Review of the Jersey Care Model

Health and Social Security Scrutiny Panel

23rd October 2020

S.R.5/2020

States of Jersey
States Assembly

États de Jersey
Assemblée des États

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1. Executive Summary

In October 2019, the Government published a briefing paper on the Jersey Care Model (JCM), which set out a framework as to how they proposed to change the way that health and care is delivered in Jersey in the future. At that time, it was advised that the framework would be "stress tested" by an external consultant, developed and brought to the States Assembly for debate in 2020. The Panel launched its review of the JCM in December 2019. Due to the on-going pandemic and enormous impact on the day-to-day running of the Health and Community Services Department, the timetable for bringing the JCM to the States Assembly was delayed. The JCM is now due to be debated on 3rd November 2020.

In Chapter 7 of our report, we examined the key proposals of the JCM and how they would change the way that care was currently delivered. We found that the main objectives of the JCM are aligned with what was previously proposed within P.82/2012 – "Health and Social Services: A New Way Forward" and are widely accepted amongst the public and key stakeholders. However, we also found that there was a lack of detail as to how the provision of care will change under the JCM and the impact the new model will have on service users, the workforce and the overall care system in Jersey. These findings made it hard to accurately assess *how* appropriate the model is for Jersey.

Whilst there is reference to some services in the JCM and reference to activity changes in Appendix 4 of the Strategic Outline Business Case, the whole care model in the community has not yet been defined. Therefore, whilst independent services might change, at this stage it is impossible to determine how the whole service will operate together. Furthermore, without the full details of how care will be moved into the community, the Panel and its advisers cannot be confident of the financial implications of this ambition. As a result, the Panel recommends that the Minister for Health and Social Services should ensure that a review of each individual care settings is undertaken, which includes the case of change, a costed service model and a detailed transformation plan. The review must be made available before the end of Tranche 1 of the implementation plan.

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. As part of our review, we conducted a targeted survey with local GPs to hear their views and opinions of the key principles of the JCM and on future working arrangements with the Health and Community Services Department (HCS). The results of the survey are set out in Appendix 3. The results show that a vast majority of GPs felt that they were not sufficiently consulted with about the proposals contained within the JCM. The results also showed that most of the GPs were not receptive to future employment opportunities contracted by HCS and did not believe that HCS

understood the on-going demands on practice in Primary Care. Furthermore, the majority of respondents were not confident the Jersey Care Model, as proposed, could be delivered or that General Practice would be adequately supported under the JCM. We found that engagement with GPs is currently not working appropriately and needs immediate attention, so that they feel significantly more involved, listened to and confident in the JCM. We also found that despite GPs support being vital to the success of the JCM, the plans to address, in detail, changes to the primary and community care offer, only feature in Tranche 3 (years 2023-2025) of the implementation plan. Therefore, the Panel recommends that the Minister should bring forward planning of future primary and community services to Tranche 1 of the implementation plan.

In Chapter 8 we consider the delivery of the Jersey Care Model. We found that due to past failures of delivering changes to our current care model, it is imperative that there is a clear implementation programme in place so that members of the public can have confidence in its delivery. We also found that there is insufficient pace and rigour behind the JCM and those responsible for its delivery are not being held accountable for considerable slippage against previously promised actions. With no end in sight to the global pandemic, there is little confidence that the combination of the current Health and Community Services team, plus its external consultancy support, will deliver the combined agendas of business as usual service delivery, reacting to the continuing pressures of the pandemic, and the JCM, in a timely manner. In the absence of a robust mechanism for maintaining overview and challenge on the detail of the JCM on a very regular basis, we recommend that an independent, non-executive Board is established to hold the executive team to account for the timely and successful delivery of the JCM. The Board would be responsible for agreeing a monthly progress report, which would be informed by a risk log and would describe progress against key monthly milestones in the overall programme. The Board would publish a report at the end of Tranche 1 (2021) which details an analysis of progress made during the first year against a pre-agreed set of outcome-based targets. The report would also include a detailed look ahead to the programme to deliver Tranche 2 of the implementation plan.

In Chapter 9 we consider the availability of the health and care workforce in our community. From the evidence we gathered, it is clear that there is a significant deficit in the current health and social care workforce, of which issues of retention are adding to the increasing pressure on these services. In addition, the proposals contained within the JCM will only exacerbate the already over stretched workforce. Whilst the Panel has been advised of staff deficits in a number of specific areas, to date, we have not been provided with any documentation that confirms the current workforce provision we have in Jersey against what will be needed going forward under the JCM. We found that in the absence of conformation of Jersey's current workforce, the Panel cannot confidently access the impact of the JCM on the future workforce.

It is widely recognised that the worldwide market for health and care professionals is very challenging. Thus, we found that unless the JCM offer is significantly more attractive than offers elsewhere (including lifestyle, cost of living, affordable housing) Jersey will struggle to import the number and type of practitioners from all the clinical disciplines it requires to fulfil the needs of the Jersey Care Model. The Panel recommends that the Minister for Health and Social Services must ensure that the workforce model is judged in the context of the worldwide shortage of health and care delivery staff. The model must therefore demonstrate how it will provide a more attractive proposition, and be more successful, than its competitors in the wider health and care workforce market. The Panel also found that there is a significant risk that the output of the future workforce plan, in terms of numbers, becomes an aspiration that will be never be realised. In order to help mitigate this, the Panel recommends that the Minister must develop a risk assessment for delivering the workforce strategy, that is to be developed as part of the JCM, in order to provide confidence that it can meet the expected demand.

In order to deliver the JCM, non-recurrent investment of £17m over a five-year period is required. In addition, the Model will require the implementation of several new services and expansion of existing out of hospital services which, over 16 years, will cost an estimated £679m. The Panel found that the JCM does provide a list of high-level service changes against projected financial implications. Whilst these are useful, the service model is yet to be completed and therefore the financial implications will be subject to change. Due to the timing of the receipt of detailed financial assumptions the Panel and its advisers were unable to adequately scrutinise the financial model and its validity. We therefore recommend that following the debate, and if the Proposition is passed, the Minister for Health and Social Services should work with the Panel to agree a timetable in which key pieces of evidence (such as proposed budgets, performance measures, workforce plans etc) are provided to Scrutiny over the length of the following Tranche in order to provide ongoing financial assurance. The Panel further recommends that in order to validate the service model and financial assumptions for each year of the implementation plan, the Minister for Health and Social Services should provide the States Assembly with an updated proposed budget for the JCM for each Tranche. This should include an annual report detailing what has been spent on the JCM at the end of that Tranche and an updated plan for the following Tranche.

The Jersey Care Model proposed the need to change the current funding mechanisms for health and care delivery. We found that the current approach to funding primary care is neither resilient nor sustainable. A capitation plus model has been proposed as the preferred primary care payment option to support the delivery of the JCM. In practical terms, a Capitation Plus model would mean that GP surgeries would receive an annual lump sum for taking care of a patient but, in addition, would receive a payment each time a GP saw a patient. However, we found that there did not appear to be wide support of the Capitation Plus model amongst Jersey's GPs or that sufficient consultation was undertaken with the wider GP workforce, beyond the Primary Care Board. The Panel therefore recommends that the Minister must

undertake further consultation with local GPs to ensure that the proposed Capitation Plus model is suitable going forward. It is imperative that the future payment model for primary care is co-created with GPs.

Approval of P.125/2019 – "Affordable Access to Primary Care Scheme", meant that the Minister for Health and Social Services was obligated to bring a Proposition to the States for debate in the third quarter of 2020, which identified a scheme that would improve access to primary care for vulnerable patients, in order that it could be implemented from 1st January 2021. The Panel is extremely disappointed that, despite this, a response to P.125/2019 was not lodged, as anticipated, alongside the JCM in September. Therefore, the Panel recommends that the Minister for Health and Social Services must ensure a Proposition is brought to the States Assembly before the end of 2020 detailing a scheme that will improve access to primary care for vulnerable patients.

The Proposition (P.114/2020) that was lodged by the Minister for Health and Social Services, proposing the JCM, simply asks the States Assembly to approve the strategic objectives of the Model and the proposals to move to the next stage of the programme, to progress to the detailed design and phased implementation. Whilst the Panel are fully supportive of the main objectives of the JCM, without greater detail of how care will be delivered under the model, the impact of the proposals on patient outcomes and the implications of its ambitions on our current workforce, it is impossible to say how supportive we are of all of its ambitions. The recommendations contained within this report would give the Panel greater confidence in approving a move to the next stage as they will allow for further clarity on details of the model, further financial assurances and greater accountability in ensuring the delivering of the JCM. We would therefore ask that the Minister agrees to all of the Panel's recommendations, so we can support the model progressing to the next stages.

2. Chair's Foreword

Following the publication of the Jersey Care Model (JCM) briefing paper in October 2019 it was clear that the Panel needed to review what was being proposed as a critical friend.

The JCM as proposed includes services provided by public, private, voluntary and community organisations. Our work therefore commenced immediately in order that we were able to fully review what was being proposed and the ability to call for evidence from a wide range of service providers. We also included a survey of local GP's, who I would like to thank for their contribution.

Access and cost of these services is critical if the new care model is to be delivered. The JCM lacked the full financial picture as would have been expected when it was presented.

The Panel in order to be able to effectively review the model have engaged an adviser with sound knowledge in this field. I would like to thank them for their input as it has been invaluable to the Panel who I would also like to thank- Deputy Carina Alves, Deputy Kevin Pamplin, Deputy Trevor Pointon and Deputy Geoff Southern – for their contribution to this review.

Deputy Mary Le Hegarat
Chair, Health and Social Security Panel

3. Key Findings

KEY FINDING 1: The main objectives of the Jersey Care Model are aligned with what was previously proposed within P.82/2012 - "Health and Social Services: A New Way Forward".

KEY FINDING 2: Jersey's current care model is unsustainable in the long term due to the Island's ageing demographics

KEY FINDING 3: No further consultation has been undertaken by the Health and Community Services Department with the general public on the Jersey Care Model since the initial engagement process in 2019.

KEY FINDING 4: It is imperative that the public are sufficiently consulted with in order that they understand, and can therefore have confidence in, the ambitions of the Jersey Care Model.

KEY FINDING 5: There is no robust system in place that demonstrates the current health and wellbeing needs of the Island. It is imperative that the 'case for change' for the Jersey Care Model is driven by broader acknowledgment of what isn't working in terms of Jersey's overall current service provision.

KEY FINDING 6: The role of Public Health in the Needs Assessment and the implementation of the Jersey Care Model, in terms of prioritising programme deliverables, will be critical.

KEY FINDING 7: Whilst it is recognised that care in the community can be better for patient outcomes, it is also acknowledged that without adequate communication and care co-ordination, patients may fall within silos. The Panel would therefore support the establishment of a Care Co-ordinator to enable oversight of a patient's journey through the health and social care system.

KEY FINDING 8: Whilst the key ambition of the Jersey Care Model - to transfer services out of the hospital and into the community - is welcomed, there is concern that, to date, there has been little investment from the Government of Jersey into community services, despite the approval of P.82 by the States in 2012.

KEY FINDING 9: The detail as to how services will be configured in the community, working across primary care, community providers, social care, intermediate services, carers or

outreach services from the hospital has not yet been developed. This lack of clarity has caused confusion about how the Jersey Care Model will operate in practice.

KEY FINDING 10: Whilst there is reference to some services in the Jersey Care Model and reference to activity changes in Appendix 4 of the Strategic Outline Business Case, the whole care model in the community has not been defined. Therefore, whilst independent services might change, at this stage it will be impossible to determine how the whole service will operate together.

KEY FINDING 11: Without the full details of how care will be moved into the community, the Panel and its advisers cannot be confident of the financial implications of this ambition.

KEY FINDING 12: To date the Panel has not received tangible evidence of the proposed new "community hubs" – what they would look like, how they would operate and what services would be delivered within them.

KEY FINDING 13: Without clear examples of what will actually be different under the Jersey Care Model, as opposed to theoretical user cases, the public are likely to remain concerned about changes to their known care provision.

KEY FINDING 14: Remodelling primary care is a core part of the Jersey Care Model, recognising that a well-functioning primary care sector is an essential underpinning of the overall model.

KEY FINDING 15: Only 7% of the GPs who responded to the Panel's survey said that they would definitely be receptive to future employment opportunities contracted by Health and Community Services.

KEY FINDING 16: In order for the Jersey Care Model to deliver on its ambitions and proposals, one of the key priorities will be to ensure that GPs are on board with the changes and are "taken along on the journey" whilst the Model progresses.

KEY FINDING 17: When local GPs were asked whether they felt they had been adequately consulted with about the proposals contained within the Jersey Care Model, only 1% of those who responded to the Panel's survey agreed.

KEY FINDING 18: A significant 85% of GPs who responded to the Panel's survey did not believe that Health and Community Services understood the on-going demands on practice in Primary Care.

KEY FINDING 19: Despite GP's support being vital to the success of the Jersey Care Model, the plans to address, in detail, changes to the primary and community care offer, only feature in Tranche 3 (years 2023-2025) of the implementation plan.
KEY FINDING 20: The engagement with GPs is currently not working appropriately and needs immediate attention, so that they feel significantly more involved, listened to and confident in the Jersey Care Model.

KEY FINDING 21: Although the creation of an Urgent Care Centre is central to the envisaged future state of secondary care, the Jersey Care Model does not clearly articulate what the Urgent Care Centre would entail.

KEY FINDING 22: Only 2% of GPs, that responded to the Panel's survey, would like to see the Urgent Care Centre (Urgent Treatment Centre equivalent) reinstated under the proposed Jersey Care Model.

KEY FINDING 23: Although the Jersey Care Model proposes that care in the community will be enhanced by increasing support to carers, there are no firm suggestions or details as to how carers will receive increased support from the Government of Jersey.

KEY FINDING 24: To date, the Health and Community Services Department has been unsuccessful in delivering the Carers' Strategy. However, we have been assured that greater focus will now be given to its delivery as part of the future work in respect of the Jersey Care Model.

KEY FINDING 25: The Panel welcomes the integration of Adult Social Care and Mental Health Services and see the change as a positive step to improving the care received by patients and vulnerable people within our community.

KEY FINDING 26: One of the key ambitions within the Jersey Care Model, in respect of mental health, is to co-locate mental health services within the main new hospital site. Due to this ambition, some options that may have previously been considered regarding the configuration of the new hospital, were not taken forward and they were too much of a dilution of the Jersey Care Model's objectives.

KEY FINDING 27: The Jersey Care Model does not define the role of mental health services within the proposed Urgent Treatment Centre of the Emergency Department.

KEY FINDING 28: The key principles of the Jersey Care Model are widely accepted amongst the public and key stakeholders. However, the lack of detail as to how the provision of care will change under the Jersey Care Model and the impact the new model will have on service

users, the workforce and the overall care system in Jersey, makes it hard to accurately assess *how* appropriate the model is for Jersey.

KEY FINDING 29: Overarching safeguarding and governance measures are going to be key to ensuring community confidence in the new delivery model and provide assurance.

KEY FINDING 30: Whilst the Jersey Care Model is often referred to as if it is a single coherent programme, it is in fact a series of inter-related projects, which combine to form the Jersey Care Model but individually all require their own delivery champions, implementation framework and an easily described, and understood, public narrative.

KEY FINDING 31: Without a Programme Management Framework, the Jersey Care Model's individual component projects cannot succeed and, critically from the Panel's point of view, it has nothing against which to measure progress. Whilst there have been references to a programme management approach, nothing has been received to review, such as a programme plan or comprehensive risk log.

KEY FINDING 32: Care must be taken to ensure that any new commissioning process is proportionate and not burdensome, especially in regard to smaller charities where investment in infrastructure has been modest and their capacity to engage in complex data collection and reporting is limited.

KEY FINDING 33: There is a risk that the role of relationships in the provision of care across the Island could be adversely impacted by a commissioning approach that is not adequality developed.

KEY FINDING 34: Due to past failures of delivering changes to our current care model, it is imperative that the new Jersey Care Model includes a clear implementation programme so members of the public can have confidence in its delivery.

KEY FINDING 35: There is insufficient pace and rigour behind the Jersey Care Model and those responsible for its delivery are not being held accountable for considerable slippage against previously promised actions.

KEY FINDING 36: With no end in sight to the global pandemic, there is little confidence that the combination of the current Health and Community Services team, plus its external consultancy support, will deliver the combined agendas of business as usual service delivery, reacting to the continuing pressures of the pandemic, and the Jersey Care Model, in a timely manner.

KEY FINDING 37: There is currently no robust mechanism for maintaining regular overview and challenge on the detail of the Jersey Care Model on a very regular basis.

KEY FINDING 38: As previously stated in the Government Plan 2020-2023, it is still the intention of the Minister for Health and Services' to have an Electronic Patient Record in place by 2022.

KEY FINDING 39: There is a lack of confidence amongst GPs as to the deliverability of digital health initiatives, due to the level of change that has been implemented to date.

KEY FINDING 40: It is not clear in the Jersey Care Model documentation or in the Digital Health and Care Strategy how the digital programme would be resourced and aligned to the Jersey Care Model or wider on-going business as usual in the Health and Community Services Department.

KEY FINDING 41: Reference to diagnostic provision is absent from both the Digital Health and Care Strategy and wider Jersey Care Model.

KEY FINDING 42: From the evidence the Panel has gathered during its review of the Jersey Care Model, it is clear that there is a significant deficit in the current health and social care workforce and issues of retention are adding to the increasing pressure on these services. In addition, the proposals contained with the Jersey Care Model will only exacerbate the already over stretched workforce.

KEY FINDING 43: Whilst the Panel has been advised of staff deficits in a number of specific areas, to date we have not been provided with any documentation that confirms the current workforce provision we have in Jersey against what will be needed going forward under the Jersey Care Model.

KEY FINDING 44: In the absence of confirmation of Jersey's current workforce, the Panel cannot confidently assess the impact of the Jersey Care Model on the future workforce.

KEY FINDING 45*:* The PwC "stress test" concluded that further work needed to be undertaken on workforce, including the emergence of issues, such as recruitment, that were not present, or as noticeable, before the arrival of Covid-19 onto the Island. Despite our request, we were not provided with further details as to the impact of the pandemic on the workforce and how that has impacted the workforce plans under the Jersey Care Model.

KEY FINDING 46: The Panel is pleased to see key initiatives planned in respect of skilling, training and retaining staff in order to build capacity and capability in the workforce.

KEY FINDING 47: It is widely recognised that the worldwide market for health and care professionals is very challenging. Thus, unless the Jersey Care Model offer is significantly more attractive than offers elsewhere (including lifestyle, cost of living, affordable housing) Jersey will struggle to import the number and type of practitioners from all the clinical disciplines it requires to fulfil the needs of the Jersey Care Model.

KEY FINDING 48: The Minister for Health and Social Services' submission to the Migration Development Policy Board concludes that, whilst Jersey can increase efforts to source local staff or reassign existing staff into community work, the health and care sector will need to recruit off-island for a range of skilled jobs.

KEY FINDING 49: There is a significant risk that the output of the future workforce plan, in terms of numbers, becomes an aspiration that will be never be realised.

KEY FINDING 50: In order to deliver the Jersey Care Model, non-recurrent investment of £17m over a five-year period is required. In addition, the Jersey Care Model will require the implementation of several new services and expansion of existing out of hospital services which, over 16 years to 2036, will cost an estimated £679m.

KEY FINDING 51: After investments, the Jersey Care Model is forecast to save £23 million per year by 2036. However, this will still leave a funding gap of a further £153m to mitigate. Efficiencies of approximately 1.8% per year will be required in order to be financially sustainable and the Panel has been assured that this level of efficiencies will be easily achievable.

KEY FINDING 52: The Jersey Care Model does provide a list of high-level service changes against projected financial implications. Whilst these are useful, the service model is yet to be completed and therefore the financial implications will be subject to change.

KEY FINDING 53: Due to the timing of the receipt of detailed financial assumptions, the Panel and its advisers were unable to adequately scrutinise the financial model and its validity.

KEY FINDING 54: The Panel will be undertaking a detailed review of the proposals to use any funds from the Health Insurance Fund (HIF) for the purposes of funding the Jersey Care Model, as part of its review of the Government Plan 2021-2024. However, concerns raised to-date in respect of the use of HIF will be considered as part of that review.

KEY FINDING 55: The current approach to funding primary care is neither resilient or sustainable.

KEY FINDING 56: A capitation plus model has been proposed as the preferred primary care payment option to support the delivery of the Jersey Care Model. In practical terms, a Capitation Plus model would mean that GP surgeries would receive an annual lump sum for taking care of a patient but, in addition, would receive a payment each time a GP saw a patient.

KEY FINDING 57: It does not appear that there was wide support of the Capitation Plus model amongst Jersey's GPs or that sufficient consultation was undertaken with the wider GP workforce, beyond the Primary Care Board.

KEY FINDING 58: Approval of P.125/2019 – "Affordable Access to Primary Care Scheme" meant that the Minister for Health and Social Services was obligated to bring a Proposition to the States for debate in the third quarter of 2020, which identified a scheme that would improve access to primary care for vulnerable patients, in order that it could be implemented from 1st January 2021. The Panel is extremely disappointed that, despite this, a response to P.125/2019 was not lodged, as anticipated, alongside the Jersey Care Model in September.

KEY FINDING 59: In 2019, the Chief Minister advised that the Jersey Care Model "*would determine the patients' needs for a new hospital, and therefore the size and shape of the hospital to be developed"*. However, now we have been told the Jersey Care Model will not influence either the shape and size of the future hospital or define the clinical and non-clinical design requirements. Instead it will inform the development of the functional brief for Our Hospital.

KEY FINDING 60: There has been a lack of clarity as to how the Jersey Care Model will directly impact the development of the future hospital, which has resulted in a lot of confusion amongst States Members and members of the public.

4. Recommendations

RECOMMENDATION 1: The Minister for Health and Social Services must ensure that a communication strategy is put in place as soon as possible to explain and support the development and implementation of the Jersey Care Model.

RECOMMENDATION 2: The Minister for Health and Social Services must ensure that Public Health is made more prominent in the shaping of the Jersey Care Model. This should include its input into the case for change and its leadership of the health and care needs assessment exercise. In addition, population health-based improvement targets should be agreed throughout the life-time of the Jersey Care Model.

RECOMMENDATION 3: The Minister for Health and Social Services should ensure that a review of each individual care setting is undertaken, which includes the case for change, a costed service model and a more detailed transformation plan. The review must be made available before the end of Tranche 1 of the implementation plan.

RECOMMENDATION 4: The Minister for Health and Social Services must define the "hub" concept before phase one of the implementation plan commences.

RECOMMENDATION 5: The Minister for Health and Social Services must ensure that the wider population of GPs, beyond the Primary Care Board, are adequately consulted with and, most importantly, listened to in respect of their views on the proposals contained within the Jersey Care Model.

RECOMMENDATION 6: The Minister for Health and Social Services must ensure that every effort is given to understanding current and future demands on practice in Primary Care, in order to ensure that the ambitions of the Jersey Care Model are realised.

RECOMMENDATION 7: The Minister for Health and Social Services should bring forward the planning of future primary and community services to Tranche 1 of the implementation plan.

RECOMMENDATION 8: The Minister for Social Services must ensure that consideration is given to the operation of the Urgent Treatment Centre during the Covid-19 pandemic and lessons are learnt from this period if an Urgent Treatment Centre/Urgent Care Centre is to be reinstated under the Jersey Care Model.

RECOMMENDATION 9: The Minister for Health and Social Services must provide clarity as to the role mental health services will play within the proposed Urgent Treatment Centre and

future Emergency Department. Specifically, the Minister must confirm whether it is the intention to have mental health staff positioned within the Emergency Department.

RECOMMENDATION 10: The Minister for Health and Social Services should more clearly define the intention of introducing the commissioning framework and provide a further explanation as to the role of procurement and how services will be selected to be subject to that procurement.

RECOMMENDATION 11: The Minister for Health and Social Services must establish a Risk Log for the top 10 risks for the successful delivery of the JCM that can be used to monitor progress.

RECOMMENDATION 12: The Minister for Health and Social Services must establish an independent, non-executive Board to hold executives to account for the timely and successful delivery of the Jersey Care Model. The Board would be responsible for agreeing a monthly progress report, which would be informed by a risk log (Recommendation 11) and would describe progress against the key monthly milestones in the overall programme. The Board would publish a report at the end of Tranche 1 (2021) which details an analysis of progress made during the first year against a pre-agreed set of outcome-based targets. The report would also include a detailed look ahead to the programme to deliver Tranche 2 of the implementation plan.

RECOMMENDATION 13: The Minister for Health and Social Services must provide evidence that the Digital Health and Care Strategy and future Workforce Strategy are comprehensive and island-relevant, and that they have informed the development of the services and future investment needs of the Jersey Care Model.

RECOMMENDATION 14: The Minister for Health and Social Services should develop a diagnostic strategy that links to the clinical, digital and workforce strategies.

RECOMMENDATION 15: The Minister for Health and Social Services must ensure that the workforce model is judged in the context of the worldwide shortage of health and care delivery staff. The model must therefore demonstrate how it will provide a more attractive proposition, and be more successful, than its competitors in the wider health and care workforce market.

RECOMMENDATION 16: The Minister for Health and Social Services must develop a risk assessment for delivering the workforce strategy that is to be developed as part of the Jersey Care model, in order to provide confidence that it can meet the expected demand.

RECOMMENDATION 17: Following the debate, and if the Proposition is passed, the Minister for Health and Social Services should work with the Panel to agree a timetable in which key

pieces of evidence (such as proposed budgets, performance measures, workforce plans etc) are provided to Scrutiny over the length of the following Tranche in order to provide ongoing financial assurance.

RECOMMMEDATION 18: In order to validate the service model and financial assumptions for each year of the implementation plan, the Minister for Health and Social Services should provide the States Assembly with an updated proposed budget for the Jersey Care Model for each Tranche. This should include an annual report detailing what has been spent on the JCM at the end of that Tranche and an updated plan for the following Tranche.

RECOMMENDATION 19: The Minister for Health and Social Services must undertake greater consultation with local GPs to ensure that the proposed Capitation Plus model is suitable going forward. It is imperative that the future payment model for primary care is co-created with GPs.

RECOMMENDATION 20: The Minister for Health and Social Services must ensure a Proposition is brought to the States Assembly before the end of 2020 detailing a scheme that will improve access to primary care for vulnerable patients.

RECOMMENDATION 21: The Minister for Health and Services should ensure that greater clarity and transparency is provided to both States Members and the general public as to how the Jersey Care Model and the 'Our Hospital' Project will interact as each develop to support increased public workforce engagement and confidence.

5. Introduction

Background and Context

In 2012, a review of Jersey's primary, secondary and tertiary care was undertaken and the results were presented to the States Assembly by the Council of Ministers in P.82/2012 'Health and Social Services: A New Way Forward'. During this time the States Assembly accepted that there was a need to redesign health and social care due to, among other things, a significant increase in demand, a lack of capacity in key service areas, cost pressures and workforce pressures. It was therefore widely recognised that Jersey needed a model of health and social care which could respond to the huge increase in demand while doing so in a way that enabled the skills of local staff to be used to the maximum and new roles created which would attract new staff to work in the Island.

In P.82/2012, the Council of Ministers asked the States Assembly to approve the redesign of health and social care services in Jersey by 2021, as outlined in the Report that accompanied the Proposition. It also asked States Members to request the Council of Ministers to bring forward detailed plans for a new hospital, proposals to develop a new model of Primary Care and proposals for a sustainable funding mechanism for health and social care all by the end of 2014. The Proposition, as amended, was accepted by the States Assembly with 46 votes for, 4 absents and 1 against.

It is understood that, whilst work has been undertaken since 2012 to meet the objectives identified in P.82/2012, the potential benefits of developing services in the community have not been realised. Furthermore, according to the Health and Community Services Department, the scale of the care model proposed in P.82/2012 was not comprehensive enough to deliver the complex health care economy the Island needed.

In May 2019, the Chief Minister presented a Report to the States Assembly which set out a phased approach for delivering a new hospital. Within that report, the Chief Minister advised that part of the work involved in developing a new hospital was to establish a new health care model for Jersey. An update report that was presented in September 2019 (R.116/2019 – 'Our Hospital Programme: Update to the States Assembly') stated:

"Since July, Health and Community Services (HCS) has been engaging with the Island's health community in developing the Jersey Care Model. The last review of Jersey's primary, secondary and tertiary care was completed in 2012, to inform the P.82[1] proposals. HCS has examined what has changed in the intervening years and has updated the model to take account of developments in clinical and healthcare practice and technology, tailored to our Island context.

[1] P.82/2012 – 'Health and Social Services: A New Way Forward'

While this is not specifically part of the 'Our Hospital' project, the development of the Jersey Care Model is a critical precondition, because it will determine the patient needs for a new hospital, and therefore the size and shape of the hospital to be developed"[2]

On 29th October, the Health and Community Services Department published details about the proposed Jersey Care Model. The briefing paper stated that the Care Model aimed to transform the delivery of healthcare within the next five years and was a continuation of the work delivered under P.82/2012. It further advised that the objective of the new model was to move some health and social care services into the community, so that islanders could avoid going to the hospital for many routine or non-urgent appointments. This would enable the hospital to focus on specialist and emergency care, full intensive care and maternity services.

Between December 2019 and April 2020, PwC (Pricewaterhousecoopers) were engaged by the Health and Community Services Department to undertake a "stress test" of the proposals contained within the JCM. On 22nd September a Proposition (P.114/2020) was lodged by the Minister for Health and Social Services Minister which asked States Members to:

1. Receive the Jersey Care Model, the Jersey Care Model Review, and JCM Strategic Outline Business Case and approve the Strategic Objectives of the Jersey Care Model;
2. Subject to the approval of proposals for investment in the JCM that will be included in the Government Plan 2021-2024, to approve the proposals to move to the next stage of the programme and to request the Council of Ministers to co-ordinate the steps for Ministers to bring forward for approval proposals for a sustainable funding model for health and social care, to be operational by the end of 2035.

The debate of P.114/2020 is due to take place on 3rd November.

The Panel's Review

The Panel wished to undertake a review of the Jersey Care Model and the proposals contained within to establish whether they were appropriate for Jersey. We also wanted to determine the impact that the proposals would have on the delivery of health and care in Jersey and the health and care sector workforce. Finally, we wanted to understand how the JCM was to be implemented and the risks associated with its implementation, including financial implications. The Panel's full Terms of Reference can be found in Appendix 1

To assist with its review of the Jersey Care Model, the Panel engaged an adviser to provide technical and specialist expertise. Following a tendering process, Attain (Health and Social Care Consultant) were appointed as the Panel's advisor. The adviser was asked to produce

[2] R.116/2019 – 'Our Hospital Programme: Update to the States Assembly

their own report on the JCM which would contain their own findings and recommendations. Attain's report can be found appended to the Panel's report in Appendix 2.

Methodology

Since the Panel began its review in November last year we have undertaken the following:

- Launched the review on the States Assembly website and on social media outlets.
- Conducted a general public call for evidence, where an advert was placed in the JEP for three consecutive weeks.
- Created posters about the Panel's review and sent them to parish halls, GP surgeries and put them up in Departments throughout the General Hospital.
- Sent out over 100 letters to targeted key stakeholders asking for feedback on the JCM. These included; GPs, Pharmacists, Dentists, Optometrists, Mental Health Services, Family Nursing and Home Care, Care Homes and Unions.
- Held a Public Hearing with Mr. Jim Hopley on 10th February 2020.
- Held a Public Hearing with the Minister for Health and Social Services and his Officers on 13th February.
- Received various briefings from the Health and Social Services Department on the JCM and its progression through the year.
- Created a targeted survey for GPs which sought their views on the four month contractual arrangement with Health and Community Services (HCS) in response to Covid-19, future working arrangements and on aspects of the JCM. The survey went live on the 28th August and ended on 18th September 2020. The results of the survey will be referenced throughout our report but the full results report can be found in Appendix 3.
- Held a further Public Hearing with the Minister for Health and Social Services and his Officers on 29th September.

Report Structure

It should be noted that the Panel's report does not attempt to address all the proposals contained within the JCM and revised versions. Rather, we have focused on, what we believe to be, the key areas of interest and the main areas of concern as a result of the consultation we have carried out with the public, key stakeholders and our own examination of the information provided to us.

6. Development of the Jersey Care Model

The lead up to the development of the JCM

P.82/2012

P.82/2012 proposed a model of health and social care that would support and enhance the elements of the current system and would, over a ten-year period, transform the system so it would continue to meet the needs of Islanders. Similar to the Jersey Care Model, the main objective of P.82/2012 was to move away from residential care and institutionalisation towards an increase in community provision. The objectives of P.82/2012 are well documented and we do not wish to go into detail about them here. However, it is worth briefly considering why therefore P.82/2012 was not delivered as previously intended and why we are now in the position of considering a new Care Model for the Island.

On 12th February 2019 Deputy R. Labey tabled a written question asking the Minister for Health and Social Services what percentage of the objectives detailed in P.82 had been delivered, in accordance with the timeline target, and the explanation for late or non-delivery. The Minister advised that 65% of those objectives had been delivered. He went on to state:

> *In terms of the overall vision, it has been a challenge to move from strategy to implementation, make an overall shift of care from hospital to the community and primary care and replicate worthwhile pilot studies on a larger scale. There is still progress to be made on digital modernisation due to complexities around systems integration, information sharing and data protection and there is still progress to be made on sustainable funding arrangements for health and social care. There has also been significant debate about the site of the Future Hospital, which has consumed substantial amounts of attention at the expense of service development.*

Furthermore, in a briefing with the Panel on 15th August 2019, the Director General of Health and Community Services confirmed that the scale of P.82/2012 was not big enough to deliver the health care needs in Jersey and that parts of the model had not been delivered due to its objectives not being aligned with a sustainable funding proposal.

At a Public Hearing in February 2020, we asked the Minister for Health and Social Services how the strategic case for changing Jersey's healthcare had developed since P.82/2012. The Minister advised:

> *P.82 set out a broad vision about delivering care in the community but for whatever reasons it did not seem to develop as quickly as necessary and I think this Jersey Care Model has got to grips with some of the detail that was needed, some of the hard questions that needed to be asked, and set out some ways in which we could achieve more rapidly that delivery of care in the community, which is now being stress tested.*[3] *(p4, Feb)*

KEY FINDING 1: The main objectives of the Jersey Care Model are aligned with what was previously proposed within P.82/2012 - "Health and Social Services: A New Way Forward".

What was the driver for developing the care model?

> *I think a realisation that the model that has just evolved in Jersey is unsustainable in the long term due to ageing demographics and the increased care that rightly our population expects.*[4]

The Panel is aware that Health and Social Care in Jersey faces a number of challenges, now and in the future, relating particularly to an increase in demand for care with the number of Islanders over the age of 65 predicted to double by 2040. At the same time, the ratio of working adults to older adult ratio is expected to fall from 3.9 to 1 to 1.8 to 1 by 2040[5]. We are told that this increase in the over-65 population will increase the demand on health and social care services and care needs. It has been estimated that 75% of 75-year olds in the UK, for example, have more than one long-term condition relating to 82% of 85-year olds.[6] In a written submission to the Panel, the Jersey Care Commission also acknowledged the changing profile of the population as one of the greatest challenges that the Island faces.[7]

The Panel was advised that the pressure of these changing demographics, coupled with the inefficiencies of our current care model, has led to the development of JCM and an increased momentum to make changes. It has long been recognised that the current health and community care model is hospital focused, with a dependency on secondary care for the provision of services. According to the JCM, this is evidenced by the fact that approximately 30,000 visits of the Emergency Department in 2018 were not classified as emergencies. In addition, the JCM acknowledges further issues with the current model, including:

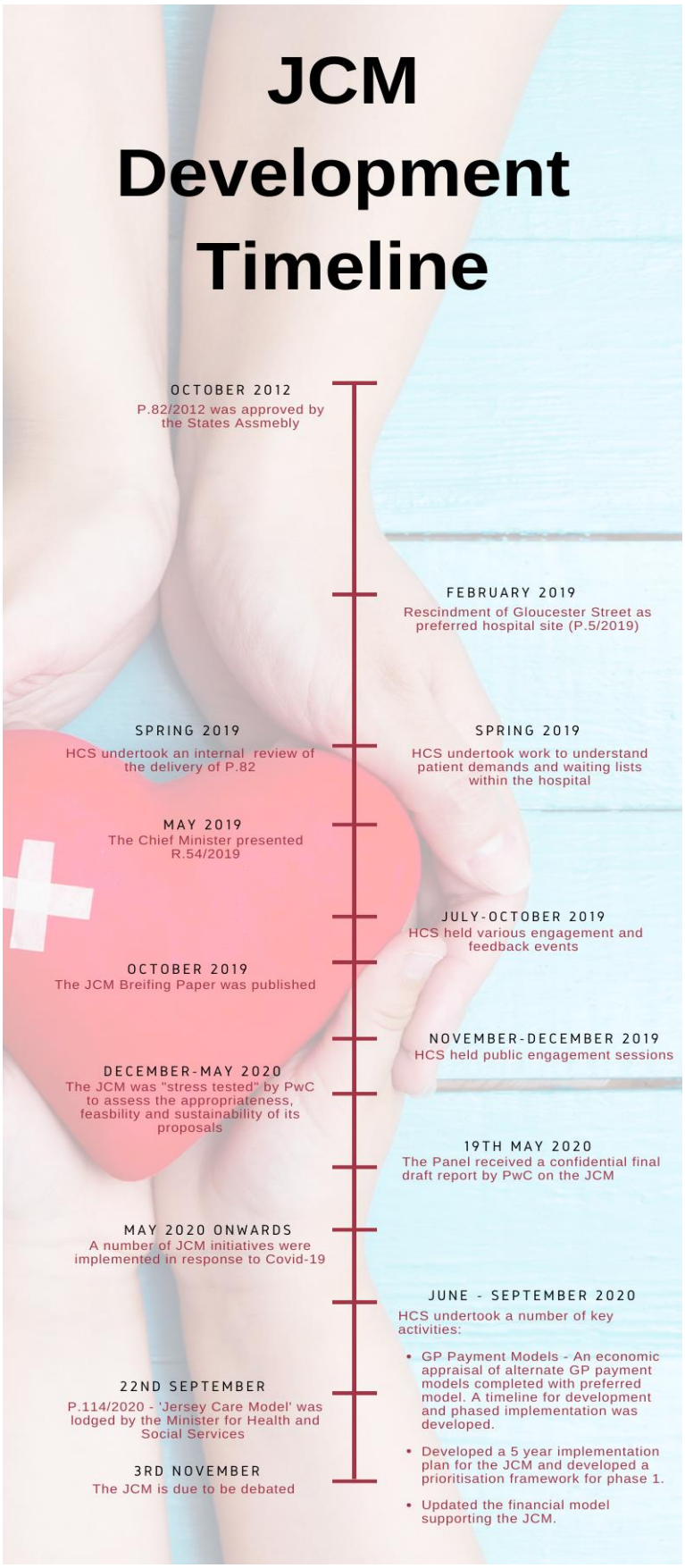
[3] Public Hearing, Minister for Health and Social Services, 13th February 2020, p4
[4] Public Hearing, Minister for Health and Social Services, 13th February 2020, p3
[5] Health and Social Services White Paper – Caring for Each other Caring for Ourselves Public Consultation Document
[6] Barnett et al 2012
[7] Written Submission, Jersey Care Commission, 22nd September 2020

1. Lack of co-ordination between primary and secondary care services and external partners.
2. Intermediate and Ambulatory Care is currently limited.
3. Limitations in preventative care.
4. Primary Care is not optimised to achieve integrated care in the current model which presents challenges to provide services across care settings.
5. Direct Access Services funding mechanisms are not in place.
6. Social Care and External Partners could be further utilised.

KEY FINDING 2: Jersey's current care model is unsustainable in the long term due to the Island's ageing demographics.

The Timeline for the Development of the JCM

At the Public Hearing with the Minister for Health and Social Services in February 2020, we questioned the Minister about the timeline for the development of the JCM to try and establish when the work began and the various processes and alternations it had been through since it was published in October 2019. The full response can be found in the transcript from the Hearing. However, to narrow down the key events in the JCM's development since October to date, we have created the below timeline:


JCM Development Timeline
OCTOBER 2012
P.82/2012 was approved by the States Assmebly
FEBRUARY 2019
Rescindment of Gloucester Street as preferred hospital site (P.5/2019)
SPRING 2019
HCS undertook an internal review of the delivery of P.82
SPRING 2019
HCS undertook work to understand patient demands and waiting lists within the hospital
MAY 2019
The Chief Minister presented R.54/2019
JULY-OCTOBER 2019
HCS held various engagement and feedback events
OCTOBER 2019
The JCM Breifing Paper was published
NOVEMBER-DECEMBER 2019
HCS held public engagement sessions
DECEMBER-MAY 2020
The JCM was "stress tested" by PwC to assess the appropriateness, feasbility and sustainability of its proposals
19TH MAY 2020
The Panel received a confidential final draft report by PwC on the JCM
MAY 2020 ONWARDS
A number of JCM initiatives were implemented in response to Covid-19
JUNE - SEPTEMBER 2020
HCS undertook a number of key activities:
GP Payment Models - An economic appraisal of alternate GP payment models completed with preferred model. A timeline for development and phased implementation was developed.
Developed a 5 year implementation plan for the JCM and developed a prioritisation framework for phase 1.
Updated the financial model supporting the JCM.
22ND SEPTEMBER
P.114/2020 - 'Jersey Care Model' was lodged by the Minister for Health and Social Services
3RD NOVEMBER
The JCM is due to be debated

The "Stress Test"

A "stress test" was completed by the international professional services consultancy company PwC (Pricewaterhousecoopers) to assess the appropriateness, feasibility and sustainability of the proposed JCM over a 6-month period (December 2019 – May 2020). A response to an FOI request on 24th July sets out the details of the work undertaken by PwC. With regard to the intended benefits of the "stress test" we were told:

> *"The public sessions were really valuable because you get group think and we stood back from it now because it is being stress tested and that is right because we were heavily involved with the model, our clinicians, so as much as you … we want the best model we can deliver but we recognise that we have been looking at it and living it for 5 months. So we have stepped back now while the teams are examining it and while there is work going on in the background, the analytical work alongside the group work, so my understanding is from conversations that have been had with me from some of the team, particularly that group that keeps coming up with stuff that we had not thought of, is coming up with better ideas for some of the stuff we thought to, particularly around stepdown beds. The things we had not even thought about. Because the firm that is doing the stress testing is an international firm, they are also bringing some benchmarking information and ideas from other countries that we have not even looked at. So I think it seems to be being really beneficial but again we are not getting really close to it because we do not want to interfere with the process. So at the end of March it will be done, then we will get that report.*[8]

It was originally anticipated that the "stress test" work that was undertaken by PwC would be completed by the end of March 2020 but, as a result of Covid-19, their work was delayed and was not finalised until May. The Panel received a copy of PwC's final draft report on 19th May, but on a confidential basis.

At the Panel's Hearing In February 2020, we were advised of a number of specific outcomes that HCS expected from PwC's work:

- *"…it will give us clear recommendations around workforce, clear recommendations around economic determinants, and clear recommendations of how that will improve or maintain patient outcomes we want it to improve."*

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

[8] Public Hearing, 13th February 2020, February, p6

- *"… it will tell us about our caseload requirement for social care particularly, because we have clear indicators that we have a deficit market at the moment; we have an unfilled package of care position because the market just is not there. We know every week how many hours we would need to satisfy the requirement from the hospital and the community, so the planners are looking at that activity, they are saying: "To do that you would need a care provider to come in and provide this amount of hours, that would equate to this number of workers."*

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

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

- *"The stress test will identify quantifiable improvements in both patient experience and outcomes for the population."*

- *…we have asked the health planners to report back to us in detail on how funding can be arranged."*

The Panel will use the outcomes (or absence of, in some cases) of the work undertaken by PwC on the above matters as reference points throughout our report.

Covid-19

Covid-19 presented HCS with an opportunity to accelerate key aspects of the JCM as Jersey, like many other jurisdictions around the world, has had change to the way that care is delivered, and Islanders are supported.

The list below summarises the changes that were made as a result of Covid-19[9]:

PUBLIC HEALTH →
Business case drafted of expansion of the team to support implementation of public health policy

PREVENTION →
- At risk groups identified and contracted by primary care clinicians
- Public were asked to work at home and take daily exercise
- Software to support self-care/telecare/telemedicine are in process of being deployed to support patients to learn about their conditions

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 (UTC) established in conjunction with the secondary care, staffed by GPs.

INTERMIDIATE CARE →
- Care Homes being used for step down capacity
- Out of hospital care is being more proactively managed
- A call centre established, which is the start of a care coordination or care hub that could be further developed

AMBULANCE →
- Admissions avoidance is being targeted, with patients either being treated at home, or turned around quickly if brought to ED
- GPs were part of the response team both at base and in the car.

UNPLANNED CARE →
- The UTC established in the hospital to treat ambulatory GP referrals, minor injuries and illnesses.

WOMEN CHILDREN's AND FAMILY CARE →
- Obstetrics and Gynaecology are operating reasonably normally, with medication to timetables to minimise risk to clients
- An on-island Cat 4 CAHMS unit was established to manage older adolescent mental health patients on Island.

PLANNED CARE →
- A pause on electives enhanced discharge process, with limited delays and no backlog.
- Advice and guidance given to GPs on various pathways and a new cross-organisation pathway site has been established.

TERITARY 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 CAHMS patient are now being delivered on Island as the UK are no longer taking new referrals.

SOCIAL CARE →
- Improvements in multi-agency safeguarding work
- Strength based practice is being deployed more effectively, keeping people in home and out of care.

DIGITAL →
- Tele & video consultations have increased

[9] JCM Review Paper

Primary Care

In response to Covid-19 a number of changes were made to primary care and its delivery. The main changes that were made were:

- Changes to the GP payment model.
- Reduced consultation fees.
- The Establishment of an Urgent Treatment Centre that was established in conjunction with secondary care and staffed by GPs.

At the heart of these changes was a "historic" agreement between the Government and GPs to work together in order to tackle the coronavirus pandemic. The agreement meant that 106 GPs were to be employed directly by Health and Community Services for a 4-month period (from 9th April – 8th August 2020). It was hoped that the agreement would give HCS more capacity and flexibility to adapt to changing needs in light of Covid-19. GPs would use their skills to:

- Sustain Primary Care Services to support Out of Hospital Care where possible
- Work with Jersey's ambulance service 24/7 to help treat patients in situ
- Work alongside hospital teams in the Emergency Department and Urgent Treatment Centre
- Provide enhanced support for Care Homes across the Island
- Provide resilience and expert skills to Health and Community Services

Commenting on the new agreement, the Minister for Health and Social Services said:

> *"This is a landmark agreement for our Island. Our shared priority is to save lives, so we have come together to ensure that Islanders can access health professionals as quickly as possible, at a time when health resources are needed most.*[10]

A response to an FOI request on 10th July 2020 by a member of the public confirmed that the maximum total cost of the contracts is expected to be £7.22m (£4.077m in relation to the Contract of Employment and £3.14m in relation to the Surgeries Agreement. It was also noted that "*the Surgeries Agreement will be subject to Open Book Accounting and Audit so that only "reasonable costs" relating to the operation of the GPs surgeries are reimbursed*."

[10] Jersey Evening Post - https://jerseyeveningpost.com/news/2020/04/09/deal-for-gps-to-be-employed-by-health-department-agreed/

GPs Fees under Covid-19

During the contracted period, GPs charged patients a reduced fee – approximately 50% less – which was subsided by Government. At the end of the contract the Government subsidy was ceased. Patients fees were amended as follows:

Treatment	***Cost***
Covid Response Team Home visit and All End of Life	Free
General Practice consultations (including phone, video and nurse consultations)	
Children aged 0-4	Free
Children and young people 5-17	£10
All other consultations	£20
Home visit	£40
Repeat consultation on same issue within 72 hours	Free
Pregnancy bundle	**£120**
Free Services	
Cervial Smear	**Free**
Childhood immunisation	**Free**
Repeat Prescription	**Free**
Prescription collection/delivery service	**Free**
Letter of referral	**Free**

Urgent Treatment Centre

The Urgent Treatment Centre (UTC) opened at the General Hospital on 14th April 2020 to offer Islanders urgent care they needed whilst ensuring that the Emergency Department only treated genuine emergencies. The majority of treatment was offered at no charge to patients unless the treatment could have ordinally been managed by a GP in the community. In that case a GP fee was applicable.

As part of the next chapter, we consider some of the responses we received to the survey we undertook with GPs, in respect of the UTC.

What engagement has been undertaken with the public?

The Panel is aware that extensive engagement has been undertaken with Health and Community Services staff and external partners (voluntary and third sector organisations) during the development of the Jersey Care Model. However, since the consultation process that was undertaken by HCS last year, there appears to have been little, if any, engagement with the public.

Between November to December 2019, HCS held 13 public engagement sessions, in which over 500 people attended in total. During our review we were advised that these sessions were extremely valuable in hearing the views of the local population in respect of the proposals contained within the model.

At a Public Hearing in February 2020, we were advised that once HCS had the "*bones of the model*" they would undertake further engagement with the public and external stakeholders.[11] However, we note that no further consultation has taken place with members of the public since HCS's initial consultation at the end of 2019. At a Hearing in September, we were told that following the debate in November 2020 and, assuming the JCM is adopted, the intention is to engage with the community then. Furthermore, it was advised that work was currently being undertaken around what that further consultation would look like.

In their report, our advisers note that, whilst the lack of communication with the public may have been considered appropriate given that the JCM has been subject to on-going evaluation, a communication plan is required to ensure that that there is not a void in which concerns about the future care model can fester. The Panel also believe that it is imperative

[11] Public Hearing, 13th February 2020

that the public are sufficiently consulted with in order that they understand, and can therefore have confidence in, the ambitions of the Jersey Care Model.

KEY FINDING 3: No further consultation has been undertaken by the Health and Community Services Department with the general public on the Jersey Care Model since the initial engagement process in 2019.

KEY FINDING 4: It is imperative that the public are sufficiently consulted with in order that they understand, and can therefore have confidence in, the ambitions of the Jersey Care Model.

RECOMMENDATION 1: The Minister for Health and Social Services must ensure that a communication strategy is put in place as soon as possible to explain and support the development and implementation of the Jersey Care Model.

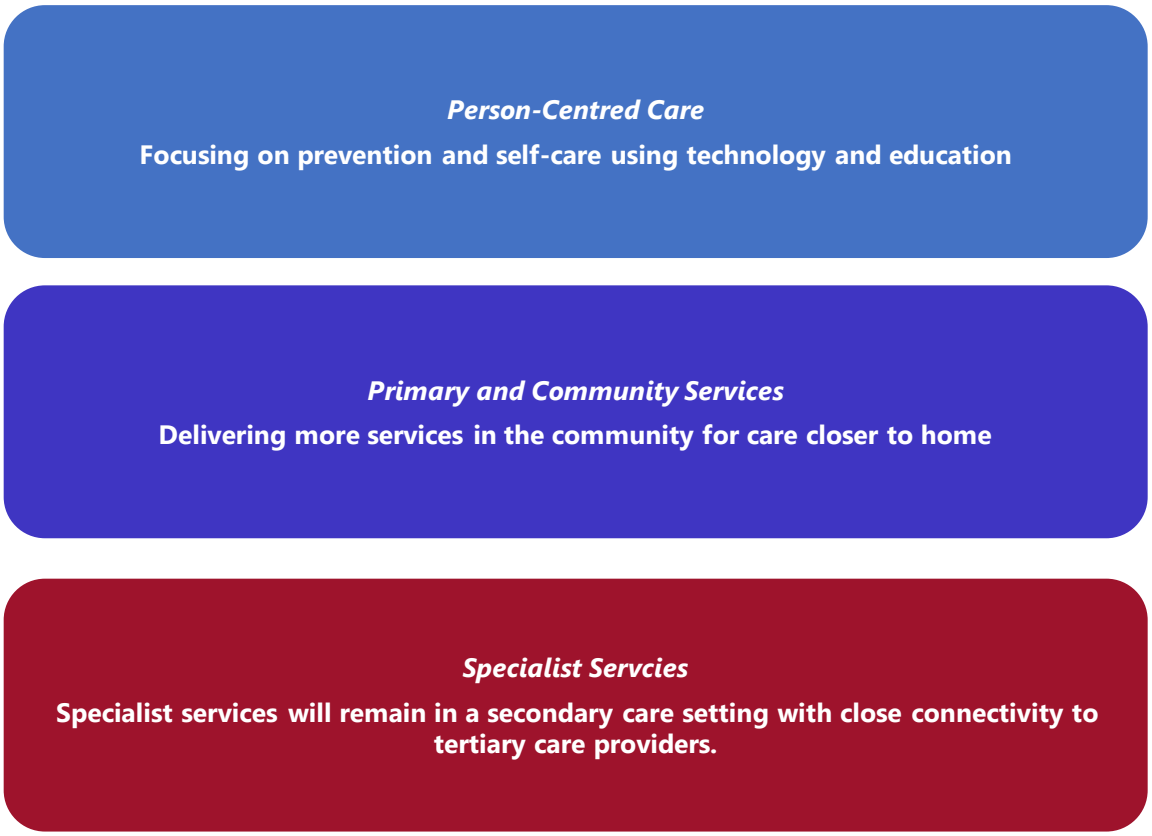
7. What is being proposed and how will it change how care is currently delivered?

Main Proposals of the JCM

The overarching objectives of the JCM 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.

In-line with the overall objectives are the core components of the JCM:



The key objectives of the JCM and its delivery are aligned with the Government's Strategic Ambition to create a health island with safe, high quality, outcome focussed, affordable care that is accessible when and where our service users need it. It is also aligned with the

Government's Common Strategic Policy to improve Islander's wellbeing and mental and physical health, and in preparing for more Islanders living longer.

The Panel asked the following question at its Public Hearing with the Minister for Health and Social Services in February 2020:

What would be your top priorities when delivering the JCM?

> *As a general rule we want to make the services more patient-centred. Delivery where patients lead, not dragging people into a huge building where that is unnecessary and reserving our secondary care for appropriate cases and raising the standard of excellence in all aspects of care.* - **Minister for Health and Social Services**.

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

> *I think we have a care model that is very much based around Gloucester Street and we do not think that … and I think we are already doing work because we demonstrably do processes within our hospital that in nearly every other jurisdiction is done external to the hospital. For us it is a model that is not so H.C.S. dominated but is a much more collaborative model whereby H.C.S. is one of a number of providers working to deliver health across the Island, and one of a number of voices determining the direction of health, which I think previously we have been the loudest and the voice with all the power. That is what we do not want going forward.*
>
> *Because it is so complex and muddled we do not have that clear line of sight to all our patients, so they leave our back door, they go home, they get packages of care - not necessarily the right packages of care because it is not patient determined - they go into a care home or a nursing home, and because the system is not co-ordinated we lose sight of those patients. We need to have sight of all of those patients…* – **Director General of Health and Community Services**

Focus on Prevention and Public Health

We acknowledge that the Jersey Care Model seeks to move away from the "unsustainable" institutional-based model into a more modern community-based model, which puts people, their family and home at the centre. Its objectives will be to ensure that care and support are person-centred and that there is a greater emphasis on prevention and community partnership.

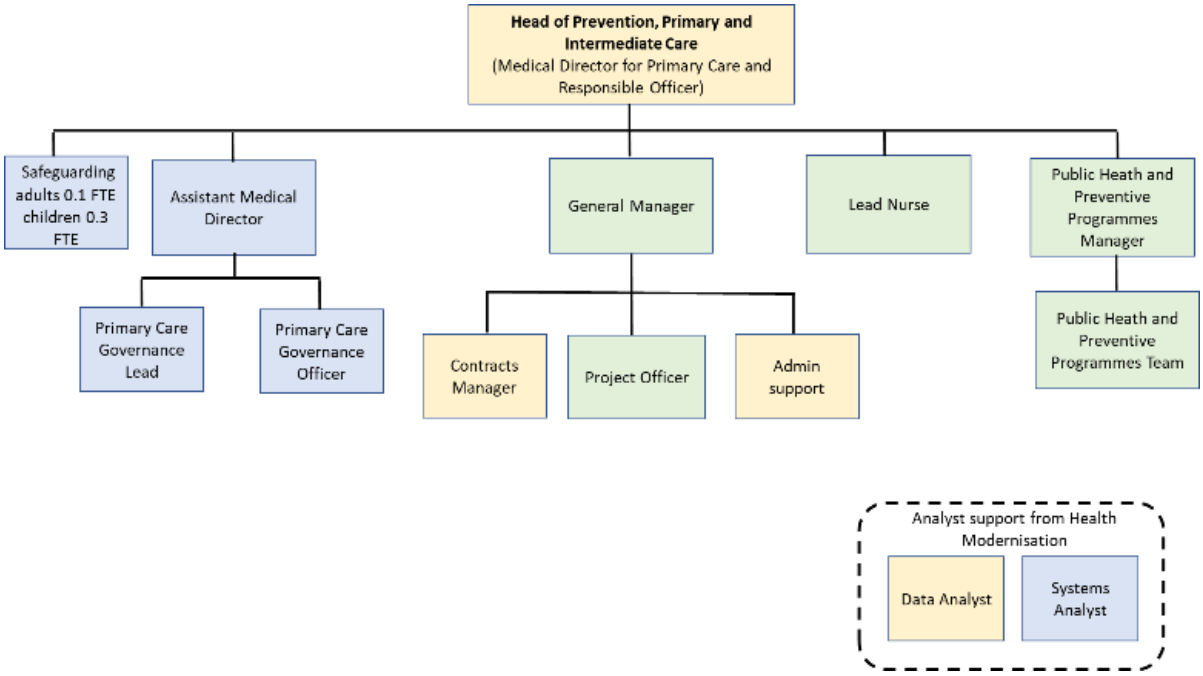
In a letter to the Minister for Health and Social Services on 11th March 2020 we asked:

What are the public health measures that the JCM is aiming to address and what are the baselines for those measures today?

> *The JCM has been developed upon the basis of CSP priority 2 'to improve Islanders wellbeing and mental and physical health'.*
>
> *The JCM inevitably has a focus on care, both primary, secondary and within the community, while public health intervention has a wider remit which includes improving the conditions in wider society that can lead to preventable illness. The JCM will contribute to public health outcomes through an increased focus on prevention and access to preventative care. Evidence based approached such as brief interventions will be employed to ensure:*
>
> - *Reduced Smoking*
> - *Healthier Eating*
> - *Increased physical activity*
> - *Reduced alcohol consumption*
> - *Increased community engagement*
>
> *This will contribute to wider public health outcomes of:*
> - *Increased employment*
> - *Improved educational attainment*
> - *Improved standards of living conditions*
> - *Improved mental health and wellbeing*[12]
>
> *Benchmarking data is not yet at a stage for publication but is planned to be so in Q2 2020.*[13]

We were further advised that a Care Group for Prevention and Intermediate Care had been purposely developed, which moved the prevention roles out from the projects team into a clinical team. According to HCS, this has meant that the Care Group was better aligned to patient care and outcomes and subject to the correct governance. We were provided with the following diagram of the current structure of the Prevention Team, which will be reviewed as part of the JCM delivery plan:

[12] Letter, Minister for Health and Social Services, 11th March 2020
[13] Letter, Minister for Health and Social Services, 11th March 2020



At the Public Hearing in February, we asked the Minister for Health and Social Services about the reasons for a greater emphasis in the JCM on prevention and early diagnosis. He advised the Panel:

> *…I think our public health vision has been too mellow and perhaps in recent years we have not given the proper emphasis to public health. So preventative care is about much more than just arranging vaccinations for school children and more tests that are being carried out in a medical setting, but it is about persuading people of the benefits of taking care of themselves and exercising regularly and having proper nutrition, that sort of thing. I have been pleased to be working recently on a health and well-being strategy which is soon going to be launched, which is going to drive a greater emphasis on all those things and go even further than sort of healthcare but talking about the determinants of health, which would be things like housing and education and ensuring that in those programmes that we think about people's well-being and how health improvements can arise as a result of that.*

In a written submission to the Panel, the Jersey Community Partnership (JCP) highlighted the need to view the implications of the Jersey Care Model not just on the delivery of health services but on education, environment, employment and housing etc. JCP wrote:

> *… [the delivery of health services] is one component part of an inter-connected system, and that funding of the model is also inter-connected. For example, investment in creating more opportunities for being active will benefit the physical health of islanders,*

but funding for sport initiatives may be silo-ed and not considered as having any implications on the delivery of the care model.[14]

The "stress test" undertaken by PwC found that "*the shift to preventive, patient-centred care and self-care will require significant investment to realise the benefits of savings, efficiencies and improved health outcomes."* Similar to PwC, Mind Jersey also recognised the need for increased funding in order to effectively deliver this ambition of the JCM. In its written submission to the Panel, it commented:

> *Agree with the prevention and early intervention approach. However, the challenge will arise in securing and allocating funding for this priority, where it will compete with many other demands and where some of the dividends will only become apparent years down the line (beyond the political cycle).*

In their report, our advisers found that the creation of a Health and Wellbeing Framework was a positive progress and that its framework should help steer the implementation programme of the JCM to ensure that health and wellbeing inequalities in Jersey are addressed. However, they also found that, whilst the Jersey Needs Assessment process is underway, currently there is no robust system to demonstrate the current health and wellbeing needs of the Island.

In their view, the role of Public Health in the Needs Assessment and the implementation of the JCM, in terms of prioritising programme deliverables, will be critical. As a result, the advisers recommend that Public Health is made more prominent in the shaping of the JCM and that this should include its input into the case for change and its leadership of the health and care needs assessment exercise. Both of which were promised in 2020 but have now been pushed back to into Tranche 1 (2021) of the implementation plan and the agreement of population health-based improvement targets throughout the lifetime of the JCM.

KEY KINDING 5: There is no robust system in place that demonstrates the current health and wellbeing needs of the Island. It is imperative that the 'case for change' for the Jersey Care Model is driven by broader acknowledgment of what isn't working in terms of Jersey's overall current service provision.

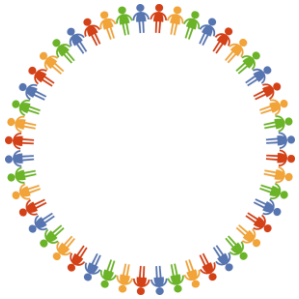
KEY FINDING 6: The role of Public Health in the Needs Assessment and the implementation of the Jersey Care Model, in terms of prioritising programme deliverables, will be critical.

RECOMMENDATION 2: The Minister for Health and Social Services must ensure that Public Health is made more prominent in the shaping of the Jersey Care Model. This should include its input into the case for change and its leadership of the health and care needs assessment exercise. In addition, population health-based improvement targets should be agreed throughout the life-time of the Jersey Care Model.

[14] Jersey Community Partnership, Written Submission,

Moving Care into the Community

Decentralised approach



The JCM outlines that Jersey currently has a secondary care focussed model of healthcare service. The majority of such activity in Jersey takes place within an acute hospital setting with a centralised provision of services. Decentralisation of services has been recommended to deliver patient-focused care, provided in the community and closer to home. It has been suggested that providing more care in the community will have benefits on patient outcomes and will allow Jersey to develop a "clinical sustainability" for the future of services across the healthcare system.[15]

It is proposed that care will be decentralised by expanding primary services and moving some of the services that are currently offered in the hospital out into the community. PwC found that the JCM will only be achieved through progressing a decentralised care model and that the shift in balance between centralised and decentralised will be enabled by transformation in digital technology, adequate provision and estates and an adequate workforce profile to deliver transformed care.

The JCM Strategic Outline Business Case (SOBC) refers to a study that was undertaken in 2011 by The Health Foundation, which showed that improved outcomes and reduced health inequalities can, when the right populations are targeted, be delivered through preventive, out of hospital care. Regarding a similar matter, in her written submission to the Panel, Nadya Wolferstan highlighted the need for increased communication and co-ordination in order to realise the benefits of moving care into the community. Nadya is an experienced Health and Social Care Lawyer, having acted for hospital trusts and commissioners for 20 years. She wrote:

> *"It is recognised that care in the community is better for patient outcomes, but it is also recognised that without adequate communication and care co-ordination, patients fall within silos and there is an increase in preventable readmissions.*[16]

Nadya sites an article written in 2017 entitled "An innovative Approach to Health Care Delivery for Patients with Chronic Conditions" which provides evidence to support her statement.

The Panel addressed this concern at a Public Hearing by asking the Minister how decentralising care would help the issue, that our system currently has, of losing sight of patients and the type of care that they are receiving. The Director General of Health and Community Services advised that improved communication will come through shared staff and through shared pool budgets. She continued:

[15] JCM Review Paper
[16] Written Submission, Nadya Wolferstan, 24th January 2020

> *At the moment one of the reasons why care is different is because we own the resource and we hold on to it, and a lot of our staff are keen to work outside the hospital - not all, and it is not going to be compulsory, as has been alluded to - but we have staff within the hospital who can provide that clear pathway management, who can go outside of Gloucester Street and work within the community, which enables us to maintain that line of sight which we do not have as well as we should at the moment because we are in our silos."*[17]

Interestingly, at a Public Hearing on 29th September, the Director General told us that it was HCS's intention to have a Care Co-ordinator who essentially manages care to enable oversight of a patients journey through the system. This is despite the absence of any mention of a care co-ordinator in the JCM Briefing paper or supporting documentation. To find out more information, we queried how much had been developed in terms of the role, the number of staff it would require to deliver and the skill set required. The Director General advised that the details of this role, and care pathways in general, would be looked at during Tranche 1 (2021-2022) of the implementation plan.

KEY FINDING 7: Whilst it is recognised that care in the community can be better for patient outcomes, it is also acknowledged that without adequate communication and care co-ordination, patients may fall within silos. The Panel would therefore support the establishment of a Care Co-ordinator to enable oversight of a patient's journey through the health and social care system.

Whilst the majority of written submissions we received showed support for the proposal to transfer services away from a hospital setting and into the community, some highlighted concerns regarding current and future investment in community services:

> ***Mind Jersey***
>
> *The major thrust of the model is to promote the transfer of services into the community where islanders can access care closer to home. There is a significant and very welcome objective – but it's one that needs to be backed up by considerable investment in existing and additional services (whether provided by GoJ or through third party charities and agencies).*

> ***Les Amis***
>
> *A fundamental part we have noted in both the Jersey Care Model Briefing Paper and the Commissioning Framework is the clear emphasis on developing community services. Our first concern is that there has been little investment in community services in the past few years and we perceive this model to the similar to the previous*

[17] Public Hearing, Minister for Health and Social Services, 13th February 2020, p16

P82 approach. This makes us question when we will see concrete evidence of true investment in community services and what financial support will be given to enable a robust foundation for future development to be built on.

KEY FINDING 8: Whilst the key ambition of the Jersey Care Model - to transfer services out of the hospital and into the community - is welcomed, there is concern that, to date, there has been little investment from the Government of Jersey into community services, despite the approval of P.82 by the States in 2012.

With regards to the proposed decentralisation approach, the Panel's advisers note the vital ambition of the JCM to increase care in the community through the use of primary care and community services. They found this intent to be sensible and agreed that there are several specialities (physiotherapy, diabetes etc.) where patients can receive more suitable care outside of the hospital setting. However, they also found that the approach to how these services will be configured in the community, working across primary care, community providers, social care, intermediate services, carers or outreach services from the hospital has yet to be defined. They also noted that this lack of clarity has caused confusion about how the JCM will operate in practice.

In addition, the advisers note that whilst there is reference to some services in the JCM and reference to activity changes in Appendix 4 of the Strategic Outline Business Case, the whole care model in the community has not been completed. Therefore, whilst independent services might change, it will be impossible to determine how the whole service will operate together. Furthermore, moving care from the hospital into the community may increase the costs due to the dispersing of the delivery of care. Without the full details of how care will be moved into the community, the Panel and its advisers cannot be confident of the financial implications. It is worth noting that the inclusion of a detailed financial model for the JCM, having not completed a detailed transformation plan for each care setting, has not given our advisers much confidence in the costing exercise. The advisers note that this finding implies that future costings have been based on a series of assumptions rather than specific plans – and the Panel has not received any evidence to date to suggest that this is not the case.

KEY FINDING 9: The detail as to how services will be configured in the community, working across primary care, community providers, social care, intermediate services, carers or outreach services from the hospital has not yet been developed. This lack of clarity has caused confusion about how the Jersey Care Model will operate in practice.

KEY FINDING 10: Whilst there is reference to some services in the Jersey Care Model and reference to activity changes in Appendix 4 of the Strategic Outline Business Case, the whole care model in the community has not been defined. Therefore, whilst independent services

might change, at this stage it will be impossible to determine how the whole service will operate together.

KEY FINDING 11: Without the full details of how care will be moved into the community, the Panel and its advisers cannot be confident of the financial implications of this ambition.

RECOMMENDATION 3: The Minister for Health and Social Services should ensure that a review of each individual care setting is undertaken, which includes the case for change, a costed service model and a more detailed transformation plan. The review must be made available before the end of Tranche 1 of the implementation plan.

"Community Hubs"

One of changes to the current model of care that has been proposed in the JCM is to 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 at strategic locations on the Island. The JCM suggests that **An Integrated Care Hub** model would ensure the continuity of care required within the health and care system and efficient planned care services that connect Primary and Secondary Care and therefore replacing traditional outpatient services.[18]

As part of the Closer to Home Initiative, a pilot hub was 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 activities which include; a mother and toddler group, after school club, nursery, youth club, and luncheon club.

Despite the aspiration to base services in "community hubs" being cited numerous times within the JCM and supporting documentation, the Panel is still unclear about what is meant by a community hub. The Panel attempted to seek clarity at its Public Hearing in February and was advised by the Director General of Health and Community Services that:

> "*We are not looking to have multiple hubs. We were in the early days then we recognised, and you were very challenging about that, that we could not afford that. But we do have a lot of the G.P. surgeries, and Rob is more informed to this, are hubs in their own right, have fantastic facilities that in other jurisdiction would be considered a hub. We just need to enable them to deliver care. We need to commission differently.*[19]

Unfortunately, this explanation did not provide the Panel with much more insight into what a hub would look like, how it would operate and what services would be delivered within it. PwC

[18] Jersey Care Model Briefing Paper, p.25
[19] Public Hearing, 13th February 2020, Feb, p.40

also noted the absence of a clear definition of an integrated hub with in the JCM, despite the fact that the future model of scheduled care is predicated on their existence. PwC also suggested that further clarity was required in the following 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*[20]

At a briefing on 28th August 2020, the Panel asked whether there would be further clarity around what was meant by "community hubs" and how this would be explained to members of the public. It was advised that work was being undertaken to describe and define the "hub concept". We did not receive further clarity in response to our request. However, at a Hearing on 29th September we were told that the "hubs" already existed through multiple forms i.e. though primary care and through facilities provisioned by Family Nursing and Home Care and Jersey Hospice etc. It was also advised that understanding the current facilities that could be used for these purposes would be work carried out in year one of the implantation of the JCM.[21]

KEY FINDING 12: To date the Panel has not received tangible evidence of the proposed new "community hubs" – what they would look like, how they would operate and what services would be delivered within them.

KEY FINDING 13: Without clear examples of what will actually be different under the Jersey Care Model, as opposed to theoretical user cases, the public are likely to remain concerned about changes to their known care provision.

RECOMMENDATION 4: The Minister for Health and Social Services must define the "hub" concept before phase one of the implementation plan commences.

[20] JCM Review Paper, p32
[21] Public Hearing, 29th September 2020

Primary Care

There are currently 13 GP practices (some with branch surgeries) and around 106 GPs in Jersey. All of these operate as independent businesses, although they have links to Health and Community Services through the primary care Medical Director, and to Social Security through the Health Insurance Fund[22]. In response to the Covid-19 pandemic, a salaried model was put in place for GPs, but this arrangement has now reverted back to a fee-for-service (FFS) payment mechanism, which was in place prior to the pandemic.

What is proposed?

According to the JCM Briefing Paper, there is currently no standardised delivery model across outpatients and the data suggests that Jersey is not servicing patients according to need and outcomes.

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. One of the ambitions of the JCM is to better support those with long term conditions and other ambulatory conditions in the community. It is recognised that there are services that are delivered in Jersey's hospital that in other healthcare systems globally would normally be delivered outside of an acute setting. In order to deliver this ambition, it is suggested that there is a need to reconfigure services in order to, for instance, move some management of long-term care outpatients into primary care. [23]

Under the case for change, the Strategic Outline Case discusses current outpatient services. It refers to Jersey's current high level of outpatient appointments, with 1,770 appointments per 1,000 population in 2018. The JCM Briefing Paper referred to a potential reduction of up to 40% in outpatient activity if the JCM principles were applied. However, following the "stress test" by PwC, it is now projected that the changes proposed in the JCM could lead to a 21% reduction in outpatient appointments which would "*reduce unnecessary waits for patients and ensure the secondary care system is able to focus on the more specialist and acute care needs for the Hospital.*"[24]

In addition to outpatient activity, the proposed model discusses the potential of moving more activity from the Emergency Department into primary care and other, more proactive,

[22] Gov.je
[23] Strategic Outline Business Case, p10
[24] JCM Review Paper

community settings. According to the Strategic Outline Case, there were approximately 30,000 visits to the Emergency Department in 2018 that were not considered emergencies.[25]

In a written submission to the Panel, Nadya Wolferstan expressed concerns regarding the potential need for specialist training for GPs if outpatient appointments were expected to be undertaken in a primary care setting. She wrote:

> *"GPs will be expected to take on some Out Patient appointments. Some referrals may be within their current expertise, but it is unclear whether specialist training may be required for selected GPs. There was some reference to dermatology and respiratory referrals to GP surgeries, presumably requiring specialist training for nominated GPs.*[26]

The Strategic Outline Case that was published on 22nd September confirmed that upskilling of staff would be required:

> *"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.*[27]

KEY FINDING 14: Remodelling primary care is a core part of the Jersey Care Model, recognising that a well-functioning primary care sector is an essential underpinning of the overall model.

Engagement with GPs

The Panel recognises that in order for the JCM to deliver on its ambitions and proposals, one of the key priorities will be to ensure that the GPs are on board with the changes and are "taken along on the journey" whilst the JCM progresses.

The JCM Briefing Paper and Strategic Outline Business Case refer to various levels of engagement with GPs, via the Primary Care Board (PCB), about the future funding model for the general practice as well as future working arrangements. As previously mentioned, during the pandemic a temporary employment contract was put in place for four months, with GPs directly employed by HCS during that time. The contract ended in August 2020 and practices returned to their usual operations at that time. At the end of the contract period, work was undertaken to look at options for potentially extending the contract in order to accelerate JCM

[25] Strategic Outline Business Case, p8
[26] Written Submission, Nadya Wolferstan, 24th January 2020
[27] Strategic Outline Business Case, p19

ambitions for changing the model on a more permanent basis. According to the JCM Proposition Report, *"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."*[28]

We will discuss the results of the survey that the Panel undertook with local GPs in greater detail later on in this chapter. However, at this point it was worth noting the responses we received when we asked GPs about possible future working arrangements. For instance, when asked whether they were receptive to future employment opportunities contracted by HCS, out of those who responded, 35% (19) GPs said probably not, 24% (13) said definitely not, 24% (13) said probably, 11% (6) said definitely yes and 7% (2) said not sure/don't know.

KEY FINDING 15: Only 7% of the GPs who responded to the Panel's survey said that they would definitely be receptive to future employment opportunities contracted by Health and Community Services.

Throughout our review, we have tried to keep abreast of discussions that have been taking place between the Health and Community Services Department and GPs, in respect of the ambitions contained within the JCM. At the Public Hearing in February we asked the Minister for Health and Social Services at what stage HCS were at in discussions with GPs to take on some services that were currently delivered within the General Hospital. The Group Managing Director told us:

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

Similarly, in a letter to the Minister for Health and Social Services in March, we asked:

Has anything to date been agreed with GPs in respect of the JCM? What is the timeline for agreeing Terms?

[28] JCM Proposition Report, p27

We are actively working with GP's, primarily through the PCB, to review the model as part of the stress test and work though feasibility of some of the enablers (digital, estates, finance, workforce and process). No terms have been agreed at this point. We have a good idea now for appetite to take on services and the potential barriers that we need to work on to enable service transition. One of the early projects is the low-income primary care access project (financially vulnerable), which will set out a framework for other services to utilise in the future. Diabetes shared care will also be agreed in 2020, which is another of the core groups we seek to address through the model (clinically vulnerable). We have also established a pathway review process involving GPs and secondary care which will facilitate changes in how and where services are delivered.[29]

The Views of GPs

As mentioned earlier, the Panel undertook a targeted survey for GPs which sought their views on the four-month contractual arrangement with HCS in response to Covid-19, future working arrangements and on aspects of the JCM. Out of 106 GPs on the Island, 74 responded to the survey. The survey commenced on 28th August 2020 and was open for three weeks. The full results of the survey can be found in Appendix 3 but we will highlight some of the Panel's key findings here.

One of the questions in the survey asked whether GPs agreed with some of the key issues with our current health care system that had been identified within the JCM. Out of the 74% (55) of respondents who answered this question we found:

- 67% (37) either agreed or strongly agreed that Primary Care is not optimised to achieve integrated care in the current model.
- 98% (54) either agreed or strongly agreed that Community Care could be further optimised.
- 85% (47) either agreed or strongly agreed that direct access services funding mechanisms are not in place.
- 85% (47) either agreed or strongly agreed that social care and external partners could be further utilised.

Other key findings from the survey responses in regard to the JCM are as follows:

Do you think you have been adequately consulted with about the proposals contained within the JCM?

- Out of those who responded, 42% (23) strongly disagreed, 44% (24) disagreed, 13% (7) were undecided, 2% (1) agreed, and 0% strongly agreed.

[29] Letter to the Minister for Health and Community Services, 11th March

Have you assisted HCS with the development of an implementation/delivery plan in respect of the proposals contained within the JCM?

- Out of those who responded, 80% (44) said no and 20% (11) said yes.

Do you understand what is being proposed under the JCM?

- Out of those who responded, 58% (32) said no, 24% (13) said not sure/don't know and 18% (10) said yes.

How confident are you that the JCM, as proposed, can be delivered?

- Out of those who responded, 62% (34) were not confident, 31% (17) were not sure/didn't know, 6% (3) were somewhat confident and 0% were either confident or very confident.

Some examples of the explanations we were provided for the above answers are as follows:

> *Because you are not listening to key players in General Practice. Or our patients.*

> *Employment of staff and retention biggest issue - skilled community practitioners don't fall out of the sky!!!*

> *Care in the community has not worked anywhere it's been tried. Note especially North London. Had to backtrack on closing hospitals at a cost of many millions*

> *Simply there is no GP buy in, currently GPs don't trust the government / health, and there is no sustainable funding mode.*

> *No longer really have faith in the government to deliver anything successfully.*

> *As the COVID period has demonstrated, there are not enough GPs currently in Jersey able to do more than offer the usual highly efficient face to face service.*

> *It sounds good but given my experience of working for 'the government' over the last 4 months I am very wary and sceptical. The government don't seem to be able to achieve simple things like sticking to the terms of our contract and paying people correctly so I'm not sure how they can achieve this complex change of system.*

> *Not fully informed about it so can't comment.*

Did HCS demonstrate an understanding of General Practice demands and practice prior to, or during the contracted period?

- Out of those who responded, 92% (51) answered no, 7% (4) answered yes and 0% answered yes.

Do HCS have an understanding of the on-going demands on practice in Primary Care?

- Out of those who responded, 85% (47) answered no, 11% (6) answered not sure/don't know and 4% (2) answered yes.

How confident are you that General Practice will be adequately supported under the JCM?

- Out of those who responded, 76% (41) were confident, 6% (3) were somewhat confident, 19% (10) were not sure/didn't know, 0% were either confident or very confident.

When we raised our concerns at a Public Hearing in September, the Director General for Health and Community Services advised that following a revision of the implementation plan for the JCM, some of the significant changes around primary care had be moved into years 3-5 (2023-2025) to allow greater time for them to work more closely with their primary care colleagues to co-create the details of the Jersey Care Model.[30] At the same Hearing it was also accepted that there needed to be more engagement with individual practitioners and their respective practices going forward in respect of the JCM.

The Panel's advisers found that GPs should be seen as, not only crucial to the successful delivery of the JCM, but the body which arguably has the greatest practical experience of the current health and wellbeing of the Island's population. In light of this, they raised concerns that the plans to address, in detail, changes to the primary and community care offer, feature at the end of the planning process - Tranche 3 (2023-2025) – rather than at the beginning. The advisers have therefore recommended that consideration should be given to bringing forward the planning of the future primary and community services envisaged in the JCM.

KEY FINDING 16: In order for the Jersey Care Model to deliver on its ambitions and proposals, one of the key priorities will be to ensure that GPs are on board with the changes and are "taken along on the journey" whilst the Model progresses.

[30] Public Hearing, 20th September, p17

KEY FINDING 17: When local GPs were asked whether they felt they had been adequately consulted with about the proposals contained within the Jersey Care Model, only 1% of those who responded to the Panel's survey agreed.

RECOMMENDATION 5: The Minister for Health and Social Services must ensure that the wider population of GPs, beyond the Primary Care Board, are adequately consulted with and, most importantly, listened to in respect of their views on the proposals contained within the Jersey Care Model.

KEY FINDING 18: A significant 85% of GPs who responded to the Panel's survey did not believe that Health and Community Services understood the on-going demands on practice in Primary Care.

RECOMMENDATION 6: The Minister for Health and Social Services must ensure that every effort is given to understanding current and future demands on practice in Primary Care, in order to ensure that the ambitions of the Jersey Care Model are realised.

KEY FINDING 19: Despite GP's support being vital to the success of the Jersey Care Model, the plans to address, in detail, changes to the primary and community care offer, only feature in Tranche 3 (years 2023-2025) of the implementation plan.

KEY FINDING 20: The engagement with GPs is currently not working appropriately and needs immediate attention, so that they feel significantly more involved, listened to and confident in the Jersey Care Model.

RECOMMENDATION 7: The Minister for Health and Social Services should bring forward the planning of future primary and community services to Tranche 1 of the implementation plan.

Secondary Care Model

Urgent Care Centre (UCC)

According to Health and Community Services data, in 2018 the Emergency Department (ED) treated 39,492 attendees, which on average is 108 attendees per day. Of those attendances, it was estimated that 37% were for major illnesses and injuries and 63% for minor illnesses and injuries and therefore the activity was skewed towards minor injuries and illness presentations. The Jersey Care Model outlines a key difference to Unscheduled Care, the splitting of the Emergency Department attendances between an Emergency Department and

Urgent Care Centre. It is proposed that the UCC would treat less urgent activity, and the Emergency Department would be reserved for resus cases and urgent activity.

As previously mentioned, an Urgent Treatment Centre was established at Jersey's General Hospital in April 2020 in response to the on-going pandemic. The UTC closed on 13th July due to the low rates of Covid-19 and the easing of lockdown measures. Whilst we understand that the UTC was set up specifically to help tackle the Coronavirus pandemic, lessons can most likely be learnt from this period if a UCC is to be established in the future, as proposed under the JCM. In the survey we undertook with the General Practitioners, we asked a number of questions regarding their experience of working within the UTC during the pandemic and views about a proposed future UTC/UCC.

The following questions, among others, were asked of the GPs in the survey about this matter:

Would you like to see the UTC reinstated under the proposed JCM?

- Out of those who responded, 38% (21) said definitely not, 29% (16) said probably not, 29% (16) said perhaps, 2% (1) said definitely yes and 2% (1) said not sure/don't know.

Should a UTC model offer unscheduled care in place of the Jersey Doctors on Call (JDOC)?

- Out of those who responded, 44% (24) said yes, 28% (15) said no and 28% (15) were unsure.

Do you think the appropriate type of care was delivered to the UTC during the contracted period?

- Out of those who responded, 78% (43) said no, 15% (8) said yes and 7% (4) said not sure/don't know.

Below are a number of explanations provided by GPs in response to the Survey question above:

> *It was there to manage Covid. It was used as a replacement for a&e.*

> *The problem with the utc was seeing patients which would normally be seen in a&e - gps do not have adequate training to do this. A much better solution is to have GPs seeing primary care patients who present to A&E so that the patients are managed by the dr / nurse with the appropriate expertise for the problem.*

> *A UTC should be a blend of A&E and JDOC. In the contract, it seemed to replace A&E and GPs were doing things outside their scope of practice. A properly designed UTC*

would see GPs managing complex patients to reduce admissions, manage short stay patients to get them back home in the shortest time. They should also be available to liaise with FNHC/Hospice/RRT out of hours to deliver joined up community care. They should not be setting fractures!

> *GPs were doing a&E work in unsafe working conditions.*

> *Initially it was a good concept on the basis of experience in other countries, such as Italy. When that didn't materialise there should have been greater emphasis on usual care and emergency care should have been moved back to the hospital sector. There seems little evidence that a UTC in the day is cost effective when there is good access to GPs and associated diagnostics - another improvement which could be implemented as a stepwise* approach to changes in a care model before major changes are introduced.

The "Stress Test" undertaken by PwC found that whilst the creation of an Urgent Care Centre is central to the envisaged future state of secondary care in Jersey, it is not clearly articulated as to what exactly a UCC would entail, beyond the fact it would manage non-urgent and standard activity.[31]

KEY FINDING 21: Although the creation of an Urgent Care Centre is central to the envisaged future state of secondary care, the Jersey Care Model does not clearly articulate what the Urgent Care Centre would entail.

KEY FINDING 22: Only 2% of GPs, that responded to the Panel's survey, would like to see the Urgent Care Centre (Urgent Treatment Centre equivalent) reinstated under the proposed Jersey Care Model.

RECOMMENDATION 8: The Minister for Social Services must ensure that consideration is given to the operation of the Urgent Treatment Centre during the Covid-19 pandemic and lessons are learnt from this period if an Urgent Treatment Centre/Urgent Care Centre is to be reinstated under the Jersey Care Model.

Shifting care from the community into the home

Social Care/Domiciliary care

According to the Jersey Care Model Briefing Paper, Jersey's current Social Care model is over-reliant on high cost/dependency residential care. Furthermore, it states that there are presently limited options for long-term care other than residential care. The Jersey Care

[31] Jersey Care Model Review Paper, P32

Commission expressed a similar concern of Jersey's current care model in its written submission to the Panel:

> *Many older people are unable to rely on family support and look to their local community health and care services to provide the necessary interventions to enable them to live independently and with dignity. This will require a concerted effort on the Government of Jersey to reshape community services to enable prevention and early intervention, to tailor individuals care packages to support those with chronic conditions, and to respond effectively at points of crisis, reducing reliance on institutional care.*[32]

In order to address these issues, the JCM proposes to:

- Support independence through bespoke care packages that incorporate assistive technology.
- Increase personal choice and work with external partners to reduce the key pressures that an ageing population presents
- Increase support to the parent/carer forum
- Develop a scalable commissioning model in partnership with external providers
- Develop a Partnership for Purpose for wide external provider network
- Create a Care coordination and signposting function to help all navigate the available options.

The JCM also proposes the establishment of a **Social Care Market Strategy** which "*will shape the sector into an independence focused 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."*[33]

In a Hearing with the Panel, it was acknowledged by the Director General of Health and Social Services that social care would, however, require greater investment to deliver a revised Social Care Market Strategy and Personalisation of patient care:

> ***Director General, Health and Community Services:***
>
> *We have had some howls of distress. So we went out on the road we met some very small private providers who were like: "Oh my God, we are here, listen to us. We are in people's homes. We can barely deliver. We do not get paid for travelling between their homes. If we get there and the traffic is bad and we have only got 15 minutes left of the 20-minute care provision we are staying for 25 minutes because we do not want to walk out, we want to deliver care. But that last 10 minutes we are not getting paid*

[32] Written Submission, Jersey Care Commission, 22nd September 2020
[33] *JCM, Oct, p12*

for." It is unregulated and that is the care market that is absolutely the soul I think of provision in a small community, and we have not invested in it. That is our intention.

A written response from the Chair of the Jersey Association of Carers Incorporated (JACI) also recognised the need for greater support for carers in order to accommodate a shift away from delivering care in residential homes and into people's homes. The Association said:

> *Care at home is preferred by many patients and Carers but Carers must feel supported with information, training and flexible respite. Emergency help must also be available if the Carer is unwell.*[34]

Furthermore, the Chair found that although the JCM proposes that care in the community will be enhanced by increasing support to carers, there are no firm suggestions or details as to how Carers will receive increased support from the Government of Jersey.

KEY FINDING 23: Although the Jersey Care Model proposes that care in the community will be enhanced by increasing support to carers, there are no firm suggestions or details as to how carers will receive increased support from the Government of Jersey.

Noticeably absent from the Jersey Care Model Briefing Paper is any reference to the Carers' Strategy. The Carers' Strategy was developed and published by JACI in June 2017. However, to date, no legislation has been brought forward in response to the Strategy and it is unclear whether any progress has been made by HCS in achieving its goals and targets. In a Public Hearing in September, the Director General accepted that HCS had been unsuccessful in delivering the Carers' Strategy so far but that it was a piece of work that they were now focused on and that it would be brought through the Jersey Care Model Steering Group.

KEY FINDING 24: To date, the Health and Community Services Department has been unsuccessful in delivering the Carers' Strategy. However, we have been assured that greater focus will now be given to its delivery as part of the future work in respect of the Jersey Care Model.

In response to a written question from Deputy Geoff Southern in June 2020, the Minister for Health and Social Services spoke about changes that had already been made to the way care is delivered as a result of Jersey's response to Covid-19, in particular regards to social care. It was advised:

> *During the response to COVID-19, we have already started to make changes that positively improve the choices people have in the way they receive their care. We have introduced an out of hours social care service, which supports people that may otherwise have moved into residential care. Many new staff from the hospitality industry have been trained as Health Care Assistants, supporting community care. The*

[34] Written Submission, Chair of the Jersey Association of Carers Inc. 22nd September 2020.

hospital discharge process has been greatly improved and is better coordinated with social care. Even before COVID-19, the social care team were working on early intervention practices, which have been shown to avoid hospital and residential care admissions. There is still much to do, but we will continue to invest in high quality care services to facilitate choice for Islanders.[35]

Mental Health

> ***"There is no health without mental health. Mental health us just as important as Physical Health.***

Current Challenges

The Jersey Care Model identifies five challenges facing Jersey's Mental Health Services, which are also consistent with most health and care jurisdictions. These are:

1. Recruitment challenge for key skilled roles such as Registered Mental Health Nurses, Medical Staff and Allied Health Professionals.
2. The current mental Health Estate doesn't provide a therapeutic environment of care
3. There is increased activity in Mental Health Services
4. There is a lack of care co-ordination and over reliance on the voluntary sector
5. The wider system of Government such as Housing and Economic prosperity need to be linked to the strategic plans for mental health.

OVERALL: Mental health services are not currently integrated with physical health services.

[35] Written Question, 16th June

In order to address these challengers, over the next 5 years the JCM promises to:

- 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
- 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.

mind Jersey
for better mental health

"

Changing the way in which islanders can access services, with more of them being provided in the community and addressing sometimes long waiting times, are also key priorities to be welcomed in the proposed new model of care.[36]

In a written submission to the Panel, the Jersey Care Commission shares its view that the list of key challengers that have been identified in the JCM regarding mental health (above) should include Dementia services and a requirement to recruit skilled social care professionals, as well as clinically trained staff with a specialism in this area.[37]

We note that work on improving mental health has already begun as a result of the concerns raised by the Panel during its assessment of mental health services. In a Public Hearing with the Minister for Health and Social Services in February we were keen to ascertain the lessons that had been learnt from implementing mental health improvements that would be used to help inform the implementation of the broader care model. The Group Managing Director for Health and Community Services informed the Panel:

[36] Written Submission, Mind Jersey, p1, 31st December 2019
[37] Written Submission, Jersey Care Commission, 22nd September 2020

> *The model, the concept for mental health and what we submitted in the Government Plan is absolutely a precursor for what we thought the J.C.M. would look like because it is about prevention and intervention being right and it is about all of the community facing aspects that stop hospitalisation in mental health. So the remit is consistent with physical health. There is a distinct difference though in that the physical health component or healthcare is in a different place of stabilisation to the mental health. So the concept is consistent but we cannot judge the year one of the mental health improvement plan as the barometer of how the physical part of our system is going to be changed. They are at different places.*

During the discussion around mental health and the recent improvements that have been made, the Director General spoke of an enhanced implementation plan, which is now in place to deliver the objectives of the Mental Health Improvement Plan. It was advised that, as a result of the work undertaken by the Panel in its review of mental health services, there are now clear outcomes and deliverables that are regularly monitored. We were also told that HCS intends to use the same methodology for the rollout of the Jersey Care Model; an overarching implementation plan that underneath will have significant programmes of work, with clear outcomes and clear deliverables that are monitored and shared with Scrutiny[38]. We consider the implementation of the Jersey Care Model later on in our report, however it is important to note here that whilst we support the approach stated above, to date, the Panel has not received a clear set of intended outcomes or deliverables for the implementation of the Jersey Care Model.

In a Public Hearing in September, we were told that the Community Crisis Team, that was established to allow a swift response to people who are at risk of admission to hospital, is an example of how the current workforce can be used in a different way to deliver an improved service (an intention of the Jersey Care Model).

Whilst there have been a number of recent improvements to mental health services and their delivery, the Group Director of Health and Community Services recognised areas that still required significant attention. For instance, at the Public Hearing in February, we were told that the current connectively between physical and mental health services was not working, and due to a lack of co-ordinated care, patients were falling through gaps and not receiving the necessary, or right, care. The Panel note that it is envisaged that the ambition of the Jersey Care Model, to personalise care and to work more collaboratively with other providers, will help improve the current issues.

[38] Public Hearing, 13th February 2020

At the time the Panel was completing its review of the Jersey Care Model, HCS announced plans to integrate Adult Social Care and Mental Health Services. We note that the integration appears to be in line with the key ambitions of the JCM. According to press release, in which the announcement was made, the integration will:

- **Improve outcomes for patients** – both services will work collaboratively to achieve improved services and outcomes.
- **Promote efficient services** – it allows innovative ways of working together, inspiring colleagues to drive positive change to the way we deliver care
- **Reflect the vision of the Jersey Care Model** – it will enable us to introduce new models of care.
- **Combine expertise and strategic priorities** – it will ensure people are at the centre of care provision.
- **Enable easier access to services** – it will create direct pathways for people to access the right service and receive help at the right time.

According to Dr Miguel Garcia Alcaraz, the Associate Medical Director and Consultant Psychiatrist for Mental Health Services, "*integration will enhance an introduction of a single pathway for people accessing our services, which will enable us to reduce fragmentation and improve communication*". Dr Garcia further added:

> *"We believe an integrated model will improve outcomes so that people receive joined-up care and easier access to services. Joint working will improve existing services and together we can tackle the challenge of increased demand for Mental Health and Adult Social Care support.*

The Panel welcomes the integration of Adult Social Care and Mental Health Services and see the change as a positive step to improving the care received by patients and vulnerable people within our community.

KEY FINDING 25: The Panel welcomes the integration of Adult Social Care and Mental Health Services and see the change as a positive step to improving the care received by patients and vulnerable people within our community.

One of the most significant changes that has been bought about by the work undertaken on the Jersey Care Model, in respect of mental health, is the ambition to co-locate mental health services within the main new hospital site. Due to this ambition, some options that may have been previously considered regarding the configuration of the new hospital, were not taken forward as they were believed to be too much of a dilution of the JCM's objectives.[39]

[39] Hospital Site Shortlisting Report

With regards to the co-location of mental health services within the main hospital, Nadya Wolferstan, in her submission to the Panel, commented:

> *The co-location of mental health services within the hospital is a laudable aim; there was no mention of the role of mental health services within either the UTC or ED despite recognition that a number of admissions through ED included management of homeless with substance misuse/ mental health problems. Is there a plan to have Psychiatric nurses in ED or will the Crisis team be contacted when required?*

KEY FINDING 26: One of the key ambitions within the Jersey Care Model, in respect of mental health, is to co-locate mental health services within the main new hospital site. Due to this ambition, some options that may have previously been considered regarding the configuration of the new hospital, were not taken forward and they were too much of a dilution of the Jersey Care Model's objectives.

KEY FINDING 27: The Jersey Care Model does not define the role of mental health services within the proposed Urgent Treatment Centre of the Emergency Department.

RECOMMENDATION 9: The Minister for Health and Social Services must provide clarity as to the role mental health services will play within the proposed Urgent Treatment Centre and future Emergency Department. Specifically, the Minister must confirm whether it is the intention to have mental health staff positioned within the Emergency Department.

What is the intended outcome for health care and service users?

The vision set by the JCM is to deliver safe, high quality care that is outcome-focused and accessible at the point of need. In order to measure the potential impact, and hopefully improvements, that the JCM will have on service user experience and care, we believe it is important to first understand the current state of care. In a Public Hearing with the Minister for Health and Social Services in February, we asked what the biggest concerns were currently in terms of outcomes of specific specialities or particular patient experience groups and in regard to clinical quality that need to be addressed by the Jersey Care Model. The Group Managing Director advised:

> *It is not just clinical and we need to be really clear about that; it is health and care. We are integrated with social care and at the heart of what we want to achieve with the Jersey Care Model we know when we look at our activity analysis, looking at our high-risk patients who are accessing our services frequently, they are being passed pillar to*

post around our health and care system. They are going between social care, between different physical specialities, between mental health and primary care, and they are not having continuity. They are having multiple assessments, multiple opinions, and they are not having good case management co-ordination, and their outcome is often leading to institutional focus care either in secondary care, in hospital, or within the care home environment. So we have set clear targets that we preserve the hospital to deal with those patients who absolutely need specialist, hospital focused intervention rather than having the hospital occupied by patients who are medically fit and do not need to be there. For the community part of our sector we really want that part to pick up and to manage patients to deliver more independent life where they do not have one choice only, which is predominantly to go into long-term institutional care. We want them to have more community care in their own usual place of residence.

(Panel Adviser):

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

Group Managing Director, Health and Community Services:

"*Outcome, yes.*[40]

In the same discussion the Group Managing Director confirmed that the "stress test", that was being undertaken at the time, would identify quantifiable improvements in both patient experience and outcomes for the population. However, we were told at the Hearing that the Jersey Care Model would improve both value for money and outcomes for service users.[41]

We are unclear to the extent in which that work was undertaken or indeed completed by PwC. Although the JCM Review Paper (appended to the Proposition) states that the proposed integrated care model is likely to deliver enhanced service user experience and care by streamlining services and workforce resources, it also goes on to highlight the lack of detail about how the JCM will positively impact service efficiencies and outcomes in reality. Furthermore, it also states that whilst proposed measures, such as an integrated care hub and an Urgent Care Centre, and proposals to strengthen primary care and prevention may provide a means of achieving improved outcomes, more detail is firstly required on their specific implementation needs including their workforce, estates and financial resource requirements.

[40] Public Hearing with the Minister for Health and Social Services, 13th February 2020, page 15
[41] Public Hearing with the Minister for Health and Social Services, 13th February 2020, page 42

In written submissions to the Panel, both Family Nursing and Home Care and Jersey Hospice Care spoke about the impact of the Jersey Care Model on the outcome for health care and services users:

Family Nursing and Home Care

> *To assess the potential impact of quality of services provided by the new model, we will need to be able to demonstrate improved outcomes for patients. There are a number of ways this can be achieved, one of which is to benchmark against other jurisdictions, others are through patient satisfaction and feedback mechanisms. Whichever methodologies are selected there will need to be a quality framework developed as part of a performance monitoring and management system. The framework will need to cover all parts of the system or pathway as this will be required in order to deliver improved outcome for patients.*[42]

Jersey Hospice Care

> *In summary the key work-streams relate to vision clarity and service co-ordination, connectivity, funding, workforce capacity, regulation, governance and prioritisation. Critically system leadership of this Model is essential. If achieved the Model has the potential to significantly improve the experience of patients and the outcomes achieved for them.*[43]

Is the JCM the right model for Jersey?

The JCM Review Paper clearly states that one of PwC's key findings is that the JCM is a suitable model for Jersey, is line with good practice for integrated care and, when implemented, will enhance quality safe and timely care. However, it also states that "*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.*"[44]

It is clear from previous reviews that have been undertaken, in respect of transforming Jersey's current care model, that there is appetite for change. The public consultation that was undertaken as part of the work around the 2011 Green Paper 'Caring for each other, caring for ourselves' demonstrated that 86% of the public were in favour of a fundamental redesign of Jersey's services. Islanders stated that they

[42] Written Submission, Family Nursing and Home Care, 20th January 2020
[43] Written Submission, Jersey Hospice Care, 17th February 2020
[44] JCM Briefing Paper, p8

wanted services that "wrapped" around the individual delivered in the community - not just at the hospital or in institutions. The ambitions set out in that paper were not realised and the JCM offers a means of addressing that.

Many organisations or individuals that the Panel heard from during the undertaking of its review recognised the benefits of a new care model and its appropriateness for the Island. For instance, the following wrote:

> ***Jersey Recovery College***
>
> *Jersey Recovery College (JRC) believes the Jersey Care Model is appropriate for Jersey. We particularly support the principles that there is no health without mental health and that services must 'involve the voices of our service users'. We also agree that the wellbeing and health of our Island is reliant on more than health services.*[45]

> ***Les Amis***
>
> *We would like to note that we are 100% supportive of the developments the government are aiming to achieve, for the betterment of islanders in general.*[46]

> ***Jersey Hospice Care***
>
> *In binary terms we have a choice. We can as a community do nothing while the demands on our healthcare system continue to increase and the proportionate available resources decline. This would risk the quality and safety of current services and inevitably place our most vulnerable at greatest risk. Alternatively, the island can support the introduction of an ambitious plan to change how care is delivered in the island so that we can have the best healthcare system – anywhere.*[47]

However, there were others who, whilst accepting the potential benefits of the model, also expressed concerns about the general lack of detail contained within the model, financial concerns and concerns about implementation, among other things. These are some examples of the responses we received:

> **Jersey Community Partnership**
>
> *Given the current care model is inappropriate for the Island and our needs, the new model – in putting Islanders' needs at the centre of the care system – is the appropriate model to be adopting. However, it is difficult to accurately assess how appropriate the model is without greater understanding of the population's health and care needs and how the model will be funded.*[48]

45 Written Submission, Jersey Recovery College, 4th February 2020
46 Written Submission, Les Amis, 30th January 2020
47 Written Submission, Jersey Hospice Care, 17th February 2020
48 Written Submission, Jersey Community Partnership, 31st January 2020

Family Nursing and Home Care

> *The new JCM is designed to provide a more sustainable Health and Social Care system that focuses on care in the community and care closer to home. Arguably most patients who require care and support would prefer to have services delivered in their own or close to their home with services that support maintaining independence. In particular for the care of children, it is important for families to be able to have choice and to keep children at home and or in education. FNHC provides community nursing service and Home care which covers pre-birth to end of life and therefore FNHC supports the overarching principles and concept of the new JCM. FNHC however does feel that there will be some challenges to implementing the model over the coming years.*[49]

In the survey we undertook with local GPs, we asked the overall extent to which they agreed that the proposed JCM was a good model of healthcare delivery for Jersey. Of the 74% (55) who responded to this question, 60% (33) were unsure or neither agreed or disagreed, 24% (13) disagreed or strongly disagreed and 16% (9) either agreed or strongly agreed. We asked for an explanation for their responses and here are some examples of their comments:

> *It will not be financially viable, nor will there be enough skilled workers available.*

> *It hasn't been worked through with primary care you need primary care on board, currently the relationship between gps and health is poor. How can you achieve JCM without improving this relationship?*

> *I feel that further consultation is appropriate - so many people don't understand the Jersey Care Model and it's not appropriate to consider implementing it without the population understanding and having their say in the JCM.*

> *Any effort to improve community-based care and reduce unnecessary secondary care use is to be welcomed for patient access/convenience and economic reasons.*

> *I haven't been told what the JCM is yet, so I can't agree or disagree with it.*

> *Don't have enough detail to make a decision.*

> *Concept good but need more detail re implementation.*

> *The idea of moving care into the community is simple to agree with, but how it is delivered is what's important. I have no confidence in the delivery.*

> *It hasn't been circulated to GPs in detail, only broad terms such as "more care in the community" - this may or may not be a good and/or efficient way of working, but if inadequately reviewed by GPs (who pick up the community work) then we cannot say.*

[49] Written Submission, Family Nursing and Home Care, 30th January 2020

Our advisers agree that the overall model proposed is line with international care models and that the approach being developed appears to be logical and should impact positively on the population of Jersey. However, we also note their concern that the JCM is still a work in progress and is considered by the Minister for Health and Social Services as a framework. As a result of this, the JCM, as it is currently written, lacks a level of detail as to the specifics of how services will change over time beyond high level assumptions. In regard to assessing whether the JCM is right for Jersey, the advisers found:

> *"As there are so many details of the JCM that are still be confirmed it means that assessment of the suitability or otherwise of the JCM is hard to establish. Many of the public submissions and discussions that we have had with key stakeholders have highlighted further information is required to provide specific detail on how the JCM will change care provision and the impact that the JCM will have for service users, the workforce and the overall care system in Jersey.*

KEY FINDING 28: The key principles of the Jersey Care Model are widely accepted amongst the public and key stakeholders. However, the lack of detail as to how the provision of care will change under the Jersey Care Model and the impact the new model will have on service users, the workforce and the overall care system in Jersey, makes it hard to accurately assess *how* appropriate the model is for Jersey.

8. Delivery of the Jersey Care Model

Responsibility for the delivery of the JCM and Governance Arrangements

According to the Strategic Outline Business Case, governance has been established to provide oversight (including clinical oversight) over the JCM review and this will continue through implementation. Four key oversight groups were established as part of the JCM Review programme to provide input, review, challenge and oversight. We have been advised that these are:

- Integrated Care System Leadership Team: formed to provide strategic leadership, direction and overall decision-making capacity 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.[50]

At a Public Hearing in February, we were provided with further information about the role of the clinical and professional senate:

> *…we have constituted a clinical and professional senate whereby our clinical and professional leaders will come together to look at the proposals put forward under the J.C.M. in a scrutiny perspective. So they are not thinking from an organisational perspective, they are thinking as a professional. "I am a lead doctor, I am a lead social worker, I am a lead O.T. (occupational therapist), physio. This is what I think about what I am seeing and this is my view about what we are proposing." That is part of our assurance and our assessment. Is it just Caroline and I and others who are group thinking in this and what do our actual clinical professional leaders think about our ideas?*[51]

The Jersey Care Model clearly, and rightly, recognises that work needs to be undertaken on clinical governance regimes. The issue of appropriate governance was a matter that was raised by a number of organisations and individuals who engaged with the Panel for this review. Examples of some of the comments raised are:

[50] Strategic Outline Business Case, p84
[51] Public Hearing, 13th February 2020, p36

Family Nursing and Home Care

> *Robust governance will need to manage, reduce and mitigate risk, provide clinical oversight and monitor complaints and incidence. In addition to clinical governance, would be the requirement for corporate governance which should include robust financial management to ensure the maximum benefit from funding allocations, with value added and costs monitored year on year.*[52]

Jersey Hospice Care

> *We believe regulation, and specifically governance, provide a quality and safety assurance that will be critical in demonstrating the Model and new ways of accessing care. Overarching safeguarding and governance measures are going to be key to ensuring community confidence in the new delivery model and provide assurance.*[53]

KEY FINDING 29: Overarching safeguarding and governance measures are going to be key to ensuring community confidence in the new delivery model and provide assurance.

During its review, the Panel queried how such an ambitious plan, such as the Jersey Care Model, would be delivered by the Health and Community Services Department, who already have an extremely busy work programme. The Director General commented:

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

In June 2020, with regards to improving and formalising the governance and delivery approach to the implementation of the JCM, the Panel asked the Minister about the Programme Management Office (PMO) that was in place. It was advised that, within HCS, there was a Modernisation Team which included a PMO and that a review of any change to the PMO function to deliver the JCM would be assessed following formal approval of the model. We queried how the Minister was intending to resource the PMO function. We were told that a gap analysis was being undertaken to ascertain what support was required to enable successful implementation and delivery. Once this was determined, any support required would be procured through the standard government process.[54]

Within the "Financial Costs" section of the JCM Strategic Outline Business Case, Programme Management Office is identified as an area that will require non-recurrent investment that

[52] Written Submission, Family Nursing and Home Care, 30th January 2020
[53] Written Submission, Jersey Hospice Care, 17th February 2020
[54] Letter, Minister for Health and Social Services, 8th June 2020.

would fall under the programme costs within the transformation programme. The total cost of the 'programme costs' is forecast to be £10.6m over a five-year period.[55] At a Public Hearing in September it was confirmed by the Group Director for Performance, Accounting and Reporting that the financial model makes provision for one-off expenditure over a period of 4 years for programme management, whether that be internal brought in by the Director General or whether that be consultants.[56]

Our advisers found that the scale of change in the JCM cannot be underestimated and therefore it will need a different specialist skill set to manage the overall programme of change. This will be in the form of a project management discipline that will describe the journey from the present to the full implementation of the JCM. The advisers also note that whilst the JCM is often referred to as if it is a single coherent programme, it is in fact a series of inter-related projects, which combine to form the JCM but individually all require their own delivery champions, implementation framework and an easily described, and understood, public narrative. As inter-related projects, some aspects could go ahead now, whereas others (particularly that dependant on major workforce changes), will require long lead-ins. With regards to a Programme Management Framework the advisers also commented:

> *"A well organised framework for project management is essential to deliver the ambition and the complexity of the JCM. Without a Programme Management Framework, its individual component projects cannot succeed and, critically from the Panel's point of view, the HSSSP has nothing against which to measure progress. One benefit of successful programme management is that it has a start and end, so it doesn't need to be seen as an on-going additional cost. It should be seen as an inevitable upfront double running cost, but successful project management defines its own lifetime. To date there have been references to a programme management approach but nothing has been received to review, such as a programme plan or comprehensive risk log.*

KEY FINDING 30: Whilst the Jersey Care Model is often referred to as if it is a single coherent programme, it is in fact a series of inter-related projects, which combine to form the Jersey Care Model but individually all require their own delivery champions, implementation framework and an easily described, and understood, public narrative.

KEY FINDING 31: Without a Programme Management Framework, the Jersey Care Model's individual component projects cannot succeed and, critically from the Panel's point of view, it has nothing against which to measure progress. Whilst there have been references to a programme management approach, nothing has been received to review, such as a programme plan or comprehensive risk log.

[55] JCM Strategic Outline Case, p71
[56] Public Hearing, 29th September 2020

With regards to overall accountability for delivery of the model, we note that the Minister for Health and Social Services holds political accountability and the Director General for Health and Community Services is the overall accountable officer from a civil servant perspective. At a Public Hearing in September we were advised that a director had been appointed and is due to start soon, who will be the accountable director for the delivery of the JCM. We were also told that she would be working with her service improvement team (consisting of 8 people) to deliver and lead this programme on behalf of HCS.[57]

Overall accountability of delivering the Jersey Care Model will be discussed in further detail later on in this chapter under the sub-heading '*Implementation of the JCM*'.

Who will deliver the care in the community?

The JCM recognises that, whilst central to the model is the development of a new hospital, it alone will not provide a sustainable system of healthcare. It also recognises that whilst the new hospital needs to be part of the health and social care system, it will need to be fully supported by high quality community provision, delivered in partnership where people can easily access care and support. Furthermore, it acknowledges that, in order to deliver a sustainable and quality care system, it is imperative to have strong partnerships with the voluntary sector, social care providers, private providers and social enterprises based on achieving shared outcomes.[58]

At a Public Hearing in February, the Group Managing Director for Health and Community Services explained how it was envisaged that care in the community would be delivered:

> *"…we are not seeking volunteers to co-ordinate this and I think there has been a confusion that in our aspiration under the voluntary sector that that means that we are expecting volunteers to co-ordinate care. We are commissioning services from voluntary providers with paid services that would be similar to in the U.K. (United Kingdom) context as a community trust. So we are not expecting these services to be delivered for free [by the voluntary and community sector]; we expect to invest within those community services, and those community services have more contact with our patients and clients than the hospital. They know the patient better, they see them on a more long-term basis. At the moment the system is weighted in a way that the hospital is making the decisions for patients, that it is only seeing for very short periods of time, rather than the consistent person who knows the patient, and that really should be the G.P. and a community service."*[59]

[57] Public Hearing, 29th September 2020
[58] Jersey Care Model Briefing paper, p39
[59] Public Hearing, 13th February 2020, p16

External Partners and Commissioning Framework

What do we know about our voluntary sector?

£80m is raised annually within the voluntary sector

The largest 4% of organisations raised £48m (62% of all income in the voluntary sector)

1 in 8 adults on the island volunteer

2/3 organisations operate without any paid staff

In a written submission to the Panel, the Jersey Community Partnership advised:

> *In 2016 we identified 535 organisations working in the field of social action. Of these the top two income-generating aims were the 'advancement of health' and 'relief of those in need'. This illustrates where effort (and therefore funding) is concentrated on within the sector. Furthermore, we identified that the sector generated in excess of £80m annually. At the end of 2019 The Charity Commissioner confirmed that registered charitable entities had an asset base of £190m and an expenditure of £70m annually. What has not been determined by the Government of Jersey is the total value of outsourced public services, and the value of these services to the community.*[60]

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. 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 ***Is currently spent on external partners from the Government's budget***

It is clear from the engagement events that were run by the Health and Community Services Department, that external partners were consulted with during the development phase of the

[60] Written Submission, Jersey Community Partnership, 31st January 2020

Jersey Care Model. In a Public hearing in February, the Minister for Health and Social Services spoke about the ambition of the JCM to work in greater partnership and collaboration with external partners to deliver healthcare in Jersey. He told the Panel:

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

The Director General for Health and Social Services added:

> *We are partners. Islanders should not want us to be the dominant partner. It should not want government to be the dominant partner. It is a collaboration in partnership.* [61]

In a written submission, Mind Jersey also spoke about their hope for a new way of working with the Government of Jersey to deliver the priorities contained within the JCM:

> *Whilst the Government of Jersey, and HCS in particular, has prime responsibility for delivering this plan, neither can do it alone nor in isolation. A new spirit of partnership and co-operation is required, and Mind Jersey is committed to work constructively with the statutory services, and other partners, to implement many of these priorities. All Government departments should have one eye on wellbeing when making decisions.*[62]

Commissioning Framework and Partnership of Purpose

We note that the current approach to commissioning in Jersey is relatively immature in comparison to other health economies. According to HCS, the approach 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. There is a current lack of a contract management function and partnerships are rarely used.

In a letter from the Minister for Health and Social Services in March, the Panel was told:

> *We are committed to working with local organisations to co-produce services for Islanders. The local voluntary sector is a significant provider of services across the community. We have developed a local commissioning framework and a Partnership*

[61] Public Hearing, 13th February 2020, p43
[62] Written Submission, Mind Jersey, 31st December 2019

of Purpose to support local organisations to work more closely together. This will further be enhanced through 2020 where we are working across government to build a central commissioning function.[63]

The Jersey Care Model Briefing Paper, that was published in October 2019, provided little detail as to the future commissioning framework. However, it did discuss the overall aims of what is hoped will be achieved through its introduction. For instance, it was advised that a relationship with contracted services should be built around a common purpose working in partnership, using payment to support the delivery of care, sharing outcomes, collaborative working ad delivering in the community with clear outcomes. Also, that commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. It was also acknowledged that delivering services to an agreed common purpose would require the development and commitment of an overarching 'Partnership of Purpose', which would provide the focus and structure for a framework. The 'Partnership of Purpose' as proposed by HCS is shown below:

Traditional Outcome Based Commissioning = An outcomes-based commissioning framework that focuses on activity aligned to HCS's strategy.

Personalisation = The process by which people with long-terms illnesses or conditions receive support that is tailored to their individual needs and wishes. It is suggested that the lack of personalisation in Jersey contributes to the high levels of occupancy in the residential estate.

Co-production = According to a review undertaken by the Department of Health, Public Health and NHS England, *commissioners should co-produce their health and care*

[63] Letter, Minister for Health and Social Services, 11th March 2020

systems with local people, using VCSE organisations as partners to do this, particularly in engaging overlooked groups and communities.

Governance and Funding = Dedicated Resource would be required to effectively monitor delivery by providers. It is proposed that multiyear funding should be available to providers to enable to plan and develop.

Market Development = A market development strategy needs to be developed to strengthen the offer that can be delivered in the community.[64]

Interestingly, the significance of the need for different commissioning arrangements in Jersey was emphasised in the work that was undertaken by PwC, where it was found that the JCM is financially sustainable and will not cost more to the consumer **if** resource allocation, funding models and commissioning arrangements are amended.[65] The "stress test" confirmed that the supporting commissioning framework, contained within the JCM, was in alignment with good practice models. However, it also found that the JCM lacked details in respect of:

- How outcomes-based, capitated contracting would occur or how personalised budgets would be managed; and
- How Strategic Partnerships with risk and reward mechanisms would be managed.

It further noted that the JCM was lacking on the approach for poor performance, or financial challengers relating to a provider.[66]

The JCM Strategic Outline case (SOC), which was lodged in September provided a diagram of the proposed JCM Commissioning framework (left). The framework details the commissioning cycle to be followed and the principles to be used for good commissioning decisions.

The SOBC also identifies options of commissioning arrangements for Primary Care, Social Care and External Partners with the intention of further review. According to the new prioritisation framework for implementation of the JCM (discussed in greater detail later on in this chapter), the plan is to implement a

[64] JCM Briefing Paper, p96
[65] JCM Review Paper, p30
[66] JCM Review Paper, p50

commissioning framework with community and social care partners in Tranche 2 (2022-2023). With specific regards to commissioning, it also confirms that 'immediate priority' will be given to:

- Agreeing on Primary Care Model and developing proposals with partners
- Agreeing on outcomes for commissioning
- Assessing gap on commission framework and key areas requiring detailed design.

The Panel received a substantial level of feedback from individuals and organisations concerning a revised commissioning framework. Some were extremely positive about its introduction. For instance, the Jersey Recovery College and Jersey Community Partnership wrote:

> ***Jersey Recovery College***
>
> *We welcome a revisioning of the commissioning framework, particularly to introduce longer contracts, the emphasis on co-production and outcomes-based commissioning.*

> ***Jersey Community Partnership***
>
> *New and effective commissioning practices will be key to achieving the JCM's vision. Collaborative commissioning for social value needs to replace the current paternalistic system. Empower communities to be directly involved in the design and implementation of services of which they will directly benefit. Co-produce the commissioning process itself, not just the commissioning of the healthcare provision. Provide the environment for innovation to flourish and don't stifle competition from VCSE providers by having tendering processes that prevent small providers or charitable consortia from applying.*

However, there were others who either questioned the necessity of a commissioning framework at all or raised concerns about increased bureaucracy:

> ***Mind Jersey***
>
> *Whilst it is understood that significant additional investment made in the primary care and voluntary sector needs to be carefully monitored and allocated, as part of a more rigorous commissioning process , care must be taken to ensure that this process is proportionate and not burdensome, especially in regard to smaller charities where investment in infrastructure has been modest and their capacity to engage in complex data collection and reporting is limited.*[67]

> ***Primary Care Board***
>
> *Collaboration rather than commissioning would provide a better way forward. Commissioning has not proved beneficial in even a large jurisdiction with much*

[67] Written Submission, Mind Jersey,31st December 2019

competition, such as the UK, and there are moves away from it. In a small island competition is not always possible or a desired outcome.[68]

Collected from the GP Survey

> *While necessary, will need more bureaucracy and the States are legendary at this. Our PCB could become part of a CCG style system.*[69]

Collected from the GP Survey

> *I quite like commissioning frameworks but in a small community, negotiated contracts are likely to be more efficient and less bureaucratic. Frankly we have a very limited market, I think commissioning will ultimately be more expensive than a negotiated contract.*[70]

KEY FINDING 32: Care must be taken to ensure that any new commissioning process is proportionate and not burdensome, especially in regard to smaller charities where investment in infrastructure has been modest and their capacity to engage in complex data collection and reporting is limited.

The Panel was assured at a Public Hearing in September that it was not HCS's intention to introduce a divisive procured system of care that sees Jersey coming into competition with itself.[71]

In their report, the Panel's advisers recognise the potential benefits of formalising the current commercial arrangements with service providers. However, they also acknowledge that there is a danger that the role of relationships in the provision of care across the Island could be adversely impacted by a commissioning approach that is not appropriately developed. They go on to say that "*if mishandled the commissioning approach could disrupt the existing large-scale volunteer workforce*, *not just through organisations but also for individual carers*." The advisers propose that the JCM should clearly identify where commissioning is already working effectively on the Island (where it drives high standards, follows best practice and delivers strong value for money) and where it is not working so well. This would provide a clear understanding of the specific factors that would improve the current commissioning model.

The advisers also argue that the JCM needs to be more explicit in its vision of procurement and how that translates into practice. The commissioning cycle (as shown above) includes 'procuring services', however it is unclear what this means in the Jersey context.

[68] Written Submission, Primary Care Board, 24th January 2020
[69] GP Survey Response, September 2020
[70] GP Survey Response, September 2020
[71] Public Hearing, 29th September 2020.

KEY FINDING 33: There is a risk that the role of relationships in the provision of care across the Island could be adversely impacted by a commissioning approach that is not adequality developed.

RECOMMENDATION 10: The Minister for Health and Social Services should more clearly define the intention of introducing the commissioning framework and provide a further explanation as to the role of procurement and how services will be selected to be subject to that procurement.

Implementation of the JCM

The Jersey Care Model Briefing Paper, that was published last year, did not provide much in the way of an implementation plan for the delivery of the JCM or details of what may be prioritised in such an extensive and ambitious programme of work. Due to past failures of delivering changes to our current care model, it is imperative that there is a clear implementation programme and members of the public can have confidence in its delivery.

At the Public Hearing in February we asked the Minister for Health and Social Services and his Officers whether there was a clear programme plan in place for the development and the delivery of the Jersey Care Model. It was advised:

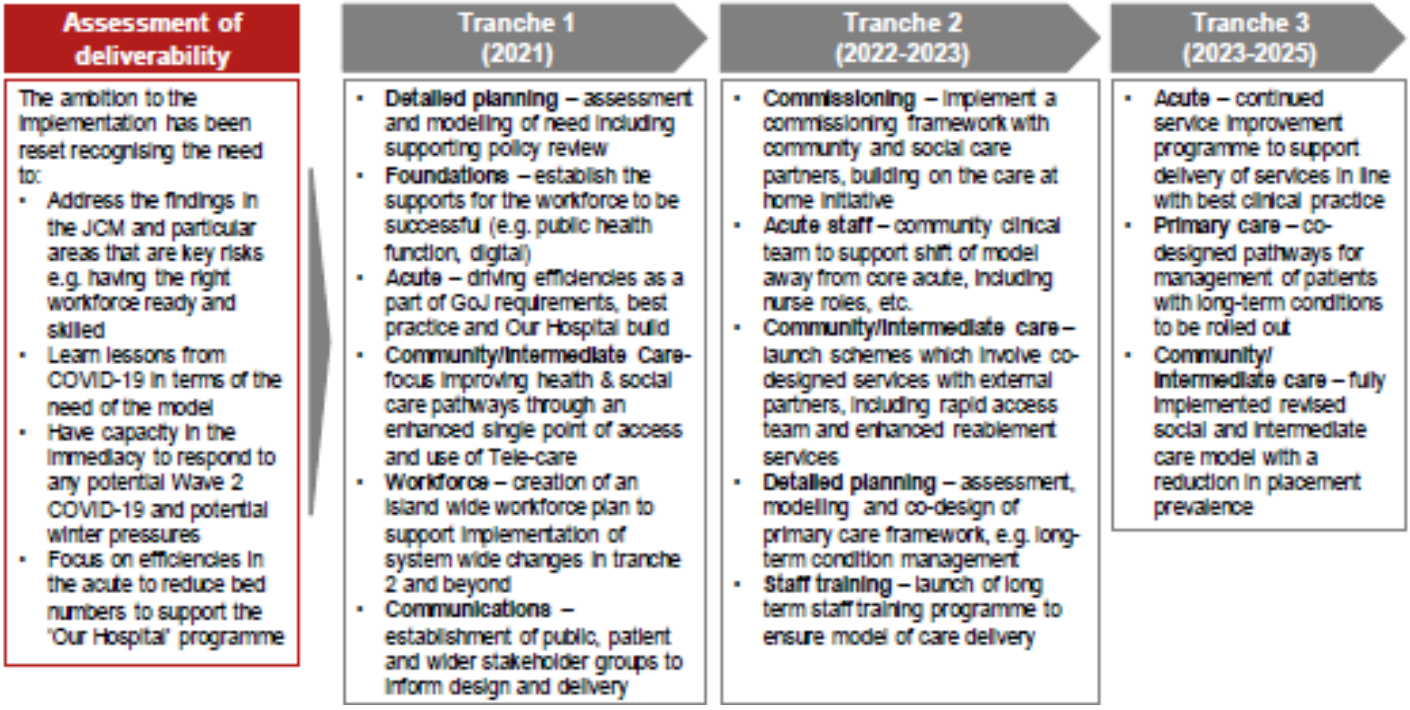
> ***Director General, Health and Community Services:***
>
> *We are talking through various implementation plans but, yes.*
>
> ***Deputy K.G. Pamplin:***
>
> *What is the timeline of the progress of that and when do you think it will be completed?*
>
> ***Director General, Health and Community Services:***
>
> *It is the end of March. At the end of March, we will have one version of it.*[72]
>
> ***Deputy K.G. Pamplin:***
>
> Sorry, Caroline, I am going to rattle through. Will you be able to provide us with that plan as soon as it is finished? Even confidentially?
>
> ***Director General, Health and Community Services:***
>
> Yes.

[72] Public Hearing, 13th February 2020, p44

Despite a number of requests to the Minister and Department, following the Hearing, we never received a draft implementation plan, as promised.

The JCM Review, that was undertaken by PwC, found that whilst the JCM identified a number of areas of focus for further work, it was absent on a broad implementation programme.[73] It also found that whilst there was momentum behind the programme, for the JCM to be successful a phased transition was proposed, given the scale of change. The review therefore identified 16 key workstreams which PwC believed key efforts should be focused towards. These included but were not limited to; clinical care models, operating model, workforce, finance, quality improvement and innovation, finance, IT and digital. The full list can be found on page 130-132 of the "JCM Review Paper" document.

Due to the Covid-19 pandemic and the emerging challengers that the Island is now facing, HCS amended the phasing of the programme "*to allow stabilisation of the platform within Jersey and internationally with the roll out of programme phased in 3 risk assessed tranches.*" The new proposed prioritisation framework for implementation is shown below:



The Strategic Outline Business Case provides some further details as to work that is intended to be undertaken in tranche one:

> *"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*

[73] JCM Review Paper

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.[74]

In a Public Hearing in September we were told that in year one of the implementation plan the intention was to target intermediate care, night sitting and 24/7 community nursing and to attach that to a more robust out of hospital setting. In order to the measure success at the end of year one, in respect of those areas, they would be looking at whether they were seeing the same volume of people coming into hospital at night, whether the ambulance service was experiencing the same level of call outs and whether the same prevalence of volume of activity was coming in through the front door of the hospital. We also queried how the public may see an impact to the services they receive at the end of year one. The Group managing Director told the Panel that by the end of 2021 they would like to see that people recognise that services are wrapped around them and can support them, that the public are starting to understand what a care co-ordinator is, and to understand reablement services better.[75]

The Panel received a briefing on the proposed tranche model for the implementation of the JCM on 28th August 2020. Following that briefing, we requested a breakdown of the impact of each tranche across a wider set of metrics other than finance (i.e. Workforce, clinical outcomes by care settings, digital enhancements, estates etc.) On 25th September, in email correspondence we were advised that this detailed work had not yet been undertaken and was due to be done as part of the 'next steps' work.

In their report, our advisers recognised that much of the work that the Panel was told would be available after the "stress test" has not been forthcoming and that most of this work will now be delivered next year. The advisers wrote:

> *In public sessions the HSSS Panel has received reassurance from the Minister and HCS officers that much of the work involved in the above would be made available to the Panel in advance of being presented to the Assembly, once it had been "stress tested". This however has not happened. Instead, it now appears, this level of detail described as "future proofing" is a major component of Tranche 1 of the JCM, planned for delivery in 2021.*

The advisers also found that there is insufficient pace and rigour behind the JCM and that those responsible for its delivery are not being held accountable for considerable slippage against previously promised actions. The advisers commented:

[74] Strategic Outline Business Case, p5
[75] Public Hearing, 29th September 2020

> *Much of the slippage of the JCM during 2020 has been attributed to Covid-19. With no end in sight to the global pandemic, there is little confidence that the combination of the current HCS team plus its external consultancy support will deliver the combined agendas of business as usual service delivery, reacting to the continuing pressures of the pandemic, and the JCM, in a timely manner, irrespective of the proposed new hospital programme. This loss of confidence is due to two fundamental faults in the current approach – firstly, that the same few people at the top of HCS appear to be tasked with this whole agenda, and secondly, that there is no robust mechanism for maintaining regular overview and challenge on the detail of the JCM on a very regular basis.*

In light of the above, our advisers have proposed that an independent non-executive Board is created to hold executives to account for their full-time responsibility to deliver a timely and successful Jersey Care Model. It is envisaged that the Board would ensure that the whole programme and its individual milestones are delivered to plan and its focus on strategy would ensure that the major enabling components (digital, workforce and engagement strategies), as well as the integration with other key government departments are in place, early enough to impact positively on the overall programme. (more detail on the proposed Board can be found on p125 of our advisers' report in Appendix 2).

One of the Panel's earlier findings alludes to the current absence, as far as we are aware, of a programme plan or comprehensive risk log. The advisers have suggested that such a Board, as described above, would be responsible for agreeing a monthly progress report, which would be informed by a risk log that included the top 10 risks of the successful delivery of the JCM, and would describe progress against the key monthly milestones in the overall programme. It is further proposed that the Board would publish a report at the end of Tranche 1 (2021) which detailed an analysis of progress made during the first year against a pre-agreed set of outcome-based targets. The report would also include a detailed look ahead to the programme to deliver Tranche 2 of the implementation plan.

KEY FINDING 34: Due to past failures of delivering changes to our current care model, it is imperative that the new Jersey Care Model includes a clear implementation programme so members of the public can have confidence in its delivery.

KEY FINDING 35: There is insufficient pace and rigour behind the Jersey Care Model and those responsible for its delivery are not being held accountable for considerable slippage against previously promised actions.

KEY FINDING 36: With no end in sight to the global pandemic, there is little confidence that the combination of the current Health and Community Services team, plus its external consultancy support, will deliver the combined agendas of business as usual service delivery,

reacting to the continuing pressures of the pandemic, and the Jersey Care Model, in a timely manner.

KEY FINDING 37: There is currently no robust mechanism for maintaining regular overview and challenge on the detail of the Jersey Care Model on a very regular basis.

RECOMMENDATION 11: The Minister for Health and Social Services must establish a Risk Log for the top 10 risks for the successful delivery of the JCM that can be used to monitor progress.

RECOMMENDATION 12: The Minister for Health and Social Services must establish an independent, non-executive Board to hold executives to account for the timely and successful delivery of the Jersey Care Model. The Board would be responsible for agreeing a monthly progress report, which would be informed by a risk log (Recommendation 11) and would describe progress against the key monthly milestones in the overall programme. The Board would publish a report at the end of Tranche 1 (2021) which details an analysis of progress made during the first year against a pre-agreed set of outcome-based targets. The report would also include a detailed look ahead to the programme to deliver Tranche 2 of the implementation plan.

Risks/enablers – Challengers to implementation

Workforce

The JCM clearly identifies the availability of an adequate workforce as a key factor in the successful delivery of its proposals. The work undertaken by PwC reconfirms this position in the acknowledgment that the feasibility of the JCM rests on an appropriate and sufficient workforce and that enabling the JCM may require significant changes. PwC's report further states that a key challenge for the workforce is recruitment and retention across the system. We consider the issues around availability of workforce in Chapter 9 – "Workforce Availability in the Community'

Finances

The "stress test" undertaken by PwC confirmed the need to consider finance, along with workforce and digital, before the Jersey Care Model is implemented. PwC also confirmed that the existing financial structures pose a challenge to Jersey's proposed future model of health and community care. In light of this a number of key financial challengers were provided:

- The current payment framework foes 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 underutilised, and extended services are not being provided.
- There are high rates of high cost residential care
- There is inequality 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 Department. This difference in pay models is driving overuse of ED for non-acute events.

We consider the issue of finances in detail in Chapter 10 of our report.

Digital

Current situation

It has long been acknowledged that Jersey's current health care system is not digitally optimised, and a massive transformation of our digital services is required in order to deliver the proposals contained within the Jersey Care Model. At a Public Hearing in February, the Director General for Heath and Community Services confirmed how vital improving our digital services was for the successful delivery of the JCM:

> *…. Absolutely, we recognise that digital is our key risk around the care model. Our number one risk on our risk register. There is an incredible amount of work going on with our digital health team around how we can have one digital voice across the Island, but we do not underestimate the challenge.*[76]

The Panel is aware from its review of the Government Plan 2020-2023, that HCS were working on developing and implementing a Digital Health and Care Strategy which aimed to replace legacy systems which are incapable of capturing and sharing information, reduce paper-based processes and improve information flow between health care organisations and service users. Currently, all general practices across the Island use EMIS, while secondary care use TrekCare and Adult Social Care and Mental Health use CarePartner.

[76] Public Hearing, 13th February 2020, p34

Jersey's Current Patient Record Systems

The Strategic Outline Business Case confirms that 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. During our review of the Government Plan last year we were advised that the aim was for HCS to be fully digital by 2021 and have an Electronic Patient Record (EPR) in place by 2022. At the Public Hearing with the Minister for Health and Social Services on 29th September, it was advised that HCS were still aiming to have an EPR in place by 2022.

KEY FINDING 38: As previously stated in the Government Plan 2020-2023, it is still the intention of the Minister for Health and Services' to have an Electronic Patient Record in place by 2022.

What is the JCM proposing?

According to the JCM Briefing Paper, the Jersey Care Model strategy and the future hospital must be digitally enabled beyond previous ambition, but what does that look like? When we queried this with the Director General for Health and Community Services, she further explained:

> *…we want to be able to prescribe without patients coming into hospital, we want to be able to see digital images without patients coming into hospital, we want to be able to share that information between clinicians. We want call and check systems that are digitally enabled that do not require people having to wear cumbersome objects around their neck and if they fall over and it falls out of reach. We are looking at all of the latest innovation around the delivery of healthcare and that is what we want for Jersey. If I am talking from an acute perspective, and it was a big conversation yesterday, having been and seen some fantastic hospitals, we want a digitally-enabled hospital.*[77]

The JCM also identifies a number of intended projects that will be undertaken which are necessary to enable people to access services more efficiently. The projects form part of the overall digital health and care strategy, which is currently being implemented, and includes:

[77] Public Hearing, 13th February 2020, p34

- 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

A substantial number of written submissions that the Panel received in respect of its review of the Jersey Care Model, stressed the importance of a digitally enabled health care system:

> ***The Primary Care Board***
>
> *Shared IT, with '**Data appropriately wrapped around the patient**' is of extremely high priority and primary care is streets ahead of secondary in its clinical use, homogeneity and use of decision support software.* Poor processes with delayed communication of discharge/outpatient reports, iatrogenic (drug related) admissions and recent deaths make this even more pressing.[78]

> ***Nadya Wolferstan***
>
> *The Care Model cannot work without the necessary IT infrastructure with all parts of the contributors to the model (GPs, hospital, mental health workers, carers) accessing the same record keeping system. Health and Social Care Information governance regimes will need to support access by a variety of professionals from a variety of HCS sites.*[79]

> ***Jersey Hospice Care***
>
> *With the right support technology could be used to bring advances across the whole system, working with partners in the island and afar. Government could incentivise both on island organisations and those from afar to share their knowledge and expertise and to be part of this ambitious vision.*[80]

How will the objectives will be achieved?

[78] Written Submission, The Primary Care Board, 24th January 2020.
[79] Written Submission, Nadya Wolferstan, 24th January 2020
[80] Written Submission, Jersey Hospice Care, 17th February 2020

We are also aware from our review of the Government Plan 2020-2023 that £5 million was approved for health service improvements (including IT development) in 2020. These funds were intended to be split between the digital and the estates infrastructure programmes. Thereafter, the Strategy implementation would continue to be implemented each year, financed from both capital and revenue. When we asked further about the budget for digital improvements at the Public Hearing in February we were advised:

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

We were also told that the challenges of delivering digital enhancements are around the current infrastructure rather than a deficit in sufficient resources to deliver them.

The survey we undertook with GPs raised some concerns about the deliverability of digital initiatives based on the lack of change that has been implemented to date. Some of examples of these are as follows:

> *GPs have been trying for years to get better IT systems linked up with hospital for ordering tests/results etc....if it hasn't happened by now what will change?!*

> *GoJ could have helped with financing the IT system in primary care but chose not to do so, again I cannot see any change here.*

> *Digital: This will be pivotal to delivering care. The States are poor at investing in IT. Health IT needs to stand outside States IT and link with the NHS spine to deliver many mora already available services.*

Whilst conducting their review, our advisers found that it was not clear within the JCM documentation or in the Digital Health and Care Strategy how the digital programme would be resourced and aligned to the Jersey Care Model or wider on-going business as usual in HCS. The advisers also found that there is little reference to diagnostic provision, not just in the Digital Health and Care Strategy, but also the wider JCM. In this respect, they commented:

> *Diagnostics should be a key element of the future care provision in Jersey not just in the hospital setting. Diagnostics are not only linked to the digital infrastructure of the health and care system but also required a specialised and in demand workforce. It is essential that the demand and capacity for diagnostics on Island are fully understood and what enabling infrastructure might be provided off island, in terms of expert interpretation of imaging by partner organisations. For any such initiatives the digital*

strategy must fully encompass linking diagnostics across care settings and the ability to share results quickly.

KEY FINDING 39: There is a lack of confidence amongst GPs as to the deliverability of digital health initiatives, due to the level of change that has been implemented to date.

KEY FINDING 40: It is not clear in the Jersey Care Model documentation or in the Digital Health and Care Strategy how the digital programme would be resourced and aligned to the Jersey Care Model or wider on-going business as usual in the Health and Community Services Department.

RECOMMENDATION 13: The Minister for Health and Social Services must provide evidence that the Digital Health and Care Strategy and future Workforce Strategy are comprehensive and island-relevant, and that they have informed the development of the services and future investment needs of the Jersey Care Model.

KEY FINDING 41: Reference to diagnostic provision is absent from both the Digital Health and Care Strategy and wider Jersey Care Model.

RECOMMENDATION 14: The Minister for Health and Social Services should develop a diagnostic strategy that links to the clinical, digital and workforce strategies.

9. Workforce availability in the Community

At the crux of the Jersey Care Model proposals is the intention to move more care away from the hospital and into the community. As we have already discussed, workforce was identified by HCS and by PwC as one of the major risks associated with the successful delivery of the JCM. In the previous chapter we discussed Health and Community Services' plan to develop a commissioning framework and a partnership of purpose framework, in order to better co-ordinate and support the additional care that will delivered in the community under this model. We also considered the new implementation approach that has been put forward by the department as a result of their own concerns regarding workforce capacity.

When we undertook our own consultation process we received a large number of concerns from key stakeholders in respect of workforce capacity in health and care services. Concerns were raised, not only about the potential impact of the JCM on the future workforce, but also regarding the demands on the current workforce provision. The Panel fully acknowledges that one can't be considered in the absence of the other. An example of some of the concerns raised in respect of workforce are as follows:

> ***Jersey Community Partnership***
>
> *"There is a shortage of care professionals in the Island and charities are already cutting services due to a lack of staff. Greater support of the VCSE sector is needed, particularly in recognising and valuing the professional services they provide. This should be a priority of the government when looking at ensuring we have the resources available to achieve vison of the care model.*[81]

> ***Les Amis***
>
> *"…the model indicates a very labour-intensive workforce to achieve it. We face a future of too much work with too few workers. By 2030, the world will be short of approximately 18 million health workers – a fifth of the required workforce needed to keep healthcare systems going. Workforce challenges are already leading to mounting pressure across care services. This is evidently an impact locally. The supply of staff has not kept pace with demand, and there are worrying shortages in key staff groups, like primary care physicians, community nursing, social workers, and health visitors. The low profile of services also makes recruitment and retention harder. For many healthcare systems, an engaged and valued workforce can reduce variation and deliver real productivity that lasts.*[82]

[81] Written Submission, Jersey Community Partnership, 31st January 2020
[82] Written Submission, Les Amis, 29th January 2020

Family Nursing and Home Care

> *The new JCM is dependent on a skilled and sustainable workforce this extends beyond the HCS and must consider the wider implications for social services and the voluntary sector. Being able to recruit and retain a suitably skilled workforce is more challenging for Jersey as an island and more work needs to be undertaken in relation to workforce/succession planning across the whole system. Equally of importance is Jersey having the ability to grow its own staff and support islanders to take up employment opportunities within the wider HCS care sector.*[83]

What do we know about our current workforce?

From the evidence the Panel has gathered during its review of the JCM, it is extremely clear that there is a huge deficit in the current health and social care workforce and issues of retention are adding to the increasing pressure on these services. In addition, the proposals contained with the JCM will only exacerbate the already highly stretched workforce. In order to understand the implications of the JCM on the workforce, it is imperative that we first understand the challenges that we currently face.

At the Public Hearing in February with the Minister for Health and Social Services, the Panel queried what work had been undertaken on demand and capacity analysis to try to establish the current workforce needs and the future needs within the hospital and community to deliver the model. It was advised:

The Minister for Health and Social Services:

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

Group Managing Director, Health and Community Services:

We have a technical group that we have established as part of the Jersey Care Model that is tasked with looking at the enabling streams that we need to run the model, and a big part of that is workforce. So we are looking at the current workforce provision, what we have, and the technical group are mapping all of our specialities across the whole sector, what are our key areas of pressure, where is the supply market for those key posts, is it sustainable, does it need to be different.[84]

Adviser 2:

[83] Written Submission, Family Nursing and Home Care, 30th January 2020
[84] Public Hearing with the Minister for Health and Social Services, 13th February 2020, p21

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

Director General, Health and Community Services:

It is the end of March. End of March we will have the report from the planners detailing exactly where we are and those kind of metrics around workforce, around outcomes. It is quite comprehensive, is it not?[85] *(Feb, p25)*

We were also told that the "stress test" work that was carried out by PwC would provide really strong recommendations around workforce and would provide an indication of whether we had the workforce available on-island, either now or in the future, to be able to deliver the JCM. At the Hearing in February it was advised that that work would be completed by the end of March. The Strategic Outline Business Case states that, during the JCM testing, the impact of proposed changes on workforce was assessed, which included projections of the additional staffing numbers for a range of staffing groups, if the model was to be implemented in 2020. It also goes on to say that "*analysis and stakeholder engagement highlighted workforce shortages in specific service areas, particularly in Intermediate Care and Clinical Support Services."* [86]**Despite this, the Panel has not been provided with any documentation that confirms the current workforce provision we have in Jersey against what will be needed going forward under the Jersey Care Model.**

At the Public Hearing in February, we asked the Minister and his Officers whether there was any understanding of where the biggest staffing pressures were currently being experienced. The Group Managing Director for Health and Community Services told us:

> *They are similar to most areas. We know that we have got a staffing deficit within mental health services - that is across the nursing workforce and the medical workforce - that we are trying to address through our Government Plan. We have some pressures in obstetric services, on maternity services. We have seen some recent difficulty with recruitment to A. and E. (Accident and Emergency), we are normally very successful in that area. Our general nursing recruitment is more favourable than the U.K. perspective. Then the other key area of workforce deficit is in the domiciliary care market. We believe that Jersey needs something different to that because low paid employment in this jurisdiction is difficult and we think that should not be low paid employment and we should be paying more for people providing personal care. So*

[85] Public Hearing, Minister for Health and Social Services, 13th February 2020, p25
[86] SOBC, p95

they are our current sort of pressure points. We have already horizon scanned and said we need different kinds of workers, we need more geriatricians, we need to preserve the specialists. We have got a good idea what we have got problems with now and we need to address, and where we need to go in terms of our future. The technical group is doing all of that work.[87]

Whilst the Panel was not provided with any gap analysis of the current workforce, we were advised at the Public Hearing on 29th September that HCS had a great deal of information in relation to what the workforce gaps were. As example, the Group Managing Director told us that there were particular staff deficits in district nursing overnight, 24/7 community nursing, night sitters and within the domiciliary care market[88]

KEY FINDING 42: From the evidence the Panel has gathered during its review of the Jersey Care Model, it is clear that there is a significant deficit in the current health and social care workforce and issues of retention are adding to the increasing pressure on these services. In addition, the proposals contained with the Jersey Care Model will only exacerbate the already over stretched workforce.

KEY FINDING 43: Whilst the Panel has been advised of staff deficits in a number of specific areas, to date we have not been provided with any documentation that confirms the current workforce provision we have in Jersey against what will be needed going forward under the Jersey Care Model.

KEY FINDING 44: In the absence of confirmation of Jersey's current workforce, the Panel cannot confidently assess the impact of the Jersey Care Model on the future workforce.

Next Steps

The Strategic Outline Case also confirmed a number of recommendations resulting from the testing of the JCM proposals. For instance, it was found that in order to achieve the ambitions of the JCM and to implement the proposed changes, a full assessment of the workforce profile and future capacity constraints needed to be undertaken. The specific recommendations were as follows:

- An island workforce strategy with a comprehensive business plan for the provision of 24-hour services.
- 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

[87] Public Hearing, 13th February 2020, p23
[88] Public Hearing, 29th September 2020

- Assessment of the existing workforce's skills and additional training needs.

At a briefing the Panel received on 28th August 2020, the Panel was advised that the PwC "stress test" concluded that further work needed to be taken on workforce, including the emergence of issues, such as recruitment, that were not present, or as noticeable, before the arrival of Covid-19 onto the Island. Furthermore, the SOBC states that "*further assessment of the deliverability of the JCM was considered following reflection of the impact of Covid-19 on the workforce."*[89] Following the briefing in August, the Panel requested further details as to the impact of Covid-19 on the workforce and how this had changed plans under the JCM. **The Panel was not provided with this information.** Interestingly, in a written submission to the Panel, the Jersey Care Commission, raised a concern that the issues that Jersey is currently experiencing in respect of recruiting and retaining permanent health and social care staff had potentially been underestimated in the JCM Briefing Paper. The Commission wrote:

> *"The document [*JCM Briefing Paper*] states that a strength is our committed workforce. However, there are real challengers in Jersey regarding the recruitment and retention of permanent health and social care staff. There is a risk that this challenge may be downplayed.*

KEY FINDING 45*:* The PwC "stress test" concluded that further work needed to be undertaken on workforce, including the emergence of issues, such as recruitment, that were not present, or as noticeable, before the arrival of Covid-19 onto the Island. Despite our request, we were not provided with further details as to the impact of the pandemic on the workforce and how that has impacted the workforce plans under the Jersey Care Model.

As a result of the further assessment of the deliverability of the JCM, the implementation plan was amended to include greater focus on workforce models during the first year (tranche 1-2021-2022). In addition to those mentioned above, the JCM identified a number of key activities that are required in order to move forward to implementation in respect of the workforce. These included:

- Understand impact of Covid-19 on workforce models
- Establishing systems to monitor workforce activity
- Efficiency review of workforce
- Detailed workforce assessment
- Developing a Workforce plan
- Developing a change management plan
- Nursing training

[89] SOBC, p95

- 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

We were advised in our Public Hearing on 29th September 2020 that in year one (2021-2022), the workforce baseline analysis and future needs assessment is the main priority for that piece of work.

The Panel is happy to see key initiatives planned in respect of skilling, training and retaining staff in order to build capacity and capability in the workforce. We received a large number of written submissions that highlighted these as areas of necessity to enable the implementation of the proposals under the JCM. Some examples of these are:

> ***Mind Jersey***
>
> *Securing and retaining a stable, well qualified and motivated workforce will be fundamental to the success of the proposed model. Commitment to the continued professional development of staff to keep them up to date, provide them with new and additional skills and also to retain them will be essential.*

> ***Family Nursing and Home Care***
>
> *There will be a requirement for the skilling up of existing staff and for staff taking on a higher level of skills and or extended roles in order to deliver care. This may require greater training and education facilities on Jersey along with the development of new partnerships with other jurisdictions*

> ***Les Amis***
>
> *There needs to be a significant focus on the workforce, specifically in relation to professionals – Nurses, Social Workers, Allied Health Professionals, etc. As well as those who provide the bulk of the work, care assistants and Health Care Assistants. There needs to be an emphasis on training and education with investment in staff to give existing and new staff flexibility and adaptability."*

KEY FINDING 46: The Panel is pleased to see key initiatives planned in respect of skilling, training and retaining staff in order to build capacity and capability in the workforce.

At the briefing in August, the Panel queried whether plans were in place to provide financial support for the training of health and social care staff. The Chief Nurse advised the Panel that a business case had been submitted as part of the Government Plan 2021-2024 to expand funding for on-island training in Jersey and initiatives to allow trained nurses to work as district

nurses. However, work had not yet been undertaken on whether a bursary scheme would be necessary to support students.

In light of the issues that Jersey already faces in respect of recruitment and retention we wanted to understand the plans going forward to ensure that the Island can attract both low paid workers and professionally qualified people to undertake these roles. At the Public Hearing in February, the Minister for Health and Social Services told us:

> *I think first of all when you look at what we could do locally, I think enhancing the pay and conditions of people who work as carers is crucial, and that hopefully would mean that it is a profession that is well respected locally and people will want to join. But I think there is also a case for saying that we will need to bring in some workforce from outside the Island. We made a submission to the Migration Policy Development Board to help them understand that we have to look at the social value of some of our workers and what they can deliver in terms of social care. Very crucial.*[90]

The Submission to the Migration Policy Development Board, which was referred to by the Minister for Health and Social Services during the Hearing, was published in March 2020 in response to a written question (WQ.129/2020) asked by Deputy Geoff Southern. The submission concludes that whilst Jersey can increase efforts to source local staff or reassign existing staff into community work, the health and care sector will need to recruit off-island for a range of skilled jobs. It goes on to stress the need of a workforce strategy that covers the whole health and social care sector's total need for off-island staff and recruit according to that need.

As highlighted by our advisers, it is widely recognised that the worldwide market for health and care professionals is very challenging. Thus, they found that, unless the JCM offer is significantly more attractive than offers elsewhere (including lifestyle, cost of living, affordable housing) Jersey will struggle to import the number and type of practitioners from all the clinical disciplines it requires to fulfil the needs of the JCM. Furthermore, with regards to building the necessary workforce capacity on-island they found:

> *The likelihood that Jersey will grow its new staff in a such a short space of time when it hasn't started to define how many or of what type is a significant risk to the credibility of the JCM. The risk therefore that the output of the workforce plan becomes an aspiration in numbers terms that are never going to be realised, is a very realistic and pertinent risk, one that impacts on the viability of the whole JCM.*

KEY FINDING 47: It is widely recognised that the worldwide market for health and care professionals is very challenging. Thus, unless the Jersey Care Model offer is significantly more attractive than offers elsewhere (including lifestyle, cost of living, affordable housing)

[90] Public Hearing, 13th February 2020, p29

Jersey will struggle to import the number and type of practitioners from all the clinical disciplines it requires to fulfil the needs of the Jersey Care Model.

KEY FINDING 48: The Minister for Health and Social Services' submission to the Migration Development Policy Board concludes that whilst Jersey can increase efforts to source local staff or reassign existing staff into community work, the health and care sector will need to recruit off-island for a range of skilled jobs.

RECOMMENDATION 15: The Minister for Health and Social Services must ensure that the workforce model is judged in the context of the worldwide shortage of health and care delivery staff. The model must therefore demonstrate how it will provide a more attractive proposition, and be more successful, than its competitors in the wider health and care workforce market.

KEY FINDING 49: There is a significant risk that the output of the future workforce plan, in terms of numbers, becomes an aspiration that will be never be realised.

RECOMMENDATION 16: The Minister for Health and Social Services must develop a risk assessment for delivering the workforce strategy that is to be developed as part of the Jersey Care model, in order to provide confidence that it can meet the expected demand.

10. Finances and Funding Arrangements

Cost of delivering the JCM

The detail as to the costs of delivering the Jersey Care Model were noticeably absent from the briefing paper that was presented in October 2019. During our consultation process, we received a number of concerns from key stakeholders about the inability to assess the suitability of the proposals contained within the JCM without the knowledge of how much it would cost and how it would be paid for. Jersey Community Partnership, for instance, commented:

> *"At the present time, with no clear indication as to how the model will be funded, or how funding mechanisms will support the new model, we struggle to evaluate its potential.*[91]

There was also a concern that history may repeat itself and, similar to P.82/2012, the JCM would not be delivered because its objectives had not been aligned with a sustainable funding proposal.

At the Public Hearing in February, we were again advised by the Minister for Health and Social Services that PwC were undertaking this work and had been asked to provide details as to the costs of delivering the JCM and how funding would be arranged. In a letter from the Minister in June, the Panel was told that the financial analysis on the JCM had been undertaken collaboratively between HCS and the GoJ Finance Team, with financial modelling support provided by PwC.

We understand that a financial model, which included the phasing of the JCM costs and benefits, was presented to the Council of Ministers in May but had since been updated to reflect the revised implementation plan and scheme prioritising work.

The latest financial model suggests the following:

- Non-recurrent investments of £17m are required to deliver the JCM over a 5-year period.
- The proposed changes under the JCM are forecast to reduce expenditure by £90m per year by 2036 compared with the 'do nothing' scenario.
- Re-provision costs of approximately £67m will be required in order to deliver the £90m of savings.
- The net savings associated with the JCM are estimated to be c. £23m per year by 2036

[91] Written Submission, Jersey Community Partnership, 31st January 2020

- As a result of a reduction in expenditure of £23m by 2036, the forecast of total expenditure in 2036 will reduce from £175m (under to the 'do nothing' scenario') to £153m (under the JCM model).

It has been proposed that net savings of £23m in 2036 will be achieved as following:

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)**

Net Saving/Investment associated with proposed change by 2036

However, in order to deliver a net saving of £23m, and therefore reduce expenditure in 2036 from £175m to £153m, Health and Community Services will have to deliver c. 1.8% efficiencies per year. According to the Strategic Outline Business Case, this level of efficiencies is in line with levels delivered by other similar health and care economies through non-transformational efficiency programmes. At a Public Hearing in September we queried how confident HCS was that they could deliver this amount of efficiencies every year for the next 17 years. The Group Director of Performance, Accounting and Reporting assured the Panel that 1.8% of efficiencies would be easily achievable:

> *"Efficiencies at that level, no, are not difficult to do. As you will appreciate 1.8 per cent is a small figure. The other thing to remember of course is this is a model and the amount of efficiencies needed will be dependent on the outcomes of the other works.*

It will vary, as I am sure we will all appreciate as we go through the next 16 years, but, no, 1.8 per cent is not a difficult number at all in budgets of this scale.[92]

Whilst it is estimated that implementation of the JCM will reduce expenditure by £23m, that still leaves a funding gap of a further £153m to mitigate. In the Hearing we asked how confident HCS that were they could find £153m of efficiencies to close the funding gap. The Group Managing Director told us:

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

KEY FINDING 50: In order to deliver the Jersey Care Model, non-recurrent investment of £17m over a five-year period is required. In addition, the Jersey Care Model will require the implementation of several new services and expansion of existing out of hospital services which, over 16 years to 2036, will cost an estimated £679m.

KEY FINDING 51: After investments, the Jersey Care Model is forecast to save £23 million per year by 2036. However, this will still leave a funding gap of a further £153m to mitigate. Efficiencies of approximately 1.8% per year will be required in order to be financially sustainable and the Panel has been assured that this level of efficiencies will be easily achievable.

In a letter to the Minister for Health and Social Services in June this year, we asked that financial assumptions had been used within the financial analysis of the JCM. It was advised that a Technical Group had been formed to provide oversight to the programme's analytics support. The group reviewed data sources, methodologies and outputs. In addition, the Finance Team undertook a further, more detailed review of the model, including individual assumptions, through regular meetings with PwC team members throughout the programme. It was further advised that the key data assumptions that had been used through the analysis included:

- *Expenditure on in-scope services have been aligned to the 2020 budget and short-term forecasts set out in the 2020-23 Government Plan.*
- *Health and care data from 2019 have been used as the starting point for the activity modelling.*

[92] Public Hearing, 29th September 2020, p23

- *Demand growth has been based on age-adjusted demographic growth (i.e. forecast growth for the age bands that utilise different health and care services) based on latest projections by SPPP.*
- *The impact of the proposed changes in the Jersey Care Model has been triangulated from the following sources and discussed at the Pod focus groups (as described in Appendices 2 and 3 of the report for purpose of the groups and membership respectively):*
    - *Benchmarking of current performance in comparison to a peer group of similar health and care economies.*
    - *International case studies on the impact of proposed new models of care (further details of case studies can be found throughout the report).*
    - *Detailed analysis of local data where specific patient/client groups are impacted by proposed changes.*[93]

According to our advisers, the detail to support the £90m cost reduction, and the £67m cost addition, which between them produce a net £23m reduction in costs over the next 16 years, is high level and has been based on possible changes in care provision (Appendix 4 of the Strategic Outline Business Case). The advisers also note that whilst reference is made to capital costs associated with the digital strategy, there is no reference to any other capital expenditure. As a result, they found that the detail behind the £23m needs to be explained together with a statement to confirm that there is either a nil capital cost or a maximum capital envelope to cover the capital costs of the JCM.

As we mention above, Appendix 4 does provide a list of high-level service changes that may result from the implementation of the proposals contained with the JCM. As the advisers have said, this is a useful guide to the potential model changes and the likely financial implications of those changes. However, as the clinical service model is yet to be completed the financial assumptions will be subject to change. The advisers believe that a process should be put in place that allows a certain amount of scrutiny of the financial implications of the clinical services changes as they take place.

Following the publication of the Strategic Outline Case, the Panel requested further details on the assumptions behind the financial model that has been proposed for the JCM. The Panel did receive further details on the assumptions but unfortunately not in enough time to allow additional questions to be asked before the completion of this report and the advisers report. As a result, we have been unable to measure the validity of the assumptions in terms of their scale, timing or phasing of implementation.

[93] Letter, Minister for Health and Social Services, 9th June 2020

KEY FINDING 52: The Jersey Care Model does provide a list of high-level service changes against projected financial implications. Whilst these are useful, the service model is yet to be completed and therefore the financial implications will be subject to change.

KEY FINDING 53: Due to the timing of the receipt of detailed financial assumptions the Panel and its advisers were unable to adequately scrutinise the financial model and its validity.

RECOMMENDATION 17: Following the debate, and if the Proposition is passed, the Minister for Health and Social Services should work with the Panel to agree a timetable in which key pieces of evidence (such as proposed budgets, performance measures, workforce plans etc.) are provided to Scrutiny over the length of the following Tranche in order to provide ongoing financial assurance.

RECOMMMEDATION 18: In order to validate the service model and financial assumptions for each year of the implementation plan, the Minister for Health and Social Services should provide the States Assembly with an updated proposed budget for the Jersey Care Model for each Tranche. This should include an annual report detailing what has been spent on the JCM at the end of that Tranche and an updated plan for the following Tranche.

How will the JCM be funded?

The Proposition of the Minister for Health and Social Services asks the States Assembly to note that Ministers intend to bring forward proposals for investment in the Jersey Care Model in the Government Plan 2021-2024. Whilst this will be considered by the Panel in greater detail during its review of the Government Plan, we wish to briefly touch on the information available to the Panel at the time of its review of the JCM.

According to the JCM Proposition Report, in order to deliver the JCM and realise the expected benefits, investment of £28.1m over this Government Plan period (2021-23) would be required before the model could deliver a net financial benefit from 2025. Of that £28.1, £17m is for non-recurrent investment over the five-year period. Non-recurrent investment is expected to fall into two main categories; Programme costs and Digital non-recurrent investments.

The Jersey Care Model Briefing Paper stated that the current funding mechanism to facilitate the services proposed in the JCM would be examined, including a review of the potential to expand the use of the Health Insurance Fund.[94]

At a Public Hearing in February, the Panel questioned the Minister and his Officers about the use of the HIF to fund the JCM. The Director General of Health and Social Services told the Panel:

[94] Jersey Care Model Briefing Paper, p18

> *The main assumption we have made is that we really need money and that is why we are going to petition to access the H.I.F. to do some double running but the whole point of doing that double running is maintaining safety and quality so that we do not just switch from one model to the next. So I think that will be one of the major frameworks that we have, to ensure that care continues as normal.*[95]

There were obvious concerns raised by members of the public, in their submissions to the Panel, in respect of using the Health Insurance Fund in the way proposed. The following are examples of some of the comments provided:

> ***Anonymous (1)***
>
> *HIF contributors have a right to expect the benefit to be paid out to fund their primary care needs and do not belong to HCS to be 'repurposed'.*

> ***Anonymous (2)***
>
> *The HIF is there for those that contribute to the fund as is the SoJ Pension Fund, what will happen when these run out of funds?*

> ***Friends of the New Hospital***
>
> *If the JCM is pushed through, we believe the HIF should be maintained for its primary purpose. The fund is in a relatively healthy position but will run out at the current rate of expenditure by 2035.*

> ***GP Survey response***
>
> *Proposal to use the HIF by Health when they have clearly demonstrated a lack of understanding of community demand and have a very poor track record on achieving projects within reasonable budgets*

Ultimately the decision as to how the JCM will be funded will lie with States Members and will be considered as part of the review of the Government Plan 2021-2024. However, during that review it will be important to reflect on the comments received here from members of the public and key stakeholders.

KEY FINDING 54: The Panel will be undertaking a detailed review of the proposals to use any funds from the Health Insurance Fund (HIF) for the purposes of funding the Jersey Care Model, as part of its review of the Government Plan 2021-2024. However, concerns raised to-date in respect of the use of HIF will be considered as part of that review.

[95] Public Hearing, 13th February 2020, p46

Changes to the current funding mechanisms

Funding for Primary Care Services in Jersey is currently sourced from a combination of service user co-payment, payments from the Health Insurance Fund and payments from Health and Community Services.

The Jersey Care Model recognised the need to reconfigure current funding streams in order to facilitate the delivery of more health and care in the community. The "stress test" also identified the current funding structures as a major risk, as they were leading to health behaviours driven by cost rather than person-centred care. PwC found that there is currently a financial incentive for islanders to seek care in secondary care, where it is free at the point of use, and a financial disincentive for general practice to move towards more efficient models of delivery. This point was raised by the Director General of Health and Social Services during a Hearing in February:

> *"G.P.s are expensive on this Island because of the way we incentivise them. So I go in to see the G.P. and I have to have a plaster put on me, the G.P. has to put the plaster on me in order to get funded so there is no incentive for them to have a multidisciplinary team of a healthcare assistant and a nurse and a therapist. We have created that system and that is what we want the model to address by pushing our staff out."*[96]

The need to change the current funding mechanism for primary care was also recognised by the majority of those who wrote to the Panel in respect of this review. Jersey Hospice Care and Mind Jersey, for example, commented:

> ***Jersey Hospice Care***
>
> *"The funding mechanism for primary care must be a key priority for change. Patient access to GPs in Jersey is exemplary but the high cost of access (borne predominantly by the service user) creates inappropriate reliance on other access points across the healthcare system."*[97]

> ***Mind Jersey***
>
> *"Changes in how GP's operate, and are funded, will be crucial and potentially the most complex issue to resolve. There can be little doubt that delivery of the model will require a realignment of at least some of the resources currently held in the Health Insurance Fund (HIF). Securing these changes will take time and the ability to overcome some long term and previously entrenched resistance."*[98]

[96] Public Hearing, 13th February 2020
[97] Written Submission, Jersey Hospice Care, 17th February 2020
[98] Written Submission, Mind Jersey, 31st December 2020

At a meeting back in September 2019, the Director General told the Panel that many people had raised concerns about the proposals to move non-acute services out of the hospital in the event that this meant that patients would be charged for care that had previously been free. The Department assured the Panel that this would not be the case. It was advised that HCS was developing a commissioning framework and that *"money will follow activity"*. For example, if GPs are asked to manage frailty, the money that HCS currently spent on frailty would move. The Panel was told:

> *"It is about getting the care where it needs to be and we will absolutely be funding that. You will get the same service now that you get but you just will not get it in that building on Gloucester Street."*[99]

In a letter to the Minister for Health and Social Services in June this year, we queried the progress that had been made in determining a new primary care funding approach. It was advised that, whilst this matter had been considered by PwC in its report to HCS, the work was being revisited in light of changes to General Practice funding models introduced through the Covid-19 response. It was also confirmed that the experience of Covid-19 had also demonstrated that the current approach to funding primary care was neither resilient or sustainable.[100]

The latest documents published in respect of the Jersey Care Model confirmed a preferred payment option to support the implementation of the JCM; a capitation system with a £10 per visit co-payment. It is suggested that a capitated system can improve access and incentivise positive behaviours for primary care providers, such as containing health costs and encouraging prevention. Furthermore, this combined with an expansion of the fee-for-service to community pharmacy could increase collaboration and integration. In their evaluation, HCS and PwC considered the following 4 options (more details can be found in 2.2 of the SOBC):

- **Option 1 – Do minimum**
- ***Option 2 – Capitation with some co-payment (for vulnerable groups or universally)***
- ***Option 3 – Capitation with no co-payment (for vulnerable groups or universally)***
- ***Option 4 – Salaried model with pay for performance for all GPs***

In a Public Hearing in September, we were advised that, in practical terms, a Capitation plus model would mean that GP surgeries would receive an annual lump sum for taking care of a patient but, in addition, would receive a payment each time a GP saw a patient. Regarding this model the Minister for Health and Social Services added:

[99] Public Hearing, 17th September 2020
[100] Letter, Minister for Health and Social Services, 18th June 2020

> *I think as far as Government are concerned that is a good method. It takes us away from the current fee-for-service model which is not ideal in this day and age and means that the G.P.s take responsibility for a cohort of patients, and that is the way, by taking responsibility, they will receive that income to keep their practices afloat.*[101]

We recognise that the numbers contained within in the SOBC in regard to the total costs of the various payment model options are indicative and have been presented for illustrative purposes. Importantly, the SOBC confirms that it has estimated that the cost of the options reviewed to patients, as a whole, is lower than the current payment models.[102]

During a briefing the Panel received in August, it was advised that Capitation Plus was widely accepted by all stakeholders, including the Primary Care Board. However, following correspondence with the Primary Care Board, it doesn't appear that there was wide acceptance. PCB advised the Panel that whilst the payment model was considered by the previous membership of the Primary Care Board, it was not considered more widely by Jersey GPs. Furthermore, we were told that discussions with the previous PCB was interrupted by Covid-19 and no further meetings took place before the lodging of the recent documentation, that confirmed the preferred payment model. The Strategic Outline Business Case does state, however, that some specific components or features of the model require further specification and that further work was required to answer five strategic questions:

1. *What is the patient qualifying criteria for Capitation funding?*
2. *What is the GP qualifying criteria for Capitation funding?*
3. *Should the patient contribution be fixed by Government of Jersey or should it be allowed to vary across GP practices?*
4. *Should the rebate vary across patient groups (greater for vulnerable groups) or should it be fixed for all?*
5. *Should the Rebate vary across services or should it be fixed across for all?*

Furthermore, in a Public Hearing in September, the Group Managing Director did recognise the need to co-create the future payment model for primary care with GPs and that this work would be driven by the clinical senate and the steering group, rather than HCS.

As we have recognised earlier on in our report, significant changes around primary care have been moved into years 3-5 (2023-2025) of the implementation plan. In respect of a new funding mechanism, we note the JCM confirms that further work is required. We also note that PwC's report to HCS emphasised the urgent need to change primary care payment mechanisms in the short term, with an opportunity to update them in the longer term. Yet, we

[101] Public Hearing, 29th September 2020
[102] SOBC, p26

are unsure as to when HCS intends to implement a funding mechanism according to the new tranche implementation approach.

KEY FINDING 55: The current approach to funding primary care is neither resilient or sustainable.

KEY FINDING 56: A capitation plus model has been proposed as the preferred primary care payment option to support the delivery of the Jersey Care Model. In practical terms, a Capitation plus model would mean that GP surgeries would receive an annual lump sum for taking care of a patient but, in addition, would receive a payment each time a GP saw a patient.

KEY FINDING 57: It does not appear that there was wide support of the Capitation plus model amongst Jersey's GPs or that sufficient consultation was undertaken with the wider GP workforce, beyond the Primary Care Board.

RECOMMENDATION 19: The Minister for Health and Social Services must undertake greater consultation with local GPs to ensure that the proposed Capitation Plus model is suitable going forward. It is imperative that the future payment model for primary care is co-created with GPs.

P.125/2019 and making healthcare available to all

Proposition P.125/2019 was brought to the States Assembly by Deputy Geoff Southern on 23rd December 2019 and asked the Minister for Health and Social Services to devise a scheme which improved access to primary care by reducing financial barriers for patients who are financially, clinically or socially vulnerable. The Proposition, as amended, was approved by States Members (41 for, 7 absent and 1 abstained) on 4th February 2020. Approval of P.125/2019 meant that the Minister for Health and Social Services was obligated to bring a Proposition to the States for debate in the third quarter of 2020, which identified the scheme, in order that it could be implemented from 1st January 2021.

The need for a new payment model to support vulnerable patients is well supported and has been recognised in a number of policy documents that have been discussed by the States Assembly over a number of years. For instance, the Government Plan 2020-2023 stated:

> *"We will deliver new models of primary care including…the development of a model to support access to primary care for vulnerable individuals.*

PwC also recognised "*removing barriers to access for vulnerable service users through re-modelling funding structure*"[103] as one of the JCM's most important objectives. Furthermore, in our survey that we undertook with Jersey's GPs, 66% (36) rated the proposal, contained within the JCM, to improve primary care access for vulnerable groups as "very important" and 31% (17) as "important".

To highlight the extent to which primary care services are accessed by these three groups, HCS has provided data which shows the proportion of GP activity associated with them:

Estimated number of GP appointments by vulnerable group, 2019[104]

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	1,160
Remaining Population (non-vulnerable)	101,090
Total GP appts	**326,260**

We also know that there is evidence that indicates that low income is linked to poor health. For instance, the 2019 Jersey Opinions and Lifestyle Survey (JOLS) collects detailed information on a wide range of topics on an annual basis, particularly the opinions and behaviours of the resident population. It provides everyone in the Island with a better understanding of social issues in Jersey, primarily so that policy decisions can be made from a more informed standpoint. The Jersey Statistics Team have run some additional cross-tabs on health vs income from the 2019 Jersey Opinions and Lifestyle Survey (JOLS) data. Some of their findings are as follows:

[103] JCM Proposition Report
[104] Strategic Outline Business Case, p49

		HouseholdCopeFinancially					
		1-Very Easy	2-Quite Easy	3-Neither	4-Quite Difficult	5-Very Difficult	Total
How is your health in general	1-VeryGood	58%	34%	31%	19%	32%	32%
	2-Good	34%	46%	40%	49%	17%	42%
	3-Fair		16%	24%	24%	23%	20%
	4-Bad	8%					6%
			4%	5%	8%	28%	
	5-VeryBad						1%
Total		100%	100%	100%	100%	100%	100%

		HouseholdCopeFinancially					
		1-Very Easy	2-Quite Easy	3-Neither	4-Quite Difficult	5-Very Difficult	Total
Have a physical or mental health condition lasting at least 12 months	1-Yes	18%	23%	26%	24%	41%	25%
	2-No	82%	77%	74%	76%	59%	75%
Total		100%	100%	100%	100%	100%	100%

This information is supported by the UK national data presented in "Health at a Price 2017" which states "*Between 2011 and 2014, almost a third (32.5%) of the UK population had experienced relative poverty at least once in their life… People living in poverty have a much lower life expectancy than those who are not, and doctors witness first-hand the impact this has on their patients' health. Poverty is also costly; the Joseph Rowntree Foundation estimated that £29 billion a year is spent on treating the conditions associated with poverty in the UK (approximately a quarter of all health spending)*."[105]

In February the Panel was advised by the Minister for Health and Social Services that he was working on a scheme that would mean that costs would no longer be a barrier to people whose income was stretched. It was further advised that the work was being undertaken alongside the care model and further details would be released later in the year.[106] At the same meeting we were told that the P.125/2020 would be lodged at the same time as the Jersey Care Model.

[105] Letter, Minister for Health and Social Services, 11th March 2020
[106] Public Hearing, 13th February 2020.

However, that did not happen, and the Panel was not provided with any explanation as to the reasons for its delay. Furthermore, we note that whilst P.125/2019 tasked the Minister to bring a Proposition for debate in the third quarter of 2021, this has not been achieved.

The Strategic Outline Business Case confirms that work is currently underway to roll the preferred Capitation Plus (with co-payment) payment model out to financial vulnerable patients via P.125/2019. HCS therefore recommends that through the implementation of the JCM, this payment model is expanded to socially and clinically vulnerable patients in Tranche 3 (2023-2025) of the implementation plan.[107]

KEY FINDING 58: Approval of P.125/2019 – "Affordable Access to Primary Care Scheme" meant that the Minister for Health and Social Services was obligated to bring a Proposition to the States for debate in the third quarter of 2020, which identified a scheme that would improve access to primary care for vulnerable patients, in order that it could be implemented from 1st January 2021. The Panel is extremely disappointed that, despite this, a response to P.125/2019 was not lodged, as anticipated, alongside the Jersey Care Model in September.

RECOMMENDATION 20: The Minister for Health and Social Services must ensure a Proposition is brought to the States Assembly before the end of 2020 detailing a scheme that will improve access to primary care for vulnerable patients.

[107] Strategic Outline Business Case, p44

11. Relationship between the Jersey Care Model and Future Hospital

We have introduced R.54/2019 earlier on in the Panel's report but for the benefit of this section it is important to look back to that document, and the updates produced thereafter in respect of the 'Our Hospital' project, to gain an understanding of how the JCM and the future hospital are linked.

R.54/2019 set out a phased approach for delivering a new hospital and, within that, advised that part of the work involved in developing a new hospital was to establish a new health care model for the Island. One of its aims for key stakeholder engagement was to determine *"how the new model of health care in Jersey, including 'Closer to Home' and mental health provision, impacts on the size of the new hospital."*[108] An update report - R.116/2019 – 'Our Hospital Programme: Update to the States Assembly') – that was presented in September 2019 confirmed that:

> *"While this is not specifically part of the 'Our Hospital' project, the development of the Jersey Care Model is a critical precondition, because it will determine the patient needs for a new hospital, and therefore the size and shape of the hospital to be developed"*[109]

Throughout our report we have highlighted a number of key issues that have been identified by HCS in the respect of the current hospital and our current secondary care system. Primarily, the Jersey Care Model refers to our secondary care model as unsustainable and over reliant on beds, both in and out of hospital.

Whilst the Jersey Care Model Briefing Paper recognises that the future secondary care system should continue to provide many of the existing functions, it also identifies key differences to what is now envisaged in respect of the hospital setting, compared to the previous OBC (Outline Business Case) for the Future Hospital. Fundamentally, HCS believes that the new hospital should be smaller in scale than originally proposed. It is believed that by improving length of stay, focusing more on ambulatory services and by utilising out of hospital services as an alternative to bed-based care, the bed base could remain a similar level to the current state and therefore circa 80 beds less than the previous OBC (280 beds were proposed in the previous OBC). In addition to this change, the JCM highlighted further key differences to the previous future hospital plan:

- Services such as Physiotherapy, Podiatry, Long Term Condition Management and those outlined in Appendix G [of the JCM Briefing Paper] can be partially or fully

[108] R.54/2019, p6
[109] R.116/2019 – 'Our Hospital Programme: Update to the States Assembly

provided in an alternative care setting outside the Hospital including home focussed community care.

- 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.

- 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 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.[110]

At a Public Hearing in February, we queried how the Jersey Care Model and its proposals regarding both secondary care and care in the community would impact the build of the future hospital. The Director General of Health and Community Services advised:

> *"The care model is influencing the hospital, because the hospital will not just be - I think is our aspiration - a deliverer of acute care; it is going to be an educative facility, and we are hoping it is going to be very much part of the community. It is one influence on the hospital build but I think what we are doing very differently this time is understanding from the clinical point of view what needs to be within those walls.[111]*

In the Site Shortlisting Report that was presented by the 'Our Hospital' Team in June 2020, it was advised that an impact assessment of the 5 proposed sites would be undertaken from a

[110] Jersey Care Model Briefing Paper, p26
[111] Public Hearing, 13th February 2020, p21

clinical perspective and that the exercise would allow the clinicians to ensure the proposals are clinically led, ensuring the optimum delivery of the brief and alignment to the JCM.

In contrast to what was advised back in 2019 within R.116/2019, the message more recently has been that the Jersey Care Model will *inform* how the future hospital will function, rather than the size and shape of the hospital, but will not *define* the clinical and non-clinical design requirements.

At a briefing in August this year, we were advised by the Group Managing Director that the Future Hospital would not be informed by the needs of the Jersey Care Model, as work from the JCM would be delivered in the community before the future hospital was completed. Rather, the clinical specification of the hospital would be based on work undertaken in scope of the respective structure. It was further advised that, how the JCM would impact the future hospital was by changing how patients use and move through the Hospital, which could lead to redistributed pathways and lead to various new outpatient settings.

Similarly, the 'Our Hospital Site Selection: Overdale' Proposition and Report (P.123/2020) states:

> *"The layout of Our Hospital will be primarily driven by the need to co-locate some services to deliver clinical adjacencies - for example, the need for an Emergency Department on the ground floor adjacent to diagnostic services with ready access to theatres. The much smaller element of design will be informed by the model of care delivery, but different delivery model options could be accommodated by different layout opportunities within a flexible site and space. Therefore, whilst the proposed JCM will inform the development of the functional brief for Our Hospital, it will not define the clinical and non-clinical design requirements.*

P.123/2020 also confirms that due to constantly evolving models of health and care delivery and the needs of Islanders as treatments and technologies continue to progress, the new hospital will be designed in a flexible way to enable clinical and non-clinical areas to be adaptable with the ability to change in layout and use.

Whilst the JCM Briefing Paper, that's was published in October 2019, suggested that the future hospital should be smaller in size than originally proposed, it is now anticipated that the future hospital will in fact be larger than was considered under the 'Future Hospital' Project. The spatial assessment reports carried out in 2013 concluded the hospital should be 63,644m2 with a footprint of 21,320m2. The new size has been estimated at 69,004m2 with a footprint of 22,243 with basement and 23,243 without. These sizes form the basis of the 2 different options being proposed for the new site.

As far as we are aware, it is thought that larger hospital site is needed due to most of the necessary clinical services to be delivered in the new hospital building being on the ground

floor. This was a requirement by the hospital clinicians and was undertaken with HCS Colleagues and the Our Hospitals clinical director using best practice in other jurisdictions. It was established that clinical services would need to be located on the ground floor of any hospital to best deliver clinical care. We have also been advised that due to an uncertain future (in light of recent pandemics), the new hospital needs to be flexible to deal with anything that arises and also needs to be future proofed for the next 30-35 years.

The Panel is aware of a number of concerns being raised by both members of the public and States Members that the site selection of the new hospital is progressing in the absence of a detailed JCM. We think it is quite clear from undertaking our review that the level at which it was anticipated that the JCM would influence the new hospital has changed overtime. There has been a lot of confusion as to the real impact of the JCM on the development of the new hospital and we think this is mainly as result of how it has been articulated to States Members and the wider public. The Panel's advisers recognise that there are significant interdependencies between the new hospital and the JCM and, as a result, there needs to be greater transparency about how the two programmes will interact as each develop to support increased public and workforce engagement and confidence.

KEY FINDING 59: In 2019, the Chief Minister advised that the Jersey Care Model "*would determine the patients' needs for a new hospital, and therefore the size and shape of the hospital to be developed"*. However, now we have been told the Jersey Care Model will not influence either the shape and size of the future hospital or define the clinical and non-clinical design requirements. Instead it will inform the development of the functional brief for Our Hospital.

KEY FINDING 60: There has been a lack of clarity as to how the Jersey Care Model will directly impact the development of the future hospital, which has resulted in a lot of confusion amongst States Members and members of the public.

RECOMMENDATION 21: The Minister for Health and Services should ensure that greater clarity and transparency is provided to both States Members and the general public as to how the Jersey Care Model and the 'Our Hospital' Project will interact as each develop to support increased public workforce engagement and confidence.

Appendix 1: Panel Membership and Terms of Reference

Panel Membership

Deputy Mary Le Hegarat

Deputy Kevin Pamplin (Vice-Chair)

Deputy Carina Alves

Deputy Trevor Pointon

Deputy Geoff Southern

Terms of Reference

1. To determine whether the Jersey Care Model is appropriate for the Island.

2. To assess how the proposed Jersey Care Model will be delivered and by whom.

3. To consider the implications of the Jersey Care Model on the delivery of health services.

4. To assess the potential impact of the new care model on patients; in respect of the quality of service provided and any financial implications.

5. To examine the possible effects of the proposals on the current and future health sector workforce.

6. To understand the proposed Jersey Care Model in the context of the future hospital and other health facilities on the Island.

Appendix 2: Adviser's Report

Attain

Improving health and wellbeing

Jersey Care Model

Health and Social Security Scrutiny Panel Report

States of Jersey
States Assembly

États de Jersey
Assemblée des États

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EXECUTIVE SUMMARY

The Jersey Care Model (JCM) being proposed is in line with international care models, and the approach being developed appears to be logical and should impact positively on the population of Jersey. The concern we have is that the JCM is still a work in progress and is regarded as a framework, as such at present does not have the level of detail about the specifics of how the services will change over time, beyond high-level assumptions.

In public sessions, the Health and Social Security Scrutiny (HSSS) Panel has received reassurance from the Minister and Health and Community Services (HCS) officers that much of the work involved in the above would be made available to the panel in advance of being presented to the Assembly, once it had been "stress-tested". This, however, has not happened. Instead, it now appears, this level of detail described as "future-proofing" is a major component of Tranche 1 of the JCM, planned for delivery in 2021.

The detailed planning due to take place under Tranche 1 is fundamental to the design of the JCM and, as such, is crucial to our understanding of how the JCM will be delivered. Without this detail, such as what the community offer will be, (i.e. what will be delivered in the community setting (hub or otherwise) rather than in the hospital) we propose it would be suitable to give support for the direction of travel, as outlined in the proposition, and approve only such resource as is required to deliver a successful completion of Tranche 1, scheduled for the end of 2021. Furthermore, given the lack of real progress during 2020, we suggest the Minister should address the governance of the JCM and / or provide a monthly report from HCS identifying progress during that month, against a pre-agreed outcomes-based programme with specific monthly delivery targets. This will engender greater confidence in the delivery of the JCM, especially while heightened challenges presented by Covid continue on current system resources.

The Island's GPs are key to the successful delivery of the JCM, being central to the delivery of the services that will develop in primary and community settings. These services and their rate and method of funding are likely to undergo significant change. It is vital, therefore that the GPs are not only aware of the changes, but also support them. The HSSS Panel's survey of GPs, suggests that this is not the case and that the confidence of the majority of GPs is something that needs to won back by HCS if the JCM is to proceed. The Director-General has stated that the JCM should be co-created with GPs, not be merely a HCS Framework. It currently reads however as a Framework as it lacks key detail. As such we concur with the proposition that support at this stage be restricted to approving the funding to move to the next stage of the programme, which is to deliver the end of Tranche 1 only.

Further recommendations to enhance the development, delivery and assurance of the JCM, starting with Tranche 1, are included throughout this report.

INTRODUCTION

The Jersey Care Model (JCM) provides an ambitious transformation of care delivery in Jersey. The JCM is broadly consistent in its direction with other modern health and social care systems developed or proposed in the UK and international. There is a clear determination that transformation is necessary to meet the needs of the Jersey population now and into the future.

The JCM is a natural successor to the P82 project, and the current JCM document provides an overview of the areas of health and social care within Jersey that are intended to be addressed. As P82 was established in 2012, there is a clear need to review the Health and Social Care model in Jersey to ensure it is fit for purpose for the Jersey population, now and in the future. While there was an agreement for a new model of care in P82, as is now, there is little consensus on why this is needed. There is a limited Case for Change, which means each individual and organisation has a different motivation and expectation for the future. The limited detail in the case for change means that there is little to measure whether or not the JCM is appropriately responding to the current problems defined in 2020.

It is acknowledged that "the hospital is not overwhelmed" (Director General Pg 30 of 13th February 2020 Hearing) and there is significant opportunity to deliver care out of the hospital setting. Based on other international models, there are a range of care activities that could be delivered in the community setting, which is seen as best practice. The Group Managing Director (13th February hearing) explained that the patient experience is the worst part of the three point quality agenda (Safety, experience and outcome) at the moment (due to multiple handoffs and being seen/treated in the wrong place). This contributes to the argument for future services to be delivered closer to home community settings. In reality, the hospital is under-utilised for acute activity. However, it is seen as the focal point for medical services in the Island, not least because it's A&E service is free at the point of delivery and so can often be used as an inappropriate alternative to accessing (paid for) primary care. The hospital is acknowledged to be in need of structural refurbishment as it is not suitable for 21st-century care.

There are elements of evidence from the limited Public Health and current system performance information that indicate that there is a growing requirement for intermediate beds and more significant provision to support patients at home or in the community. Where intermediate care exists, it is acknowledged to work well, based on conversations with the Executive. However it does not appear to optimise its capacity (by greater patient flow and bed management). Most activity going forward is expected to be non-acute although we have not seen evidence to base this on.

The logic for the JCM appears to be sound, but the approach to developing the new Model and what the Model should be is not agreed. Also, the method by which the plans would be realised (programme management) is not yet in place. Our concern is that there is so little evidence on which to base decisions and take forward the Model.

When the JCM was launched in October 2019, it should perhaps have been more appropriately viewed as a consultation document, to spark wide discussion and debate rather than a government strategy as it was too early and too lacking in detail to be described as a plan or strategy. The Minister himself has referred to the JCM as a 'Framework' (29th September 2020 Hearing).
The JCM is very wide-ranging, and because it is so wide-ranging and ambitious, it is relatively straight forward to challenge. However, there is a real risk that not supporting the JCM will lead to further

years of inactivity and political standoff, whereas what is needed is the start of action to deliver the required changes to the whole system. Constant change/development is a key component of modern service management; managers are not employed to maintain the status quo. There is a danger of nothing happening if it is all described as being part of one large JCM. It is more helpful to see the JCM as a flotilla of services going forward, inter-related but all at a planned different pace depending on their scale and complexity.

REVIEW OF THE MODEL PROPOSED

Overarching direction of Model

The objectives of the Jersey Care Model (JCM) are defined in the business case and provide appropriate direction for the future provision of healthcare in Jersey. These objectives are:

- Ensure care is person-centred with a focus on prevention and self-care, for both physical and mental health
- 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
- Redesign of Health and Community services so that they are structured to meet the current and future needs of Islanders

These are in line with many other health and care systems internationally in aiming to reduce the reliance on secondary care by focusing on prevention and delivery of care closer to home, via primary and community provision. The focus on meeting the needs of the current and future population of Jersey and the recognition of the importance of addressing both physical and mental health needs is vital to ensure that the JCM has a tangible impact across the Island.

The Minister for Health has described the JCM as a framework that will evolve, and it has been noticeable that the contents of the JCM has changed over the past year since the original documents were issued and engagement took place in Autumn 2019. This development over time is to be expected and often encouraged, especially with the unprecedented impacts of the Covid-19 pandemic. As there are so many details of the JCM that are still to be confirmed, it means that an assessment of the suitability or otherwise of the JCM is hard to establish. Many of the public submissions and discussions that we have had with key stakeholders have highlighted further information is required to provide specific detail on how the JCM will change care provision and the impact that the JCM will have for service users, the workforce and the overall care system in Jersey.

The creation of a Health and Wellbeing Framework is positive progress, and this should help steer the implementation programme of the JCM, to ensure that it addresses health and wellbeing inequalities in Jersey. While the Jersey Needs Assessment process is underway, there is not yet a robust system to demonstrate the current health and wellbeing needs. The role of the Public Health in the Needs Assessment and the implementation of the JCM, in terms of prioritising programme deliverables will be critical. A limited case for change has been included in the business case, which provides a helpful baseline of the current provision that the JCM is being implemented to address. The range of metrics

included in this case for change can offer the basis for future impact assessment of the JCM on an annual basis. The JCM includes an intent for greater prevention and early intervention; therefore, Public Health disciplines in developing these activities and monitoring year on year impact is paramount. In line with the desire to move the care and management of patients out of formal secondary care into self-managed and preventative care, it would be expected that the outcomes that are to be delivered would be identified. For these outcomes, we would expect the baseline to be established, with a method for on-going assessment defined and targets for future changes to the outcome also agreed. The Health and Wellbeing Framework, at the moment, does not include these metrics, and we did not receive the evidence requested to inform this aspect in the review.

Recommendation 1: Public Health needs to be more prominent in its shaping of the JCM. Specifically, this should include its input into the case for change, and its leadership of the health and care needs assessment exercise, both promised in 2020 but now pushed back into Tranche 1 (2021) and the agreement of population health-based improvement targets throughout the lifetime of the JCM. The case for change needs to be driven by broader acknowledgement of what isn't working in terms of Jersey's overall current service provision.

Implications for Care settings

The transfer of care delivery from the prime site at the hospital to more care closer to home is a stated ambition of the JCM. This intent appears to be sensible, and there is data to indicate that there are several specialities (e.g. Physiotherapy, diabetes, etc.) where patients can receive more suitable care outside of the hospital setting.

It is important that the JCM learns from experience "…whilst work has been undertaken since 2012 to meet the objectives identified in P82/2012, the potential benefits of developing services in the community have not been realised. Furthermore, according to the Health and Community Services Dept, the scale of the care model proposed by P.82/2012 was not big enough to deliver the health care the Island needed." (ref: HSSSP review of the proposed JCM, engagement brief).

The key elements of the future Model are outlined at a high level in various documents, most notably in the Proposition Report where there is a list of initiatives that are proposed for each component listed. All the initiatives included in the plan document are consistent with the overarching Model aims to deliver the majority of care out of the hospital setting and are in common with many other future care models proposed internationally. The PWC stress testing review includes the top ten benefits of the JCM including reducing and delaying people's need for care, through investment in preventative services and expanding existing crisis response services to lower avoidable inpatient admissions. These are very laudable and desirable ambitions that will have a big impact on the care of the population and should deliver financial benefit. At present, the delivery mechanism for these changes in care is not clear.

Investment in primary care is a priority we have heard on numerous occasions, and this should be developed as part of the early transformation programme. Currently, this has been moved to Tranche 3, from 2023, which is likely to result in concern over how these services might change. The JCM has to explain what is proposed, how it will be implemented and who it will impact. Primary care on its own is an extensive, complex and emotive programme of work that could subsume the JCM, if not split into clear sub-projects (such as finance and contracts, clinical pathways, etc.). Moving to a new system

mustn't be at the expense of practitioners having the time to care (as is currently the case). It needs to be widely recognised (it is by the Executive) that time to care is a major difference in patient experience of the Jersey system as opposed to the NHS, and a major plus point that needs to be maintained. It has the benefit of being a very positive indicator at the moment that needs to be kept, as opposed to a negative indicator that needs to be changed.

Conscious of GPs being fundamental to the successful delivery of the JCM, with significant changes anticipated in service delivery at primary and community level, as well as the need for a new funding model, the HSSS Panel commissioned its own comprehensive survey to assess (amongst other things) the understanding of and support for the JCM amongst the Island's GPs. The results were extreme in their negativity and need to be taken seriously as they attracted responses from more than half of the GPs.

The Director-General acknowledged that whilst the JCM has been developed with the input of a Primary Care Board, this Board did not necessarily represent the full GP community and that they had some way to go to achieve this objective. The Director-General said that the JCM should be co-created with GPs, not just be a framework, yet "framework" (as the Minister conceded) is an accurate description of the Model as currently drafted. The GPs should be seen not only as crucial to the delivery of the JCM – without their support it simply cannot happen – but the body which arguably has by far the greatest practical experience of the current health and wellbeing of the 'Island's population. Their knowledge, as well as their support, is vital to the JCM's success. It is also concerning that the plans to address in detail the changes to the primary and community care offer, feature at the end of the planning process, in Tranche 3, rather than at the beginning.

Throughout the development of the JCM there has been a consistent approach to increasing care in the community through the use of primary care and community services. The approach to how these services will be configured in the community, working across primary care, community providers, social care, intermediate services, carers or outreach services from the hospital has yet to be defined. While the intent and ambition are appropriate, without this clarity, there has been some confusion about how the JCM will operate in practice.

The current Model is understood by the local population. There are a set of ingrained behaviours, and any move that appears to develop a Jersey version of the NHS is unlikely to be well received. Where there are clinically advantageous models of care these need to be explained. The consultation has begun to provide this explanation, and some of the feedback from the Executive team respects this.

There is a level of familiarity around accessing services at the hospital and nervousness has developed around the community hub approach, included in the JCM, as it had not been fully formulated when discussed at parish meetings. The approach referred to in the Public Hearings appears to be building on good practice in the current system and provides a clear evidence trail for the public to follow.

In meetings hosted by the panel, the discussion on specifically how a community hub might function (how many are there, where are they, who works there, what services are offered and to whom, etc.) remain only spoken of as examples. To date, we have not received tangible evidence of the proposed new hubs to gain a better understanding of one of the fundamental changes proposed by the JCM.

The intention to move services into the community will relieve pressure on the hospital and provide greater ability to access them across the Island. This needs to be more clearly explained to the population, with example pathways demonstrated. The current JCM does not provide the level of explanation and impact on different patient cohorts.

There has been a lot of comment at the engagement events, through written submissions and at Panel Hearings about the potential community hubs that were proposed in the original JCM paper. As the community hubs have not been defined and the scope of services to be provided by them have not been detailed, they have come to represent potential confusion about what the JCM is going to deliver in practice. Without clear examples of what will actually be different as opposed to theoretical user cases, the public are likely to remain concerned about changes to their known care provision.

There has been a prioritisation process conducted, and the assumptions have informed the financial modelling. However, until the detail around actual service changes are known, this is lack of clarity causes concern. It is replicated in the limited detail about how secondary and tertiary as well as specialised care, will be provided through the JCM. As the JCM evolves, these services may be further refined, and the clarity provided; however, at this stage, it is not clear how service models will change and so impact on patient care.

Further iterations of the JCM need to be clearer about the shift of activity and patients that will move from the hospital to the community setting. While there are references to some services (such as physiotherapy and diabetes) in the JCM and reference to activity changes in Appendix 4 of the Business case, the whole care model in the community is not defined. This means that while independent services might change, without seeing the whole Model (if even at staging points along with the transition (e.g. year 1, year 2, etc.)) it is not possible to determine how the whole service will operate. In healthcare, there are a great many clinical interdependencies, that impact the workforce, digital and estates factors to deliver safe and coherent care to patients. The JCM provides the principles, what is required now is a much more detailed outline of how this will actually be delivered and how the Model will continue to function, and the risks to care will be managed throughout. While this is a clinical model by moving services from one place (i.e. the hospital) to multiple places (i.e. the community) costs may go up due to dispersing the delivery of care. As we don't have the detailed care model we cannot be confident on the financial implications.

There should be fuller reviews of each of the service settings that can then add to the JCM whole. The Mental Health plan, developed in 2019, provides a good example for this and that rationale should especially be applied to primary care and out of hospital services. Without this level of robustness, services are in danger of not being fully understood. In this way, it would be possible to understand the intended plan for each of the services that are part of the JCM.

Care setting examples include:

- Primary care
- Community services
- Mental health
- Outpatient services
- Intermediate care
- Acute services
- Tertiary services

- Domiciliary care
- Social care

Recommendation 2: A review of each care setting should be developed to include the case for change, a costed service model and a more detailed transformation plan, and made available by the Minister before the end of Tranche 1.

Recommendation 3: Following the completion of the service reviews, a comprehensive set of integrated service pathways needs to be developed, with involvement and agreement from those integral to their delivery.

Recommendation 4: The engagement with GPs is currently not working appropriately and needs immediate attention, so that they feel significantly more involved, listened to and confident in the JCM. Consideration should also be given to bringing forward the planning of the future primary and community services envisioned in the JCM.

COMMISSIONING

The commissioning framework outlines an intention to formalise the commercial arrangements with service providers. This intent seems sensible and will:

- support improved clarity of services provided,
- give improved confidence in the quality and appropriateness of care provision.
- help understand what money is spent and value for money,
- should enable data collection from providers, and
- ensure a more comprehensive alignment of services across the Island.

While the intent to 'professionalise' commissioning arrangements is positive, there has been significant recognition of the role of relationships in the provision of care across the Island, and there is a danger this could be adversely impacted by a commissioning approach that is not appropriately developed. If mishandled the commissioning approach could disrupt the existing large scale volunteer workforce, not just through organisations but also for individuals carers. The potential costs of replicating this capacity and capability could outstrip any envisaged care improvement or financial savings.

The JCM should identify where commissioning is already seen to work effectively on the Island (where it drives high standards, follows best practice and delivers strong value for money) and likewise where this is not the case. The JCM should demonstrate how the proposed new commissioning framework would address this disparity, and over what timeframe, with a clear reference to the specific factors that would improve the current commissioning model.

The commissioning cycle provided includes 'procuring services', the definition of this needs to be articulated for the Jersey system as it could lead to unintended consequences to the construct of care provision in Jersey, such as:

- Create concern that significant red tape will be introduced for providers and for HCS to manage the market
- Infrastructure for the States to manage the market may outweigh the benefits of this Model – costs, expertise, impact on providers, relationships, etc

- As competition will mean many 3rd sector providers will not be prepared (administratively, skill sets, and ethically) to compete, will there be training or funding to support the development of local volunteers to prepare for bidding
- Change in the configuration of the 'Jersey market.'
- Is there an appetite for a set of new providers to enter the Jersey care market, possibly to the detriment of local provision?

The JCM needs to be more explicit in its vision for procurement and how that translates into practice.

Recommendation 5: More clearly define the intention of introducing the commissioning framework, clearly explain the role of procurement and outline how services will be selected to be subject to procurement.

ENABLERS

Digital

There are some fundamental elements of the care system that should be more digitally enabled to ensure that care is delivered. These are simple things like accessing care records within a hospital or GP practice, being able to print information or share information between organisations which are basic requirements to do the day job and these need to be addressed as a priority. There is now a digital strategy that has begun to move forward the digital agenda by developing a baseline of the existing digital infrastructure across the health services and is also delivering new services. These include a procurement underway for an electronic care record and electronic pharmacy management and GP ordering for radiology also in progress.

There is very little reference to diagnostic provision within the JCM. Diagnostics should be a key element of the future care provision in Jersey, not just in the hospital setting. Diagnostics are not only linked to the digital infrastructure of the health and care system but also require a specialised and in-demand workforce. It is essential that the demand and capacity for diagnostics on Island are fully understood and what enabling infrastructure might be provided off Island, in terms of expert interpretation of imaging by partner organisations. For any such initiatives, the digital strategy must fully encompass linking diagnostics across care settings and the ability to share results quickly.

Digital has been recognised as a critical risk to the JCM and more widely to the effective delivery of health and care across Jersey. In the JCM business case funding has been requested for further digital investment, which is a fundamental precursor to the implementation of the JCM. What is not clear in the JMC documentation or the Digital strategy is how the digital programme will be resourced and aligned to the JMC or wider on-going business as usual in the HCS. Having clear ownership of the digital plan for health and ensuring it is suitably resourced will be vital to ensuring on-going success.

There are significant opportunities for Digital Jersey to have a rapid impact on the delivery of healthcare in Jersey as well as support development of the broader economy of Jersey. This opportunity should be recognised across government to generate economic advantages for Jersey and invested in as such. Medtech is an emerging market globally, and Jersey could become a major centre of innovation for this sector due to the unique geographic situation (an island with borders), attractive to multi-national technology firms seeking a location to develop technology and access to funding providers. At present, there is interest in this vision; however, this should be supported and recognised for the huge potential beyond better care provision itself.

Workforce

All parties appear to recognise that there is a need to review and revise the health and social care workforce in Jersey to meet the future needs of the population. In line with the wider JCM this is expected to require increased workforce resources to work outside of the hospital environment.

Currently, HCS is unable to provide a clear statement of the existing workforce or give an outline of the future workforce needed to deliver the JCM. Still, they know that they will have to train or import nurses, Allied Health Professionals and social workers. Jersey mirrors where UK professional staff groups are in inadequate supply, so it will be critical that there is a recruitment and retention approach to attract these key staff groups. Intermediate Care nursing will be the first area that has been identified for development, but from what has been articulated and evidenced the HR mechanisms are not in place to enact the scale of requirement. We understand that all Unions (including the RCN, Midwives and Unite) support the JCM for the elements of personalisation, choice and the non-medical Model.

Reference to the existence of a clinical senate is beneficial for on-going clinically-led co-production although while currently it is made clear it is for primary care and secondary care medics, it would be helpful to ensure it includes Allied Health Professionals and other care professionals (e.g. potentially domiciliary care and social care). There is no real collective organisation of the voluntary sector, nor an oversight framework for their work, both of which are essential now and even more so in the future as it's assumed they take on even more responsibility.

As we don't yet know what the workforce is today it is hard to assess the impacts on the future . However, what is clear is that there are pressures on the workforce at present, in common with many other jurisdictions, so new approaches are required.

It is not clear how staff will move from hospital roles to work in the community as this transition has not be defined clearly yet with role descriptions or quantities involved, so it is hard to assess the ability to achieve this.

It is well known that the worldwide market for health and care professionals is very challenging. The NHS alone currently has many thousands of vacancies at the moment, and most comparable systems elsewhere are similarly dependent on expensive short term locum cover in several different professional disciplines. Unless the JCM offer, therefore, is significantly more attractive than can be found elsewhere (therefore including lifestyle, cost of living, associated supportive policies such as access to affordable housing etc.) quite simply Jersey will struggle to be able to import the number and type of practitioners of all clinical disciplines that it requires to fulfil the needs of the JCM.

Along with the recruitment and retention challenges, it is essential to understand how the staff with suitable skills might be moved between existing providers. In the UK, staff are subject to TUPE regulations that enable the transition between organisations, while protecting their rights. There are different Terms and Conditions between the various care providers in Jersey, so managing this transfer, without a legal framework such as TUPE, will require fuller consideration.

Some of the same factors that currently increase the cost of the JCM in the future - an ageing society and a growing population - are the factors that demand a larger health and care workforce to support the Island's population. The likelihood that Jersey will grow its new staff in a such a short space of time when it hasn't started to define how many or of what type is a significant risk to the credibility of the

JCM. The risk therefore that the output of the workforce plan becomes an aspiration in numbers terms that are never going to be realised, is a very realistic and pertinent risk, one that impacts on the viability of the whole JCM.

Estates

The physical infrastructure necessary for the delivery of the JCM is undefined while the delivery model for the service changes is not clear. The JCM has referenced the use of existing health and care and other facilities across the Island for the provision of future services however there is little detail on these facilities or how they will be commissioned and operated.

Within the financial assumptions in the business case, no assumptions have been made for potential capital investment for estates. As the intention is to provide services in the community in many buildings owned by partner organisations, this might be a prudent assumption; however, it is not clear whether this is accurate. There is a significant body of work to be completed to understand the current publicly-owned estate profile as well as from the possible partner organisations across Jersey to assess their fit for purpose and identify suitable locations from which different services could be delivered. Existing health premises owned by primary care providers are assumed to be available to provide future services; however, the costs and conditions associated are unknown as no discussions have been undertaken.

There are a large number of commercially owned residential care beds that could be considered an option to support intermediate care provision in future and reduce the length of stay in hospital provision. The commercial modelling for this element of the JCM needs to be assessed and fully validated as part of any commissioning discussion as there will be the opportunity to influence the market that exists in Jersey to achieve the best value for the population.

Without a clinical model, the estates' strategy is unlikely to be accurate. Therefore the requirement for the intermediate and domiciliary care beds is essential. It is not clear how much focus has been on modelling the demand and capacity for these care settings.

Data Management

Several documents refer to a Population Health Management (PHM) approach for the JCM; this has not been fully articulated, however, it is an approach that could have real benefit to targeting those members of the population that need specific intervention. PHM is the use of data to segment the population according to their risk profile and to manage their health on an on-going basis proactively. The PWC review highlighted this as an opportunity of the JCM, which will require an improved data strategy incorporated into the JCM. To implement this approach, there needs to be a comprehensive and robust data management structure in place for Jersey health and care. It appears elements of the approach are being developed, as evidenced by the Jersey Performance Framework, however more granular data specifically for all health provision is required.

Recommendation 6: The digital and workforce strategies are key enablers to the successful delivery of the JCM. The panel needs to see evidence that these strategies are comprehensive and island-relevant, and that they have informed the development of the services and future investment needs of the JCM.

Recommendation 7: the JCM should develop a diagnostic strategy that links to the clinical, digital and workforce strategies.

Recommendation 8: The workforce model needs to be judged in the context of the worldwide shortage of health and care delivery staff. The Model, therefore, needs to demonstrate how it will provide a more attractive proposition and is more likely to be successful than its competitors in the health and care workforce market.

Recommendation 9: HCS should develop a risk assessment for delivering the JCM workforce strategy to give confidence that it can meet the expected demand.

Recommendation 10: HCS should establish a data management strategy and adopt a population health approach to focus on who, what and where to target the rollout of the new Model. Using the GP registers in primary care and hospital information to target local priority patients would be more effective and deliver impact quickly.

FINANCE

The scope for this review does not include the requirement to assess the financial Model for the JCM, however, we think it is important to note that we have not been able to review the assumptions that have informed the financial model developed for the business case.

There is a revenue cost model with very detailed annual costs, albeit with high-level detail on how the costs have been derived. At the Panel Hearings, we have heard reference to additions built into the Model attributed to inflation, demographic change and population growth. Still, the details to support the £90m cost reduction, and the £67m cost addition, which between them produce a net £23m reduction in costs over the next 16 years is high level, based on possible changes in care provision, in the Business case Appendix 4. There is a reference to capital costs associated with the digital strategy but not for any other capital expenditure (excluding the cost of the new hospital, which is not covered by this 'panel's work). The detail behind the £23m needs to be explained together with a statement to confirm that there is either nil capital cost or a maximum capital envelope within which to cover the capital costs of the JCM. Not including this information may present a risk to the deliverability of the JCM, as any further capital costs may not be budgeted.

As we received the assumptions that inform the JCM financial model from the HCS at a very late stage of this review we have not been able to raise further questions in the Hearings. It has been very helpful to review these assumptions however we have been not able to measure the validity of the assumptions in terms of their scale, timing or phasing of implementation. This reflects a challenge within this review where some important evidence (for example financial assumptions, workforce details, clinical model definition, digital strategies, performance measures, etc) has been received at the very last minute, which has hindered timely and comprehensive investigation. While to some degree this is understandable as the JCM is a dynamic programme however for robust scrutiny in future there needs to be greater planning of what will be shared with the Panel and the timescales clearly stated.

We understand that the finances are indicative at this stage, and as we have only recently seen the assumptions, we cannot give a clear steer on the validity of the financial Model. From now on, there needs to be an on-going programme that updates the finance model for scrutiny of each tranche.

Appendix 4 of the Business case includes a breakdown of the potential changes in the delivery of care (e.g. the movement of some ED activity to primary care or reduction of physiotherapy) which at this stage is a useful guide to the potential service model changes and likely financial implications. As the clinical service model is not complete, these financial assumptions will be subject to change; therefore there needs to be a process that assesses the financial implications of the clinical services changes as they are made. This assurance process is important as the clinical Model will impact on the workforce, digital infrastructure and estates required both at the new service provision and wherever the service is moving from. Also it is also likely that any movement of clinical service (e.g. from the hospital to the community) will require the double running of costs (which is to be expected). Therefore the financial costs of this should be fully understood.

Recommendation 11: If the proposition is approved then the Panel should expect to pre-agree, with HCS, the timing of key pieces of evidence (such as proposed budgets, performance measures, workforce plans, etc) over the length of the following Tranche to provide on-going financial assurance.

Recommendation 12: The service model and financial assumptions should be validated for each Tranche, HCS should provide an updated proposed budget for the JCM for each Tranche. This should include an annual report stating what has been spent on the JCM in the previous Tranche and an updated plan for the following Tranche. This should include programme costs as well as costs associated with service changes and efficiency delivered.

ENGAGING WITH SERVICE USERS AND THE WORKFORCE TO SUPPORT DELIVERY

The initial engagement and consultation process highlighted that there is a well informed and active population with a real interest in the JCM. Part of the delivery approach will be to understand the programme of engagement to maintain appropriate information is shared. This will be important as the JCM will require changes in behaviours across the population to ensure the best adoption of new service provision.

It has been notable in the submissions since the roadshow events in Autumn 2019 how little engagement and communication with the public there has been. This may have been considered pertinent as the JCM has been subject to on-going evolution and the implications are yet to be finalised. However, there needs to be a communications plan to ensure that there is not a void in which concerns about the future Model can fester. We understand that there have been some changes in the communications team at the HCS, but it is critical that the communications strategy is rapidly formalised for the public, press and the workforce so that there can be a coordinated approach.

Recommendation 13: Develop a communication strategy to explain and support the JMC development and implementation

APPROACH TO DELIVERY

The panel has already received written evidence from several sources expressing concern with the lack of detail on how the JCM will be put in place. The public feedback is particularly well informed, accurate, and much of it comes from those who hold key positions as the spokesperson for collective groups/organisations. It cannot be ignored or simplified into 1 or 2 key questions for the JCM review. These contributions also expect a degree of "constant improvement" as part of any managerial responsibility, therefore making changes to improve performance whilst continuing to deliver "business as usual".

The scale of change described in the JCM, however, cannot be underestimated. It will need a different specialist skill set to manage the overall programme of change. This project management discipline will describe the journey from the present to the full implementation of the JCM.

The JCM is often referred to as if it is a single coherent programme. In contrast, in reality, it is a series of inter-related projects, which combine to form the JCM but individually all require their delivery champions, implementation framework and an easily described and understood public narrative. As inter-related projects, some aspects could go ahead now, whereas others (particularly those dependent on major workforce change) will need long lead-ins. The JCM does not currently provide the details around how any phasing might be delivered.

A well-organised framework for project management is essential to deliver the ambition and the complexity of the JCM. Without a Programme Management Framework, its component projects cannot succeed and, critically from the 'panel's point of view, there is nothing against which to measure progress. One benefit of successful programme management is that it has a start and end, so it doesn't need to be seen as an on-going additional cost. It should be seen as an inevitable upfront double running cost, but successful project management defines its lifetime.

To date, there have been references to a programme management approach, but nothing has been received to review, such as a programme plan or comprehensive risk log.

There is insufficient pace and rigour behind the JCM. Those responsible for its delivery are not being held accountable for considerable slippage against previously promised actions. HCS is juggling the delivery of both business as usual and the JCM, whilst also attempting to manage the implications of Covid-19. The agenda of the JCM – developing new policy, strategic planning and driving transformational change, defining designing and implementing the future – is different from the business as usual delivery of day to day services.
The same Executive team is accountable for the delivery of hospital 'Business as Usual' (BAU), the Health and Community Service, the response to Covid-19, the JCM and the new hospital development. This is an extensive portfolio and includes some potential for conflicts of interest. For example, if a new commissioning framework is introduced, the HCS will be commissioning, and performance managing providers but will be unable to performance manage the hospital, which is the main provider. As a result, there are capacity, capability and accountability issues to be resolved to ensure a credible delivery plan and appropriate governance is in place. In addition, there are significant interdependencies between the new hospital and the JCM, therefore, there needs to be greater

transparency about how the two programmes will interact as they each develop to support increased public and workforce engagement and confidence.

Much of the slippage of the JCM during 2020 has been attributed to Covid-19. With no end in sight to the global pandemic, there is little confidence that the combination of the current HCS team plus its external consultancy support will deliver the combined agendas of business as usual service delivery, reacting to the continuing pressures of the pandemic, and the JCM, in a timely manner, irrespective of the proposed new hospital programme. This loss of confidence is due to two fundamental faults in the current approach.Firstly that the same few people at the top of HCS appear to be tasked with this whole agenda, and secondly, that there is no robust mechanism for maintaining regular overview and challenge on the detail of the JCM on a very regular basis.

There is enough in both the BAU plus Covid agenda and the JCM agenda to require separate senior leadership for each. Attempting to run either programme without separate defined and dedicated leadership is likely to overstretch those responsible and lead to failure to deliver at the pace required of each programme. The two different programmes also require very different approaches and, with them, different skill sets, BAU being essentially day to day operational delivery, whilst JCM requires well-developed change management skills.
A non-executive board with an independent chair could sit between the HCS executives and the Minister to give the degree of regular and systematic oversight, with both appropriate challenge and support, to ensure that the JCM continues, within its proposed timescales and budget, at the right level of quality. The board would determine the overall strategy for the JCM, and ensure an appropriate organisational culture for its delivery. It should hold relevant complementary skills to sit alongside those of the executives and have ultimate responsibility for signing off the regular reporting of progress to both the Minister and the panel. It would ensure that the whole programme and its milestones are delivered to plan, and its focus on strategy would ensure that the major enabling components (particularly digital, workforce and engagement strategies), as well as the integration with other key government departments, are in place early enough to impact positively on the overall programme. Although outside the scope of this report, such a Board would also be well placed to oversee the programme management of the Island's new hospital development.

The Board should meet in public and be the main independent source of regular assurance to the Island's population on the appropriate pace, cost and quality of the delivery of the JCM. This would provide the assurance that is currently missing from an independent source and doesn't stop the HSSS Panel from commissioning its own surveys or "deep dives" into individual components of the JCM as is currently the case.

Recommendation 14: Establish a Risk log for the top 10 risks for the successful delivery of the JCM, that can be used to monitor progress.

Recommendation 15: The delivery functions (HCS and JCM (possibly Our Hospital too)) should be separated, with JCM delivery subject to a much more rigorous and constant oversight than is currently the case. An independent non-executive board should be created to hold executives to account for their full-time responsibility to deliver a timely and successful JCM.

Recommendation 16: This Board would hold responsibility for agreeing the monthly progress report described under the overarching recommendation above, and would complete 2021 with an annual

report which detailed analysis of progress against pre-agreed outcomes-based targets for the completion of Tranche 1, and offered a detailed look ahead to the programme to deliver Tranche 2.

RECOMMENDATIONS

Recommendation 1: Public Health needs to be more prominent in its shaping of the JCM. Specifically, this should include its input into the case for change, and its leadership of the health and care needs assessment exercise, both promised in 2020 but now pushed back into Tranche 1 (2021) and the agreement of population health-based improvement targets throughout the lifetime of the JCM. The case for change needs to be driven by broader acknowledgement of what isn't working in terms of Jersey's overall current service provision.

Recommendation 2: A review of each care setting should be developed to include the case for change, a costed service model and a more detailed transformation plan, and made available by the Minister before the end of Tranche 1.

Recommendation 3: Following the completion of the service reviews, a comprehensive set of integrated service pathways needs to be developed, with involvement and agreement from those integral to their delivery.

Recommendation 4: The engagement with GPs is currently not working appropriately and needs immediate attention, so that they feel significantly more involved, listened to and confident in the JCM. Consideration should also be given to bringing forward the planning of the future primary and community services envisioned in the JCM.

Recommendation 5: More clearly define the intention of introducing the commissioning framework, clearly explain the role of procurement and outline how services will be selected to be subject to procurement.

Recommendation 6: The digital and workforce strategies are key enablers to the successful delivery of the JCM. The panel needs to see evidence that these strategies are comprehensive and island-relevant, and that they have informed the development of the services and future investment needs of the JCM.

Recommendation 7: the JCM should develop a diagnostic strategy that links to the clinical, digital and workforce strategies.

Recommendation 8: The workforce model needs to be judged in the context of the worldwide shortage of health and care delivery staff. The Model, therefore, needs to demonstrate how it will provide a more attractive proposition and is more likely to be successful than its competitors in the health and care workforce market.

Recommendation 9: HCS should develop a risk assessment for delivering the JCM workforce strategy to give confidence that it can meet the expected demand.

Recommendation 10: HCS should establish a data management strategy and adopt a population health approach to focus on who, what and where to target the rollout of the new Model. Using the GP registers in primary care and hospital information to target local priority patients would be more effective and deliver impact quickly.

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Recommendation 16: This Board would hold responsibility for agreeing the monthly progress report described under the overarching recommendation above, and would complete 2021 with an annual report which detailed analysis of progress against pre-agreed outcomes-based targets for the completion of Tranche 1, and offered a detailed look ahead to the programme to deliver Tranche 2.

Contact

Struan Coad
Director
E: Struan.coad@attain.co.uk#

Attain
2-4 Packhorse Road, Gerrards Cross
Buckinghamshire SL9 7QE
United Kingdom
0203 435 6590
contacts@attain.co.uk

Appendix 3: GP Survey Results Paper

GP Survey Results Paper

Working under COVID-19 and the Future Jersey Care Model

The Panel undertook a survey targeted at the estimated 106 GP's who are currently operating in Jersey. The survey was made available to GP's on 28th August and was closed on 18th September 2020.

The Panel undertook this survey with the intention of gathering data about the experiences of GP's in relation to recent direct employment by Health and Community Services ('HCS'), working within the Urgent Treatment Centre ('UTC') and proposed future working arrangements under the Jersey Care Model.

A total of 74 GPs responded to the survey, and out of that total 55 GPs (74%) completed the survey and 19 (26%) partially completed the survey. A number of questions in the survey invited open-ended responses but we have not provided specific details of these in order to mitigate the risk of GP confidentiality being compromised.

Section 2 - About you and your usual work (74% provided responses):

Question 1. How many patients do you see during an average week?

- The mean, average number of patients, seen by GP respondents was 116 per week with 75% of the 55 respondents to this section see 100 or more patients per week.

Question 2. How many hours do you practise as a GP on an average week?

- The mean, average number of hours practised per week, by GP respondents was 46 hours per week with 62% of the 55 respondents to this section working more than 40 hours per week.

Question 3. How many years have you practised as a GP in Jersey? (rounded to the nearest year)

- The mean, average number of years practised as a GP in Jersey, was 17 years with 47% of respondents to this section with more than 10 years' experience as a practising GP in Jersey.

Section 3 – Direct employment under Health and Communities Services Department (HCS) (74% provided responses):

Question 4. Were you directly employed by HCS recently?

- 75% (41) of respondents were directly employed by HCS recently with 22% (12) employed part time and 4% (2) were not directly employed by HCS recently.

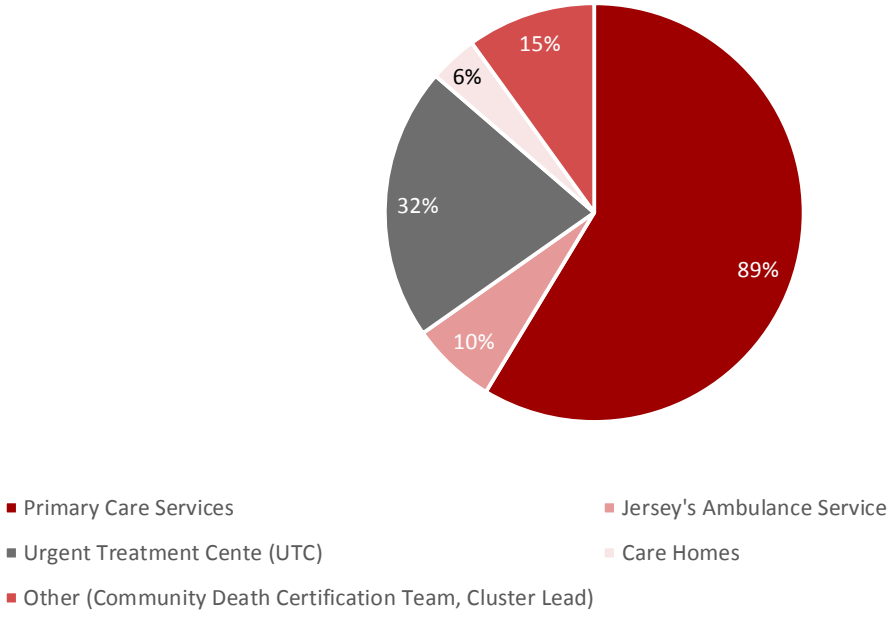
Section 4 – Working in HCS (72% provided responses):

Question 5. Which area(s) of health care did you work in whilst directly employed by HCS? (please tick all that apply)

- 89% (47) responded with Primary Care Services;
- 9% (5) responded with Jersey's Ambulance Service;
- 32% (17) responded with Urgent Treatment Centre (UTC);
- 6% (3) responded with Care Homes;

- 15% (8) responded with 'other', which included the Community Death Certification Team and as 'Cluster Lead'.
    - Other – Comments: 8% (4) of respondents who answered this question worked in the Community Death Certification Team and 4% (2) worked as a Cluster Lead.

Which area(s) of health care did you work in whilst directly employed by HCS? (please tick all that apply)



Section 5 – Those who worked in the Urgent Treatment Centre 9UTC) (23% provided responses):

Question 6. Overall, how would you rate your experience of working in the UTC on a scale of 1 for "Excellent" down to 5 for "Very poor"?

- (17 responses) The average response was 2.53.
    - Out of those who responded, 82% (14) provided written feedback: 57% (8) of those who provided written feedback cited poor management and communication and 43% (6) expressed concern that the work undertaken in the UTC was not suitable for GP's.

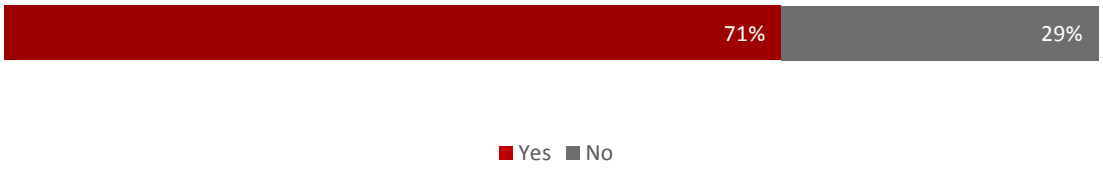
Question 7. How would you rate communication between GPs and other HCS employees whilst working in the UTC on a scale of 1 for "Excellent" down to 5 for "Very poor"?

- (17 responses) The average response was 2.41.

Question 8. How much of the care that you provided to patients in the UTC was typical of the type of care you would usually provide in general practice?

- 47% (8) responded with some and 35% (6) responded very little with 12% (2) responding most and 6% (1) responding with none.

Question 9. Did you experience any operational issues in the UTC?



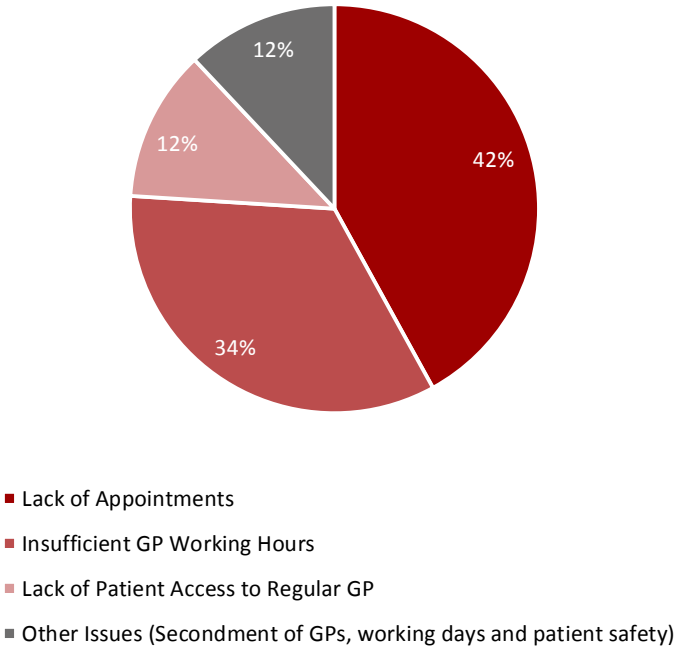
- 12 answered yes with 5 answering no.
    - 79% provided written feedback: 82% (9) of those who provided written feedback cited poor IT support and training and 36% (4) cited poor management.

Section 6 – Impact on 'Business as Usual' (72% (55) provided responses)

In **Question 10**. the Panel found that 87% (48) of GP's were aware of patients that experienced problems with accessing their GP during the period in which GP's were redeployed to HCS, compared with 13% (7) who did not.

- 80% (44) of those who answered 'yes' provided written feedback: 34% (15) of those who answered 'yes' with written feedback, cited insufficient GP working hours and 42% (18) cited insufficient numbers of GP appointments.

Problems accessing GPs during redeployment to HCS - Key Findings

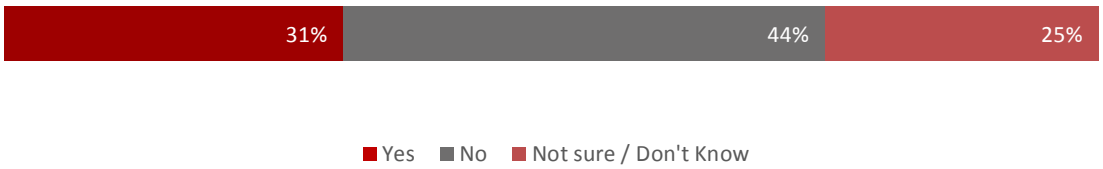


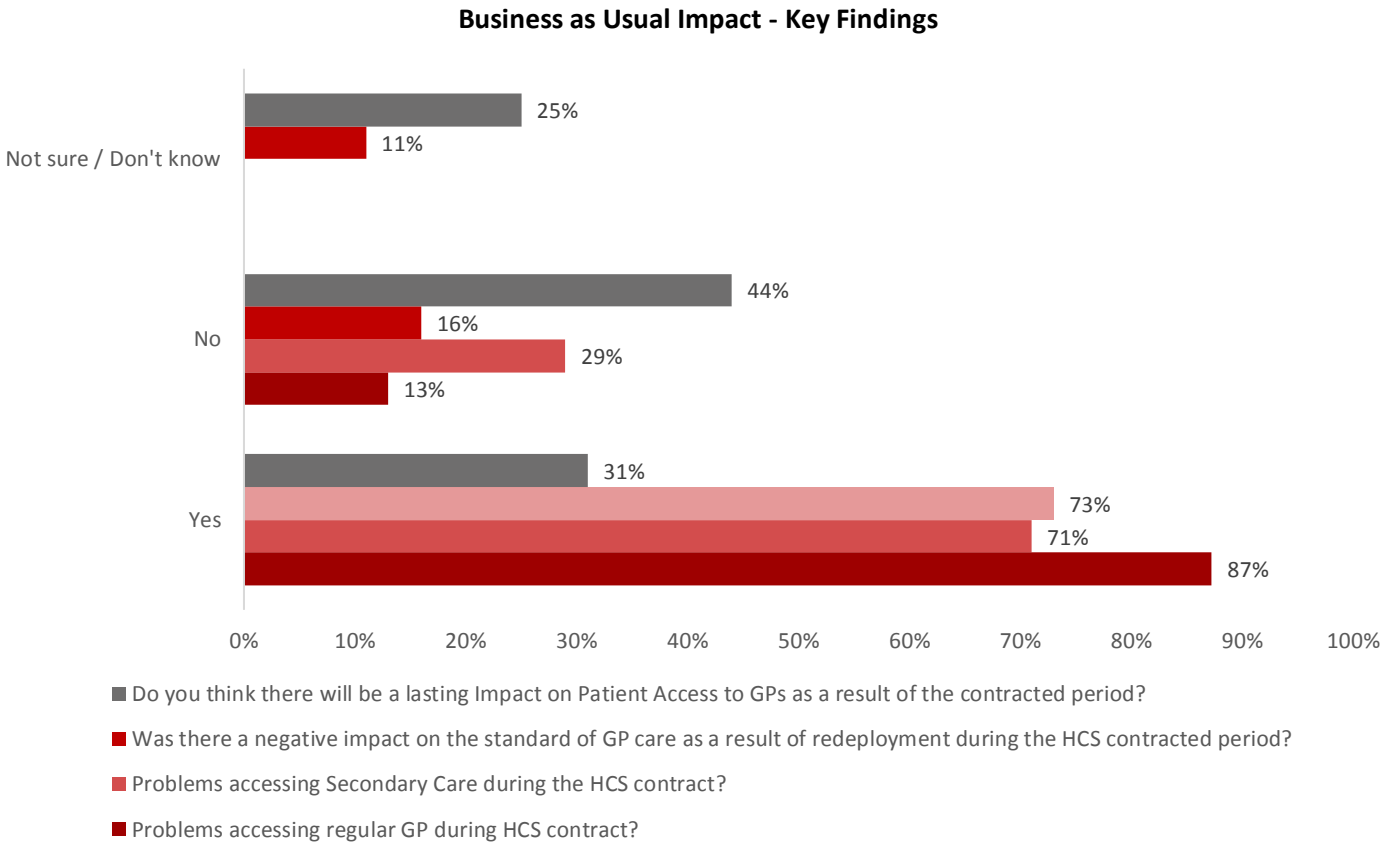
In **Question 11**. the Panel found that 71% (39) of GP's either experienced difficulties themselves or were aware of other GP's having difficulties, accessing secondary care during the contracted period, compared with 29% (16) who did not.

In **Question 12**. 73% (40) of GP's indicated that the standard of care usually provided to patients in practise was negatively affected as a result of the redeployment of GP's to HCS, compared with 16% (9) who responded No and 11% (6) who were Not Sure or Didn't Know.

- **75% (41) of those who answered 'yes' to Q.12 provided written feedback:** 12% (5) of those who answered, 'yes' with written feedback, cited a negative impact on 'continuity of care' and 10% (4) cited a negative impact on patient waiting times.

In **Question 13**. the Panel noted that 44% (24) GP's did not believe the 4-month contract with HCS would have a long-lasting impact on the accessibility of patients to their General Practise, with 31% (17) responding with Yes and 25% (14) responding with Not sure / Don't Know.



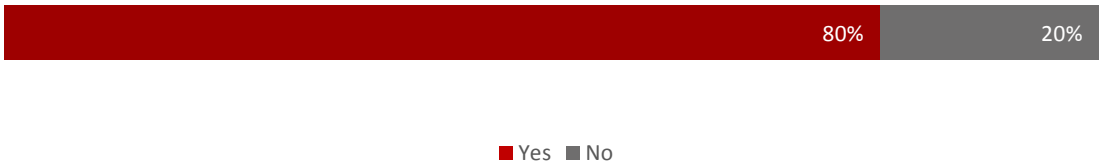


Section 7 – Future Working Arrangements under the Jersey Care Model (JCM) (74% (55) provided responses)

Question 14. Do you think you have been adequately consulted with about the proposals contained within the JCM?

- 44% (24) disagreed with 42% (23) strongly disagreeing, 13% (7) undecided and 2% (1) in agreement.

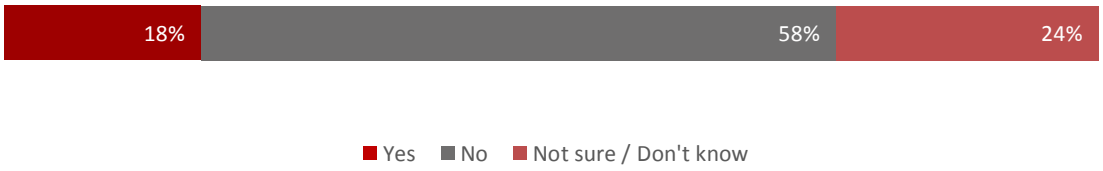
In **Question 15.** the Panel found that only 20% (11) of GP's had assisted HCS with the development of an implementation/delivery plan in respect of the proposals contained within the JCM, with 80% (44) not providing such assistance.



Question 16. How do you rate communication between GPs and HCS about the proposed JCM and future working arrangements, on a scale of 1 for "Excellent" down to 5 for "Very Poor"?

- The average response to this question was 3.31.
    - If "poor" or "very poor", please provide further details: 75% (41) of respondents provided further details with 15% (6) of those who provided feedback citing a lack of consultation with GP's and 12% (5) cited insufficient detail in the JCM proposals.

Question 17 asked GP's whether they understood what is being proposed under the JCM, 58% (32) of GP respondents did not understand what is being proposed under the JCM, with 20% (10) responding Yes and 24% (13) were Not sure or Didn't Know.



Question 18. How confident are you that the JCM, as proposed, can be delivered?

- 63% (34) were not confident, 31% (17) were not sure or didn't know and 6% (3) were somewhat confident.
    - 65% of respondents provided written feedback to explain their answer: 20% of those who provided written feedback cited a lack of confidence about the funding of the JCM and 20% cited a lack of confidence in the community focus of the JCM.
- 34% (12) of those who provided written feedback expressed concern about the Government's track record of investments in IT infrastructure, 31% (11) expressed concern about the provision of funding for the JCM and 28% (10) cited insufficient staffing numbers and a lack of workforce skills to fulfil the requirements of the JCM.

Question 19. The JCM describes a number of key issues with our current health care system, as part of the rationale for developing a new care model. Please indicate how much you agree or disagree that the following are key issues.

	Strongly agree	Agree	Not sure/don't know	Disagree	Strongly disagree		Response Total
The current model is focused on delivery of care in a secondary care setting	18.2% (10)	27.3% (15)	18.2% (10)	30.9% (17)	5.5% (3)		55
Intermediate and Ambulatory Care is currently limited	18.2% (10)	69.1% (38)	7.3% (4)	5.5% (3)	0.0% (0)		55

Question 19. The JCM describes a number of key issues with our current health care system, as part of the rationale for developing a new care model. Please indicate how much you agree or disagree that the following are key issues.

	Strongly agree	Agree	Not sure/don't know	Disagree	Strongly disagree		Response Total
Primary Care is not optimised to achieve integrated care in the current model	21.8% (12)	45.5% (25)	18.2% (10)	12.7% (7)	1.8% (1)		55
Community Care could be further optimised	38.2% (21)	60.0% (33)	1.8% (1)	0.0% (0)	0.0% (0)		55
Direct Access Services funding mechanisms are not in place	50.9% (28)	34.5% (19)	12.7% (7)	1.8% (1)	0.0% (0)		55
Social Care and External Partners could be further utilised	32.7% (18)	52.7% (29)	7.3% (4)	0.0% (0)	7.3% (4)		55
						answered	55
						skipped	0

Question 20. In order to meet the objectives of the Jersey Care Model, it has been suggested that a transformation of secondary care services to the provision of care in the community may be required. How would you rate the following proposals in terms of importance?

	Very important	Important	Not sure / Don't know	Not very important	Not at all important		Response Total
A Commissioning Framework for Primary Care and external partners	16.4% (9)	41.8% (23)	34.5% (19)	5.5% (3)	1.8% (1)		55
A Workforce Strategy that shifts settings of care for key roles	16.4% (9)	45.5% (25)	30.9% (17)	5.5% (3)	1.8% (1)		55
A revised provision offer in the Community	23.6% (13)	49.1% (27)	27.3% (15)	0.0% (0)	0.0% (0)		55
Greater investment in mental health	49.1% (27)	45.5% (25)	3.6% (2)	1.8% (1)	0.0% (0)		55

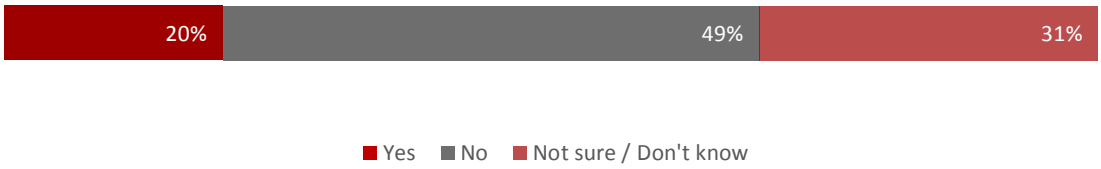
Investment in Social Care to deliver a revised Market Strategy and Personalisation	30.9% (17)	50.9% (28)	14.5% (8)	3.6% (2)	0.0% (0)		55
A Partnership of Purpose with external partners	10.9% (6)	23.6% (13)	54.5% (30)	7.3% (4)	3.6% (2)		55
Digital enhancements	38.2% (21)	49.1% (27)	10.9% (6)	1.8% (1)	0.0% (0)		55
Transparency re commercial strategy for secondary care	48.1% (26)	31.5% (17)	18.5% (10)	1.9% (1)	0.0% (0)		54
Revised contractual framework for Tertiary Care	14.8% (8)	22.2% (12)	51.9% (28)	5.6% (3)	5.6% (3)		54
A Cross-Government prevention initiative	18.2% (10)	34.5% (19)	41.8% (23)	1.8% (1)	3.6% (2)		55
Access for vulnerable groups	65.5% (36)	30.9% (17)	1.8% (1)	1.8% (1)	0.0% (0)		55
Culture and Risk tolerance	27.3% (15)	29.1% (16)	40.0% (22)	3.6% (2)	0.0% (0)		55
						answered	55
						skipped	0

Question 21. Do you have concerns with any of the following areas, that are required to enable the implementation of the JCM and to support care delivery across the health and care system? (please tick all that apply)

- 88% (43) responded with Workforce availability in the community;
- 53% (26) responded with A Commissioning Framework;
- 92% (45) responded with Finances;
- 71% (35) responded with Digital;
- 45% (22) responded with Estates.

29 out of 49 respondents to this question provided written feedback.

Question 22 asked GP's if they understood what is being proposed under the Jersey Care Model, regarding "community hubs", 49% (27) of GP's did not understand the JCM proposals for "Community Hubs", in contrast to 20% (11) who responded Yes and 31% (17) who were Not sure or Didn't know



Question 23. Overall, to what extent do you agree that the proposed JCM is a good model of healthcare delivery for Jersey?

- 2% (1) strongly agreed;
- 15% (8) agreed;
- 33% (18) neither agreed nor disagreed;
- 15% (8) disagreed
- 9% (5) strongly disagreed;
- 27% (15) were not sure or didn't know.

51% (28) of respondents to this question provided written feedback: 21% (6) of respondents who provided written feedback cited a lack of detail in the JCM proposals.

Question 24. Are you receptive to future employment opportunities contracted by HCS?

- 11% (6) responded with definitely yes;
- 24% (13) responded with perhaps;
- 35% (19) responded with probably not;
- 24% (13) responded with definitely not;
- 7% (4) responded with not sure or didn't know.

58% (32) of respondents to this question provided written feedback: 16% (5) cited poor management and 13% (4) cited issues with non-payment.

Question 25. Would you like to see the UTC reinstated under the proposed JCM?

- 2% (1) responded with definitely yes;
- 29% (16) responded with perhaps;
- 29% (16) responded with probably not;
- 38% (21) responded definitely not;

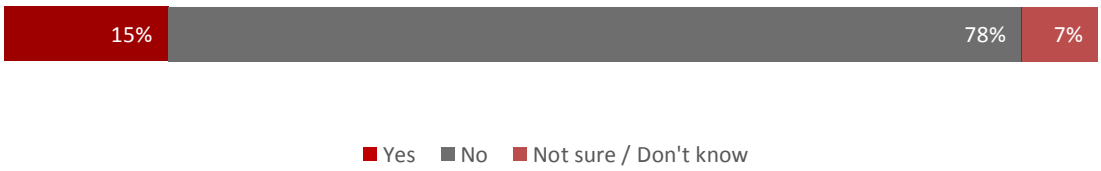
- 2% (1) responded with not sure or didn't know.

Question 26. Should a UTC model offer unscheduled care in place of the Jersey Doctors on Call (JCOC)? the Panel found that 44% (24) Yes, with 28% (15) No and 28% (15) Not sure or Didn't know.

Question 27. Should a UTC be commissioned by HCS as a hospital service or should a private company be commissioned to provide the service?

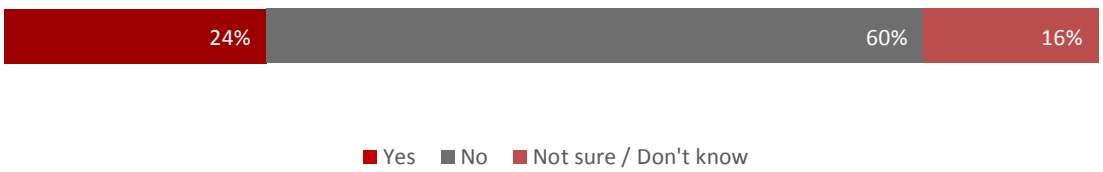
- 41% (22) answered Commissioned by HCS;
- 6% (3) answered Commissioned by a private company;
- 54% (29) answered not sure or don't know.

In **Question 28,** the Panel found that 78% (43) of GP's did not believe the appropriate type of care was diverted to the UTC during the contracted period, compared with 15% (8) of GP's who responded Yes and 7% (4) who were Not sure / Don't know



- 65% (36) of respondents to this question provided written feedback: 42% (15) of respondents who answered No and provided written feedback expressed concern about GP treatment of minor injuries

In **Question 29**, the Panel noted that 60% (33) of GP's did not think the fee structure for patients receiving treatment at the UTC was appropriate for patients who could have ordinarily been managed by a GP in the community, compared with 24% (13) who responded Yes and 16% (9) who were Not sure or Didn't know



In **Question 30**, the Panel found that 93% (51) of GP's did not believe that HCS demonstrated an understanding of General Practise demands and practise prior to, or during, the contracted period, compared with 7% (4) who were not sure or didn't know, and 0% who responded yes.

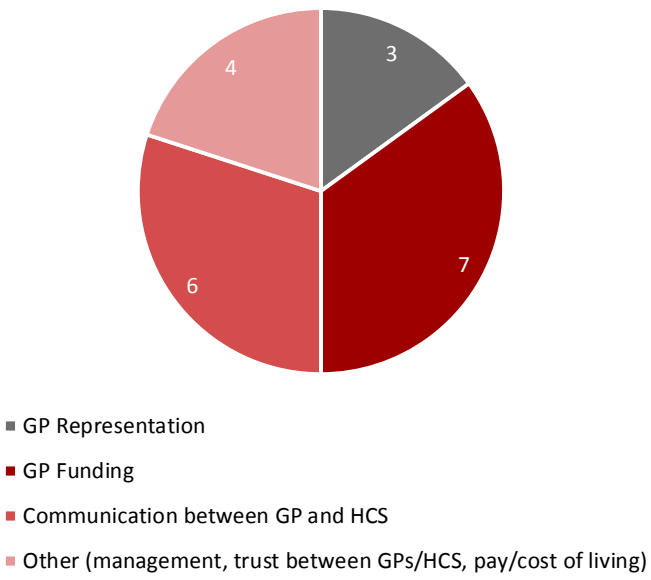
In **Question 31**, the Panel noted that 85% (47) of GP's did not believe HCS understood the on-going demands on practise in Primary Care, contrasted with 4% (2) who responded Yes and 11% (6) who were Not sure or Didn't know.

Question 32. How confident are you that General Practice will be adequately supported under the JCM?

- 0% answered confident and very confident;
- 19% (10) were not sure or didn't know;
- 6% (3) were somewhat confident;
- 76% (41) were not confident.

The survey received 18 comments and suggestions regarding the matters raised in the survey, illustrated in the below pie chart:

Question 33. JCM – Key Issues from GP comments and suggestions



States Greffe | Morier House | Halkett Place |St Helier | Jersey | JE1 1DD

T: +44 (0) 1534 441 020 | E: statesgreffe@gov.je | W: Statesassembly.gov.je