablement / independence service that would be offered in the community and closer to home.

To support and develop Clinical Support services further in hospital and community care, the JCM outlines the further incorporation of Clinical Support services into MDT’s. Together, these changes correspond with the JCM’s aims of community focussed care, reducing the activity centred in the hospital footprint and improving service user experience by delivering care closer to home.

When considering the provision of these services in the community in Jersey, stakeholders noted the need to assess the suitability of community estates, with appropriate facilities for the outpatient services required, as exampled by physiotherapy outpatient services shown in Figure 45.

4c. Clinical Support Services

Detailed impact assessment findings

Figure 45: Top 5 physiotherapy outpatient appointments by service (2018)

In considering the context of Jersey for this change, the challenges in workforce capacity highlighted by stakeholders, and the redesign of pathways and processes to provide more services in the community may impact the operational efficiencies seen through centralised services. Community-based provision of services supported by MDT's is a key aim of the JCM, and may help to realise the benefits of community services with the workforce including Clinical Support Services. These benefits have been reflected in practice and have realised wider benefits across the healthcare system, in Secondary Care for example (Figure 46).

A core challenge in the realisation of this change in the JCM will be the provision of adequate workforce numbers to mitigate against potential reduction in operational efficiencies through providing care in the community[51].

"The safety aspect of this change is dependent on increases in the workforce, including physiotherapists, podiatrists and OTs"– Clinical Support Services Stakeholder

Therefore, whilst this change aligns with healthcare trends to provide care in the community, Clinical Support Services should consider further co-ordination of the workforce, and recruitment and retention strategies for these services, with development of robust organisational structures to support expanded roles.

Figure 46: MDT care home support[52]
Hospital admission rates in North Staffordshire and Stoke on Trent were increasing, reflective of an ageing population. A new Care Home Coordination Centre (CHCC) was developed and implemented to support people living in care homes. The scheme involved Community GP services, local hospices, community home physiotherapy and care home pharmacists.

A comparison of the pilot care homes selected for the project and other care homes has shown a 10% reduction in A&E attendance and admission to hospital.

Mixed assessments of feasibility challenge the repatriation of cancer services without a cancer strategy

The JCM highlights that whilst connections with tertiary centres should be strengthened, cancer services need to be more prominent on-island. Whilst the outline of potential repatriation of services to Jersey was broad, the JCM highlighted the opportunity for closer working with Guernsey, in order to deliver more services closer to home.

Assessment for the reason for this change is the basis of improving service user experience, reducing the impact of sending service users off-island for treatment, this was reiterated by stakeholder assessments.

When assessing the context of the change for Jersey with stakeholders, there were mixed assessments on the capability, safety and subsequent operational efficiencies that could be realised for this change. Challenges around workforce capacity was determined to affect the capability and safety considerations for this change. Specifically, specialist skills required to provide effective and safe cancer care on-island were identified as a potential limiting factor.

4c. Clinical Support Services

Detailed impact assessment findings

The financial impact of this change was discussed by stakeholders. Whilst there was acknowledgement of available charitable funds, and opportunities for public-private partnerships, the financial impact of the initial set-up of services, including procurement of high-cost equipment, may be compounded by lost savings through repatriation of activity, particularly in regard to economies of scale, with an indication of case numbers outlined in analysis (Figure 47).

Analysis on the feasibility of this change highlights two key considerations that need to be further developed. Firstly, the number of cases that would be needed to provide economies of scale in order to provide cost-effective and full complement of services to Jersey. Secondly, the sustainability of a cancer workforce to provide full complement of cancer services on-island will need to be fully investigated to understand the cost-benefit analysis of providing services on-island.

In summary of this review, development of a cancer strategy will be critical to delineate what cancer services can be provided, and provide clarity on the future for cancer care on-island. Other small islands within the UK[53] and internationally[54], in developing their cancer plans, have outlined key areas for development for their services, with Isle of Man exampled in Figure 48. As a result, a developed cancer strategy for Jersey may offer the potential to reduce the impact on current service provision described by stakeholders in this review.

Figure 47: Analysis on cancer off-island activity

In 2019, 185 cases in total were sent off-island, with radiotherapy, paediatric oncology and interventional radiology going to Southampton. This was an increase of 28 cases on 2018.

Figure 48: Isle of Man National Cancer Plan 2012-2022

Key points to consider for the cancer plan for Jersey:

- **Continuity of strong UK relationships** to provide a full complement of services
- **Development of cancer intelligence** by collecting a strong base of evidence to enable service planning and monitoring
- **Implementation of digital tools** to effect accurate data collection and results sharing
- **Prevention and early diagnosis** are considered as part of the strategy
- **The development of MDT's** to provide effective cancer care
- **Consideration of Children and Young People** with cancer
- **Alignment with supporting strategies**, including workforce and digital strategies.

Increasing the capacity of Clinical Support services is challenged by workforce limitations

The JCM outlines the need for increased capacity for services within Clinical Support services, noting specifically Clinical Investigations, Radiology and MRI capability and mobile equipment functions.

Testing with stakeholders highlighted challenges specifically around the capacity of the current workforce, and further difficulties in recruitment and retention were discussed as limiting factors by stakeholders. The impact on estates was also deemed substantial by stakeholders, specifically, the investment in community estates and high-cost equipment.

Workstream analysis

4c. Clinical Support Services

Detailed impact assessment findings

Analysis to review this change has been conducted, investigating and comparing the number of MRI and CT exams conducted in Jersey (Figures 50 and 51 respectively). Despite the caveat of the unique geographical context of Jersey, indications that an increase in CT exams would be in line with comparators, however this may be more challenging in MRI, due to the high number of exams already being carried out.

Whilst noting the challenges in recruitment and retention for Jersey (see workforce section for more information), to mitigate against these challenges, digital opportunities to improve operational efficiencies are being leveraged in the UK, particularly with regards to image reporting (see Figure 49), which could additionally be considered for services in Jersey.

In summary of the review of increased capacity, Jersey would be challenged to implement this without significant investment, and efficiencies to increase capacity may be better realised through digital opportunities.

Figure 49: Improving capacity for radiology reporting[55]

The East Midlands Radiology Consortium (EMRAD) was established across seven hospital trusts to combat shortages in workforce for radiology reporting. This consortium uses a cloud-based system to share images widely across the network, to allow reporters to work flexibly across trusts.

This model allows trusts that are experiencing workforce shortages to increase capacity for radiology reporting and avoid costly third-party solutions.

Figure 50: MRI exams carried out per 1,000 population

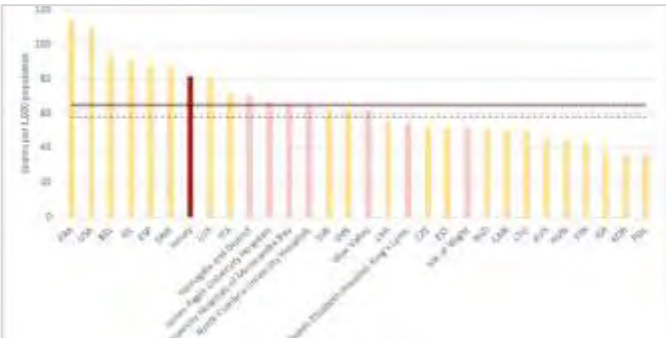
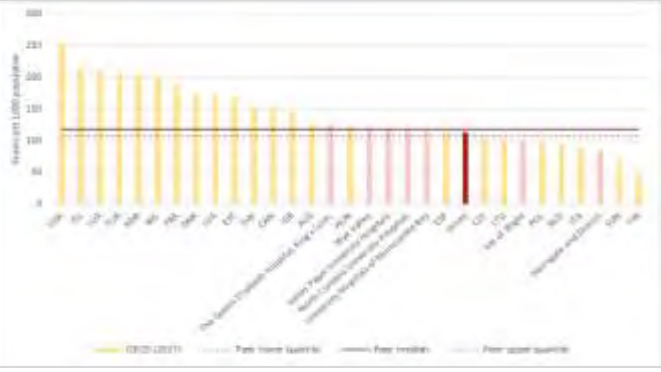


Figure 51: CT scans carried out per 1,000 population



Developing 'near testing' capability needs substantial investment in infrastructure

The JCM outlines the aim to connect Clinical Support services to Primary Care and develop 'near testing' capability, highlighting this change for Pathology and Wider Radiology services.

'Near testing' has been considered as part of the JCM to improve service user experience by decentralisation of services and provide testing closer to home in the community. 'Near testing', although not specified in detail in the JCM, also known as point-of-care testing, is an investigation taken at the time of consultation [56]. And may range from simple tests such as blood glucose monitoring, to screening programmes[57].

4c. Clinical Support Services

Detailed impact assessment findings

Stakeholders noted that the context of Jersey is important to consider for this change, as historically, satellite screening clinics have found challenges in workforce capacity, coupled with the location of the clinics reducing the service user experience of the service compared with centralised clinics.

Infrastructure was a recurring challenge highlighted throughout the assessment for this change, including digital integration, estates capacity and travelling arrangements for staff. With testing outside of the centralised service, stakeholders highlighted the importance of robust governance and quality assurance, and the current accreditation status of services.

'Near testing', whilst may be acceptable to service users who don't have to travel as far, may cause inefficiencies associated with time from test to results, factoring in transport of samples back to centralised labs for results. In addition, variation in results has been identified as a challenge in the UK, with actions to consolidate pathology centres underway[58] .

Overall, there is a need to further delineate what services could be applicable for 'near testing' as crucial to develop this change. On reflection of the efficiencies and potential quality of results from a centralised model, this change will need further development on what 'near testing' can be safely provided in the community, in line with a workforce plan, robust governance frameworks and consistent operational policies.

Beyond the cancer strategy and workforce planning, further consideration of changes to Clinical Support Services is needed to develop the JCM

1. Further development of plans, including implementation and operational plans, for service user services in Clinical Support Services will be required to fully develop and implement the changes set out in the JCM
2. Continue to empower service users and consider the accessibility of mental health service users/ children/ vulnerable adults to services delivered through Clinical Support Services
3. Develop extended provision of pharmacy services, including hospital outreach and outpatient dispensing
4. Develop a dedicated capacity for diagnostics to deliver same day emergency care therapy input into front door care of emergency service users
5. Improving the tendering of goods, tertiary services and sourcing of preparations, with the potential to work with Guernsey to achieve this.

Additional changes for Clinical Support Services:

Reflecting on the JCM, key stakeholders felt that the JCM was missing a focus on **implementation planning, pharmacy services, diagnostic capacity and goods tendering**

Key recommendations for Clinical Support services

1. Development of a cancer strategy will be crucial to support more prominent cancer services
2. Comprehensive workforce planning will help deliver more community based services, such as physiotherapy
3. Additional recruitment for workforce is needed to help increase workforce capacity for Clinical Support services
4. Delineation of 'near testing' capability need to be defined in order to assess whether this change is feasible for Jersey

Workstream analysis

5. Intermediate Care

Summary of findings from JCM testing

8	proposed JCM changes reviewed
8	additional JCM changes identified
18	stakeholders engaged

- The JCM outlines the transformation of intermediate care into a high-functioning service that is deeply embedded in the community and operates 7 days a week from 8am-8pm delivered through bed-based care, home-based care, crisis response and reablement
- The review found the changes outlined in the JCM **to be appropriate** for Intermediate care mode in Jersey – particularly those centred around **community services, including rapid response and reablement**
- However, for implementation to be **successful a detailed digital and workforce strategy** should be considered

1.3 ***Average ease of implementation score***

1.1 ***Average feasibility score***

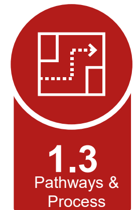
Average ease of implementation score by enabler

1.5 Digital

0.6 Estates

1.8 Workforce

1.5 Finance



1.3 Pathways & Process

Average feasibility score by change area

1.9 Capability

1.3 Safety

1.3 Operational Efficiency

0.8 Acceptability

0.6 Patient experience

> "To overcome the described limitations, Jersey could collaborate with voluntary services to fulfil human and financial resource needs"

> "Jersey lacks the ability to implement [Discharge to Assess] – this is largely owing to a lack of workforce, step down pathways, and ways of working together between medical and social care"

Workstream analysis

5. Intermediate Care

Detailed impact assessment findings

Strengthening Jersey's Intermediate care service could mitigate challenges with quality, value and experience

In its current state, Jersey's intermediate care function is small and disjointed. It primarily operates as a one-off service, with the majority of its activity seen in general inpatient care, as a result of substantial gaps in workforce and finance.

The JCM outlines five key changes for Intermediate care that focus on strengthening home-facing services

The JCM outlines the transformation of intermediate care into a high-functioning service that is deeply embedded in the community and operates 7 days a week from 8am-8pm. This will prove integral to shift care delivery away from acute settings. The JCM sets to achieve this through four core services:

1. **Bed-based:** Connect to broader community services (i.e. Closer to Home) to support 24/7 care needs, including frailty and elderly care
2. **Crisis response:** Expand hospital-at-home/rapid response service
3. **Reablement:** Develop early secondary care discharge with a discharge to assess model
4. **Home-based:** Intermediate services to have access to home-facing enabler services including domiciliary care.

These changes were scored as moderately challenging to implement and likely feasible. The testing identified the need for a workforce and digital strategy for implementation and highlighted connections with the community as essential to optimising the impact of the

Opportunities and challenges:

Opportunity for **rapid response, discharge to assess and home-facing services**

Challenge in **workforce** and **digital** limit ability to implement 7 day a week service

The review identified an opportunity to strengthen existing partnerships with community services

The majority of Jersey's intermediate care services are delivered by Family Nursing & Home Care (FNHC), an external partner. The JCM review highlighted an opportunity to explore partnerships with the wider third sector outside of FNHC.

£80m | raised annually through government funds and donations

These partnerships could be used to fulfil gaps in the community workforce and financial resources.

> "To overcome the described limitations, Jersey could collaborate with voluntary services to fulfil human and financial resource needs" - Key stakeholder

This seems achievable in the future as there has been evidence of successful collaboration in the past. In fact, Jersey's intermediate care services has a track record for partnering with the third sector to deliver value in the community. For example, Jersey's partner FNHC implemented a 7am-11pm operating service and an electronic system in 2019.

Connecting with community services could…

70% | reduction in service users in **residential care**

Testing the opportunity to connect with third sector community services identified minimal barriers to implementation as a result of Jersey's strong history of partnerships, which is promising given the analysis supporting the review showed that it could reduce.

service users in nursing and residential care by 46% and 70% respectively. To optimise the value of this opportunity, the review identified the need for ring-fenced estate and budgets for these services.

5. Intermediate Care

Detailed impact assessment findings

There is an opportunity to expand existing crisis-response services to lower avoidable inpatient admissions

In 2014, Jersey developed a Rapid Response and Reablement Service (RRRS) in partnership with FNHC. Six years later, the service still has low activity, despite the high rate of low acuity ED admissions that would be better treated by this service. This represents an opportunity to increase the uptake of this service to target the number of unnecessary hospital admissions and shift care delivery to the community in line with the JCM. In this instance, learnings from Camden's[59] successful Rapid Response Service are important (Figure 52).

Figure 52: Camden's Rapid Response Service support unwell service users to remain in their home or the community, rather than be admitted to hospital. The service supported **80% of their service users to avoid hospital admission**, resulting in a **total 10.4% reduction** in emergency admissions.

The evidence supports the opportunity to develop Jersey's RRRS service in Jersey. In the literature, CNWL called out the importance of pathways & processes and strong partnerships with local initiatives in delivering a successful rapid response service. Jersey already has the described pathways in place for implementation. However, to optimise the value this service could offer, Jersey will need to formalise it's pre-existing rapid response pathways and establish stronger and more transparent links with community resources.

Reablement and home-based care could be employed to maximise the impact of crisis-response services

Analysis suggests that an average of 25 beds were being used each week by delayed patients across the second half of 2019. This represents a key issue for service provision as the evidence supporting the review suggests that an increased length of stay can impact service user outcomes and service efficiencies. The JCM outlines an opportunity to target length of stay by implementing a discharge to assess model, supported by home-facing enabler services. The discharge to assess model will support service users to leave the hospital early and continue their care in the community as supported by home-facing services, such as domiciliary care. This sentiment is supported by the evidence from Newcastle[60], where a similar service was implemented (Figure 53).

Figure 53: Newcastle upon Tyne Hospitals (NUTH) showed that of their sample service user pool, **89% were discharged early** either to their home (85%) or a place of residential care (15%), **reducing total length of stay to 25 days**. Together, this **reduced the total average occupancy** rates.

Reflecting on this evidence, it is important that discharge to assess and home-facing services are pursued given their ability to target length of stay, whilst supporting two of the four core components of the JCM's Intermediate care offering: home-based care and reablement. However, the JCM review identified barriers to implementation with workforce. More specifically, Jersey will need to upskill their current workforce and create community-focused multi-disciplinary roles. To conclude, Jersey will need to develop a workforce strategy to define how its current workforce will implement these services.

"Jersey lacks the ability to implement [Discharge to Assess] owing to a lack of multi-disciplinary workforce" – Intermediate Care Stakeholder

Workstream analysis

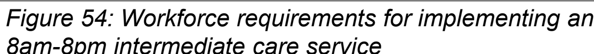
5. Intermediate Care

Detailed impact assessment findings

Central to the vision for the JCM is a community-focused intermediate care function that runs 8am-8pm every day

Currently, care is primarily delivered as a one-off service, with the majority of activity seen in general inpatient settings (56%) and community mental health (20%). This represents a shift in care delivery into the community, which could be supported by the aforementioned opportunities.

Figure 54: Workforce requirements for implementing an 8am-8pm intermediate care service



Workforce requirements

Every service user will require:

- 1 rapid response team
- 9 physiotherapy visits
- 21 domiciliary/rehab support

Impact

50%

reduction of ED attendances for falls

The analysis supporting the review showed that if implemented, a community-focused intermediate care function could reduce ED attendance for falls by 50%. However, despite its potential impact, the JCM review identified this change as not feasible given current workforce (Figure 54). Reflecting on the assessment and supporting analysis, one stakeholder acknowledged that this change could be implemented if it was supported by "precise resourcing and rota development using staffing and pathways modelling". Beyond this, it would also require core training plans and job profiles, that reflect a wider multi-disciplinary workforce. This presents a significant challenge given that an 8am-8pm service is central to achieving the aims set for intermediate care by the JCM. To mitigate this, a detailed workforce strategy could be developed.

> "Jersey lacks the workforce required to implement this change in a safe manner... and lacks the capabilities to provide 24/7 services and support" – Intermediate Care Stakeholder

Outside of workforce challenges, the review highlighted interoperability as a key barrier to implementation

When testing the JCM, stakeholders reported that intermediate care services lack digital interoperability, particularly between care provided by HCS and external partners, such as FNHC.

> "It is difficult to navigate people to the right service owing to limited interoperability between systems" – Intermediate Care Stakeholder

During the review, it was noted that the lack of digital interoperability affects the ability to navigate service users between services. Stakeholders recognised that this could negate the potential benefits of implementing the identified opportunities, including linking with community initiatives and external partners, as well as developing integrated, community-facing rapid response, home-facing enabler and discharge to assess services. This is because poor digital interoperability would affect care delivery and operational efficiencies, as well as service user and staff experience.

> "Jersey has a strong voluntary services presence, however they lack digital interoperability [with HCS service providers] through online systems / databases" – Intermediate Care Stakeholder

The analysis undertaken by the review has outlined the potential value of digital interoperability by demonstrating the impact of successfully implementing the JCM changes as a whole. More specifically, if the JCM were to implement home-facing enabler services, rapid access to secondary diagnostic care, patient-centred planning and links with community-facing initiatives then there could be a 48% reduction in 65+ service users in nursing homes. Ultimately, the analysis shows that benefits cannot be realised if each change is implemented in isolation.

5. Intermediate Care

Detailed impact assessment findings

Beyond workforce and digital, further consideration of changes to Intermediate Care is needed to develop the JCM

1. Development of co-ordinated transport pathways and support between intermediate care and primary / secondary / tertiary
2. Intermediate care to establish protocols and pathways for community care
3. Intermediate care to partner with the Third sector to deliver community services
4. Integrate telehealth service to provide assistance to intermediate care functions as demonstrated by Airedale NHS Foundation Trust who saw a 40% decrease in demand for GP services, 33% decrease in ED attendance, and a 25% reduction in non-elective hospital admissions
5. Re-design workforce to include mental health practitioners in intermediate care services
6. Establish a culture shift to support Allied Health Professionals in being respected within the intermediate care workforce
7. Develop means of supporting carers operating within intermediate care
8. Create a front door workforce to support care delivery in service users place of residence.

Additional changes for Intermediate Care:

Reflecting on the JCM, key stakeholders felt that the JCM was missing a focus on **transportation** and **telehealth** services, as well as a **clear workforce strategy**.

The review found the JCM changes to be appropriate, although implementation should consider workforce and digital

The review demonstrated that the key changes outlined in the JCM are appropriate, however they would need to be considered alongside a workforce and digital strategy. Furthermore, stakeholders continuously emphasised the significance of a single point of access in the community, potentially in the form of a community hub, that could be linked to a wide range of resources. This was one of the key themes that emerged from the review, alongside the significance of reablement and home-facing services.

Key recommendations for Intermediate Care services

1. Develop a detailed workforce strategy that considers upskilling the core workforce, recruitment and retention of talent, as well as integrated ways of working across providers
2. Develop a detailed digital strategy that covers digital interoperability between providers, as well as an island-wide IT platform
3. Implement the identified key changes for Intermediate care, that focus on providing bed-based care, crisis response, home-based care, and reablement services
4. Establish a culture shift to support the implementation of the identified changes, specifically by encouraging ways of working across multiple teams with an emphasis on the use of Allied Health Professionals and partnerships with external providers
5. Consider strengthening telehealth service offering and integrate with Intermediate care services

Workstream analysis

6. Women and Children's Services

Summary of findings from JCM testing

10 proposed JCM changes reviewed

4 additional JCM changes identified

11 stakeholders engaged

The JCM does not currently set out a detailed vision for Women and Children's services under the new care model. The key changes from current service provision set out are:

1. Integrate **primary and secondary paediatric services**
2. Establish a **Paediatric Assessment Unit**, co-located with Paediatrics
3. Develop transition pathways from **children's to adults' services**
4. Improve children's health through **paediatric public health initiatives**

Additional changes to the care model identified during the review include: providing more gynaecology care in the community; establish a pre-conception advice service; have follow-up hysterectomy clinics be nurse-led; improve ambulatory care through enhancing laparoscopic skills and increasing day cases.

Women and Children's services require a more detailed vision of the future care model to be set out. Comprehensive workforce and estates strategies are needed to fully understand the requirements to implement the proposed model.

1.2 *Average ease of implementation score*

0.5 *Average feasibility score*

Average ease of implementation score by enabler

Average feasibility score by change area

"Integrating secondary and community paediatric services would deliver better targeted services "

"A whole island, all ages approach is needed to reduce levels of childhood obesity"

"Transition pathways are needed to provide a safe service"

6. Women and Children's Services

Detailed impact assessment findings

Detailed planning is needed to understand the envisaged future state of Women and Children's services in Jersey

Women's health services are currently delivered in a predominantly acute setting, with the majority of obstetrics and gynaecology care provided at the hospital. Paediatric health services are also delivered mainly through the hospital, with a large number of paediatric ED attendances and referrals into paediatrics observed.

Review of the JCM highlighted that description of the future state of Women and Children's services in Jersey was less robust compared to other areas of the model. However, the JCM sets out some key changes to the current state of health and care provision:

1. Integrate primary and secondary paediatric services, working closely with GPs to provide care and advice in home and community settings
2. Establish a Paediatric Assessment Unit (PAU) with shared facilities for CAMHS, co-located with Paediatrics
3. Develop transition pathways from children's to adults' services and associated commissioning arrangements to support this
4. Improve children's health through a number of initiatives supported by paediatric public health: increase the number of Year 6 pupils who are a health weight; increase the number of two year olds who reach developmental milestones; reduce the number of under 18s requiring a dental extraction; and increase the number of pupils who report a good quality of life.

The JCM also states that Child and Adolescent Mental Health Services (CAMHS) are to transfer from Health and Community Services (HCS) into Children and Young People's services (CYPES).

Testing demonstrated that these changes are moderately easy to implement and likely to be feasible.

Analysis and review of good practice from elsewhere suggests that the proposed changes to the model of care would be beneficial to Jersey's health system and in line with accepted good practice.

Opportunities and challenges:

Opportunity to integrate **primary and secondary** paediatric services

Challenges surrounding visibility over available treatment / clinical pathway options

There is an opportunity to integrate primary and secondary paediatric services

This could be achieved by working closely with GPs to provide care and advice in home and community settings. Currently, GPs and paediatric doctors do not work closely together, and there is a lack of paediatric expertise in primary care, as well as a cost associated with accessing GP care. Integrated paediatric services would mean that paediatric doctors could hold outreach clinics in GP surgeries, providing an alternative to accessing paediatric care in an acute setting.

Integrating services through the proposed 'Connecting Care for Children' model offers an opportunity to reduce the burden of unnecessary paediatric ED attendances, and improve the way children's care is delivered [61], as has been seen in north west London [62] (Figure 55).

Figure 55: 'Connecting Care for Children' is a paediatric integrated care model which addresses the disproportionately high rates of paediatric A&E and outpatient attendance in London. Using child health hubs there has been an increase in engagement with expertise and specialist outreach, with one reducing new hospital appointments by 39% and A&E attendances by 22%.

Jersey has a high number of children aged 0-9 attending the ED compared to its peers (Figure 56). Analysis has shown that if attendance rates were reduced to the peer lower quartiles, 21% of attendances for age 0-9 would move out of hospital, equivalent to approximately 1,100 by 2035. Approximately 580 attendances per year for ages 10-19 could also move out of hospital by 2035.

6. Women and Children's Services

Detailed impact assessment findings

Figure 56: ED attendances per 1,000 population aged 0-9

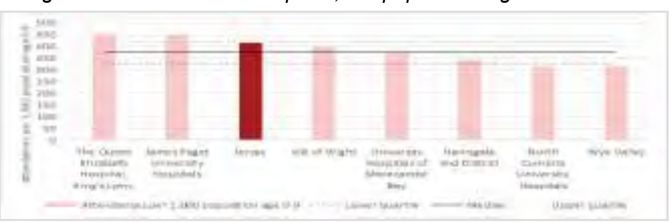
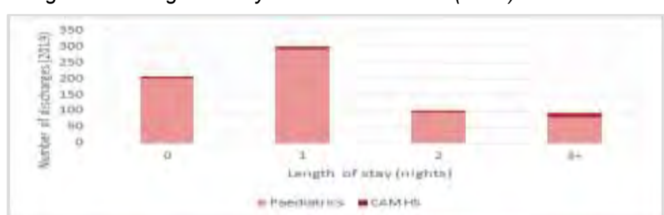


Figure 58: Length of stay distribution at JGH (2019)



Health literature called out not only significant reductions in unnecessary A&E and outpatient attendances, but an improvement in service user and carer experience, with service users preferring appointments at the GP and parents and carers stating increased confidence in taking their child to the GP.

Given the identified opportunity to reduce demand on Jersey's paediatric ED attendances, and the evidence in health literature that paediatric integrated care models reduce secondary care usage and improve service user satisfaction, integrating primary and secondary paediatric services in Jersey is advisable. Further consideration of the necessary digital tools and pathway design to support integration is recommended.

Co-locating a PAU with Paediatrics may enable more effective paediatric emergency care

Jersey is seeing increasing attendance and admission rates for infants, children and young people, as detailed in the JCM. The majority of cases are short stays, that may be eligible to be assessed in a PAU (see Figure 57). This would free up capacity in the emergency care setting to focus on emergency admissions.

Figure 57: Paediatric admissions - length of stay
Of the emergency paediatric admissions in 2019:

- **30%** had a zero night length of stay
- **43%** stayed for one night (Figure 58)

These admissions could be eligible to be treated in a PAU. Based on 2019 activity, the PAU would need to have **capacity for 2-6 service users, including 1-4 service users overnight.** Over the year, at 2019 activity levels, this would be equivalent to an average of **1.4 service users arriving per day** (maximum of 6) with **0.8 stays per night** (maximum of 4).

This change in service provision has also been seen in the UK where short-stay PAUs have been shown to provide effective care, and resulted in reductions in admissions to inpatient wards [63]. The potential gains in productivity by co-location to paediatric units have also been seen by other healthcare providers [64] (see Figure 59). The benefits of PAU co-location are dependent on the proposed staffing model. As stakeholders recommended that paediatric staff should staff the PAU, co-location with the paediatrics ward should be considered for implementation of the care model.

Figure 59: Barnsley Paediatrics Assessment Unit
Barnsley Hospital had a separate Paediatrics Assessment Unit, Emergency Department and Paediatrics Wards, with staff and service users having to walk daily between departments. There was also huge demand on the emergency department, partly due to high admission rates for children in Barnsley. In October 2019, work began to build a co-located PAU with a Paediatrics Emergency Department. The aim is to improve service user and staff experience through reducing time spent between departments and also increase capacity for adults in the Emergency Department.

Developing transition pathways may support the provision of joined-up, holistic care for people of all ages

Testing suggested that various services struggle with the transition from children's to adults' services, leading to confusion around what care is available at a vulnerable time. Transition pathways provide continuity of care, improving safety and service user experience by making sure that service users experience a smooth transition between one type of care and another.

6. Women and Children's Services

Detailed impact assessment findings

Under the new care model, transition pathways would be in place to support the transition between children's to adults', and adults' to older adults' services. A clear definition of what comprises a transition pathway is not given in the JCM, however during testing, stakeholders strongly supported the development of such pathways, stating that this needs to be done to provide a safe service, particularly for young people aged 16-18.

Evidence suggests that the creation of transition pathways increases the support and interventions available to service users [65], as has been seen at Sheffield Teaching Hospitals (Figure 60).

Figure 60: The Children and Young People Lead Nurse role was created to support young people with complex needs to transition between children's and adult services, supporting all clinical specialist areas. This resulted in improved service user flow, with 24% more young people being correctly referred to the Mental Health Liaison Service, better service user experience, and expanded multidisciplinary working.

Findings from the review demonstrated that developing transition pathways would address a gap in service provision which is seen at vulnerable periods in service users' lives. Furthermore, evidence from the health literature suggests that the development of pathways and standardised practice means that high quality care at transition is available to all service users, irrespective of the complexity of their needs. Evidence also suggests that having a coordinated approach to transition is beneficial to the experience of service users and their families. Having a central point of contact may enable service users and families to better access services, leading to better outcomes and fewer delays in care.

It is therefore recommended that transition pathways are developed, with further consideration given to the workforce requirements to implement this, In particular, stakeholders highlighted closer working with GPs and robust, effective teaching and education as key to supporting the implementation of transition pathways.

"Various services struggle with the transition – this change *needs* to happen to provide a safe service." Paediatric Services Stakeholder

There is an opportunity to improve children's health through a number of initiatives supported by public health

The JCM states four key aims to improve children's health which are set out in the Children and Young People's Plan 2019-2023:

- Increase the number of Year 6 pupils (10-11 years old) who are a healthy weight
- Increase the number of two year olds who reach their developmental milestones in all domains
- Reduce the number of under 18s who require a dental extraction
- Increase the number of pupils who report they have a good quality of life.

All of the above aims are underpinned by a need for extensive public health initiatives, and all support the physical and emotional wellbeing of Jersey's young people. Evidence shows that adverse experiences in the early years of life [66] impact negatively on the developing brain and other organs, and such impacts often manifest in later adult years as chronic disease, including mental health disorders. Investing in children's wellbeing is therefore a means to investing in generations of healthy adults to come.

In 2017/18, 32% of Year 6 pupils were overweight or obese, while 20% of reception pupils were overweight or obese. Analysis has shown that Jersey has a relatively low proportion of children overweight or obese compared to peers, but that Jersey moves from the lowest ranked area for obesity amongst reception pupils to the fourth lowest ranked for obesity amongst Year 6 pupils (Figures 61 and 62).

This suggests that the rate of increase between reception and Year 6 may be higher than the peers.

Jersey Care Model

6. Women and Children's Services

Detailed impact assessment findings

This would suggest that implementing interventions at an early age would support more children to maintain a healthy weight as they get older.

Figure 61: Proportion of children overweight age 4-5

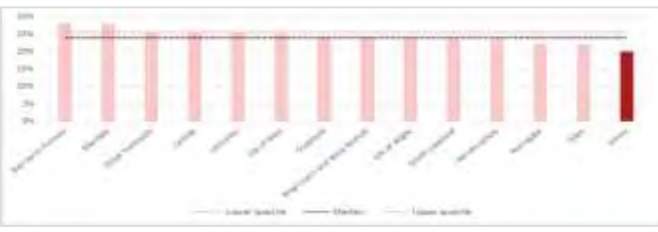
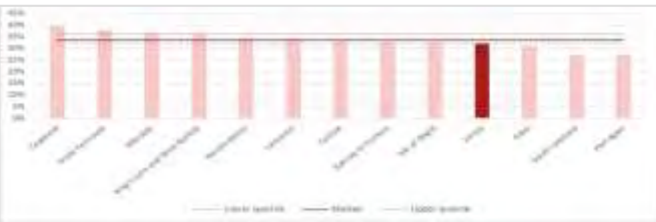


Figure 62: Proportion of children overweight age 10-11



Engagement with the public health team during the review suggested that the JCM should integrate with Early Years programmes, particularly around nutrition, and should link to the offer being developed through the 'Closer to Home' initiative. The benefits of nutrition education and tackling childhood obesity through prevention initiatives [79] have been documented elsewhere (Figure 63).

Figure 63: 'Let's get kids fit' is a structured education programme developed in the West Midlands to inform and educate mothers on the importance of nutrition in infancy and childhood. This resulted in a decrease in the number of mothers who agreed that babies cannot have too much milk, from 47% to 8%, showing the importance of education in nutrition as a tool to prevent childhood obesity.

The proposed initiative to reduce obesity levels in Year 6 children should be implemented, as analysis of Jersey data and examples of good practice demonstrate that early intervention around diet and nutrition help children to maintain a healthy weight, which in turn supports a healthy adolescence and adulthood. The review identified that further consideration should be given to introducing a breastfeeding initiative and establishing an integrated food and nutrition strategy in support of this change.

"This would deliver operational efficiencies in the long term, as it would reduce the number of adults undergoing bariatric surgery, or who suffer from diabetes or cardiovascular disease." Paediatric Services Stakeholder

Beyond a PAU and transition pathways, further consideration of changes to Women and Children's Services is needed to develop the JCM

1. Increase the amount of gynaecology care provided in primary care settings and reduce referrals into secondary care. This could be achieved by pathway reconfiguration and GP education
2. Establish a pre-conception service to offer advice to service users with pre-existing conditions and co-morbidities who are looking to conceive, such as diabetics and smokers
3. Consider the potential for follow-up hysterectomy clinics to be nurse-led rather than consultant-led
4. Ambulatory care can be improved to reduce acute admissions – this could be achieved through enhancing laparoscopic skills and increasing day case activity

Additional changes for Women and Children's services:

Reflecting on the JCM, key stakeholders felt that the JCM was missing a focus on **gynaecology care in the community, pre-conception services** and **follow-up clinics**

6. Women and Children's Services

Detailed impact assessment findings

Key recommendations for Women and Children's services

1. Work up operational plans to support the proposed changes for Women's Health. In the course of reviewing the JCM, it was noted that significant proposed changes to Women's Health services are absent from the JCM. Further work is required to operationalise the additional changes identified by stakeholders
2. Work with colleagues in CYPES and Public Health to develop a plan for how HCS, CYPES and Public Health will work together to deliver the changes proposed in the JCM
3. Develop a comprehensive workforce strategy, considering the workforce requirements to provide more women's health care in the community, and for GPs to work closely with paediatric doctors in an integrated care model
4. Develop a robust estates strategy, considering the estates requirements to support the increased provision of outpatient care in community settings, and the co-location of a PAU to the paediatrics ward
5. Design care pathways to support the new model of care, in particular in support of the proposed additional changes to the JCM. There may also be capability development requirements in support of increasing laparoscopic and day case activity to reduce acute admissions in Women's Health.

Workstream analysis

7. Primary Care and Prevention

Summary of findings from JCM testing

11 proposed JCM changes reviewed

11 additional JCM changes identified

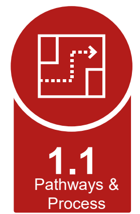
27 stakeholders engaged

- The JCM outlines key changes for primary care, including the **development of prevention and self-care programmes**; improved **access to vulnerable service users**; and the creation of a 24/7 multi-disciplinary primary care workforce to support care delivery in the community
- The review found that the changes outlined by the JCM to be **easy to implement**, however they **overlooked opportunities to target wider determinants of health and at-risk populations** using **Public Health Management**
- For implementation to be successful a **digital, workforce and estates strategy** will be required, as well as governance frameworks.

1.4 *Average ease of implementation score*

0.6 *Average feasibility score*

Average ease of implementation score by enabler



1.1	1.3	1.8	1.7	1.1
Digital	Estates	Workforce	Finance	Pathways & Process

Average feasibility score by change area

1.5	0.4	0.6	0.5	0.3
Capability	Safety	Operational Efficiency	Acceptability	Patient experience

"The impact of this will be determined by the agreement made by Government / States on the Primary Care and Prevention funding process"

"This will require increased number of advanced care practitioners to support the need for larger primary care workforce and a shift towards MDT working to fulfil needs of complex service users"

7. Primary Care and Prevention

Detailed impact assessment findings

There is a need for Primary care and prevention services to adapt to current challenges with health and care quality

In line with the projected challenges across the system, including key issues with demographic growth and comorbidities, the pressures felt by Primary care and prevention services are expected to increase. The current service structure is unsustainable owing to the limited integration with Secondary and community care and the ongoing requirement for service users to pay for care.

> "We must evolve our health and care system to meet service users' needs... This will include testing new approaches to the delivery of primary health care, with more support from the community and Parishes, through multidisciplinary teams" – JCM

Affordable access to services and multi-disciplinary working are central to the new model of car

The way in which care is delivered in Jersey is set to fundamentally change as we transition from a hospital-centric to a community focused model of care. Primary care and prevention services will prove integral to this transition and delivering on the future care needs of Jersey's population. The JCM outlines six key changes required to achieve this:

1. Innovate and promote resources that help citizens with self-care for themselves, their families and loved ones to improve health outcomes
2. Expand and enhance prevention and screening to identify and treat risk factors, pre-cursors and disease as early as possible
3. Improve and remove potential barriers to access for service users who are financially, clinically and socially vulnerable
4. Maintain the existing excellent rapid access to Primary Care services
5. Repurpose existing Secondary Care resources into preventive and Primary Care services to try and reduce current over-reliance on our Secondary Care services
6. Provide and support high quality multidisciplinary care, 24-hours a day, 365 days a year – with the right care in the right place at the right time.

These key changes outlined in the JCM were tested to be moderately easy to implement and likely feasible. However, the changes overlook the need to target the wider determinants of health to achieve patient-centric care, which is outlined as the vision for the JCM. To this point, the testing saw a need to divide Primary care and Prevention as two separate services, as by joining the two together, preventative services become too medicalised

The testing also identified the need for a detailed workforce, estates and digital strategy for implementation, as well as emphasised the significance of affordable access; prevention and self-care programmes; and multi-disciplinary ways of working in optimising the impact of the JCM.

Opportunities and challenges:

Opportunity to **expand access** to primary and preventative services and develop a network of resources linked to a **community hub**

Challenges in repurposing secondary care services and developing **24/7 workforce**

The review highlighted a key opportunity to remove barriers to access for vulnerable service users

The literature highlights the significance of health inequalities. Research from 25 European countries shows that health inequalities costs 700,000 deaths, 33 million cases of ill health, and €980 billion per year(80).

In Jersey, health inequalities are being perpetuated by the current barriers to Primary care access. Here, the privately funded Primary Care model limits access for the most vulnerable of society, including

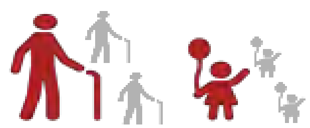
Workstream analysis

7. Primary Care and Prevention

Detailed impact assessment findings

financially, clinically and socially disadvantaged. This includes the 1 in 3 children and 1 in 3 pensioners who occupy low income brackets. As a consequence, a proportion of the Jersey population struggle to access Primary care – this does not include access to other Secondary care services (Figure 64).

***Figure 64:** Proportion of population who struggle to access Primary care and prevention services*



***1 in 3** pensioners and children occupy low income brackets, which affect their ability to access Primary care services owing to **high consultation fee**.*

The review tested the opportunity to improve Primary care access to vulnerable service users as outlined in the JCM with key stakeholders. Stakeholders recognised that this would prove integral to achieving the vision laid out in the JCM, without presenting significant barriers to implementation. This is supported by the analysis performed by the review showing increased access. However, Jersey would need to consider the long-term financial impacts of this opportunity to secure sustainable access. This challenge could be mitigated by a detailed finance strategy that remodels the current funding structure.

"The impact of [improved access] will be determined by the… Primary Care funding process" – Primary Care Stakeholder

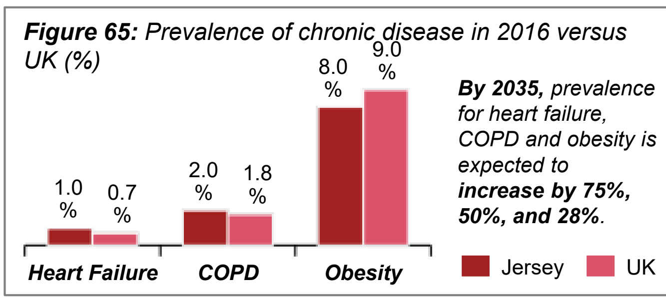
Stakeholders also reflected on the potential impact of wider Primary care access, noting it could improve system-wide efficiencies by reducing secondary care service requirements. To this point, this shift in care delivery would also increase demand on GP services, which would need to be reflected in the workforce. To conclude, benefits realisation is dependent on future workforce and funding structures. Therefore to implement this opportunity, these structures would need to be explored in greater detail for this to be feasible.

By testing the opportunity to expand access, the review identified the need to increase prevention and self-care

The World Health Organisation in their report "the Case for Investing in Public Health" argue that prevention offers a cost-effective means of targeting health inequalities and wider health outcomes. Their argument is built on the premise that financially, clinically and socially vulnerable service users are at a greater risk of developing health issues. Therefore to target health risk in Jersey, improving access to care will need to be complimented with preventative measures to help shape health behaviours.

The opportunity for prevention and self-care as outlined in the JCM was tested against quantitative and qualitative analysis. This identified a strong case for prevention as the evidence highlighted a strong prevalence of chronic conditions in Jersey, relative to the UK, which is expected to grow (Figure 65).

***Figure 65:** Prevalence of chronic disease in 2016 versus UK (%)*



By 2035,** prevalence for heart failure, COPD and obesity is expected to **increase by 75%, 50%, and 28%.

The broader opportunity for self-care lies in Jersey's current approach to chronic conditions. In 2018, the General hospital held on to approx. 40,000 avoidable outpatient visits which could have been avoided entirely by patient education and self care, or delivered in the community, or by GPs. This could be targeted by promoting self-care to reduce reliance on services and target outcomes. An example is the Symphony Programme in the UK[68], which links service users with coaches and resources (Figure 66).

Figure 66: The **Symphony Programme** covers an enhanced primary care function that support service users to better **manage** their **own conditions** using health coaches, who coach **service users** on their condition and link them with community resources.

7. Primary Care and Prevention

Detailed impact assessment findings

Using the Symphony Programme as an example, the opportunity for prevention and self-care was viewed as easy to implement. However, the JCM would need more detail on how self-care could be achieved. In addition to this, Jersey would need to develop a detailed workforce and estates strategy to outline the additional resources required. In addition to this, Jersey would need to remodel its funding structure, which does not incentivise prevention or self-care.

> "[Prevention and self-care programmes] will need additional space as GP space is often sublet... the workforce will also need to extend beyond GPs, [we] lacks the community and clinical pharmacists" – Primary Care Stakeholder

When evaluating the broader prevention agenda, it becomes clear that the JCM places too strong an emphasis on clinical preventative services. It overlooks the opportunity for preventative services that target the wider determinants of health, such as housing and wellbeing. These types of services could be explored through the Closer to Home initiative, which offers a broad range of holistic community services at monthly roadshows. In addition to this, the JCM overlooks the opportunity to identify and target high-risk populations with these types of holistic services. Moving forward, Jersey should consider Public Health Management opportunities to support the broader prevention agenda.

Jersey could develop a network of resources linked to a community hub with a single point of access

This will compliment Jersey's prevention and self-care agenda by linking service users to the appropriate community resources to better manage their condition, for example the Closer to Home initiative.

The opportunity to build a network of support resources linked through community hubs as outlined in the JCM tested to be difficult to implement. This was as a result of poor digital interoperability between primary and community care, as well as the limited functionality of Electronic Health Records as prominent barriers to implementation. Given this, if the appropriate digital resources were in place then this opportunity could be feasible. To conclude, Jersey would need to develop a digital strategy that defines the next steps for achieving interoperability to meet the implementation needs of a community hub.

Stakeholders acknowledged the need to repurpose secondary care services and resources into primary care ones

This is because the proposed JCM will impact on primary care activity levels, which will need to be met with more workforce and estate. In its first year, Jersey will experience an additional 12,000 GP appointments, which will rise to 240,000 by 2065. Repurposing secondary services could provide the resources required by the JCM, whilst reducing over-reliance on secondary care (Figure 67).

Figure 67: *Impact of repurposing secondary care services*

Described change	*Impact*
Repurposing secondary care services *into primary care*	Reduce follow up outpatients for: • Dermatology by 12%, • Cardiology by 32%, • Neurology by 30%, • General medicine by 35% • Respiratory medicine by 50%

Despite the need for repurposing, it presents strong barriers to implementation. In that without clear specifications of how this would be enacted in the JCM, it is unclear how the current estate and workforce resources would be repurposed.

Underpinning the identified opportunities is the need to provide a multi-disciplinary, 24/7 care service

Providing 24/7 care using a multi-disciplinary offers a means of catering to the complex needs of Jersey's ageing population.

> "There is a need for a shift towards MDT working to fulfil needs of complex service users" – Primary Care Stakeholder

7. Primary Care and Prevention

Detailed impact assessment findings

The review tested this as difficult to implement given limited workforce and current funding structure. This is supported by the evidence performed by the review. A detailed workforce strategy that covers an approach to recruitment and retention, as well as culture change would be advised.

To achieve the opportunities identified, Jersey needs to review its current payment structure

When testing the JCM with key stakeholders, they assessed that remodelling Jersey's current payment structure would be central to realising its potential value. They noted that this is because the current payment structure disincentivises service users from attending Primary care by encouraging them to seek Secondary care services that are free-of-charge. In addition to this, it discourages GP practices from collaborating or innovating services as their primary income is through GP appointments. Beyond workforce and finance, further consideration of changes to Intermediate Care is needed to develop the JCM

Additional changes to Primary Care and Prevention services were identified during the review:

1. Make online service user records universal and accessible to all
2. Implement system governance and regulatory frameworks
3. Establish GP recruitment needs through workforce analysis, followed by recruitment and retention
4. Expand use of quality improvement frameworks to encourage pilots for innovative working
5. Establish means of collaborative working between primary and secondary care, as well as social and mental health services
6. Support the budget in following the service user as services shift out of secondary care
7. Incentivise immunisation through drives
8. Drive the development of holistic hospices and end of life care, with consideration for carers
9. Develop respite care residences with access to step up and step down care
10. Explore activity-based payment models
11. Develop sustainable workforce through retention strategy that emphasises training of staff
12. Develop formalised relationships with family / carers to expand workforce and at-home care

Additional changes for Primary Care and Prevention:

Key stakeholders felt the JCM was missing a focus on **governance** and **regulatory frameworks**, and **workforce** and **finance**.

The review highlighted the need to further consider workforce, digital, and finance before implementation

The review found the key changes outlined in the JCM as moderately easy to implement, however they overlook the workforce, digital and funding requirements for patient-centric care.

Key recommendations for Primary Care and Prevention services:

1. Develop a workforce, estates and digital strategy that considers the core requirements of the JCM
2. Align on funding strategy for primary care that can support financing and improved access
3. The outlined strategies will need to be in place to support the smooth implementation of the JCM
4. Following implementation, focus should turn to community-focused MDT ways of working that emphasis prevention first and community care
5. Broader Public Health Management opportunities should be explored with a view of targeting the wider determinants of health

Enablers

Digital

- In Jersey, there are challenges with digital **interoperability** and visibility over available **digital estate**
- The review identified opportunities to **innovate care** delivery with the use of new **digital solutions and services**
- The review **recommendations** the implementation of efficient interoperable IT systems and flexible changes to support the new JCM, which will require investment an estates assessment

Estates

- The review identified **challenges with** achieving the **estates needs** of the JCM
- However, the review also identified opportunities to **repurpose existing estates** to support the shift in care delivery into the community
- To progress the JCM to implementation, it was recognised that an **estates strategy** would be required

Workforce

- The review identified major challenges with the **lack of focus on skill development** in the JCM, as well as gaps in the workforce, particularly in **Intermediate Care** and **Clinical Support Services** that could affect efforts to implement the JCM
- However, the review **recommended** Jersey pursue several opportunities to realise the full benefit of the JCM, including the transition to **a multi-disciplinary workforce** and inter-agency working with **external partners**

Finance

- The JCM review identified challenges in the **current** funding and payment **frameworks**, including **high costs** of and inequity for low socio-economic groups
- The analysis supporting the review, which highlighted that **failure to change the current** model of care will lead to **significant** financial **pressures –** in total, the **JCM** is forecast to **avoid £198m of expenditure growth between 2021 and 2036**

Pathways and Processes

- The JCM review identified opportunities to **streamline** current pathways and processes; improve **referral** management; **partner with Guernsey;** and reduce ED admissions
- Alternatively, challenges were identified in **lack of workforce capability and financial resources,** compounded by the current payment model

Enablers

Outline of enablers

As outlined in the workstream analysis section, the proposed changes to current care delivery set out in the JCM were tested for ease of implementation against five key enablers

Digital – the digital tools, systems, technologies and capabilities required to support care delivery across the health and care system

Estates – the buildings, facilities and equipment required to support care delivery across the health and care system

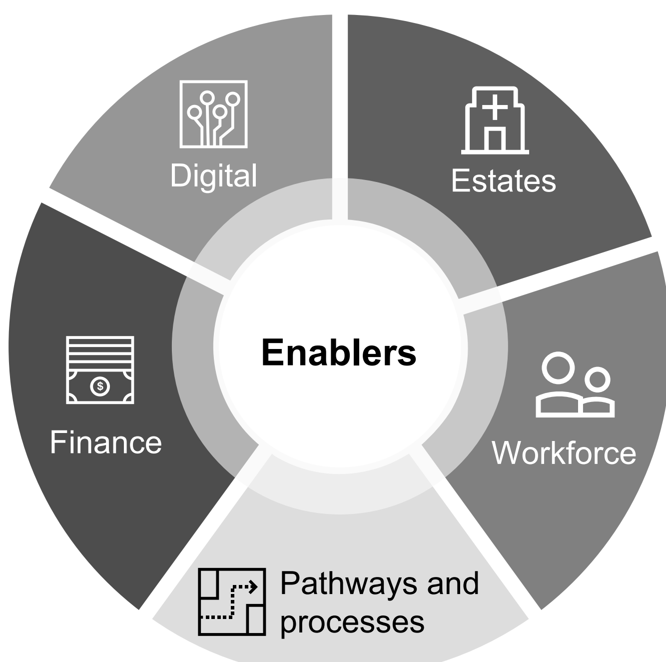
Workforce – the staff, skills, training and capabilities required to deliver care

Pathways and processes – the care pathways, clinical and operational processes required to support care delivery and enable service users to access care

Finance – the investment, funding streams and payment mechanisms required to enable care delivery across the health and care system

The following section sets out the overarching findings pertaining to these enablers across all of the workstreams in the JCM.

Figure 68: Outline of different enablers



Digital

Detailed enabler findings

Digital was identified in the JCM testing as a key enabler to the transformation of Jersey's health and community care

At a high level, the JCM describes a future health and community care system and Future Hospital which are digitally enabled and digitally optimised to transform care experience and bring therapeutic benefits to all ages and complexities. Though the JCM does not set out in detail the proposed benefits of a digitally optimised system, comparative models demonstrate that this will be required to:

- Improve value, through delivering services more efficiently at a lower cost
- Improve service user and staff experience through greater choice in care provision and supported self management - both key drivers for the development of the new care model.

The changes proposed in the JCM will require the effective use of existing technology in use in the existing health system, alongside innovative forms of technology, to be able to transform support the delivery of sustainable services.

In addition to this, a digitally enabled model should support the provision of an integrated care system and PMH through interoperable digital systems and robust data management. This should support the strategic aims of the JCM of improving population health, whilst realising savings..

The digitally-enabled model set out in the JCM is more ambitious than previously proposed

The ambitious vision of the JCM is anticipated to impact on the physical scale and requirements of the both the Hospital and community care IT infrastructure. There will need to be a significant increase in access to devices, WiFi and training.

Further to this, integrated reporting systems could reduce off-island activity and associated costs. For example greater connectively could reduce the number of samples going off-island and improving turnaround times for diagnostics and provide options for greater collaboration with systems like Guernsey and France.

The proposed JCM changes were tested against qualitative and quantitative analysis to identify key challenges and opportunities for the JCM.

Opportunities and challenges:

Challenge in understanding the **available digital estate** across providers and achieving **digital interoperability**

Opportunity to innovate care deliver with the use of new **digital solutions and services**

An assessment of current digital estate was highlighted as an essential next step in system-wide transformation for Jersey

An assessment of the current technology and estate plan is not detailed in the JCM, but would be needed to support the implementation of the proposed changes. This would enable prioritisation of digital initiatives, such as the Digital Skills Strategy [69], and other associated interventions required to the JCM.

In all the workstreams there are innovative digital opportunities that stakeholders identified that were not in the JCM.

Figure 69: In 2018, Jersey launched a **Digital Skills Strategy** to provide an educational road map to a successful digital-tech workforce. The strategy was created due to the low level of digital skills in Jersey's workforce. Key recommendations of the strategy include a **digital skills partnership** and **labour market insights** to continually monitor industry's evolving technical skill requirements.

Digital

Detailed enabler findings

Digital solutions and upskilling will be key to patient centred care.

This included opportunities to develop digitally enabled tertiary pathways for specialist care using telemedicine for clinics and off-site specialists.

"Telemedicine is key for clinical support services, including telemedicine options for clinics and for dial in specialists off site" – Key stakeholder for Clinical Support Services

"Data sharing arrangements are needed for effective data transfer to tertiary centres" – Key stakeholder for Mental Health

To digitally optimise the new care model greater interoperability is required between systems

Testing identified that the current lack of digital interoperability between care systems will impact the ease of implementing the proposed JCM changes. For example, primary care, secondary care and mental health records are not currently transferable between providers. This is a potential barrier to the effective implementation of an integrated care hub between primary and secondary care, and a community hub linking resources through a single point of access.

Figure 70: Opportunity for integrated reporting identified by analysis supporting review

Digital interoperability between primary and secondary care → **5-8%** ***reduction in follow-up appointments***

"Digital is key for the implementation of changes in the JCM such as co-located mental health services and community-based crisis response" – Key stakeholder for Mental Health

"For secondary care – better connectivity to primary care and mental health is needed for management of activity" – Key stakeholder for Unscheduled Care

Spotlight on interoperable systems

Testing also highlighted the need to establish interoperable digital systems between providers to realise the full value of the changes outlined in the JCM.

Key considerations for Jersey:

- *Including mental health patients in the proposed integrated hub model: The lack of interoperability between Physical and mental health electronic patient records is affecting the quality of care delivery in mental health services. This is a result of poor continuity of care between services. This could be resolved through an integrated care hub model as outlined in the JCM that includes mental health outpatients*

- *Use interoperable systems to detect high risk patients as a part of the wider prevention agenda: integrated report systems offer a means of storing and tracking data. This capability could be used to identify at-risk patients and target them with preventative services*

Figure 71: Queensland Health in Australia implemented **Cerner integrated electronic medical records (ieMR**) across five hospitals to reduce the inefficiencies of paper-based notes [70]. As a result of this system, an average of **6,500 patients' medical records** are opened daily, leading to greater operational efficiency. More specifically, by reducing drug administration and monitoring errors by **14%,** drug dispensing and supply incidents by **33%, 28-day** emergency re-admissions by **17%** and healthcare-associated infections by **37%.**

This evidence suggests that digital interoperability offers a means of improving service efficiencies and impact on patient experience, Jersey should include interoperability and associated governance structures in their future model of care. Including this in the JCM will support the future development of innovative digital tools and solutions for care management.

Digital

Detailed enabler findings

The review identified interdependencies between digital and all other enablers, highlighting its significance to the JCM

The potential for digital to support specific service areas across the system in line with other enablers was highlighted. More specifically, the review identified the significance of digital in supporting the expansion of community services, the paid carer workforce and home care services. This was identified to be particularly significant for Women's and Child Health, as well as Mental Health. This is supported by evidence where implementing digital solutions and services has shown beneficial to other capabilities [(71)].

Spotlight on digital innovation

The review highlighted the need to increase the role of digital innovation in the new model of care. Effective use of technology, including both technology currently in use within Jersey's health system and innovative forms of technology, can support the delivery of sustainable services.

Key considerations for Jersey:

- *Innovative technologies can combat key issues with the health services: Technology can be used to improve value, through delivering services more efficiently at a lower cost, as well as improve service user and staff experience through greater choice, connectivity and access.*

Figure 72: Due to the shortages in psychiatric physicians in remote areas of Nebraska, **a telepsychiatry programme** was launched. Instead of attending the one hospital in Omaha for outpatient appointments, patients could travel to one of **six sites** across the state and speak virtually to a clinician. As a result, in **2017,** there were more than **900 telepsychiatry visits** for more than **300 patients,** psychiatrists saved **26 hours** in windshield time, patients had to travel **96,000 miles** fewer annually by travelling to offices for calls rather than Omaha and there was a 50% reduced **'no show' rate** of appointments.

Key recommendations for digital:

1. An assessment of the current digital estate including digital technologies currently available, to inform planning, prioritisation and development
2. Investment in digital solutions with the development of associated governance and data sharing structures
3. Implement efficient, interoperable IT systems to enable sharing of data and capacity information, reducing waiting times and unnecessary duplication
4. Prioritise flexible solutions which can be adapted to the rapidly changing health and social care landscape.

Estates

Detailed enabler findings

Rethinking estates will enable the shift away from Jersey's current hospital centric model as outlined in the JCM

The JCM proposes a significant shift of activity from secondary care settings into the community as there were a high number of avoidable visits per year to secondary care including low acuity ED admissions and 40,000 outpatient visits identified, both of which could have been avoided by better care management in primary and community settings (Figure 73).

For this to be achieved the use of current estate will need to be reimagined, in particular, community estates may need to be repurposed or developed. Developing the island wide estate profile should support the JCM aim of providing person centred care closer to home, whilst creating efficiencies and value in the system.

The JCM review identified a number of specific estate changes that will support a shift in focus to community care

The JCM proposes a shift in the provision of services from the hospital, secondary care estate, to community based estate such as primary care centres and home based care.

Estate changes described in the JCM include:

- **Primary care:** Shifting the provision of services currently delivered in secondary care services into primary care, including utilising Jersey's non-acute bed-base
- **Intermediate care:** Expansion of rapid response, reablement and frailty services to support care delivery in the home
- **Secondary care:** Establishing an Emergency Care Centre that comprises an acute and emergency floor model with a co-located Urgent Care Centre, as well as reallocating secondary care services to shift outpatient referrals into the community and other secondary care services moved to digital or community based services where possible.

Testing the JCM identified two key avenues for estates transformation to support future care delivery

Two key areas of focus identified for estates to support the changes outlined in the JCM are:

1. **Reimagining secondary care estate:** adapting the current secondary care estate profile including reallocating services to primary care
2. **Building integrated community hubs:** create networks of community services available through a single point of access in community hubs linked through rapid response and reablement services.

These areas will require significant change to current estate and a clear view of the future estate requirement and strategy would be required. Despite these needs, stakeholders in Review perceived estates as having a lower impact and change than finance and workforce.

Opportunities and challenges:

Opportunity to **repurpose existing estates** and form strategic partnerships with **parishes**

Challenge to clarify **estates needs** and **strategy**

Figure 73: In 2012, £12 million was invested into building a Community and Health Centre in Sparkbrook, Birmingham, offering both health and council services on one site. The centre serves population of 15,000 and offers a variety of services, including dental services, baby clinics, stop smoking clinics and physiotherapy. There are also rooms for community use and events, offices for start-up social enterprises, a library and garden. As part of the NHS Friends and Family test, 97% of patients recommend this service, highlighting the success of the centre.

Estates

Detailed enabler findings

Stakeholders outlined the positive impact estates changes will have on both the potential operational efficiencies and patient experience if they can support facilitating discharge back into the community. This is supported be the evidence from a community health centre in Birmingham (Figure 73 on prev. page)[72].

The JCM review identified substantial barriers to reimagining the secondary care estate profile

Testing the opportunity to repurpose secondary care estate with key stakeholders highlighted barriers to implementation, including limited estates capacity.

The JCM further lacks detail regarding how this change will be implemented. For example, there is limited detail on the estates requirements for the future ECC, or descriptions of which secondary care estates will be repurposed and how.

It is recommended that a detailed estates strategy including with a full assessment of current secondary care estate is completed to further understand the estate needs, in light of the Our Hospital programme.

Stakeholders were supportive of the proposed JCM change to reimagine secondary care estate

"This change may deliver operational efficiencies at a system level, however this may not be realised at a service level." – Key stakeholder for Scheduled Care

"A redesign of the current estate could focus more on the discharge of patients, compared to the current estate which is focussed on admissions" – Key stakeholder for Scheduled Care

The Review identified a need to develop community estates to support the implementation of the new care model

The JCM identified a need to shift care from a secondary care to primary and community care. In order to achieve this, there must be consideration for primary and community estates.

This additional activity will need to be reflected additional in the community estates capacity. Given current primary care estate is at capacity, there would be a need to adapt and develop existing resources and service provision to support this demand. In response, the JCM proposes adapting community estate to lessen demand on primary and secondary care services and estate. This includes:

- **Developing an integrated care hub** that connects primary and secondary care and replaces traditional outpatient service
- **Creating a single point of access** through community hubs that are linked to a network of support resources including the Closer to Home initiative
- **Strengthening intermediate services,** including reablement, rapid response and home-facing enabler services to provide more care in the home.

"Good community estates means less demand for beds in wards" – Key stakeholder for Adult Social Care

Evidence suggests that good community estate can act as a means of reducing over-reliance on health services. For example, the Program of All-inclusive Care for the Elderly (PACE) in America used a community-based model of care to reduce demand on secondary services and estate by supporting the elderly to receive care in the community (Figure 74)[73].

Figure 74: The Program of All-inclusive Care for the Elderly (PACE) has created a **community-based model of care** that coordinates medical and social services for the over 55s. The model currently operates out of **260 PACE community centres** and supports **50,000 seniors to receive their care in the community.** Each PACE patient has their own **healthcare plan**, with researching demonstrating that through this plan PACE patients present with better outcomes than non-PACE patients.

Enablers

Estates

Detailed enabler findings

Though the PACE programme operates on a larger geographical and financial scale, similar models could be explored in Jersey through strategic partnerships with the Parish system to provide similar community services and overcome issues with limited estate capacity in Primary and Secondary care. This would represent a future opportunity for partnerships between Parishes.

Stakeholders reflecting on the opportunity to optimise the use of community estate:

"There is currently inadequate infrastructure in the community for the [integrated care hub model] to work" – Key stakeholder for Scheduled Care

"GP practices and community services are at capacity in terms of estate… Strategic partnerships with parishes could overcome the described issues" – Key stakeholder for Primary Care and Prevention

Spotlight on decentralisation

The review highlighted the need to establish care closer to patient's place of residence to support further integration of the future care model in the community

Key considerations for Jersey:

- *Single point of access: A single point of access in the community will be essential to efficient and effective flow and embedding the new care model in the community*
- *Workforce and estates need to be embedded in the community: Workforce, both voluntary and public, need to be connected with the community*
- *Delivering care at home: supporting care delivery at home will require a new means of approaching an estates assessment*

Spotlight on digitally-enabled estate

The review highlighted the need to support digitally-enabled estates development moving forward.

Key considerations for Jersey:

- *Delivering care at home: can residents estates be repurposed, for example fitted with home monitoring device to reduce estates requirements*
- *Adapting estates to meet digital needs: when repurposing estate there is an opportunity to build digital tools into the new estate – this will require substantial planning and funding*

Key recommendations for estates:

1. Perform a detailed estates assessment that details current estate and how this will need to change to meet identified changes
2. Develop an estate strategy that outlines how current estate will be adapted or built out to meet the aims set by the JCM
3. Repurpose existing secondary care estate
4. Develop community estate resource pool

Enablers

Workforce

Detailed enabler findings

Workforce is key to realising the ambition set out in the JCM

The existing committed health and community care workforce in Jersey is identified as a key strength of the health and care economy and foundational to any plans for future change. Both specialist and non-specialist workforce will be crucial to support the implementation of the new model of care, and to supporting the sustained success of future services.

A multi-professional workforce will be required to deliver the proposed integrated care model and provide high-quality multidisciplinary care, 24-hours a day. This will be true for the delivery of individual care for service users and for implementing new models of service delivery such as integrated hubs and virtual hubs. The new model of care will require an increase in workforce numbers, particularly in the community. Therefore effective use of digital options and appropriate estate will be key to supporting the workforce in working effectively to deliver care in the proposed model.

Opportunities to mitigate against challenges in workforce capacity have been outlined in the JCM

With the current population of Jersey around 105,500, the availability and sustainability of adequate healthcare workforce numbers in Jersey presents a unique challenge.

Factors including the geographical and political context of Jersey, in addition to the cost of living and availability of accommodation, provide challenges to recruitment and retention. In this context options to develop novel training, recruitment packages and flexible working should be explored to support the growth of a diverse workforce able to meet the needs of the people of Jersey.

The challenges of recruiting and retaining staff is not unique to Jersey being reflected elsewhere in the UK and internationally. In the UK the current national shortage of >100,000 staff is projected to reach 250,000 by 2030 (74), highlighting a need to change workforce roles and models.

If issues in workforce numbers do not match those required for the new model there may be risks of community services focussing on task-based care, instead of providing holistic patient-centred care through thorough assessments and preventative measures (75).

Opportunities to develop the workforce to meet the current and future needs of Jersey are outlined in the JCM. A key finding from this review was that there is an absence of a current island-wide workforce strategy and the need to develop this.

A number of challenges were outlined in the JCM:

- **A lack of focus on skill development**, for example in Primary Care, due to the current secondary care focussed model
- **Gaps in the workforce** are notable, particularly in Intermediate Care and Clinical Support Services

Opportunities to develop the workforce were also outlined:

- ✔ **Developing a multidisciplinary workforce,** working in effective care channels across services in health and social care
- ✔ **Enhancing partnerships** with wider providers to further extend workforce capacity and capability
- ✔ A **review of the funding and finance** mechanisms to achieve a strong, sustainable workforce model
- ✔ **Transforming the working culture** to incentivise change, and embody the principles of care outlined in the JCM

Workforce

Detailed enabler findings

During the JCM testing, the impact of proposed changes on workforce was assessed

This included projections of the additional staffing numbers for a range of staffing groups, if the model were implemented in 2020, and projections for staffing numbers if the model were running in 2065.

Analysis and stakeholder engagement highlighted workforce shortages in specific service areas, particularly in Intermediate Care, and Clinical Support Services. The current rates of locums was highlighted as a key challenge given the associated high cost and impact on a reduction in investments in the substantive workforce. In addition to this the 2065 projections highlighted the need for a substantial increase in extended roles for allied health professionals, which will require training and development of the current workforce alongside the increased recruitment to new posts.

The feasibility of the proposed changes was assessed including capability, operational efficiencies and safety. Testing this across the seven workstreams the changes were assessed as moderately feasible overall. It was concluded that there is capability in the system to implement the proposed changes set out in the JCM, given the necessary resources to achieve these, and that the changes would support operational efficiencies and safety. To achieve this key steps would need to be undertaken including a full assessment of the workforce profile and future capacity constraints, in addition to development of the organisational culture.

Core to the JCM is delivering an integrated model of care through a multi-professional workforce

This will support the provision of person centred care through connecting Primary and Secondary Care and centring care provision around a person's needs rather than by condition. Establishing multi-disciplinary teams (MDTs) have been shown as key to supporting this, such as in the integrated care initiatives developed in the UK to address high levels of demand for Primary and Emergency Care (see Figure 75).

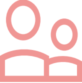
Figure 75: Hubs in West Yorkshire[76]
NHS and social care hubs, where health, housing and social care, voluntary and community partners work together are examples of where a range of workforce groups are coordinated to provide holistic care with an efficient use of resources. Teams of social care and health professionals and coordinators triage referrals with an urgent care team for any patient needing rapid care. Once triaged patients are seen by the most effective staff group to address their issues, including nurses, occupational therapists, physiotherapists, social care workers, voluntary workers, housing officers or mental health workers. In six months the Hubs have seen almost **2,000 people including 636 urgent referrals**.
This model allows patients who may otherwise receive fragmented care, with multiple referrals and handovers, to be **seamlessly supported** whilst making the most effective use of available workforce.

Spotlight on multi-professional workforce

The review highlighted the need to further consider how to establish a workforce that could provide effective, personalised care

Key points for consideration:

- *The long term condition management would be enhanced by multidisciplinary teams co-ordinating and providing patient-centred care*
- *Establishment of a 24/7 workforce model can support round the clock care in the community through multi-disciplinary teams, including out of hours GP, secondary care clinicians and workforce in the community*



Workforce

Detailed enabler findings

Leveraging digital is key to supporting workforce in multi-disciplinary teams

This assessment identified a number of opportunities and interdependencies associated with digital were highlighted throughout the JCM review to support the workforce. International examples demonstrate how hospital services can be developed to become fully digitally enabled, supporting workforce and estate constraints (Figure 76). Challenges may arise due to limited digital infrastructure, and lack of integration across services (please refer to Digital section).

To effectively use digital to support workforce education and training should also be considered, including additional IT training required for staff in order to maximise the effectiveness of virtual care.

Figure 76: Mercy Virtual Hospital[77]
A pioneer of this approach in the US, Mercy Virtual Hospital provides examples of where teams of medical professionals, using digital technologies, can "roam" wards and treat patients through video conferencing and telephone consultations. Mercy Virtual delivers virtual care services to 600,000 patients across seven states in the US, improving patient outcomes and access while reducing total cost of care. Operating 24-hours a day and is staffed with more than 300 clinicians, it's often called "a hospital without beds"

Maximising use of appropriate primary-care and community workforce will be key to releasing capacity from hospital

The JCM and analysis conducted during testing highlighted a shortage in the current workforce numbers and a historical focus of activity, training and development, into secondary care. This presents a current challenge which the new model seeks to overcome, however the new model is dependent of a significant increase in workforce, particularly in primary and community care. Future workforce planning will need to incorporate both new roles, such as extended practitioner groups for allied health professionals, and partnerships with voluntary sector and communities. Community service initiatives have demonstrated substantial benefits including reduced non-elective admissions and attendances (Figure 77).

Figure 77: Living well initiative[78]
In a rural and financially deprived area, Living Well is a partnership between the voluntary sector, health, social care and local people. Driven by GP champions, Living Well aims to help people who are socially isolated and highly dependent on services to improve their quality of life and aims to reconnect people with their communities. Analysis of the first phase has shown that:

- 49% reduction in non-elective admissions
- 36% reduction in emergency department attendances
- 28% reduction in the number of people being admitted to a community hospital
- 20% reduction in the length of time people stayed in a community hospital
- 20% selfreported improvement in mental wellbeing
- 8% reduction in social care costs; and
- 4% increase in out-patient appointments.

Spotlight on enhancing partnerships

The review highlighted the need to extend workforce capacity and capability

Key points for consideration:

- *Working with local communities and partners to expand community-based capacity (see External Partners section) and support growth of the carer workforce.*
- *The reliance on external partners should also be considered as a potential challenge in considering the sustainability of the core healthcare workforce*
- *Potential benefits of network/partnership should be assessed in development of cancer services*

Enablers

Workforce

Detailed enabler findings

Spotlight on training and development

To meet the needs for increased provision of community based services a range of workforce development plans will be required, including the development of extended/ practitioner roles, support for carers and volunteers and increased recruitment.

Key points for consideration:

- *Continuing professional development needs should be considered as a tool to attract and retain community workforce*[79]
- *Developing advanced practitioner roles was highly recommended in developing a community focused intermediate care function*
- *Development of training for paediatric and adult staff to support transition pathways between children's to adults' services*
- *Increase the support provided to carers, including the review of training programmes to strengthen carer's core skills and offer greater learning opportunities*

Spotlight on transforming culture

The review highlighted that developing culture is key to supporting the delivery of the JCM, in particular:

Key points for consideration:

- *Development the workforce culture to stimulate innovation/new ways of working and avoid a 'blame culture' – Mental Health and Adult Social Care*
- *Training needs to be supported by a culture shift in the workforce, which could be driven by leadership with champions at all levels – Intermediate Care*

Key recommendations for workforce

1. An island workforce strategy with a comprehensive business plan for the provision of 24-hour
2. Enhanced support for carers
3. Continued development of partnership models with External Partners
4. Develop the multidisciplinary workforce with extended roles including pharmacists, nursing, physiotherapy, mental health workers,
5. Development of Primary Care Practitioners with Special Interests, e.g. Dermatology
6. Assessment of existing workforce's skills and additional training needs
7. Extended roles should also include occupational therapists
8. The role of carers and external partners as a key part of the workforce should be included

Enablers

Finance

Detailed enabler findings

Existing financial structures pose a challenge to Jersey's proposed future model of health and community care

The JCM highlights that whilst investment in health remains a strong political priority, there are some key financial challenges that need to be tackled first. These include the following:

- The current payment framework does not incentivise self-care, collaboration or innovation
- There is a lack of funding and utilisation in specific service areas, specifically pharmacy, nursing, dental and optometry are under-utilised and extended services are not being provided
- There are high rates of high cost residential care
- There is inequity in access to health and community care, particularly for low socio-economic groups that are unable to afford primary care services
- At present hospital based emergency healthcare treatment is free at the point of use. In contrast, GPs are privately run and not part of the Health and Community Services (HCS) department. This difference in pay models is driving overuse of ED for non-acute events

Reviewing the existing financial structures to support the new model of care will increase access to care for vulnerable groups and deliver on the JCM

During the JCM testing, engagement with stakeholders across the system has identified finance as a key enabler to improving healthcare in Jersey. This could be achieved through enhanced funding structures and transforming payment frameworks, which will:

- Encourage investment to develop new services to meet current and future demand, based on demographic changes
- Increase accessibility to care, particularly for clinically, socially, and vulnerable people
- Support the allocation of financial resources across Jersey Island, encouraging the shift in service use from secondary to primary and community care

Opportunities and challenges:

Challenge in the **current** funding and payment **frameworks**, including **high costs** of and inequity for low socio-economic groups

Opportunity to support investment, **access to care** and allocation of financial resources

A key consideration for the JCM is the additional funding required to support the increased provision of primary care to meet the potential reduction of secondary care outlined in the JCM. For example, implementing rapid access and 'near testing' would require a redistribution of the HCS budget.

To meet the funding requirements of expanding primary and community services, stakeholders have suggested co-operation with external partners to provide specific services. Stakeholders cited the example of needing to meet the high costs of equipment required to deliver cancer services on-island, as outlined in the JCM. It was expressed that financial and resource support from external partners could be an option to assist with these needs. External partners could also support increasing access to affordable housing to support carers, which could reduce total investment required by HCS.

"Should see repurposing of budget to shift funding towards primary care" – Primary Care Stakeholder

Another consideration is the availability of investment. For example, investment in Adult Social Care is required to support the increased provision of care advice and support for families as outlined in the JCM. Similarly, workforce will require investment for training and recruitment to support the development of multi-disciplinary teams and the expansion of the roles for pharmacists, nurses, physiotherapists and mental health workers as outlined in changes associated with Clinical Support Services.

Finance

Detailed enabler findings

Figure 78: Partnering with the Third sector[81]
In order to tackle insufficient capacity in the community to treat the growing elderly population in non-acute settings, PACE (a US non-profit organisation) delivered care in community centres across 31 States to 50,000 seniors who otherwise would require care in a nursing home setting. This resulted in reducing the days spent in hospital to an average of 0.2 days, in comparison to 0.8 days for non-PACE enrolees. This highlights the importance of government and third sector partnerships to address limitations with financial resources and that establishing a strict framework for government funding and regulation is important for programme sustainability.

Payment models are key to generating needed finances whilst increasing accessibility

Outside of funding structures, stakeholders identified payment models as a key enabler in delivering on the vision outlined in the JCM. The vision set by the JCM is to encourage the shift in service use from secondary care into primary and community care services, which will be supported by changes to workforce and estates. To realise the potential impact of these changes, the payment structure will need to be reviewed. This is because service users may be disincentivised from using future services, such as 24/7 community care, if they have to pay for out of hour GP visits.

"Service users may refuse night services if they are required to pay, which could result in under utilisation of services" – Key stakeholder for Primary Care and Prevention

The JCM proposes a range of payment frameworks that could be implemented to overcome these challenges, including international models like NHS care, social health funds, private/public health insurance schemes and blended models.

Key recommendations for finance

The following recommendations include those identified in the JCM and through testing of proposed changes through engagement of stakeholders. The recommendations advised to take forward include:

- Reviewing the funding structure in order to support the shift from secondary to primary care
- Identifying potential new funding streams, including expanding public contributions to social security, general taxation/ indirect taxes/charges or prescription charges for some medicine
- Reviewing the payment framework, potentially charging for A&E and supporting those unable to afford to pay. This could be through expanding the income support system, such as the use of Primary Care Medical cards
- Implementing personalised budgets for service users' care, supported by on-line banking

Additional recommendations identified include improving the tendering of goods, tertiary services and sourcing of preparations, with the potential to work collaboratively with Guernsey or France to achieve efficiencies and economies of scale.

Finance

Financial Impact of the JCM

An assessment of the financial impact associated with the changes proposed in the JCM has been undertaken

This has considered the patient flows around the Jersey health and care system, and the impacts that these have in terms of income and expenditure for the system. The following areas have been considered in scope for the analysis:

1. All income and expenditure associated with the Health and Community Services Department
2. The Health Insurance Fund (HIF) and Long Term Care (LTC) fund, which sit within the Customer and Local Services department
3. Income and expenditure associated with Child and Adolescent Mental Health Services (CAMHS) within the Children, Young People, Education and Skills Department
4. Additional expenditure associated with Public Health changes proposed in the JCM, within the Strategic Policy, Planning and Performance Department.
5. Individual contributions to General Practice.

Our financial modelling has considered two main scenarios:

1. The 'do nothing' scenario, i.e. the forecast income and expenditure impacts associated with continuing with the existing model of care
2. The 'do something' scenario, i.e. the forecast income and expenditure impacts associated with implementing the Jersey Care Model as well as understanding the one-off costs required

Within the 'do something' scenario we have split out our analysis into each of the individual interventions contained within the JCM (noting that some interventions occur in multiple focus groups). For each of these interventions, our analysis shows both the avoided cost growth/savings associated with implementing the proposed change and also the addition costs required in the new care setting (reprovision costs).

Failure to change the model of care will lead to significant financial pressures for health and care services

While GoJ has made significant investments into health and care services in recent years (and has projected to continue to do so in the Government Plan), health and care expenditure is forecast to outstrip these investments due to a number of factors including:

- **Growing population:** The population of Jersey is forecast to grow by over 19% by 2036.
- **Increased health needs:** Demand for healthcare services forecast to grow by a faster rate than the growth in population, primarily due to an aging population with increasingly complex health needs. For example, through looking at current usage of hospital beds and how patient groups are going to change over time, demand for hospital beds has been estimated to grow by over 31% by 2036.
- **Cost of healthcare is increasing:** Inflation in the healthcare sector is typically higher than other parts of the economy. It has been assumed that healthcare costs will increase by an average of 3% per year.

We have forecast that, without making changes to the care model, expenditure on the HCS department will grow from £234m in 2020 to £288m in 2025 and £457m by 2036. This will create a £125m funding pressure by 2036 even if GoJ continues to increase HCS allocations in line with projections in the Government Plan.

There are also likely to be similar pressures in other departments including on the following relevant areas:

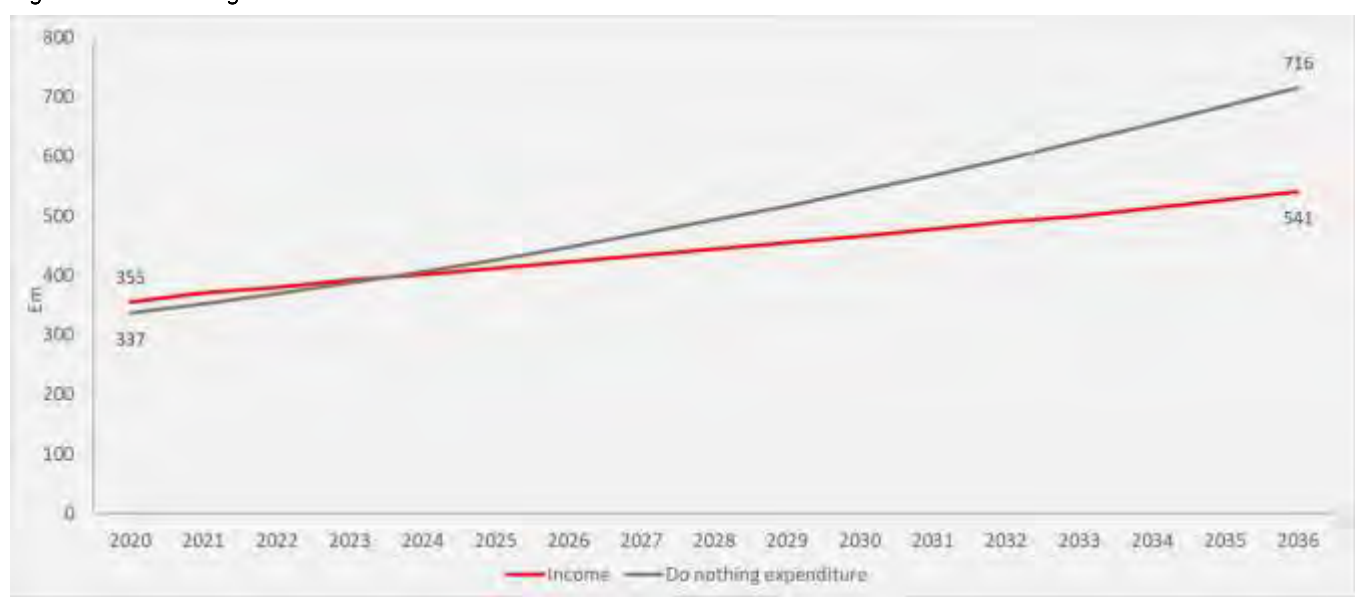
- **Customer and Local Services:** The Long Term Care (LTC) fund and, to a lesser extent, the Health Insurance Fund (HIF) are forecast to face financial pressures as expenditure grows faster than income.
- **Children, Young People, Education and Skills:** Child and Adolescent Mental Health Services (alongside other children's services) are forecast to have a financial pressure of just under £2.5m by 2036.

Finance

Financial Impact of the JCM

Do nothing financial forecast

Figure 79: Do nothing financial forecast



Do nothing financial forecast

Table 4: Do nothing financial forecast

(Income)/expenditure (£m)	2020	2036
Health and Community Services	(234)	(333)
Customer and Local Services	(107)	(182)
Children, Young People, Education and Skills	(4)	(4)
Strategic Policy, Planning and Performance	-	-
Patient/User Contributions	(11)	(21)
Total income	**(355)**	**(541)**
Health and Community Services	234	457
Customer and Local Services	89	230
Children, Young People, Education and Skills	3	7
Strategic Policy, Planning and Performance	-	-
Patient/User Contributions	11	21
Total expenditure	**337**	**716**
Income (over)/under expenditure	**(18)**	**175**

Finance

Financial Impact of the JCM

In total the JCM is forecast to avoid just under £23m of expenditure growth in total for the health and care system by 2036

For each of the changes proposed in the JCM, we have estimated how patient flows will be impacted and then modelled an appropriate change in forecast expenditure.

This includes both areas where activity will reduce (i.e. removing patients from in hospital settings) and where they will increase (i.e. provision of new services to enable the change). On the following pages we will refer to the first of these as ‘gross financial savings’ and the second as ‘re-provision costs’. The combination of these two will give the ‘net financial savings’.

This approach is summarised in the flow diagram below.

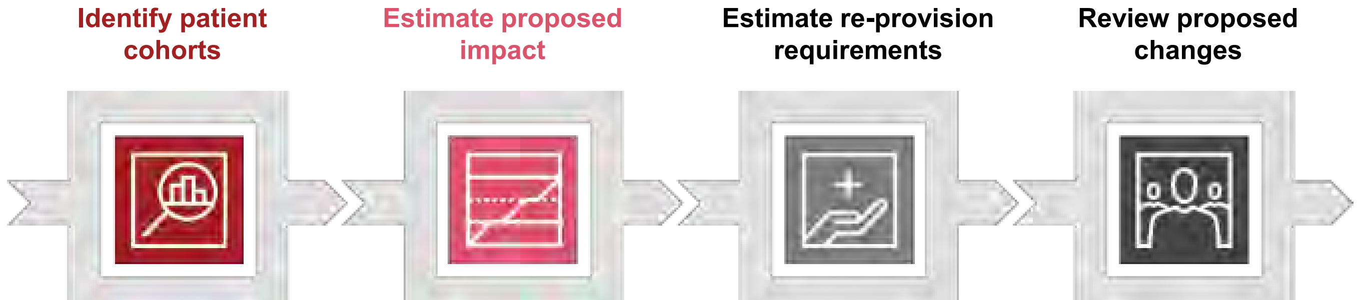
Assumptions associated with each of the proposed interventions

The assumed impacts across all on activity within current care settings are described in table 5.

Table 5: Assumed impact on hospital activity on care areas

Area	Assumed impact on hospital activity
ED	Reduce total ED attendances by 10%
ED	Reduce ED attendances age 65+ by 18%
ED	65% of remaining ED attendances go to the UCC, taken from non-urgent and standard activity
Inpatient	Reduce hospital admission rates by 17%
Inpatient	Reduce length of stay for stranded patients by up to 25 beds
Inpatient	Reduce mental health bed days by 27%
Outpatient	Move Trauma & Orthopaedics (23%), ENT (12%), Ophthalmology (7%), Community Dental Services (90%), Gastroenterology (20%), Podiatry (50%) out of hospital
Outpatient	Move Dermatology (12%), Cardiology (32%), Neurology (30%), General Medicine (35%), Respiratory Medicine (50%) follow-ups out of hospital
Social care	Move residential care placements by 70% and nursing care placements by 46%

Figure 80: Summary of approach



Each change in the JCM was reviewed and an impacted patient cohort (i.e. over 65s) was identified.

Bespoke analyses were then undertaken for each change, estimate the proposed impact in the current care setting. These were reviewed by the Technical Group.

Based on the amount of activity impacted by a change, a reprovision requirement in terms of the new care setting could also be estimated.

The impacts modelled were then reviewed within the relevant Pod focus groups, iterating for feedback where required.

Finance

Financial Impact of the JCM

Estimating the net saving associated with the proposed changes

Through applying the activity change assumptions (as set out on the previous page), making allowances for the fact that some costs are fixed and will not move as activity increases or decreases, we have been able to estimate net savings associated with the proposed changes in the JCM.

These savings are summarised in the table below. Overall the changes are forecast to reduce expenditure by £90m per year by 2036 as compared with the 'do nothing' scenario. However, £67m per year of re-provision costs have been estimated to be required in order to deliver these savings. As a result, the net savings associated with the JCM are estimated to be c. £23m per year by 2036.

Estimated non-recurrent investments of £31m (spread over five years from 2021 to 2025) will be required to deliver these savings.

Through implementing the changes proposed in the JCM, the financial sustainability of Jersey's health and care system will be significantly improved

By combining the impacts shown above with the 'do nothing' scenario, we are able to estimate a 'do something' scenario including the impacts of the JCM.

In this scenario, expenditure in the health and care system will be c. £23m lower by 2036. This significantly reduces the affordability challenge in that year to c. £153m. Assuming the system addresses this challenge from 2026 onwards (after full implementation of the JCM), system-wide efficiencies of c. 2% per year will be required to be financially sustainable. This is in line with the levels delivered in other similar health and care economies.

Further details on the 'do something' scenario are shown on the following page.

Table 6: Net (saving)/investment associated with proposed change in 2036

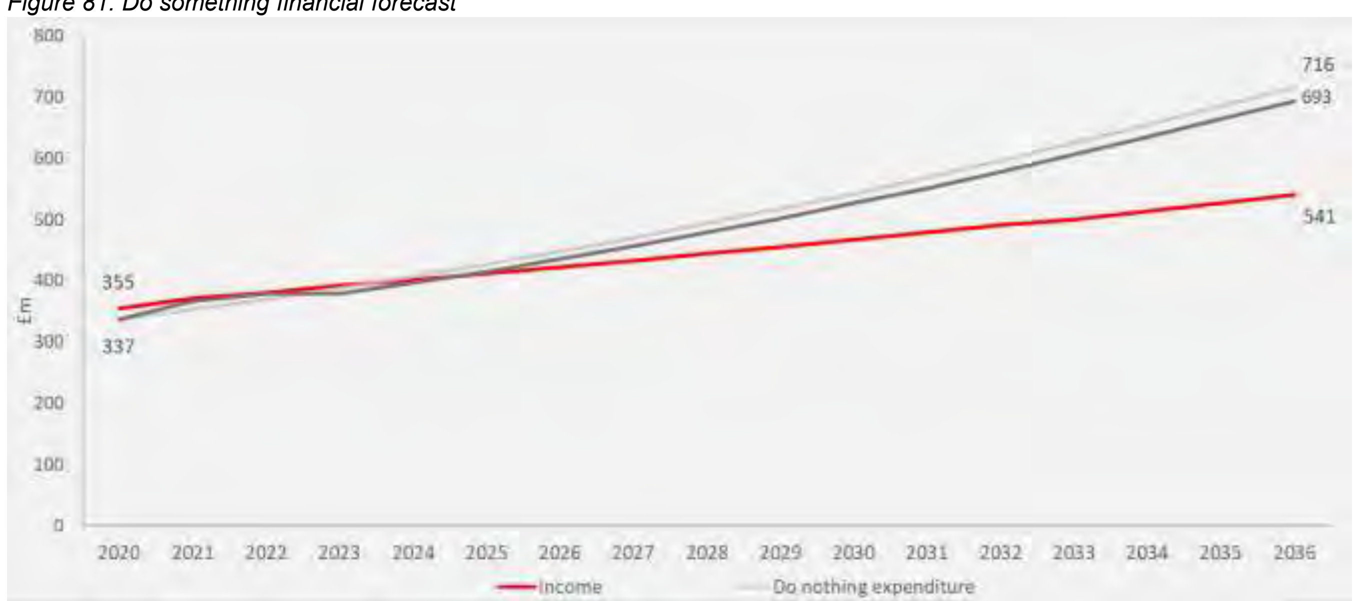
Assumed impact on hospital activity	Net (saving)/investment associated with proposed change in 2036 (£m)
Reduce total ED attendances by 10%	<(1)
Reduce ED attendances age 65+ by 18%	-
65% of remaining ED attendances go to the UCC (non-urgent/standard activity only)	(1)
Reduce hospital admission rates by 17%	(14)
Reduce length of stay for stranded patients over 60 years old by 65%	(6)
Reduce mental health bed days by 27%	(3)
Move Physiotherapy (100%), Trauma & Orthopaedics (23%), ENT (12%), Ophthalmology (7%), Community Dental Services (90%), Gastroenterology (20%), Podiatry (50%) out of hospital	-
Move Dermatology (12%), Cardiology (32%), Neurology (30%), General Medicine (35%), Respiratory Medicine (50%) follow-ups out of hospital	(1)
Move residential care placements by 70% and nursing care placements by 46%	(9)
Other investments required by the JCM	11
Total impact of the proposed changes	**(23)**

Finance

Financial Impact of the JCM

Do something financial forecast

Figure 81: Do something financial forecast

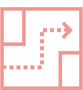


Do something financial forecast

Table 7: Do nothing financial forecast

(Income)/expenditure (£m)	2020	2036
Health and Community Services	(234)	(333)
Customer and Local Services	(107)	(182)
Children, Young People, Education and Skills	(4)	(4)
Strategic Policy, Planning and Performance	-	-
Patient/User Contributions	(11)	(21)
Total income	**(355)**	**(541)**
Health and Community Services	234	483
Customer and Local Services	89	181
Children, Young People, Education and Skills	3	7
Strategic Policy, Planning and Performance	-	1
Patient/User Contributions	11	21
Total expenditure	**337**	**693**
Income (over)/under expenditure	**(18)**	**153**

Pathways and Processes



Detailed enabler findings

Transforming to an integrated care system will have a significant impacts on pathways and processes

The JCM identifies the need for a whole system transformation towards a community-based, digitally-enabled system. This shift will have a significant impact on the pathways and processes currently in place today, changing these and also requiring new ones to be created that align to new ways of working.

Four key areas of focus identified for pathways and processes to support the changes outlined in the JCM are:

1. Reducing Emergency Department admissions through expanding primary and community care and building an Urgent Care Centre (UCC)
2. Strengthening tertiary pathways and repatriating activity to Jersey
3. Developing pathways for long-term conditions
4. Enabling people to stay independent in their homes for as long as possible

Pathway redesign is required to reduce Emergency Department Admissions and strengthen primary and community care

The aim of this change is to enable the Hospital to focus on acute treatment and pathways, so that diagnostic, ambulatory, day case and intervention focussed services are prioritised.

One way of achieving this prioritised focus is to streamline current pathways and processes so that only the most acute cases are encouraged to seek hospital care, with all other cases being re-directed to a primary or community setting. This approach is reflected in the case study below (see Figure 82) as a means of reducing ED admissions.

Figure 82: First Response Service Pilot[82]
As a response in Bradford to a variation in the provision of 'out of hours' mental health crisis services, in 2014, a First Response Service pilot was implemented. This was a 24/7 integrated crisis management service, streamlining the care pathway by creating a single point for access. From January to September 2015, Bradford Royal Infirmary saw 555 patients in A&E, compared to 927 over the same period in 2014. This has saved more than £1.8 million.

In order to achieve this change, it is necessary to shift both workforce and finance into primary care preventative care services. Stakeholders have highlighted that this may be assisted by involving community-based professionals in designing care pathways to enable people to be aware of services offered.

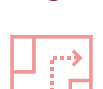
Spotlight on Urgent Care Centres

The JCM proposes establishing a UCC to reduce ED admissions, This was tested as part of the review.

Key points for consideration:

- *This will need to be considered during planning for the hospital site to co-located the UCC alongside acute and emergency services and manage non-urgent and standard activity*
- *It was identified that the success of this change is closely linked with payment models and finance as an enabler*

"In implementing pathways and processes, a phased approach could be used whilst waiting for a New Hospital Build" – Unscheduled Care Stakeholder



Pathways and Processes

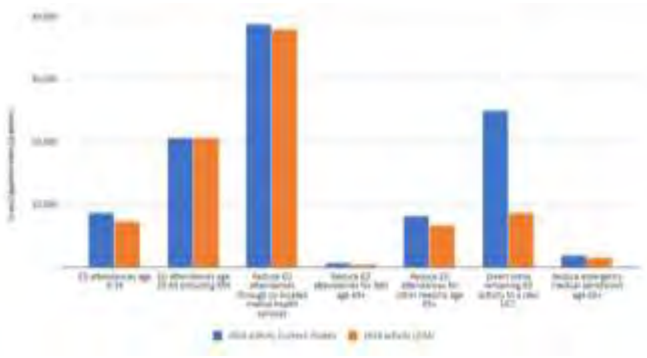
Detailed enabler findings

Establishing a UCC could reduce ED admissions, particularly for non complex service users

This is supported by evidence (see Figure 83), and further supported with analysis highlighting the impact of changes from the JCM on ED attendances.

Figure 83: Building an Urgent Treatment Centre in the Isle of Wight[83]
In the Emergency Department, Isle of Wight patients have to wait long periods before being able to access care. In October 2019, 70,9% patients at St Mary's hospital were seen within four hours, in comparison to the national average of 79.8%. Hence, in November 2019, the hospital built an Urgent Treatment Centre where patients with minor illnesses and injuries requiring immediate care can call 111 to book an appointment. As a result, in January 2020 74.8% patients in the emergency department were seen within four hours, with all 2,594 patients seen in the Urgent Care Centre within this time.

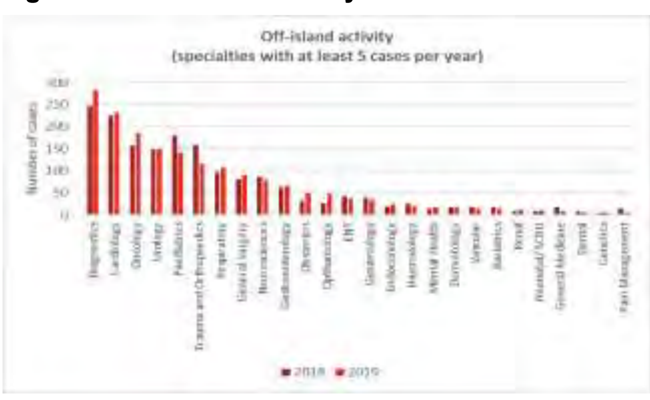
Figure 84: Summary of JCM unscheduled care impacts on current activity



Strengthening tertiary pathways and repatriating activity to Jersey could improve value and patient experience

The JCM outlines an aim of repatriating activity where possible, including bariatrics and oncology. Analysis demonstrates the services off-island that Jersey residents are utilising, highlighting that currently oncology services are the third most subscribed off-island activity.

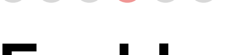
Figure 85: Off-island activity



"Some specialised radiotherapy would also be required to be provided off-island but overall this would provide a substantially better patient experience" – Scheduled Care Stakeholder

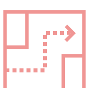
The development of on-island oncology services would reduce the need for off-island travel to receive care. However this would need to be supported by the development of strong pathways and processes.

To achieve value and clinical quality through provision of adequate volumes partnerships with Guernsey should be considered in the development of any new pathways. A similar opportunity was identified to develop pathways to partner with Guernsey and provide CAMHS inpatient facilities. This would only be achievable if service level agreement were put in place to comply with NICE guidelines. This partnership approach is demonstrated in the case study (Figure 86).



Enablers

Pathways and Processes



Detailed enabler findings

Figure 86: Capacity-building initiatives in the Caribbean[84]
A small island in the Caribbean lacked the appropriate resources to deliver effective cancer services in isolation. Therefore, through collaboration and partnerships, they have developed essential infrastructure for cancer care and upskilled the workforce to deliver this. One initiative has been establishing partnerships with allied countries for flow of information, expertise and financial resources. The work is currently ongoing, with further initiatives planned to deliver better care.

Developing pathways for long-term conditions could improve referral management between Primary and Secondary Care

The JCM highlights the need to develop clinical pathways for long-term conditions, such as diabetes, COPD, cardiovascular disease and epilepsy. This pathways development could be facilitated by education of GPs focused on increasing their confidence to manage chronic conditions outside of the acute setting. This model has been demonstrated to improve referral management in diabetes care (see Figure 87).

Figure 87:'Super Six' model for diabetes care[85]
In Portsmouth and South East Hampshire, there was an increasing referral rate from primary to secondary care, leading to 18 month waiting times for consultant appointments. In 2011, the 'super six' model was introduced, where unless a patient fell under one of the six patient groups that had complex needs, all other diabetes patients were seen by GPs. This was rolled out across 82 GP practices where there were 32,000 people with diabetes. As a result, more diabetes patients have been seen by GPs and monthly diabetes referrals reduced to zero, reducing pressure on secondary care.

It is important to recognise that if there are development of pathways for long-term conditions and these are based in the community, there will be a greater dependency on the non-acute workforce. This outcome is highlighted in JCM analyses that already suggests that based on current patterns of service usage in Jersey, demand for GP appointment would be expected to grow by 25% by 2035.

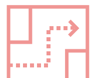
"Connecting primary and secondary care to provide efficient planned care services will reduce hospital attendance but would require additional recruitment to support community hub" – Scheduled Care Stakeholder

Enabling people to stay independent in their homes for longer could reduce the impact on health services

The JCM has identified the need to move management of long-term conditions into the community, with well-structured pathways. The case study below highlights the benefits of care being provided in people's homes (see Figure 88).

Figure 88: Norway SUSTAIN project[86]
To enable older people with medical and social care needs to live at home, two coordinated initiatives were introduced between 2015 and 2019 in Oslo and Surnadel as part of the SUSTAIN project. One initiative introduced a care pathway to assist patients with healthcare services following hospital discharge. This included rehabilitation services at home, expanding day centres expanded, reviewing medication and shared decision-making. Another initiative involved home rehabilitation with a multi-disciplinary team to encourage daily independence. The initiatives improved functional ability and social participation, reducing reliance on care homes. Both initiatives showed signs of success but further improvements in workforce capacity would aid future success.

Pathways and Processes



Detailed enabler findings

JCM identifies opportunities and challenges to transform current pathways and processes

Pathways and processes opportunities identified in the JCM:

- **Streamlining current pathways and processes**, enabling people to understand how to access services
- **Improving referral management for long-term conditions**
- **Partnerships with Guernsey** to provide joint specialist services
- **Reducing ED admissions** through improving primary and community care pathways.

Challenges for the pathways and processes outlined in the JCM:

- **Lack of workforce capability** to deliver processes in the community
- **Pathway redesign** required to establish an UCC
- **Payment model** currently in place where primary care is fee-based may limit the success of shifting care from secondary to primary and community settings as people may be unwilling to pay for services
- **Partnerships with Guernsey** may be limited if demand differs for services and if there are distinct payment models.

Key recommendations for pathways and processes

The following recommendations include those identified in the JCM and through the testing, as part of a multi-year programme of work, that will be required to transform services from secondary focussed services to community provision:

1. An assessment of the current state including pathways and processes that are currently in use
2. Establish an Urgent Care Centre, which is co-located with acute and emergency services at the hospital to reduce dependence on EDs
3. Streamline crisis management processes, creating a single point of access, so that only the most acutely ill patients attend hospital
4. Involve community-based workers in pathway design. This could through the setting up a clinical forum to manage and agree pathways
5. Expand GP education, through use of virtual e-clinics and multi-disciplinary teams to reduce the number of urgent referrals
6. Identify potential partnerships with Guernsey and initiate communication in how joint service delivery may be achieved

Implementation of JCM

Implementation planning

- There has been a significant amount of progress made in a relatively short period of time in the transformation of the health and care model
- The challenges Jersey's health system is currently facing presents a **need to transition the JCM from a conceptual framework into reality**
- This can be achieved through implementation, design, governance and PMO planning and management

Key high level considerations and next steps

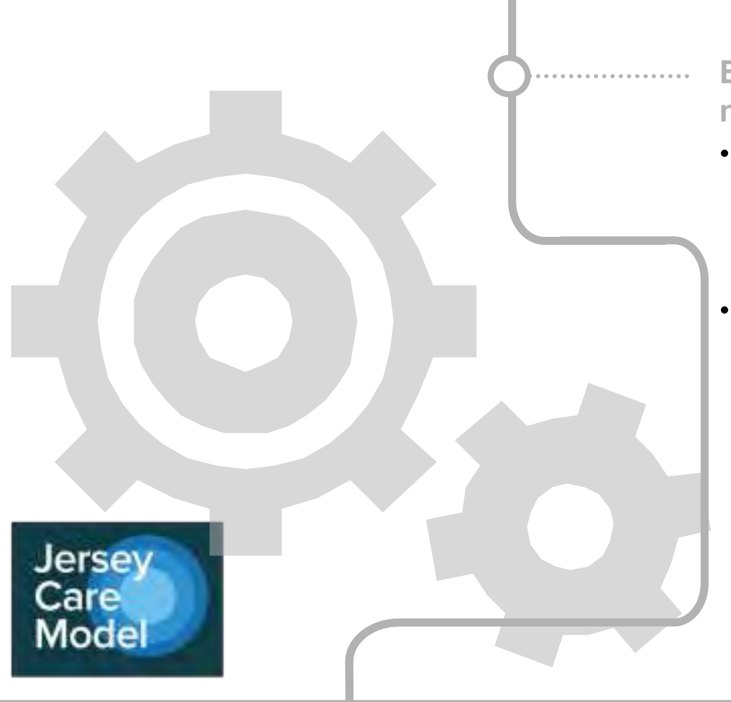
- As a part of this review, **16 workstreams for implementation**, for which key efforts should be focused towards, were identified
- These include, **clinical care models**, operating model, quality improvement and innovation, **IT and digital** and more…
- Prioritisation of these activities should be made in light of the need from the **COVID-19 pandemic**

Implementation of clinical workstreams

- Through detailed discussions with stakeholders, the JCM review identified a **number of 'quick wins'** for Jersey and associated considerations for each

Enterprise transformation and portfolio management

- Implementing the Jersey Care Model will be a **complex, multi-year transformation**, which requires a rigorous **portfolio management approach**
- An agile but coordinated portfolio approach to delivering change is needed, and setting up and maintaining a central **Portfolio Management Office (PMO)** will be central to this



Implementation of JCM

Implementation planning

There has been a significant amount of progress made in a relatively short period of time in the transformation of the health and care model

Since the summer of 2019:

- The JCM Vision, ambition and key principles have been defined
- Core features and changes of the clinical models have been developed
- Understanding of key changes to funding models for primary care have been determined
- The model has been tested and proven to be financially and clinically sustainable, where, changes to funding models, workforce, estates and digital are seen.

The challenges Jersey's health system is currently facing presents a need to transition the JCM from a conceptual framework into reality

There are ambitious targets; momentum can easily faulter at this point where the amount of change and activity required is overwhelming.

As highlighted in the overarching Review themes, it is recommended that there is a focus on and a need for four key activities as outlined below, including implementation, design, governance and PMO planning and development.

In some cases this will be relatively straightforward to 'get started'; initiatives and/or pilots are being developed or underway and will be implemented or scaled across Parishes.

In other cases, there is a need to completed further detailed design work which may require partnering with a number of individuals from different organisations and professions. Co-ordination, alignment on ambition and resources and time to complete the work will be important.

Competing priorities – COVID-19 and 'Business as Usual'

Health and care system transformations do not occur in a vacuum. There are existing care services that must continue to be delivered throughout the transformation. The COVID-19 pandemic represents other priorities that will need to be managed through the implementation of the transformation programme.

There needs to be flexibility in the implementation plan, and realism on how much can be achieved. For example, the COVID-19 pandemic will impact who, how and when planning can continue. However it also presents real opportunity for innovation which is already being seen. This should be harnessed and move to business as usual.

Activity	No.	Description
Implementation planning across key workstreams of activity including clinical and support workstreams	01	Making sure that activities are phased and interdependencies are mapped through. It is suggested in the first instance that a
Detailed design planning for clinical services	02	The focus should be on mobilising teams to commence on quick wins, while not losing focus on areas that have been identified as requiring further design
Establishment of governance and processes (including prioritisation)	03	This will be to support the prioritisation and decision making so that implementation remains in line with the ambition of the JCM
Establishment of a formalised programme management office and processes	04	There is a need to support clinical and management staff to effect and manage change. The intent should be that this transitions to a governance body on implementation.

Implementation of JCM

Key high level considerations and next steps

Partnerships with others will be key, including with Guernsey

As identified during the review, developing strong partnerships will help support the implementation of the JCM. There are clear opportunities for potential partnerships with Guernsey and France, including partnerships around the provision of digital, workforce and shared services. Detail of this should be explored ahead of implementation.

As a part of this review, we identified 16 key workstreams of effort which key efforts should be focused toward. Note that these are not exhaustive, nor do they need to be grouped in this form.

Note - With the current COVID-19 pandemic, timeframes for activities have been removed. Further consideration is required to the team that will be available to deliver on these activities.

	Immediate priority	Key activities following	Short term year 1 outcome
Clinical care models	• Prioritisation of clinical areas for progress / implementation • Integrate JCM with public health plans in GoJ	• Develop clinical pathways for key 'cohorts' across the system (e.g. aged, long term conditions) • Implement quick wins	• Strengthened wellness/self-care model in partnership with GoJ Public health • Clinical priorities agreed with change in care delivery seen in alignment with JCM
Operating model	• Draft the target operating model and supporting functions and services across workstreams and enablers	• Identification of capabilities required for operating model • Detailed design of digital front door in first instance	• Detailed design of all key cross-cutting operating model functions
Quality improvement & innovation	• Assessment of existing quality improvement model	• Consider alternative models to promote innovation and support funding schemes • Refine quality improvement model	• Agreed continuous quality improvement model in place • Innovation programme identified and launched
Business Intelligence (incl PHM)	• Understand current datasets (incl. supporting governance arrangements) • Engagement on lead factor to become rising risk and how to identify individuals	• Develop strategy for PHM incl associated governance requirements • Develop a data strategy • Consider different PHM systems	• Agreed PHM approach and preferred model • Data strategy in place • Ability to progress to contracting for PHM system

IT & Digital	• Understand existing IT requirements from the JCM interventions proposed incl:
	  • Jersey Care Record
	  • Regulatory systems
	  • Performance monitoring
	  • Outcomes
	• Understand digital requirements for JCM and new digital opportunities
		• Understand requirements for digital front door and bookings
		• Outline of system requirements and initial market sounding for IT partners
		• Digital strategy developed
		• Prioritisation of digital initiatives completed with a focus on flexible solutions which can be adapted to the rapidly changing landscape
			• IT and Digital strategy in place
			• Understanding of IT and digital requirements for the system
			• Market sounding for partners in place in line with Our Hospital work

Implementation of JCM

Key high level considerations and next steps

	Immediate priority	Key activities following	Short term year 1 outcome
Finance	• Detail modelling on one-off costs (fully costed and put into modelling) • Refine the impact of the Our Hospital specification • Refine the modelling and activity profiles so that it can move into delivery	• Consider funding models proposed • Model designed for financial management including principles, rules regarding pooling budgets and capitated contracts • Governance arrangements for financial oversight and monitoring developed and transition plan in place	• Refined modelling completed • Primary care funding model agreed with transition plan in place • Financial management approach developed
Workforce	• Consolidate workforce data • Identify workforce including non-health • Develop workforce plan / strategy and business plan for the provision of 24-hour cover	• Design new roles across system • Develop external partnership model • Recruitment planning for new models	• Workforce assessment, gap analysis completed • Defined key roles in place (incl. new positions)
Estates	• Complete estate profile and gap analysis	• Estate plan developed with plans for existing secondary and community estate	• Estate plan in place fed into Our Hospital and phasing
Human Resources	• Identify team to support design / implementation (incl. project managers, clinical input, learning and development teams) • Recruit team (dedicated PMO, clinical and workstream leads)	• HR/IR plan developed based on workforce requirements (incl joint teams, external partners) • Work with regulatory / registration bodies on needs for JCM • Design strategic HR function	• Resource arrangements in place for implementation • HR/IR plans in place to support new ways of working
Strategic Planning	• Refresh of the Jersey Joint Strategic Needs Assessment • Identify potential non-hospital/non-health workforce in alignment with GoJ Public Health strategy • Identify areas of opportunity to strategically partner in JCM	• Strategic plan refresh of Our Hospital as a part of the hospital / precinct build • Develop plan for strategic partnerships with other systems (e.g. Guernsey, France, UK systems) • Engage with non-health and care professionals with strategy for broader care model	• Clarity on strategic needs and target at risk individuals • Expanded plan relating to whole of Jersey approach to health and care • Alignment of JCM with Our Hospital programme • Clarity on target strategic partners (incl. other systems)

Governance (incl PMO)	• Identify resource requirements for JCM implementation / oversight
	• PMO:
	  • Develop programme plan
	  • Develop reporting and oversight functions
		• Identify governance needs for JCM and develop proposed model
		• Identify governance role for external partners including strategic partners in future JCM
			• Governance and associated groups and roles are clear and aligned with existing arrangements

Implementation of JCM

Key high level considerations and next steps

	Immediate priority	Key activities following	Short term year 1 outcome
Commissioning	• Agree on primary care model and develop proposal with partners • Agree on outcomes for commissioning • Assess gap on commissioning framework and key areas requiring detailed design	• Refine commissioning arrangements for primary care model • Detailed commissioning framework design incl. strategic commissioning function • Work with external partners on commissioning arrangements	• Strategic commissioning function agreed • Plan in place to shift to new commissioning model in pilot areas
Change Management (incl. L&D)	• Assessment of change areas (incl scoring severity) and workforce, service users and carers	• Assess capability gaps (skills) in workforce, service users and carers • Develop change management plan to transition to a new business-as-usual • Learning and development plans developed in key priority areas in first instance	• Key staff and service users understand impact of JCM • Staff and service user learning and development plans developed
Community Engagement & Communica-tions	• Communication of the outcome of Review and the next steps	• Develop communication plan in line with the overarching programme plan	• Key stakeholders are aware of the key developments of the JCM

Implementation of JCM

Implementation of clinical workstreams

Through detailed discussions with stakeholders, the JCM review identified a number of 'quick wins' for Jersey and associated considerations for each. In addition some subsequent areas of focus have been highlighted throughout the report which will require further planning and project work before implementation. Additional review will be required from the government centralised around how to prioritise these areas in order to better align the goals of the government and have the greatest overall impact.

	Potential 'quick win' areas	Key considerations
Mental Health	• Further refine the definition of the Crisis Prevention and Intervention service and undertake further analysis to quantify the full expected impact of the service on inpatient bed configuration. • Consider options for initiatives to reduce ED attendances by high intensity users, reviewing examples of good practice.	• Review the estates requirements associated with co-locating physical and mental health services at the future hospital, considering opportunities to decommission existing estates and the associated financial impact. • Develop a robust mental health workforce strategy, including training and recruitment needs to develop a multidisciplinary workforce and how to address the recruitment challenge for key skilled roles such as mental health nurses • Undertake further analysis to quantify the full expected impact of the Crisis Prevention and Intervention service on inpatient bed configuration. • Review existing payment mechanisms and consider alternative options that would incentivise use of primary and community care over ED attendance
External Partners	• Continue to develop the Partnership of Purpose to provide the structure and focus for a new commissioning framework.	• To successfully implement the JCM, there needs to be a clear, system-wide workforce strategy that covers external providers and HCS and establishes the workforce needs for the JCM • This could be complimented by a digital estates assessment and strategy to support integration and interoperability of digital tools, solutions and systems between external partners and HCS • Explore future partnerships through networked working with community hubs or single service provision supported by a traditional commissioning model • Use the more holistic and non-traditional services offered by external partners to support the prevention agenda by target high-risk populations
Adult Social Care	• Further develop the prevention approach, considering international good practice and successful initiatives from elsewhere. • Explore the potential for partnerships with digital and telecoms providers to provide the assistive technology referred to in the JCM.	• Review existing commissioning arrangements and explore the funding structures required to support the establishment of personal budgets • Assess existing digital infrastructure and future digital capability needs to support the use of assistive technology in delivering care packages • Develop a workforce strategy to address increasing demand for social care provision in the community, considering initiatives and potential policy requirements to recruit and retain social care workers, as well as how best to work with external partners and the voluntary workforce • Further develop the prevention approach, considering international good practice and successful initiatives from elsewhere.

Implementation of JCM

Implementation of clinical workstreams

	Potential 'quick win' areas	Key considerations
Scheduled Care	• Develop implementation plans for increasing day case surgery, reducing procedures of limited clinical effectiveness and undertake further assessment of areas of growth according to island need.	• Increasing day case surgery capacity should be further explored as a viable option, and further analysis into other suitable areas to increase day case surgery should also be investigated • Regular reviews should be undertaken of Jersey's procedures of limited clinical effectiveness policy and the numbers of procedures undertaken that are covered by this • Provision of ambulatory care and reablement services will require further refining and development for the design of pathways and processes • The development of the 'Integrated Care Hub' will need extensive assessments across all areas to define what services will be provided and appropriate estates to be used • Development of a workforce strategy with consideration for transformation of traditional ways of working is required • A review of the funding model in co-ordination with integration with Primary Care providers will need to be pursued.
Unscheduled Care	• Further consider the proposed acute floor model changes when designing a new hospital estate to optimise the delivery of Unscheduled Care services.	• The provision of adequate estates for the acute floor model is central to developing an optimised emergency and urgent care setting • With analysis recommending moving some activity to Primary Care, a review of funding and charging models will be required • Capacity requirements for the PAU should be taken into account when co-locating to the Paediatric ward • A comprehensive workforce strategy is required to underpin service provision for Unscheduled Care • More prominent ambulatory assessment will require further development with Intermediate Care to understand the limitations and challenges with the proposed servicE • Further design of emergency services will be required to provide adequate care in a timely manner
Clinical Support Services	• Further develop a cancer strategy to assess what cancer services can be provided on-island. • Further refine and develop implementation plans to delineate what services, such as physiotherapy services, could be fully provided in the community.	• Development of a cancer strategy will be crucial to support more prominent cancer services • Comprehensive workforce planning will help deliver more community based services, such as physiotherapy • Additional recruitment for workforce is needed to help increase workforce capacity for Clinical Support services • Delineation of 'near testing' capability need to be defined in order to assess whether this change is feasible for Jersey

Implementation of JCM

Implementation of clinical workstreams

	Potential 'quick win' areas	Key considerations
Intermediate Care	• Implement the identified key changes that focus on providing bed-based care, crisis response, home-based care, and reablement services	• Develop a detailed workforce strategy that considers upskilling the core workforce, recruitment and retention of talent, as well as integrated ways of working across providers • Develop a detailed digital strategy that covers digital interoperability between providers, as well as an island-wide IT platform • Implement the identified key changes for Intermediate care, that focus on providing bed-based care, crisis response, home-based care, and reablement services • Establish a culture shift to support the implementation of the identified changes, specifically by encouraging ways of working across multiple teams with an emphasis on the use of Allied Health Professionals and partnerships with external providers • Consider strengthening telehealth service offering and integrate with Intermediate care services
Women and Children's Services	• Set out a detailed vision of the future care model for Women and Children's services, in particular working up operational plans to support the proposed changes for women's health. • Work with colleagues in CYPES and Public Health to develop a plan for how HCS, CYPES and Public Health will work together to deliver the changes proposed in the JCM	• Work up operational plans to support the proposed changes for Women's Health. In the course of reviewing the JCM, it was noted that significant proposed changes to Women's Health services are absent from the JCM. Further work is required to operationalise the additional changes identified by stakeholders • Work with colleagues in CYPES and Public Health to develop a plan for how HCS, CYPES and Public Health will work together to deliver the changes proposed in the JCM • Develop a comprehensive workforce strategy, considering the workforce requirements to provide more women's health care in the community, and for GPs to work closely with paediatric doctors in an integrated care model • Develop a robust estates strategy, considering the estates requirements to support the increased provision of outpatient care in community settings, and the co-location of a PAU to the paediatrics ward • Design care pathways to support the new model of care, in particular in support of the proposed additional changes to the JCM. There may also be capability development requirements in support of increasing laparoscopic and day case activity to reduce acute admissions in Women's Health.
Primary Care and Prevention	• Explore broader public health management opportunities with a view to targeting the wider determinants of health.	• Develop a workforce, estates and digital strategy that considers the core requirements of the JCM • Align on funding strategy for primary care that can support financing and improved access • The outlined strategies will need to be in place to support the smooth implementation of the JCM • Following implementation, focus should turn to community-focused MDT ways of working that emphasis prevention first and community care • Broader Public Health Management opportunities should be explored with a view of targeting the wider determinants of health.

Implementation of clinical workstreams

As you move into the detailed planning phase of the JCM, new ideas will inevitably arise and decisions will need to be made around prioritisation

Moving from high level design into detailed service planning and design will mean that new projects and changes to the model are proposed. The transformation process is of course not static, and the political, economic and regulatory landscape may change quickly and unexpectedly.

As such, the prioritisation tool below may support you to prioritise projects and programmes in keeping with your vision and strategic aims.

Does this fit with our strategic aims?
Yes → Do we have strengths to deliver this?
No → GoJ would need to establish its position for further discussion based on the following questions:

- How would this better meet the needs of our service users?
- Would this improve the quality of care we provide?
- Would this benefit our staff?
- Does it support financial stability?

Do we have strengths to deliver this?
Yes → Does this support financial stability?
- Yes → Pursue
- No → Does this meet an unmet health need for our population?
  - Yes → Consider the different funding options available
  - No → Do not pursue

No → Does this support financial stability?
- Yes → Can we build or buy in capacity?
  - Yes → Pursue¹
  - No → Do not pursue
- No → Does this meet an unmet health need for our population?
  - Yes → Consider the different funding options available
  - No → Do not pursue

No → Is this a service we have delivered before?
- No → GoJ would need to establish its position for further discussion (see questions above)
- Yes → Does this support financial stability?
  - Yes → Do we have the capacity to delivery this?
    - Yes → Pursue²
    - No → Does this meet an unmet health need for our population?
      - Yes → Can we build or buy in capacity?
        - Yes → Pursue³
        - No → Do not pursue
      - No → Do not pursue
  - No → Does this meet an unmet health need for our population?
    - Yes → Consider the different funding options available
    - No → Do not pursue

1. Our options for, and the cost of, buying in or building capacity would need to be carefully considered as capacity is the limiting factor. The option otherwise fits in with our strategic aims and is compatible with the strengths we need to support this.
2. This option will not necessarily be supported through our emerging or existing strengths, however it does fit with our strategic aims, supports financial stability and is within our capacity to deliver. It is therefore worth considering whether this option is an option we wish to consider and which additional strengths we would need to grow to support this.
3. Our options for, and the cost of buying in or building capacity would need to be carefully considered as capacity is a limiting factor. The option will not necessarily be supported by our strengths, however as it supports financial stability and fits with our strategic aims, it is worth considering this option.

Implementation planning

Enterprise transformation and portfolio management

Implementing the Jersey Care Model will be a complex, multi-year transformation, which requires a rigorous portfolio management approach

The changes to current care delivery set out in the JCM are across numerous different workstreams, with wider, cross-cutting changes to enabling functions such as digital, estates and workforce. Such a complex programme of change requires a rigorous portfolio management approach in order for the vision set out in the JCM to be achieved and for the desired benefits to be seen by staff, stakeholders and service users alike.

The next step is to begin the detailed planning phase. The proposed changes will need shaping into projects and programmes, each of which will require a Project/Programme Initiation Document (PID), setting out its scope, governance and outcomes.

As part of the JCM review, indicative costs associated with implementing the JCM have been provided across workstreams, but further work will be needed to fully cost up the delivery of the proposed changes to the care model through individual programmes and projects.

An agile but coordinated portfolio approach to delivering change is needed, and setting up and maintaining a central Portfolio Management Office (PMO) will be central to this

The PMO will not only weigh up priorities and coordinate activities, but should provide education to the people running JCM projects, enabling a consistent approach across the health and care system. During the review, great enthusiasm for the new care model was demonstrated, but this needs to be harnessed and channelled through a coordinated, stepped approach to change.

Robust transformation control governance will also need to be in place. A design authority with a clear vision for the future state who make sure that the portfolio of change holds to a set of clearly defined design principles, is an important starting point for strategic oversight, alongside the PMO overseeing day to day activity.

As set out in the Review, a number of 'quick wins' were identified for the implementation of the JCM. First, the 'no regrets' decisions which align to the vision should be achieved through an agile 'sprint'. These 'no regrets' decisions should take place alongside horizon scanning and planning for the future. Understanding what the steps are that need to be taken now, to enable large-scale change in the future, is key to successful enterprise transformation.

Appendices

Appendix Contents

The table below outlines the contents of the appendix, including an overview of supporting references, our approach, workstream changes and initial analysis.

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Appendix 1: Supporting References

The table below outlines key abbreviations and acronyms used in the body of this report for reference.

Acronyms and Abbreviations	
A&E – Accident and Emergency	HCS – Health and Community Services
ASC – Adult Social Care	HDU – High Dependency unit
CAMHS – Children and Adolescent Mental Health Service	HER – Electronic Health Record
CCG – Clinical Commissioning Group	IoT – Internet of Things
CDS – Community Dental Service	ITU – Intensive Treatment Unit
CHCC – Care Home Coordination Centre	JCH – Jersey Community Hospital
CLS – Customer and Local Services	JCM – Jersey Care Model
CNWL – Central and North West London	JCR – Jersey Care record
CT – Compute Tomography	JETS – Jersey Emergency Transfer Service
CYPES – Children, Young People, Education and Skills	LTC – Long Term Care
ECC – Emergency Care Centre	MDT – Multidisciplinary Team
ED – Emergency department	MRI – Magnetic Resonance Imaging
EMI – Elderly Mentally Ill	NUTH – Newcastle upon Tyne Hospitals
EMRAD – East Midlands Radiology Consortium	PACE – Program of All-inclusive Care for the Elderly
FNHC – Family Nursing & Home Care	PAU – Paediatric Assessment Unit
GEMS – Geriatric Emergency Medical Service	PHM – Population Health Management
GI – Gastrointestinal	UCC – Urgent Care Centre
GP – General Practice	RRRS – Rapid Response and Reablement Service
H&SS – Health and Social Services	

Appendix 1: Supporting References

It is acknowledged that there are clinical terms that may not be well understood to all readers, the table below outlines key terms and associated definitions.

Glossary

Term	Definition
Acute care	A branch of secondary health care where a person receives active but short-term treatment for a severe injury or episode of illness.
Allied Health Professionals	Healthcare professionals providing a range of diagnostic, technical, therapeutic and support services in connection with healthcare, including osteopaths, paramedics, physiotherapists and dieticians.
Ambulatory Care	Medical services provided without hospital admission, performed on an outpatient basis.
Care pathways	Represent cohorts of people who use the health and social care system in different ways.
Clinical Support Services	Services which are needed for the system to work, consisting of pharmacies, therapies, dietetics, transport, contact centre and switchboard.
Commissioning	Develops and sets the strategic commissioning framework using correct population and systems intelligence data to support decisions.
External Partners	Voluntary sector, social care providers, private providers and social enterprises.
Holistic Approach	A holistic approach means that we are interested in engaging and developing the whole person.
Inpatient	A patient that stays in hospital whilst being treated.
Integrated Care Model	Connecting Primary and Secondary Care to provide efficient planned care services.
Intermediate Care	Multidisciplinary service helping service users to be as independent as possible, providing support and rehabilitation to those at risk of hospital admission or who have just been in hospital.
Multidisciplinary teams	A group of healthcare professionals who are members of different disciplines, for example psychiatrists, social care workers.
Outpatient	A patient that does not stay in hospital whilst being treated.
Primary Care	Healthcare provided in the community where a patient has initial contact with a medical professional who may refer them on to a specialist.
Reablement Services	Planned approach to community care to help service users re-establish daily living skills
Scheduled Care	Health and social care planned in advance with an appointment.
Secondary Care	Hospitals and outpatient specialist clinics that service users attend follow a referral from primary healthcare services.

Appendix 1: Supporting References

It is acknowledged that there are clinical terms that may not be well understood to all readers, the table below outlines key terms and associated definitions.

Glossary

Term	Definition
Stakeholder	An individual or group that can influence, or be influenced by the Jersey Care Model.
Telehealth	The use of electronic information and telecommunication to support long-distance care.
Tertiary Care	Specialised care delivered by consultants, usually on referral from primary or secondary care, involving highly specialised equipment and expertise.
Triage	The assignment of degrees or urgency to illnesses and wounds to decide on necessary treatment and allocating treatment to service users based on need.
Unscheduled Care	Health and social care that is unplanned or outside of normal daytime hours.
Discharge to Assess	A facilitated discharge model that support service users to leave secondary care services early and continue their care assessment in the community
‘Near testing’	Also known as point-of-care testing, is an investigation taken at the time of consultation) and may range from simple tests such as blood glucose monitoring, to screening programmes.

Appendix 2: Our approach

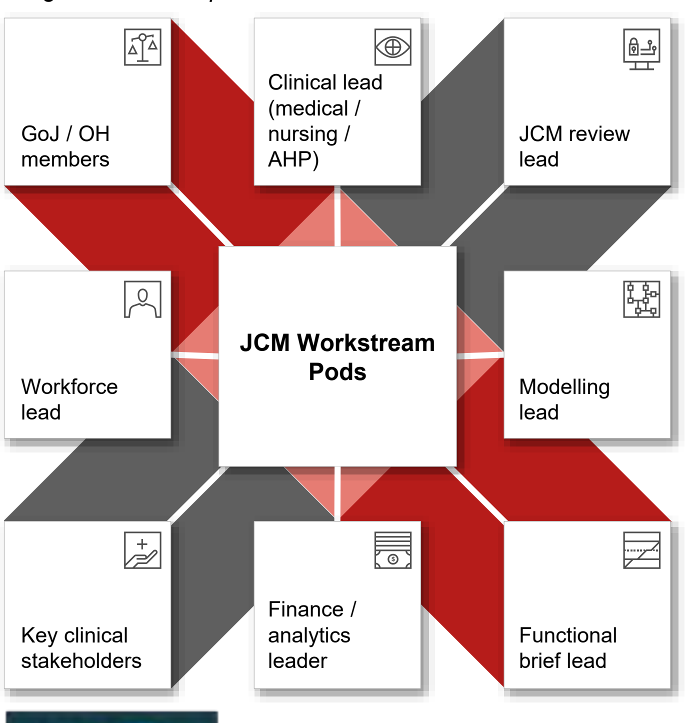
Clinical engagement

This review was dependent on strong engagement with clinicians in Jersey

This review was conducted independently without prejudice or bias from stakeholders within the Jersey health and commuity care system. The conclusions made and recommendations developed were based on:

- **Quantitative analysis completed independently**, and as a part of the JCM (having been firstly assessed)
- **Comparative analysis with 'good' practice models** and interventions internationally
- **Professional judgement**, through experience working in and with health and care systems internationally
- **Clinical engagement with key stakeholders** associated with the seven workstreams outlined in the JCM

Figure 1: the composition of the JCM Workstream Pods

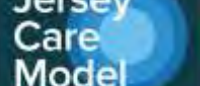


The ability to provide a thorough and comprehensive review over the 11 week period, was dependent on clinical engagement. We recognise that those that work within the health and care system in Jersey have a unique perspective; to this end clinical engagement was critical for this review to:

1. *Provide context to the delivery of health and community care in Jersey, including the current state, challenges and opportunities*
2. *Outline and provide further detail regarding the purpose, intent and rationale for the features of the new care model*
3. *Assess the feasibility and ease to implement given the unique characteristics of care in Jersey*

Our approach to clinical engagement

Given the timeframes, to facilitate this engagement we conducted a series of 1:1 interviews and set up a number of 'JCM Workstream Pods' (Figure 1). These pods were formed of key stakeholders for the review, including of medical, nursing and managerial colleagues. Each Pod attended a series of focus groups that allowed Pod members to perform a deep-dive assessment of the proposed JCM changes in their specific workstream, as well as a review of the initial outputs from the data analysis (see Figure 2 on page 151). This provided insight and challenge of the JCM for the review, whilst supporting ongoing input and testing of the review's supporting quantitative analysis.



Appendix 2: Our approach

Approach to the review

JCM Workstream Pods

As shown in Figure 1, JCM Workstream Pods were developed for each workstream that was outlined in the JCM Briefing Paper. Given the inherent variation in type of services the Secondary Care workstream was separated into three Pods.

Each JCM Workstream Pod was met with twice over the 11 week period, utilising existing team meetings (detailed on page 155 onwards)[1] to work through the JCM framework (Figure 2).

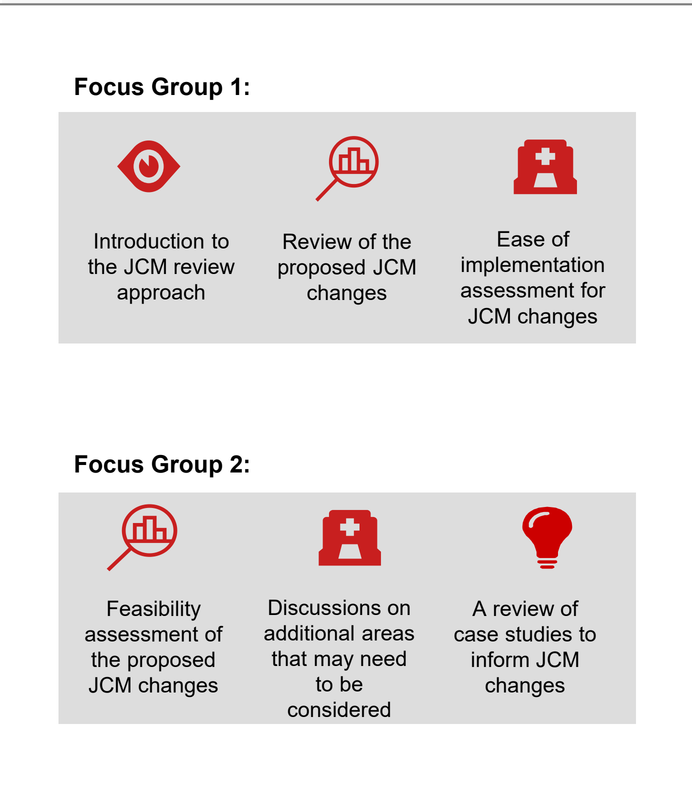
During these meetings, the Workstream Pods reviewed the JCM against a series of assessment frameworks. The first assessment framework tested the JCM changes within each workstream for ease of implementation, the second for feasibility. These were carried out over the course of two meetings in two distinct focus groups.

The response across the system was positive with high levels of engagement across all areas.

Figure 2: The framework for reviewing the JCM with Workstream Pods

A JCM Workstream Pod was created for each workstream defined by the JCM:

Each JCM Workstream Pod underwent a series of assessments through two focus groups:



[1] Due to the COVID-19 response, the workshops scheduled during the w/c 16 March 2020 were cancelled – Mental Health, Scheduled Care, Unscheduled Care and Adult Social Care so that proposed attendees could continue to focus on the prioritised activities. 1-to-1 meetings were scheduled with the Pod Lead/s as the agreed alternative.

Appendix 3: Governance Structure

Overview of governance arrangements

Governance Groups

Governance has been established to provide sufficient oversight, including clinical oversight, over the programme.

There are four key oversight groups that have been established as a part of the programme to provide sufficient input, review, challenge and oversight:

JCM Workstream Pods: split up by workstream, as defined in the JCM. The groups provided input into the context of the JCM and supported testing of the model.

Steering Group: formed to provide strategic leadership, direction and overall decision-making capability for the JCM review.

Clinical and Professional Senate: provided strategic oversight and recommendations on the outputs of the JCM review. It is proposed that the Senate will continue to make decisions regarding the implementation and delivery of the JCM beyond the completion of the review.

Technical Group: created to oversee data analytics, modelling and provide decision-making capability in relation to quantitative analysis.

Reporting lines within JCM Review Governance

There were clear lines of reporting to provide assurance and assess findings with a cross-section of clinical and professional staff within HSC and care provision. This minimises undue influence of those who may have developed or will be affected by the review outcomes. The reporting lines are outlined below:

JCM Workstream Pods provide assessments of the impact of the JCM and ease of implementation

↓

Assessments provided to Senate who provide a holistic assessment incl. on safety / quality and provide recommendations

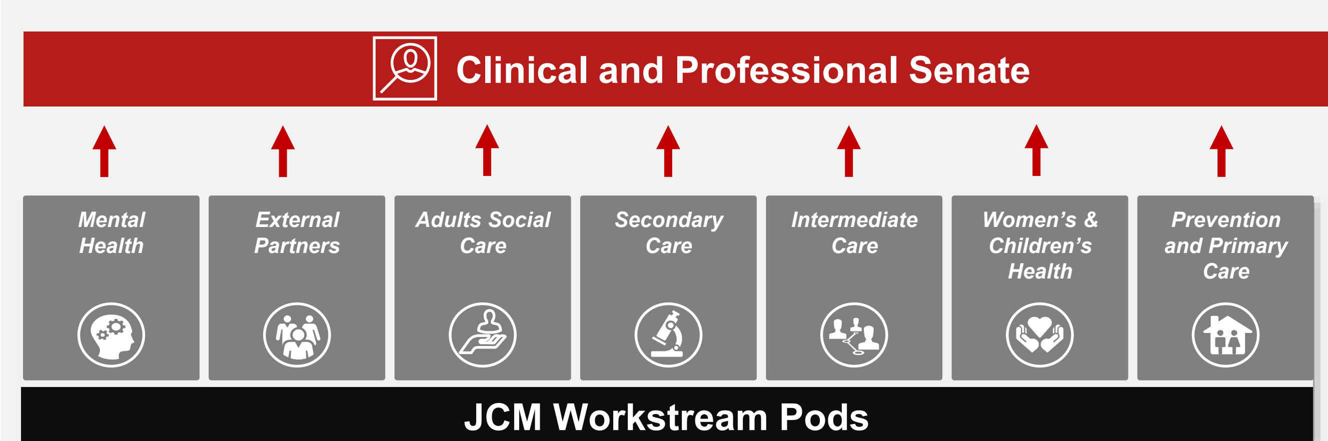
↓

Findings presented to Steering Group to provide sign-off on findings and considerations

↓

Recommendations submitted to respective government agencies

Governing principles of reporting lines	*Project team to work collectively with Pods and Senate*
	Technical group provide oversight over data / analysis



Appendix 3: Governance Structure

Outlined in the table below are the terms of reference for the professional and clinical senate.

Professional and Clinical Senate Terms of Reference

Area	Details
Purpose	• The Clinical and Professional Senate is a forum for oversight, direction and providing recommendations for the key activities of the JCM review, including the work of the JCM Workstream Pods between January 2020 and April 2020. The Clinical and Professional Senate will sign off of the framework used for assessment as well as the initial outputs from the JCM Workstream Pod and provide comment on any key outputs from the JCM review which are contrary to the original model proposed. • Following completion of the JCM review the Clinical and Professional Senate may continue to support the work towards implementation once the JCM review is complete.
Membership	• Patrick Armstrong, Rose Naylor, Adrian Noon, Miguel Garcia, Cheryl Power, Isabelle Watson, Peter Gavey, Effie Liakopoulou, Simon Chapman, James Mair, Muktanshu Patil, Sam McManus, Paul McCabe, Lesley Hill, Susan Turnbull, Phil Terry • Administrative support – Lara Haskins
Authority	• Accountable and responsible to the JCM steering/delivery group for the conduct of its work
Advisory	• Responsible for providing recommendations about the direction of the JCM review and workstreams associated with the review.
Chair	• Patrick Armstrong
Reporting	• Update in JCM steering/delivery group as requested
Meetings and Quorum	• Monthly meetings January 2020 to April 2020. Meeting outcomes to feed JCM steering/delivery group updates • Will be deemed inquorate for decision making in the absence of the Medical Director/ Chief Nurse
Key responsibilities	• Provide oversight and direct the work of the JCM Workstream Pods • Oversee all work and approve all initial outputs, conclusions and recommendations in the JCM review • Identify and uphold appropriate member attendances for each Pod
Indicative agendas	• **Session 1** – Introduction to the programme and methodology; sign off of framework used for JCM review work • **Session 2** – Presentation of emerging findings and progress for each JCM Workstream Pod • **Session 3** – Review of initial draft JCM review outputs

Appendix 3: Governance Structure

Outlined in the table below are the terms of reference for the steering group.

Steering Group Terms of Reference

Area	Details
Purpose	• The Steering Group is a forum for strategic leadership, direction and overall decision-making capability for the Jersey Care Model review programme of work, in the context of wider Health modernisation programmes • The role of the Steering Group is to provide senior level review and approval of deliverables, including sign off of the JCM review paper, as well as providing comment on the direction of the programme of work. • Following completion of the JCM review the Steering Group will continue to support the work towards implementation of the JCM.
Membership	• Adrian Noon, Cheryl Power, Isabel Watson, Miguel Garcia Alcaraz, Rose Naylor, Effie Liakapoulou, James Mair, Lindsey Hill, Muktanshu Patil, Paul McCabe, Peter Gavey, Sam McManus, Simon Chapman, Susan Turnbull, Patrick Armstrong • Administrative support – Lara Haskins
Authority	• Accountable and responsible to the Corporate Strategy Board for the conduct of its work • Authorised to direct the work of the Clinical and Professional Senate and JCM Workstream Pods
Decision making	• Responsible for decisions about the direction of the JCM review programme of work • Responsible for the sign-off of deliverables, following the recommendations and review from the Clinical and Professional Senate
Chair	• Caroline Landon
Reporting	• Update in Corporate Strategy Board as requested
Meetings and Quorum	• Monthly meetings January 2020 to April 2020. Meeting outcomes to feed Corporate Strategy Board updates, as requested • Will be deemed inquorate for decision making in the absence of the Director General HCS and Modernisation Director
Key responsibilities	• Provide oversight and direct the work of the JCM review programme • Oversee all work and sign-off all outputs and recommendations included in the JCM review • Identify and uphold appropriate member attendances for key JCM review stakeholder engagement groups
Indicative agendas	• **Session 1** – Introduction to the programme and methodology; sign off of approach for JCM programme • **Session 2** – Presentation of key emerging themes and discussions in Clinical and Professional Senate • **Session 3** – Review of programme outputs and initial review of the draft JCM review paper

Appendix 4: Workstream Members

We would like to acknowledge the following workstream members who supported the development of the Jersey Care Model Review.

Overview of workstream members

Jersey Care Model Review Workstream Leads

Workstream	Members	
Mental Health	Jake Bowley Claire Ryder Jennie Pasternak Beth Moore Rachel McBride	James le Fevre Jason Wyse Ed Dingle Miguel Garcia-Alcaraz
External Partners	Emelita Robbins Paul McGinnety Paul Simmonds Angela Falle Jocelyn Butterworth Chris Dunne Raymond Cooper Shaun Findlay	Phil Romeril Patricia Winchester Secretary John Hodge Jason Wyse Alex Wiles Malcolm Ferey
Adult Social Care	Paul Rendell Jo Poynter	Sam McManus Isabel Watson
Scheduled Care	Mike Richards Alan Thomson Miklos Kassai Effie Liakopoulou	David Ng Ajay Kumar Jessie Marshall
Unscheduled care	Adrian Noon Valter Fernandez Sam McManus	Simon Chapman Lindsey Le Masurier
Clinical Support Services	Nick Dodds Jackie Tardivel	Adrian O'Keeffe Paul McCabe
Intermediate Care	Rob Sainsbury Jo Poynter Clare Stewart Valter Fernandes Paul Michel Simon Chapman	Sam McManus Paul Rendell Jennie Pasternak Isabelle Watson Adrian Noon
Women and Children's Services	Fiona Nelson Muktanshu Patil	Sharon Summers-Ma Alex Watt
Primary Care and Prevention	Adrian Noon Phil Terry Nigel Minihane	Ed Klaber Claire Sambridge

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Mental Health	1. Develop community-based alternatives to hospital care 2. Develop co-located mental health services and focus on community-based crisis prevention and response 3. Invest in primary care-led mental health care with a focus on prevention and early intervention, and community intervention, e.g. home enablement/care 4. Work with local communities and partners to expand community-based capacity for recovery-oriented, person-centred care and support (e.g. housing, employment, social support) 5. Review demand and capacity for mental health care and redesign our mental health care system to meet islanders' needs 6. Establish the front door as an Emergency Care Centre, including mental health assessment 7. Design the integrated hub model of care to include mental health outpatients, as outlined in the secondary care model 8. Offer timely integrated crisis care and support over a 24 hour period through establishing and fully rolling out the Crisis Prevention and Intervention Service 9. Develop a complex trauma pathway 10. Develop tertiary pathways for specialist care, considering provider options in partnership with Guernsey and the case for change for repatriation of off-island longer-term specialist activity to Jersey 11. Develop a plan for on-island CAMHS inpatient facilities for shared care purposes, exploring the potential for provision in partnership with Guernsey 12. Establish self-care and education programmes to enable people to look after themselves better	No additional changes were identified as part of the review

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Adult Social Care	1. Further develop and implement an Adult Social Care strategy 2. Develop and implement the Social Care Market Strategy to shape the social care sector into an independence focused model 3. Develop an integrated, community-based approach to social care supported by increased community capacity and local strategic commissioning 4. Invest in preventative services to reduce or delay people's need for care 5. Increase the range of services available to support people in the community and increase the number of people who can be paid carers 6. Enable people to make their own choices about how they are supported by developing personalised approaches like self-directed support and personal budgets 7. Support independence through bespoke care packages that incorporate assistive technology 8. Increase and improve the provision of information and advice on care and support for families	No additional changes were identified as part of the review

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Scheduled Care	1. Develop an integrated care hub model to provide efficient planned care services, connecting primary and secondary care and replacing traditional outpatient services 2. Develop virtual hubs where specialist secondary care is closely connected with primary care, with secondary care clinicians providing advice and guidance to primary care 3. Provide outpatient activity in an out of hospital setting, reducing hospital-based outpatient activity for services including physiotherapy, T&O, ENT, ophthalmology and community dental services 4. Set specialist functions to effective clinical pathways based on island need, and manage the anticipated requirement for increased day surgery, endoscopy and non-invasive procedures capacity 5. Improve referral management between primary and secondary care facilitated by education for general practice, to reduce referrals into acute settings for long term conditions 6. Develop connectivity to planned tertiary care and specialist services, repatriating more patient activity to Jersey in the new hospital facility 7. Optimise acute bed base by reducing length of stay, increasing the use of day case surgery, ambulatory care, reablement services and community-based rehabilitation 8. Develop co-located mental health services 9. Develop the hospital's clinical environment to be adaptable to reflect demographic pressure areas where increased capacity may be needed	1. Increase the earlier connection of physiotherapy services to patients who are deemed "at risk", by working more closely with GP services to standardise process for referral to physiotherapy services 2. Integrate recruitment and retention strategies as part of the overall workforce strategy, as a key component for developing a community-based workforce 3. Develop a patient centred approach to care, empowering patients to determine the most suitable care provision

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Unscheduled Care	1. Establish an Emergency Care Centre that provides all of the existing urgent and unscheduled care access, maintaining the ability to manage urgent, very urgent and resuscitation patient activity with a specialist medically led model of emergency care 2. Develop an acute and emergency floor model, with a co-located Urgent Treatment Centre to manage non-urgent and standard activity 3. Develop the unscheduled care model to include more prominent ambulatory assessment, particularly older person's rapid access to multi-professional services outside the hospital 4. Develop connectivity to tertiary and specialist services via a Jersey Emergency Transfer Service	1. Development of acute care services in close co-ordination with Mental Health acute care, including Mental Health Assessment service, particularly in the first 48 hours of care (with a 28-30 acute bed base for assess, treat, referrals). 2. Develop the community emergency care model, including development of ambulance/advanced paramedic roles to assess patients in the community to prevent admission in Hospital 3. A patient transport service review to be undertaken and consider ambulance escort capacity with expansion of JETS 4. Increase the dedicated access of services to community beds 5. Further development of model to include HDU/ITU and development of an outreach team 6. Development of closer connections with justice department and home affairs to improve integration with wider services for effective, holistic care

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Clinical Support Services	1. Increase Clinical Investigations capacity, Radiology capability (including MRI and CT scanning) and mobile equipment functions 2. Increase the connectivity of clinical support services to primary and intermediate care through rapid access and 'near testing' 3. Provide services such as physiotherapy and podiatry partially or fully in an out of hospital setting, including home-focused community care 4. Develop the MDT workforce to include expanded roles of pharmacists, nursing, physiotherapy and mental health workers 5. Make cancer services more prominent on the island, and develop a cancer strategy for Jersey	1. Further development of service plans, including implementation and operational plans, for individual services in Clinical Support services 2. Development of estates, workforce and funding to meet capacity and demand future projected increase in demand for Clinical Support services 3. Continue to empower patients and consider the accessibility of mental health patients/children/vulnerable adults to services delivered 4. Develop a fully effective, multiskilled MDT workforce with expanded roles, for patient assessment continuity 5. Develop extended provision of pharmacy services, including hospital outreach and outpatient dispensing 6. Develop a dedicated capacity for diagnostics to deliver same day emergency care therapy input into front door 7. Improving the tendering of goods, tertiary services and sourcing of preparations , with the potential to work with Guernsey to achieve this 8. Increase the integration of clinical support services between primary and secondary care, including increasing provision of services within GP practices, such as blood donation and phlebotomy

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Intermediate Care	1. Develop a Community Focused Intermediate Care function incorporating Frailty and Older Person's Rapid Access running 7 days a week 8am-8pm connected to a care overnight community function 2. Connect Community Focused Intermediate Care Function to broader community services (i.e. Closer to Home initiative) to support 24/7 care needs including end of life care 3. Intermediate services to have access to home-facing enabler services including domiciliary care 4. Intermediate services to have rapid access to secondary care diagnostics 5. Expansion of hospital-at-home/rapid response service 6. Develop early facilitated discharge from secondary care to drive a Discharge to assess model 7. Develop person centred planning to maximise independence, confidence and resilience 8. Intermediate services introduced to provide support to the social and long term care sector (residential and nursing) aligning with the personalisation agenda	1. Intermediate services to implement telehealth / telecare programme 2. Development of co-ordinated transport pathways and support between intermediate care and primary / secondary / tertiary 3. Intermediate care to offer 24/7 services 4. Intermediate care to establish protocols and pathways for community care 5. Intermediate care to partner with the Third sector to deliver community services 6. Re-design workforce to include mental health practitioners in intermediate care services 7. Establish a culture shift to ensure all Allied Health Professionals are respected within the intermediate care workforce 8. Develop means of supporting carers operating within intermediate care 9. Create a front door workforce

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Women and Children's Services	1. Integration of paediatric services between secondary and community care, including closer working with GPs to give advice and care within home and community settings 2. Increase patient and public engagement within service development and provision 3. Improve timely access to Child and Adolescent Mental Health (CAMHS) services to support early intervention and improved access to services 4. Develop transition pathways from children's to adults' services and associated commissioning arrangements to support this 5. Develop the service provision for preventative services with partners in Children, Young People, Education and Skills (CYPES) 6. Reduce levels of Year 6 pupils who are overweight 7. Improve the number of 2 year olds meeting developmental milestones 8. Increase the number of pupils who report they have a good quality of life 9. Reduce the number of under 18s requiring a dental extraction 10. Establish an acute Paediatric Assessment Unit including shared care facilities for CAMHS patient pathways	1. Increase the amount of gynaecology care provided in primary care settings and reduce referrals into secondary care. This could be achieved by pathway reconfiguration and GP education 2. Establish a pre-conception service to offer advice to patients with pre-existing conditions and co-morbidities who are looking to conceive, such as diabetics and smokers 3. Consider the potential for follow-up hysterectomy clinics to be nurse-led rather than consultant-led 4. Ambulatory care can be improved to reduce acute admissions – this could be achieved through enhancing laparoscopic skills and increasing day case activity

Appendix 5: Workstream Changes

Overview of workstream changes

	Changes identified in the JCM	Additional changes identified by stakeholders during the review
Primary Care and Prevention	1. Identify and implement opportunities to increase the support provided to carers 2. Improve access to diagnostics and specialist advice and guidance through primary care channels 3. Expand and enhance prevention, self-care and screening programmes 4. Improve access for clinically, socially and financially vulnerable people to all primary care services, making it easier and more affordable to use 5. Maintain the existing rapid access to primary care services 6. Repurpose existing secondary care resources into preventative and primary care services, reducing over-reliance on secondary care resources 7. Develop clinical pathways for long term conditions 8. Explore options for a 24/7 hospital-based primary care service for those otherwise unable to access care and provide support for all other 24/7 services 9. Build a network of community support resources, linked with the Closer to Home initiative, with a single point of access to multiple services based in community hubs 10. Develop the MDT workforce to include expanded roles of pharmacists, nursing, physiotherapy and mental health workers to provide 24/7 high quality multidisciplinary care 11. Develop shared learning and knowledge transfer between primary and secondary care	1. Make online patient records universal and accessible to all 2. Implement system governance 3. Establish GP recruitment needs through workforce analysis, followed by recruitment and retention drive 4. Expand use of quality improvement frameworks to encourage pilots for innovative working 5. Establish means of collaborative working between primary and secondary care, as well as social and mental health services 6. Ensure budget follows the patient as services shift out of secondary care 7. Incentivise immunisation through immunisation drives 8. Drive the development of holistic hospices and end of life care, with additional consideration for carers and support staff 9. Develop respite care residences with access to step up and step down care 10. Explore activity-based payment models 11. Develop sustainable workforce through retention strategy that includes emphasis on training and education of staff 12. Develop formalised relationships with family and carers to expand the traditional workforce and enable at-home care delivery

Appendix 6: Initial Analysis

Initial analysis conducted: peer selection

For benchmarking purposes, we have selected areas with which to compare Jersey's health and community care activity. Guernsey and Isle of Man will always be included as comparators where data is publicly available. The following selection criteria were applied to select areas in England to use as comparators:

- Single health system population: a single commissioner and a single acute provider (only one commissioner has more than 20% of their expenditure at the provider, and at least 80% of that commissioner's expenditure is with that provider)
- The population is classified as at least 30% rural
- The acute provider is medium, small or multi-service (only applies to Isle of Wight)

Where possible, statistics from Ireland, New Zealand and Singapore will also be shown as international examples.

Area	Population	% of population in rural areas	Type of provider
Jersey	**106,800**	**69.1%**	
Guernsey	62,286	68.6%	
Isle of Man	83,314	47.4%	
NHS Morecambe Bay CCG / University Hospitals of Morecambe Bay NHS Foundation Trust	330,572	38.1%	Acute – medium
NHS North Cumbria CCG / North Cumbria University Hospitals NHS Trust	318,631	54.1%	Acute – small
NHS Harrogate and Rural District CCG / Harrogate and District NHS Foundation Trust	160,533	32.9%	Acute – small
NHS Herefordshire CCG / Wye Valley NHS Trust	192,107	54.0%	Acute – small
NHS Great Yarmouth and Waveney CCG / James Paget University Hospitals NHS Foundation Trust	217,681	30.2%	Acute – small
NHS West Norfolk CCG / The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	175,904	64.2%	Acute – small
NHS Isle of Wight CCG / Isle of Wight NHS Trust	141,538	32.3%	Acute – multi-service
Ireland	4,857,100	36.8%	
New Zealand	4,942,500	13.5%	
Singapore	5,638,700	0%	

Appendix 6: Initial Analysis

Initial analysis conducted: benchmarking

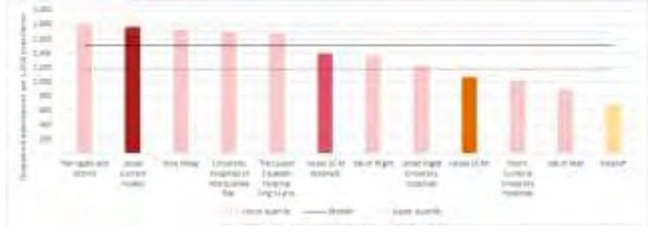
High level benchmarking analysis will be carried out to compare acute activity in Jersey to the peers. The purpose of this analysis is

1. where there is a quantitative assumption stated in the JCM on the amount of activity that would move out of hospital, to test whether this assumption is within expected bounds, and
2. where there is not a quantitative assumption stated in the JCM, to provide an initial estimate of the amount of activity that would move out of hospital, for validation by the workstreams

Outputs of the benchmarking analysis conducted so far are given in the appendix.

Example: outpatients

The JCM suggests a potential reduction of 40% of outpatient activity. 21% of this reduction has been identified in detail as a shift to primary or community care or a reduction through one-stop pre-assessments and virtual clinics.



Key findings

1. Jersey currently has a relatively high level of outpatient appointments (1.8 appointments per 1,000 population in 2018), above the peer upper quartile
2. A 40% reduction in outpatient activity would bring Jersey to below the lower quartile
3. The more detailed changes outlined in the JCM which lead to a 21% reduction would shift Jersey to the lower half of the peers
4. There may be opportunity to reduce or move out of hospital another 12% of activity on top of this 21% (23,000 attendances in 2018) through further examination of current outpatient clinics, which would bring Jersey to the lower quartile of the peers

The 40% reduction in outpatient activity proposed in the JCM appears to be a high estimate.

The 21% reduction detailed for the top 5 specialties appears to be within expected bounds, and there may be opportunity to reduce hospital outpatient activity further.

Appendix 6: Initial Analysis

Initial analysis conducted: case study analysis

Case study analysis will also be carried out to estimate the impact of JCM interventions on levels of hospital activity. Initial case study analysis has covered the impact of 24/7 mental health crisis response.

The JCM highlights that 24/7 Mental Health support will reduce ED use where patients could be better cared for at home by crisis response teams.

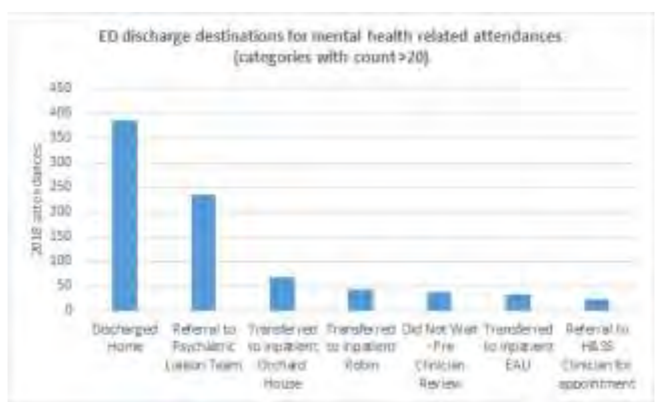
The purpose of this analysis is to estimate the proportion of ED attendances that could be expected to move out of hospital.

Existing ED activity analysis

- Existing ED activity analysis conducted for the JCM review shows that 2.4% of ED activity (960 attendances in 2018) may be due to MH (attempted suicide, deliberate self harm, psychiatric or referred to psychiatric liaison team)
- Of these:
  - 41.6% of MH related attendances were discharged home
  - 22.1% were referred to Psychiatric Liaison Team
  - 7.3% were transferred to Orchard House

Case study examples of community based 24/7 First Response Service

Bradford District Care NHS FT	• 60% reduction in people needing to attend the emergency department
Cambridgeshire and Peterborough NHS FT	• 20% reduction in the use of the emergency department for mental healthcare • 26% reduction in attendances who were admitted to acute hospitals from the emergency department



The potential impact of 24/7 Mental Health support on secondary care activity, at 2018 levels, is 190-580 fewer ED attendances and 50 fewer emergency admissions per year (increasing over time). Capacity to support this level of need would be required in the community.

Appendix 6: Initial Analysis

'Do Nothing' Growth Assumptions

Demand growth assumptions

Demand growth has been projected over a 16 year time period from 2020 to 2036. This has been calculated by considering how the population which currently use health and care services is forecast to change over time.

By segmenting the demand for services into individual age bands and then applying the forecast population growth figures as provided by the Strategic Policy, Performance and Population (SPPP) team, we have been able to estimate how demand for each service will change.

This is summarised in the graph below and the table to the right.

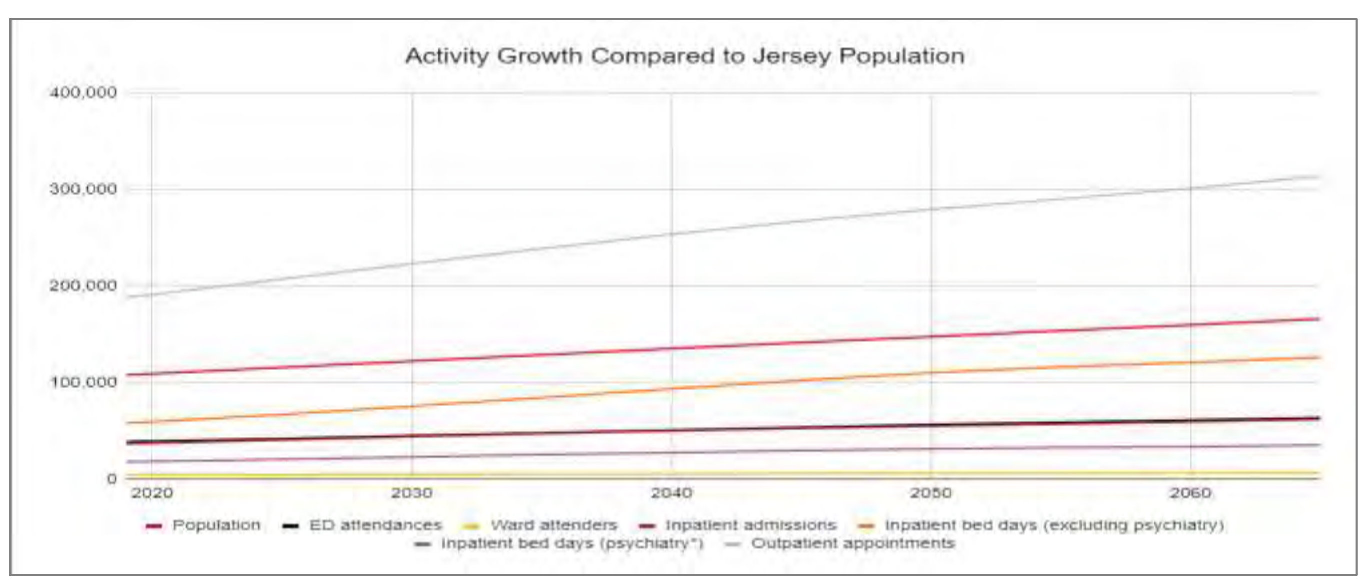
Inflation assumptions

Inflation has been assumed to be 3% per year except where more detailed assumptions have been developed as part of the Government Plan

Table: Growth rate of services

Service description	Growth rate (2020 to 2036)
A&E attendances	21,2%
Day case admissions	23.3%
Elective admissions	23.3%
Non-elective admissions	30.5%
Outpatients first appointments	22.9%
Outpatient follow-up appointments	24.2%
Outpatient procedures	24.2%
Women, children and family care	15.4%
Mental health	34.3%
Primary care	17.8%
Social care	55.0%

Figure: Activity growth compared to Jersey population



Appendix 7: Outputs from Focus Groups

Workshop summary - Mental Health focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: -*

JCM changes discussed: 12

Additional changes identified: 0

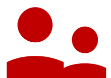
What was covered?

Introduction to the JCM review approach

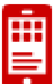
Review of the proposed JCM changes

Ease of implementation assessment for JCM changes

Overarching themes from workshop



Mental, physical and social health should be combined to form overall "care" for the people of Jersey



Digital platforms would increase the integration between Mental Health services and Primary, Secondary and Community services

Additional education, training and upskilling the workforce would increase the provision of Mental Health services

**Note: No attendee list was taken for this focus group*

Appendix 7: Outputs from Focus Groups

Workshop summary - Mental Health focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 1*

JCM changes discussed: 12

Additional changes identified: 0

What was covered?

A summary of outputs from focus group 1

Feasibility assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

A review of case studies to inform JCM changes

Overarching themes from workshop

A review of case studies to inform JCM changes

Providing community-based care is important to enabling recovery

Discharge planning is key as the most effective treatment is in a non-acute setting.

**Note: Owing to the COVID-19 pandemic, the focus group was held with the Pod lead instead of with the whole Pod*

Appendix 7: Outputs from Focus Groups

Workshop summary - External Partners focus group

Focus group workstream
Mental Health
External Partners
Adult Social Care
Scheduled Care
Unscheduled Care
Clinical Support Services
Intermediate Care
Women and Children's Services
Primary Care and Prevention
Attendees: 15
JCM changes discussed: -*
Additional changes identified: 0

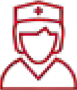
What was covered?

Introduction to the JCM review approach

Overview of JCM testing outcomes, including ease of implementation assessment

Identifying challenges and opportunities for External Partners and reviewing case studies

Overarching themes from workshop



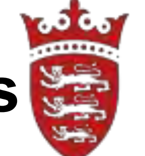
Workforce has a limited capability due to poor retention, lack of training opportunities and financial incentives

Importance of overcoming communication barriers between primary care, secondary care and external partners

Improved partnership between teams, and creating multi-disciplinary teams, will be critical to ensure integrated services

**Note: External partners reviewed the JCM as a whole instead of as distinct changes*

Appendix 7: Outputs from Focus Groups



Workshop summary - Adult Social Care focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 9

JCM changes discussed: 8

Additional changes identified: 0

What was covered?

Introduction to the JCM review approach

Initial impact assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

Overarching themes from workshop

Telehealth / telemedicine could support rapid access to care and the communication between care settings

Domestic residences should be re-purposed to support care delivery in home settings, e.g. improving accessibility

Review of funding and payment model if care delivery is to be performed primarily in place of residence and outside of acute care

On-island training resources need to be adapted to reflected workforce, patient and carer needs

Appendix 7: Outputs from Focus Groups

Workshop summary - Adult Social Care focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 1*

JCM changes discussed: 8

Additional changes identified: 0

What was covered?

A summary of outputs from focus group 1

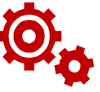
Feasibility assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

A review of case studies to inform JCM changes

Overarching themes from workshop

The capacity of the workforce is a key component for the feasibility of the JCM, especially in the private sector

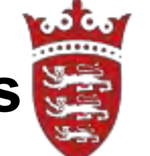


A commissioning team is key to co-ordinating care

The capability of the JCM changes depends on financial resources being available, particularly in the private sector

**Note: Owing to the COVID-19 pandemic, the focus group was held with the Pod lead instead of with the whole Pod*

Appendix 7: Outputs from Focus Groups



Workshop summary - Scheduled Care focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 21

JCM changes discussed: 6

Additional changes identified: 3

What was covered?

Introduction to the JCM review approach

Initial impact assessment of the proposed JCM changes

Early discussions on additional areas that may need to be considered

Overarching themes from workshop

Scheduled care cannot work in isolation from other workstreams, especially unscheduled care

Recruitment and retention strategies will play a pivotal role in the future service provision for Scheduled Care

Digital capability is an important enabler to have effective service provision in the community

Appendix 7: Outputs from Focus Groups

Workshop summary - Scheduled Care focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 1*

JCM changes discussed: 9

Additional changes identified: 0

What was covered?

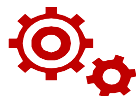
A summary of outputs from focus group 1

Feasibility assessment of the proposed JCM changes

Overarching themes from workshop

Recruiting a workforce with the appropriate level of experience is a key component for the feasibility of the JCM

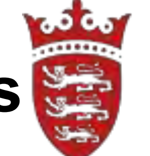
The current Estates are not sufficient for the island to provide all desired services



It is critical that the primary and secondary care sectors work more closely together

**Note: Owing to the COVID-19 pandemic, the focus group was held with the Pod lead instead of with the whole Pod*

Appendix 7: Outputs from Focus Groups



Workshop summary - Unscheduled Care focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 10

JCM changes discussed: 5

Additional changes identified: 8

What was covered?

Introduction to the JCM review approach

Initial impact assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

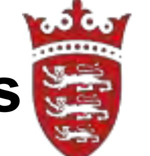
Overarching themes from workshop

Integration of digital platforms to enable access across workstreams is key to deliver effective patient care

Development of the current workforce and investment in training and upskilling will play a major role in realising the JCM changes

The location of wards, units and centres will be critical to ensure effective service provision across Unscheduled care

Appendix 7: Outputs from Focus Groups



Workshop summary - Unscheduled Care focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 1*

JCM changes discussed: 4

Additional changes identified: 0

What was covered?

A summary of outputs from focus group 1

Feasibility assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

A review of case studies to inform JCM changes

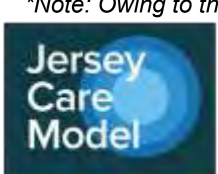
Overarching themes from workshop

Location of services is important but so to is adjacencies to wards.

Changes are moderately to highly feasible with further workforce resources required to implement a UCC.

Although it is important to analyse the number of ED attendances, it is key to assess the acuity level of the patients as this determines overall impact.

**Note: Owing to the COVID-19 pandemic, the focus group was held with the Pod lead instead of with the whole Pod*



Appendix 7: Outputs from Focus Groups

Workshop summary - Clinical Support Services focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 13

JCM changes discussed: 5

Additional changes identified: 6

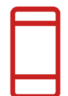
What was covered?

Introduction to the JCM review approach

Initial impact assessment of the proposed JCM changes

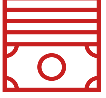
Discussions on additional areas that may need to be considered

Overarching themes from workshop



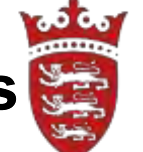
Digital solutions are integral to enabling community based provision of Clinical Support services

Current workforce challenges may be exacerbated if services are required to deliver care in the community



With a centralised current model, financial investment and incentivization would need to increase to support community work

Appendix 7: Outputs from Focus Groups



Workshop summary - Clinical Support Services focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 11

JCM changes discussed: 5

Additional changes identified: 0

What was covered?

A summary of outputs from focus group 1

Feasibility assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

A review of case studies to inform JCM changes

Overarching themes from workshop

The capacity of the workforce is a key component for the feasibility of the JCM review

Quality assurances will need to be considered with delivering of services outside of a hospital setting

The operational efficiencies of moving services into the community at a service level compared to a system level will need to be taken into consideration

Appendix 7: Outputs from Focus Groups

Workshop summary - Intermediate Care focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 7

JCM changes discussed: 8

Additional changes identified: 9

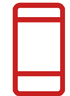
What was covered?

Introduction to the JCM review approach

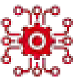
Initial impact assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

Overarching themes from workshop



Telehealth / telemedicine could support rapid access to care and the communication between care settings



Integration across digital services, including apps and online systems e.g. EMIS, should be considered in future JCM changes

Care should be provided through a single point of access

There needs to be a shift in care provision from acute to community settings underpinned by a health and social care model

Appendix 7: Outputs from Focus Groups

Workshop summary - Intermediate Care focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 11

JCM changes discussed: 8

Additional changes identified: 0

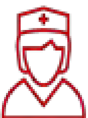
What was covered?

Introduction to the JCM review approach

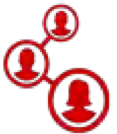
Overview of JCM testing approach and ease of implementation assessment

Further feasibility assessment of JCM changes and review case studies

Overarching themes from workshop



Challenges in workforce and training, could be combated using a workforce strategy



Need to engage the public with the JCM to increase acceptance and possible impact on experience

Support cultural shift in service users to support the shift in care delivery from acute services to the community

Appendix 7: Outputs from Focus Groups

Workshop summary - Women and Children's Services focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 9

JCM changes discussed: 10

Additional changes identified: 4

What was covered?

Introduction to the JCM review approach

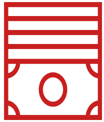
Initial impact assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

Overarching themes from workshop

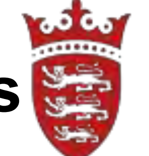
Social media/digital apps will provide increased communication and engagement with the community

Increased training and additional workforce numbers will enable care provision



An increased level of financial support will be required to successfully implement the proposed changes

Appendix 7: Outputs from Focus Groups



Workshop summary - Women and Children's Services focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 7

JCM changes discussed: 11

Additional changes identified: 0

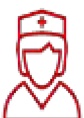
What was covered?

Overview of JCM review approach

Overview of JCM testing approach and ease of implementation assessment

Further feasibility assessment of JCM changes and review case studies

Overarching themes from workshop



Increasing workforce and staff training is key to achieving the proposed changes

Need to engage young people with the JCM to understand their impact on experience and enable to changes to be effectively implemented

Feasibility of recommendations dependent on ability develop co-ordinated pathways for prevention, intervention and referrals

Appendix 7: Outputs from Focus Groups

Workshop summary - Primary Care and Prevention focus group 1

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 18

JCM changes discussed: 11

Additional changes identified: 11

What was covered?

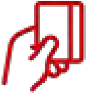
Introduction to the JCM review approach

Initial impact assessment of the proposed JCM changes

Discussions on additional areas that may need to be considered

Overarching themes from workshop

Online access to one singular patient record that is accessible across the health system for both patients and clinicians



Review of payments for patients, as well as a review of current funding structure for primary care as Jersey undergoes a shift in focus from acute to primary care

Develop current workforce with a focus on utilising allied health professionals, supported by a drive in recruitment of GPs and community nurses

Appendix 7: Outputs from Focus Groups

Workshop summary - Primary Care and Prevention focus group 2

Focus group workstream

Mental Health

External Partners

Adult Social Care

Scheduled Care

Unscheduled Care

Clinical Support Services

Intermediate Care

Women and Children's Services

Primary Care and Prevention

Attendees: 9

JCM changes discussed: 11

Additional changes identified: 0

What was covered?

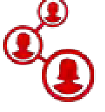
Overview of JCM review approach

Overview of JCM testing approach and ease of implementation assessment

Further feasibility assessment of JCM changes and review case studies

Overarching themes from workshop

Challenges in workforce could be mitigated by focused implementation in areas of greatest need



Need to engage the public with the JCM to increase acceptance and possible impact on experience

Support cultural and behavioural change in service users and GPs to build acceptance of the shift in care delivery from GP led services to the community

Appendix 8: Stakeholder Engagement

Stakeholders engaged as part of the Jersey Care Model review

We would like to acknowledge the commitment and dedication of the individuals outlined in the table below, who were engaged as part of the review of the Jersey Care Model.

Stakeholders			
Adrian Noon	Emelita Robbins	Lauren Wilson-Kelly	Phil Romeril
Adrian O'Keeffe	Emma O'Connor	Lee Hayward	Phil Terry
Agnetta Nerac	Emma Ward	Lesley Hill	Philip Le Sueur
Ajay Kumar	Fiona Nelson	Lindsey Ash	Philippa Daubeney
Alan Thompson	Helen Goulding	Lindsey Le Masurier	Philippa MacAndrew
Alex Crowther	Hilary Lucas	Lizzie Guise	Rachel McBride
Alex Watt	Hugh Raymond	Louise Hotton	Raymond Cooper
Alex Wiles	Ian De La Cour	Louise Journeaux	Richard Bannister
Amanda Eidukas	Isabel Watson	Lyndon Farnham	Richard Bell
Andrew Carter	Isobel Hamon	Malcolm Ferey	Richard Glover
Andrew Heaven	Jackie Tardivel	Maria Benbown	Richard Renouf
Andy Scate	Jake Bowley	Mark Queree	Robert Sainsbury
Angela Falle	James Le Feuvre	Mark Wilbourn	Rose Naylor
Ashok Handa	James Mair	Martin Knight	Rowland Huelin
Assumpta Finn	Jan Auffret	Martin Warnette	Roy Valentine
Beth Moore	Jason Wyse	Michelle West	Ryan McNay
Bronwen Whittaker	Jennie Pasternak	Miguel Garcia-Alcaraz	Samantha McManus
Carl Walker	Jennifer Newall	Mike Richardson	Sara Kynicos
Caroline Landon	Jessie Marshall	Mike Thomas	Sarah Blake
Charlie Parker	Jim Hopley	Miklos Kassai	Sarah Shaw
Cheryl Kenealy	Jo Poynter	Muktanshu Patil	Sean Pontin
Chris Dunne	Jocelyn Butterworth	Natalie Mallet	Sebastian Perez
Chris Jury	John Hodge	Nick Dodds	Sharon Summers-Ma
Christine Blackwood	John Le Fondré	Nigel Minihane	Shaun Findlay
Claire Ryder	John Quinn	Oliver James	Simon Chapman
Claire Sambridge	John Rogers	Oonagh Butler	Stephen Bull
Clare Fitton	Josh Brien	Pamela Hobbs	Stephen Hardwick
Clare Stewart	Joss Douthwaite	Patricia Winchester	Steve Jackson
Cristina Ferreira	Judith Gindill	Patrick Armstrong	Steve Mair
Darren Skinner	Karen Pallot	Patrick Le Coz	Sue Duhamel
David Ng	Karen Veljovic	Paul McCabe	Tony Hocking
David Queen	Kate Biljon	Paul McGinnety	Tracey Perchard
Deborah O'Driscoll	Kate Southern	Paul Michel	Val Howard
Dennis Pimblott	Kemi Akinpelu	Paul Rendell	Valter Fernandes
Ed Klaber	Kerry Bartlett	Paul Simmons	Washington Gwatidzo
Edgar Dingle	Kevin Lewis	Peter Gavey	Wendy Baugh
Effie Liakopoulou	Lauren Jones	Petra Schinle	

Government of
JERSEY

Gouvèrnément
d'JÈRRI

APPENDIX 3

Government of Jersey

Business Case 2020

Project Code:	TBC by Investment Appraisal Team
Business Case Title:	Jersey Care Model Strategic Outline Case
Primary Department:	HCS – Health & Community Services
Secondary Department(s):	

	Name	Signatures
Lead Author:	Stephen Bull	
Project Owner:	Stephen Bull	
Lead Finance Business Partner:	Jo Larkin	
Senior Responsible Owner:	Hilary Lucas	
Primary Department Director General:	Caroline Landon	
Lead Minister:	Richard Renouf	

Executive summary

Introduction

The purpose of this Strategic Outline Case (SOC) is to set out the financial and operational case for change for the introduction of a new model of care for Jersey: the Jersey Care Model (JCM). The JCM will lead to a more integrated, proactive way of caring for Islanders, which relies less on hospitalisation and encourages self-care and care in the community.

Strategic case

The Strategic Case is driven by a clear financial and operational case for change and is in line with Government of Jersey policy. There is a desire through the JCM to:

1. Ensure care is person-centred with a focus on prevention and self-care, for both physical and mental health
2. Reduce dependency on secondary care services by expanding primary and community services, working closely with all partners, in order to deliver more care in the community and at home.
3. Redesign of Health and Community services so that they are structured to meet the current and future needs of Islanders.

Alignment with Government policy
The JCM is closely aligned with the Government of Jersey's ambition to create a healthy island with safe, high quality, outcome focussed, affordable care that is accessible when and where our service users need it. It also aligns closely with the Government of Jersey's Common Strategic Policy – in particular to improve Islanders' wellbeing and mental and physical health, and in preparing for more Islanders living longer. Indeed, without the JCM, analysis suggests that the current health system would be overwhelmed by Islanders who are expected to live longer.

Case for change
While many services within Jersey are performing well currently, there is room to improve in some areas, and services are not future proofed. Jersey expects the population to grow by 13% between 2019 and 2030, with a growing proportion in age groups that have greater health and care needs. By 2036, around one in five of the population would be 65 or over. The result of this demographic change would be a significant growth in those accessing services, particularly when the prevalence of long-term conditions in this group is taken into account (more than half of Islanders aged over 60 have two or more long term conditions).

Economic Case

The Economic Case sets out the proposed changes to the care model and payment options that support delivery of this care model. In total, the analysis has considered two care model scenarios – a 'do nothing' and a 'do something' scenario – and four payment model options through a combination of reviewing and engaging with stakeholders and quantitative analysis.

The two care model scenarios were informed by the 69 proposed changes across the nine workstreams of the JCM (see Appendix 1 for a full list of recommended changes). Each of these changes required individual assessment against a range of criteria including feasibility, impact on enablers, and impact on activity as part of a formal JCM review.

This assessment has informed the 'do nothing' and 'do something' scenarios included in this Economic Case options appraisal, as well as the additional options surrounding funding. In a 'do nothing' scenario

there would be no changes to the current health and care system or the associated finance, workforce, IT and digital or infrastructure changes. In the ‘do nothing’ scenario care would continue to be provided disproportionately in the acute sector. In a ‘do something’ scenario the proposed changes would be adapted to implement the JCM.

In terms of payment models, the JCM is not proposing changes to many of these, particularly those relating to services currently provided by the Health and Community Services (HCS) department, which will continue to be provided by HCS. There are also a number of areas where new commercial structures will be required, which are covered in detail in the Commercial Case. This leaves primary care as a substantial area which is currently commissioned externally but for which changes may be required to implement the JCM. The analysis considered four payment options for primary care (focused on GP services) from expanding the current fee-for-service (FFS) mechanism to include community pharmacy, to a capitated system (with or without co-payment), to a GP salaried model, the latter being a model temporarily put in place in response to the COVID-19 pandemic.

The review of the JCM recommended that the ‘do something’ model should be taken forward, as it outlines a strong, patient-centred approach to delivering healthcare in Jersey, in line with current trends in healthcare worldwide. It found that the proposed integrated care model is likely to deliver enhanced service user experience and care by streamlining services and workforce resources. It also includes a number of priority actions for implementation across the system (detailed in the Management Case). In addition, a number of key areas will require further development, to facilitate full system implementation of the model and these will be developed in subsequent phases.

To complement the JCM review, quantitative analysis found that the ‘do something’ scenario is financially sustainable and will not cost more to the consumer if resource allocation, funding models and commissioning arrangements are amended.

By 2036, the JCM is forecast to avoid £23m of recurrent expenditure growth for the health and care system. Over the 16-year period modelled, the net present value saving associated with the JCM is estimated to be £118m.

The analysis also found that the preferred payment option for primary care to support the implementation of the JCM is a capitated system with co-payment. A capitated system can improve access and can incentivise positive behaviours for primary care providers such as containing health costs and encouraging prevention. Work is already underway through Proposition 125/2019 to implement this model for Financially Vulnerable patients with further work underway to support Socially and Clinically Vulnerable groups. This capitated system could additionally be complemented by expanding the current FFS model to community pharmacy to increase collaboration and integration.

Commercial Case

The Commercial Case sets out the unique opportunity that the JCM offers to introduce new commissioning models and develop an integrated health and care system on island to improve residents’ outcomes and drive value for money for Jersey as a whole. This will be underpinned by the core principles of collaboration and partnership.

The Case describes the current approach to commissioning which is based on the specification and procurement of services, rather than on desired outcomes for targeted groups, with contracting being the norm.

Several commercial structures that may support the JCM, based on international good practice in health and care commissioning, are proposed. A central island contract management function should be considered, as this would support the future commercial changes.

The procurement strategy and approach are detailed, including a greater use of strategic partnerships and utilising the Commissioning Framework, which has been developed to support the Jersey Care system leaders commissioning the JCM.

To deliver the model, different parts of the health and social care system must work collaboratively to coordinate services. A far closer partnership will allow partners to work together to drive up the quality of care and improve outcomes by meeting the current and future needs of the population in Jersey. This is particularly relevant in relation to increased use of technology as an enabler.

Implementing the JCM (with its available models, options and opportunities) will have a significant impact across the entire health and care system. The Commercial Case explores these for the primary care, social care and external partners sectors.

Financial Case

The Financial Case sets out the financial forecasting associated with the JCM (as described in the Strategic and Economic Cases) and the proposed commercial structures that will enable this (as described in the Commercial Case).

In order to deliver the JCM and recognise the expected benefits, non-recurrent investment of £17m over a five-year period (2021-25) is required.

In addition to the non-recurrent investment, the JCM requires the implementation of several new services and expansion of some existing out of hospital services. Over the 16 years to 2036, these have been estimated to cost a total of £679m.

As a result of these investments, over 16 years, the JCM is forecast to avoid a total of £874m in expenditure growth compared to the ‘do nothing’ scenario (where no changes are made to the health and care system). Net of the recurrent investment requirement there is a total forecast reduction in expenditure growth of £195m compared to the ‘do nothing’ scenario, which falls to an impact of £178m once non-recurrent investment has also been removed.

As a result of the JCM, sustainability of Jersey’s health and care system is forecast to significantly improve. From 2025 onwards, the savings associated with the JCM start to exceed the investments.

While a residual affordability challenge of £153m remains following implementation of the JCM, efficiencies of c. 1.8% per year will be required to be financially sustainable above implementation of the JCM. This is in line with the levels delivered in other similar health and care economies.

Management Case

The Management Case sets out the structures that need to be in place to deliver this change programme effectively.

The changes to current care delivery set out in the JCM are across numerous different workstreams, with wider, cross-cutting changes to enabling functions such as digital, estates and workforce. Such a complex programme of change requires a rigorous portfolio management approach in order for the vision set out in the JCM to be achieved and for the desired benefits to be seen by staff, stakeholders and service users alike.

The management case outlines the governance structure of the JCM and how roles will function alongside one so that the model is effective in providing a modern, community-based care model. The governance for the JCM will run in parallel to the governance for Our Hospital Project.

Following a review of the JCM, a multi-year implementation plan has been developed with key projects prioritised. Given the assessment through the JCM review and through planning it is been determined that the implementation of the JCM will be completed in three tranches. The emphasis of the first tranche will be on detailed planning, particularly around workforce and change management, to be able to support our health and care professionals to be able to deliver in the new model, implementing the necessary foundations to deliver on the new model, and driving care delivery through enhancing intermediate care. Implementation will need to be phased, to be able to shift to the new model, while being able to be responsive to any immediate needs on the system, including COVID-19.

The next step is to develop Project/Programme Initiation Documents (PID) for priority programmes, setting out scope, governance and outcomes.

Robust transformation control governance will also need to be in place. A design authority with a clear vision for the future state who make sure that the portfolio of change holds to a set of clearly defined design principles, is an important starting point for strategic oversight, alongside the Portfolio Management Office (PMO) overseeing day to day activity. An indication of how this will work is set out in the Case.

1. The Strategic Case

Introduction

The purpose of this Strategic Outline Case (SOC) is to set out the case for change for the introduction of a new model of care for Jersey; the Jersey Care Model (JCM).

A separate SOC has been submitted for the build of a new hospital, 'Our Hospital', which will fit the Island's future care needs and allow the Government of Jersey to deliver secondary care in a sustainable way.

The Strategic Case is structured as follows:

- Section 1.1 describes the JCM and sets out the strategic objectives.
- Section 1.2 provides an overview of the strategic context. It sets out the proposed changes of in the model of care and how they align with government policy and vision.
- Section 1.3 sets out the case for change. It describes the current state of health and wellbeing in a scenario where there are no changes to the current model of care.

1.1 Project Description & Objectives

1.1.1 Project Description: The Jersey Care Model

The aim of the JCM is to move health and community services in Jersey away from the traditional secondary care focused model towards a community-based model that puts individuals at the centre. Person-centred care will increasingly be delivered by primary care and community partnerships which focus on prevention; self-care and patient education programmes will enable people to look after themselves better. These services will be expanded to meet the demands of the changing needs of the Islanders, while technology will also be fully utilised to allow people to manage their own health. The hospital will focus on acute treatment, and where possible services offered currently in hospital will be moved out into the community.

1.1.2 The Jersey Model of Care Objectives

The JCM has 3 overarching objectives, which are aligned with the Government strategic ambitions. These are to:

1. Ensure care is person-centred with a focus on prevention and self-care, for both physical and mental health
2. Reduce dependency on secondary care services by expanding primary and community services, working closely with all partners, in order to deliver more care in the community and at home
3. Redesign of Health and Community services so that they are structured to meet the current and future needs of Islanders

1.2 Strategic Context

1.2.1 Overview of the Jersey Care Model

The JCM aims to transform health and social care in order to improve Islander's wellbeing and mental and physical health. To achieve this, it proposes adopting a person-centred approach whereby care is affordable, safe and accessible, being provided in the places where people need it the most.

The current health and social care model is acknowledged to be primarily hospital focussed, with a dependency on secondary care provisions. This is best evidenced by approximately 30,000 visits to the Emergency Department in 2018 that were not considered emergencies.

There is a recognition that improvements can be made to the way in which Jersey organises and delivers care to adapt to demographic changes. Under the JCM care will be decentralised through expanding primary services and reducing the dependence on secondary care in order to develop care in the community. Care will be proactive rather than reactive and put individuals at the centre. Technology will also be used to allow people to manage their own health.

The care model encompasses all parts of the system, spanning nine workstreams. The model proposes several changes within each workstream, which are summarised in Table 1.1:

Table 1.1: Summary of changes proposed in the JCM

Care area	Summary of changes
Primary Care and Prevention	Prevention will be targeted by expanding public health, prevention, self-care and screening programmes as well as repurposing existing secondary care resources into preventative and primary care services. Care in the community will be enhanced by increasing support to carers and improving access to primary care services for the clinically, socially and financially vulnerable. The existing rapid access to these services will be maintained and will provide access to diagnostics and specialist advice. Within the community, there will be a network of support resources with a single point of access to services based in community hubs. A multidisciplinary workforce will expand current roles to provide 24/7 high quality care.
Adult social care	Care will be moved into the community by increasing community capacity and through local strategic commissioning, the range of services available in the community, the number of people who can be paid carers and the provision of information and advice on care and support. Independence will be supported through bespoke care packages that incorporate assistive technology, investment in preventative services and the development of personalised approaches.
Mental Health	Investment will be made in primary care-led mental health care. Community based alternatives to hospital and co-located mental health services will focus on crisis prevention and early intervention and will work with the local community and partners to expand community-based capacity for care. Self-care and education programmes will also be utilised. The model will establish the front door as an Emergency Care Centre, and offer integrated crisis care and support over 24 hours by establishing the Crisis Prevention and Intervention Service.
External partners	Continue to leverage the experience and support of the volunteer sector and other partners within the community sector to support the model.
Scheduled Care	An integrated hub model will be introduced to provide planned care services, connecting primary and secondary care. Referral management between primary and secondary care will be facilitated by education and support for general practice. Outpatient activity will be provided outside the hospital wherever possible, reducing hospital-based outpatient activity for certain services. Specialist functions will be set to effective clinical pathways based on island need and will manage anticipated future requirements. Connectivity to planned tertiary care and specialist services will be further developed, with more patient activity repatriated to the new hospital. The hospital's clinical environment will be adaptable to changes in demographics. The acute bed base will be optimised by reducing length of stay, increasing the use of day surgery, and moving further services back into the community.

Care area	Summary of changes
Unscheduled Care	The model will establish an Emergency Care Centre to provide urgent and unscheduled care access with a specialist medically led model of emergency care. The unscheduled care model will also include more prominent ambulatory assessment, particularly rapid access for the frail patients to out of hospital services. An acute Paediatric Assessment unit will be established and share care facilities for Child and Adolescent Mental Health Services (CAMHS) patient pathways. The Jersey Emergency Transfer Service will connect to tertiary and specialist services.
Clinical Support Services	Capacity for clinical investigations will be increased by MRI and CT scanning capabilities and mobile equipment functions. Rapid access and 'near testing' will increase connectivity to primary and intermediate care. A multi-disciplinary team (MDT) workforce will expand current roles of staff in the community; services such as physiotherapy will be provided fully or partially out of hospital. Cancer services will be more prominent.
Intermediate Care	The model will develop a Community Focused Intermediate Care function which incorporates Rapid Access and runs 7 days a week 8am-8pm connected to a care overnight community function. This will be connected to broader community services to support 24/7 care needs. Intermediate services will have access to home-facing enabler services and secondary care diagnostics. Services will also be introduced to support the social and long term care sector. There will be expansion of the hospital-at-home/rapid response service and early facilitated discharge from secondary care, and technological solutions will be implemented to support people to stay well at home. Person centred planning will maximise independence.
Women and Children's Services	The service provision for preventative services will be developed with partners in Children, Young People Education and Skills. Paediatric services will be integrated between secondary and community care and include closer working with GPs in the community. There will be a co-located women's and children's services unit in the hospital. Rapid access to CAMHS services will support early intervention and access to services; transition pathways from children's to adults' services will also be developed.

The table above summarises the JCM recommended changes to the current care model. The review of the proposed changes to the care model has formed the basis for the 'do something' scenario; a scenario where these changes are adapted. In comparison, in the 'do nothing' scenario there would be no changes to the current health and care system or the associated finance, workforce, IT and digital or infrastructure changes. The 'do nothing' and 'do something' scenarios are assessed in the Economic and Financial Cases.

To support the delivery of the JCM recommended changes, there is a need to change the current payment mechanisms in primary care and an opportunity to move service services, particularly those related to the management of long term conditions, into the community. There is increasing international evidence that improved outcomes and reduced health inequalities can, when the right populations are targeted, be delivered through preventive, out of hospital care.[1] In addition, a number of early intervention and prevention programmes have been shown to be a cost-effective way of delivering care, particularly for those with risk of long term conditions.[2] There is recognition that the current configuration of services and the current payment model in primary care were not set up to deliver care in this way.

Remodelling primary care is a core part of the JCM, recognising that a well-functioning primary care sector is an essential underpinning of the overall model. In response to the COVID-19 pandemic, a salaried model was put in place, however the arrangement has now reverted back to a fee-for-service (FFS) payment mechanism. There is agreement across the island that this FFS payment mechanism for primary care will not allow the proposed changes to be deliverable. A set of payment mechanisms for primary care are

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1 The Health Foundation, Getting out of Hospital, June 2011, https://www.health.org.uk/sites/default/files/GettingOutOfHospital_fullversion.pdf

2 See, for instance, European Observatory on Health Systems and Policies Series, *Promoting Heath, Preventing Disease: The Economic Case,* Open University Press, 2015

assessed in the Economic Case. As part of the JCM, Jersey has an ambition to better support those with long term conditions and other ambulatory conditions in the community. There is recognition that there are services which in other healthcare systems globally are normally delivered outside of an acute setting. In order to realise this ambition, there will be a need to reconfigure services in order to, for instance, move some management of long term care from outpatients into primary care (see case for change for more detail on current outpatient services).

1.2.2 The JCM is aligned to government policy

The JCM is aligned to Government of Jersey policy in four key ways:

- The JCM is aligned with the government vision set out for the Health and Community Services.
- The JCM supports the governments' commitment to provide affordable, efficient and cost-effective public services.
- The JCM aligns with the Government of Jersey's Common Strategic Priorities.
- The JCM aligns with the Government of Jersey's public health goals.

The Government of Jersey has set out **its vision for Health and Community Services** (HCS); to create a healthy island with safe, high quality, outcome focussed, affordable care that is accessible when and where our service users need it.[3] Traditionally, health and care in Jersey has relied on a secondary care focused model. This has contributed towards centralised, institutional based care, with disjointed discharge routes back into the community and limited access to reablement to support those being discharged. In order to deliver truly patient focussed, outcome-based care, there is a need to implement a model which allows for a more holistic view of health and care, and to develop a stronger model for out of hospital care. The new model of care set out in the JCM aims to provide sustainable and high quality services for the people of Jersey.

The government has also committed to providing affordable, efficient and cost effective public services which meet the standards that Islanders expect. The proposals for the JCM align with the Government of Jersey's **Common Strategic Policy**, which focuses of five strategic priorities[4]:

- We will put children first.
- We will improve Islanders' wellbeing and mental and physical health.
- We will create a sustainable, vibrant economy and skilled local workforce for the future.
- We will reduce income inequality and improve the standard of living.
- We will protect and value our environment.

In particular, the JCM has an ambition to improve Islanders' wellbeing and mental and physical health, and to enable Islanders to enjoy long, healthy and active lives. This strategy also takes seriously the commitment to reduce inequalities and improve standards of living. Therefore, the degree to which options have a financial impact on the individual have been considered, particularly if more care takes place in parts of the health system where there is currently a co-pay element.

Finally, the JCM aligns with the Government of Jersey's **Common Strategic Priorities**: this alignment is set out below in Table 1.2.

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3 Government of Jersey, Jersey Care Model Briefing Paper, October 2019, https://www.gov.je/SiteCollectionDocuments/Health%20and%20wellbeing/ID%20Jersey%20Care%20Model%20Briefing%20Paper%2020191029%20LJ.pdf

4 Government of Jersey, Common Strategic Policy, 2018, https://statesassembly.gov.je/assemblyreports/2019/r.11-2019%20small%20amd%20page%205.pdf?_ga=2.115253255.1406391748.1584887934-1962226745.1584630621

Table 1.2: Alignment with Common Strategic Priorities

CSP Priority

CSP 2.1 Improve Islander's wellbeing and mental and physical health – by supporting Islanders to live healthier, active, longer lives

- The JCM will support Islanders to prevent ill-health and adopt self-care as part of its shared commitment with Islanders to maintain a healthy lifestyle.
- Self-care and patient education programmes will enable people to look after themselves more effectively, using technology to empower people to manage their health and care. Promoting resources that help citizens with self-care will improve health outcomes of individuals and their families.
- Expanding and enhancing prevention and screening will enable the identification and treatment of risk factors, pre-cursors and disease as early as possible.
- The improvement and removal of potential barriers to access for financially, clinically and socially vulnerable patients to all primary care services, including dentistry, will make them easier and more affordable to use. This will in turn create conditions which in the long term will reduce the most common diseases and preventable death, supporting Islanders to live healthier, active, longer lives.

CSP Common Theme

Preparing for more Islanders living longer

- The JCM supports Islanders in living healthier, more active lifestyles as outlined above which will support good health into old age. Planned changes for the workforce consider the changing needs of the island as the proportion of older Islanders increases.
- Expanding primary care services will enable the older demographic to interact less with secondary services. Expanding intermediate care will allow more care to be provided in Islander's own homes, including 24/7 community nursing so that people are supported at home overnight. Geriatricians will support the high volume of older demographic activity.
- The introduction of a community focussed Intermediate Care function will incorporate Frailty and Older Person's Rapid Access that runs 7 days a week from 8am-8pm and is connected to a core overnight community function. The service will have access to secondary care diagnostics, step up-down provision and home facing enabler services, and will be connected to broader community services to support 24/7 care needs including end of life care. This service will support the changes in the social and long-term care sector from bed based to home faced care provision. The focus is to keep Islanders out of hospital and to provide service through primary care and at home.

Jersey Performance Framework

Health and Wellbeing

Justification

Jersey's performance framework includes statements on health and wellbeing which are used to inform on the quality of life in Jersey and see how it is progressing. Each of the five areas under the heading of health and wellbeing have several outcomes and indicators sitting beneath them.[5] These are outlined below with explanation on how the JCM addresses them:

- **Islanders benefit from healthy lifestyles:** The JCM prioritises education and self-care programmes to enable people to stay healthy and optimise lifestyle choices.
- **Islanders are protected against social and environmental health hazards:** The model focuses on person-centred care in the community, providing more services to patients at home and linking into wider Government systems such as Housing.

5 See Jersey Performance Framework for full details: https://www.gov.je/government/planningperformance/governmentperformance/pages/governmentperformancemeasures.aspx

- **Islanders can access high quality, effective health services:** Moving care into the community will enable users to access services more easily. The model will improve access to primary care for patients who are financially, clinically and socially vulnerable. Expanded prevention and screening will also allow for illnesses to be identified and treated as early as possible.
- **Islanders with long term health conditions enjoy a good quality of life:** Improved primary care and community services will enable treatment of long-term conditions in the community, allowing people to receive more care at home and minimising their effect on day-to-day activities. Personalisation of support will also allow people to feel in control of their own health.
- **Mental health and wellbeing are fundamental to quality of life in Jersey:** The care model identifies that there is no health without mental health; it is just as important as physical health. The model will improve the mental health and wellbeing of Islanders through services which are recovery-focused, person centred and integrated incorporating legal safeguards and practices that facilitate community partnership and social inclusion.

Improving public health

A Government Plan 2020-23 priority is to improve Islanders' wellbeing and mental and physical health. In particular, it aims to bring a new focus on wellbeing through a Health and Wellbeing Policy Framework. The approach focuses on sustainable wellbeing; a holistic, integrated approach to measuring how Jersey is performing across three domains: community wellbeing; environmental wellbeing; and economic wellbeing.

This is a radical approach which places public health firmly in the context of the wider determinants of health, seeing them as part of the same challenge. Jersey is focussing on five areas under the heading of health and wellbeing, each of which has several outcomes and indicators sitting beneath them[6]:

1. Islanders benefit from healthy lifestyles.
2. Islanders are protected against social and environmental health hazards.
3. Islanders can access high quality, effective health services.
4. Islanders with long-term health conditions enjoy a good quality of life.
5. Mental health and wellbeing are fundamental to quality of life in Jersey.

Good health is key to individuals' wellbeing and brings many benefits, including enhanced access to education and the job market, better productivity, reduced health care costs, good social relations, and of course, a longer life. Preventable chronic diseases are now amongst the main causes of disability and death in Organisation for Economic Co-operation and Development (OECD) member countries. These are conditions which are largely preventable through lifestyle changes, particularly related to nutrition, exercise, smoking and alcohol intake.[7]

Improving public health and tackling the wider determinants is a primary focus of both Government of Jersey policy and the JCM, across all workstreams. The new model of care has a part to play in improving public health:

- **Adult Social Care:** Moving towards developing health literacy before, after and during care, to promote patient understanding of and planning for their own needs and how to stay well. Consideration should be given to how prevention is supported and resourced to become integrated as a key component of self-care approaches.
- **Intermediate care:** Opportunities exist across proposed changes to capitalise on 'expert patient' approaches that prevent escalation of disease and encourage self-management of conditions. This links to health literacy opportunities as well as support for brief interventions and signposting to appropriate community support and service offers.
- **Women's and Children's Health:** Maternal health is of key importance, with strong evidence showing the impact of the first 1,001 days of life on future health outcomes. There would be benefit in

6 A complete list of these outcomes and indicators is available at https://www.gov.je/Government/PlanningPerformance/GovernmentPerformance/Pages/GovernmentPerformanceMeasures.aspx

7 OECD Better Life Index, http://www.oecdbetterlifeindex.org/topics/health/

developing universal community approaches to supporting mothers/parents, aligning and building on existing community provisions. Flexibility in provision and access should be considered – for example in relation to existing payment for antenatal and community midwife services in primary care vs secondary, to increase equitable access.

- There is a need to direct some Health Visiting and school nursing capacity to support existing strategic commitments, for example around preventative programmes such as reducing children's exposure to second-hand smoke in the home. The model should integrate with early years programmes, for example around nutrition and dental health, into the offer being developed through 'Closer to Home'.
- **Prevention and Primary Care:** Addressing the current issue of affordable access to primary care services for the financially vulnerable is key to reducing health inequality. Increasing access to these groups, aligned with preventative approaches would reduce pre-disease risk factors that escalate to more costly, complicated disease outcomes.
- **Secondary scheduled care:** Should include Making Every Contact Count approach that prepares patients in advance of admission and upon release to support recovery. This should include signposting and social prescribing to support preparedness and recovery as well as sustaining improved health.
- **Secondary Care Clinical Support and Unscheduled Care:** Build infrastructure for protection against communicable disease include sexual health, blood borne viruses and build pandemic preparedness plans.
- **Emergency Care:** Making Every Contact Count – embedding brief intervention (extending beyond alcohol) as part of triaging assessment and signposting. This could be included as part of the generic health assessment and include safeguarding provisions for both adults and children.
- **Mental Health:** There is an opportunity to embed the principle of recovery and hope through personalisation of care supported by social prescribing and digital support (i.e. on-line brief interventions, apps and face-to-face but on-line access). In addition, there should be a greater focus on getting up-stream of mental health problems developing and/or escalating by connecting key protective factors with the delivery of services and community support as part of a pro-active offer. This should be linked to developing policy that addresses the wider determinants of health to shape improved conditions for mental health.

1.2.3 Getting to this point has been part of a ten-year development of services

Over the last decade, a series of White Papers and publications have set out the vision for health and care services in Jersey and developed the JCM to achieve this vision.

In 2011, the Jersey Health and Social Services published the **Green Paper 'Caring for each other, caring for ourselves'**.[8] This set out a thirty year vision and a ten year plan for health and care services on the island of Jersey, including for how health and care services would be modernised and expanded in the community to deliver more round-the-clock care with a view to reducing admissions. It set out a desire to move towards a less medicalised, paternalistic approach to care and mirrored aspirations elsewhere in the world to better integrate services to provide a more joined up approach.[9] The Green Paper also acknowledged the need for a new hospital, and within this context for the new care model to facilitate a shift to a more community focused model of care at the point at which a new hospital was built.

In 2012, this was developed into a **White Paper** which develops the ten year plan in more detail. Consultation on the White Paper highlighted concerns around access to primary care, and the barriers that the current co-payment presented for children and those on low incomes to accessing care.[10]

Following the publication of the White Paper, and in the same year, the Government of Jersey published **Health and Social Services: a new way forward** (P82).[11] This set out a clear case for change in the way services are delivered in order to be sustainable and avoid service closures and rationing going forward.

8 Government of Jersey, Green Paper, Caring for each other, Caring for ourselves, May 2011, https://www.gov.je/md/MDAttachments/Health%20and%20Social%20Services/Decisions%20in%202011/mdhss20110021.pdf
9 World Health Organisation, Integrated care models: an overview, October 2016 http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf
10 Government of Jersey, White Paper, Caring for each other, Caring for ourselves, 2012 https://statesassembly.gov.je/assemblyreports/2012/r.082-2012.pdf
11 Government of Jersey, Health and Social Services: a new way forward, 2012 https://statesassembly.gov.je/assemblypropositions/2012/p.082-2012.pdf

This white paper has set the foundation for the strategic direction of health and social care on the island of Jersey.

The **Jersey Care Model** sets out in more detail how the new model of care would be delivered.[12] This was published in 2019 alongside ongoing community engagement.

In 2020, the Government of Jersey published their **Operational business plans,** including for Health and Community Services.[13] This articulated the vision to enable Islanders to live longer, healthier and more productive lives by ensuring the provision of safe, sustainable, affordable and integrated services that are delivered in partnership with others was restated, along with five key objectives:

- Redesign of the health and social care system to deliver safe, sustainable and affordable health and community services
- Improved health outcomes by reducing the incidence of mortality, disease and injury in the population
- Improved consumer experience of Health and Community Services
- Promotion of an open culture based on good clinical and corporate governance with a clear emphasis on safety
- Manage the Health and Community Services budget to deliver services in accordance with the Government Plan and our aligned efficiency programme

1.3 Case for change

1.3.1 There is a strong case for change for moving towards a new model of care

The current mode of delivery in Jersey is outdated and does not meet the demand of a changing, ageing population. There is more to be done to treat people in a proactive manner, and to decrease the amount of time people need to spend in hospital when they are ill. This section describes the case for change and sets out the current state of health and wellbeing on Jersey.

1.3.2 Jersey has a growing and ageing population, which has an impact on health and wellbeing

Ageing and growing population

Like many health systems, Jersey is seeing changes to its population and health care needs due to an ageing population and growing levels of long-term conditions. Jersey expects the population to grow by 13% between 2019 and 2030, with a growth in the proportion of people aged over 65 from 17% to 19%. By 2036, around one in five of the population would be 65 or over.

While the population is projected to grow by 54%, hospital activity is projected to grow faster under the current model of care owing to the ageing population having higher care needs. In a do-nothing scenario, Jersey can expect to see an increase in ED attendances of 12%, inpatient admissions of 20% and bed days of 30% (27% in psychiatric care). By 2055 bed days will have doubled. The do-nothing scenario is simply not sustainable if the island is to carry on providing a high standard of care.

Population growth and demand and capacity

The 'do nothing' growth assumptions are based on latest demographic growth scenarios data provided by Jersey Statistics. A number of assumptions have been made in modelling population change, demographic change and associated demand and capacity. See the Financial Case for a full detail of these assumptions.

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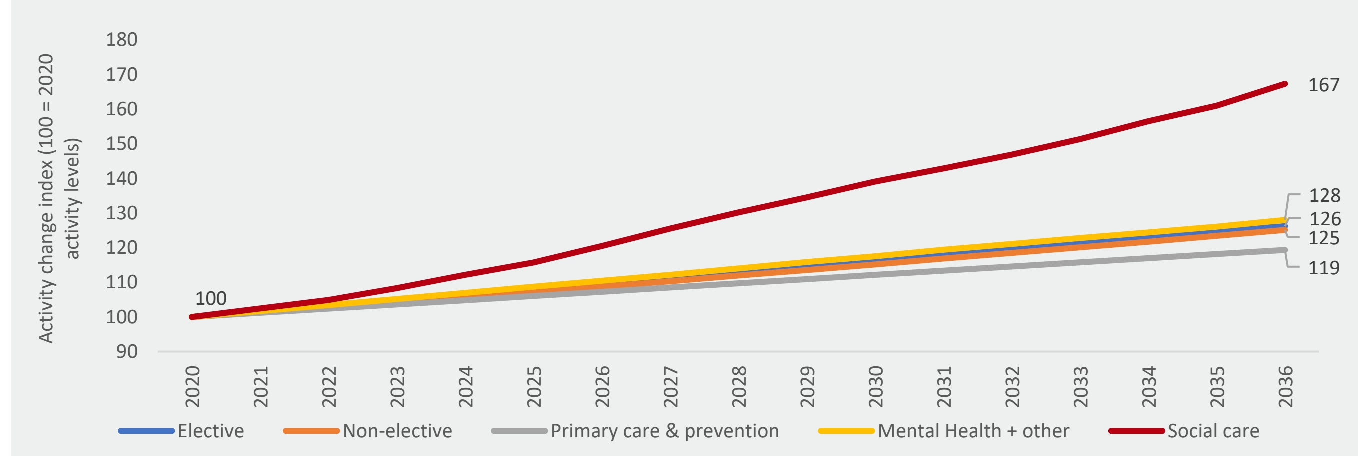
12 Government of Jersey, Jersey Care Model Briefing Paper, October 2019, https://www.gov.je/SiteCollectionDocuments/Health%20and%20wellbeing/ID%20Jersey%20Care%20Model%20Briefing%20Paper%20 20191029%20LJ.pdf
13 Government of Jersey, Departmental Operational Business Plans, 2020 https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/Draft%20Business%20Plans%20for%202020%20 20191024%20CB.pdf

In a do nothing scenario there is projected to be increased demand across all areas, with up to a 35% increase in activity in non-elective in hospital care by 2036.

Figure 1.1: Do-nothing activity changes: Assumed growth in activity by service (relative to 2020 activity levels)

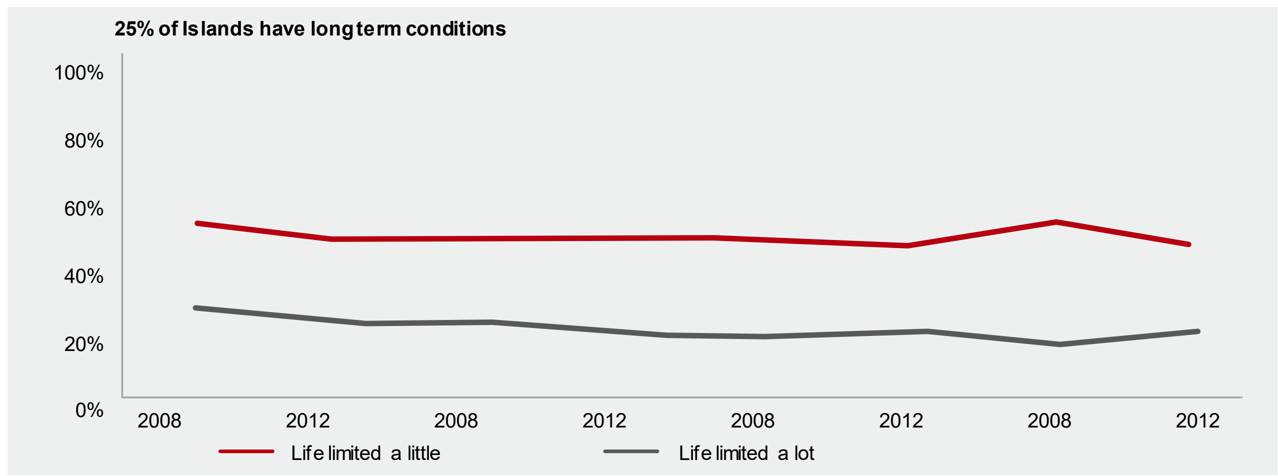


Increase in chronic conditions and comorbidities

The management of long-term conditions in the community is being considered under the JCM. In 2019, 25% of Islands identified as having a long-standing illness, while 47% said that their life was limited a little by their health and 19% said their life was limited a lot. These figures have stayed relatively constant over the last 10 years. According to figures obtained through the Jersey Quality Improvement Framework (JQIF), the most prevalent conditions in the Jersey population are hypertension (13%); obesity (8%); depression in over 19s (6%); and diabetes (6%). Prevalence of all these conditions is slightly lower than recorded in England.

Around 8% of our population have two or more conditions. This increases to more than half of the population over 60.

Figure 1.2: Percentage of Islanders with long term conditions



In 2015, the Government of Jersey Social Policy Unit commissioned a survey of households to establish the prevalence of disability in Jersey. The survey found 14% of all residents living in private households (around 13,900 residents) had a disability as defined by the UK Equality Act 2010 (that is, they have a physical or mental condition or illness lasting or expected to last 12 months or more which impacts on their ability to carry out day to day activities a little or a lot).

In part due to the ageing population, and due to the impact of lifestyle, it is expected that Jersey will see an increase in people with multiple conditions. Those with multiple complex care needs result in higher clinical and administrative costs, particularly if poorly managed. The impact of this would be significant, with a significant increase in activity in both outpatients and emergency care.

Health and wellbeing

Jersey has much to be proud of in terms of the wellbeing of its population. A child born in Jersey between 2016 and 2018 could expect to live to an age of 82.6 years. New-born boys could expect to live, on average, for 80.8 years and new-born girls could expect to live, on average, for 84.6 years. This compares to 77.5 years for boys born in Jersey in the period from 2003-05 and 82.3 years for girls.[14] This improvement has slowed down in the last decade; a change which is also evident in several countries across Europe, North America and Australia. Life expectancy at birth in Jersey is not only higher than in England, Scotland or Wales, but is amongst the best in the world. Healthy life expectancy is also high, with around 83% of an average individual's life spent in good health.[15]

However, as our population ages there is more that could be done to support our population to live healthy lives for longer. Currently, 15% of adults smoke either daily or occasionally. While this figure is dropping, it is still a significant minority of the population. In addition, 23% of adults in Jersey who drink alcohol do so at potentially harmful or hazardous levels (although hospital admissions for alcohol related conditions are falling). Only 51% of Islanders meet the recommended level of physical activity, and 35% eat the recommended amount of fruit and vegetables.[15]

Jersey has a relatively low proportion of children who are overweight or obese compared to the peer areas. Jersey also has high levels of inactivity in young people, with 80% of children not doing recommended levels of physical activity.[15]

- The average BMI of year 6 pupils has stayed the same since 2011 but this hides variations across age groups.
- In 2017/18, 20% of reception pupils (age 4-5) were overweight or obese (24% of boys and 16% of girls), while 32% of year 6 pupils were overweight or obese (34% of boys and 29% of girls).
- A lower proportion of children living in rural parishes were overweight or obese.
- A higher proportion of children attending non-fee paying schools were overweight or obese.

Mental health

Islanders report an average mental wellbeing score on the short Warwick-Edinburgh scale as 26 – in line with the rest of the UK. However, 27% of Islanders have high levels of anxiety; 21% are lonely often or some of the time; and 49% of working Islanders say they spend too much time at work – a figure which has steadily risen from 37% in 2013. 71% of working adults say they spend too little time on hobbies and interests, and more than half say they spend too little time with their families.[15]

The number of attendances to ED for a mental health problem has been rising, and in 2019 there were 932 attendances. This equates to a rate of 873 attendances per 100,000 population, the highest rate since 2013. 22% of these attendances involved deliberate self-harm and over the last three years, the Emergency Department has dealt with an average of 204 self-harm cases a year.

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14 Government of Jersey, Mortality and life expectancy, https://www.gov.je/Government/JerseyInFigures/Health/Pages/MortalityLifeExpectancy.aspx
15 Jersey's Performance Framework: measuring sustainable wellbeing, https://embed.resultsscorecard.com/Scorecard/Embed/64769

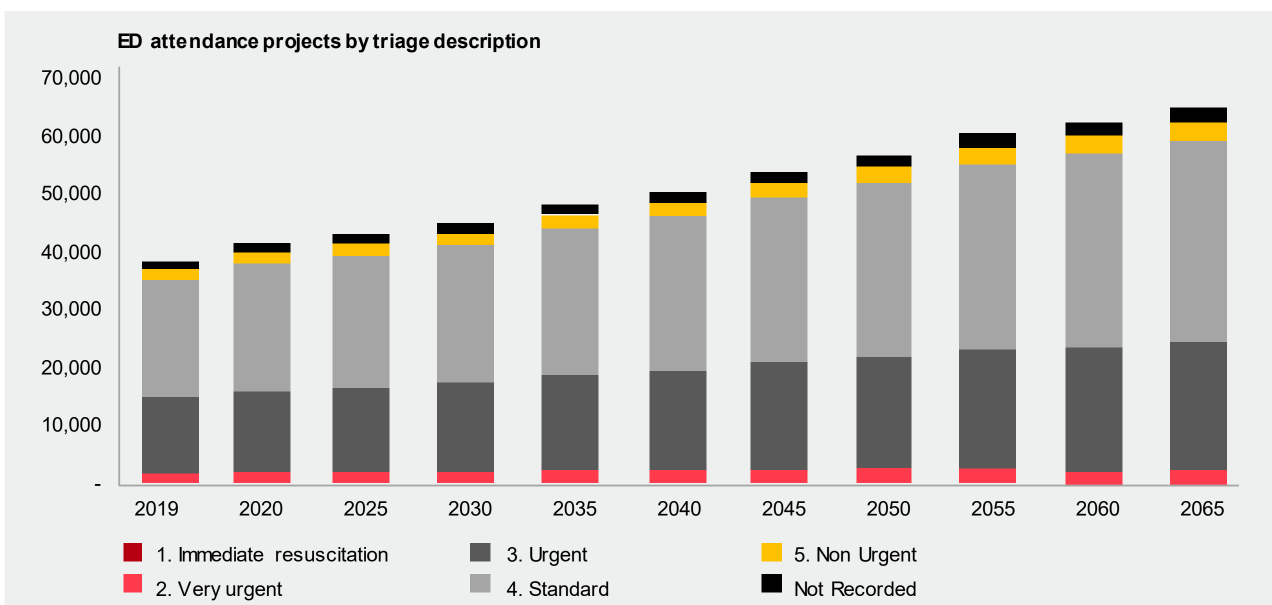
1.3.3 While Jersey has a lot to be proud of, there is room for improvement in the clinical model

There is more that could be done to reduce pressures on the emergency department (ED)

While Jersey has similar ED attendance to peers, there is potential to move more activity into primary care and other, more proactive, community settings. In a do nothing scenario, ED attendances are projected to grow by 16% by 2030, with high acuity cases projected to grow more quickly as the population ages.

Jersey currently has a similar ED attendance rate to its peers, at 370 attendances per thousand population. If the attendance rate in Jersey were at the peer lower quartile, this would be equivalent to 10% of minor ED attendances moving to primary care (3,986 in 2018). Without intervention it is projected that there will be significant growth in ED attendance, equivalent to approximately 5,000 attendances by 2035 and 6,600 attendances by 2065.

Figure 1.3: ED attendance is projected to rise



There is more that could be done to prevent those with mental health conditions facing a crisis

ED activity analysis shows that 2.4% of ED activity (960 attendances in 2018) may be due to mental health. These include activities associated with attempted suicide, deliberate self-harm, psychiatric or referred to psychiatric liaison team.

Of these:

- 41.6% of mental health related attendances were discharged home.
- 22.1% were referred to Psychiatric Liaison Team.
- 7.3% were transferred to Orchard House.

Children are presenting at ED at a higher rate than in similar health systems

Jersey has high rates of paediatric Emergency Department (ED) attendances, where potentially care could be provided in primary and community care. Jersey currently has a high level of children aged 0-9 attending ED, above the peer median, while the rate of attendance for ages 10-19 is at the peer median.

Reducing rates to the peer lower quartiles would mean:

- 19% of attendances for age 0-9 (878 attendances in 2018) would move out of hospital, equivalent to approx. 1,000 by 2035.
- 11% of attendances for age 10-19 (471 attendances in 2018) would move out of hospital, equivalent to approx. 570 by 2035.

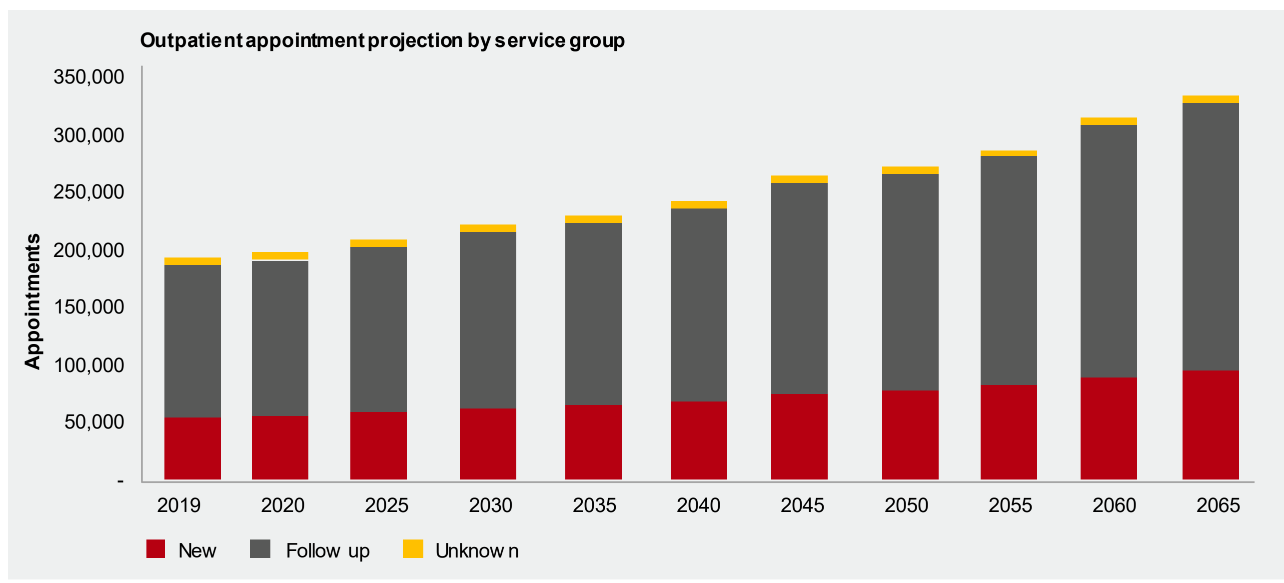
However, primary and community care could need additional capacity for the equivalent of approximately 1,600 minor children's A&E attendances per year by 2035; this could be significantly higher following population education and a review of policy and payment mechanisms.

Outpatient appointments are higher than average, suggesting some activity could be moved out of hospital

Jersey currently has a relatively high level of outpatient appointments with 1,770 appointments per 1,000 population in 2018, which is above the peer upper quartile. Overall outpatient appointments are projected to grow by 67% by 2065 in a 'do nothing' scenario, with follow ups projected to grow slightly more quickly and new appointments slightly less quickly. This could be related to the inconsistencies in user co-payments, whereby outpatient services are free at the point of use, while general practice is not.

A 40% reduction in outpatient activity would bring Jersey to below the lower quartile. The more detailed changes outlined in the JCM which lead to a 21% reduction in outpatients would shift Jersey to the lower half of the peers. There may be opportunity to reduce or move out of hospital another 12% of activity on top of this 21% (23,000 attendances in 2018) through further examination of current outpatient clinics, which would bring Jersey to the lower quartile of the peers.

Figure 1.4: Outpatient appointments are projected to rise



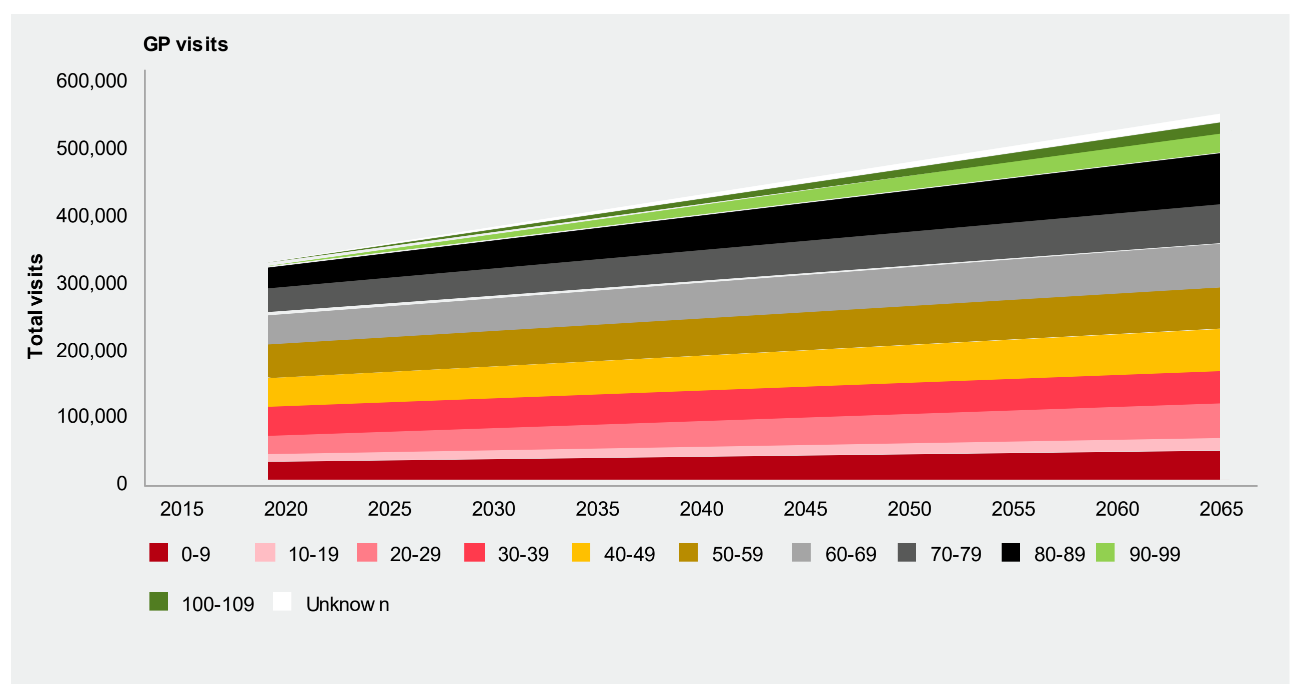
Inpatient length of stay is projected to increase dramatically

Overall inpatient length of stay (excluding psychiatry) is projected to grow by 117% by 2065 in a 'do nothing' scenario, with inpatient mental health length of stay increasing by 95%. This is driven by an increase in older, more complex patients, and will have a significant impact on the bed base needed by the island in a 'do nothing' scenario.

There is increasing demand for general practice

By 2026, there will be an estimated 70,000 GP consultations annually, an increase of 16%.

Figure 1.5: GP appointments are projected to rise



The current service has operational and workforce challenges. It has been identified through the JCM review that there is a need to upskill the current workforce to establish skills needed to deliver the model. As primary care providers take on more responsibility for the management of long-term conditions, there will be the need to develop primary care services equipped to meet the requirements of service users who were previously cared for in a secondary care setting. Education and upskilling of staff will be required to support them in taking on responsibility for more specialist areas. Expansion of diagnostic services will require recruitment and training, and potential expansion of the services provided by pharmacy will require some training.

In addition, there is a requirement for an increase in the adult social care and community nursing workforce; this is likely to present a recruitment challenge as the island looks to train, identify and recruit appropriately qualified staff. More multidisciplinary teams will support flexible care provision based on changing patient needs to meet future demand.

There is an important role for self-care, alternative delivery models (e.g. virtual clinics and technologically enabled services) and a greater use of non-traditional health and care workforce. However, while these are essential features of the workforce model, they will not replace the need to increase training and recruitment of healthcare professionals who can support Islanders in the management and prevention of long-term conditions.

1.3.4 Digital infrastructure needs upgrading to modernise the service

Jersey is currently implementing a digital health and care strategy in order to deliver a vision of using technology to deliver accessible, joined-up, person-centred care that is safe, effective and efficient, where data is used intelligently to improve every aspect of care, and where innovation flourishes.

The current strategy requires every significant part of the health and care system to implement interoperable electronic patient records (EPR). There is work ongoing to identify and procure the most appropriate EPR solution for the hospital; as well as other modern systems for other main business areas such as mental health and social care.

There is more to be done to create a structured, comprehensive record which enables linkage across services by way of a unique identifier. This would enable Jersey to both provide a better patient experience by having appropriate access to information at the point of care and enable more effective planning around

health inequalities and the wider determinants of health. Jersey would be able to build a large, more comprehensive data set (currently contained in a health information layer and largely used for administrative purposes) in order to better understand the full picture of the health of the island.

Currently all general practices across the island use EMIS, while secondary care use TrakCare and Adult Social Care and Mental Health use CarePartner. There is aspiration to create a Jersey Care Record which would provide a comprehensive repository of real-time individual health and care information which Islanders have access to, and would go beyond the current, relatively limited, ability to connect records.

1.3.5 System to respond to changing needs following COVID-19

Jersey has been successful in its response to COVID-19, including its abilities to limit the spread, and shift the way in which we deliver care to meet changing needs. Many of the changes made upfront to the way we deliver care, in response to the pandemic, was in alignment with the principles of the Jersey Care Model. In particular: supporting self-care and empowering individuals to identify symptoms and manage their own care; driving a greater amount of care, and therefore resources, into the community; sharing of data and information; enhancing the pathways between primary, intermediate and secondary care; and, collaboration between teams across health and care.

There were also a lot of innovation seen, including changes in how we delivered care. For example, the development of a temporary Urgent Treatment Centre, and greater use of technology including telemedicine, 'apps' and digital information including the use of social media platforms.

While there is a need to revert back to some parts of the previous model of care, particularly where services were delayed or reduced to divert necessary resources, it is acknowledged that there are a number of services and changes that should not only remain, but be further enhanced.

1.4 Dependencies and constraints

As a major strategic change of the care model, the JCM programme of work will cut across multiple departments. Key interdependencies are set out below.

Table 1.3: Dependencies across government departments

Department	Impact, dependency or linkage	Engagement
Corporate Portfolio Management Office	This is a strategic programme of work for a major government department. Therefore, there will be: • Regular reporting up to PMO • Support required to drive cross government element	They have been briefed on the programme
Commercial Services	May be involved in the procurement and contracting elements, particularly commissioning in the event that a cross government commissioning organisation is set up.	Some initial engagement
Jersey Property Holdings	May become involved if reconfiguration of public estate is required (e.g. to provide clinics in the community)	Limited to date
Modernisation & Digital	Required to support implementation of the HCS digital strategy and BAU digital services across the health sector	Heavily involved in the development of digital strategy
People & Corporate Services	Required to support on HR elements, particularly in the development of an island wide workforce strategy	Limited to date
Strategic Policy, Planning and Performance	Required to support on any significant policy updates or legislation connected with the care model, and the coordination and delivery of public health initiatives	Public Health has been heavily engaged with the development of the JCM

Department	Impact, dependency or linkage	Engagement
Treasury and Exchequer	Involved in funding decisions and any reconfiguration of funding required	Some engagement
Any other relevant government departments	Children, Young People, Education and Skills are engaged in the prevention agenda, including child and adolescent mental health Customer and local services are engaged in social care provision and front door, including merging single point of access	Strong engagement

2. The Economic Case

Jersey case lead: Caroline Landon

Introduction

The Economic Case sets out the proposed care model and payment options that support the delivery of this care model. In total, the analysis has considered two care model scenarios and four payment model options through a combination of reviewing and engaging with stakeholders and quantitative analysis.

Table 2.1: Care model scenarios and payment model options considered in the Economic Case

Payment models in Primary Care	'Do nothing' scenario	'Do something' scenario
Current fee-for-service model	✓	
Option 1: Expand fee-for-service to community pharmacy		✓
Option 2: Capitated system (with co-payment)		✓
Option 3: Capitated system (without co-payment)		✓
Option 4: GP salaried model		✓

Section 2.1 describes the review process for the new design of the JCM and the impacts on activity and costs (see the Financial Case for more details).

The two care model scenarios were informed by the proposed changes across the nine workstreams of the JCM. The JCM review started with a list of 69 recommended changes to the current care model, which spanned 9 workstreams (see Appendix 1 for a full list of recommended changes). Each of these changes required individual assessment against a range of criteria including feasibility, impact on enablers, and impact on activity as part of a formal JCM review. This analysis has informed the assessment of the impact on activity and costs under a 'do nothing' and 'do something' scenario. In a 'do nothing' scenario there would be no changes to the current health and care system or the associated finance, workforce, IT and digital or infrastructure changes and care would continue to be provided disproportionately in the acute sector. In a 'do something' scenario the proposed changes would be adapted to implement the JCM.

Section 2.2 describes the options for payment mechanisms in primary care to support the implementation of the JCM recommended changes.

The analysis undertaken has focused on expanding access for vulnerable groups and improving incentives for more integrated primary care focused on prevention. The analysis has considered payment options from expanding the current fee-for-service (FFS) payment mechanism to include community pharmacy, to a capitated system (with and without co-payment) to a GP salaried model. The section concludes with a recommendation on the preferred payment mechanism for primary care to achieve the goals of the JCM.

In terms of payment models, the JCM is not proposing changes to many of these, particularly those relating to services currently provided by the Health and Community Services (HCS), which will continue to be provided by HCS. There are also a number of areas where new commercial structures will be required, which are covered in detail in the Commercial Case. This leaves primary care as a substantial area which is currently commissioned externally but for which changes may be required to implement the JCM.

The analysis of the payment options can give a view on the impact of the proposed changes on primary care (e.g. the change in States funding). The JCM financial modelling described in detail in the Financial Case

provides a comprehensive view on the impact of the proposed changes across Jersey's health and care system.

More details on the financial forecasting associated with the JCM and the proposed commercial structures that will enable it are described in the Commercial and Financial Cases.

2.1 The Long List of Options for the JCM

2.1.1 Long list of options

The JCM options started with a list of 69 recommended changes to the current care model, which spanned nine workstreams (see Appendix 1 for a full list of recommended changes). Each of these changes required individual assessment against a range of criteria including feasibility, impact on enablers, and impact on activity. This analysis has informed the activity and cost modelling set out below. This assessment has informed the 'do nothing' and 'do something' scenarios included in this Economic Case options appraisal, as well as the additional options surrounding funding.

As there are a near infinite number of variations based on the range of options selected, there is not a formal long list of options: rather, the changes have been assessed through a formal process and the assumptions made through this process inform the 'do something' case (see the Financial Case for detail of assumptions).

The care model has been through an independent review to determine a) the ease of implementation of each of the recommendations; b) the feasibility of each of the recommendations and c) the assumptions that should be applied to activity assumptions in a 'do something' scenario.

In addition to the care model, there are several options around payment mechanisms for primary care which are available to support the 'do something' scenario. The payment mechanism options for primary care are outlined in more detail in section 2.2.

Development of the Jersey Care Model

While developing the JCM there was significant engagement with stakeholders which has impacted the 'do something' scenario. This took part in two phases.

1. **Phase one.** As part of the development of the care model during August and September 2019 there were a number of engagement and feedback events. During these sessions, questions, answers and feedback were received along with email responses. These were analysed and as appropriate reflected in the JCM which was presented to the Political Oversight Group and the Council of Minister. These included sessions with:

   – HCS staff including:

- Medical staff
- Nurses
- Allied Health Professions
- Social workers
- Registered Managers
- Porters
- Domestic staff
- Catering Staff

   – Government departments including:

- Children's, Young People and Education Services CYPES
- Justice and Home Affairs JHA

- Customer and Local Services CLS
- Treasury and Exchequer
- Growth, Housing and Environment GHE
- Strategic Policy, Planning and Performance SPPP
- Chief Operating Office
- Office of the Chief Executive

  - All GP practices within their surgeries
  - Key stakeholders and external partners

2. **Phase two.** Wider engagement took place where questions, answers and feedback were received along with email responses. These were analysed and as appropriate reflected in the JCM which was presented to the Political Oversight Group and the Council of Ministers.

The purpose of this engagement, which took place between August and December 2019, was to shape the care model and agree that the 69 recommendations were the correct ones to take forward. Full detail of the engagement process is in Appendix 7.

Process for reviewing the Jersey Care Model against critical success factors

Following this period of engagement, an independent review was undertaken. Firstly, there was an initial review undertaken of the changes proposed in the JCM, using the information from public consultations and through a series of 1:1 clinical engagement meetings. To facilitate engagement, a number of 'JCM Workstream Pods' were set up. These were focus groups for insight, assessment and development of options for services and were comprised of medical, nursing and managerial colleagues. As shown in Figure 2.1 below, JCM Workstream Pods were developed for each JCM workstream. In JCM Workstream Pods, key stakeholders assessed the changes outlined in the JCM. To do this, they assessed the ease of implementation of each change to evaluate the impact on the enablers digital, estates, workforce, finance and pathways and processes. Secondly, Pods carried out a feasibility assessment to evaluate the capability, safety, operational efficiency, acceptability and impact on patient experience of the changes.

Finally, changes were assessed against international case studies to identify opportunities which could be incorporated into the JCM and stakeholders also identified interdependencies with other workstreams in order to give a holistic view of the model.

Furthermore, part of the review has involved quantitative analysis. This has enabled identification of potential impacts on hospital activity of the JCM based on evidence from other systems and/or benchmarking against similar populations elsewhere. Hence, based on the estimated additional demand and JCM assumptions, an estimate was calculated as to the additional capacity required in non-acute services. This analysis was tested with Workstream Pods which agreed on areas where further analysis was required.

The purpose of this review was to:

a. assess the changes proposed in the JCM;
b. review the potential challenges that may require further development prior to system implementation;
c. review the interdependencies between areas of care; and
d. provide a high-level implementation plan, outlining the key next steps in the journey to transforming health and social care in Jersey.

This framework and process has supported the development of:

a. assumptions on activity growth, which have been used to inform the financial impact of the model;
b. considerations for developing the model further.

These findings were provided to HCS in April, to be published following.

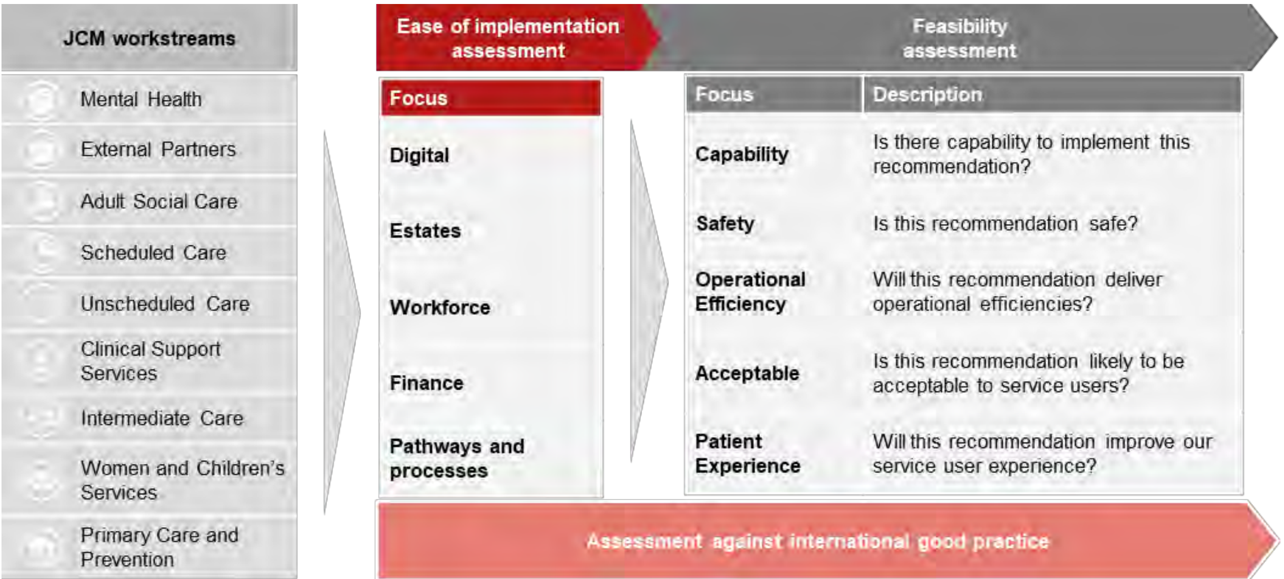
Critical success factors and investment objectives

During the review, several success factors were set out. In providing a 'stress test' the review sought out to answer the following three questions:

1. To test the 'Ease of implementing the new JCM model': What is the change from today? How significant is this proposed change to the delivery of health and care services?
2. To then test how 'Feasible' the proposed change is: What is the impact (e.g. How safe is the model? What is the impact on patient experience and operational efficiencies?) Can the model be implemented (e.g. Is there the capability? Is it acceptable?)?
3. Finally, taking a holistic perspective: Do the workstreams collectively work together? Does literature show alternate models that are preferred over that outlined in the JCM?

The following framework has been used to assess the JCM.

Figure 2.1: Framework used to assess recommendations



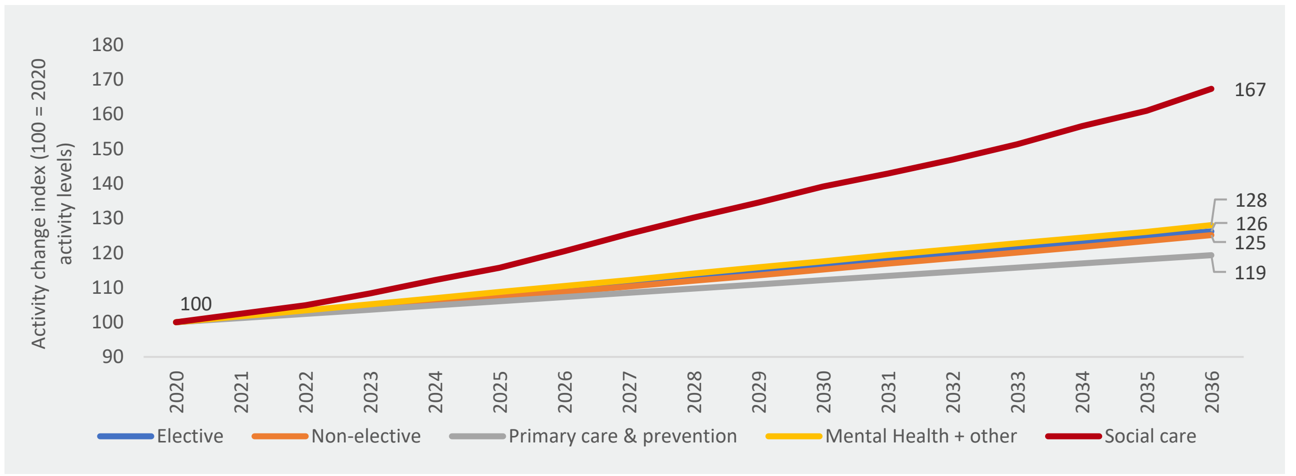
2.1.2.1 Do nothing scenario for the JCM

Description of the 'do nothing' scenario for the JCM

In the 'do nothing' scenario there would be no changes to the current health and care system or the associated finance, workforce, IT and digital, or infrastructure changes. Care would continue to be provided disproportionately in the acute sector. The payment models around community services would not change, and there would not be a conscious shift towards a more preventative, proactive model of care.

Within the 'do nothing' scenario the system would expect to see significant, continued growth in activity across the health and care sector, as set out in the following figure.

Figure 2.2: Do nothing growth assumptions



2.1.2.2 Do nothing costs

In the 'do nothing' scenario, where provision remains predominantly provided by the acute sector but demand and activity increase due to a growing and aging population, the service will face a significant affordability challenge driven by an increase in activity. **In the 'do nothing' scenario there is a predicted growth in cost across the system of 112%.** This would see the total expenditure on health and care services rise from £378m (£337m plus £42m of non-recurrent COVID-19 expenditure) to £716m by 2036.

Table 2.2: Do nothing costs summary

Department	Workstream	2020 – budgeted expenditure (£m)	2036 – forecast expenditure (£m)	% change
HCS	Secondary Scheduled Care	59	111	87%
HCS	Clinical Support Services	35	64	82%
HCS	Commissioning & Partnerships	12	24	95%
HCS	Mental Health	23	46	102%
HCS	Non-Clinical Support Services	29	52	82%
HCS	Primary Care & Prevention	11	23	99%
HCS	Social Care	21	55	168%
HCS	Unscheduled Care	14	24	79%
HCS	Women Children & Family Care	15	28	87%
HCS	Other	15	31	99%
CLS	Primary Care & Prevention	33	82	148%
CLS	Social Care	56	149	166%
CYPES	Mental Health	3	7	106%
SPPP	Public Health	-	-	-
Patient / User Contributions	Primary Care & Prevention	11	21	99%
Multiple	Additional COVID-19 Expenditure	42	-	(100%)
All		**378**	**716**	**89%**

A number of assumptions in addition to the activity assumptions (in section 2.1.2.1), agreed by the technical group, inform this 'do nothing' scenario. These are set out in Section 4.2 of the Financial Case.

2.1.2.3 Do nothing benefits

While there will be no re-provision costs in maintaining the status quo, there are few benefits for continuing to provide services in the current form. While there are some areas where Jersey performs well against quality measures, there is no guarantee that this would continue as demand increases and the service becomes more stretched.

2.1.2.4 Assumptions

The assumptions were developed in partnership with clinicians, managers, finance teams and other stakeholders across the system. Assumptions were validated through the following process:

1. Initial assumptions were developed in discussion with key stakeholders.
2. Assumptions were validated by the technical group over four sessions, which had membership from financial and operational leads across the system. Full membership and terms of reference for the technical group can be found in Appendix 3.
3. Assumptions were further validated at a workstream level by clinical and operational stakeholders.

The full list of assumptions for this option are detailed in the Financial Case.

2.1.3.1 Do something scenario for the JCM

Description of the 'do something' scenario

There is a single 'do something' scenario for the JCM, recognising that significant progress has been made in setting out and engaging clinicians and stakeholders with a model which will enable Jersey to develop a more modern, proactive care system. These changes are across multiple workstreams representing all areas of care received by the people of Jersey (see Strategic Case section 1.2 for details).

There are 69 recommended changes across these nine workstreams of the JCM (see Appendix 1 for full list). Each of these proposed changes were assessed individually in terms of feasibility, impact on enablers, and impact on activity. This analysis has informed the activity and cost modelling set out below.

As there are a near infinite number of variations based on the range of options selected, there is not a formal long list of options: rather, the changes have been assessed through a formal process and the assumptions made through this process have informed the do something costings.

Detail of the 'do something' scenario can be found in the Strategic Case section 1.2 and Appendix 1.

Impact of the 'do something' scenario on activity

In a 'do something' scenario it is projected that there will be lower use of A&E and fewer outpatients appointments than in a 'do nothing' scenario. There is also projected to be a reduction in bed days, particularly associated with elective and non-elective admissions.

Figure 2.3: change in activity (attendances or admissions)

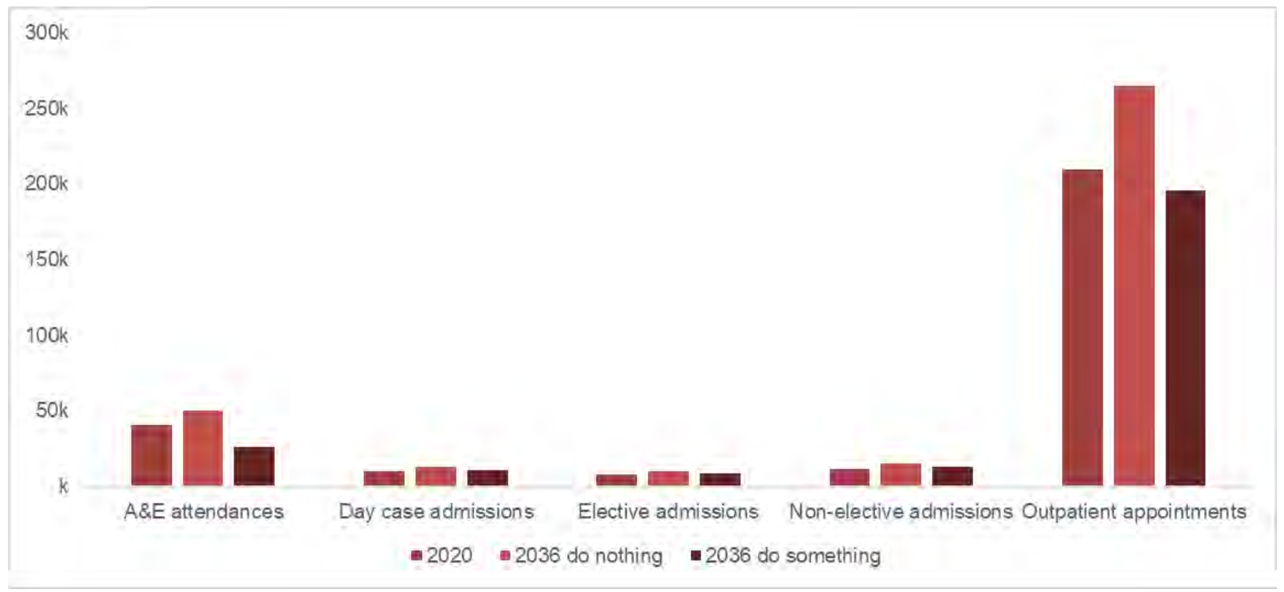
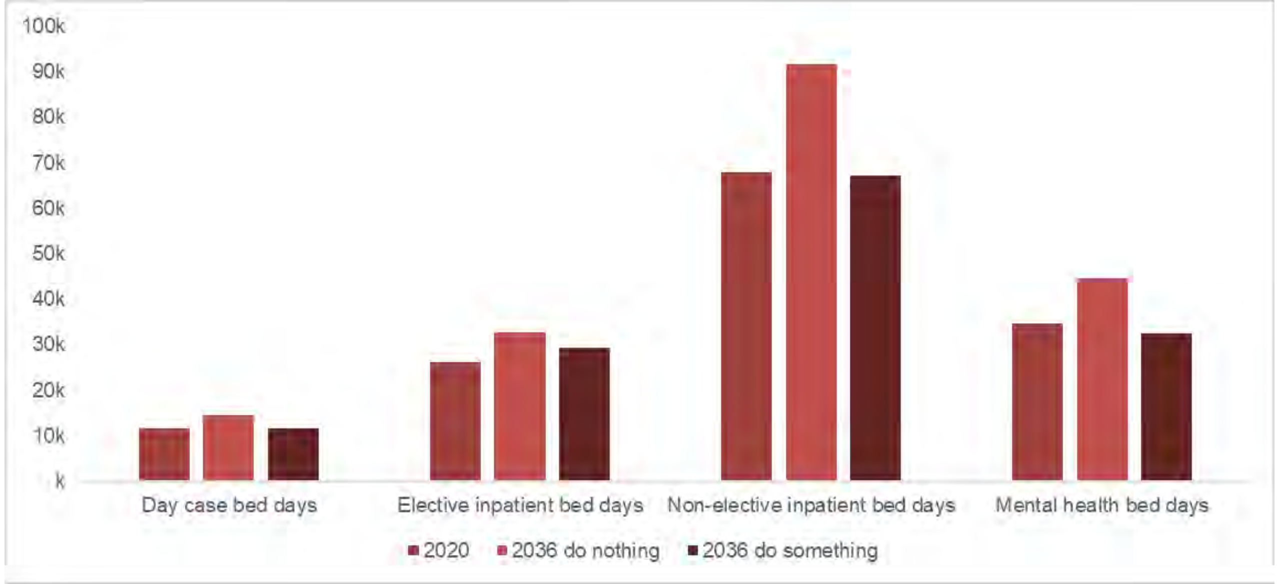


Figure 2.4: change in activity (bed days)



Do something evaluation

Each of the 69 recommendations has been assessed against feasibility and ease of implementation. From this review and engagement with stakeholders this is the optimal model to deliver care.

Table 2.3: Ease of Implementation framework (low demonstrates easy to implement)

	Digital	Estates	Workforce	Finance	Pathways & Processes
Mental Health	*Moderate*	*Low*	*Moderate*	*Moderate*	*Moderate*
Adult Social Care	*Moderate*	*Moderate*	High	*Low*	*Moderate*
Scheduled Care	*Low*	*Low*	*Moderate*	*Moderate*	*Moderate*
Unscheduled Care	*Moderate*	*No impact*	*Moderate*	*Moderate*	*Low*
Clinical Support Services	*Moderate*	*Moderate*	*Moderate*	*Moderate*	*Moderate*
Intermediate Care	*Moderate*	*No impact*	*Moderate*	*Moderate*	*Low*
Women and Children's Services	*Low*	*Low*	*Low*	*Low*	*Low*
Primary Care and Prevention	*Low*	*Low*	*Moderate*	*Moderate*	*Low*
Change impact average by enabler	*Moderate*	*Low*	*Moderate*	*Moderate*	*Moderate*

Table 2.4: Feasibility assessment framework (high demonstrates a good level of feasibility)

	Safety	Operational efficiency	Patient experience
Mental Health*	-	-	-
Adult Social Care	***Moderate***	***High***	***High***
Scheduled Care*	-	-	-
Unscheduled Care*	-	-	-
Clinical Support Services	***Moderate***	***Moderate***	***Moderate***
Intermediate Care	***Moderate***	***Moderate***	***High***
Women and Children's Services	***High***	***High***	***High***
Primary Care and Prevention	***High***	***High***	***High***

** Assessment was completed by intervention or change overall not by each attribute, therefore result not able to be put into the model in this form*

Overall it was felt that there was a high and positive impact on these key areas; moderate scorings were often result of:

- Concern over the workforce or other resources required to facilitate the new model.
- Expectation that the change is so significant that service users may not, in the initial stages respond well to the change.

Further analysis completed within this review showed that through these models there will be improved timely access to care and ultimately, the JCM will achieve financial return.

The key findings of the review were as follows:

Overarching model and workstreams

- **Overall the model is in line with good practice for integrated care,** and the benefits of safe, effective and quality care can be realised through further alignment of resources to encourage care to be passed back to the individual**.**

- **There were some areas identified that may need to be repositioned and developed** in further detail to fully implement the change outlined, for example, cancer services repatriation.

- **There is still further work required to detail the model within a number of workstreams** outlined in the JCM, and further consideration of other areas, including private care, for example.

Further enhancements to the JCM could be made for preventative care, expansion to alternative settings and population health management

- The shift to **preventative, patient centred care and self-care will require significant** investment to realise the benefits of cost reductions, efficiencies and improved health outcomes.

- To realise real benefit, a **Population Health Management (PHM) approach should be adopted as a key feature** of the prevention agenda, through a risk-focussed approach to service user care.

- To be a leading model globally, the **JCM will need to expand the care model beyond traditional settings and workforce**, within schools, businesses and urban planning and alternative wellness models can incorporate a wider workforce.

The JCM will avoid expenditure growth, but feasibility of the model will depend on adequate workforce and investment in digital infrastructure

- **The model is financially sustainable** and will not cost more to the consumer if resource allocation, funding models and commissioning arrangements are amended. By 2036, **the JCM is forecast to 1of recurrent expenditure growth** across the health and care system.

- **Feasibility of the JCM rests on an appropriate and sufficient workforce**; enabling the JCM may require significant changes, a key challenge for the workforce is recruitment and retention across workstreams, additional considerations should also be around training and development, multi-disciplinary teams, workforce culture and external partners.

- There are further dependencies on a number of capital enablers to realise its benefits, including **digitally enabling a full system transformation**.

The implementation of the JCM will need to consider the alignment across partners and transition models to fully complement the change to a decentralised model

- The **level of alignment**, commitment across partners will be imperative to achieve the benefits along with a strong cultural shift not only from the health service, but Islanders as well.

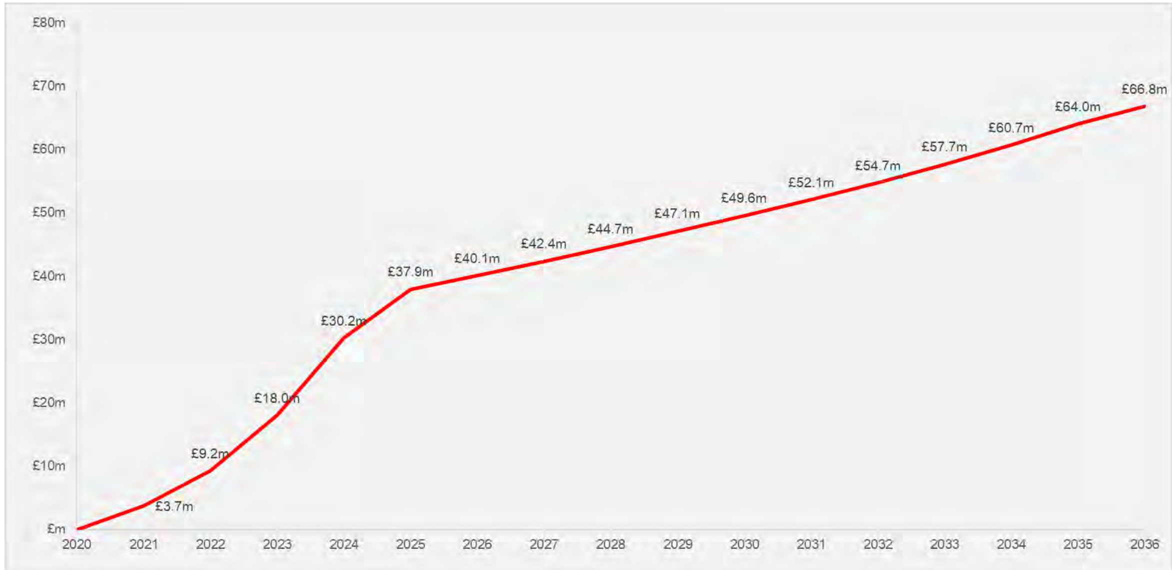
- As part of **implementation** planning there is a need to focus on **transition models** while key enablers and new models are being developed and implemented.

- The JCM will only be achieved through a **decentralised care model.** This shift in balance between centralised to decentralised care will be enabled by transformation in digital technology, adequate provision and estates, and importantly, an adequate workforce profile to deliver transformed care.

2.1.3.2 Do something recurrent costs

Re-provision of activity from the hospital to out-of-hospital settings is expected to cost in the region of £4m in 2021 and increase to £67m in 2036 as the JCM interventions are implemented in full and with the corresponding increase in baseline activity.

Figure 2.5: 'Do something' recurrent costs associated with delivery of the JCM



2.1.3.3 Do something benefits

Financial benefits

Analysis of the financial benefits for the 'do something' case suggest that there will be a 'do something' gross impact of £90m per annum by 2036. When accounting for the recurrent costs of re-provision net cost reductions of around £23m per annum are expected by 2036. See section 4.2 for details of impact assumptions by intervention.

Figure 2.6: 'Do something' gross impacts from delivery of the JCM

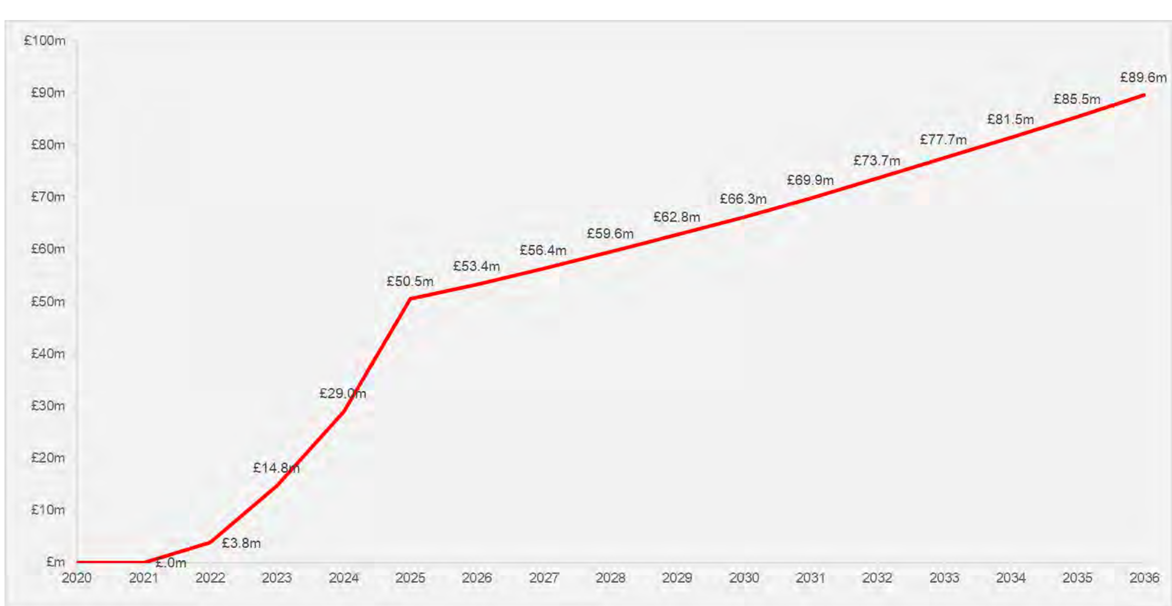


Figure 2.7: 'Do something' net benefits from delivery of the JCM

See section 4.1 for further details of gross and net benefits.

Non-financial benefits

There are several impacts on care both in and out of hospital which would be anticipated as outcomes of a changed model of care.

Table 2.5: Non-financial benefits

Number	Benefit
Benefit 1	Increase CT examination capacity
Benefit 2	Move some ED activity to primary care
Benefit 3	Reduce ED attendances through co-located mental health services
Benefit 4	Reduce child ED attendances
Benefit 5	Reduce ED attendances for falls age 65+
Benefit 6	Reduce ED attendances for other reasons age 65+
Benefit 7	Divert some remaining ED activity to a new UTC
Benefit 8	Reduce hospital admission rates
Benefit 9	Reduce emergency medical admissions age 65+
Benefit 10	Repatriate bariatrics and spinal injury cases
Benefit 11	Reduce length of stay for stranded patients
Benefit 12	Repatriate interventional radiology
Benefit 13	Reduce MH average length of stay to GIRFT target of 34.6 days
Benefit 14	Replace traditional hospital outpatient services with community/integrated care
Benefit 15	Move physiotherapy outpatients to the community
Benefit 16	Reduce T&O outpatients

Benefit 17	Reduce ENT outpatients
Benefit 18	Reduce Ophthalmology outpatient activity
Benefit 19	Move Community Dental Service outpatients to community dental practices
Benefit 20	Reduce Gastroenterology referrals
Benefit 21	Reduce Dermatology, Cardiology, Respiratory and Endocrine (including Diabetes) referrals
Benefit 22	Reduce follow up rates
Benefit 23	Reduce Gynaecology outpatients
Benefit 24	Move Podiatry Education outpatients to the community
Benefit 25	Increase Pneumococcal Polysaccharide Vaccine (PPV) uptake age 65
Benefit 26	Reduce care home placements to England 3rd quartile

2.1.4 Net Present Value

Based on this analysis, the Net Present Value associated with the proposed changes over a 16-year period has been estimated at **£118m**.

Table 2.6: Net Present Value

	2021	2022	2023	2024	2025	2026	2027	2028
Net Present Value								
Total Costs	(7.9)	(12.9)	(21.4)	(33.4)	(40.4)	(40.1)	(42.4)	(44.7)
Total Benefits	-	3.8	14.8	29.0	50.5	53.4	56.4	59.6
Net Benefit of Option	(7.9)	(9.1)	(6.6)	(4.5)	10.1	13.3	14.0	14.9
Discount Factor 3.5%	100%	97%	93%	90%	87%	84%	81%	78%
Present value	(7.9)	(8.8)	(6.2)	(4.0)	8.8	11.1	11.3	11.6

	2029	2030	2031	2032	2033	2034	2035	2036
Net Present Value								
Total Costs	(47.1)	(49.6)	(52.1)	(54.7)	(57.7)	(60.7)	(64.0)	(66.8)
Total Benefits	62.8	66.3	69.9	73.7	77.7	81.5	85.5	89.6
Net Benefit of Option	15.7	16.7	17.8	18.9	20.0	20.8	21.4	22.8
Discount Factor 3.5%	75%	73%	70%	68%	65%	63%	61%	59%
Present value	11.8	12.1	12.5	12.8	13.0	13.1	13.0	13.4

	Total
Net Present Value	
Total Costs	**(695.8)**
Total Benefits	**874.3**
Net Benefit of Option	**178.0**
Discount Factor 3.5%	
Present value	**117.7**

2.2 Mechanisms for primary care to deliver 'do something'

There is agreement across the island that the current funding model for primary care will not allow our strategic intent to be deliverable. In terms of payment models, the JCM is not proposing changes to many of these, particularly those relating to services currently provided by the Health and Community Services (HCS), which will continue to be provided by HCS. There are also a number of areas where new commercial structures will be required, which are covered in detail in the Commercial Case. This leaves primary care as a substantial area which is currently commissioned externally but for which changes may be required to implement the JCM.

Previous reviews between 2015-18 have identified inequity and barriers to transformation of care within Jersey. There are only limited government financial levers (Jersey Quality Improvement Framework (JQIF)) available to improve outcomes, allow more care to be delivered closer to home and encourage self-care. In considering the options available a broad range of international models have been considered including:

- NHS (majority is free at point of use, e.g. GP services), salaried GPs.
- Social health funds, Household Medical Accounts, Universal Medical Cards.
- Private / public health insurance schemes (e.g. the Netherlands).
- Blended models (the majority), whereby there is a mixture of 'user pays', capitation (payment for list size or special groups), fee-for-service (FFS) payments and various Performance Related Framework payments from central government (e.g. JQIF).

Funding for primary care services in Jersey is sourced from a combination of service user co-payments, payments from the Health Insurance Fund (HIF), and payments from Health and Community Services (HCS) (paid for by general taxation). Please refer to the Commercial Case for a detailed breakdown of primary care funding. Increased provision of primary care services is likely to require extra funding, repurposing of current budgets or reducing the spend on Secondary Care into the future

Options for reconfiguring current funding streams include:

- Moving funds and resources from secondary to primary care with concomitant activity changes.
- Combination/redistribution of the HIF and HCS budgets.
- Ring fenced budget for prevention and screening.

Possible new streams of funding include:

- Expand public contributions to social security or general taxation/indirect taxes/charges
- Prescription charges for some medicines

It should be noted that there is the potential to access funds from the HIF on a one-off basis in order to offset double running costs in primary and secondary care during a period of transition.

Under the current payment FFs mechanism in primary care, the Government of Jersey has only limited financial levers (JQIF) available to improve outcomes, drive care into the community, encourage self-care and achieve the aspirations of the Prevention and Primary Care Strategy. The options for reform consider different combinations of fee-for-service (FFS), capitation, salary and pay-for-performance mechanisms. All options have the potential to improve the identified weaknesses in the current payment mechanism and support the ambitions of the new JCM set out in the Strategic Case.

The recent and developing experience with COVID-19 has also demonstrated that the current approach to funding primary care is neither resilient nor sustainable.

This section sets out four options for a reformed payment mechanism in primary care settings, focused on General Practice FFS consultations. These options can be considered either in isolation or combination.

- **Option 1: Do minimum.** Expanding the current FFS approach to allow services to be delivered in other settings (e.g. community pharmacy), combined with JQIF or an alternative outcomes-based incentives mechanism (e.g. PharmOutcomes) and HIF.

- **Option 2: Capitation with some co-payment (for vulnerable groups or universally).** This would include capitated lump sum funding for vulnerable groups (financially vulnerable (those who are unable to afford the required GP consultations, either in the short or long term, identified by those on income support); clinically vulnerable (those with one or more long term conditions); or socially vulnerable (identified as those below the age of 9, adolescents between 10-19 years, people aged 70 or older and pregnant women) combined with a smaller co-payment, and JQIF. **This could be expanded to the total population.**
- **Option 3: Capitation with no co-payment (for vulnerable groups or universally).** As in Option 2 but without co-payment, i.e. the lump sum fee would completely cover the cost of GP consultations for these groups, and JQIF. **This could be expanded to the total population.**
- **Option 4: Salaried model with pay for performance for all GPs**. All GPs would be employed directly by the Government of Jersey.

These options and the approach to estimating the cost of each option is set out in more detail in Appendix 2. There are other options such as changing the payment mechanism for long-term care (e.g. long-term care fund) or secondary care (e.g. charging for ED appointments) which are not considered in detail in this section.

In the options set out below, assumptions have been made as to which Islanders are considered to fall into vulnerable groups. These are defined as follows for the purpose of this analysis:

- Financially vulnerable population (FVP), i.e. those on income support
- Socially vulnerable population (SVP), i.e. those below 9 years old, adolescents, those above 70 years old and pregnant women
- Clinically vulnerable population (CVP), i.e. those with one or more chronic conditions.

An indicative cost has been estimated – for the Government of Jersey and for the patients – of each of the options described. A detailed description of the approach, assumptions and sources is provided in Appendix 2.

Summary of options

Option 1: Do minimum (expanded fee for service)

This option involves expanding services across the primary care providers such as community pharmacy. Community pharmacies have started to provide enhanced services such as medicine use reviews but there is potential to expand the current FFS scheme to more services and settings. The advantages of this option are that it incentivises more efficient use of services, improves accessibility and supports integrated care through an enhanced role of non-medical staff, especially community pharmacy and nurses.

An enhanced service – minor ailments services – that can be delivered by community pharmacy has been used as an example to show the impact on the volume of activity for GPs and the financial implications for the Government of Jersey and patients.

It is estimated that in 2019 there were a total of 52,200 GP appointments for minor ailments services (MAS) and an additional 2,700 ED attendances for MAS. It is estimated that community pharmacy could provide 46,100 or 84% of these MAS consultations that currently occur in GP and ED.

To estimate the cost of providing MAS in community pharmacy it is assumed the rebate claimed will be the same as the current GP consultation rate of £20 per visit and the co-payment will be on average £10 per visit. It is also estimated that the current average co-payment for GP consultations is £32 per visit. This estimate is based on the average patient charge in 2019 across GP consultations (surgery, home, special and aux) for which a rebate was claimed from the HIF.

It is estimated that the total cost for the States and patients of providing MAS in community pharmacy, GPs and ED in 2019 would be £1.1m and £0.7m respectively (including some consultations that will continue to

occur in ED and GP settings). In comparison, it is estimated that the cost for the States and patients of providing MAS only in GPs and ED in 2019 was £1.3m and £1.7m respectively.

It is also estimated that the total discounted cost of providing minor ailments services (MAS) in community pharmacy, GPs and ED between 2021 and 2024 would be c.37% lower than the total discounted cost of providing MAS only in GPs and ED. This is driven by a lower cost for patients due to the lower co-payment and savings from a reduction in ED attendances. Reducing the rebate per visit for MAS would provide further services. Based on the activity assumptions for a 'do-nothing' and 'do-something' scenario, the total discounted cost for the States of providing MAS in Community Pharmacy, GPs and ED between 2021 and 2024 would be £7.4m and £7.8m respectively.

Table 2.7: Estimated cost of providing MAS in Community Pharmacy and GPs, 2021-2024 (PV, £, 2019 prices)

	'Do-nothing' (2021-2024)		'Do-something' (2021-2024)	
Present Values (PV), 2019 prices	**Current MAS – GPs and ED only**	**Option 1 – MAS in CP, GPs and ED**	**Current MAS – GPs and ED only**	**Option 1 – MAS in CP, GPs and ED**
Government funding	£5.2m	£4.5m	£5.3m	£4.8m
Patient co-payments	£6.5m	£2.9m	£7.1m	£3.0m
Total costs	**£11.7m**	**£7.4m**	**£12.4m**	**£7.8m**

Option 2 and 3: Capitation+ and full capitation (no co-pay)

This option explores moving to a capitation+ (cap and co-pay) or full capitation model (no co-pay) for GPs. The lump-sum fee (i.e. the cap per patient) and total costs of moving to this payment model are estimated for:

- Financially vulnerable population (FVP), i.e. those on income support
- Socially vulnerable population (SVP), i.e. those below 9 years old, adolescents, those above 70 years old and pregnant women for the purposes of this analysis
- Clinically vulnerable population (CVP), i.e. those with one or more chronic conditions to cover GP appointments related to treatment of their long-term conditions (LTCs)
- A combined scheme which covers all these vulnerable groups.

Also considered is a universal model where a capitation+ or full capitation (no co-pay) scheme is available for the total population of Jersey.

To estimate an indicative cost of moving to a capitation+ or full-capitation (no co-pay) payment model the following steps were taken:

- Identified the group of people to be included
- Analysed historical data to identify the average annual visits to GPs, co-payments and rebate for each group, focused on fee-for-service (FFS) GP consultations

Key assumptions used in the modelling:

- The estimated cap reflects the income that GPs currently receive from government (in the form of rebates) and patient charges (in the form of co-payments) from the HIF. In 2019, it is estimated that there were 326,270 GP FFS consultations that resulted in total patient charges of c.£10.3m and total rebate from the HIF of c.£6.5m. This means that, in total, a universal capitated system would only reflect GP income from FFS consultations.
- The estimated cap reflects the income that GPs currently receive from rebates and co-payments rather than the cost of delivering the service. This means that the estimated cap could be an overestimate.

- The estimated cap reflects the income that GPs currently receive from rebates and co-payments for all types of GP consultations including home visits, special and auxiliary visits and surgery visits, the latter constituting c.94% of all GP consultations in 2019.
- The estimated cap for CVP reflects the GP visits that individuals with long-term conditions (LTCs) make for treatment of their LTC (rather than general GP advise).
- The estimated cap for CVP does not reflect visits to specialist clinics that could also be conducted at GP settings. For the clinically vulnerable, it is estimated that if an estimated 0.9 specialist appointments for LTCs are to be done by GPs the cost of the scheme to the Government of Jersey would be £1.2m and £0.3m to the patients in 2019.
- The estimated cap does not reflect additional services that GPs provide patients that are not captured in the available data (e.g. referrals, scripts). Estimates suggest that GP income from other services not included in the HIF could range between 10% to 15% of their total income; a proxy for additional cost of performing these services. This means that the estimated cap could be an under-estimate.
- The estimated total cost assumes that only a proportion of the population will register and attend GPs. This is based on 2019 data on GP consultations and Jersey population statistics.
- For a capitation+ (cap and co-pay) model, it is assumed that, on average, patients would pay £10 per visit.

The table below provides an indicative cap size for the three vulnerable groups: the second column provides an estimate of the lump-sum fee under a capitation+ model where patients also pay £10 per visit while the third column provides an estimate of the lump-sum fee under a full-capitation model where there is no co-payment. Note that individuals could be included in more than one group (e.g. someone on income support could also be above 70 years of age (socially vulnerable) and have more than 1 chronic condition (clinically vulnerable).

Table 2.8: Estimated average cap size (lump-sum fee) by patient in each group, 2019

	Capitation+ (Cap and co-pay)	Full capitation (no co-pay)
Clinically vulnerable (with 1 or more conditions) - LTC visits only[16]		
1 LTC	£82	£101
2 LTCs	£143	£174
3 LTCs	£189	£228
>4 LTCs	£252	£301
Socially vulnerable (age-related)		
0-19 years	£76	£108
> 70 years	£293	£349
Pregnant women	£90	£119
Financially vulnerable		
Tier 1: <70 years	£163	£207
Tier 2: >70 years	£335	£396
All population		
Universal cap	£162	£201

[16] This capitation fee estimate covers GP appointments associated with treatment of LTCs – a proxy is used by estimating the average number of GP appointments for all populations and people with LTCs and using the difference.

The total cost of the different schemes and options considered below reflect the overall gross cost of implementing each option. The government and patients already provide funding and co-payments for FFS GP consultations. In 2019, it is estimated that GPs received a total of c.£16.9m in income from FFS consultations; c.£10.3m from patients and c.£6.5m from HIF rebates. This implies that if the government were to introduce a universal capitation scheme it would no longer need to spend the estimated c.£6.5m from HIF rebates.

The **total cost of a full-capitation scheme for FVP, SVP and CVP in isolation** in 2019 has been estimated at £2.4m, £6.3m and £4.5m, respectively. It is noted that the CVP scheme would cover only GP appointments related to their chronic conditions for individuals with more than one chronic condition. In comparison, a universal capitation scheme is estimated to cost £16.9m for patients who attended GPs in 2019 (c. 84,000 patients). As noted above, the total cost of a universal capitation scheme reflects only FFS GP consultations rather than all GP services and associated GP income (see Option 4 for more details on the sources of GP income).

Similarly, for a capitation+ (with co-pay) model with a co-pay of £10 per visit, it is estimated that **the total cost of a capitation+ scheme for FVP, SVP and CVP in isolation** in 2019 would be £1.9m, £5.0m and £3.7m for the States and £0.5m, £1.2m and £0.8m for the patients. In comparison, a universal capitation scheme is estimated to cost the States £13.6m and the patients a total of £3.3m. The total cost of providing the three schemes combined is estimated further below.

Table 2.9: Estimated GP appointments and total cost for each scheme separately, 2019

	Number of patients	Number of appointments	Capitation+		Full Capitation (no co-pay)
			Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions): LTC visits only					
	31,200	80,290	£3.7m	£0.8m	£4.5m
Socially vulnerable (age-related)					
	28,510	121,910	£5.0m	£1.2m	£6.3m
Financially vulnerable					
	10,200	47,985	£1.9m	£0.5m	£2.4m
Total population (universal capitation for patients attending GPs)					
	84,045	326,270	£13.6m	£3.3m	£16.9m[17]

[17] Note that this estimate is based on rebate and patient co-payment activity generated through GP FFS appointments and does not account for income generated through other services (e.g. scripts, referrals) or other government funding (e.g. HCS).

It is estimated that the **three vulnerable groups combined** constituted c.69% of GP appointments in 2019. Table 2.10 show the proportion of GP activity associated with the three vulnerable groups.

Table 2.10: Estimated number of GP appointments by vulnerable group, 2019

Vulnerable groups	Estimated GP appointments
Clinically vulnerable only	41,970
Socially vulnerable only	100,750
Financially vulnerable only	25,920
Clinically and socially vulnerable	27,910
Clinically and financially vulnerable	6,250
Socially and financially vulnerable	18,220
Clinically, socially and financially vulnerable	4,160
Remaining population (Non-vulnerable)	101,090
Total GP appts	**326,270**
Total CVP (incl. SVP and FVP)	*80,290*
Total SVP (incl. CVP and FVP)	*151,040*
Total FVP (incl. CVP and SVP)	*54,550*

- Nearly 50% of the 326,270 appointments (c. 154,000) in 2019 were from individuals with one or more long term conditions (LTCs). This finding is consistent with research from the Department for Health, which found that patients with long-term conditions account for approximately 50% of all GP appointments.[18]

- However, it is estimated that only half of those appointments were appointments related to their long-term conditions (LTCs) (c. 80,290) The remaining appointments (i.e. not related to their chronic condition) have therefore been included in the SVP and FVP schemes where there is overlap across vulnerable groups. This ensures that the cost estimates reflect the additional appointments made by a patient who may be both clinically and socially vulnerable.

- Out of the c. 80,290 LTC appointments, it is estimated that 27,910 were from individuals who are also socially vulnerable (e.g. below 20 or above 70 years or pregnant), 6,250 were from individuals who are on income support and c. 4,160 were from individuals who are both socially and financially vulnerable. The remaining 41,970 appointments were from individuals who have LTCs, are aged between 20 and 69 years (i.e. not socially vulnerable) and are not on income support.

- An additional 100,750 appointments were estimated for people who are socially vulnerable and not on income support. This includes GP appointments for people with LTCs (i.e. CVP) that are not related to the treatment of their LTCs.

- An additional 25,920 appointments were estimated for individuals on income support who are aged between 20 and 69 (i.e. not socially vulnerable) and have no identified LTCs. This includes GP appointments for people with LTCs (i.e. CVP) that are not related to the treatment of their LTCs.

- Finally, an additional 18,220 appointments were estimated for individuals who are both socially vulnerable and on income support. This includes GP appointments for people with LTCs (i.e. CVP) that are not related to the treatment of their LTCs.

[18] Department of Health (2012), Long-term conditions compendium of Information: 3rd edition

- The estimated number of appointments for the population not covered under these three schemes is 101,088 or 31% of total GP appointments in 2019.

It is also estimated that **implementing the three schemes together** in 2019 would cost the States a total of £10.7m in a full-capitation model and £8.5m in a capitation+ (with co-pay) model. It is estimated that an additional £5.9m or £4.8m in a full-capitation or capitation+ model would be required to cover the remaining population using a universal cap. It is noted that the CVP scheme would cover only LTC-related GP appointments for individuals with more than one LTC. For individuals who are clinically vulnerable but also socially and / or financially vulnerable, the scheme would cover additional GP appointments for issues other than treatment of their LTCs.

Table 2.11: Estimated GP activity and cost for the three schemes combined, 2019

Number of patients	Number of appointments	Capitation+		Full Capitation (no co-pay)
		Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only				
31,200	80,290	£3.7m	£0.8m	£4.5m
Socially vulnerable (age-related) – for individuals with LTCs includes only regular / miscellaneous GP visits are included[19]				
17,270	118,970	£3.7m	£1.2m	£4.9m
Financially vulnerable – for individuals who are also clinically vulnerable only regular / miscellaneous GP visits are included (note that financially vulnerable who are also socially vulnerable are captured above)				
4,290	25,920	£1.0m	£0.3m	£1.3m
Total vulnerable groups				
52,780	**225,180**	**£8.5m**	**£2.3m**	**£10.7m**
Rest of the population				
31,260	101,090	£4.8m	£1.1m	£5.9m

The cost of a full-capitation and capitation+ (with co-pay) model for the three schemes separately has also been estimated through 2021-24 in the 'do nothing' and 'do something' scenarios. Further detail on the assumptions and methodology used as part of this calculation can be found in Appendix 2.

The **total cost of a full-capitation scheme for FVP, SVP and CVP in isolation through 2021-24** has been estimated at £9.6m, £25.9m and £18.1m in the **'do nothing' scenario**, respectively. In comparison, a universal capitation scheme that would cover FFS GP consultations for all patients who attend GPs is estimated to cost £67.4m (in net present value 2019 prices).

In the **'do something' scenario**, **the total cost of a capitation scheme for FVP, SVP and CVP in isolation through 2021-24** has been estimated at £10.2m, £27.3m and £19.1m respectively. In comparison, a universal capitation scheme that would cover FFS consultations for patients attending GP consultations is estimated to cost £71.3m.

[19] Note that individuals with LTCs will be covered for the additional regular / miscellaneous GP appointments. These appointments are captured in the second column (number of appointments) but the patients are only identified once, in this case as CVP.

Table 2.12: Estimated cost for each scheme separately, 'do nothing' and 'do something' 2021-24 (NPV, 2019)

Do 'nothing' scenario			Do 'something' scenario		
Capitation+		Full capitation (no co-pay)	Capitation+		Full Capitation (no co-pay)
Government funding	Patient charge	Government funding	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) LTC visits only					
£14.9m	£3.3m	£18.1m	£15.7m	£3.4m	£19.1m
Socially vulnerable (age-related)					
£20.9m	£5.0m	£25.9m	£22.1m	£5.3m	£27.3m
Financially vulnerable					
£7.7m	£1.9m	£9.6m	£8.2m	£2.0m	£10.2m
Total population (universal capitation)					
£54.4m	£13.0m	£67.4m	£57.6m	£13.7m	£71.3m

The total cost of **implementing the three schemes together** (a combined scheme) is also estimated between 2021 and 2024.

In a **'do nothing' scenario**, the **total cost for the States of a combined full-capitation or capitation+ scheme for FVP, SVP and CVP through 2021-24** has been estimated at £43.6m and £34.4m, respectively. The total cost for providing a full-capitation or capitation+ scheme for the remaining population over the same period is also estimated at £23.2m and £18.7m, respectively.

In the **'do something' scenario**, the **total cost for the States of a combined full-capitation or capitation+ scheme for FVP, SVP and CVP in through 2021-24** has been estimated at £46.5m and £36.6m, respectively. The total cost for providing a full-capitation or capitation+ scheme for the remaining population is also estimated at £24.6m and £19.8m, respectively.

Table 2.13: Estimated cost for the three schemes combined, 'do nothing' and 'do something' 2021-24 (NPV, 2019)

Do 'nothing' scenario			Do 'something' scenario		
Capitation+		Full Capitation (no co-pay)	Capitation+		Full Capitation (no co-pay)
Government funding	Patient charge	Government funding	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only					
£14.9m	£3.2m	£18.1m	£15.8m	£3.4m	£19.2m

Socially vulnerable (age-related) - for individuals with LTCs includes only regular / miscellaneous GP visits are included[20]					
£15.5m	£4.9m	£20.3m	£16.6m	£5.4m	£22.0m
Financially vulnerable - for individuals who are also clinically vulnerable only regular / miscellaneous GP visits are included (note that financially vulnerable who are also socially vulnerable are captured above)					
£4.0m	£1.0m	£5.0m	£4.3m	£1.1m	£5.3m
Total vulnerable population					
£34.4m	**£9.1m**	**£43.6m**	**£36.6m**	**£9.9m**	**£46.5m**
Rest of the population					
£18.7m	£4.8m	£23.2m	£19.8m	£4.7m	£24.6m

Option 4: Salaried model for GPs

This option explores moving to a full salaried model for GP services in Jersey. This would be similar to the model applied as a temporary measure as an initial response to COVID-19 in April 2020. To estimate the cost of a salaried GP model, the following were analysed:

- The sources of GP income in 2019. It is noted that the estimates are based on 2018 data.
- The costs of running a GP practice in 2019 based on Government of Jersey estimates.
- The forecasted GP activity and associated FTE GPs in the 'do-nothing' and 'do-something' scenarios between 2021 and 2024.

It is estimated that the total cost of running the 13 GP practices in Jersey in 2019 could be around £10.8m. It is also estimated that total income across the 13 GP practices in Jersey is c. £24.4m. These estimates imply that the total net income (revenues less costs) for the 13 GPs in Jersey is c. £13.6m or an average salary of £160,300 per GP. The average income before tax for contractor GPs in England was estimated at £113,400 in 2019, or £142,000 including 25% on-costs.[21]

Table 2.14 below describes the sources of income for GPs for 2019 (these estimates are based on GP funding data for 2018). Please refer to the Commercial Case for a more detailed breakdown.

- £10.1m comes from patient charges, the majority driven by patient co-payments for GP consultations
- Another £10.0m comes from the HIF in the form of rebates for GP consultations, funding for JQIF and other services such as the pathology benefit.
- Out of the £10.0m that GPs receive from the HIF, around £6.7m is received in the form of rebates for GP consultations. This figure (£6.7m) differs from the estimate used in the analysis for Options 2 and 3 (£6.5) due to different sources of data and different years: the former is based on 2018 Government of Jersey estimates of all GP sources of income from the government while the latter is based on HIF data on rebates for GP consultations in 2019.
- A further £1.3m is paid to GPs for a set of services from the Health and Community Services (HCS)
- It is estimated that GPs receive additional income from patients from services that are not eligible for government funding such as referrals and scripts. This is estimated at c. £3m for 2019.

[20] Note that individuals with LTCs will be covered for the additional regular / miscellaneous GP appointments. These appointments are captured in the second column (number of appointments) but the patients are only identified once, in this case as CVP.
[21] Unit Costs of Health and Social Care (2019)

Table 2.14: Estimated GP income sources, 2019

Income source for GPs	Estimated income for 2019
Income from patients (co-payments)	£10,059,100
Income from HIF (rebates, JQIF, pathology benefit, etc.)	£9,957,600 (£6.7m from GP consultations rebates)
Income from HCS	£1,265,600
Other income (referrals, scripts) – estimated	£2,681,100-£3,643,700
Total income across all 13 GP practices and 85 FTE GPs (mid-point in range)	**£24,444,700**

It is also recognised that in addition to the annual running costs of GP practices outlined above, there will also be one-off implementation costs associated with the purchase of goodwill and state infrastructure. These are estimated to be c. £33.9m in 2019.

Table 2.15: Total estimated costs of a GP salaried model (excluding one-off costs), 2019

	Estimated costs of GP salaried model
GP (FTEs)	85
GP salary, incl. on-costs (estimate based on income less cost)	£160,300
Total salary costs	£13,624,700
Total running costs (estimated based on running 13 GP practices privately)	£10,820,000
Total estimated annual cost	£24,444,700

It is estimated that the number of FTE GPs will increase from 87 in 2021 to 91 in 2024 and from 89 to 100 in a 'do-nothing' and 'do-something' scenario respectively. It is also estimated that the increased activity and FTEs will require additional practices and, therefore an increase in cost of running the GP practices.

Based on these forecasts, it is estimated that between 2021 and 2024, the total cost of a GP salaried model in terms of GP salaries will range between £54.2m and £57.3m in a 'do-nothing' and 'do-something' scenario respectively. In addition, the total cost of running the GP practices, based on the costs of running the practices privately, is estimated to be between £41.8m and £43.4m. It is noted that these estimates are based on GP income and an estimated margin of 45% and based on estimates of running GP practices privately. This excludes the one-off implementation costs which are estimated to be c. £33.9m in 2019 prices.

It is noted that the estimated GP income reflects all services provided by GPs. In comparison, the analysis in Options 2 and 3 that assessed a universal capitation scheme reflects only FFS GP appointments which in 2019 accounted for c.£16.7m out of a total GP income of around £24.5m.

Table 2.16: Total estimated GP income and running costs, 2021-2024 (NPV, 2019)

	'Do-nothing'	'Do-something'
Total salary costs	£54.3m	£57.5m
Total running costs (estimated based on running GP practices privately)	£41.9m	£43.5m
Total estimated cost (2021-2024)	**£96.2m**	**£101.0m**

Recommended option

Based on the analysis described above the preferred option for primary care payment models in Jersey, assuming implementation from 2021 onwards, is Option 2 – a capitation+ (with co-payment) payment model. Work is currently underway to roll this out to financial vulnerable patients via Proposition 125/2019. Therefore, it is recommended through the implementation of the Jersey Care Model that this payment model is expanded to socially and clinically vulnerable patients. In the first instance, through Tranches 1 and 2, support for socially and clinically vulnerable patients will be enhanced through implementation of improved care models, particularly through population health management approaches, enhanced intermediate care, and preventative and early intervention models. Extension to the capitation plus model to these groups will be considered in Tranche 3 which will proposed to be in year 3 of implementation of the Jersey Care Model.

Therefore, the numbers are indicative below for illustrative purposes; further work will be required when funding requests to implement an enhanced model in year 3.

Option 1 – expanding services using the current fee-for-service model could complement Option 2 to support further integration of community pharmacies and other providers.

Table 2.17: Total estimated costs for the States across options, 2019 and 2021-2024 'Do something' (NPV, 2019)

	2019 estimates	2021-2036 'Do something'
Preferred combination of options		
Option 2 (Cap+) – SVP and CVP	£6.5m	£126.5m
Other options		
Option 1 – MAS in CP and GPs	£1.1m	£14.2m
Option 2 (Cap+) – FVP only	£1.9m	£35.1m
Option 2 (Cap+) – SVP only	£5.0m	£102.7m
Option 2 (Cap+) – CVP only	£3.7m	£68.1m
Option 2 (Cap+) – Combined schemes or	£8.5m	£161.6m
Option 2 (Cap+) – Universal	£13.6m	£248.5m
Option 3 (Cap) – FVP only	£2.4m	£43.7m
Option 3 (Cap) – SVP only	£6.3m	£126.5m
Option 3 (Cap) – CVP only	£4.5m	£82.9m
Option 3 (Cap) – Combined schemes	£10.7m	£205.2m
Option 3 (Cap) – Universal	£16.9m	£307.1m
Option 4 – Full salaried model (based on estimated GP income)	£14.7m (salary costs) £10.8m (running costs)	£264.9m (salary costs) £191.7m (running costs)

- As described in the introduction to this section, no single payment mechanism can incentivise all the desired behaviours. A capitation+ model can improve access for vulnerable groups and incentivise positive behaviours for primary care providers such as containing health costs and encouraging prevention. This combined with an expansion of the fee-for-service to community pharmacy can increase collaboration and integration. The co-payment element can incentivise positive behaviours for individual use of primary care. Adapting Option 2 allows the Government of Jersey the flexibility to subsidise the co-payment element for certain groups or move to full capitation (no co-pay).
- Option 2 for the FVP is currently being worked up in greater detail by the HCS team. It is estimated that the cost for the States of providing this scheme to FVP only between 2021 and 2036 would be c. £35.1m.
- It is estimated that providing the three schemes together would cover c.69% of GP appointments in 2019.
- In 2019, a capitation+ scheme (with co-pay) model for the three schemes combined is estimated to cost the States c.£8.5m. The total cost of implementing the same scheme to cover FFS appointments for the all patients attending GPs (universal capitation+ scheme) would be £13.6m. The States currently pay between £6.5-6.7m in the form of rebates from the HIF to cover FFS appointments. This means that the States would 'save' this amount and would need to pay a total of c.£13.6m (or c.£7.0m net) in the form of a lump-sum fee to GPs to cover the same set of services.
- Between 2021 and 2036, the total cost for the States of a capitation+ (cap and co-pay) model for the combined schemes under a 'do-something' scenario is estimated to be £161.6m.
- If the capitation+ scheme was to be implemented universally to cover FFS GP appointments for all patients, the scheme would cost the States c. £248.5m over the same period.
- Option 1 involves expanding the services that can be offered by community pharmacy and other primary care providers and consultants (e.g. nurses) using the current fee-for-service payment mechanism. This option can sit alongside a capitation+ system and should focus on enhanced services that can be offered more effectively in settings other than GPs. A list of potential services in presented in Appendix 2.

- Finally, it is noted that the cost of a GP salaried model covers all GP services and is based estimates of income from different sources. The estimated GP income for FFS consultations in 2019 is c.£16.9m which reflects the estimated cost of a universal full capitation scheme that covers this type of appointments for all patients attending GP services.

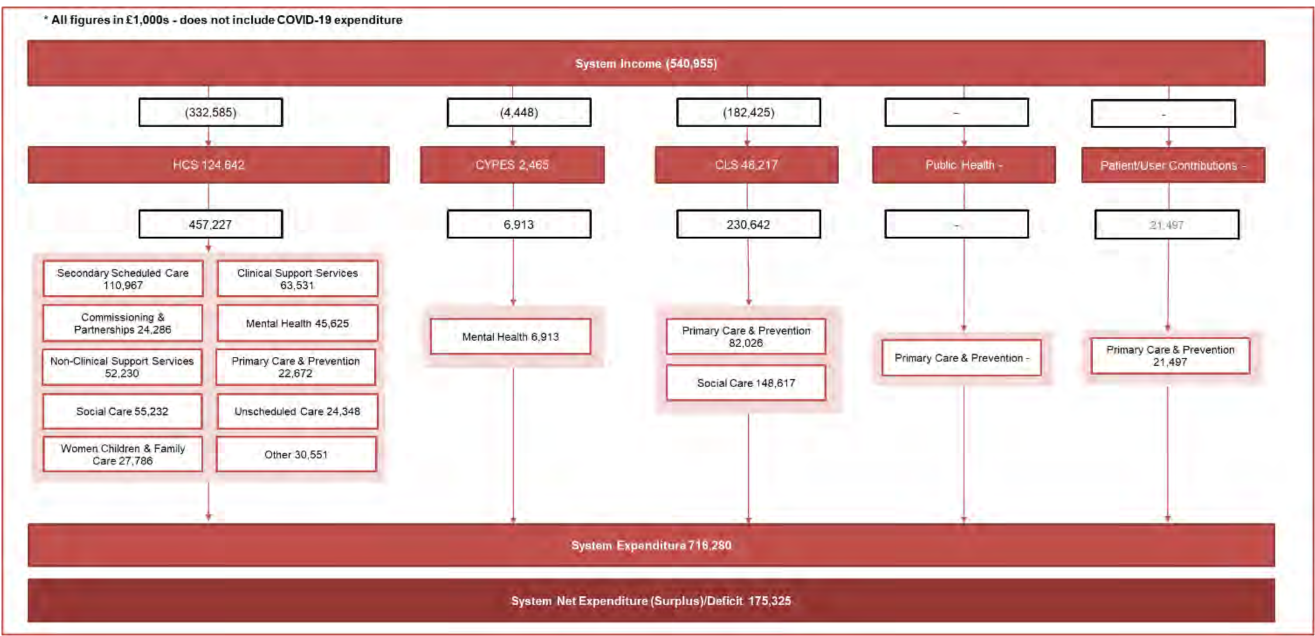
These preferred options are likely to deliver further benefits not captured in this analysis. These include reduced need for secondary care through increased access to primary care but also incentives for GPs to maintain costs as a result of capitation but also upskilling of other primary care workers such as community pharmacy and more integrated care.

It is estimated that the cost of these options to patients as a whole is lower than the current payment models. This is driven by the lower average co-payment of £10 per visit assumed in the capitation+ model. However, note that patients aged 0-9 will continue to pay, on average, the same co-payment as they do in the current model; currently, it is estimated that the average co-payment per visit for patients aged 0-9 is £9.80.

2.3 Do Something: Benefits Realisation

In a 'do nothing' scenario, projected to 2036, it is anticipated that the system income will rise to £541m, with a system expenditure of £716m (excluding non-recurrent expenditure on COVID-19). This will lead to a system deficit of £175m.

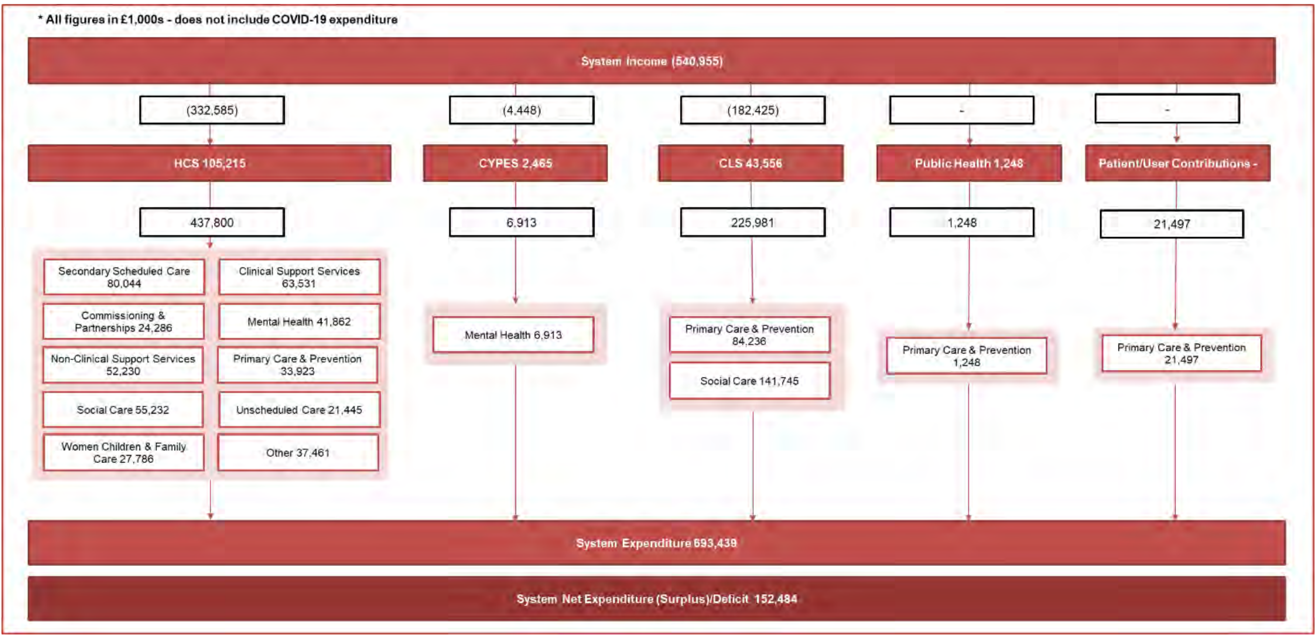
Figure 2.8: Network of spend in a 'do nothing' scenario



All figures in £1,000s

Conversely, in a 'do something' scenario, again projected to 2036, it is anticipated that the system expenditure will only rise to £693m while system income remain unchanged. This will lead to a system deficit of £152m and further savings or additional funding will be required in order to close this residual gap. The areas with significantly lower spend will include secondary scheduled care and unscheduled care. Conversely, there will be a greater level of investment in social care and primary care and prevention.

Figure 2.9: Network of spend in a 'do something' scenario



All figures in £1,000s

2.4 Risks

There are a number of risks associated with delivery of the 'do something' scenario.

Table 2.18: summary of risks

Summary of Risks – Do something				
Key Risks	**Probability (0-5)**	**Impact (0-5)**	**Overall Score (P x I)**	**Mitigation**
Cost of double running services / facilities during the transition period	3	3	9	These costs have been factored into the cost profiling for the model
Sufficient community resources cannot be recruited on a sustainable basis to support the model	3	4	12	A detailed workforce strategy and plan, setting out training and recruitment plans, will be developed as part of the initial planning and implementation phases
The market for community services will not be able to develop either in the volume required or in the timeframe required	3	4	12	Close working with the community sector so that the sector is engaged and understands the direction of travel to adjust their business models. Consider how the pace of change allows for organisations to adjust with the model development.

Summary of Risks – Do something				
Key Risks	**Probability (0-5)**	**Impact (0-5)**	**Overall Score (P x I)**	**Mitigation**
Confidence in the delivery of the new model of care will not be sufficient before designs for new hospital need to be set	2	2	4	A review of the JCM has been undertaken to provide confidence and to stress test. On-going governance of the model development will provide assurance.
Sufficient programme resources will not be made available to deliver the care model	2	4	8	Assumptions around required resources have been tested through the JCM review and built into the financial assumptions.
Coordination and alignment of cross-government services	2	2	4	Establish a PMO to support coordination between departments
Change in culture around established service delivery model will be too great to enable change at the scale required	3	3	9	Staff engagement plan should take into account the cultural change required, while payment mechanisms should reinforce the model.
Total Score Value				

2.5 Conclusion on preferred option

The review of the JCM recommended that the 'do something' model should be taken forward, as the JCM outlines a strong, patient-centred approach to delivering healthcare in Jersey, in line with current trends in healthcare worldwide. It found that the proposed integrated care model is likely to deliver enhanced service user experience and care by streamlining services and workforce resources. It also includes a number of priority actions for implementation across the system (detailed in the Management Case). In addition, several identified key areas will require further development to facilitate full system implementation of the model and these will be developed in subsequent phases. As a result, it is proposed that the implementation occurs over three tranches – with the first two focusing on, but not limited to, setting the foundations for the system including the workforce and digital systems, driving efficiencies and enhancing primary and intermediate care with changes sought to primary care payment models in Tranche 3.

The analysis found that the 'do something' scenario is financially sustainable and will not cost more to the consumer if resource allocation, funding models and commissioning arrangements are amended.

In terms of primary care delivery models, the analysis also found that the preferred payment option to support the implementation of the JCM is a capitated system with a £10 per visit co-payment. A capitated system can improve access and incentives positive behaviours for primary care providers such as containing health costs and encouraging prevention. Work is already underway through Proposition 125/2019 to implement this model for Financial Vulnerable patients. Building upon this work, this Strategic Outline Case recommends ultimately expanding this payment model to Socially and Clinically Vulnerable groups in Tranche 3.

This capitated system can be complemented by expanding the current fee-for-service model to community pharmacy to increase collaboration and integration. While the decision as to which payment structure to use will in part be a political decision, analysis has shown that the current model is not sustainable as part of the new JCM.

3 The Commercial Case

3.1 Introduction

3.1.1 The new direction of commissioning

The opportunity

The JCM provides an opportunity to apply new commissioning models, which have been successfully implemented throughout the UK, Europe and United States, that can be adapted to Jersey's unique context. These include the development of an integrated care system that will improve outcomes for the island's residents, increase competition in the health and care markets and drive value for money for both residents and the Government of Jersey.

The model will be based on the ethos and principle of collaboration and build on the existing strong tradition of partnership working on the island, while facilitating significant improvements in the service offering across the primary care, social care and external partners sectors.

Please refer to section 3.2 for information on proposed contractual structures to support the JCM.

3.1.2 Current context

The current approach to commissioning in Jersey is relatively immature in comparison to other health economies. It is primarily based on the specification and procurement of services, rather than on desired outcomes for targeted groups and for the island population as a whole. Contracting is the norm, with very little use of partnerships. In addition, there is a lack of a contract management function.

While this is acknowledged by all key stakeholders, there is also an overwhelming will and aspiration to move forwards in a new commissioning direction to develop the JCM.

General Practice and Community Pharmacy

The existing primary care system in Jersey is primarily funded by a mixture of State subsidies and direct payments from individuals. To see a GP, patients pay a consultation fee alongside a government contribution. Patients are free to choose where they seek medical advice. GPs and pharmacists are private businesses in direct competition with each other, and the market is characterised by low barriers to entry. Prescriptions are currently free.

Patient access to their GP is currently good and same day appointments are usually available; good patient experience is also reported. As patients may have a degree of choice over their GP, they should compete on price and quality of care (although patients may face switching barriers). However, Jersey currently faces a range of challenges that will need to be addressed when considering the procurement of future services. An ageing population will put more pressure on health services in primary care. A large proportion of GPs are approaching retirement, whilst other roles including nurse practitioners and pharmacists are underutilised. Current co-payment mechanisms mean vulnerable patient groups, whose demand for care tends to be higher, face barriers to accessing primary care. GP services also currently vary in pricing, discounting and costing which creates inefficiencies and contributes to inequality in the health system. The current payment mechanisms limit the development of wider roles for practice nurses and pharmacists. Separate funding systems across primary and secondary care incentivises the use of secondary care services over primary, such as individuals presenting in ED when primary care would be more appropriate because it is free to access.

Long Term Care

The Long Term Care scheme provides financial support to residents likely to need care at home or in residential/ nursing care for the rest of their lives. Currently there is not a well-established marketplace in Jersey for home care and domiciliary care. Within certain organisations providing these services, a large proportion of staffing is outsourced. A lack of care provision during evenings and weekends drives people to use more expensive services, as well as resulting in a greater number of people in residential care. As intermediate care does not play a large role within services currently provided, partially due to lack of investment, many beds are currently used for long term health conditions.

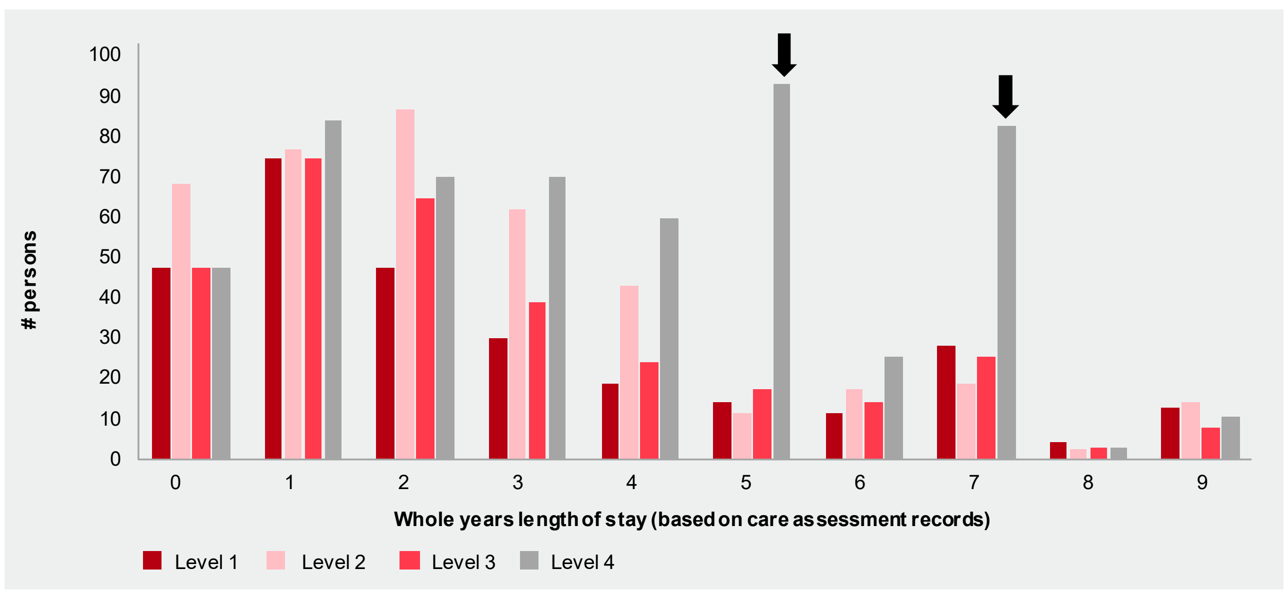
Care level and placement types as of February 2020 are shown in Figure 3.1 below. Individuals that qualify for the LTC scheme are allocated to one of four care levels[22]:

- Level 1 = Needs a moderate level of support (e.g. morning and evening support)
- Level 2 = Needs a high level of support (e.g. regular visits during the day)
- Level 3 = Needs a very high level of support
- Level 4 = Needs an extremely high level of support (24-hour supervision required)

The arrows in Figure 3.1 highlight the large number of people who require extremely high levels of support that are staying in care for an extended period of time.

In comparison, data collected by SALT (Short and Long Term Support) shows that of those receiving long term care in England, it is most common to be in receipt of care in the community.[23] The largest number of clients over 65 received long term care in the community using CASSR (Councils with Adult Social Services Responsibilities) managed personal budgets. However, in the same period residential care accounted for the highest share of gross current expenditure.

Figure 3.1: Care levels and placement types as of February 2020



Source: PwC Primary Care Modelling LTC datasets, 2020

It is also evident that the majority of these people are in residential care, compared to domiciliary care.

[22] Government of Jersey, Long Term Care Scheme General Information, July 2018 https://www.gov.je/SiteCollectionDocuments/Benefits%20and%20financial%20support/LTC%20General%20Information%20Booklet%20%20170417%20JJ.pdf

[23] NHS Digital, Adult Social Care Activity and Finance Report, England 2018-19, October 2019, https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19/4.-long-term-care#references

Figure 3.2: Number of people in residential care vs domiciliary care as of February 2020

Source: PwC Primary Care Modelling LTC datasets, 2020

Third Sector

Jersey has a well-established third sector. There is a strong history of volunteering on the island; 30% of residents regularly donate their time and two out of three organisations operate without any paid staff. The third sector is varied; from large organisations which function with a small proportion of government contribution, to those much smaller organisations which are reliant on donations. Residents prefer to support smaller charities where they are personally affected by the cause.[24] Whilst some providers greatly benefit from fundraising, others dealing with issues not prioritised by the public, such as homelessness, tend to miss out on volunteers and donations and subsequently struggle to deliver services. In recent times, the volunteer age profile has increased with many volunteers falling into the over 65 age bracket. Jersey also has low unemployment and tight immigration laws, making staffing difficult. These combined, highlight a lack of resilience in the sector, something which has become more pressing in light of COVID- 19.

A Commissioned Service Review identified that many of the organisations HCS works alongside should be re-commissioned with an extended contract duration. Many services are reliant on HCS funding, and provisions are often above and beyond their original contract agreement. Organisations noted the need for an open and functioning relationship with the Government of Jersey and to work in close partnership with health and community services.

The strength of the sector gives an opportunity to create a system wide approach that builds on this strength through a transparent partnership to improve health and social care across the whole population. Continued relationships with external partners will allow people to connect to the appropriate providers within the community without introducing complexity into the system. Moving forward there is a need to help develop the marketplace, link organisations and develop further a volunteers' network. There is also a need to move away from short term contracts to enable organisations to plan more effectively. Long-term contracts provide incentivisation for investment, both financial and in workforce development/deployment.

[24] Island Global Research, Charitable Giving in 2018 - Online Survey Jersey, Guernsey & the Isle of Man, April 2019.
https://www.islandglobalresearch.com/

The proposed fees, payments and funding flows required to operational the new JCM, are captured and detailed in the Economic and Financial Cases.

3.1.3 Existing Contractual Arrangements

Primary Care

GP services were contracted in 2018 as outlined below:

Table 3.1: Current GP contracting arrangements

Service	Funding Channel	Contract Value
GP Frailty Cluster	HCS	£100,000
MH & social prescribing cluster	HCS	£100,000
JQIF	HIF	£1,586,500
Shingles Immunisations (cost of vaccines)	HIF (HCS)	£12,168 (£12,200)
Pneumococcal immunisations (cost of vaccines)	Service users (included in dispensing fees)	No set fee, depends on practice
Flu immunisations (cost of vaccines – children) (cost of vaccines – at risk adults, 65y+) (cost of vaccines – private adults)	HIF (HCS) (Service Users) (Service Users)	£380,000 (£132,000) (£118,000)
Cervical Smears	HIF	£183,800
6 week baby check	HIF HCS	£18,414 £18,885
Childhood Immunisations (cost of vaccines)	HIF HCS (HCS)	£116,650 £170,533 (£520,000)
FFS consultations	HIF Service Users	£6,708,036 £9,941,130
Prescriptions[25]	Service Users	
Pathology Benefit	HIF	£932,000
JDOC	HCS	£128,000
Long Term Wards	HCS	£84,000

Source: Costs Data provided by Government of Jersey

[25] Island Service users pay for repeat prescriptions, i.e. they pay to see their GP to prescribe. Detailed data is not currently available.

And within **pharmacy**:

Table 3.2: Current pharmacy contracting arrangements

Service	Funding Channel	Contract Value
Dispensing fees	HIF	£6,742,954
Medicine costs[26]	HIF	£12,707,046
Smoking Cessation Service	HCS	£37,000
Nicotine Replacement Therapy (NRT) Products	HCS	£67,000
Flu Immunisations	HIF Service Users	£75,000 £23,000
Medicines Use Reviews	HIF	£25,000
Diabetes Ancillaries	HIF	£1,200,000

Source: Costs Data provided by Government of Jersey

The State provides limited funding for optometry and dental services; hospital optometry and dental care is free whilst primary care optometry and dental care services are paid for through direct service user (patient) contributions.

Long Term Care

The Long Term Care scheme is funded by the State alongside contributions from income tax. Individuals are able to claim the LTC benefit once their assessed care costs have reached a cap. If in a care home, non-care costs including accommodation and daily living expenses are not covered and require co-payment.

Voluntary, Social and Community Services

Jersey has historically enjoyed the support of an active and highly regarded voluntary sector. In addition, HCS holds key partnerships with a number of organisations which have been managed by the Health Modernisation Team.

Approximately 100 organisations are currently involved in providing a wide range of services in the community, however not all are commissioned by HCS and the Government of Jersey (HCS are still dependent on these non-commissioned providers).

Please refer to Appendix 6 for a non-comprehensive schedule of HMT's commissioning arrangements by organisation, service and 2019 contract value.

HCS contract 'Co-operative Channel Islands' to deliver the subsidised product scheme (SPS). SPS provides products to over 1,200 people every month. This includes Stoma, Urinary, Continence and Dietary which are 100% subsidised by HCS at a total value of £1,200,000. Gluten free products are subsidised by the HIF, costing £451,000.

[26] Dispensing fees and medicine costs were only available as one total figure for 2018. To calculate the breakdown into dispensing fees and medicine costs separately for 2018, the 2017 proportional split was applied to the 2018 figure.

3.2 Proposed commercial structures to support the JCM

3.2.1 Introduction

The JCM-enabling commercial structures must offer flexibility and allow for continuous improvement and collaboration while ensuring efficiencies across are shared between both commissioners and providers.

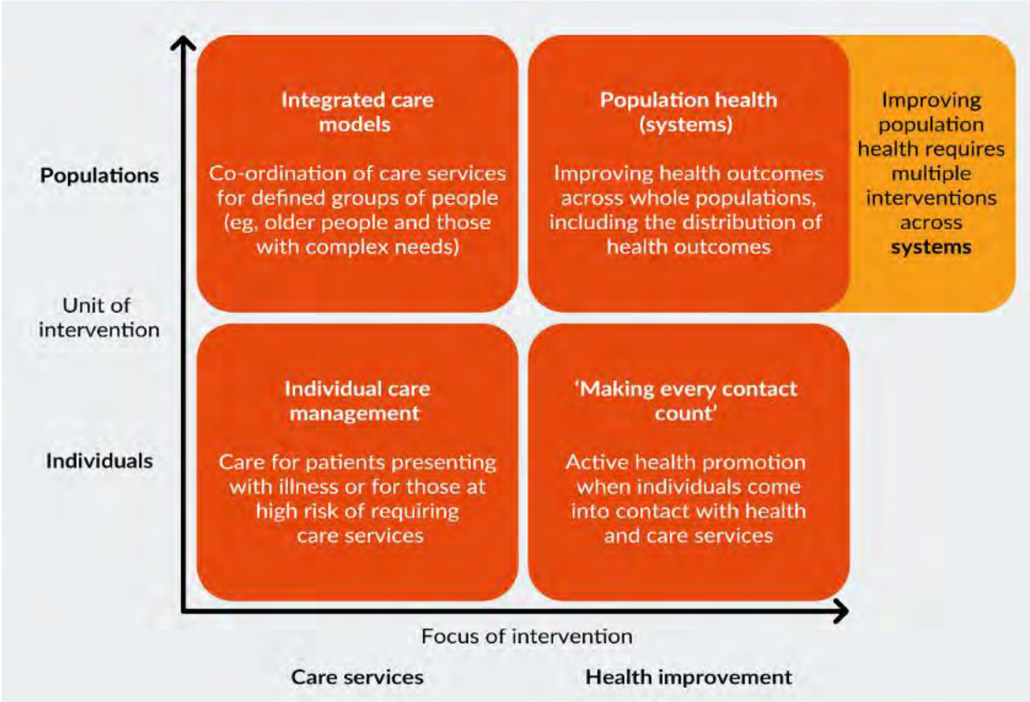
The commercial structures should incorporate learnings and best practice from international commissioning models with an emphasis on partnership workings.

3.2.2 International health and care commissioning

Health and care commissioning have changed significantly in many parts of the world during the last decade. There is broad acknowledgement that greater integration of care leads to improved health outcomes and greater financial efficiencies for local systems. Many variants of integrated models have been developed; however, all have the goal of attempting to make health care systems accountable for the wellness and wellbeing of defined populations. Rather than only reactively treating illness, they also attempt to address the causes of illnesses and incentivise the promotion of wellness.

The diagram below represents the primary focus areas of population health systems.

Fig 3.3: Focus of population health systems[27]



Health systems that are seeking to introduce new integrated care models will often focus on the following themes:

Model of care: To promote wellness and patient-centric healthcare with a focus on patient journeys across multiple organisations and/or settings in a co-ordinated manner.

Population based capitated commissioning: To promote wellness across a population. Capitated payments to providers are based on a weighted population – with well-defined access and outcome targets.

27 The Kings Fund, https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems

Corporatisation – To consolidate both health and social care under a single management control structure and ensure that this structure is accountable for the wellness of the island residents.

Private sector and external partners participation - leveraging wider experience, skill, scale and efficiency to support the delivery of health and social care in an integrated manner, aligned to the JCM.

Although the introduction of these models faced criticism (particularly at the start) that they are primarily driven by the desire of cutting spend, there is a consensus that progress has been made in tempering the ever-rising demand for in-hospital care.

International commissioning models

The intentions of the Jersey Care Model Commissioning Framework, including enhanced joint commissioning (between different GoJ departments), integrated commissioning at local level and the usage of personal budgets, are hallmarks of modern integrated care systems (ICS)/accountable care systems.

In England, the introduction of the Health and Social Care Act in 2012 brought about sweeping changes to the commissioning function, including delegation of responsibilities from national to local level and greater interaction between commissioners and providers – to support a greater integrated care model. [28]

More recently, ICSs have been established, enabling planning to be undertaken at a system-level with the additional involvement of local authorities (including city and town councils). Integrated care provider contracts (where commissioners contract with a single organisation to deliver services to a specified local population under one budget) are becoming more common. While the suggested population number for a single STP is often above circa 1 million, much of the attributes can be incorporated in Jersey which faces similar challenges to larger and more populated health systems.

Variants of these models include:

Primary and Acute Care Systems (PACS), which co-ordinate primary care, hospital, community and care services to improve health outcomes. Core components of a successful PACS include:

- Targeted population health
- Enhanced primary care
- Integrated community care teams
- Integrated access to acute and emergency care services
- Improved access to specialist and elective care
- Self-care, prevention and person-centred care
- Third sector and community engagement and activation

Multispecialty Community Providers (MCPs), which focus on providing services and offering care nearer to patients' homes, rather than in a hospital setting. Core components of success MCPs include[29]:

- A population health and care model focused on proactive and preventative care tailored around the needs of the individual
- Empowering patients and local people to support each other and themselves in their health and care
- Multi-disciplinary health care professionals working within an organisation that has accountability for the delivery of health and care services for their population
- Contracting and payment systems that incentivise and enable the delivery of services for population health

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[28] The Kings Fund, https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing

[29] The Kings Fund New models of care programme for PACs and MCPs, 7 June 2016

All these models are fundamentally underpinned and supported by primary care. As the JCM is further developed, Jersey will be able to develop its own bespoke model, utilising the learnings from different international models, while attempting to minimise the flaws.

Partnerships

Close working relationships and the partnership ethos are hallmarks of these models. In Jersey, arrangements which allow for working closer without stifling competition will be sought, alongside those which promote and reward innovation and achieve Value for Money for the island.

There is already a strong tradition of partnership working on the island which will be enhanced to improve outcomes, increase competition and drive value for money.

Due to the possibility of introducing cross-governmental commissioning and the development and introduction of a bespoke contract management function, robust and lean governance arrangements will be critical to deliver efficiencies and value for money without jeopardising service provision. Arrangements would also need to be flexible to identify and address future financial and performance challenges, and collaborative to ensure functions are not duplicated and there is clarity, legitimacy and expediency in decision-making.

As an example of financial governance for partnership structures, a STP in the East of England has collectively agreed to establish a Finance and Activity Group to scrutinise and challenge local system finances as well as highlight potential opportunities and risks to the Partnership, and a 'System Investment Group' to develop and prioritise transformational capital and revenue investment across the local system. Each partner remains accountable to its own governance arrangements.

3.3 Procurement Strategy and Approach

3.3.1. Introduction

Support from the Government of Jersey, residents and other relevant stakeholders will be essential to implement the change in strategy required to deliver the JCM. The JCM Review has identified that whilst there is some hesitation amongst providers (particularly GPs) on how the model will affect the current operating system, many providers have shown enthusiasm for the proposed changes, which include:

Strategic Partnerships (SP)

To improve how people are supported across the community, a number of areas will be developed through partnerships. To deliver the model will require different parts of the health and social care system working collaboratively to coordinate services. A far closer partnership will allow partners to work together to drive up the quality of care and improve outcomes by meeting the current and future needs of the population in Jersey. This is particularly relevant in relation to increased use of technology to support the delivery and increased provision of services in the community and at home. To develop strategic partnerships, HCS will use traditional commissioning combined with moving towards structures such as accountable organisations agreements, to share risks and rewards. This approach will incentivise increased efficiency and quality of services as well as improving access and affordability.

The Jersey Care Model Commissioning Framework

The commissioning framework has been developed to support the Jersey Care system leaders commissioning the JCM. Open and transparent working in partnership with providers and other partners including the voluntary sector and taking a strategic approach to commissioning will reduce duplication and maximise the current expertise and resources available. The framework details the commissioning cycle to be followed and the principles to be used for good commissioning decisions.

Fig 3.4: Commissioning cycle[30]

The framework is designed to support collaborative working within commissioning by encouraging open communication with providers and other partners in the care system to achieve the best possible outcomes for Jersey residents. A key element of this is assessing the value of services by measuring outcomes as opposed to activity. A collaborative approach to commissioning is essential to establish a range of outcome measures that appropriately reflect the health and social care environment as it changes. These should be tailored to the level of funding, service type and organisation size, and encourage sustainability of support provision. The model will reward positive outcomes for individuals, encouraging collaborative working between organisations to manage common resources.

Joint Commissioning

Different GoJ departments should look to increase the number and scope of jointly commissioned services where possible. There are many challenges such as housing that currently impact the health sector, impacting both staff and patients. There are also a number of bespoke services targeted at vulnerable individuals which would benefit from a collaborative approach from HCS to jointly develop and fund these services. A move towards joint commissioning would help coordinate better links between relevant services and increase efficiency by avoiding crossover and working collaboratively to best serve the community. This will require formal implementation of joint working between commissioning bodies and Government of Jersey departments.

Integrated Commissioning at a Local Level

The unique Parish system in Jersey requires a flexible approach to commissioning and service delivery to meet Parishioners needs. This will involve HSC working with partners to commission at a micro level where appropriate.

Personal Budgets

The JCM aims to introduce personal budgets to enable people to identify their own needs and have more control over their care and support services. Partnerships will be essential to developing personalisation to support choice and control for patients. Providing a real alternative to institutional care will increase the

[30] Government of Jersey, Jersey Care Model Commissioning Framework, January 2020

range of services available in the community, as well as increasing opportunities for paid carers. Whilst personal budgets may not directly result in financial savings, they add value by improving outcomes for users and increasing levels of satisfaction.

Contracting arrangements

Contracting arrangements will use standard Government of Jersey terms and conditions with an enhanced emphasis on quality outcomes, for example using key performance indicators and pay mechanisms that fairly and transparently share gain and losses, based on the risks each party absorbs – these being hallmarks of integrated care systems and accountable care organisations throughout the world. While limited scale will always be a challenge in Jersey, the introduction of competition is various sectors will be sought.

These arrangements will also be informed by the new Commissioning Framework and other elements of the procurement strategy and approach outlined in this section.

3.3.2 Sector Focus: External Partners

Implementing the JCM will require strategic arrangements in the marketplace, and partners working together in a multi-organisational collaborative approach. Whilst one or two pieces of procurement may be recommended, the changes to the sector will not be presented as a commercial opportunity. The focus will be on better health outcomes for individuals as opposed to competing for procurement on a commercial basis.

HCS depends heavily on service provided by organisations, therefore promoting resilience within the sector is a key ambition of the JCM. Charities are already heavily involved in healthcare in Jersey and a valued and trusted partner. Several external partners are members of the HCS Board and the JCM Steering Committee (such representation is now becoming more prevalent in England too, with external partners sitting on the Partnership Boards of ICSs and STPs).

Therefore, the commercial opportunity will be focused on obtaining more financial support for organisations by working collaboratively and increasing the quality of services.

To address the concerns of organisations, contracts have been extended to allow long term planning. There will also be a large focus on co-production (which is renowned to drive quality improvements) so that money follows the activity. Managing a single budget to deliver a range of services can enhance the effectiveness of partnership working.

There are several models that could be utilised to enable the delivery of effective partnership working on the island. These range from 'informal' arrangements (which are unlikely to achieve the ambitions of the JCM), contractual arrangements with third sector partners (which are currently in place), and partnerships via a new-constituted legal entity, through to a full-integration model (which is unlikely in the Jersey context and would diminish competition). There is also the potential to introduce an island body in the sector which would provide support to smaller organisations in areas such as training and recruitment to help maximise their services.

Benefits

- The JCM will build on the current strengths of healthcare in Jersey such as the parish system and strong relationship with the third sector.
- A focus on prevention and early intervention will enable early help offers to be provided by volunteers, so the more skilled workforce is able to address the higher end of needs. This will mean that the right level of resource is aligned with the right people, increasing efficiency.
- The model will allow a wide range of services to be delivered closer to where people live.
- Clustering of organisations will help bring those in similar areas together to deliver the model.

3.3.3 Sector Focus: Primary Care

With the remodelling of primary care being a core component of the JCM, substantial changes to the contracting structure for both GPs and the wider primary care sector are needed. This may include a primary care contract, to be introduced for the first time, for GPs and community providers, which would enable multi-skilled teams and multiple providers to participate in service delivery. While further detailed preparatory work and engagement is underway, this could take a tiered approach of initially including GPs and thereafter the wider primary care sector, including community pharmacy, dental, ophthalmology and physiotherapy. This sector could be empowered with the necessary funding to enable contracting with other providers for a given pathway, for example Year of Care for residents with long terms conditions, including diabetes.

In England as an example, the 'Core GP Contract' for essential services forms the centrepiece of the primary care contracting framework, with additional contracts for enhanced services.

It is imperative that this structure incentivises and benefits the entire system and avoids retaining any perverse incentives that are a feature in the current provision of primary care services. There are a number of available structures, in addition to a GP contract, that could achieve these aims.

For example, the Government of Jersey could form a Contractual Joint Venture, with primary care providers, including GPs and community pharmacy. While details pertaining to the legal structure, funding flows, governance arrangements and risk and gain share mechanisms would need to be carefully developed, it would be anticipated that all relevant services would form part of a single contract, with staff (where relevant) and assets "transferred in". One partner would act as "Host", with all partners having defined responsibility for operations, implementation and strategy.

Other options for primary care may include:

- A GP Federation: this is an example of a corporate joint venture where the parties create a new legal entity to deliver services on their behalf.
- Super-partnerships: Large-scale single partnerships created through list growth and formal partnership mergers.
- Multi-practices[31]: Small-scale GP partnerships managing multiple practices and services.

3.3.4 Sector Focus – Social Care

Working in partnership with social care partners will allow for the development of new and enhanced services. For example, the opportunity to partner with residential care providers may enable the introduction of other services such as step-up /step-down care, which is not a current offering on the island, as well as respite care.

Presently the scope of the Long-Term Care (LTC) fund is limited in what it can provide to users, with benefits only extended to care related costs. Personalisation, specifically the introduction of personal budgets, will allow for more autonomy over how individuals manage their own care, while involving family members in providing care to those with life-long conditions would increase the availability of carers.

Technology may also increase the efficiency of the LTC fund. Incorporating assistive technology will make the management of long-term conditions more flexible and help individuals to stay in their homes, and out of residential care, for longer.

3.3.5 Payment models

The commercial structures must support the new payment models, for primary care, community pharmacy and community services, which are detailed in the Economic Case.

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[31] Nuffield Trust, New models of primary care: practical lessons from early implementers, December 2013
https://www.nuffieldtrust.org.uk/files/2017-01/new-models-of-primary-care.pdf

These options can be tested and evaluated against several financial and commercial parameters, including:

Table 3.3: Potential payment mechanisms – financial and commercial parameters

Parameter	Description
Control	Is there a clear preference for the GoJ to retain long term control over the proposed payment model
Value for Money (VfM)	Will it offer Value for Money for Jersey, as a whole? Reflects the differences of the options and how the GoJ's covenant (if applicable) could be utilised to secure improved VfM terms.
Affordability	An estimate of the ongoing annual cost to GoJ / the individual (including vulnerable groups
Risk and risk transfer	The principle of transferring risks to third parties where they are best placed to manage and mitigate those risks, and where Value for Money can be maintained
Third party requirements	Requirements from external partners that must be considered

3.3.6 Addressing Workforce Issues

Employment issues present a significant risk to the JCM. As more core functions of care move into the community, the roles and requirements of the workforce will change and a resilient workforce, able to adapt to these changes, will be needed.

Full details on workforce implications, including the need for a cross-island labour market strategy, are outlined in section 5.2.4 of the Management Case.

3.3.7 Key risks

A number of key risks to the commercial delivery of JCM have been identified, including:

Table 3.4 Key risks

Note: '5' being the highest probability and greatest impact; '0' being the lowest and least, respectively.

Risk	Probability (0-5)	Impact (0-5)	Mitigation
Inappropriate capping mechanisms	2	4	The capping mechanism should be agreed by both providers and commissioners, taking into account the stated goals and ambitions of the JCM. All capped amounts (both activity-based and financial) should be evidence-based.
Inappropriate financial gain/loss sharing mechanisms included in the payment design	2	4	The payment mechanism must be devised to enhance and enable the models of care within the JCM. The risk being borne by each individual party (and their potential contributions) must be taken into account.
Quality and outcomes incentives not well aligned, leading to a provider restricting access or reducing the quality of care provided	3	5	Quality and desired outcomes must be unequivocal and measurable, to allow for stringent performance monitoring and the imposition of penalties on providers.
Exclusion of certain types and settings of care	1	3	The commercial structures to be introduced and amended to enable the JCM, must consider and incorporate all

Risk	Probability (0-5)	Impact (0-5)	Mitigation
leading to incentives to providers to shift care to another setting			types and settings of care on a holistic basis. This will also maximise the potential for capitation to support integrated care on the Island
Employment issues, particularly within social care where roles are not financially attractive. *(see section above)* A lack of a marketplace in homecare has resulted in outsourcing of staff within some organisations Heavy reliance on provision of community services by volunteers in the third sector, the majority of which are over 65	4	4	A cross island labour market strategy that includes housing, immigration and training will address immediate concerns as well as long term provisions The JCM intends to introduce training and education to the wider community, including family members to increase care offering in the community

The above risks and the wider resilience challenges of the sector have become even more evident and pressing during the current COVID-19 pandemic. It has also emphasised that a change in many current ways of working (for example only contributing to GP consultations that are held face-to face) is critically needed.

4 The Financial Case

Jersey case lead: Jo Larkin

4.1 Summary of the financial case

4.1.1 Introduction

The purpose of this section is to describe the financial forecasting associated with the JCM (as described in the Strategic and Economic Cases) and the proposed commercial structures that will enable this (as described in the Commercial Case).

The financial modelling that has been undertaken has considered the following areas in-scope for changes:

1. All income and expenditure associated with the Health and Community Services (HCS) department.
2. The Health Insurance Fund (HIF) and Long Term Care (LTC) fund, which sit within the Customer and Local Services (CLS) department.
3. Income and expenditure associated with Child and Adolescent Mental Health Services (CAMHS) within the Children, Young People, Education and Skills (CYPES) Department.
4. Additional Public Health services proposed through the JCM[32] within the Strategic Policy, Planning and Performance (SPPP) Department).
5. Individual contributions to General Practice.

References to the “health and care system” (or “system”) in the remainder of this chapter include the totality of these in-scope areas.

Within the modelling, two primary scenarios have been considered:

1. The ‘do nothing’ scenario where the care model is assumed to remain unchanged except to account for growing demand for services over time.
2. The ‘do something’ scenario where the 69 recommendations, as laid out in the JCM Briefing Paper and validated through the JCM Review, are implemented. A number of GP payment options have been considered within this option.

The modelling time period is a period of 16 years (2021 to 2036). Both the ‘do nothing’ and ‘do something’ scenarios are modelled over this period on a year by year basis.

4.1.2 Non-recurrent investment requirement

Non-recurrent investment of £17m over a five-year period (2021-25) is required to enable the delivery of the JCM and recognise the expected benefits.

The investment is expected to fall across two main categories:

- **Programme costs:** These are the costs associated with the transformation programme required to deliver the JCM. It is expected this programme would operate over a five-year period. The costs associated with this would cover PMO support, organisational development support, communications support and digital transformation subject matter expert(s).
- **Digital non-recurrent investment:** The JCM describes the requirement for several new digital tools for use across the health and care system. These include investment required for integrated care records

[32] As a result of only considering additional Public Health expenditure proposed through the JCM, Public Health expenditure has only been included in the ‘do something’ scenario.

and JCR, core record systems, hub and micro services, and analytics. These investments have been split between non-recurrent revenue and capital expenditure lines.

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

Further details on the breakdown of this non-recurrent investment requirement can be found in sections 4.2.3 and 4.3.4.

4.1.3 Recurrent investment requirement

In addition to the non-recurrent investment, the JCM requires the implementation of a number of new services and expansion of some existing out of hospital services. Over the 16 years to 2036, these have been estimated to cost a total of £679m.

The new services required through the JCM primarily relate to out of hospital provision of health and care services that avoid hospital care (inpatient or outpatient) or long-term care placements.

These have been assumed to ramp up from 2021 and, by 2036, they will cost £67m per year. An element of double running has been assumed between the new services coming online and benefits being achieved. In particular unless otherwise identified through the implementation plan, it has been assumed that changes will take 12 months from the implementation of the new service before the impacts of the JCM are fully delivered (leading to an initial net recurrent investment in 2021 to 2024).

Further details on this recurrent investment requirement can be found in sections 4.2.3 and 4.3.3.

4.1.4 Net financial benefits

Over 16 years, the JCM is forecast to avoid a total of £874m in expenditure growth compared to the 'do nothing' scenario. Net of the recurrent investment requirement there is a total reduction in expenditure growth of £195m compared to the 'do nothing' scenario.

The JCM changes are forecast to recurrently reduce expenditure by £90m per year by 2036 as compared with the 'do nothing' scenario. Taking account of additional recurrent investments described above, the net financial impact of the JCM is expected to be £23m by 2036.

As seen in section 2.1.4 in the Economic Case, Treasury guidance recommends discounting future values at 3.5% per year. When this is applied to the above benefits, the Net Present Value saving associated with the JCM is estimated to be £118m over 16 years. Without discounting for future values, the return on investment over the 16 years modelled is estimated to be around 11:1.

Impact assumptions for each of the 69 JCM changes have been validated as part of the JCM Review. The largest impacts are seen for interventions targeting reductions in residential and nursing care placements (£10m per year net financial impact by 2036) and interventions targeting reductions in hospital admission rates (£14m per year net financial impact in 2036). There are also several changes that deliver net negative financial benefits. However, all of these benefits should be considered alongside the clinical benefits set out in the Strategic and Economic Cases.

For the purposes of the financial modelling the 69 JCM changes have been grouped into 25 interventions and the impacts associated with each of these can be found in sections 4.2.3 and 4.3.3.

4.1.5 Sustainability of the system

As a result of the JCM, sustainability of Jersey's health and care system is forecast to significantly improve such that forecast benefit exceeds the forecast increase in expenditure by 2025 and fully pays back the investment by 2027.

The 'do nothing' financial challenge for the system is forecast to be £175m by 2036. In the 'do something' scenario this falls to a residual financial challenge of £152m. Further system-wide efficiencies of c. 1.8% per

year will be required to be financially sustainable. This is in line with the levels delivered in other similar health and care economies. Further details on the sustainability of the health care system can be found in section 4.4.

4.2 Financial Costs

4.2.1 Current financial position

Current expenditure has been based upon detailed financial information for each of the relevant departments, aligned with the Government Plan 2020-23.[33] In total, the system is forecast to spend £378m in 2020 (£337m plus £42m of non-recurrent expenditure related to COVID-19). The system expenditure is summarised in the following table.

Table 4.1: Current expenditure summary

Department	Description	2020 expenditure £m
HCS	Scheduled secondary care	59.5
HCS	Clinical support services	35.0
HCS	Commissioning and partnerships	12.5
HCS	Mental health	22.6
HCS	Non-clinical support services	28.8
HCS	Primary care and preventions	11.4
HCS	Social care	20.6
HCS	Unscheduled care	13.6
HCS	Women, children and family care	14.8
HCS	Other	15.3
HCS	Sub-total expenditure	233.9
CLS	Health Insurance Fund expenditure	33.2
CLS	Long Term Care fund expenditure	55.5
CLS	Sub-total expenditure	88.7
CYPES	Child and Adolescent Mental Health Services (CAMHS) expenditure	3.3
SPPP	Additional Public Health expenditure	-
Patient/User Contributions	General Practice contributions[34]	10.8
Multiple	Additional non-recurrent expenditure on COVID-19	41.5
Total		**378.3**

[33] Government of Jersey, Government Plan 2020-2023, https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/ID%20Government%20Plan%202020-23%20VB.pdf and Government of Jersey, Government Plan 2020–2023: Further information on additional revenue expenditure and capital and major projects expenditure, https://statesassembly.gov.je/assemblyreports/2019/r.91-2019.pdf?_ga=2.76914709.1406391748.1584887934-1962226745.1584630621

[34] For the purposes of the whole system financial modelling, General Practice contributions are assumed to pass through from income to expenditure in the 'do nothing' case but are included here so alternative funding models can be included in the financial analysis.

In 2020 this expenditure is funded through £397m of income (including both Government budget allocations and other income sources).

As a result of this income and expenditure, the system is currently forecast to operate at a net surplus position of £18.4m in 2020. This is primarily being driven by surpluses in the Health Insurance Fund (£9.0m) and the Long Term Care fund (£9.2m), both of which are restricted to funding specific benefits for the people of Jersey and therefore are not normally available for general funding of health and care services.

Aside from these restricted funds, the system is currently forecast to operate a small surplus of c. £200k in 2020.

Given current expenditure related to the COVID-19 pandemic, any surpluses described above, including those related to the Health Insurance Fund and Long Term Care fund, may be used to secure the future sustainability of public services across Jersey and therefore cannot be assumed to be available for funding of the changes proposed in the JCM.

4.2.2 Do nothing financial forecast

The 'do nothing' scenario assumes that the model of care remains the same and delivery of services are only modified to accommodate changes in demand. In this scenario, the health and care system is forecast to experience significant growth in expenditure due to a number of factors (see section 4.2.2 for further details on each of these):

- **Growing population:** The population of Jersey is forecast to grow by over 19% by 2036, meaning that there will be a larger number of people requiring health and care services.
- **Increased health needs:** Demand for healthcare services forecast to grow by a faster rate than the growth in population, primarily due to an aging population with increasingly complex health needs. For example, through looking at current usage of hospital beds by different age bands and forecasts of how each of those age bands are going to change over time, demand for hospital beds has been estimated to grow by over 31% by 2036.
- **Cost of healthcare is increasing:** Inflation in the healthcare sector is typically higher than other parts of the economy due to the impact of technological enhancements and introduction of new or enhanced drugs and clinical treatments. For the purposes of this modelling, it has been assumed that healthcare costs will increase by an average of 3% per year.

As a result of these growth factors, without changes to the health and care system or delivery of substantial efficiencies, **expenditure is forecast to grow by 89% by 2036** (from £378m to £716m).

Further details on this expenditure growth can be seen in the following table with a full annual breakdown provided in Appendix 4.

Table 4.2: Forecast expenditure growth ('do nothing' scenario)

Department	Description	2020 budgeted expenditure £m	2036 forecast expenditure £m	% increase from 2020 to 2036
HCS	Scheduled secondary care	59.5	111.0	87%
HCS	Clinical support services	35.0	63.5	82%
HCS	Commissioning and partnerships	12.5	24.3	95%
HCS	Mental health	22.6	45.6	102%
HCS	Non-clinical support services	28.8	52.2	82%
HCS	Primary care and preventions	11.4	22.7	99%
HCS	Social care	20.6	55.2	168%
HCS	Unscheduled care	13.6	24.3	79%
HCS	Women, children and family care	14.8	27.8	87%
HCS	Other	15.3	30.6	99%
HCS	Sub-total expenditure	233.9	457.2	95%
CLS	Health Insurance Fund expenditure	33.2	82.0	147%
CLS	Long Term Care fund expenditure	55.5	148.6	168%
CLS	Sub-total expenditure	88.7	230.6	160%
CYPES	Child and Adolescent Mental Health Services expenditure	3.3	6.9	106%
SPPP	Additional Public Health expenditure	-	-	-
Patient/User Contributions	General Practice contributions	10.8	21.5	99%
Multiple	Additional non-recurrent expenditure on COVID-19	41.5	-	(100%)
Total		**378.3**	**716.3**	**89%**

Further details on the assumptions that underpin this scenario can be found in section 4.2.2 of this document.

4.2.3 Do something financial forecast

The 'do something' scenario incorporates the changes proposed in the JCM. These have been modelled, first in terms of activity flows and subsequently in terms of financial impacts (based on assumed unit costs with fixed and variable portions).

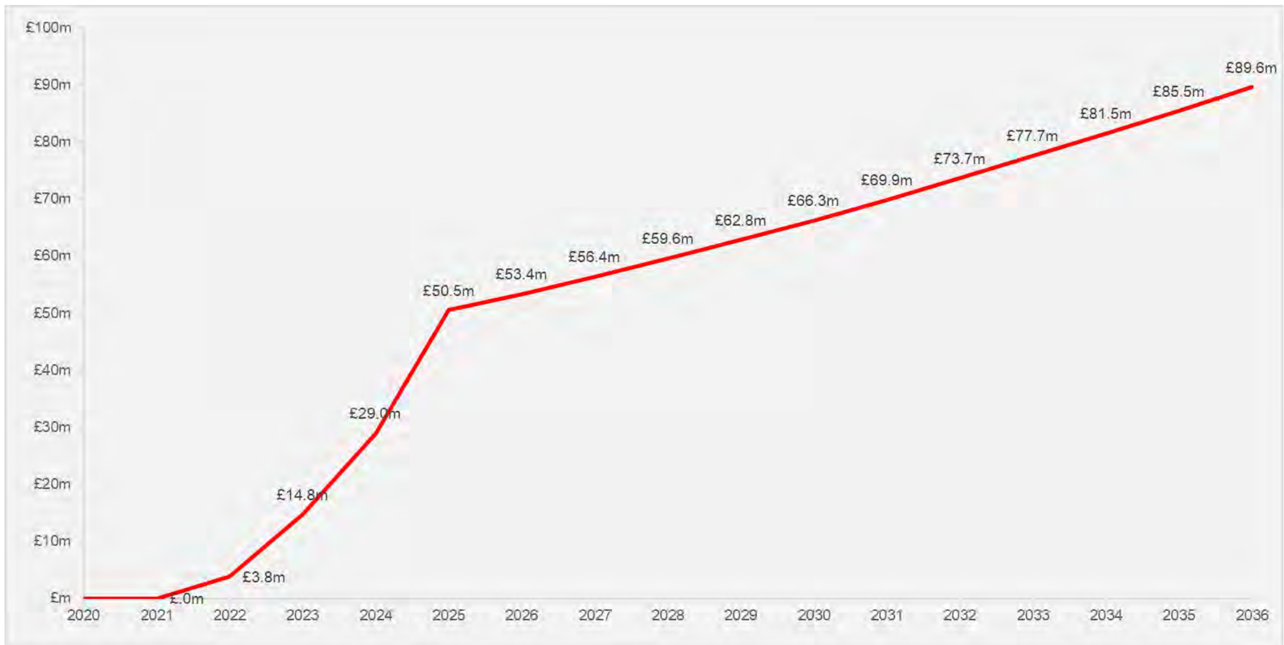
This includes modelling of:

- Areas where activity will reduce compared to the 'do nothing' scenario (i.e. moving patients out of hospital settings), leading to 'gross financial impacts'.
- Areas where activity will increase compared to the 'do nothing' scenario (i.e. provision of new services to enable the change), leading to 're-provision costs'.
- The combination of these two will give the 'net financial impacts'.

Further details on the estimated impacts associated with the care model, as well as other assumptions, can be found in section 4.2.3 of this document.

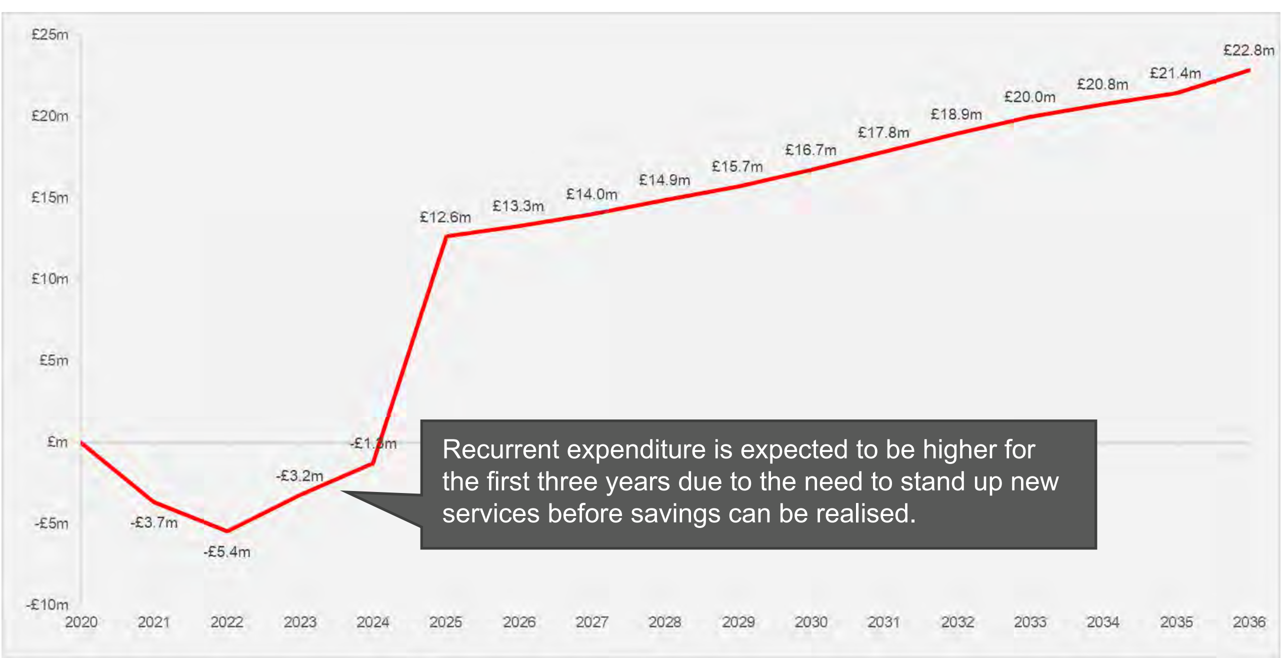
Overall, the changes are forecast to recurrently **reduce expenditure by £89.6m by 2036** as compared with the 'do nothing' scenario. Primarily these changes in expenditure relate to hospital-based services and social care. The growth in these gross financial impacts is shown in the following graph.

Figure 4.1: Recurrent gross financial impacts associated with the JCM



In order to deliver this gross financial impact, however, significant investments are required in alternative care settings. The total re-provision costs associated with the JCM have been estimated to grow to £66.8m by 2036. As a result of these additional costs, the net financial impact of the JCM is expected to be £22.8m by 2036 and the growth of this impact is shown in the graph below.

Figure 4.2: Recurrent net financial impacts associated with the JCM



In estimating the re-provision costs, it is important to note that an element of double running has been assumed between the new services and the current ones. In particular unless otherwise indicated through

implementation plans, it has been assumed that it will take 12 months from the implementation of the new service before the impacts of the JCM are fully delivered. It is expected that this assumption will be further developed as more detailed implementation plans are prepared for each of the changes proposed.

Further details on the impact of each of the proposed interventions are shown in the table below (the IDs in this table correspond to the more detailed change descriptions in tables 4.8 and 4.9).

Table 4.3: Net financial impact by intervention

ID	Intervention description	Gross financial impact in 2036 £m	Reprovision cost in 2036 £m	Reprovision costs/gross financial impacts[35]
1	Reduce ED attendances by 10%	(0.7)	0.5	67%
2	Reduce ED attendances age 65+ by 18%	(0.3)	0.5	162%
3	65% of remaining ED attendances go to the UCC, taken from non-urgent and standard activity	(2.3)	1.5	67%
4	Reduce JGH hospital admission rates by 17%	(15.5)	1.3	8%[36]
5	Reduce Physiotherapy outpatient activity by 100%	(1.9)	1.9	98%
6	Reduce Trauma and Orthopaedics outpatient activity by 23%	(0.6)	0.6	102%
7	Reduce ENT outpatient activity by 12%	(0.2)	0.1	68%
8	Reduce Ophthalmology outpatient activity by 7%	(0.2)	0.4	191%
9	Reduce Gastroenterology outpatient activity by 20%	(0.3)	0.1	24%
10	Reduce Gynaecology outpatient activity by 32%	(1.0)	0.5	44%
11	Reduce Community Dental Service outpatient activity by 90%, all in age under 12	(0.9)	2.4	252%
12	Reduce Dermatology follow-up appointments by 12%	(0.1)	<0.1	30%
13	Reduce Cardiology follow-up appointments by 32%	(0.3)	0.1	26%
14	Reduce Neurology follow-up appointments by 30%	(0.4)	0.1	32%
15	Reduce General Medicine follow-up appointments by 35%	(0.6)	0.5	80%
16	Reduce Thoracic Medicine follow-up appointments by 50%	(0.4)	0.2	55%
17	Reduction Podiatry Education outpatients by 100% (50% of total Podiatry outpatients)	(0.1)	0.1	70%
18	Reduce mental health bed days by 27%	(3.7)	0.3	7%
19	Reduce bed days by 65% for patients over 60 age with a length of stay of more than 7 days (excluding mental health)	(8.3)	2.3	27%
20	Reduce residential care placements by 70%	(32.7)	32.2	99%
21	Reduce residential care placements by 46%	(19.1)	10.4	55%
22	Introduction of a 24/7 multidisciplinary team (MDT)	-	2.6	
23	Additional intermediate care resources	-	6.1	
24	Additional Public Health expenditure	-	1.2	

[35] 100% in this column indicates an intervention where the re-provision costs are the same as the current service costs. More than 100% indicates interventions that will cost more than the current provision while less than 100% indicates interventions that will cost less.

[36] It is important to note that this reprovision cost is lower as a proportion of the gross impacts than may otherwise be expected. This is due to hospital admission benefits also partially being delivered through the investments set out in rows 22 to 26 of this table, which do not directly have benefits assigned to them.

ID	Intervention description	Gross financial impact in 2036 £m	Reprovision cost in 2036 £m	Reprovision costs/gross financial impacts[35]
25	Additional expenditure for an overnight registrar in ED	-	0.3	
26	Recurrent expenditure associated with capital investments	-	0.9	
	Total	**(89.6)**	**66.8**	**75%**

The impacts shown above have partially offset the growth in expenditure seen the 'do nothing' scenario, leading to the 'do something' scenario. Following implementation of the JCM, expenditure in the health and care system is estimated to be £22.8m lower by 2036. Further details on this revised expenditure can be seen in the table below.[37]

Table 4.4: Forecast expenditure growth ('do something' scenario)

Department	Description	2020 budgeted expenditure £m	2036 'do nothing' forecast expenditure £m	2036 'do something' forecast expenditure £m	% change compared to 'do nothing'
HCS	Scheduled secondary care	59.5	111.0	80.0	-28%
HCS	Clinical support services	35.0	63.5	63.5	-
HCS	Commissioning and partnerships	12.5	24.3	24.3	-
HCS	Mental health	22.6	45.6	41.9	-8%
HCS	Non-clinical support services	28.8	52.2	52.2	-
HCS	Primary care and preventions	11.4	22.7	34.0	50%
HCS	Social care	20.6	55.2	55.2	-
HCS	Unscheduled care	13.6	24.3	21.1	-12%
HCS	Women, children and family care	14.8	27.8	27.8	-
HCS	Other	15.3	30.6	37.5	23%
HCS	Sub-total expenditure	233.9	457.2	437.6	-4%
CLS	Health Insurance Fund expenditure	33.2	82.0	84.2	3%
CLS	Long Term Care fund expenditure	55.5	148.6	141.7	-5%
CLS	Sub-total expenditure	88.7	230.6	226.0	-2%
CYPES	Child and Adolescent Mental Health Services expenditure	3.3	6.9	6.9	-
SPPP	Additional Public Health expenditure	-	-	1.2	-
Patient/User Contributions	General Practice contributions	10.8	21.5	21.5	-
Multiple	Additional non-recurrent expenditure on COVID-19	41.5	-	-	-
Total		**378.3**	**716.3**	**693.4**	**-3%**

[37] The implementation costs detailed within the existing Intermediate Care business case (55% of the recurrent costs) have been factored into the revised 'do-something expenditure'. The remaining 45% of these costs have already been factored into the reprovision costs for the JCM interventions. In 2036 this amounts to £6.3m of expenditure and is captured within the HCS-Other line in Table 4.4.

In addition to the recurrent investments contained within the 'do something' financial modelling described above, a number of non-recurrent investments are also required. These fall into two main categories, which are as follows:

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

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

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

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

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

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

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

In total an investment of £17.0m is currently estimated to be required in order to deliver the JCM. More detailed work to refine the estimates associated with these non-recurrent costs should be undertaken following agreement to this SOC. This work should tailor the requirements within each of the categories above to the specifics of the JCM following the recommendations set out in the JCM Review.

Table 4.5b: Summary of cost and benefits for JCM

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

4.3 Assumptions

4.3.1 Introduction

The assumptions described in this section set out the basis for calculating each of the costs identified in section 4.1. They are broken down into the following categories:

1. **Assumptions associated with the 'do nothing' financial modelling:** These include assumptions relating to activity growth, inflation and fixed/semi-variable/variable costs.
2. **Assumptions associated with the 'do something' recurrent financial modelling:** These include the impact assumptions relating to each of the changes proposed within the JCM, including required re-provision costs associated with new service elements.
3. **Assumptions associated with the 'do something' non-recurrent financial modelling:** These include the assumptions used to estimate the programme costs and digital investment requirements.

4.3.2 Assumptions associated with the 'do nothing' financial modelling

Activity growth assumptions

The 'do nothing' cost projections are based on an increased growth in activity due to an aging population and net migration.

- Projected population year of age uses the latest demographic growth scenarios data provided by Statistics Jersey.
- The scenario used assumes net migration of +1,000 people per year, as this most closely resembles continuation of recent levels. Average annual net inward migration over the decade 2005 – 2015 was 900 persons per year, while net migration in 2013 to 2015 averaged 1,000 persons inward, each year. It is important to note that this assumption may need to be reviewed once the full impact of COVID-19 on the island's population is understood.
- Within this scenario, the population of Jersey is forecast to grow from just over 109,000 in 2020 to just over 130,000 by 2036.
- Modelling of demand growth makes the assumption that service usage patterns for each year of age remain the same as current patterns:

  - i.e. if there were 800 Emergency Department attendances per thousand 85 year olds in 2019 then there will be 800 Emergency Department attendances per thousand 85 year olds in 2065; however, the proportion of 85 year olds in the population will have grown.
  - This is in line with the assumption in the Disease Projections publication, which assumes that current patterns of disease prevalence will continue.

- The four mental health patients discharged in 2019 with length of stay over 5 years have been excluded as outliers.
- 80% of mental health patients have length of stay <10 weeks, and 96% have length of stay <1 year.
- These total demand projections currently include private patients. Private patients are included in the 'do nothing' growth assumptions, as these patients will still be using services, but excluded from JCM impacts under the assumption that the JCM will not affect these patients.

As a result of this modelling, some points of delivery (such as social care, which is predominantly accessed by an older population) are forecast to grow significantly more rapidly than others.

A breakdown of these growth rates by point of delivery can be seen in the table below. Further details on this growth for each year can be found in Appendix 4.

Table 4.6: Activity growth assumptions by point of delivery

Area	2020 activity	2036 activity	Unit	Average annual growth	Growth compared to 2020
Scheduled Care – Day Case Inpatient	9,935	12,448	Admissions	1.4%	25.3%
Scheduled Care – Elective Inpatient	8,114	10,170	Admissions	1.4%	25.3%
Scheduled Care – Non-Elective Inpatient	11,327	15,292	Admissions	1.9%	35.1%
Scheduled Care – Outpatient First	46,198	57,872	Appointments	1.4%	25.1%
Scheduled Care – Outpatient Follow-Up	161,338	204,737	Appointments	1.5%	26.7%
Unscheduled Care	39,460	48,638	ED attendances	1.3%	23.3%
Women Children & Family Care	1,100	1,285	Population: Age<1	1.0%	16.8%
Clinical Support Services	157,589	199,167	Hospital activity	1.5%	24.3%
Non-Clinical Support Services	157,589	199,167	Hospital activity	1.5%	24.3%
Primary Care & Prevention	331,016	412,209	GP visits	1.4%	24.5%
Mental Health	22,935	29,513	Appointments	1.6%	28.7%
Commissioning & Partnerships	109,180	130,053	Population	1.1%	21.3%
Social Care	475,403	795,385	Days claimed	3.3%	67.3%
Other	157,589	199,167	Hospital activity	1.5%	24.3%

Cost assumptions

In addition to the above activity growth assumptions, the following assumptions relating to costs have been used in order to inform the ‘do nothing’ scenario:

1. **Cost inflation** has been assumed to be 3% per annum, for both pay and non-pay for the entire modelling period.
2. **Marginal cost assumptions:** In undertaking the modelling, it has been assumed that any increase/decrease in activity will cause both variable and semi-variable costs to increase/decrease by the same proportion. Fixed costs are assumed not to change in response to changes in activity. It should be noted that, particularly for the semi-variable cost elements described above (i.e. staff costs), the above will only be true in the medium term.
3. The distribution of **fixed/semi-variable/variable** costs from the PLICS data are applied uniformly across pay/non-pay costs from the HCS budget.
4. **Semi-variable cost:** An assumption has been made that in the long run 50% of the semi variable costs will be variable costs and the remainder will be fixed costs.

Further details on the distributions of fixed, semi-variable and variable costs by point of delivery are shown in the table below.

Table 4.7: Fixed and semi-variable/variable costs proportions by point of delivery

Department	Area	Point of delivery/description	Fixed cost %	Semi-variable cost%	Variable Cost%
HCS	Scheduled secondary care	Day case admissions	6%	81%	13%
HCS	Scheduled secondary care	Elective admissions	5%	71%	24%
HCS	Scheduled secondary care	Non-elective admissions	6%	85%	8%
HCS	Scheduled secondary care	Regular day admissions	5%	60%	36%
HCS	Scheduled secondary care	Outpatient first attendances	8%	76%	16%
HCS	Scheduled secondary care	Outpatient follow-up attendances	7%	68%	25%
HCS	Scheduled secondary care	Outpatient procedures	7%	77%	16%
HCS	Clinical support services	All	6%	79%	15%
HCS	Commissioning and partnerships	All	0%	0%	100%
HCS	Mental health	All	8%	73%	19%
HCS	Non-clinical support services	All	6%	79%	15%
HCS	Primary care and preventions	All	100%	0%	
HCS	Social care	All	0%	10%	
HCS	Unscheduled care	All	5%	89%	6%
HCS	Women, children and family care	All	0%	0%	100%
HCS	Other	All	0%	0%	100%
CLS	Health Insurance Fund expenditure	All	0%	0%	100%
CLS	Long Term Care fund expenditure	All	0%	0%	100%
CYPES	Child and Adolescent Mental Health Services expenditure	All	0%	0%	100%
CYPES	Other Children's Services expenditure	All	0%	0%	100%
SPPP	Additional Public Health expenditure	All	0%	0%	100%
Patient/User Contributions	General Practice contributions	All	0%	0%	100%

4.3.3 Assumptions associated with the 'do something' recurrent financial modelling

Impacts associated with the JCM

The financial modelling currently contains 21 interventions and for each of these, there is both an impact on the current care setting and on the new care setting.

The following two tables detail the impact associated with each of these interventions. It is important to note that the ID numbers associated with the changes are consistent between the two tables, i.e. the additional services to be provided under ID 3 in table 4.9 are the ones required in order to deliver the impact shown under ID 3 in table 4.8.

Table 4.8: Impacts in current care settings

ID	Area/point of delivery/description	High level description of the change to the current care setting	Assumed impact on current activity	Activity impact in current care setting %
1	Unscheduled care	Move some ED activity to primary care	Reduce ED attendances by 10%	10%
2	Unscheduled care	Reduce ED attendances for other reasons age 65+	Reduce ED attendances age 65+ by 18%	18%
3	Unscheduled care	Divert some remaining ED activity to a new UCC	65% of remaining ED attendances go to the UCC, taken from non-urgent and standard activity	65%
4	Scheduled secondary care (all)	Reduce hospital admission rates	Reduce JGH hospital admission rates by 17%	17%
5	Outpatient appointments (all)	Reduce physiotherapy outpatients	100% reduction in physiotherapy outpatient activity	100%
6	Outpatient appointments (all)	Reduce Trauma and Orthopaedics outpatients	Reduce Trauma and Orthopaedics outpatient activity by 23%	23%
7	Outpatient appointments (all)	Reduce ENT outpatients	Reduce ENT outpatient activity by 12%	12%
8	Outpatient appointments (all)	Reduce Ophthalmology outpatients	Reduce Ophthalmology outpatient activity by 7%	7%
9	Outpatient appointments (all)	Reduce Gastroenterology referrals	Reduce Gastroenterology outpatient activity by 20%	20%
10	Outpatient appointments (all)	Reduce Gynaecology outpatients	32% reduction in Gynaecology outpatient activity	32%
11	Outpatient appointments (all)	Move Community Dental Service outpatients to community dental practices	Reduce Community Dental Service outpatient activity by 90%, all in age under 12	90%
12	Outpatient follow-up appointments	Reduce Dermatology follow-up appointments	Reduce Dermatology follow-up appointments by 12%	12%
13	Outpatient follow-up appointments	Reduce Cardiology follow-up appointments	Reduce Cardiology follow-up appointments by 32%	32%
14	Outpatient follow-up appointments	Reduce Neurology follow-up appointments	Reduce Neurology follow-up appointments by 30%	30%
15	Outpatient follow-up appointments	Reduce General Medicine follow-up appointments	Reduce General Medicine follow-up appointments by 35%	35%
16	Outpatient follow-up appointments	Reduce Thoracic Medicine follow-up appointments	Reduce Thoracic Medicine follow-up appointments by 50%	50%
17	Outpatient follow-up appointments	Move Podiatry Education outpatients to the community	Reduction Podiatry Education outpatients by 100% (50% of total Podiatry outpatients)	50%
18	Scheduled secondary care (Adult mental illness)	Reduce mental health average length of stay to Getting It Right First Time (GIRFT) target of 34.6 days	Reduce bed days by 27%	27%

ID	Area/point of delivery/description	High level description of the change to the current care setting	Assumed impact on current activity	Activity impact in current care setting %
19	Scheduled secondary care (All specialties other than adult mental illness)	Reduce length of stay for stranded patients (>7 days) by the equivalent of up to 25 beds (the average used by delayed medically fit patients)	Reduce bed days by 65% for patients over 60 age with a length of stay of more than 7 days (excluding mental health)	65%
20	Social care (Residential care)	Reduce care home placements to England 3rd quartile	Reduce residential care placements by 50%	50%
21	Social care (Residential care)	Reduce care home placements to England 3rd quartile	Reduce residential care placements by 46%	46%

Table 4.9: Additional expenditure required in the new care setting

ID	Area/point of delivery/description	High level description of the additional expenditure required in the new care setting	Activity conversion	Unit cost per activity unit (£)
1	Primary care and prevention	Additional General Practice appointment	100%	59
2	Primary care and prevention	Seen by a rapid response team	100%	157
3	Primary care and prevention	UCC attendance	100%	52
4	Primary care and prevention	70% of activity: 2x weekly occupational therapy visits, 3x weekly physiotherapy visits + 3x daily domiciliary care/rehab support worker visits + 1 community nurse visit per 2 days + 1x daily social worker visit 30% of activity: replace with intermediate care/step down bed	25%	389
5	Primary care and prevention	Additional Community Physiotherapy appointment	100%	37
6-7	Primary care and prevention	Additional General Practice appointment	100%	52
8	Primary care and prevention	Additional Community Ophthalmology appointment	100%	145
9-10	Primary care and prevention	Additional General Practice appointment	100%	52
11	Primary care and prevention	Additional Community Dentist appointment	100%	147
12-16	Primary care and prevention	Additional General Practice appointment	100%	52
17	Primary care and prevention	Additional Community Podiatrist appointment	100%	37
18	Primary care and prevention	1 additional Mental Health professional visit per 3.5 bed days reduced	29%	49
19	Social care	35% 3x daily domiciliary care/rehab support visits 30% replace with care home days 20% 1x social worker visit 15% replace with intermediate care/step down bed	100%	101

ID	Area/point of delivery/description	High level description of the additional expenditure required in the new care setting	Activity conversion	Unit cost per activity unit (£)
20	Social care	3x daily visits by domiciliary care/rehab support worker 1 community nurse visit per 2 days	100%	97
21	Social care	3 x daily visits by domiciliary care worker	300%	75

Other JCM impact assumptions

The following additional JCM impact assumptions have been made in order to complete the financial modelling for this SOC for implementation:

- Impact associated with interventions has been phased evenly over a five-year period from 2021 to 2025 based on the proposed tranche of each intervention in the implementation plan.
- The average cost of a bed day when these are released without removing the preceding admission has been assumed to be £260 in line with the England average.
- Twelve months of double running costs have been assumed for any element of re-provision costs. This means that the care elements described in Table 4.9 are built into the financial modelling twelve months earlier than the impacts described in Table 4.8.

4.3.4 Assumptions associated with the 'do something' non-recurrent financial modelling

Programme costs

Programme costs have been estimated top down based on expenditure on the Stockport Together programme[38], which similarly worked to transform the model of care across a health and care economy and contained the key features set out in section 4.1.4.

The costs of this programme were £8.5m per year for a population of 301,000. This has been scaled for Jersey's population and is assumed to be required for the five years from mid-2020 to mid-2025. This has further been reduced by one third following a comparison of the requirements of the two programmes.

Estates capital investment

It is important to note that this SOC does not describe the capital investment associated with Jersey's new hospital/health campus. These are detailed separately in the 'Our Hospital' SOC. As a result, no capital expenditure associated with the JCM has been included in this Financial Case.

Digital capital investment

The changes proposed in the JCM will be enabled through a series of digital investments. These have been worked up in detail for the period between 2021 and 2024 and include cost estimates for schemes which include core record systems, integrated care records, hub and micro services, and analytics. These one-off costs have been estimated to be £4.3m over the four-year period. There are additional recurrent costs of around £0.5m per annum, which result in a total investment cost of £10.7m over the period. The modelling assumes the rate of recurrent costs assumed in this (once adjusted for inflation) continue through to 2036.

[38] Further details on the costs of this programme can be found at: The health Foundation, Making change possible: a Transformational Fund for the NHS, https://www.kingsfund.org.uk/sites/default/files/field/field_related_document/appendix-2-making-change-possible-a-transformation-fund-for-the-nhs-jul15.pdf

4.4 Funding options

4.4.1 Funding options in the ‘do nothing’ scenario

In the ‘do nothing’ scenario, income growth has been forecast in line with projections from the Government Plan (assuming consistent growth for 2024 and beyond). In these projections system-wide income is forecast to grow from £397m (£355m plus £42m of non-recurrent funding for COVID-19) in 2020 to £541m by 2036.

These forecasts demonstrate that, if the system were to make no changes to the care model and excluded non-recurrent expenditure on COVID-19, expenditure on the HCS department will grow from £234m in 2020 to £457m in 2036 (as shown in section 4.1). This compares to an income forecast of £333m for 2036 and leads to a £125m funding pressure even if GoJ continues to increase HCS allocations in line with projections in the Government Plan and no efficiencies are delivered.

There are also likely to be similar pressures in other departments including on the following relevant areas:

- **Customer and Local Services:** The Long Term Care (LTC) fund and, to a lesser extent, the Health Insurance Fund (HIF) are forecast to face financial pressures totalling £48m by 2036 as expenditure grows faster than income.
- **Children, Young People, Education and Skills:** Child and Adolescent Mental Health Services are forecast to have a financial pressure of over £2m by 2036 (more than a third of the total expenditure in that year).

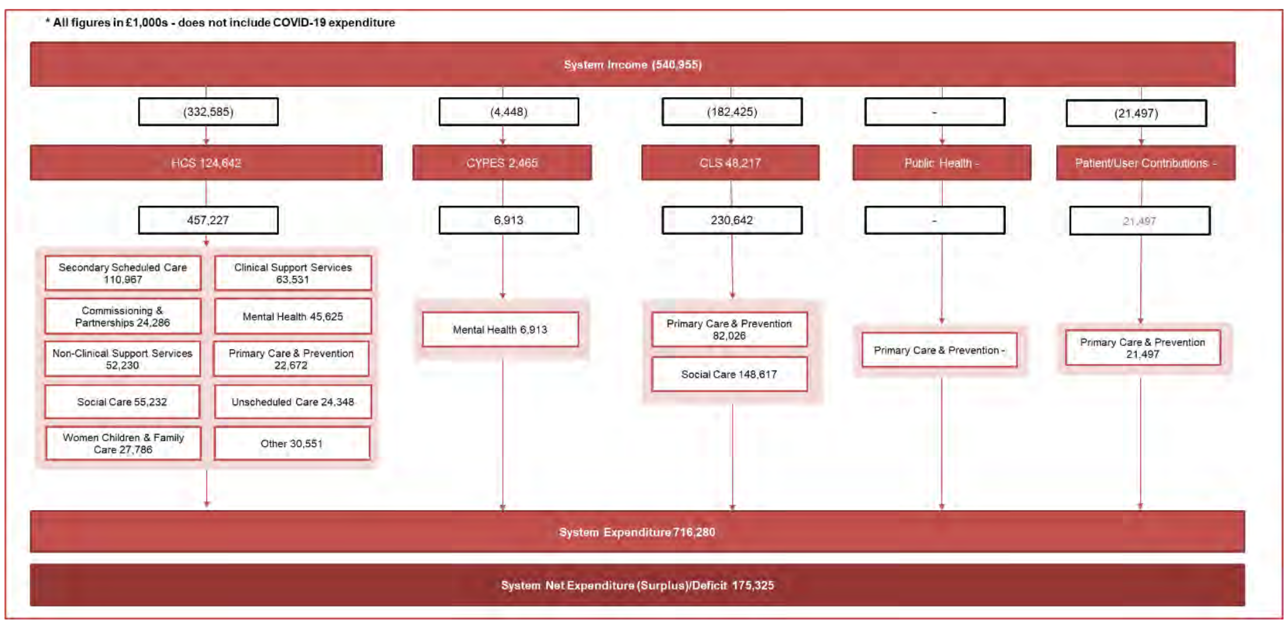
In total, these income and expenditure movements lead to a worsening of the health and care system’s position of £194m from a net surplus of £18m in 2020 to a deficit of £175m by 2036. This is summarised in the following table.

Table 4.10: Income and expenditure over time ('do nothing' scenario)

Department	Department	2020 budgeted (income)/ expenditure £m	2036 forecast (income)/ expenditure £m	% increase from 2020 to 2036
Expenditure	Health and Community Services	233.9	457.2	95%
	Customer and Local Services	88.7	230.6	160%
	Children, Young People, Education and Skills	3.3	6.9	106%
	Strategic Policy, Planning and Performance	-	-	-
	Patient/User Contributions	10.8	21.5	99%
	Additional Non-Recurrent COVID-19 Expenditure	41.5	-	(100%)
	Total expenditure	**378.3**	**735.7**	**89%**
Income	Health and Community Services	(233.9)	(332.6)	42%
	Customer and Local Services	(106.9)	(182.4)	71%
	Children, Young People, Education and Skills	(3.6)	(4.4)	25%
	Strategic Policy, Planning and Performance	-	-	-
	Patient/User Contributions	(10.8)	(21.5)	99%
	Additional Funding for COVID-19 Expenditure	(41.5)	-	(100%)
	Total income	**(396.7)**	**(541.0)**	**36%**
(Surplus)/deficit	Health and Community Services	(0.0)	124.6	
	Customer and Local Services	(18.2)	48.2	
	Children, Young People, Education and Skills	(0.2)	2.5	
	Strategic Policy, Planning and Performance	-	-	
	Patient/User Contributions	-	-	
	Additional Non-Recurrent COVID-19 Expenditure	-	-	
	Total	**(18.4)**	**175.3**	

This leads to flows of funding in the 'do nothing' scenario as shown in the network of spend diagram below.

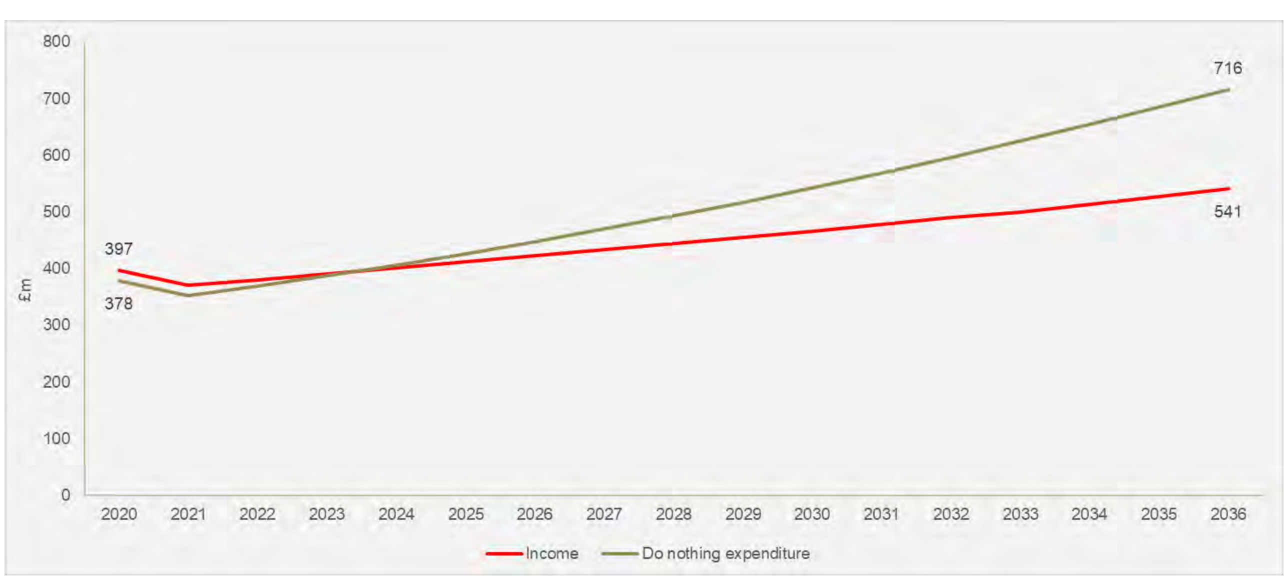
Figure 4.3: Network of spend in 2036 in the 'do nothing' scenario



All figures in £1,000s

The development of this financial challenge over time is shown in the graph below with the full year by year financial challenge provided in Appendix 4.

Figure 4.4: Income and expenditure over time ('do nothing' scenario)



Where other health and care economies have faced similar financial challenges and not made significant changes to their care model, these challenges have had to be managed through one or more of the following approaches:

- **Increased funding** of health and care services by the Government of Jersey (either through reallocation of funding from other public services or increased taxation).

- **Increased efficiencies** within the current care model, i.e. the existing health and care staff base seeing an increasing number of patients. In this case, these efficiencies would need to be significantly greater than those historically achieved in Jersey or other similar health and care systems.
- **Constraining demand for services**, including measures such as rationing of access to specific groups within the population.

4.4.2 Funding options in the 'do something' scenario

In the 'do something' scenario, there are forecast to be significant reductions in expenditure as set out in section 4.1. However, income is forecast to remain the same as in the 'do nothing' scenario and, as a result, the affordability challenge in 2036 reduces to £152.5m. Full details on the breakdown of this financial challenge by the departments that make up the health and care system are shown in the following table.

Table 4.11: Income and expenditure over time ('do something' scenario)

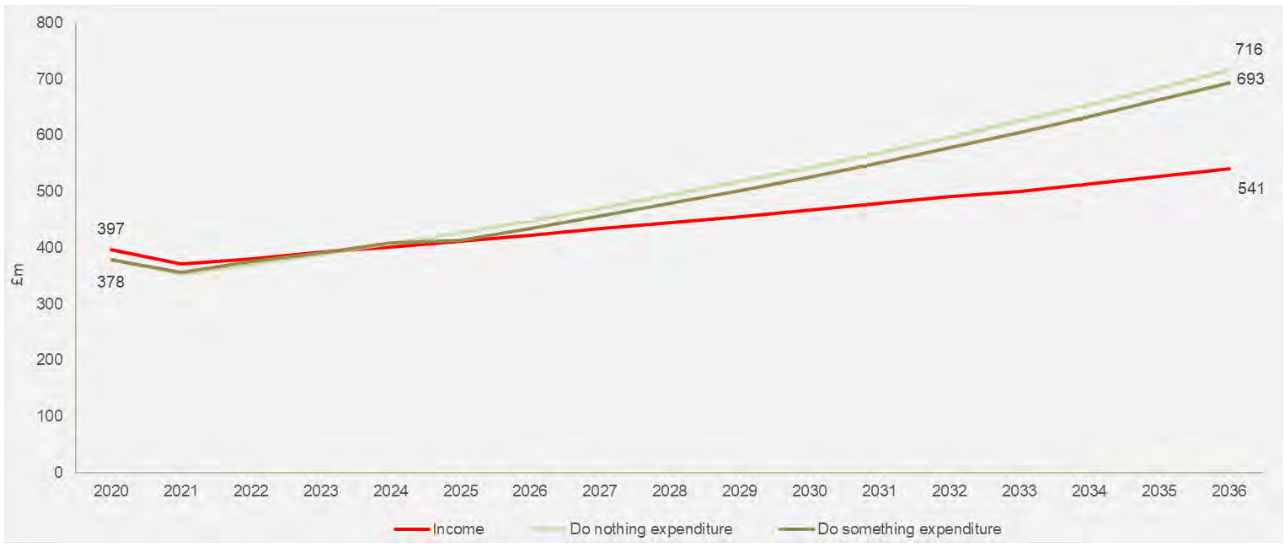
Department	Department	2020 budgeted (income)/ expenditure £m	2036 forecast (income)/ expenditure £m	% increase from 2020 to 2036
Expenditure	Health and Community Services	233.9	437.8	87%
	Customer and Local Services	88.7	233.1	162%
	Children, Young People, Education and Skills	3.3	6.9	106%
	Strategic Policy, Planning and Performance	-	1.2	-
	Patient/User Contributions	10.8	21.5	99%
	Additional Non-Recurrent COVID-19 Expenditure	41.5	-	(100%)
	Total expenditure	**378.3**	**693.4**	**83%**
Income	Health and Community Services	(233.9)	(332.6)	42%
	Customer and Local Services	(106.9)	(182.4)	71%
	Children, Young People, Education and Skills	(3.6)	(4.4)	25%
	Strategic Policy, Planning and Performance	-	-	-
	Patient/User Contributions	(10.8)	(21.5)	99%
	Additional Funding for COVID-19 Expenditure	(41.5)	-	(100%)
	Total income	**(396.7)**	**(541.0)**	**52%**
(Surplus)/deficit	Health and Community Services	(0.0)	105.0	
	Customer and Local Services	(18.2)	43.6	
	Children, Young People, Education and Skills	(0.2)	2.5	
	Strategic Policy, Planning and Performance	-	1.2	
	Patient/User Contributions	-	-	
	Additional Non-Recurrent COVID-19 Expenditure	-	-	
	Total	**(18.4)**	**152.5**	

In order to close the residual gap of £152.5m, further efficiencies will be required by 2036. In the intervening years, however, the health and care system will be considerably more sustainable as shown in the year by year breakdown of this position in Appendix 4.

In particular, the system is forecast to operate at a net surplus until 2024 before further cost reductions or investments are required. The efficiencies will need to reduce expenditure by c. 1.8% per year, which is in line with the levels delivered in other similar health and care economies.

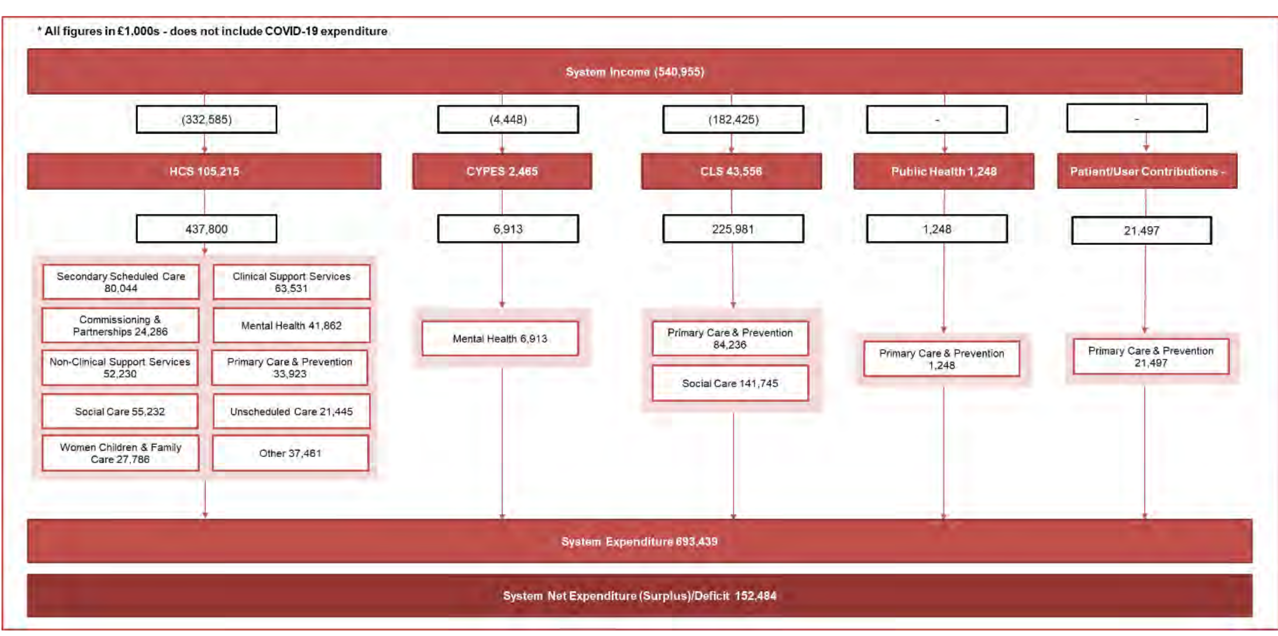
The revised income and expenditure positions for the system over time are shown in the graph below.

Figure 4.5: Income and expenditure over time ('do something' scenario)



This leads to flows of funding in the 'do nothing' scenario as shown in the network of spend diagram below.

Figure 4.6: Network of spend 2036 in a 'do something' scenario



All figures in £1,000s

5 The Management Case

5.1 Project Governance

The multi-year programme of work required to transform services from secondary focussed services to community provision will require strong management and governance. Fundamental to this work is the development of a governance structure that supports the implementation of a care model that is fit for purpose. To fully integrate services a governance structure needs to be highly coordinated and involve all parties working towards a common purpose.

This SOC outlines the governance structures which will be used to oversee future delivery of the JCM. Clear roles and responsibilities within the framework will allow for the smooth functioning of systems. Essential to this is clarity on who is involved in decision-making and where responsibility lies. This management case outlines the governance structure of the JCM and how roles will function alongside one so that the model is effective in providing a modern, community based care model. The governance for the JCM will run in parallel to the governance for Our Hospital Project. Both governance structures will feed into the overarching joint programme governance.

5.1.1 Lessons learned from best Practice Programme Management

Programmes often fail when they get the basics wrong. A programme should be clearly aligned to an organisation's strategy with effective planning from the outset; poor estimates in the planning phase are a common reason for project failure.[39] These can include poorly defined goals and objectives, changes in scope mid project, and insufficient resources. A lack of strong leadership and teamwork can also lead to failure to successfully deliver change.

Best practise involves enabling people to deliver change by giving them the right resources, training and tools. Engagement between executive teams and those delivering the programme will improve the results of the programme. A fast and flexible approach is also key to delivering effective change programmes in the times of rapid change; the recent and developing experience of COVID-19 has demonstrated the necessity for structures which allow for clear decision making as plans change. Finally, a successful programme will measure progress throughout, identifying key risks and issues as they arise in order to change course when needed. The NHS has a specific framework for managing improvement projects. Their approach includes six key stages: Start Out, Define & Scope, Measure & Understand, Design & Plan, Implement, and Handover & Sustain.[40] This approach follows standard good practice in programme management and while the content of programmes may vary, having a consistent, recognised structure from initiation to completion which allows for efficient planning and management is essential to ensure the goals of the JCM are met successfully for Islanders. The JCM is currently moving towards through the detailed design and planning phase and towards the implementation phase.

5.1.2 Governance Arrangements

Governance has been established to provide oversight (including clinical oversight) over the JCM review and this will continue through implementation.

There are four key oversight groups that were established as a part of the JCM Review programme to provide input, review, challenge and oversight:

- Integrated Care System Leadership Team (formerly the JCM Steering Committee): formed to provide strategic leadership, direction and overall decision-making capability for the JCM review.

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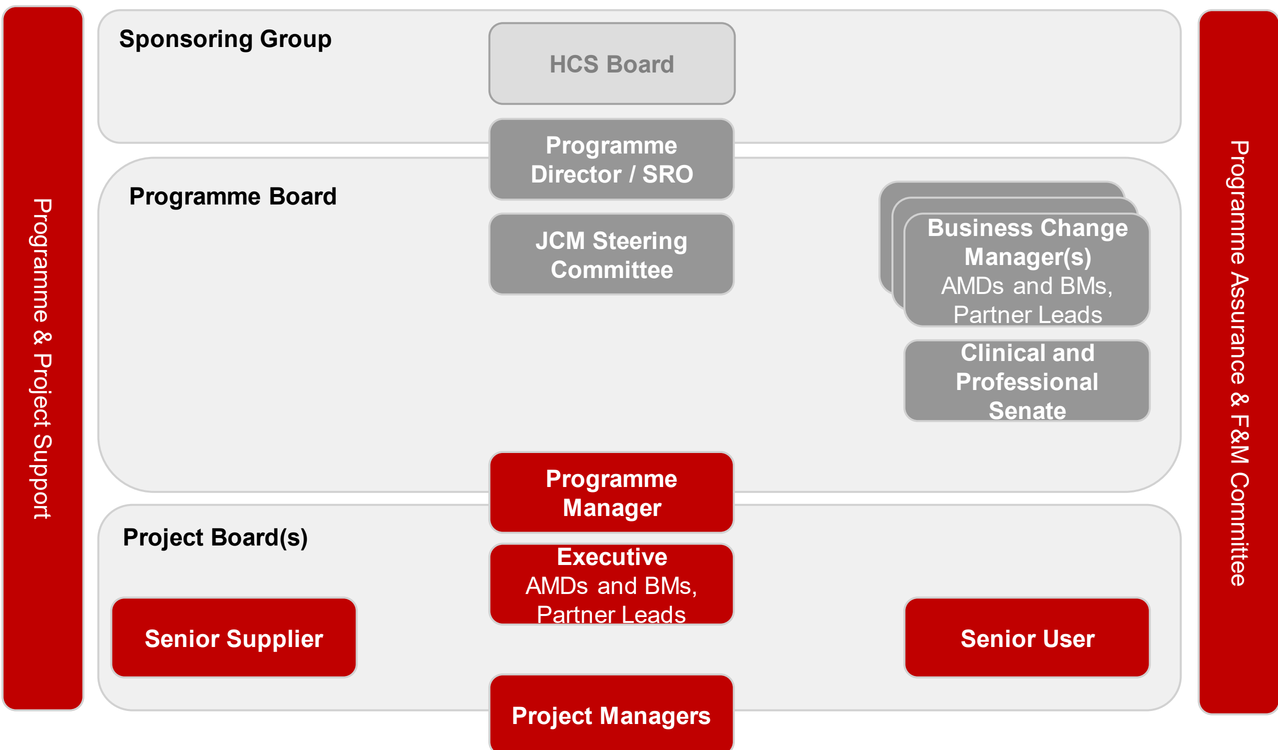
[39] PwC, 4th Global Portfolio and Programme Management Survey, September 2014, https://www.pwc.ch/en/publications/2017/global-ppm-survey.pdf

[40] NHS Improvement, Project Management – An Overview, https://improvement.nhs.uk/documents/2147/20190501_project-management-overview.pdf

- Clinical and Professional Senate: provided strategic oversight and recommendations on the outputs of the JCM review. It is proposed that the Senate will continue to make decisions regarding the implementation and delivery of the JCM beyond the completion of the review.
- Technical Group: created to oversee data analytics, modelling and provide decision-making capability in relation to quantitative analysis.

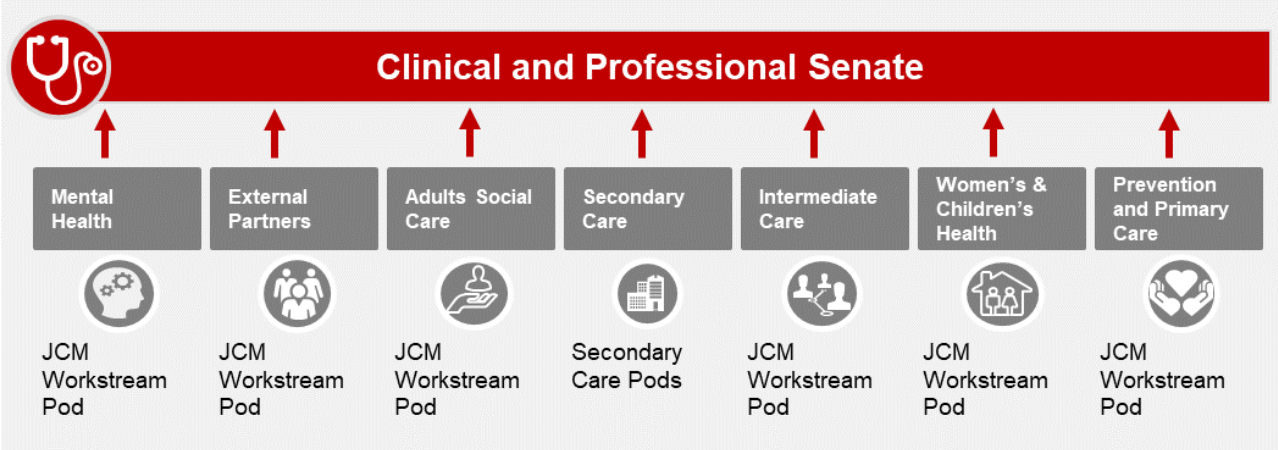
These groups will continue as part of the implementation of the programme.

Fig 5.1: JCM Governance Structure (draft)



The JCM Workstream pods are groups split up by workstream, as defined in the JCM. The groups provided input into the context of the JCM and supported testing of the model, and a decision is to be made as to whether this is the correct mechanism to continue to enable robust clinical challenge as the model develops and is implemented.

Fig 5.2: JCM workstream structure



5.2 Project Plan, Performance and Risks

As part of implementation, HCS will need to implement a formal PMO to manage reporting and risks. This will use MSP Project Methodology with a project team consisting of a Senior Responsible Office, a Programme Manager and specialist resources to implement the JCM.

Reporting from the PMO will align with the governance structure set out above. The timing and frequency or reports will be set out in a programme initiation document at the start of the programme but should include:

- Regular highlight reports
- Risk and issues registers
- Financial reporting against budget

5.2.1 Project Plan & Milestones

Implementing the JCM will be a complex, multi-year transformation, which requires a rigorous portfolio management approach. The changes to current care delivery set out in the JCM are across numerous different workstreams, with wider, cross-cutting changes to enabling functions such as digital, estates and workforce. Such a complex programme of change requires a rigorous portfolio management approach in order for the vision set out in the JCM to be achieved and for the desired benefits to be seen by staff, stakeholders and service users alike.

A high level implementation plan has been developed in which key priorities has been shaped into projects and programmes. The next step is to begin the detailed planning phase in which prioritised projects will require a Project/Programme Initiation Document (PID), setting out its scope, governance and outcomes.

As part of the JCM review, indicative costs associated with implementing the JCM have been provided across workstreams, but further work will be needed to fully cost up the delivery of the proposed changes to the care model through individual programmes and projects.

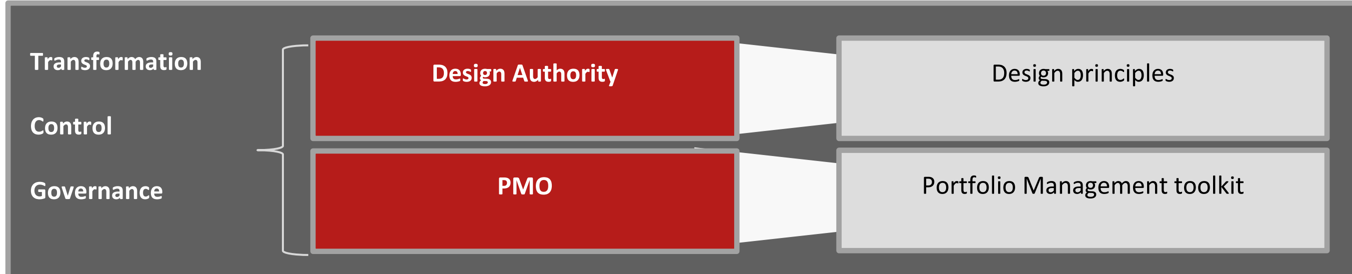
Establishing a PMO

An agile but coordinated portfolio approach to delivering change is needed. Setting up and maintaining a central Portfolio Management Office (PMO) will be central to this.

The PMO will not only weigh up priorities and coordinate activities but should provide education to the people running JCM projects, enabling a consistent approach across the health and care system. During the review, great enthusiasm for the new care model was demonstrated, but this needs to be harnessed and channelled through a coordinated, stepped approach to change.

Robust transformation control governance will also need to be in place. A design authority with a clear vision for the future state who make sure that the portfolio of change holds to a set of clearly defined design principles, is an important starting point for strategic oversight, alongside the PMO overseeing day to day activity.

Fig 5.3 Transformation control governance



Programme management costs are included in the implementation costs and include the costs for not just the PMO, but also the programme costs required to make the implementation of the JCM a success, including Organisational Development (OD) programmes, communications, and digital transformation subject matter expert(s).

Table 5.1: Programme costs including PMO and OD programme

Description (£m)	2020	2021	2022	2023	2024	2025	Total
Programme costs	-	2.1	2.1	2.1	2.2	2.2	**10.6**

5.2.1 Project Plan & Milestones

A detailed five year programme plan has been developed in order to reach the point where there is a fully developed and operational new care model. The programme plan is split across the multiple workstreams of the JCM (i.e. the care areas) with five enabling workstreams. Due to the stage of development that this programme is at, the most significant milestones are to obtain sign off and a go/ no go decision. In order to achieve this there are two major milestones to meet in coming months.

Table 5.2: Key milestones for sign off process

Date	Milestone
June	Debate in assembly
November	Government plan and funding decisions

As a part of the JCM review, 16 key workstreams of effort were identified for which key efforts should be focused toward. Note that these are not exhaustive, and the grouping of them is subject to change as the programme develops.

The JCM review found that while there is momentum behind the programme, for the JCM to be successful a phased transition is proposed given the scale of change. Therefore a prioritisation exercise was completed in the development of the Implementation plan identifying schemes and then prioritising them.

The total list of schemes were identified through the process outlined in Figure 5.4. Objectives outlined in the JCM paper and the JCM Review were collated to form the ‘JCM objectives. In order to meet the JCM objectives, schemes were developed through a number of opportunity channels, including schemes developed in response to COVID-19, and a gap analysis assessment of current state and the future JCM. A list of 237 schemes were identified and ratified by HCS Executive Team for transformation of the current healthcare system to the future state JCM.

Fig 5.4: JCM scheme collation methodology

Scheme collation methodology

JCM Briefing Paper
The JCM changes outlined for workstreams (Oct19)

JCM Review
The additional recommendations for workstreams and identification of enablers (May20)

JCM objectives
Workstream changes, additional recommendations and enabler recommendations from the JCM and JCM Review were collated to form objectives for the transformation of current services to meet the proposed state of the JCM

Covid-19 schemes
Schemes developed in response to Covid-19

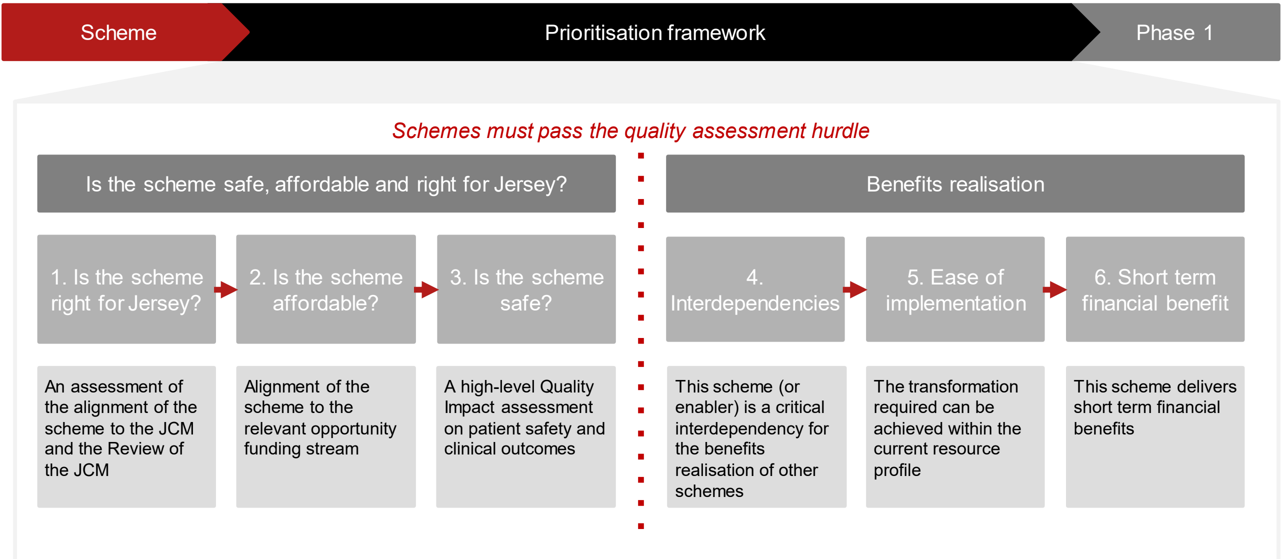
Gap analysis
Gap analysis assessment of the current state and the proposed future state of the JCM

Schemes

Using the schemes listed in Covid-19 schemes and gap analysis assessments, schemes were developed to take the services from the current state to the JCM future state

The schemes were appraised through the prioritisation framework whereby quality, safety and benefits realisation were assessed in order to validate that the proposed schemes are suitable for implementation, and which schemes would be selected and targeted for the Phase 1 (first 12 months) of implementation. The approach is outlined in Figure 5.5. This narrowed a list of schemes to 67 for Phase 1. Of the 67, 44 related to directly to clinical pathways, and 23 to supporting functions, system or 'enablers'.

Fig 5.5: JCM prioritisation framework for implementation



A supporting Implementation plan, including mapping of schemes to JCM objectives, financial models (per the Financial case) and interdependencies were recorded.

5.2.2 Tranche approach in response to COVID-19 to support deliverability

In developing a realistic and achievable implementation plan we reviewed the deliverability of the JCM. In light of the emerging challenges the island is facing post COVID-19, phasing of the programme has been amended to allow stabilisation of the platform within Jersey and internationally with the roll out of programme phased in 3 risk assessed tranches outlined in Figure 5.6.

Fig 5.6: JCM prioritisation framework for implementation

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

These tranches are still in line with the key areas as identified within the independent review, of which a summary of key areas of focus is outlined in Table 5.3. As noted, the areas of focus upfront are targeted at detailed planning to establish the foundations of the JCM, and clear communication of the programme progress and changes, to islanders and staff.

Table 5.3: Priorities for implementation

	Immediate priority	Key activities following	Initial outcomes sought
Clinical care models	• Prioritisation of clinical areas for progress/implementation • Integrate JCM with public health plans in GoJ	• Develop clinical pathways for key 'cohorts' across the system (e.g. aged, long term conditions) • Implement quick wins	• Strengthened wellness/self-care model in partnership with GoJ Public health • Clinical priorities agreed with change in care delivery seen in alignment with JCM
Operating model	• Draft the target operating model and supporting functions and services across workstreams and enablers	• Identification of capabilities required for operating model • Detailed design of digital front door in first instance	• Detailed design of all key cross-cutting operating model functions
Quality improvement and innovation	• Assessment of existing quality improvement model	• Consider alternative models to promote innovation and support funding schemes • Refine quality improvement model	• Agreed continuous quality improvement model in place • Innovation programme identified and launched
Business intelligence (incl. Population Health Management (PHM))	• Understand current datasets (including supporting governance arrangements) • Engagement on leading indicators to identify rising risk individuals	• Develop strategy for PHM including associated governance requirements • Develop a data strategy • Consider different PHM systems	• Agreed PHM approach and preferred model • Data strategy in place • Ability to progress to contracting for PHM system

	Immediate priority	Key activities following	Initial outcomes sought

IT and digital	• Understand existing IT requirements from the JCM interventions proposed including:
	  ○ Jersey Care Record
	  ○ Performance monitoring
	  ○ Outcomes
	  ○ Understand digital requirements for JCM and new digital opportunities
		• Understand requirements for digital front door and bookings
		• Outline of system requirements and initial market sounding for IT partners
		• Digital strategy refreshed
		• Prioritisation of digital initiatives completed with a focus on flexible solutions which can be adapted to the rapidly changing landscape
			• IT and Digital strategy in place
			• Understanding of IT and digital requirements for the system
			• Market sounding for partners in place in line with Our Hospital work

Finance	• Detail modelling on one-off costs (fully costed and put into modelling) • Refine the impact of the Our Hospital specification • Refine the modelling and activity profiles	• Consider funding models proposed • Model designed for financial management including principles, rules regarding pooling budgets and capitated contracts • Governance arrangements for financial oversight and monitoring developed and transition plan in place	• Refined modelling completed • Primary care funding model agreed with transition plan in place • Financial management approach developed
Workforce	• Consolidate workforce data • Identify workforce including non-health • Develop workforce plan/strategy and business plan for the provision of 24-hour cover	• Design new roles across system • Develop external partnership model • Recruitment planning for new models	• Workforce assessment, gap analysis completed • Defined key roles in place (incl. new positions)
Estates	• Complete estate profile and gap analysis	• Estate plan developed with plans for existing secondary and community estate	• Estate plan in place fed into Our Hospital and phasing
Human resources	• Identify team to support design / implementation (incl. project managers, clinical input, learning and development teams) • Recruit team (dedicated PMO, clinical and workstream leads)	• HR/IR plan developed based on workforce requirements (including joint teams, external partners) • Work with regulatory / registration bodies on needs for JCM • Design strategic HR function	• Resource arrangements in place for implementation • HR plans in place to support new ways of working
Strategic planning	• Refresh of the Jersey Joint Strategic Needs Assessment • Identify potential non-hospital/non-health workforce in alignment with GoJ Public Health strategy • Identify areas of opportunity to strategically partner in JCM	• Strategic plan refresh of Our Hospital as a part of the hospital/precinct build • Develop plan for strategic partnerships with other systems (e.g. Guernsey, France, UK systems) • Engage with non-health and care professionals with strategy for broader care model	• Clarity on strategic needs and target at risk individuals • Expanded plan relating to whole of Jersey approach to health and care • Alignment of JCM with Our Hospital programme • Clarity on target strategic partners (incl. other systems)

	Immediate priority	Key activities following	Initial outcomes sought
Governance (incl. PMO)	• Identify resource requirements for JCM implementation/oversight • Develop programme plan • Develop reporting and oversight functions	• Identify governance needs for JCM and develop proposed model • Identify governance role for external partners including strategic partners in future JCM	• Governance and associated groups and roles are clear and aligned with existing arrangements
Commissioning	• Agree on primary care model and develop proposal with partners • Agree on outcomes for commissioning • Assess gap on commissioning framework and key areas requiring detailed design	• Refine commissioning arrangements for primary care model • Detailed commissioning framework design incl. strategic commissioning function • Work with external partners on commissioning arrangements	• Strategic commissioning function agreed • Plan in place to shift to new commissioning model in pilot areas
Change management (incl. L&D)	• Assessment of change areas (including scoring severity) and workforce, service users and carers	• Assess capability gaps (skills) in workforce, service users and carers • Develop change management plan to transition to a new business-as-usual • Learning and development plans developed in key priority areas in first instance	• Key staff and service users understand impact of JCM • Staff and service user learning and development plans developed
Community engagement and communications	• Communication of the outcome of Review and the next steps	• Develop communication plan in line with the overarching programme plan	• Key stakeholders are aware of the key developments of the JCM

5.2.3 Performance Measurement Plan

The Government of Jersey has commissioned an independent review of the feasibility of the JCM. The review has been built on integrated care system examples, clinical and operational insight provided by Pod members, and benchmarking analysis. The scope of this review is to:

- Assess the feasibility of changes proposed in the JCM against a framework
- Inform analysis and test JCM recommendations against best practice

The review will be delivered at the end of March, which will include recommendations by workstream. There will be a further technical appraisal which will run until June.

The following benefits have been identified as part of the review:

Table 5.4: Benefits of JCM

Number	Benefit
Benefit 1	Increase CT examination capacity
Benefit 2	Move some ED activity to primary care
Benefit 3	Reduce ED attendances through co-located mental health services
Benefit 4	Reduce child ED attendances
Benefit 5	Reduce ED attendances for falls age 65+
Benefit 6	Reduce ED attendances for other reasons age 65+
Benefit 7	Divert some remaining ED activity to a new UCC
Benefit 8	Reduce hospital admission rates
Benefit 9	Reduce emergency medical admissions age 65+
Benefit 10	Repatriate bariatrics and spinal injury cases
Benefit 11	Reduce length of stay for stranded patients
Benefit 12	Repatriate interventional radiology
Benefit 13	Reduce MH average length of stay to GIRFT target of 34.6 days
Benefit 14	Replace traditional hospital outpatient services with community/integrated care
Benefit 15	Move physiotherapy outpatients to the community
Benefit 16	Reduce T&O outpatients
Benefit 17	Reduce ENT outpatients
Benefit 18	Reduce Ophthalmology outpatient activity
Benefit 19	Move Community Dental Service outpatients to community dental practices
Benefit 20	Reduce Gastroenterology referrals
Benefit 21	Reduce Dermatology, Cardiology, Respiratory and Endocrine (including Diabetes) referrals
Benefit 22	Reduce follow up rates
Benefit 23	Reduce Gynaecology outpatients
Benefit 24	Move Podiatry Education outpatients to the community
Benefit 25	Increase Pneumococcal Polysaccharide Vaccine (PPV) uptake age 65
Benefit 26	Reduce care home placements to England 3rd quartile

5.2.4 Risk Mitigation Plan

Initial risks to the implementing the JCM have been identified; these will continue to be developed as the programme moves forward.

Table 5.5: Risks and mitigations

Risk	Probability (0-5)	Impact (0-5)	Mitigation
Cost of double running services / facilities during the transition period	3	3	These costs have been factored into the cost profiling for the model
Sufficient community resources cannot be recruited on a sustainable basis to support the model	3	4	A detailed workforce plan, setting out training and recruitment plans, will be developed as part of the initial planning and implementation phases
The market for community services will not be able to develop either in the volume required or in the timeframe required	3	4	Close working with the community sector so that the sector is engaged and understands the direction of travel to adjust their business models. Consider how the pace of change allows for organisations to adjust with the model development.
Confidence in the delivery of the new model of care will not be sufficient before designs for new hospital need to be set	2	2	A review of the JCM has been undertaken in order to provide confidence and to stress test.
Sufficient programme resources will not be made available to deliver the care model	2	4	Assumptions around required resources have been tested through the JCM review and built into the financial assumptions.
Coordination and alignment of cross-government services	2	2	Establish a PMO to support coordination between departments
Change in culture around established service delivery model will be too great to enable change at the scale required	3	3	Staff engagement plan should take into account the cultural change required, while payment mechanisms should reinforce the model.
Inappropriate capping mechanisms.	2	4	The capping mechanism should be agreed by both providers and commissioners, taking into account the stated goals and ambitions of the JCM. All capped amounts (both activity-based and financial) should be evidence-based.
Inappropriate financial gain/loss sharing mechanisms included in the payment design.	2	4	The payment mechanism must be devised to enhance and enable the models of care within the JCM. The risk being borne by each individual party (and their potential contributions) must be taken into account.
Quality and outcomes incentives not well aligned, leading to a provider restricting access	3	5	Quality and desired outcomes must be unequivocal and measurable, to allow for stringent performance monitoring and the imposition of penalties on providers.

Risk	Probability (0-5)	Impact (0-5)	Mitigation
or reducing the quality of care provided.			
Exclusion of certain types and settings of care leading to incentives to providers to shift care to another setting.	1	3	The commercial structures to be introduced and amended to enable the JCM, must consider and incorporate all types and settings of care on a holistic basis. This will also maximise the potential for capitation to support integrated care on the island.
Heavy reliance on provision of community services by volunteers in the third sector, the majority of which are over 65.	1	2	Will need to be addressed through a cross-island labour market strategy to address immediate concerns as well as the longer-term provision for the island. This would need to include housing, immigration, training and other sectors.

5.2.5 Communications and engagement

Stakeholder Engagement

Public engagement to date has consisted of public meetings held in every parish throughout the island in November and December 2019 to increase public knowledge of the JCM. Public presentations outlined the current secondary care focused system and highlighting how an extended stay in hospital can negatively affect health outcomes, particularly for the older patients. The structure of the new person-centred care model was then introduced. The key differences introduced by the new model were then explained, followed by how the changes would be implemented. The presentation finished by explaining commissioning intentions and an overview of engagement to date.

The following engagements groups have been established as part of the review structure:

- JCM workstream pods are aligned with the workstreams outlined in the JCM
- A JCM Steering Group provides strategic leadership, direction and overall decision-making capability for the JCM review in the context of wider health modernisation programmes.
- The Clinical and Professional Senate provides strategic oversight and recommendations on the JCM review outputs. Going forward this group will act as a sustainable forum for ongoing discussions regarding implementation and delivery of the JCM.
- The Technical group consists of Performance, Informatics and Finance representatives. It oversees JCM review activities involving data analysis, modelling, providing oversight and decision-making capability.

Moving forward, our approach to engagement will align with the Government of Jersey's Communications Strategy and Plan.[41]

We will look to engage a number of key stakeholders on key aspects of our vision and model. These stakeholders will include:

- Internal
  - Staff
  - Management Executive Team
  - Volunteers

[41] Government of Jersey, Communications Strategy and Plan, 2019, https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/ID%20Comms%20Strategy%20and%20Plan%20190222%20CC.pdf

    - Trade union and staff-side representatives
    - GoJ Executive Management Team
    - Key partners in other GoJ Departments
    - Ministerial Teams, primarily in Health & Community Services and Customer & Local Services.
- External
    - Patients and their relatives/carers
    - The public of Jersey
    - Special interest groups
    - Health partners (local and national)
    - External partners in health and care
    - Third sector; voluntary and community partners
    - Media: Print, Broadcast, Online & Social

We intend to go back out to the public to have ongoing discussion with them about the development of the model and understanding their needs and requirements going forwards, building on the initial round of discussions. A full engagement and communications plan will be drawn up in due course.

5.2.6 Workforce Requirements

During the JCM testing, the impact of proposed changes on the workforce was assessed. This included projections of the additional staffing numbers for a range of staffing groups if the model were implemented in 2020, and projections for staffing numbers if the model were running in 2065. Analysis and stakeholder engagement highlighted workforce shortages in specific service areas, particularly in Intermediate Care and Clinical Support Services. The current rate of locums was highlighted as a key challenge given the associated high cost and impact on a reduction in investments in the substantive workforce. In addition to this the 2065 projections highlighted the need for a substantial increase in extended roles for allied health professionals, which will require training and development of the current workforce alongside the increased recruitment to new posts.

The feasibility of the proposed changes was assessed including capability, operational efficiencies and safety. Testing this across the seven workstreams the changes were assessed as moderately feasible overall. It was concluded that there is capability in the system to implement the proposed changes set out in the JCM, given the necessary resources to achieve these, and that the changes would support operational efficiencies and safety. To achieve this, key steps would need to be undertaken including a full assessment of the workforce profile and future capacity constraints, in addition to development of the organisational culture.

The following recommendations include those identified in the JCM and through the testing:

- An island workforce strategy with a comprehensive business plan for the provision of 24-hour
- Enhanced support for carers
- Continued development of partnership models with External Partners
- Develop the multidisciplinary workforce with extended roles including pharmacists, nursing, physiotherapy, mental health workers,
- Development of Primary Care Practitioners with Special Interests, e.g. Dermatology
- Assessment of existing workforce’s skills and additional training needs.

Further assessment of the deliverability of the JCM was considered following reflection of the impact of COVID-19 on the workforce. It is acknowledged that in delivering the JCM the first tranche includes further focus on workforce models to be able to create a stable platform for the deliverability of the JCM and achievement of its objectives – therefore additional planning time working alongside system partners will be required.

The JCM review identified that to move toward implementation, a number of key activities are required. Given the nature of the activity, revisions to the phasing of clinical implementation and benefits have been made since the last COM. Key activities in addition to those identified above include:

- Understand impact of COVID-19 on workforce models – including the long term impacts on workforce supply as the market stabilises
- Establishing systems to monitor workforce activity – effort has been seen to better capture workforce data during COVID-19: effort is being made to formalise collection ongoing
- Efficiency review of workforce – in line with benchmarking (note – model cost developed on benchmark services and achievement of 3rd quartile performance)
- Detailed workforce assessment – reviewing the capacity and capability of the current and future workforce model to deliver the programme and refine assumptions for the model
- Developing a Workforce plan – with clarity on labour market strategy, career pathways for pressure points including agreeing substitution and extension roles
- Developing a Change management plan – with a change assessment for key affected workforce and a supporting plan.

Further work is also required on building capacity and capability in the workforce to encourage skilling islanders and retaining them in delivering health and care. Key initiatives are proposed to include:

- Nursing training – acknowledging that nursing workforce may need to enhance or expand skills to drive care, increase to expand public health, general nurses up to masters level, mental health nurses on Island
- Encouraging new entrants through re-training displaced hospitality workers into health care to expand capacity, particularly in low skilled workforce
- Enhancing key worker accommodation to support recruitment and retention of staff on Island which otherwise may be prohibitive to target workforce.

Appendix 1: Changes to model of care as part of the Jersey Care Model

A wide range of changes have been suggested as part of the JCM. These are detailed below.

Workstream	Area	Recommended change
Adult Social Care	Personalisation	ASC01: Further develop and implement an Adult Social Care strategy
Adult Social Care	Personalisation	ASC02: Develop and implement the Social Care Market Strategy to shape the social care sector into an independence focused model
Adult Social Care	Personalisation	ASC03: Develop an integrated, community-based approach to social care supported by increased community capacity and local strategic commissioning
Adult Social Care	Personalisation	ASC04: Invest in preventative services to reduce or delay people's need for care
Adult Social Care	Personalisation	ASC05: Increase the range of services available to support people in the community and increase the number of people who can be paid carers
Adult Social Care	Personalisation	ASC06: Enable people to make their own choices about how they are supported by developing personalised approaches like self-directed support and personal budgets
Adult Social Care	Personalisation	ASC07: Support independence through bespoke care packages that incorporate assistive technology
Adult Social Care	Personalisation	ASC08: Increase and improve the provision of information and advice on care and support for families
Intermediate Care	Community independence	IC01: Develop a community focused intermediate care function incorporating frailty and older person's rapid access, running 7 days a week 8am-8pm and connected to a core overnight community function
Intermediate Care	Community independence	IC02: Connect community focused intermediate care function to broader community services (i.e. Closer to Home initiative) to support 24/7 care needs including end of life care
Intermediate Care	Supporting services	IC03: Intermediate services to have access to home-facing enabler services including domiciliary care
Intermediate Care	Supporting services	IC04: Intermediate services to have rapid access to secondary care diagnostics
Intermediate Care	Supporting services	IC05: Expand hospital-at-home/rapid response service
Intermediate Care	Supporting services	IC06: Develop early facilitated discharge from secondary care to drive a discharge to assess model
Intermediate Care	Person-centred care	IC07: Develop person-centred planning to maximise independence, confidence and resilience

Workstream	Area	Recommended change
Intermediate Care	Person-centred care	IC08: Introduce intermediate services to provide support to the social and long term care sector (residential and nursing) aligning with the personalisation agenda
Women & Children's Health	Primary, community and secondary services	WCH01: Integration of paediatric services between secondary and community care, including closer working with GPs to give advice and care within home and community settings
Women & Children's Health	Primary, community and secondary services	WCH02: Increase patient and public engagement within service development and provision
Women & Children's Health	Primary, community and secondary services	WCH03: Improve timely access to Child and Adolescent Mental Health (CAMHS) services to support early intervention and improved access for services
Women & Children's Health	Primary, community and secondary services	WCH04: Develop transition pathways from children’s to adults' services and associated commissioning arrangements to support this
Women & Children's Health	Primary, community and secondary services	WCH05: Co-locate women and children's services as a unit within a hospital
Women & Children's Health	Wider health and prevention services	WCH06: Develop the service provision for preventative services with partners in Children, Young People, Education and Skills (CYPES)
Women & Children's Health	Wider health and prevention services	WCH07: Reduce levels of Year 6 pupils who are overweight
Women & Children's Health	Wider health and prevention services	WCH08: Improve the number of 2 year olds meeting developmental milestones
Women & Children's Health	Wider health and prevention services	WCH09: Increase the number of pupils who report they have a good quality of life
Women & Children's Health	Wider health and prevention services	WCH10: Reduce the number of under 18s requiring a dental extraction
Women & Children's Health	Wider health and prevention services	WCH11: Develop co-located mental health services and focus on community-based crisis prevention and response
Primary Care & Prevention	Primary and community services	PC01: Identify and implement opportunities to increase the support provided to carers
Primary Care & Prevention	Primary and community services	PC02: Improve access to diagnostics and specialist advice and guidance through primary care channels

Workstream	Area	Recommended change
Primary Care & Prevention	Prevention and screening services	PC03: Expand and enhance prevention, self-care and screening programmes
Primary Care & Prevention	Primary and community services	PCP04: Improve access for clinically, socially and financially vulnerable people to all primary care services, making it easier and more affordable to use
Primary Care & Prevention	Primary and community services	PC5: Maintain the existing excellent rapid access to primary care services
Primary Care & Prevention	Primary and community services	PC06: Repurpose existing secondary care resources into preventative and primary care services, reducing over-reliance on secondary care resources
Primary Care & Prevention	Primary and community services	PC07: Develop clinical pathways for long term conditions
Primary Care & Prevention	Person-centred care	PC08: Explore options for a 24/7 hospital-based primary care service for those otherwise unable to access care and provide support for all other 24/7 services
Primary Care & Prevention	Primary and community services	PC09: Build a network of community support resources, linked with the Closer to Home initiative, with a single point of access to multiple services based in community hubs
Primary Care & Prevention	Primary and community services	PC10: Develop the MDT workforce to include expanded roles of pharmacists, nursing, physiotherapy and mental health workers to provide 24/7 high quality multidisciplinary care
Primary Care & Prevention	Primary and community services	PC11: Develop shared learning and knowledge transfer between primary and secondary care
Scheduled Care	Outpatients and community care	SCSC01: Develop an integrated care hub model to provide efficient planned care services, connecting primary and secondary care and replacing traditional outpatient services
Scheduled Care	Outpatients and community care	SCSC02: Develop virtual hubs where specialist secondary care is closely connected with primary care, with secondary care clinicians providing advice and guidance to primary care
Scheduled Care	Outpatients and community care	SCSC03: Provide outpatient activity in an out of hospital setting, reducing hospital-based outpatient activity for services including physiotherapy, T&O, ENT, ophthalmology and community dental services
Scheduled Care	Outpatients and community care	SCSC04: Set specialist functions to effective clinical pathways based on island need, and manage the anticipated requirement for increased day surgery, endoscopy and non-invasive procedures capacity
Scheduled Care	Outpatients and community care	SCSC05: Improve referral management between primary and secondary care facilitated by education for general practice, to reduce referrals into acute settings for long term conditions
Scheduled Care	Specialist services	SCSC06: Develop connectivity to planned tertiary care and specialist services, repatriating more patient activity to Jersey in the new hospital facility
Scheduled Care	Inpatient services	SCSC07: Optimise acute bed base by reducing length of stay, increasing the use of day case surgery, ambulatory care, reablement services and community-based rehabilitation

Workstream	Area	Recommended change
Scheduled Care	Inpatient services	SCSC08: Develop co-located mental health services
Scheduled Care	Inpatient services	SCSC09: Develop the hospital's clinical environment to be adaptable to reflect demographic pressure areas where increased capacity may be needed
Clinical Support Services	Clinical investigations	SCSS01: Increase Clinical Investigations capacity, Radiology capability, including MRI and CT scanning, and mobile equipment functions
Clinical Support Services	Clinical investigations	SCSS02: Increase the connectivity of clinical support services to primary and intermediate care through rapid access and 'near testing'
Clinical Support Services	Outpatients and community care	SCSS03: Provide services such as physiotherapy and podiatry partially or fully in an out of hospital setting, including home-focused community care
Clinical Support Services	Outpatients and community care	SCSS04: Develop the MDT workforce to include expanded roles of pharmacists, nursing, physiotherapy and mental health workers
Clinical Support Services	Cancer services	SCSS05: Make cancer services more prominent on the island, and develop a cancer strategy for Jersey
Unscheduled Care	Emergency care	SCUC01: Establish an Emergency Care Centre that provides all of the existing urgent and unscheduled care access, maintaining the ability to manage urgent, very urgent and resuscitation patient activity with a specialist medically led model of emergency care
Unscheduled Care	Emergency care	SCUC02: Reduce the size of the front door of the hospital to an acute and emergency floor model, with a co-located Urgent Treatment Centre to manage non-urgent and standard activity
Unscheduled Care	Emergency care	SCUC03: Establish an acute Paediatric Assessment Unit including shared care facilities for CAMHS patient pathways
Unscheduled Care	Ambulatory care	SCUC04: Develop the unscheduled care model to include more prominent ambulatory assessment, particularly older person's rapid access to multi-professional services outside the hospital
Unscheduled Care	Tertiary care	SCUC05: Develop connectivity to tertiary and specialist services via a Jersey Emergency Transfer Service
Mental Health	Primary and community services	MH01: Develop community-based alternatives to hospital care
Mental Health	Primary and community services	MH02: Develop co-located mental health services and focus on community-based crisis prevention and response
Mental Health	Primary and community services	MH03: Invest in primary care-led mental health care with a focus on prevention and early intervention, and community intervention, e.g. home enablement/care
Mental Health	Primary and community services	MH04: Work with local communities and partners to expand community-based capacity for recovery-oriented, person-centred care and support (e.g. housing, employment, social support)
Mental Health	Specialist services	MH05: Review demand and capacity for mental health care and redesign our mental health care system to meet Islanders' needs
Mental Health	Specialist services	MH06: Establish the front door as an Emergency Care Centre, including mental health assessment
Mental Health	Specialist services	MH07: Design the integrated hub model of care to include mental health outpatients, as outlined in the secondary care model

Workstream	Area	Recommended change
Mental Health	Specialist services	MH08: Offer timely integrated crisis care and support over a 24 hour period through establishing and fully rolling out the Crisis Prevention and Intervention Service
Mental Health	Specialist services	MH09: Develop a complex trauma pathway
Mental Health	Specialist services	MH10: Develop tertiary pathways for specialist care, considering provider options in partnership with Guernsey and the case for change for repatriation of off-island longer-term specialist activity to Jersey
Mental Health	Specialist services	MH11: Develop a plan for on-island CAMHS inpatient facilities for shared care purposes, exploring the potential for provision in partnership with Guernsey
Mental Health	Person-centred care	MH12: Establish self-care and education programmes to enable people to look after themselves better

Appendix 2: Detail behind economic analysis

Option 1: Do minimum (expand FFS)

This option involves expanding services across the primary care providers such as community pharmacy. Community pharmacies have started to provide enhanced services such as medicine use reviews but there is potential to expand the current FFS scheme to more services and settings. The advantages of this option are that it incentivises more efficient use of services, improves accessibility and supports integrated care through an enhanced role of non-medical staff, especially community pharmacy and nurses. Findings from the Jersey Opinions and Lifestyle survey (2017) of c.1,300 households found that[42]:

- 92% of respondents would like to be able to see a practice nurse rather than a GP for a routine or minor health issue
- 88% would like to be able to make an appointment with a high street pharmacist for advice
- 93% would like high street pharmacists to offer 'drop in' clinics for basic health checks.

This option can be considered in combination with a capitation scheme or a GP salaried scheme.

Community pharmacies in England and Wales can be commissioned to provide a wide set of services. For example, the Community Pharmacy Contractual Framework (CPCF) is made up of three different service types: essential services (e.g. dispensing medicines, repeat dispensing, discharge medicine service) which are provided by all pharmacy contractors and are commissioned by NHS England, advanced services which can be provided by all contractors once accreditation requirements have been met and are commissioned by NHS England and locally commissioned enhanced services in response to the needs of the local population. On this basis, community pharmacies in Jersey could provide the following services, among others:

- New Medicine Service
- Appliance Use Reviews
- Medicine Use Reviews (already provided by some community pharmacies)
- Minor Ailments Services
- Public health services (e.g. emergency hormonal contraception, needle and syringe programme, supervised methadone administration)

An enhanced service – minor ailments services – that can be delivered by community pharmacy has been used as an example to show the impact on the volume of activity for GPs and the financial implications for the GoJ and patients.

Approach and results

It is estimated that in 2019 there were a total of 52,200 GP appointments for minor ailments services (MAS) and an additional 2,700 ED attendances for MAS. It is estimated that community pharmacy could provide 46,100 or 84% of these MAS consultations that currently occur in GP and ED.

[42] Government of Jersey (2017), Jersey Opinions and Lifestyle Survey (2017), https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/R%20Opinions%20and%20Lifestyle%20Survey%202017%20report%2020171130%20SU.pdf

Table A2.1: Estimated volume of MAS consultations in 2019

	MAS in 2019	Assumptions	Source
GP consultations	52,200	16% of total GP visits	PSNC (Pharmaceutical Services Negotiating Committee)[43]
ED attendances	2,724	7% of total ED attendances	PSNC
Total MAS appointments	55,000		
% who would have gone to Community Pharmacy	84%		PSNC
Total MAS appointments in Community Pharmacy	46,200		

To estimate the cost of providing MAS in community pharmacy it is assumed the rebate claimed will be the same as the current GP consultation rate of £20 per visit and the co-payment will be on average £10 per visit. It is also estimated that the current average co-payment for GP consultations is £32 per visit. This estimate is based on the average patient charge in 2019 across GP consultations (surgery, home, special and aux) for which a rebate was claimed from the HIF.

It is estimated that the total cost for the States and patients of providing MAS in community pharmacy, GPs and ED in 2019 would be £1.1m and £0.7m respectively (including some consultations that will continue to occur in ED and GP settings). In comparison, it is estimated that the cost for the States and patients of providing MAS only in GPs and ED in 2019 was £1.3m and £1.7m respectively.

Table A2.2: Estimated cost of providing MAS in Community Pharmacy (CP), GPs and ED in 2019 (£, 2019 prices)

	Option 1(MAS in CP, GPs and ED)			Current estimate (MAS in GPs and ED)	
	Community Pharmacy	**GPs**	**ED**	**GPs**	**ED**
Number of appointments	46,200	8,350	450	52,200	2,800
Government funding	£924,000	£167,050	£38,300	£1,044,060	£245,700
Patient charge	£462,000	£264,820		£1,655,120	
Total cost	**£1,387,000**	**£431,870**	**£38,750**	**£2,699,180**	**£245,700**

Another approach to estimate the cost of providing the service is to identify the amount taken to provide the service and the average earnings for pharmacists. Using the average time for a GP face to face consultation (10 minutes) and the average hourly earnings of a pharmacist (£25-£30 per hour), it is estimated that the average cost per MAS consultation – accounting only for employment costs and excluding wider business costs, is around £4-5.[44] According to a study by Aberdeen University, costs per consultation in community

[43] PSNC, Essential facts, stats and quotes relating to Minor Ailments Services, https://psnc.org.uk/services-commissioning/essential-facts-stats-and-quotes-relating-to-minor-ailments-services/

[44] ONS, ASHE. to calculate the average hourly cost per worker, these rates are uplifted by 25% to take into account employers' National Insurance and pension contributions as well as other on-costs. This is the same assumption as the one used in the Cost of Service Inquiry (PSNC).

pharmacy are around £29.30 compared to GPs (£82.34) and emergency departments (£147).[45] Further analysis and additional information on community pharmacy is required to estimate the appropriate fee per consultation.

Note that the analysis does not assess additional benefits such as the impacts of increased accessibility on illness. The analysis above reflects the benefits in terms of cost savings to patients and the government by moving MAS consultations from GPs and ED to Community Pharmacies. Although not estimated, additional benefits can arise from increased time for GPs to provide other services and reduced demand and costs for urgent care. For example, it was found that c. 7% of ED attendances involve consultations for minor ailments, a cost to the Government of Jersey.[46] Community pharmacy offers a more cost effective provision of treatment for MAS; for example, the average cost of an A&E attendance with no investigation and no significant treatment in the NHS is £89 per incident compared to around £40 for a GP consultation.[47]

Long run estimates, 2021-2024

To provide an estimate for a MAS in Community Pharmacy over 2021-2024, the forecasted GP appointments in a 'do-nothing' or 'do-something' scenario were used (see Section 4.2 for more details), and the same approach as above was applied. It was also assumed that there would be an annual inflation rate of between 2%-3% (see the Financial Case for more details) and discount rate of 3.5% to develop a total estimate in net present values.[48]

It is also estimated that the total discounted cost of providing minor ailments services (MAS) in community pharmacy, GPs and ED between 2021 and 2024 would be c.37% lower than the total discounted cost of providing MAS only in GPs and ED. This is driven by a lower cost for patients due to the lower co-payment and savings from a reduction in ED attendances. Reducing the rebate per visit for MAS would provide further services. Based on the activity assumptions for a 'do-nothing' and 'do-something' scenario, the total discounted cost for the States of providing MAS in community pharmacy, GPs and ED between 2021 and 2024 would be £7.4m and £7.8m respectively.

Table A2.3: Estimated cost of providing MAS in Community Pharmacy and GPs, 2021-2024 (PV, £, 2019 prices)

	'Do-nothing' (2021-2024)		'Do-something' (2021-2024)	
Present Values (PV), 2019 prices	Current MAS – GPs and ED only	Option 1 – MAS in CP, GPs and ED	Current MAS – GPs and only	Option 1 – MAS in CP, GPs and ED
Government funding	£5,174,400	£4,511,520	£5,304,410	£4,749,140
Patient co-payments	£6,597,690	£2,897,360	£7,071,180	£3081610
Total costs	**£11,773,100**	**£7,408,870**	**£12,375,590**	**£7,830,740**

[45] Watson et al (2014), https://bmjopen.bmj.com/content/5/2/e006261.full

[46] PSNC

[47] Unit Cost database v2.0, Greater Manchester CBA, April 2019

[48] We use discounting to aggregate costs and benefits occurring at different points in time. Discounting enables us to take into account society's time preference for incurring costs and benefits. We discount the costs and benefits by the social time preference rate of 3.5%. This rate is recommended in HM Treasury Green Book to bring the figures to a net present value (NPV) to ensure we are able to compare costs and benefits for a given year, and overall, even if these are experienced in earlier or later years.

Option 2 and 3: Capitation+ and Full Capitation (no co-pay)

This option explores moving to a capitation+ or full capitation (no co-pay) model for GPs. The lump-sum fee and total costs of moving to this payment model are estimated for:

- Financially vulnerable population (FVP), i.e. those on income support (c. 10,200 in 2019)
- Socially vulnerable population (SVP), i.e. those below 9 years old, adolescents, those above 70 years old and pregnant women for the purposes of this analysis (c. 36,670 in 2019)
- Clinically vulnerable population (CVP), i.e. those with one or more chronic conditions (c. 31,200 in 2019) to cover GP appointments related to treatment of their long-term conditions (LTCs).

Also considered is a universal model where a capitation+ or full capitation (no co-pay) scheme is available for the total population of Jersey.

There are several steps in the process to understanding an appropriate value for capitation of specific patient groups.

- Identify the patient cohort who would benefit the most from prevention and have high or unplanned use of services. As above, the groups considered are financially, socially, and clinically vulnerable.
- Define a set of services to be covered. To maximise the potential for capitation to support integrated care it should cover all settings otherwise each provider is incentivised to shift the patient's care to another setting. Only GP services are reviewed in this analysis, but this scheme should be combined with pay-for-performance to reduce incentives for referrals.
- Estimate the capitation payment based on the average annual spend per patient. This can be adjusted by associated risk (e.g. age, health profile).
- Define quality and outcome incentives so that the providers do not restrict access or reduce quality of care, e.g. targets related to clinical quality of care or volume of activity.

Approach and results

To estimate an indicative cost of moving to a capitation+ or full-capitation payment model the following steps were taken:

- Identified the group of people to be included
- Analysed historical data to identify the average annual visits to GPs, co-payments and rebate for each group, focused on fee-for-service (FFS) GP consultations

Key assumptions and limitations:

- The estimated cap reflects the income that GPs currently receive from government (in the form of rebates) and patient charges (in the form of co-payments) from the HIF. In 2019, it is estimated that there were 326,269 GP FFS consultations that resulted in total patient charges of c.£10.3m and total rebate from the HIF of c.£6.5m. This means that, in total, a universal capitated system would only reflect GP income from FFS consultations.
- The estimated cap reflects the income that GPs currently receive from rebates and co-payments rather than the cost of delivering the service. This means that the estimated cap could be an overestimate.
- The estimated cap reflects the income that GPs currently receive from rebates and co-payments for all types of GP consultations including home visits, special and auxiliary visits and surgery visits, the latter constituting c.94% of all GP consultations in 2019.
- The estimated cap for CVP reflects the GP visits (and associated GP income) that individuals with long-term conditions (LTCs) make for treatment of their LTC (rather than general GP advise).
- The estimated cap for CVP does not reflect visits to specialist clinics that could also be conducted at GP settings. For the clinically vulnerable, it is estimated that if an estimated 0.9 specialist appointments for LTCs are to be done by GPs the cost of a capitation+ scheme (with co-pay) to the Government of Jersey would be £1.2m and £0.3m to the patients in 2019.[49]

[49] These estimates are based on the number of specialist appointments made by diabetic patient to the Diabetic Centre. This is estimated by dividing the total number of specialist appointments made in 2019 (3,801) by the total number of patients (4,270).

- The estimated cap does not reflect additional services that GPs provide patients that are not captured in the available data (e.g. referrals, scripts). Estimates suggest that GP income from other services not included in the HIF could range between 10% to 15% of their total income; a proxy for additional cost of performing these services. This means that the estimated cap could be an under-estimate.
- The estimated total cost assumes that only a proportion of the population will register and attend GPs. This is based on 2019 data on GP consultations and Jersey population statistics.
- For a capitation+ model, it is assumed that, on average, patients would pay £10 per visit.

The total cost of the different schemes and options considered below reflect the overall gross cost of implementing each option. The government and patients already provide funding and co-payments for FFS GP consultations. In 2019, it is estimated that GPs received a total of c.£16.9m in income from FFS consultations; c.£10.3m from patients and c.£6.5m from HIF rebates. This implies that if the government were to introduce a universal capitation scheme it would no longer need to spend the estimated c.£6.5m from HIF rebates.

To estimate **the total cost of each scheme separately** in 2019 a set of key data were used:

- The number of patients in each group have been identified using 2019 population estimates (107,871)
- The number of patients attending GP consultations have been identified using 2019 GP consultation data. In total, c.84,045 attended GP consultations in 2019. This proportion is used to estimate the total cost of each option (rather than the total population).
- The number of FFS GP appointments with associated rebates and patient co-payment from Government of Jersey HIF data for 2019.
- The number of people with LTCs and their average number of GP appointments from Jersey Statistics.

The table below provides an indicative cap size for the three vulnerable groups: the second column provides an estimate of the lump-sum fee under a capitation+ (with co-pay) model where patients also pay £10 per visit while the third column provides an estimate of the lump-sum fee under a full-capitation model where there is no co-payment. Note that individuals could be included in more than one group (e.g. someone on income support could also be above 70 years of age (socially vulnerable) and have more than 1 chronic condition (clinically vulnerable).

Table A2.4: Estimated average cap size (lump-sum fee) by patient in each group, 2019

	Capitation+ (Cap and co-pay)	Full capitation (no co-pay)
Clinically vulnerable (with 1 or more conditions) - LTC visits only[50]		
1 LTC	£82	£101
2 LTCs	£143	£174
3 LTCs	£189	£228
>4 LTCs	£252	£301
Socially vulnerable (age-related)		
0-19 years	£76	£108
> 70 years	£293	£349

[50] This capitation fee estimate covers GP appointments associated with treatment of LTCs – a proxy is used by estimating the average number of GP appointments for all populations and people with LTCs and using the difference.

Pregnant women	£90	£119
Financially vulnerable		
Tier 1: <70 years	£163	£207
Tier 2: >70 years	£335	£396
All population		
Universal cap	£162	£201

The **total cost of a full-capitation scheme for FVP, SVP and CVP in isolation** in 2019 has been estimated at £2.4m, £6.3m and £4.5m, respectively. In comparison, a universal capitation scheme is estimated to cost £16.9m for patients who attended GPs in 2019 (or £21.7m for the total population of 107,871). As noted above, the total cost of a universal capitation scheme reflects only FFS GP consultations rather than all GP services and associated GP income (see Option 4 for more details on the sources of GP income). The total cost of providing the three schemes combined is estimated further below.

Similarly, for a capitation+ (with co-pay) model, it is estimated that **the total cost of a capitation+ scheme for FVP, SVP and CVP in isolation** in 2019 would be £1.9m, £5.0m and £3.7m for the States and £0.5m, £1.2m and £0.8m for the patients. In comparison, a universal capitation scheme is estimated to cost the States £13.6m and the patients c.£3.3m.

For each scheme, Table A2.5 indicates:

- The number of patients based on registered GP patients attending GPs in 2019 (rather than total population)
- The number of GP appointments for each group
- The estimated total cost of providing GP services using the current payment mechanism (rebate and patient co-payment)
- The estimated total cost of providing GP services using a capitation+ model (cap and co-pay) with the lump-sum fees (i.e. the cap) outlined in the table above
- The estimated total cost of providing GP services using a full capitation (no co-pay) model with the lump-sum fees outlined in the table above.

Some key limitations are noted. The introduction of a capitated fee will automatically lower the barriers of access which might increase the number of people in each scheme (e.g. growth in the number of financially vulnerable people registering and seeking GP consultations). Moreover, the estimates are based on GP activity data associated with rebates. This means that the estimates do not directly account for other GP activity (e.g. referrals, scripts) for which GPs do not claim rebates from the States.

Table A2.5: Total estimated GP activity and costs for each scheme separately, 2019

	Number of patients	Number of appointments	Current (Estimate)		Capitation+ Estimate		Full Capitation (no co-pay) Estimate
			Government funding	Patient charge	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) – LTC visits only							
1 LTC	18,353	34,712	£694,239	£1,155,267	£1,502,387	£347,120	£1,849,506
2 LTCs	7,701	23,685	£473,707	£863,747	£1,100,600	£236,853	£1,337,453
3 LTCs	3,270	12,662	£253,243	£491,135	£617,756	£126,622	£744,378
>4 LTCs	1,898	9,231	£184,626	£386,012	£478,325	£92,313	£570,638

	Number of patients	Number of appointments	Current (Estimate)		Capitation+ Estimate		Full Capitation (no co-pay) Estimate
			Government funding	Patient charge	Government funding	Patient charge	Government funding
CVP total	**31,222**	**80,291**	£1,605,815	£2,896,160	£3,699,068	£802,908	£4,501,976
Socially vulnerable (age-related)							
0-19 years	14,449	46,125	£922,493	£636,292	£1,097,539	£461,247	£1,558,786
> 70 years	13,174	73,203	£1,464,064	£3,131,521	£3,863,553	£732,032	£4,595,585
Pregnant women	896	2,584	£51,678	£53,863	£79,702	£25,839	£105,541
SVP total	28,519	121,912	£2,438,235	£3,821,676	£5,040,794	£1,219,118	£6,259,911
Financially vulnerable							
Tier 1: <70 years	8,601	38,218	£764,363	£1,016,606	£1,398,787	£382,181	£1,780,969
Tier 2: >70 years	1,599	9,767	£195,336	£437,307	£534,974	£97,668	£632,642
FVP total	10,200	47,985	£959,699	£1,453,913	£1,933,762	£479,849	£2,413,611
All population							
Universal cap	84,045	326,269	£6,525,380	£10,344,519	£13,607,209	£3,262,690	£16,869,899[51]

To estimate the total cost of providing a capitation+ or full capitation (no co-pay) for **all three groups together** some key assumptions were used based on activity data:

Table A2.6: Key assumptions to estimate total cost of combined schemes, 2019

Assumption	Proportion (%)	Key Source
Proportion of people aged below 20 who have at least one LTC	4.2%	Population data, Government of Jersey Statistics
Proportion of people aged above 70 who have at least one LTC	80.1%	Population data, Government of Jersey Statistics
Proportion of people aged between 20 and 69 who have at least one LTC	27.7%	Population data, Government of Jersey Statistics
Proportion of pregnant women who have at least one LTC	22.5%	Population data, Government of Jersey Statistics
Proportion of GP appointments for people aged below 20 who are financially vulnerable	18.7%	Population data, HIF data
Proportion of GP appointments for people aged above 70 who are financially vulnerable	13.2%	Population data, HIF data

[51] Note that this estimate is based on rebate and patient co-payment activity generated through GP FFS appointments and does not account for income generated through other services (e.g. scripts, referrals) or other government funding (e.g. HCS).

Assumption	Proportion (%)	Key Source
Proportion of GP appointments for pregnant women who are financially vulnerable (based on population aged 20-50)	12.4%	Population data, HIF data
Proportion of people below 20 of total LTC appointments	2%	Population data, Government of Jersey Statistics
Proportion of people above 70 of total LTC appointments	37.9%	Population data, Government of Jersey Statistics
Proportion of people aged between 20 and 69 of total LTC appointments	60.1%	Population data, Government of Jersey Statistics
Proportion of appointments from FVP as total GP appointments	14.7%	HIF data
Proportion of population aged between 20 and 69 who are pregnant	1.2%	Population data, Government of Jersey Statistics

It is estimated that the **three vulnerable groups combined** constituted c.69% of GP appointments in 2019. Table A2.7 and Figure A2.1 show the proportion of GP activity associated with the three vulnerable groups.

Table A2.7: Estimated number of GP appointments by vulnerable group, 2019

Vulnerable groups	Estimated GP appointments
Clinically vulnerable only	41,970
Socially vulnerable only	100,753
Financially vulnerable only	25,920
Clinically and socially vulnerable	27,911
Clinically and financially vulnerable	6,252
Socially and financially vulnerable	18,217
Clinically, socially and financially vulnerable	4,158
Remaining population (Non-vulnerable)	101,088
Total GP appts	**326,269**
Total CVP (incl. SVP and FVP)	*80,291*
Total SVP (incl. CVP and FVP)	*151,039*
Total FVP (incl. CVP and SVP)	*54,547*

- Nearly 50% of the 326,269 appointments (c. 154,000) in 2019 were from individuals with one or more long term conditions (LTCs). This finding is consistent with research from the Department for Health, which found that patients with long-term conditions account for approximately 50% of all GP appointments.[52]

- However, it is estimated that only half of those appointments were appointments related to their LTC (c. 80,291) The remaining appointments (i.e. not related to their LTC) have therefore been included in the SVP and FVP schemes where there is overlap across vulnerable groups. This ensures that the cost estimates reflect the additional appointments made by a patient who may be both clinically and socially vulnerable.

[52] Department of Health (2012), Long-term conditions compendium of Information: 3rd edition

- Out of the c. 80,291 LTC appointments, it is estimated that 27,911 were from individuals who are also socially vulnerable (e.g. below 20 or above 70 years or pregnant), 6,252 were from individuals who are on income support and c. 4,158 were from individuals who are both socially and financially vulnerable. The remaining 41,970 appointments were from individuals who have LTCs, are aged between 20 and 69 years (i.e. not socially vulnerable) and are not on income support.

- An additional 100,753 appointments were estimated for people who are socially vulnerable and not on income support. This includes GP appointments for people with LTCs (i.e. CVP) that are not related to the treatment of their LTCs.

- An additional 25,920 appointments were estimated for individuals on income support who are aged between 20 and 69 (i.e. not socially vulnerable) and have no identified LTCs. This includes GP appointments for people with LTCs (i.e. CVP) that are not related to the treatment of their LTCs.

- Finally, an additional 18,217 appointments were estimated for individuals who are both socially vulnerable and on income support. This includes GP appointments for people with LTCs (i.e. CVP) that are not related to the treatment of their LTCs.

- The estimated number of appointments for the population not covered under these three schemes is 101,088 or 31% of total GP appointments in 2019.

Figure A2.1: Estimated number of GP appointments by vulnerable group, 2019

To provide an indicative **cost estimate of providing a capitation+ or full capitation (no co-pay) for all three groups together**, unique individuals have been identified that are included within each of these groups. This process has involved:

- Ordering vulnerable patient cohort groups based on the average cap size per patient; and
- Using HIF data and EMIS data (for clinically vulnerable individuals) to estimate the number of unique patients in each vulnerable group. This process was used so that the total estimated cost of the combined schemes does not include patients who may belong to two or more groups (e.g. those with a long-term condition who are also financially vulnerable).
- The analysis first considered patients who are clinically vulnerable and estimated the total cost of the scheme. This is the same as providing the scheme separately.

- To estimate the total cost of providing the scheme to those who are SVP but are not already captured by the CVP scheme, analysis was undertaken to:
    - Estimate the number of people in the SVP groups who are also CVP
    - For these people, the estimated cost only includes GP visits that are not related to treatment of their LTCs.
- Similarly, to estimate the cost of providing the scheme to those who are FVP but are not SVP (i.e. only those who are FVP and aged 20 to 69) analysis was undertaken to estimate the number of FVP who are also CVP. The total cost includes only the GP visits for this group that are not related to their LTC.

It is also estimated that **implementing the three schemes together** in 2019 would cost the States a total of £10.7m in a full-capitation model and £8.5m in a capitation+ model. It is estimated that an additional £5.9m or £4.8m in a capitation or full-capitation model would be required to cover the remaining population using a universal cap. It is noted that the CVP scheme would cover only LTC-related GP appointments for individuals with more than one LTC. For individuals who are clinically vulnerable but also socially and / or financially vulnerable, the scheme would cover additional GP appointments for issues other than treatment of their LTCs.

Table A2.8: Estimated GP activity and cost for the three schemes combined, 2019

	Number of patients	Number of appointments	Current (Estimate)		Capitation+ Estimate		Full Capitation (no co-pay) Estimate
			Government funding	Patient charge	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only							
	31,222	80,291	£1,605,815	£2,896,160	£3,699,068	£802,908	£4,501,976
Socially vulnerable (age-related) - for individuals with LTCs includes only regular / miscellaneous GP visits are included							
	17,270	118,970[53]	£2,379,395	£2,551,987	£3,741,685	£1,189,698	£4,931,382
Financially vulnerable - for individuals who are also clinically vulnerable only regular / miscellaneous GP visits are included (note that financially vulnerable who are also socially vulnerable are captured above)							
	4,291	25,920[54]	£518,407	£767,095	£1,026,298	£259,203	£1,285,501
Total vulnerable population							
	52,783	**225,181**	**£4,503,618**	**£6,215,242**	**£8,467,051**	**£2,251,809**	**£10,718,859**
Rest of the population							
	31,262	101,088	£2,293,248	£3,644,035	£4,790,659	£1,146,624	£5,937,283

It is noted that the analysis presented above does not consider additional indirect benefits of a capitated+ or full capitation (no co-pay) system. For example, improved equity of access under a capitation system would generate significant savings through reduced use of secondary care. The Unit Cost Database (a database which brings together more than 800 national cost estimates from government reports and academic studies) estimates that the cost of an A&E attendance is £160 per incident.[55] By removing or reducing the co-payment element of primary care activity, a capitated system incentivises target population groups to avoid unnecessary visits to emergency departments (where there is currently no user charge). A study by L'Esperance et al (using a sample of 7,478 practices in the UK) found that capitation supplements were

[53] As explained above, this figure also includes the non-LTC related appointments of people who are both clinically and socially vulnerable

[54] As explained above, this figure also includes the non-LTC related appointments of people who are both clinically and financially vulnerable

[55] Unit Cost database v2.0, Greater Manchester CBA, April 2019

significantly associated with reduced secondary care utilisation, including: reduced A&E attendances, reduced emergency admissions and reduced Ambulatory Care Sensitive Conditions (ACSC) admissions. They estimated that an additional cost of £5,720 in capitation supplements per 1,000 registered patients was offset by modelled secondary care savings of £6,280, representing a saving of 110% of the notional investment in capitation supplements.[56]

Long run estimates, 2021-2024

Finally, the cost of the full-capitation and capitation+ schemes were estimated through 2021-24 in the 'do-nothing' and 'do-something' scenarios. These costs were estimated by:

- Using the activity assumptions described in Section 4.2 to understand:
    - population forecasts by age group; and
    - the number of additional GP appointments made in the 'do nothing' and 'do something' scenarios.
- The cost of both a capitation+ and full capitation (no co-pay) scheme were then calculated using both the population forecasts and GP activity estimates in each scenario.

A number of assumptions were used as part of this analysis:

Table A2.9: Key assumptions to estimate total cost of combined schemes, 2021-2024

Assumption	2021	2022	2023	2024	Key Source
Total population	110,487	111,799	113,115	114,426	Government of Jersey
Total appointments ('*do nothing*' scenario)	335,469	339,898	344,662	349,570	See Section 4 for more details
Total appointments ('*do something*' scenario)	343,106	355,408	368,303	381,585	See Section 4 for more details
Share of population on income support	9.5%	9.5%	9.5%	9.5%	Government of Jersey, HIF data
Share of population that are clinically vulnerable	29%	29%	29%	29%	Government of Jersey
Inflation	2.5%	2.7%	1.9%	2.30%	See Section 4 for more details
Discount factor	3.5%	3.5%	3.5%	3.5%	HM Treasury, Green Book

'Do-nothing' scenario in 2021-24

The **total cost of a full-capitation scheme for FVP, SVP and CVP in isolation through 2021-24** has been estimated at £9.6m, £25.9m and £18.1m in the **'do nothing' scenario**, respectively. It was also estimated that the total cost of adopting the three schemes together (i.e. accounting for overlap of patients) would be £43.5m. In comparison, a universal capitation scheme for patients attending GP consultations is estimated to cost £67.4m (in net present values 2019 prices).

Similarly, for a capitation+ model, it is estimated that the total cost of a capitation+ scheme for FVP, SVP and CVP in isolation in 2021-24 would be £7.7m, £20.9m and £14.9m for the States and £1.9m, £5.0m and £3.2m for the patients, respectively. It is also estimated that the total cost of adopting the three schemes

[56] Veline L'Esperance et al, Impact of primary care funding on secondary care utilisation and patient outcomes: a retrospective cross-sectional study of English general practice (2017). Available here: https://bjgp.org/content/67/664/e792. Accessed 25th March 2020.

together (i.e. accounting for overlap of patients) would be £34.3m for the States and £9.1m for the patients. In comparison, a universal capitation+ scheme is estimated to cost £54.5m for the States and £13.0m for the patients.

Table A2.10: Total estimated costs for each scheme separately, 'Do-nothing' 2021-24 (NPV, 2019)

	Current (Estimate)		Capitation+		Full Capitation (no co-pay)
	Government funding	Patient charge	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only					
	£6,458,035	£11,650,904	£14,879,922	£3,229,018	£18,108,940
Socially vulnerable (age related)					
	£9,967,224	£15,884,286	£20,867,898	£4,983,612	£25,851,510
Financially vulnerable					
	£3,810,187	£5,820,178	£7,725,272	£1,905,094	£9,630,365
Total population (universal cap)					
	£25,972,824	£41,447,678	£54,434,090	£12,986,412	£67,420,502

The table below shows the **estimated cost of implementing all three schemes together**, i.e. accounting for overlap of patients across the groups.

The **total cost for the States of a combined full-capitation scheme for FVP, SVP and CVP through 2021-24** has been estimated at £43.5m (or £34.3m in a combined capitation+ scheme) in the **'do nothing' scenario**. The total cost for providing a full-capitation scheme for the remaining population is also estimated at £23.2m over the period, a total cost of £66.6m.

Table A2.11: Total estimated costs for the three schemes combined in a 'do-nothing' scenario, 2021-2024 (NPV, 2019)

	Current (Estimate)		Capitation+		Full Capitation (no co-pay)
	Government funding	Patient charge	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only					
	£6,458,035	£11,650,904	£14,879,922	£3,229,018	£18,108,940
Socially vulnerable (age related) - excluding those with LTCS					
	£9,732,018	£10,585,266	£15,451,275	£4,866,009	£20,317,285
Financially vulnerable - excluding the clinically and socially vulnerable					
	£2,027,324	£2,999,865	£4,013,527	£1,013,662	£5,027,189
Total vulnerable population					
	£18,217,378	**£25,236,035**	**£34,344,724**	**£9,108,689**	**£43,453,413**

	Current (Estimate)		Capitation+		Full Capitation (no co-pay)
	Government funding	Patient charge	Government funding	Patient charge	Government funding
Rest of the population					
	£8,945,741	£14,226,005	£18,698,876	£4,472,871	£23,171,746

‘Do-something’ scenario in 2021-24

It is estimated that the total cost of a full-capitation scheme for **FVP, SVP and CVP in isolation** between **2021-2024 in a do-something scenario** would be £10.2m, £27.3m and £19.1m, respectively. It is also estimated that the total cost of adopting the three schemes together (i.e. accounting for overlap of patients) would be £46.4mm. In comparison, a universal capitation scheme is estimated to cost £71.3m.

Similarly, for a capitation+ model, it is estimated that the total cost of a capitation+ scheme for FVP, SVP and CVP in isolation in 2021-24 would be £8.2m, £22.1m and £15.7m for the States and £2.0m, £5.3m and £3.4m for the patients, respectively. It is also estimated that the total cost of adopting the three schemes together (i.e. accounting for overlap of patients) would be £36.5m the States and £9.8m for the patients. In comparison, a universal capitation+ scheme is estimated to cost £57.6m for the States and £13.7m for the patients.

Table A2.12: Total estimated costs for each scheme separately, ‘Do-something’ 2021-24 (NPV, 2019)

	Current (Estimate)		Capitation+		Full Capitation (no co-pay)
	Government funding	Patient charge	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only					
	£6,827,937	£12,318,284	£15,732,252	£3,413,968	£19,146,221
Socially vulnerable (age related)					
	£10,539,547	£16,798,529	£22,068,302	£5,269,773	£27,338,076
Financially vulnerable					
	£4,028,029	£6,153,349	£8,167,363	£2,014,014	£10,181,378
Total population (universal cap)					
	£27,458,540	**£43,820,905**	**£57,550,175**	**£13,729,270**	**£71,279,445**

The table below shows the **estimated cost of implementing all three schemes together**, i.e. accounting for overlap of patients across the groups.

In the **‘do something’ scenario**, the **total cost for the States of a combined full-capitation scheme for FVP, SVP and CVP in through 2021-24** has been estimated at £46.4m (or £36.5m in a combined capitation+ scheme). The total cost for providing a capitation scheme for the remaining population is also estimated at £24.5m over the period, a total cost of £70.9m.

Table A2.13: Total estimated costs for the three schemes combined in a 'do-something' scenario, 2021-2024 (NPV, 2019)

	Current (Estimate)		Capitation+		Full Capitation (no co-pay)
	Government funding	Patient charge	Government funding	Patient charge	Government funding
Clinically vulnerable (with 1 or more conditions) - LTC visits only					
	£6,827,937	£12,318,284	£15,732,252	£3,413,968	£19,146,221
Socially vulnerable (age related) - excluding those with LTCS					
	£10,724,812	£11,196,423	£16,558,829	£5,362,406	£21,921,235
Financially vulnerable - excluding the clinically and socially vulnerable					
	£2,142,997	£3,171,028	£4,242,526	£1,071,499	£5,314,025
Total vulnerable population					
	£19,695,746	**£26,685,735**	**£36,533,608**	**£9,847,873**	**£46,381,481**
Rest of the population					
	£9,456,006	£15,037,542	£19,765,545	£4,728,003	£24,493,548

Option 4: Salaried model for GPs

This option explores moving to a full salaried model for GP services in Jersey. To estimate the cost of a salaried GP model, the following were analysed:

- The sources of GP income in 2019. It is noted that the estimates are based on 2018 data.
- The costs of running a GP practice in 2019 based on Government of Jersey estimates.
- The forecasted GP activity and associated FTE GPs in the 'do-nothing' and 'do-something' scenarios between 2021 and 2024.

Approach & results

To estimate the cost of a salaried model for GPs, the **total income** earned by all 13 GP practices was estimated across Jersey in 2019 at c.£24.4m. This is made up of £21.3m known sources of income – from the HIF, HCS and patient co-payments (based on data on 2018 funding for GPs; the underlying contracts are further explored in the Commercial Case) and an estimated £2.7m-£3.6m income from referrals, scripts and death certificates (for which GPs receive no funding from the government).

Table A2.14 below describes the sources of income for GPs for 2019. Please refer to the Commercial Case for a more detailed breakdown.

- £10m comes from patient charges, the majority driven by patient co-payments for GP FFS consultations
- Another £10m comes from the HIF in the form of rebates for GP FFS consultations, funding for JQIF and other services such as the pathology benefit.
- Out of the £10m that GPs receive from the HIF, around £6.7m was received in the form of rebates for GP FFS consultations. This figure (£6.7m) differs from the estimate used in the analysis for Options 2 and 3 (£6.5) due to different sources of data and different years: the former is based on 2018 Government of Jersey estimates of all GP funding from the government while the latter is based on HIF data on rebates for GP FFS consultations in 2019.
- A further £1.3m is paid to GPs for a set of services from the Health and Community Services (HCS)
- It is estimated that GPs receive additional income from patients from services that are not eligible for government funding such as referrals and scripts. This is estimated at c. £3m for 2019.

Table A2.14: Estimated GP income sources, 2019

Income source for GPs	Estimated income for 2019
Income from patients (co-payments)	£10,059,100
Income from HIF (rebates, JQIF, pathology benefit, etc.)	£9,957,600 (£6.7m from GP consultations rebates)
Income from HCS	£1,265,600
Other income (referrals, scripts) – estimated	£2,681,100-£3,643,700
Total income across all 13 GP practices and 85 FTE GPs (mid-point in range)	**£24,444,700**

To gain a better understanding of GP activity and income, a bottom-up analysis was undertaken. To estimate the total income associated with average GP activity per year (using 2019 as our basis) the following were identified:

- Number of appointments or activities per year (by type)
- Average duration per appointment or activity
- Cost of GP per hour for patient and non-patient related activity based on NHS estimates

A combination of sources including NHS and Egton Medical Information Systems (EMIS) data were used (see table below for details). The volume of GP activity that is not charged was identified (e.g. telephone consultations or review of patient records). Although GPs do not directly receive income for these services, a cost-based approach was used to provide an indicative cost of performing these services.

It was estimated, using this approach, that total GP income (based on cost for providing the services) could range between £19.1m and £20.3m in 2019. This provides further reassurance of the total income estimated above using Government of Jersey estimates of GP funding and complementing for additional services not reflected in funding from the HIF and HCS.

Table A2.15: Estimated cost of providing GP services (2019)

Type of service	Number per year[57]	Time taken to perform service (minutes) [58]	Cost of GP time per hour[59]	Indicative income by service (£)
Activities associated with income				
GP Consultation (non-home visit)	309,326	9.22	£255	12,120,900
GP Consultation (home visit)	16,943	45	£255	3,240,300
Scripts	74,129	5	£255	1,575,200
Referrals	42,200 – 87,500	5	£255	896,800 – 1,859,400
Death certifications	820	60	£255	209,100
Flu vaccination	12,000 – 15,000	5	£255	255,000 – 318,800
Smear test	4,428	20	£255	376,400
Child immunisation	5,752	10	£255	244,500
Activities not associated with income				
Telephone consultations	15,534	5.4	£156	218,100
Review of patients (e.g. results)	230 working days	180 (per day)	£156	107,600
Other non-patient activity	230 working days	30 (per day)	£156	17,900
Total				**19.1-20.3m**

The second step of our analysis estimates the **total costs associated with running a GP practice**. The Government of Jersey estimates of the average running costs of a GP practice have been used to develop assumptions. The estimates were adjusted for different practice size. It should be noted, however, that these may underestimate the true cost of business for GP practices in Jersey and that further consultation with these practices would be required to estimate a more accurate cost of business for GP practices in Jersey.

Table A2.16: Estimated GP practice running costs per year (2019)

Type of cost	0-4,999 patients	5,000-9,999 patients	10,000-14,999 patients	15,000-19,999 patients	20,000+ patients

[57] Consultations based on HIF data, other volumes based on Government of Jersey estimates.

[58] Face to face and telephone consultation time (Hobbs et al. 2019), other duration based on Government of Jersey estimates.

[59] Unit Costs of Health and Social Care (2019), £255 or £156 GP cost per hour of patient contact or non-patient contact respectively.

Employee costs	£136,000	£384,000	£746,000	£885,000	£1,124,000
Office & general business	£84,000	£237,000	£460,000	£545,000	£692,000
Premises	£43,000	£120,000	£234,000	£277,000	£352,000
Total per practice	£263,000	£742,000	£1,440,000	£1,708,000	£2,168,000
Number of practices in Jersey	4	6	1	1	1
Total cost in Jersey			**£10,820,000**		

It is also recognised that in addition to the annual running costs of GP practices outlined above, there will also be one-off implementation costs associated with the purchase of goodwill and state infrastructure. Table A2.17 below provides indicative estimates from the Government of Jersey. Further analysis is required to provide more accurate estimates and assess the time period of payments.

Table A2.17: Estimated total one-off costs of moving to a GP salaried model (2019)

Type of cost	Estimated value (£)	Source / Assumptions
Goodwill	£31,875,000	£375k per GP FTE (Government of Jersey estimates)
GoJ infrastructure	£2,000,000	GoJ estimates
Total	**£33,875,000**	

In summary, it is estimated that the total cost of running the 13 GP practices in Jersey in 2019 could be around £10.8m. It is also estimated that total income across the 13 GP practices in Jersey is between £24m – £25m. These estimates imply that the total net income (revenues less costs) for the 13 GPs in Jersey is c. £13.6m or an average salary of £160,300 per GP. The average income before tax for contractor GPs in England was estimated at £113,400 in 2019, or £142,000 including 25% on-costs.[60]

Table A2.18: Total estimated costs of a GP salaried model (excluding one-off costs), 2019

	Estimated costs of GP salaried model
GP (FTEs)	85
GP salary, incl. on-costs (estimate based on income less cost)	£160,300
Total salary costs	£13,624,600
Total running costs (estimated based on running 13 GP practices privately)	£10,820,100
Total estimated annual cost	£24,444,700

Long run estimates, 2021-2024

To estimate the total income of GPs between 2021 and 2024 it is assumed that all GP services will increase in line with the assumptions on GP consultations and workforce requirements in the 'do-nothing' or 'do-something' scenarios. Similarly, 2019 estimates are used for the cost of running a GP practice, uplifted for inflation and additional GP practices required. The key assumptions include:

- The analysis described above is used to estimate average income per FTE of £287,600

[60] Unit Costs of Health and Social Care (2019)

- The forecasted GP appointments and workforce requirements as described in Section 4.2 are used.
- It is also assumed that an additional 3 GPs implies one new practice (0-5,000 patient size), an additional 5 GPs implies one new practice (5,000-10,000 patient size) and an additional 10 GPs implies one new practice (10,000-15,000 patient size).

It is estimated that the number of FTE GPs will increase from 87 in 2021 to 91 in 2024 and from 89 to 100 in a 'do-nothing' and 'do-something' scenario respectively. It is also estimated that the increased activity and FTEs will require additional practices and, therefore an increase in cost of running the GP practices.

It is estimated that between 2021 and 2024, the total cost of a GP salaried model in terms of GP salaries will range between £54.2m and £57.3m in a 'do-nothing' and 'do-something' scenario. In addition, the total cost of running the GP practices, based on the costs of running the practices privately, is estimated to be between £41.8m and £43.4m. It is noted that these estimates are based on GP income and an estimated margin of 45% and based on estimates of running GP practices privately. This excludes the one-off implementation costs which are estimated to be c. £33.9m in 2019 prices.

It is noted that the estimated GP income reflects all services provided by GPs. In comparison, the analysis in Options 2 and 3 that assessed a universal capitation scheme reflects only FFS GP appointments which in 2019 accounted for c.£16.7m out of a total GP income of around £24.5m.

Table A2.19: Total estimated GP income and running costs, 2021-2024 (NPV, 2019)

	'Do-nothing'	'Do-something'
Total salary costs	£54,230,250	£57,332,367
Total running costs (estimated based on running GP practices privately)	£41,790,213	£43,433,804
Total estimated cost (2021-2024)	**£96,020,463**	**£100,766,171**

Appendix 3: Technical Group Terms of Reference

Technical Group Terms of reference

Aim

The main aim is to help facilitate between members of the group the analytical requirements of the Jersey Care Model review and Our Hospital programme, including; the sharing of information, agreement on the scope and direction, and to discuss analysis and findings.

Objectives

The objectives of the Technical working group are:

1. To discuss the scope of analytics and modelling work required by the programme and agree direction
2. To facilitate the sharing of national and local datasets, and discuss timelines for delivery
3. To facilitate the sharing of GoJ analytical models as required by the project
4. To review and validate assumptions used within the modelling
5. To review relevant analytical outputs/models produced by the consultants and discuss their interpretations
6. To discuss relevant blocks to progress and other issues (analytics/other)

The Technical Group will be responsible for the following

1. Work collaboratively with members of the GoJ, PwC and MJM to ensure successful results of the programme
2. Review and sign off the analytical approach used for the Jersey Care Model review analysis
3. Review and sign off analytical outputs produced for the Jersey Care Model review
4. Review and sign off the model specification document for the Our Hospital demand and capacity modelling
5. Review and sign off all assumptions used in the demand and capacity modelling
6. Review and sign off demand and capacity model outputs

Accountability

The Technical Group will be shared between the JCM review and the Our Hospital programme and is accountable to the Steering Groups for both programmes.

Membership
Below is a list of those appointed to the Technical group based on their expertise and experience:

Name	Position
Robert Sainsbury (Chair)	Group Managing Director for HCS
Patrick Armstrong	Medical Director
Rachel McBride	General Manager, Mental Health
Rose Naylor	Chief Nurse, HCS
Paul Ahier	Senior Informatics Analyst
Joanne Larkin	Head of Finance Business Partnering

Lauren Jones	Finance Business Partner
Pamela Hobbs	Finance Business Partner
Darren Skinner	HR Director
Isabel Watson	Chief Social Worker
Paul McGinnety	Deputy Director Primary & Community Pathways
Andrew Carter	Governance and Performance Analyst
Sam Lempriere	Informatics Manager
David O'Brien	PwC Partner
Rosie Oglethorpe	PwC consultant
Monica Mittal	PwC consultant
*Other	

*Additional persons may also attend this meeting as and when required to meet the overall objectives of the programme

Appendix 4: Details behind financial modelling

Table A4.1: Annual growth assumptions

Area	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Scheduled Care – Day Case	1.7%	1.6%	1.7%	1.7%	1.7%	1.5%	1.5%	1.7%	1.6%	1.3%	1.5%	1.3%	1.2%	1.2%	1.2%	1.1%	25.3%
Scheduled Care – Elective Inpatient	1.7%	1.6%	1.7%	1.7%	1.7%	1.5%	1.5%	1.7%	1.6%	1.3%	1.5%	1.3%	1.2%	1.2%	1.2%	1.1%	25.3%
Scheduled Care – Non Elective	2.0%	2.0%	1.9%	2.0%	1.9%	2.1%	1.9%	2.0%	1.9%	1.9%	2.1%	1.8%	1.8%	1.8%	1.9%	1.8%	35.1%
Scheduled Care – Outpatient First	1.7%	1.6%	1.7%	1.7%	1.7%	1.5%	1.5%	1.7%	1.6%	1.3%	1.5%	1.3%	1.2%	1.2%	1.2%	1.1%	25.1%
Scheduled Care – Outpatient Follow-Up	1.6%	1.6%	1.6%	1.5%	1.5%	1.5%	1.5%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.3%	1.3%	1.2%	26.7%
Unscheduled Care	1.4%	1.4%	1.4%	1.4%	1.3%	1.4%	1.3%	1.4%	1.4%	1.3%	1.4%	1.3%	1.3%	1.2%	1.3%	1.2%	23.3%
Women Children & Family Care	0.6%	1.0%	0.8%	0.9%	1.1%	0.8%	1.1%	1.0%	1.0%	0.9%	1.0%	0.9%	1.0%	1.0%	1.0%	1.0%	16.8%
Clinical Support Services	1.7%	1.7%	1.7%	1.5%	1.6%	1.6%	1.5%	1.5%	1.5%	1.4%	1.5%	1.4%	1.4%	1.3%	1.4%	1.3%	24.3%
Non-Clinical Support Services	1.7%	1.7%	1.7%	1.5%	1.6%	1.6%	1.5%	1.5%	1.5%	1.4%	1.5%	1.4%	1.4%	1.3%	1.4%	1.3%	24.3%
Primary Care & Prevention	1.5%	1.4%	1.3%	1.4%	1.5%	1.4%	1.5%	1.5%	1.5%	1.4%	1.4%	1.4%	1.3%	1.3%	1.3%	1.3%	24.5%
Mental Health	1.5%	1.4%	1.3%	1.6%	1.6%	1.5%	1.8%	1.8%	1.7%	1.6%	1.7%	1.6%	1.6%	1.5%	1.6%	1.5%	28.7%
Commissioning & Partnerships	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	21.3%
Social Care	3.3%	2.5%	2.4%	3.3%	3.5%	3.1%	4.1%	4.2%	3.7%	3.3%	3.4%	2.7%	2.8%	3.0%	3.4%	2.8%	67.3%
Other	1.7%	1.7%	1.7%	1.5%	1.6%	1.6%	1.5%	1.5%	1.5%	1.4%	1.5%	1.4%	1.4%	1.3%	1.4%	1.3%	24.3%

Table A4.2: Annual 'do nothing' expenditure

Organisation	Workstream	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036
HCS	Secondary Scheduled Care	59.5	61.8	64.3	66.9	69.6	72.4	75.3	78.3	81.5	84.7	88.1	91.6	95.2	98.9	102.8	106.8	111.0
HCS	Clinical Support Services	35.0	36.3	37.8	39.2	40.8	42.3	44.0	45.7	47.5	49.3	51.2	53.2	55.2	57.3	59.4	61.7	63.5
HCS	Commissioning & Partnerships	12.5	13.0	13.6	14.1	14.7	15.4	16.0	16.7	17.4	18.1	18.9	19.7	20.6	21.4	22.3	23.3	24.3
HCS	Mental Health	22.6	23.5	24.5	25.6	26.8	28.0	29.3	30.6	32.1	33.5	35.0	36.6	38.3	40.0	41.8	43.6	45.6
HCS	Non-Clinical Support Services	28.8	29.9	31.0	32.3	33.5	34.8	36.2	37.6	39.0	40.5	42.1	43.7	45.4	47.1	48.9	50.7	52.2
HCS	Primary Care & Prevention	11.4	11.9	12.4	13.0	13.5	14.1	14.8	15.5	16.1	16.9	17.6	18.4	19.2	20.0	20.9	21.7	22.7
HCS	Social Care	20.6	21.7	22.9	24.4	26.0	27.6	29.6	31.8	33.9	36.1	38.5	40.7	43.1	45.7	48.7	51.6	55.2
HCS	Unscheduled Care	13.6	14.1	14.6	15.2	15.7	16.3	16.9	17.5	18.2	18.9	19.6	20.3	21.1	21.8	22.6	23.5	24.3
HCS	Women Children & Family Care	14.8	15.4	16.0	16.6	17.3	18.0	18.7	19.5	20.3	21.1	21.9	22.8	23.7	24.7	25.6	26.7	27.8
HCS	Other	15.3	16.0	16.8	17.6	18.4	19.2	20.1	21.0	21.9	22.9	24.0	25.0	26.1	27.3	28.4	29.7	30.6
CLS	Primary Care & Prevention	33.2	34.5	35.9	37.1	39.4	41.9	44.5	47.2	50.2	53.4	56.8	60.4	64.3	68.3	72.6	77.2	82.0
CLS	Social Care	55.5	60.0	64.9	69.9	74.3	79.1	84.1	89.5	95.2	101.0	107.1	113.6	120.4	127.7	134.3	141.3	148.6
CYPES	Mental Health	3.3	3.5	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.3	5.5	5.8	6.0	6.3	6.6	6.9
SPPP	Public Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Patient/User Contributions	Primary Care & Prevention	10.8	11.3	11.8	12.3	12.8	13.4	14.0	14.6	15.3	16.0	16.7	17.4	18.2	19.0	19.8	20.6	21.5
Multiple	Additional COVID-19 expenditure	41.5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total	**378.3**	**353.0**	**370.1**	**387.9**	**406.9**	**426.6**	**447.8**	**470.1**	**493.4**	**517.4**	**542.7**	**568.9**	**596.4**	**625.2**	**654.6**	**685.0**	**716.3**

Table A4.3: Annual Impact by intervention

ID	High level description of the change to the current care setting	Annual gross impact of interventions £m															
		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036
1	Move some ED activity to primary care	0.1	0.1	0.2	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7
2	Reduce ED attendances for other reasons age 65+	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3
3	Divert some remaining ED activity to a new UCC	0.3	0.6	0.9	1.3	1.4	1.5	1.5	1.6	1.7	1.8	1.8	1.9	2.0	2.1	2.2	2.3
4	Reduce hospital admission rates	1.9	4.1	8.5	8.9	9.4	9.8	10.3	10.8	11.3	11.9	12.4	13.0	13.6	14.2	14.8	15.5
5	Reduce physiotherapy outpatients	-	0.3	0.5	0.8	1.2	1.2	1.3	1.3	1.4	1.5	1.5	1.6	1.7	1.7	1.8	1.9
6	Reduce Trauma and Orthopaedics outpatients	-	0.1	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	0.6
7	Reduce ENT outpatients	-	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
8	Reduce Ophthalmology outpatients	-	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2
9	Reduce Gastroenterology referrals	-	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3
10	Reduce Gynaecology outpatients	-	0.1	0.3	0.5	0.7	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	1.0	1.0	1.1
11	Move Community Dental Service outpatients to community dental practices	-	0.1	0.3	0.4	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9
12	Reduce Dermatology follow-up appointments	-	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
13	Reduce Cardiology follow-up appointments	-	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3
14	Reduce Neurology follow-up appointments	-	0.1	0.1	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4
15	Reduce General Medicine follow-up appointments	-	0.1	0.2	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6
16	Reduce Thoracic Medicine follow-up appointments	-	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4
17	Move Podiatry Education outpatients to the community	-	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
18	Reduce mental health average length of stay to Getting It Right First Time (GIRFT) target of 34.6 days	-	0.5	1.0	1.6	2.3	2.4	2.5	2.6	2.7	2.9	3.0	3.1	3.3	3.4	3.6	3.8

		Annual gross impact of interventions £m															
ID	**High level description of the change to the current care setting**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**
19	Reduce length of stay for stranded patients (>7 days) by the equivalent of up to 25 beds	-	2.3	4.5	4.7	4.9	5.2	5.4	5.7	6.0	6.3	6.6	6.9	7.2	7.6	7.9	8.3
20	Reduce care home placements to England 3rd quartile	-	7.1	15.4	16.3	17.4	18.5	19.7	20.9	22.2	23.6	25.0	26.5	28.1	29.5	31.1	32.7
21	Reduce care home placements to England 3rd quartile	-	4.2	9.0	9.5	10.1	10.8	11.5	12.2	13.0	13.7	14.6	15.4	16.4	17.2	18.1	19.1
	Total	**2.3**	**19.9**	**41.6**	**46.1**	**50.5**	**53.4**	**56.4**	**59.6**	**62.8**	**66.3**	**69.9**	**73.7**	**77.7**	**81.5**	**85.5**	**89.6**

Table A4.4: Annual do something expenditure

Organisation	Workstream	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036
HCS	Secondary Scheduled Care	59.5	61.8	61.1	60.2	57.1	53.7	55.7	57.8	59.9	62.2	64.5	66.9	69.3	71.9	74.5	77.2	80.0
HCS	Clinical Support Services	35.0	36.3	37.8	39.2	40.8	42.3	44.0	45.7	47.5	49.3	51.2	53.2	55.2	57.3	59.4	61.7	63.5
HCS	Commissioning & Partnerships	12.5	13.0	13.6	14.1	14.7	15.4	16.0	16.7	17.4	18.1	18.9	19.7	20.6	21.4	22.3	23.3	24.3
HCS	Mental Health	22.6	23.5	24.0	24.6	25.1	25.7	26.9	28.1	29.4	30.8	32.2	33.6	35.1	36.7	38.4	40.0	41.9
HCS	Non-Clinical Support Services	28.8	29.9	31.0	32.3	33.5	34.8	36.2	37.6	39.0	40.5	42.1	43.7	45.4	47.1	48.9	50.7	52.2
HCS	Primary Care & Prevention	11.4	11.9	13.1	16.4	19.9	21.4	22.4	23.4	24.4	25.4	26.5	27.6	28.8	30.0	31.3	32.6	33.9
HCS	Social Care	20.6	21.7	22.9	24.4	26.0	27.6	29.6	31.8	33.9	36.1	38.5	40.7	43.1	45.7	48.7	51.6	55.2
HCS	Unscheduled Care	13.6	14.3	14.8	14.4	14.0	14.5	15.0	15.6	16.1	16.7	17.3	18.0	18.6	19.3	20.0	20.7	21.4
HCS	Women Children & Family Care	14.8	15.4	16.0	16.6	17.3	18.0	18.7	19.5	20.3	21.1	21.9	22.8	23.7	24.7	25.6	26.7	27.8
HCS	Other	15.3	18.5	21.3	22.3	23.2	24.2	25.2	26.3	27.4	28.6	29.8	31.0	32.3	33.6	35.0	36.4	37.5
CLS	Primary Care & Prevention	33.2	34.5	35.9	37.8	40.8	43.3	45.9	48.8	51.8	55.1	58.5	62.2	66.2	70.3	74.6	79.3	84.2
CLS	Social Care	55.5	60.3	67.8	72.0	78.0	74.6	79.6	84.8	90.3	95.8	101.6	107.7	114.2	121.1	127.8	134.9	141.7
CYPES	Mental Health	3.3	3.5	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.3	5.5	5.8	6.0	6.3	6.6	6.9
SPPP	Public Health	0.0	0.6	0.8	0.8	0.9	0.9	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2	1.2	1.2
Patient/User Contributions	Primary Care & Prevention	10.8	11.3	11.8	12.3	12.8	13.4	14.0	14.6	15.3	16.0	16.7	17.4	18.2	19.0	19.8	20.6	21.5
Multiple	Additional COVID-19 Expenditure	41.5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total	**378.3**	**356.7**	**375.6**	**391.2**	**408.2**	**414.0**	**434.5**	**456.1**	**478.5**	**501.7**	**526.0**	**551.1**	**577.4**	**605.2**	**633.8**	**663.6**	**693.4**

Appendix 5: Workstream Analysis

A summary of findings from JCM testing within several workstreams are outlined below:

Figure A5.1: Mental health

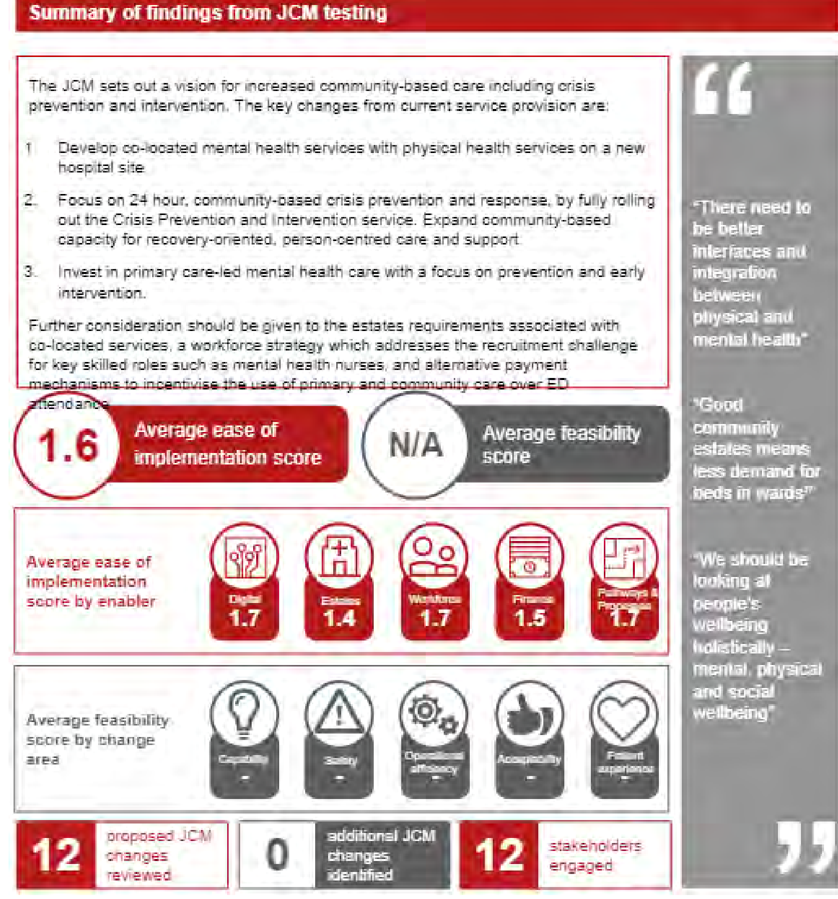


Figure A5.2: Adult Social Care

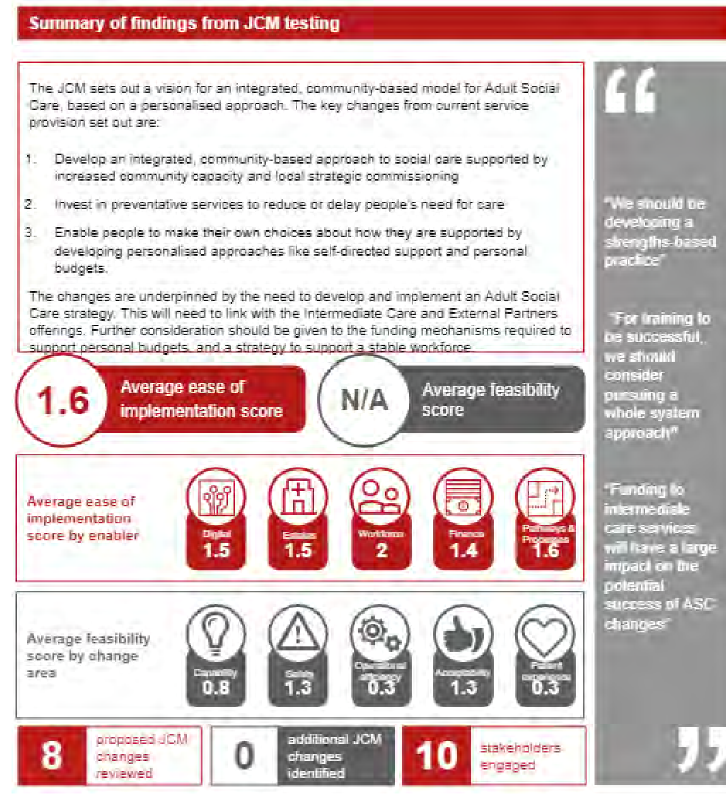


Figure A5.3: Scheduled care

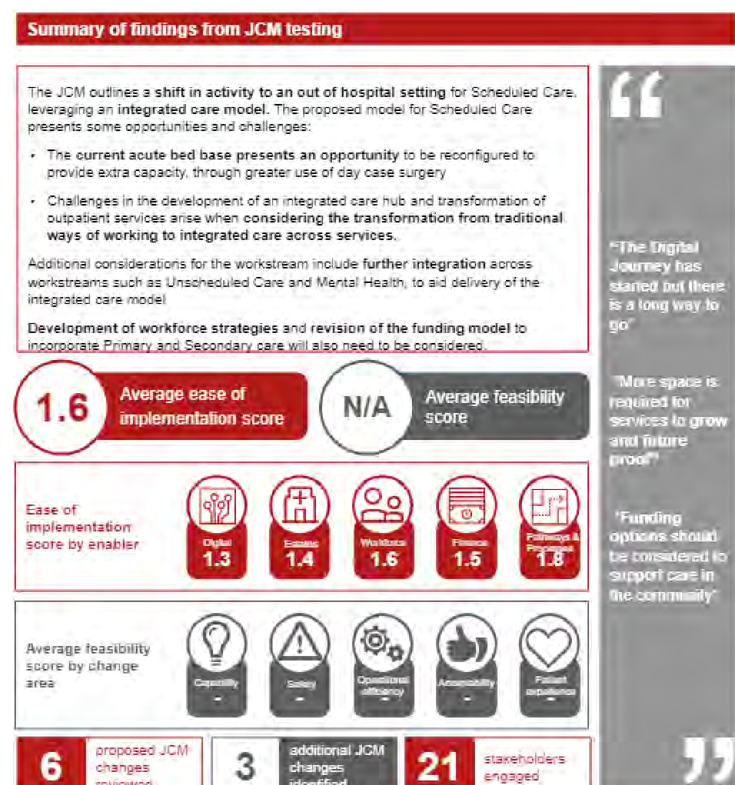


Figure A5.4: Unscheduled care

Summary of findings from JCM testing

Unscheduled care is looking to transform the current acute and emergency care, namely from an **ED department to an Emergency Care Centre (ECC)** with a redesign of the acute floor model, to **increase bed capacity** through robust admission process and improved discharge.

- The **development or redesign of estates** to support the proposed floor model for Unscheduled Care will provide the opportunity to establish the ECC model
- Challenges to transform from current service provision to incorporate more **ambulatory assessments** into Unscheduled Care will need to be addressed in order to realise benefits seen elsewhere.

Further considerations for Unscheduled Care include a **review of the funding and charging models** due to proposed closer integration with Primary Care and further development of **emergency transfer service plans**.

"Developing information sharing capability will be key to effectively manage patient care across pathways"

"A financial exercise to investigate and assess workforce and estates would be needed"

"Workforce links to other hospitals should continue to be developed"

1.5 Average ease of implementation score

N/A Average feasibility score

Ease of implementation score by enabler

Digital	Estates	Workforce	Finance	Pathways & Processes
1.6	1.3	1.7	1.6	1.4

Average feasibility Score by change area

Capability	Safety	Operational efficiency	Acceptability	Patient experience
-	-	-	-	-

5 proposed JCM changes reviewed

8 additional JCM changes identified

10 stakeholders engaged

Figure A5.5: Clinical Support Services

Appendix 6: HMT Commissioning agreements

Table A6.1: non-comprehensive schedule of HMT's commissioning arrangements by organisation, service and 2019 contract value.

Organisation	Service	2019 Contract Value
Family Nursing Homecare	Health visiting, community paediatric nursing, school nursing, district nursing, sustained home visiting and Rapid response and Reablement team	£7,036,000
Hospice	Partnership arrangement with Jersey Hospice to deliver specialist palliative care services	£513,999
Shelter (including JHOG)	To provide accommodation and support for homeless people over a number of units as well as outreach support.	£1,112,431
Jersey Alzheimer' Association	Provide a Saturday club for people living with mild to moderate stage dementia and a 24hr helpline.	£34,168
Refuge	To provide temporary safe accommodation to women and their children suffering from domestic violence.	£209,458
Listening Lounge	Provision of a Listening Lounge 10.00 to 22.00 7 days per week drop in sessions and counselling appointments.	£134,664
Silkworth Lodge	To enable individuals to achieve independent living whilst remaining absent from alcohol and/or drugs.	£402,168
Communicare	The provision of a weekly friendship club including day activities, transport and food mainly run by volunteers.	£8,518
Age Concern	Provide a frozen meal delivery service to service users twice a week and occasional transport for clients receiving lunch at the age concern centre.	£16,964
Mind	To provide a range of support services to carers of people with mental health problems.	£78,902
My Voice	Provide independent advocacy services to people with significant mental health problems or those who lack capacity who do not have support from a significant other.	£232,000
Good Companions	Day care/activities for 40 individuals daily with a range of activities that promote social interaction. Transport to the day centre, refreshments and lunch.	£39,504
Headway	Provide day support for adults with acquired brain injuries as well as day centre services.	£29,000
Relate	Provide information and guidance to people who are going through, or have gone through, the separation or divorce process.	£33,374

Organisation	Service	2019 Contract Value
Recovery College	Provides a range of free courses so support understanding and knowledge of mental health conditions, recovery, wellbeing and life skills.	£121,000
Citizens Advice	Champion the rights of individuals and promote equality and justice for all citizens by providing free advice and maintaining the Jersey Online Directory.	£363,634
Call and Check	Regular visits are made by referred individual's postmen to find out how the recipient is and if there is anything they need.	£100,000

Sources: Government of Jersey, Overview – Partnerships, Primary Care, Assistive Technology, April 2020 and HCS Partner Overview, April 2019

Appendix 7: Engagement events

Partner engagement sessions

Primary Care – group session 1, 19th June (estimate 30 attendees mainly GPs, a few Pharmacy)

Primary Care – group session 2, 11 Sep (estimate 20 people, mainly pharmacy and dental)

General Practice, surgery visits (Rob Sainsbury + 1 (various):

Date	Time	Audience	Location
09-Aug	12:00-13:00	GPs	Route de Fort Surgery
12-Aug	12:30-13:30	GPs	Indigo Medical Practice
28-Aug	18:00-19:00	GPs	7 David Place Surgery (+ GPs from Windsor Medical Practice, Atlantic Surgery, Clifden House)
29-Aug	12:45-14:00	GPs	Health Plus GP Practice
29-Aug	18:00-19:00	GPs	Island Medical Centre
02-Sep	18:30-19:30	GPs	Lister House
02-Sep	20:00-20:30	GPs	Cleveland Clinic
03-Sep	19:00-20:00	GPs	Co-operative Medical Care
04-Sep	19:00-20:00	GPs	Lido Medical Practice
06-Sep	TBC	GPs	Castle Quay Medical Practice

External Partners – Group session 30 July

Attended by

- Jersey Hospice Care Emelita Robbins
- Family Nursing & Home Care (FNHC) Bronwen Whittaker
- Silkworth Trust Jason Wyse
- Cheshire Homes Jim Hopley
- Diabetes Jersey Bill O'Brien
- Call and Check Joe Dickinson & Phil Romeril
- Jersey Alzheimer's Association Sean Pontin
- Headway Ray Cooper
- Shopability Edward Trevor Edward Trevor
- Liberate Vic Tanner-Davy
- Mind James Le Feuvre

External Partners – Wider Engagement

Multiple visits by Rose Naylor and Paul McGinnety to Voluntary organisations

Date	Audience	Contact	Notes
30-Jul	Mind	James Le Feuvre	
30-Jul & 31-Jul	Jersey Hospice Care	Emelita Robbins	
30-Jul	Headway	Ray Cooper	
30-Jul	Jersey Alzheimer's Association	Sean Pontin	
30-Jul	Jersey Employment Trust	Jocelyn Butterworth	
30-Jul	Diabetes Jersey	Bill O'Brien	
30-Jul & 06-Aug	Age Concern	Paul Symonds	
30-Jul	Silkworth	Jason Wyse	
01-Aug	Good Companions	Angela Falle	
02-Aug	Communicare	Tony Hocking	
02-Aug	Woman's Refuge	Judith	
06-Aug	Coop	Ian Winstanley	
06-Aug	Relate	Amanda	
21-Aug	Mental Health Cluster	Sean McGonigle	
22-Aug	Jersey Sport	Catriona Mcallister	
22-Aug	Independent Advocacy Service – MyVoice	Patricia Winchester	
22-Aug	LV Homecare	Edgar Dingle	
22-Aug	Les Amis	Shaun Findlay	
22-Aug	Tutela	Caroline	
22-Aug	Autism Jersey	Chris Dunne	
23- Aug	Closter to Home Steering Group	Sally Haine	
23-Aug	Jim Hopley – Disability Partnership	Jim Hopley	
28 – Aug	Red Cross	Nick Chandler	
29-Aug	Jersey Recovery College	Beth Moore	
04-Sep	Citizens Advice Bureau	Malcolm Ferry	
09-Sep	Shelter	Guy Le Maistre	
04-Sep & 27 Nov	Care Federation	Various	27 Nov was full meeting at Little Sisters of the poor will all members. CLS management also in presenting re LTC fund.
10th Sept	Mencap	LD Cluster	Sean McGonigle – contact through the Cluster
10th Sept	LD Cluster	Sean McGonigle	

Date	Audience	Contact	Notes
15th Sept	Oxygen Therapy	Through Jim Hopley	Information sent to organisations with opportunity to comment
11th Sept	Beresford Street Kitchen	LD Cluster	Sean McGonigle – contact through the Cluster
15th Sept	Stroke Association	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	Eyecan	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	dDeaf	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	Jersey Association of Carers Incorporated	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	Jersey Disability Partnership	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	St John Ambulance	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	Enable Jersey	Through Jim Hopley	Information sent to organisations with opportunity to comment
17th Sept	Jersey Cancer Trust	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	CLIC Sargent Cancer Care for Children	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	Donna Annand Melanoma Charity (The)	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept	Jersey Brain Tumour Charity (The)	Through Jim Hopley	Information sent to organisations with opportunity to comment
17th Sept	Jersey Cancer Relief	Through Jim Hopley	Information sent to organisations with opportunity to comment
17th Sept	After Breast Cancer Support Group	Through Jim Hopley	Information sent to organisations with opportunity to comment
15th Sept & 17th October	Macmillan Cancer Support Jersey	Through Jim Hopley	Information sent to organisations with opportunity to comment and follow – up session held with the team.

Open Sessions for HCS and Gov Staff

Day	Date	Time	Audience	Location
Mon	02-Sep	15:30-16:30	All HCS	Rose Bay Room, Rosewood House, St Saviour's Hospital
Tue	03-Sep	13:45-14:30	All HCS	Staff Meeting Room, Samares Ward, Overdale Hospital
Tue	03-Sep	14:45-15:45	All HCS	Big Meeting Room at Poplars, Overdale Hospital
Thu	05-Sep	12:00-13:00	All HCS	St Helier Room, Eagle House
Fri	06-Sep	12:15-13:00	All HCS	Halliwell Lecture Theatre, JGH*
Fri	06-Sep	13:00-13:45	All HCS	Halliwell Lecture Theatre, JGH*

Tue	10-Sep	12.15-13.00	All Gov	HCS Area, Broad Street Office

Staff were also given the email address and followed up by a One question Smart Survey

Targeted Sessions

Day	Date	Time	Audience	Location
Thu	22-Aug	13:30-14:00	Senior Sisters Meeting	Room 1 Education Centre, JGH
Wed	04-Sep	13:00-14:00	HCS Soft facilities staff only	Halliwell Lecture Theatre, JGH
Mon	09-Sep	14:00-14:45	Registered Managers Group	Dining Hall, Sandybrook Nursing Home
Tue	10-Sep	09:00-10:00	Medical Staffing Committee (MSC) (all consultants)	Halliwell Lecture Theatre, JGH
Wed	Weekly	4.30-5.30	All Associate Medical Directors	4th Floor Peter Crill House

Government Senior Officers and Politicians

Date	Audience
03-Sep	Corporate Strategy Board
03-Oct	Political Oversight Group for Our Hospital Project
16-Oct	Council of Ministers
18-Oct	Health and Community Services Scrutiny Panel (private briefing)
21-Oct	States Members briefing

Public Engagement

- Press Briefing – 28 Oct
- Social media launch – 28 Oct
- Leaflet drop to all houses in Jersey – 18 Nov

Public Engagement Sessions

- St Martin: Public Hall Thursday, 28 November 1-3pm (estimate = 50 people)
- St Mary: Parish Hall Friday, 29 November 1-3pm (estimate 30 people)
- St John: Parish Hall Saturday, 30 November 10.30am-12.30pm (estimate 30 people)
- St Helier: Town Hall Monday, 2 December 1-3pm (estimate 60 people)
- Trinity: Parish Hall Monday, 2 December 6.30-8.30pm (estimate 30 people)
- St Helier: Town Hall Tuesday, 3 December 6.30-8.30pm (estimate 20 people)
- St Peter: Parish Hall Wednesday, 4 December 6.30-8.30pm
- St Ouen: Parish Hall Thursday, 5 December 1-3pm
- St Brelade: Parish Hall Thursday, 5 December 6.30-8.30pm
- Grouville: Parish Hall Friday, 6 December 1-3pm
- St Clement: Parish Hall Saturday, 7 December 10.30am-12.30pm
- St Lawrence: Parish Hall Tuesday, 10 December 1-3pm
- St Saviour: Primary School Wednesday, 11 December 6.30-8.30pm

Appendix 8: Engagement in the JCM review

Technical group membership

Stakeholders engaged as part of the Jersey Care Model Review

We would like to acknowledge the commitment and dedication of the individuals outlined below, who were engaged as part of the review of the Jersey Care Model.

Stakeholders			
Adrian Noon	Effie Liakopoulou	Lauren Wilson-Kelly	Petra Schinle
Adrian O'Keeffe	Emelita Robbins	Lee Hayward	Phil Romeril
Agnetta Nerac	Emma O'Connor	Lesley Hill	Phil Terry
Ajay Kumar	Emma Ward	Lindsey Ash	Philip Le Sueur
Alan Thompson	Fiona Nelson	Lindsey Le Masurier	Philippa Daubeney
Alex Crowther	Helen Goulding	Lizzie Guise	Philippa MacAndrew
Alex Watt	Hilary Lucas	Louise Hotton	Rachel McBride
Alex Wiles	Hugh Raymond	Louise Journeaux	Raymond Cooper
Amanda Eidukas	Ian De La Cour	Lyndon Farnham	Richard Bannister
Andrew Carter	Isabel Watson	Malcolm Ferey	Richard Bell
Andrew Heaven	Isobel Hamon	Maria Benbown	Richard Glover
Andy Scate	Jackie Tardivel	Mark Queree	Richard Renouf
Angela Falle	Jake Bowley	Mark Wilbourn	Robert Sainsbury
Ashok Handa	James Le Feuvre	Martin Knight	Rose Naylor
Assumpta Finn	James Mair	Martin Warnette	Rowland Huelin
Beth Moore	Jan Auffret	Michelle West	Roy Valentine
Bronwen Whittaker	Jason Wyse	Miguel Garcia-Alcaraz	Ryan McNay
Carl Walker	Jennie Pasternak	Mike Richardson	Samantha McManus
Caroline Landon	Jennifer Newall	Mike Thomas	Sara Kynicos
Charlie Parker	Jessie Marshall	Miklos Kassai	Sarah Blake
Cheryl Kenealy	Jo Poynter	Muktanshu Patil	Sarah Shaw
Chris Dunne	Jocelyn Butterworth	Natalie Mallet	Sean Pontin
Chris Jury	John Hodge	Nick Dodds	Sebastian Perez
Christine Blackwood	John Le Fondre	Nigel Minihane	Sharon Summers-Ma
Claire Ryder	John Quinn	Oliver James	Shaun Findlay
Claire Sambridge	John Rogers	Oonagh Butler	Simon Chapman
Clare Fitton	Josh Brien	Pamela Hobbs	Stephen Bull

Stakeholders			
Clare Stewart	Joss Douthwaite	Patricia Winchester	Stephen Hardwick
Cristina Ferreira	Judith Gindill	Patrick Armstrong	Steve Mair
Darren Skinner	Karen Pallot	Patrick Le Coz	Tony Hocking
David Ng	Karen Veljovic	Paul McCabe	Tracey Perchard
David Queen	Kate Biljon	Paul McGinnety	Val Howard
Deborah O'Driscoll	Kate Southern	Paul Michel	Valter Fernandes
Dennis Pimblott	Kemi Akinpelu	Paul Rendell	Washington Gwatidzo
Ed Klaber	Kerry Bartlett	Paul Simmons	Wendy Baugh
Edgar Dingle	Kevin Lewis	Peter Gavey	

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