
STATES OF JERSEY



JERSEY CARE MODEL: BRIEFING PAPER

**Presented to the States on 31st October 2019
by the Minister for Health and Social Services**

STATES GREFFE

FOREWORD

Governments across the developed world are having to consider how they best meet the health and social care needs of populations that are, on average, living longer and with ever more complex conditions. This has to be accomplished in the light of medical advances and within the bounds of affordability, value for money and sustainability.

Against this global backdrop, the Jersey Care Model presents a vision of how the Government of Jersey proposes to adapt and reconfigure the services it offers to support safe, high quality, efficient care.

The Jersey Care Model continues the journey begun with the recasting of the healthcare system set out in *Health and Social Services: A New Way Forward* ([P.82/2012](#)) that was supported by the States Assembly. Health and social care is constantly evolving, and flexibility and innovation are key. Nearly a decade on, the new Jersey Care Model refreshes and refocuses that blueprint for future care in Jersey, seeing services delivered in different ways – with moves away from an institutional bed-based model to one founded on more support within the community, an enhanced role for primary care and voluntary and community sector partners, and a new hospital that concentrates on specialist and ‘life and limb’ care.

The Jersey Care Model will inform the Government’s ‘Our Hospital’ project in terms of the activity that will be carried out in a future hospital. In so doing, the Jersey Care Model will influence the size, shape and function of a new hospital.

Our mental and physical health services should be fit for purpose, support equitable access, and be more integrated around the needs of Islanders. Care should be provided when and where it is needed most. Funding and staffing reconfiguration will be needed to support service redesign. Existing resources will be repurposed around the system. Safe, patient-focused, outcome-based care is the prize.

Over the coming months, this strategic vision of an integrated healthcare service based on clinical priorities, different care settings and new methods of delivery, that will mean care is accessible when and where Islanders need it, will be presented to Islanders and further refined and developed as necessary. Challenges will need to be addressed, particularly around recruitment, reform of primary care services, and different ways of working with partners. Health economists will evaluate and robustly cost the strategy to ensure that the proposals are viable in terms of deliverability, sustainability and cost.

I look forward to working with fellow Ministers, Scrutiny Panels, other States Assembly Members, and stakeholders, in developing the Jersey Care Model to ensure that we can move forward with confidence in securing the best health outcomes for Islanders in the years to come.



Jersey
Care
Model

Briefing Paper

Health and Community Services

October 2019

CONTENTS

Health and Community Services Ambition and Vision	5
Our Proposed Care Model.....	6
Workstream Details.....	14
Prevention and Primary Care.....	15
Intermediate Care.....	20
Secondary Care.....	23
Mental Health.....	28
Children’s Health.....	33
Adult Social Care	35
External Partners	39
APPENDICES.....	45
Primary Care	45
Appendix 1: The Common Strategic Policy re Primary and Prevention	45
Appendix 2: Definitions.....	46
Appendix 3: Population demographics and multi-morbidity projections.....	47
Appendix 4: Strategic Aims – more details.....	52
Appendix 5: Enabling the Strategy	53
Appendix 6: Notes on Intermediate Care.....	54
Appendix 7: Primary Care pharmacists - example of value opportunity	55
Intermediate Care.....	56
Appendix 8: Intermediate Care Service Definition – High Level.....	56
Secondary Care.....	60
Appendix 9: Emergency Care.....	60
Appendix 10: Day Surgery Theatre Utilisation	66
Appendix 11: Step Down Care AND Intermediate Care	67
Appendix 12: Hospital Service Analysis.....	68
Appendix 13: Government Plan 2020-23 Business Cases.....	76
External Partners	80
Appendix 14: Background and Context.....	80
Appendix 15: Framework for partnerships with the Voluntary Sector, Private Sector and Social Enterprises	84
Appendix 16: Definitions, Acronyms and Abbreviations	97

Definitions

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

Tertiary Care	<p>Tertiary care refers to highly specialised treatment such as neurosurgery, organ transplantation, complex cancer care and secure forensic mental health services and is not available on Island</p> <p>A smaller number of hospitals in the UK provide what is called 'tertiary care', which means the third level of care. This is where hospitals, such as Great Ormond Street for children, and Southampton Neurological Centre, look after patients sent to them by other hospitals for highly specialised care. Jersey sends patients typically to the UK for most tertiary care.</p>
Social Care	<p>Care across the Island provided by either Government of Jersey, commissioned charities or private companies for those Islanders, who need additional support and assistance in order to live comfortably, for example help with washing or eating, respite services, and end-of-life care.</p>

Our ambition is aligned to the Government of Jersey's strategic priority (Common Strategic Policy 2018) to improve Islanders' wellbeing and mental and physical health.

To achieve our ambition, we will:

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

Health and Community Services Vision

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

Building on our strengths

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

Among our strengths are:

- Our committed workforce
- The breadth and depth of our services, despite the small size of our population
- Timeliness of services compared with many jurisdictions
- Our Parish system and wider community assets
- Our carers in the community
- Access to investment in health remains a strong political priority
- Our long-term care benefit scheme
- Our resilient Primary Care and the prevalence of GPs in the Island
- The unique blend of Primary and Secondary Care
- A strong culture of voluntary work.

OUR PROPOSED CARE MODEL

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

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

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

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

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

Jersey Care Model: current state assessment

Secondary Care Focused Model

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

Intermediate and Ambulatory Care

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

Prevention, Primary, Community

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

Community Care

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

Direct access services

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

Social Care and External Partners

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

Jersey Care Model

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

The model is based around these components:

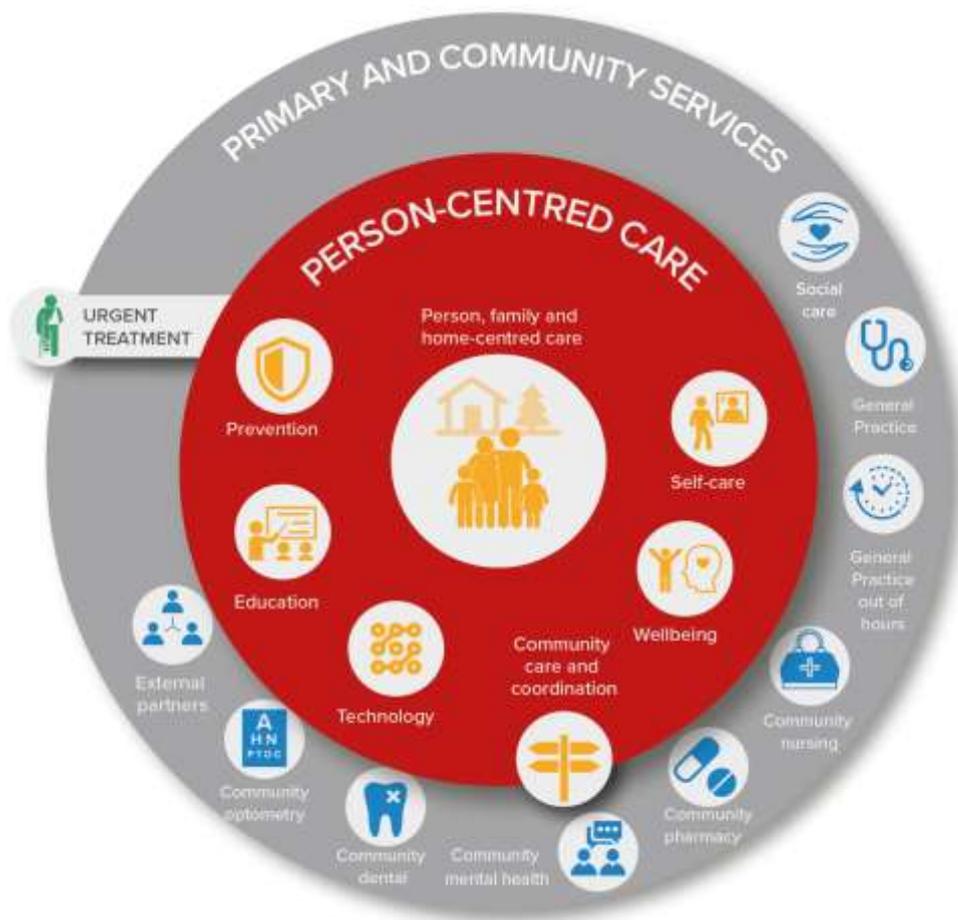
- i. Person-centred care
- ii. Primary and community services
- iii. Specialist services

Person-centred care



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

Primary and Community Care



Primary Care

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

Intermediate and Ambulatory Care

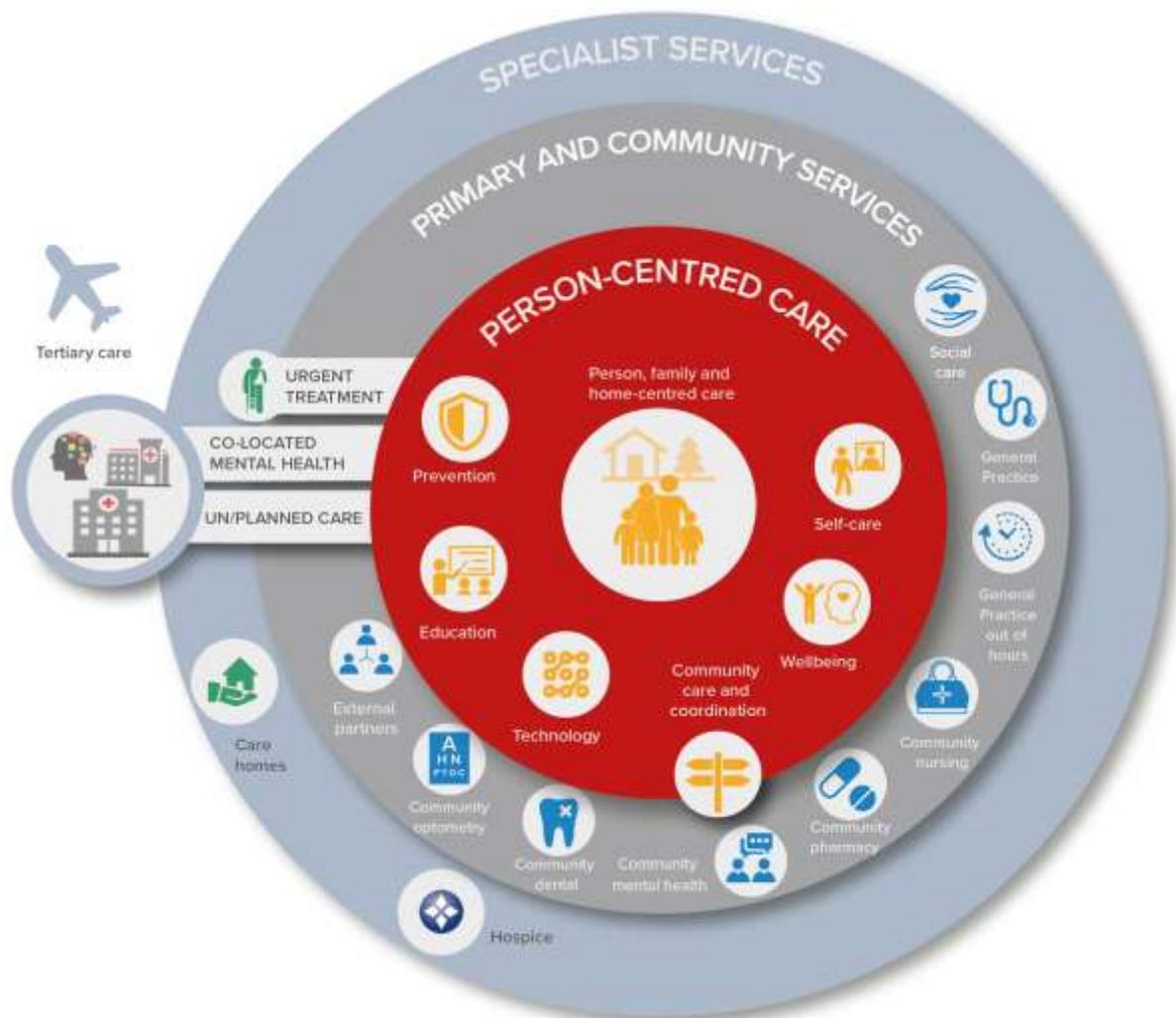
- Rapid response and reablement as default options - delivered in patients' homes, care homes or hospital
- Positive risk taking; risk assessment and planning for people to achieve their goals
- Person centred planning; maximise independence, confidence and resilience
- Focus on crisis response and home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

Social Care and External Partners

- Support independence through bespoke care packages that incorporate assistive technology

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

Specialist Services



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

KEY DIFFERENCES

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

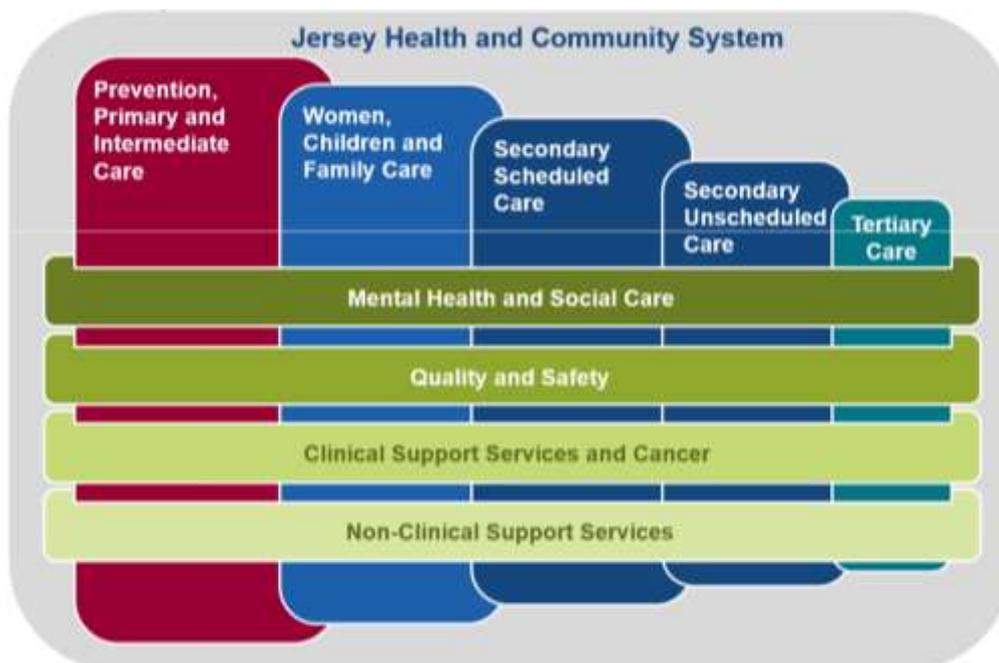
HOW WILL WE MAKE THIS HAPPEN?

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

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

HCS ORGANISATIONAL STRUCTURE

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



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

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

WORKSTREAM DETAILS

The following sections outline the proposed direction of travel for each main workstream of the Jersey Care Model.

They present an overview of our current state and highlight opportunities to develop our model of care in order to support the current and anticipated needs of islanders and to support the requirements analysis for Our Hospital.

Consideration has been given to: existing strategies, analysis of activity, a review of delivery against strategy, and opportunities to deliver services in a different way to ensure that we have a truly integrated healthcare service across Jersey.

Workstreams:

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

PREVENTION AND PRIMARY CARE INTRODUCTION

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

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

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

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

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

“Primary Health Care (PHC) is a whole-of-society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people’s needs and preferences (both as individuals and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment.

With its emphasis on promotion and prevention, addressing determinants, and a people-centred approach, PHC has proven to be a highly effective and efficient way to address the main causes of, and risk factors for, poor health, as well as for handling the emerging challenges that may threaten health in the future.”

WHO Vision for Primary Health Care 2018

OUR FUTURE CARE MODEL – STRATEGIC AIMS FOR PRIMARY CARE

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

1. Innovate and promote resources that help citizens with **self-care** for themselves, their families and loved ones to improve health outcomes
2. Expand and enhance **prevention and screening** to identify and treat risk factors, precursors and disease as early as possible
3. Improve and remove potential barriers to **access** for patients who are financially, clinically and socially vulnerable
4. Maintain the existing excellent rapid access to Primary Care services
5. Re-purpose existing Secondary Care **resources** into preventative and Primary Care services, thus reducing current over-reliance on our Secondary Care services
6. Provide and support high quality multidisciplinary care, **24 hours a day, 365 days a year** – with the right care in the right place at the right time.

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

IMPROVING ACCESS TO SPECIFIC PRIMARY CARE SERVICES FOR SPECIFIC GROUPS

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

Financially vulnerable

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

Clinically vulnerable

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

Socially vulnerable

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

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

PREVENTION AND SCREENING

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

Opportunities for expanding prevention and screening include:

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

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

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

DEVELOPING THE MULTIDISCIPLINARY WORKFORCE

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

We will consider expanded roles, including:

- **Pharmacists** – non-medical prescribing, supporting GP practices and Care Homes, funded Medication Use Reviews, preventative services
- **Nursing** – expand use of Practice Nurses, non-medical prescribing, long-term conditions management and intermediate care, prevention
- **Physiotherapy** – we will assess the viability of direct access physiotherapy for musculoskeletal conditions, increase community exercise programmes (e.g. frailty), consider non-medical prescribing if appropriate
- **Mental Health workers** – ‘There is no health without mental health’ and primary mental health care needs to be as accessible as any other – we will review primary mental health care, explore use of Primary Care mental health workers in practices, encourage

mental health first-aid at work training, and develop online cognitive behavioural therapy (CBT) delivery (GP cluster work ongoing)

- **Social prescribing** – linked with the **Closer to Home** initiative – we will build a network of community support resources, with a single point of access to multiple services based in community hubs advising on resources available – e.g. walking groups, community groups, exercise as medicine initiatives (exercise referral scheme). This will also improve support for carers.

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

FUTURE FUNDING MODELS FOR PRIMARY CARE

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

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

Funding for Primary Care services in Jersey is sourced from a combination of: service user co-payments, payments from the Health Insurance Fund (HIF), and payments from Health and Community Services (paid for by general taxation). Increased provision of Primary Care services is likely to require extra funding, repurposing of current budgets or reducing the spend on Secondary Care into the future.

Reconfiguration of current funding streams

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

Potential new funding streams

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

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

CONCLUSIONS

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

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

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

INTERMEDIATE CARE

INTERMEDIATE CARE INTRODUCTION

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

CURRENT POSITION

The current position on the island is as follows:

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

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

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

FUTURE STATE

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

Key Service Attributes for Jersey

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

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

We expect the service to provide:

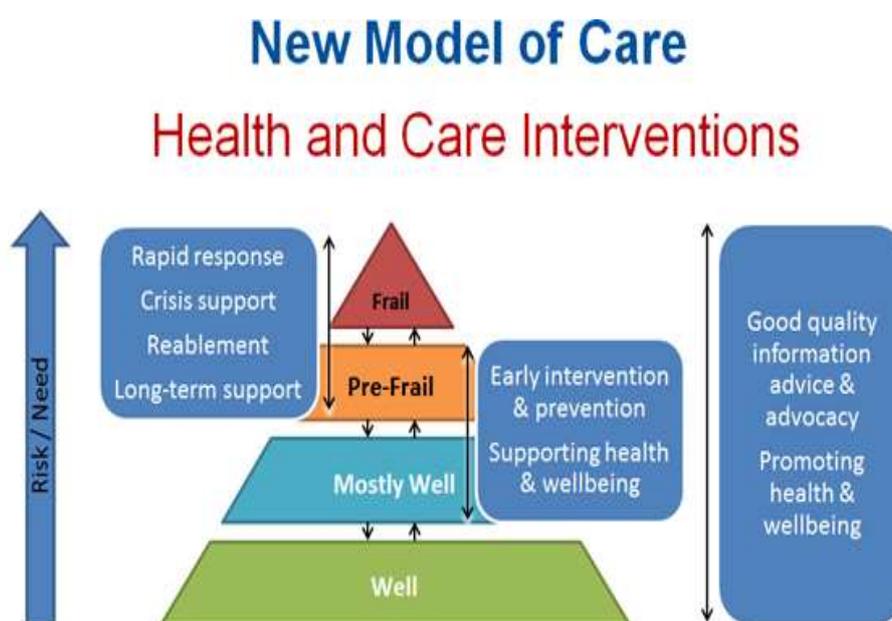
- Urgent Rapid Response (Nursing Assessment and Support - Intervention)
- Urgent Social Care Assessment and Support – Care direction
- Urgent Therapy Assessment and Support (Physio and / or Occupational therapist) – equipment and support
- Rapid deployment of Reablement support or enhanced care at home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

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

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

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

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



Key expectations of the service

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



SECONDARY CARE

SECONDARY CARE INTRODUCTION

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

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

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

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

CURRENT STATE AND KEY ISSUES

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

- The current acute hospital/Secondary Care system cannot be sustained in the existing hospital building, and, there is clear recognition that the original 'Case for Change' for a new hospital remains
- The current service reflects that of a small 'District General Hospital' which doesn't necessarily match the demographic pressures the Island faces. The previous OBC for the Future Hospital determined more beds would be required to meet the needs of the ageing demographic, but, modern health and care strategy would determine that institutional bed-based services are not always the best solution for these pressures. We believe the future model of Secondary Care should not mirror the NHS District Hospital specification and should reflect more modern and international concepts for Hospital services
- The model of care for the Island is currently over reliant on 'beds' both in and out of hospital
- The current service has workforce and operational challenges

- The system is not digitally optimised
- Mental Health has not been considered to be in scope previously, but we believe it is integral to the future state
- Optimising truly integrated physical, mental and social care services has not been considered enough in future physical capacity requirements of the new hospital. In determining future hospital needs there must be interrogation across the entirety of the health and care system and its strategic capability.

The clinical and professional leadership teams across HCS believe the model of care delivery in Jersey needs to change. In essence, our system of healthcare has focused on an over reliance of bed-based care within institutional care settings from Hospital to Residential and Nursing care. Given the most significant demographic of health care utilisation is among our older population it is therefore important that our system of care reflects this need.

FUTURE STATE: SECONDARY CARE MODEL

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

The **Front Door of the Hospital** will require an Emergency Care Centre that provides all of the existing Urgent and Unscheduled Care access.

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

An **Acute Paediatric Assessment Unit** should be provided in a co-located Emergency Care setting, this should include shared care facilities for CAMHS (Child and Adolescent Mental Health Services) patient pathways.

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

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

Inpatient capacity (the number of beds) need to be set to trajectories of need based on effective integrated care pathways. Our initial evaluation indicates that there should be no increase in bed base beyond the current position. We are anticipating a range of 150-210 beds, but further modelling is required. This is a smaller bed base than the previous scheme

at around 280 beds. The clear rationale for this change is that the demographic growth outlined in the previous OBC should have targeted Out of Hospital services as an alternative to bed-based care. The assumptions also identified the existing and future hospital bed base can be further optimised by an improvement in Length of Stay and more focus on Ambulatory assessment and admission avoidance schemes.

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

Infection Prevention and Control compliance with isolation capacity will need to be maintained and we believe the previous concept of adaptable wards to ensure sufficient cubicle capacity that includes flexibility to open bays is the best option for the new Secondary Care facility.

Specialist functions such as theatres, cardiology, renal, pain services etc. will be set to effective clinical pathways based on island need and so we would anticipate **increased day surgery and endoscopy capacity** based on current disease prevalence analysis.

An Integrated Care Hub model will ensure the continuity of care required within the health and care system. This will ensure we have efficient planned care services that connect Primary and Secondary Care and so replacing traditional outpatient services.

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

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

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

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

The hospital must be digitally optimised.

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

KEY DIFFERENCES TO PREVIOUS FUTURE HOSPITAL PLAN

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

Key differences:

- The bed base of the Hospital would remain a similar level to current state and be circa 80 beds fewer than proposed in the previous OBC.
- Services such as Physiotherapy, Podiatry, Long Term Condition Management can be partially or fully provided in an alternative care setting outside the Hospital including home focused community care. Any re-provision outside the future hospital would need to ensure the de minimus of the hospital isn't compromised so that the facility is able to run in the most efficient way.
- The Outpatient service is proposed to operate in a different way by adopting virtual Hubs for specialist advice and guidance and continuity in care that connects the entirety of the health and care system. The new approach for planned care management and in particular chronic disease management would see the previous 'Westaway Court' concept removed from future plans. The activity planned within the Westaway court concept is believed to be adaptable and more appropriate for Primary Care services with close connectivity to specialist Secondary Care via a 'virtual Hub' concept, with Secondary Care clinicians providing advice and guidance to Primary Care.
- Capacity in the future building should be modular in nature so that clinical environments can be adapted to reflect demographic pressure areas such as gastroenterology, renal or cancer services for example where increased capacity may be needed. The environment should also be flexible enough to adapt to future care innovation for increased day surgery and non-invasive procedures, which can result in requiring fewer inpatient beds.
- The new facility should be co-located with a small inpatient mental health unit (Campus model) so that services can be closer integrated. This will ensure clinical and non-clinical support services are concentrated in one campus rather than spread across the Island as they are currently.
- The new facility needs greater ambition for digital optimisation than the previous scheme, which is again anticipated to impact on the physical scale and requirements of the Hospital.
- The new facility needs to operate with confidence that out of hospital primary, community, social and intermediate care services are managing increased activity, therefore protecting the Acute Hospital capacity for true hospital-based care need.

SECONDARY CARE CONCLUSION

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

The revised Acute Services Strategy would envisage;

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

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

MENTAL HEALTH

MENTAL HEALTH INTRODUCTION

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

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

VISION

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

KEY ISSUES

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

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

PLANS

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

Over the next five years we will:

- Review and manage our capacity and demand for care by redesigning our mental health care system
- Develop community-based alternatives to hospital-based care and offer timely integrated crisis care and support over a 24-hour period.
- Significantly improve the safety and effectiveness of services using data and evidence to drive quality improvement and optimal performance
- Invest in Primary Care led mental health and focus on preventing mental ill health as well as intervening early to give people the best chance of recovery
- Work with local communities and a range of partners to promote social justice and expand capacity for recovery-oriented care and support (e.g. housing, employment, social support)
- Invest in digital solutions which can transform the care experience and bring therapeutic benefits to all ages and complexities
- Stabilise our workforce by investing in people with relevant experience, knowledge, skills and competence who are committed to Jersey and can work together to make the best use of the talent and resources available on the Island
- Enhance the fabric and design of our facilities
- Listen to and value the experience of those with lived experience and work with them to improve our mental health system through co production and service evaluation
- Embed an organisational culture that embraces all of the above values in the systems, processes and institutions within our island community.

TRANSFORMING OUR CARE OFFER

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

Person centred care, shaped (importantly) by the experience of those who live with mental illness is at the heart of this transformative process and is the means by which people are helped and supported as an equal partner in their own care to recover and regain their usual life. We know better outcomes are achieved when services are community based, recovery oriented, integrated and evidence based and when the system of care embraces the principle of co-production¹ and partnership.

¹ Co-Production: *When an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered (Care Act 2014 – Department of Health UK)*

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

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

STRATEGIC AND IMPROVEMENT OBJECTIVES

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

(A) STABLE AND HIGH PERFORMING WORKFORCE

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

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

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

(C) PREVENTION AND EARLY INTERVENTION

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

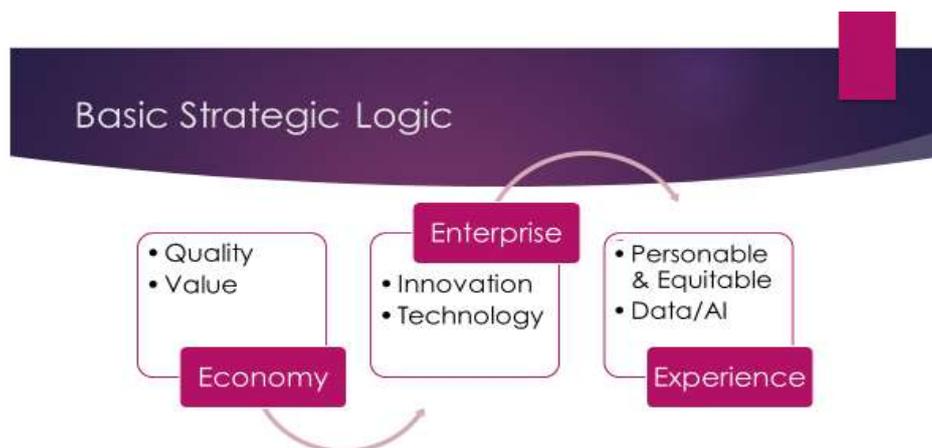
(D) APPROPRIATE ENVIRONMENT AND FACILITIES

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

(E) CUSTOMER-FOCUSED DELIVERY

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

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



We plan to shape the economy of our resources and transition these in ways that remove inefficiency and ineffectiveness to deliver real improvement in the quality and value of the service we offer. We will be enterprising and constantly seeking new ways of working to improve our productivity and deliver good care. Our ambition is to deliver a care experience that is timely, personable and equitable, shaped, informed and influenced by advances in technology and innovation, relevant evidence and the experience of those who use services. The dimensions of our work will include:

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

INPATIENT SERVICES

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

MENTAL HEALTH CONCLUSION

The statement “Without mental health there can be no true physical health”² was made by the first Director General of the WHO over half a century ago. In 2011 the UK Government adopted “no health without mental health” as the starting position to develop their strategic ambition to mainstream mental health care in England. A change never seen before was evident in this strategy - the focus on outcomes and the importance of public health and social justice as the cornerstones of better mental health. In Jersey, we have set out our own immediate outcomes and pursuing these until we start the refresh our strategic ambition from 2020 and beyond.

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

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

In essence, HCS has concluded that we will require;

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

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

² *No Health without Mental Health* UK: a cross government mental health outcomes strategy for people of all ages (Department of Health, February 2011)

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

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

As part of the Government Plan HCS has submitted a number of business cases outlining strategic intent for adult, child and adolescent mental health services.

CHILDREN'S HEALTH

Children and Young People's Plan

The Children and Young People's Plan 2019-23 is a fundamental new plan for Jersey's children, young people and families, which aims to make sure Jersey is the best place to grow up and also improves everyday lives. The Government of Jersey has developed the plan to achieve better outcomes for children and young people so that they have the brightest futures possible.

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

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

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

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

Ambition

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

Why?

Good health is an essential foundation for children's quality of life. Often healthy behaviours (e.g. a balanced diet, regular exercise avoidance of tobacco and alcohol) established in childhood can last into adulthood and reduce the chances of developing a chronic condition later in life. There can be no health without mental health, yet demand for child mental health

services are continuing to increase. Timely access to health services is important in securing a healthy start to life. In addition, wider factors such as good quality housing, active transport, and access to parks and countryside are recognised as having a key role to play in supporting healthy childhoods.

Key policy areas

- Public Health Strategies
- Mental Health Strategy
- Disability Strategy
- Sustainable Transport Policy
- St Helier Masterplan
- Primary Care Strategy
- Open Space Strategy
- Culture Strategy

HOW WE WANT TO MAKE A DIFFERENCE	KEY INSIGHTS
Increase the number of Year 6 pupils who are a healthy weight	<ul style="list-style-type: none"> • Average BMI has stayed the same since 2011 but hides variations • Cost of fresh food is higher than processed alternatives - impacting low incomes families • High employment rates challenge family and work-life balance • Variation in exercise and fresh food consumption can be shown according to ethnicity and school • Rates of breastfeeding initiation are lower than European average but similar to England's average
Increase the number of two-year olds who reach their developmental milestones in all domains	<ul style="list-style-type: none"> • Percentage of two-year olds reaching their developmental milestone is already good • Delay in communication domains are the most common factor in a child not reaching their milestones locally • Parenting and home learning environment critical to achieving developmental goals • The new Early Years Quality Framework was introduced in September 2018
Reduce the number of under 18s who require a dental extraction	<ul style="list-style-type: none"> • Increasing number of children in the Community Dental Service seen for teeth extraction • Timely access to the Community Dental Service is a key issue • Children who attend States primary schools, are of Portuguese ethnicity or who live in single parent households were least likely to have visited a dentist in the previous year
Increase the number of pupils who report they have a good quality of life	<ul style="list-style-type: none"> • Jersey children's 'Health Related Quality of Life' score is slightly lower than European average • Increasing trend over years on low levels of self-esteem among young people • 13% of Jersey children lived in households below relative low-income threshold. 44% of single-parent households find it difficult to cope. • Access to communal spaces and social/recreational activities likely to be key factors in reporting a good quality life.

CONNECTING CARE FOR CHILDREN

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

Our model will have key components:

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

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

We will also work closely with our partners in Children, Young People Education and Skills (CYPES) to support the wider Government agenda on delivering preventative services.

This will build on our 'Early Help' approach and will ensure that our functions and services are closely aligned to the wider children's services across the Island.

A key area of focus for HCS and CYPES will be to improve care and support for Child and Adolescent Mental Health services in Jersey and both departments have a role to play in driving better early intervention and improved access for services.

ADULT SOCIAL CARE

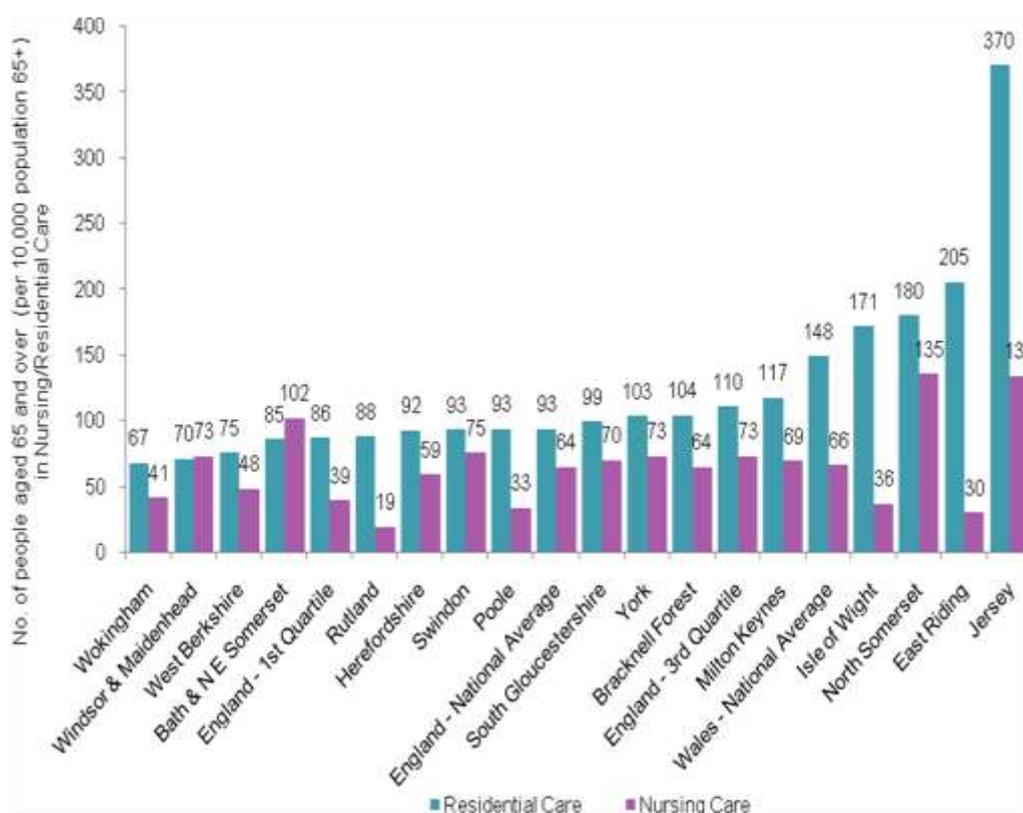
Health spending has risen steadily over the past three decades and has accelerated since the turn of the century to average 8.83% of Gross Domestic Product (GDP) for countries that were members of the Organisation for Economic Co-production and Development (OECD).

³ <http://www.oecd.org/els/health-systems/health-data.htm>

It is anticipated that if no specific policies are employed to move away from current trends the health sector spending is projected to rise to nearly 14% of GDP by 2060⁴.

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

Jersey has an ageing population like many jurisdictions and to support people we need to be innovative and change our current model of delivery which is not sustainable. If we consider the below diagram we can see that our use of residential beds has been significantly higher than anywhere in the UK. Unless we change direction, these pressures will impact the entire Jersey economy.⁵



We will need to work in partnership with Customer and Local Services (CLS) to reduce the pressure on the Long Term Care (LTC) fund to develop the introduction of personal budgets which will increase the range of services available to support people in the community as well as increasing the number of people who can be paid carers. £46.97m paid to support 1,320 people in long term care. 85 people were supported each month (on average) to continue living at home with a domiciliary care package, where the individual needs are particularly complex, and costs exceed the Long Term Care Benefit.

HCS also spend around £5.8m annually on packages of care and respite that do not meet the criteria for the Long Term Care fund.

⁴ <https://www.oecd.org/economy/health-spending.pdf>

⁵ July 2019 -1002 residential and nursing beds – 3% capacity

SOCIAL CARE PERSONALISATION

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

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

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

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

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

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

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

Personalisation and service users and carers

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

purchasing services to meet needs – are all transformed through personalised care. This will call upon other professionals of course in determining more complex needs and in assessing and supporting those needs.

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

EXTERNAL PARTNERS INTRODUCTION

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

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

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

CURRENT POSITION

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

A KPMG report in 2016: *The Jersey Charity Survey*⁶ highlighted the following;

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

There is a great opportunity in Jersey to create a different system wide approach that builds on the strengths of this sector through a transparent partnership approach to drive improvement in health and social care across the whole population. The case for change is clear and the need to direct people's attention to what's important without introducing

⁶ <https://www.jerseycommunitypartnership.org/media/1022/survey-final.pdf>

complexity into the system will require a different relationship. However, there are a number of areas that can be developed to improve how we support people across the community, such as;

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

OPPORTUNITIES

Our partner organisations are ideally placed to support a new and innovative system of health and social care. From supporting homeless people who are 60 times more likely to visit the Emergency Department in a year compared to the general population⁷ to access the support they need through to reducing the unnecessary length of stay for some patients in hospital by providing care and support in people's homes through an agile intermediate care offer.

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

CARE CLOSER TO HOME

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

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

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

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

⁷ https://www.theguardian.com/society/2019/jul/02/homeless-people-60-times-more-likely-visit-ae-study?CMP=share_btn_link

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

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

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

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

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

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

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

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

Initial Feedback

Jersey Library - Children’s session:

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

“I didn’t know you did e-magazines, that’s really useful, I’ll have a look”

“Fantastic idea having you here”

Jersey Library - Adult Session:

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

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

Citizens Advice Jersey

“This is fantastic! I can now get this sorted without having to go to town, thanks for the advice”

Jersey Sport, David Kennedy (General Manager)

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

Social Work, Kate Profitt (Social Worker)

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

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

COMISSIONING FRAMEWORK

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

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

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

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

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

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

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

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

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

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



EXTERNAL PARTNERS CONCLUSION

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

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

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

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

PRIMARY CARE APPENDICES

[>>> Click here to return to Primary Care section](#)

APPENDIX 1: THE COMMON STRATEGIC POLICY RE PRIMARY AND PREVENTION

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

Five strategic priorities were identified

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

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

APPENDIX 2: DEFINITIONS

[>>> Click here to return to Primary Care section](#)

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

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

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

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

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

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

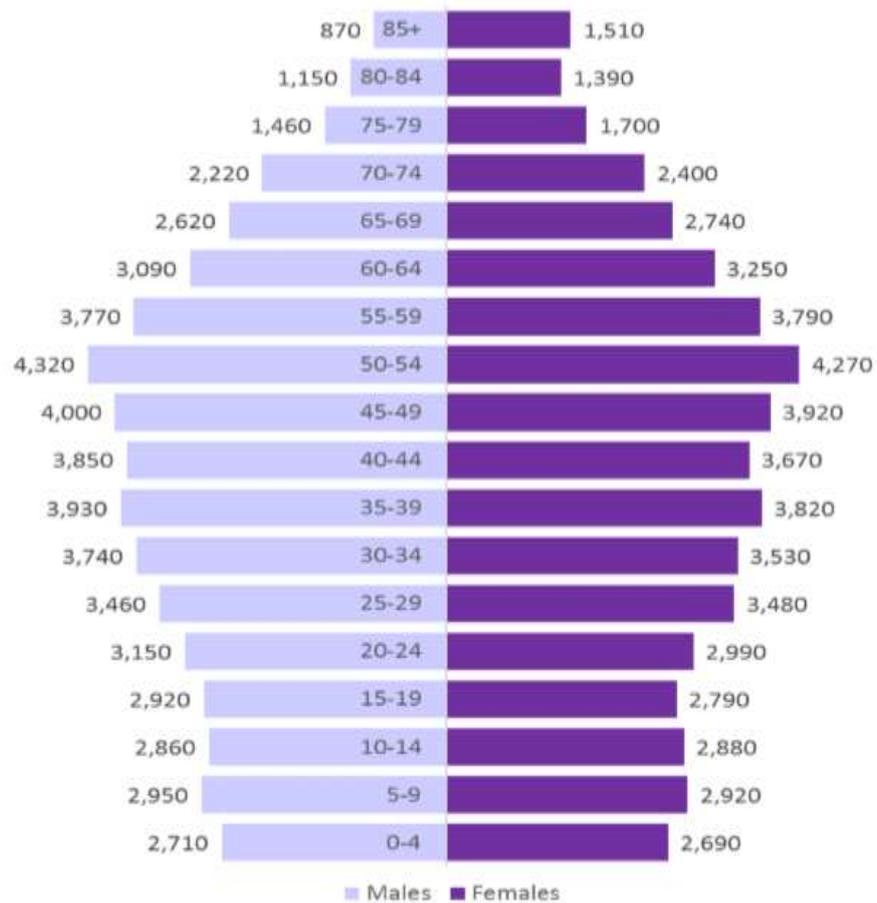
Primary Care: Primary care in Jersey consists of general practice services, community pharmacy, dentistry and optometry. Primary care plays a crucial role in delivering core health care services while having responsibility for referrals to help patients gain access to a large range of other healthcare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

APPENDIX 3: POPULATION DEMOGRAPHICS AND MULTI-MORBIDITY PROJECTIONS

[>>> Click here to return to Primary Care section](#)

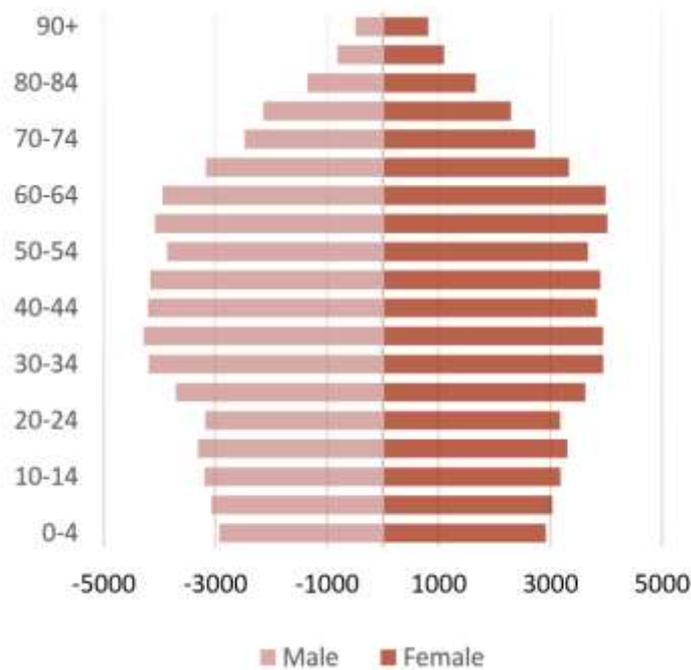
In the next decade Jersey will face a growing and ageing population, a rising tide of chronic illness, higher expectations of care from the next generation, and the availability of new treatments and technologies.

The resident population of Jersey at year-end 2018 is estimated as 106,800. Estimates of the distribution of people in each age and gender group is demonstrated as follows:



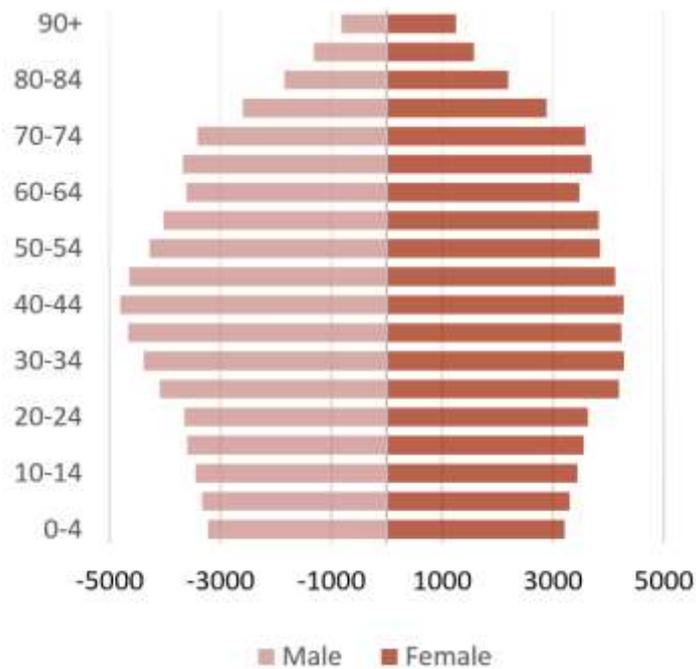
Jersey Resident Population 2018 Estimate, SJ

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



Jersey Resident Population 2026 Estimate, SOJ

By 2036, the population increases by another 11%, to 130,000. Around one in five (22%) of the population would be aged 65 or over.



Population Projections 2016-2036 PHSU, SOJ

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

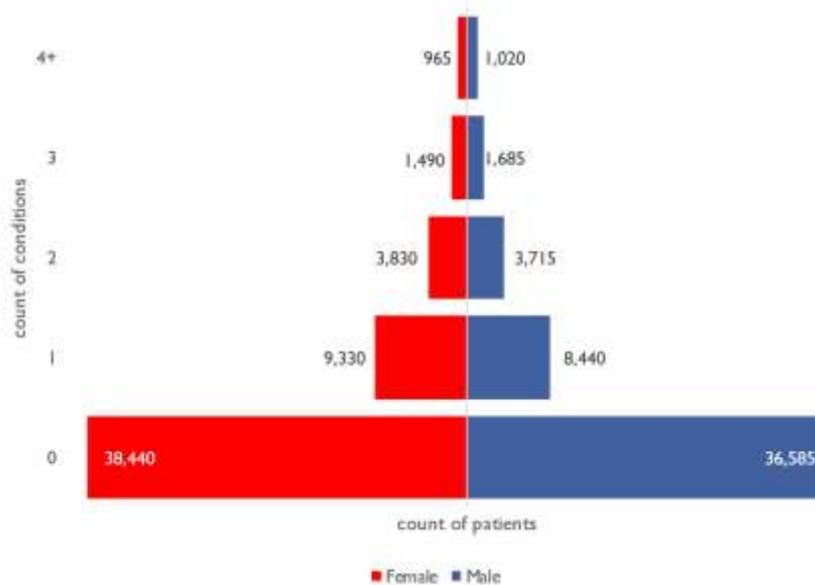
The projected increase in population size and change in its age profile will be reflected in an increase in GP consultations:

- It is estimated that there will be an additional 70,000 GP consultations each year by 2026, bringing the total to 502,000 (an increase of 16%)
- by 2036, it is estimated there will be an additional 143,000 consultations compared to 2016 (an increase of 33%) bringing the number of consultations to 575,000 per year⁸

Figures from the General Practitioner Central Server (GPCS) showed 105,490 people as registered with a Jersey GP and active on 31 December 2017.

An analysis of the numbers of patients with 13 identified long-term conditions was conducted by Statistics Jersey, including the 12 long-term conditions recorded as part of the Jersey Quality Improvement Framework (JQIF) and cancer (with the exception of non-melanoma skin cancer).

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



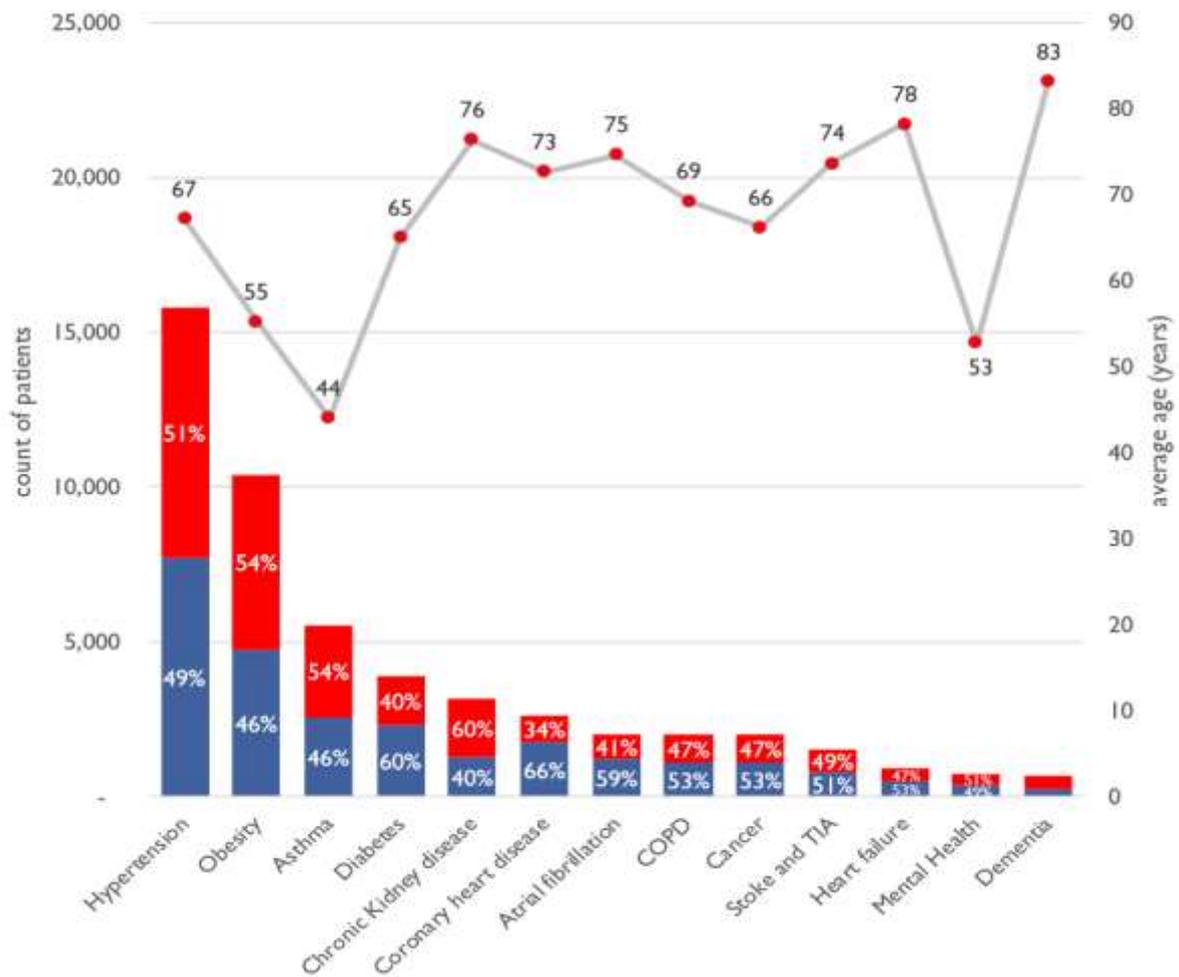
Progressively fewer patients had a higher number of the conditions:

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

⁸ Disease Projections 2016-2036 PHSU, SOJ

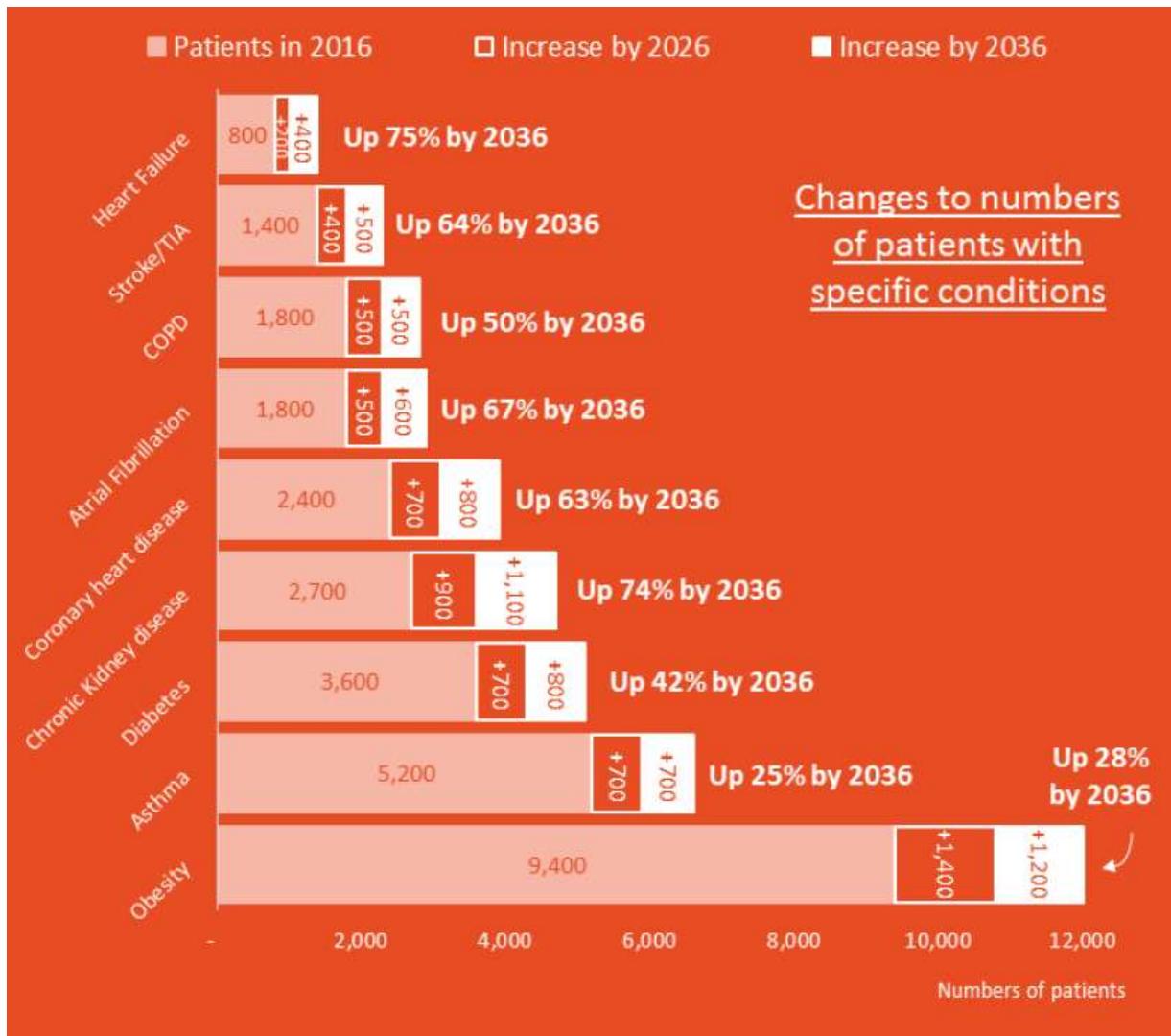
The graph below shows the count and average age of Jersey GP patients with each type of morbidity (note: patients with multi-morbidity are linked to more than one condition)⁹:

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



⁹ Prevalence of health conditions in Jersey and their multi-morbidity, SJ 2018

By 2026 and 2036 there are significant projected increases in patient numbers for many of these conditions¹⁰:



Disease Projections 2016-2036, SJ 2016

¹⁰ Disease Projections 2016-2036 PHSU, SOJ

APPENDIX 4: STRATEGIC AIMS – MORE DETAILS

[>>> Click here to return to Primary Care section](#)

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

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

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

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

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

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

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

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

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

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

APPENDIX 5: ENABLING THE STRATEGY

[>>> Click here to return to Primary Care section](#)

DIGITAL CARE

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

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

WORKFORCE PLANNING, EDUCATION AND TRAINING

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

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

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

GOVERNANCE

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

APPENDIX 6: NOTES ON INTERMEDIATE CARE

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

Expand our hospital-at-home/Rapid Response service

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

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

Expand our re-enablement/frailty service

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

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

APPENDIX 7: PRIMARY CARE PHARMACISTS – EXAMPLE OF VALUE OPPORTUNITY

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

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

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

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

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

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

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

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

References

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

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

[>>> Click here to return to Primary Care section](#)

INTERMEDIATE CARE

APPENDIX 8: INTERMEDIATE CARE SERVICE DEFINITION – HIGH LEVEL

[>>> Click here to return to Intermediate Care section](#)

Key Service Attributes for Jersey

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

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

We expect the service to provide:

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

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

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

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

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

New Model of Care

Health and Care Interventions



Key Expectations of the Service

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

NICE Definition (for reference)

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

Intermediate care

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

Bed-based intermediate care

Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care

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

Crisis response

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

Home-based intermediate care

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

Home care

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

Person-centred approach

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

Positive risk taking

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

Reablement

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

Core principles of intermediate care, including reablement

Ensure that intermediate care practitioners:

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

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

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

Intermediate care practitioners should:

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

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

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

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

SECONDARY CARE APPENDICES

APPENDIX 9: EMERGENCY CARE

[>>> Click here to return to Secondary Care section](#)

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

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

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

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

Perhaps what is most striking about the ED attendances is the case mix. Figure 1B demonstrates the acuity of ED attendances (by Manchester triage category – Figure 1A) at JGH in 2018. Grouping all P1, 2 and 3 attendances as ‘majors’ and all other activity as ‘minors’ demonstrates as 63% Minor: 37% Major split in acuity.

When compared to the NHS type 1 Emergency Departments the split is 62% Major: 38% minor.

FIGURE 1A: MANCHESTER TRIAGE CATEGORIES

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

FIGURE 1B: JGH ACUITY BREAKDOWN (L) v NHS TYPICAL ACUITY BREAKDOWN (R)

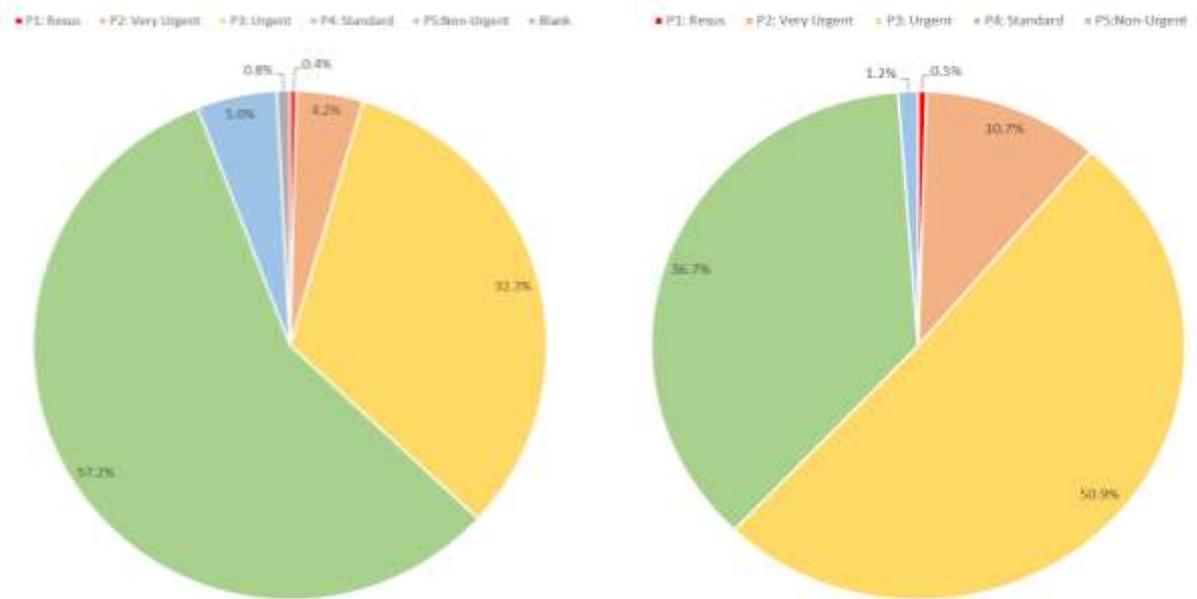
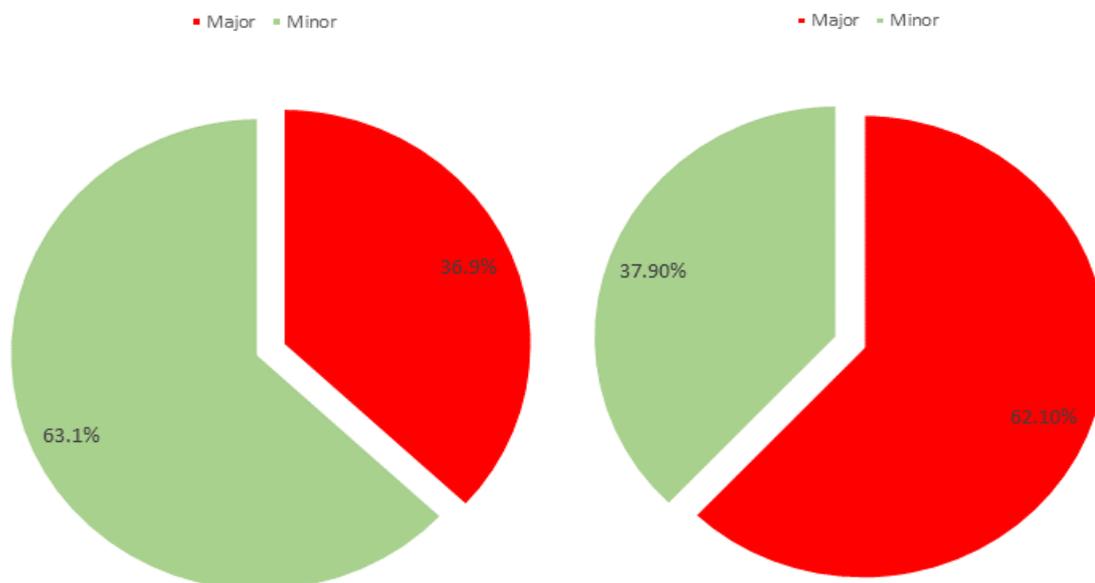


FIGURE 1C: JGH MAJOR/MINOR BREAKDOWN (L) v NHS TYPICAL MAJOR/MINOR BREAKDOWN (R)



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

FUTURE MODEL CONSIDERATIONS

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

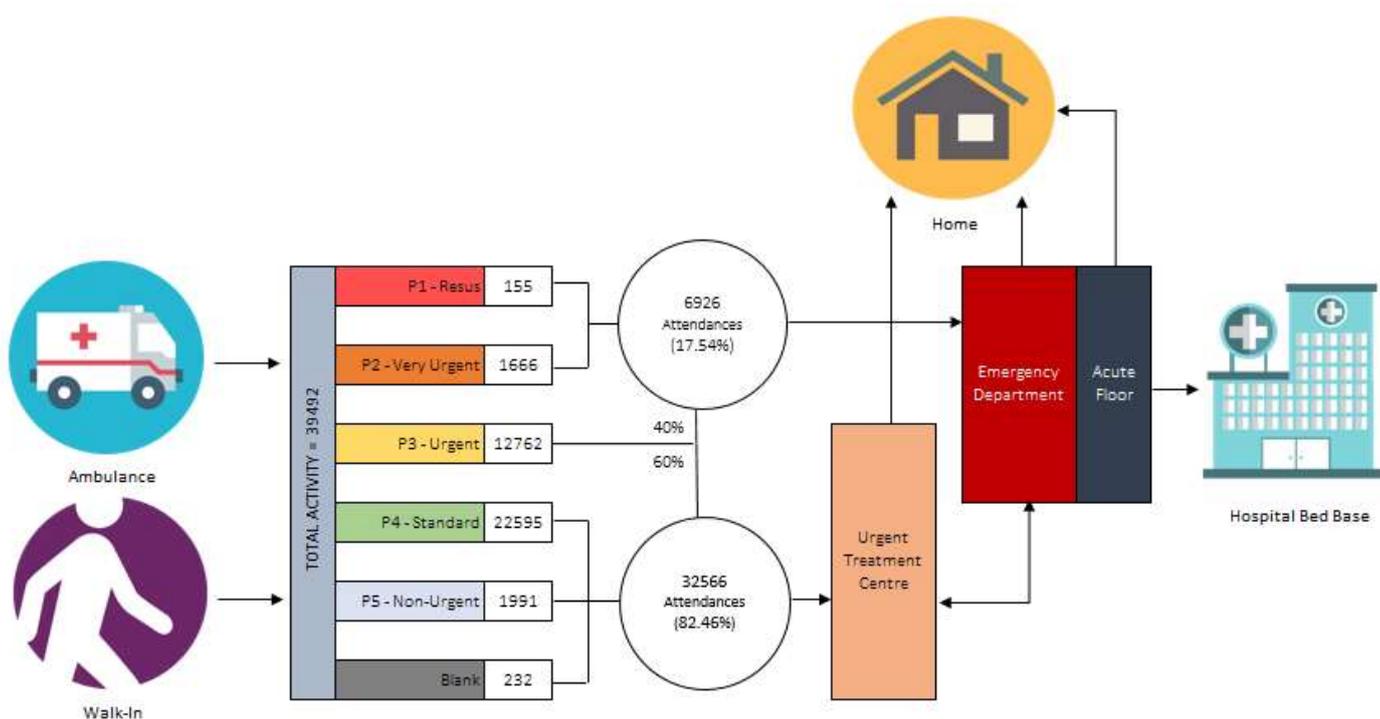
Non-urgent and standard activity which is a significant part of the current volume of patients could be managed within an urgent care centre that is closely connected to the Emergency Care department. The Urgent Care Centre (UCC) will need careful consideration in relation to policy as a high volume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

In terms of workforce requirements, we would envisage;

- The need for specialist Emergency Department medical staffing
- A stronger emphasis on Emergency Nurse Practitioners and enhanced Reregistered Nurse roles
- A stronger emphasis on Multi-Professional teams such as Physio's, Social Workers and Occupational Therapists

- GPs and Acute Care Physicians should be considered for part of the model, particularly GPs for the UCC element
- Care of the Elderly physicians are needed to support the high volume of older demographic activity
- Near testing and diagnostic support staff will be needed
- Mental Health liaison practitioners – Medical and Nursing will be required
- The role of the Health Care Assistant in Emergency Care needs to be expanded and optimise.

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



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

1. Admission avoidance
2. Length of stay reduction

Admission avoidance

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

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

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

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

Length of stay (LoS) reduction

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

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

FUTURE MODEL CONSIDERATIONS

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

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

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

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

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

APPENDIX 10: DAY SURGERY THEATRE UTILISATION

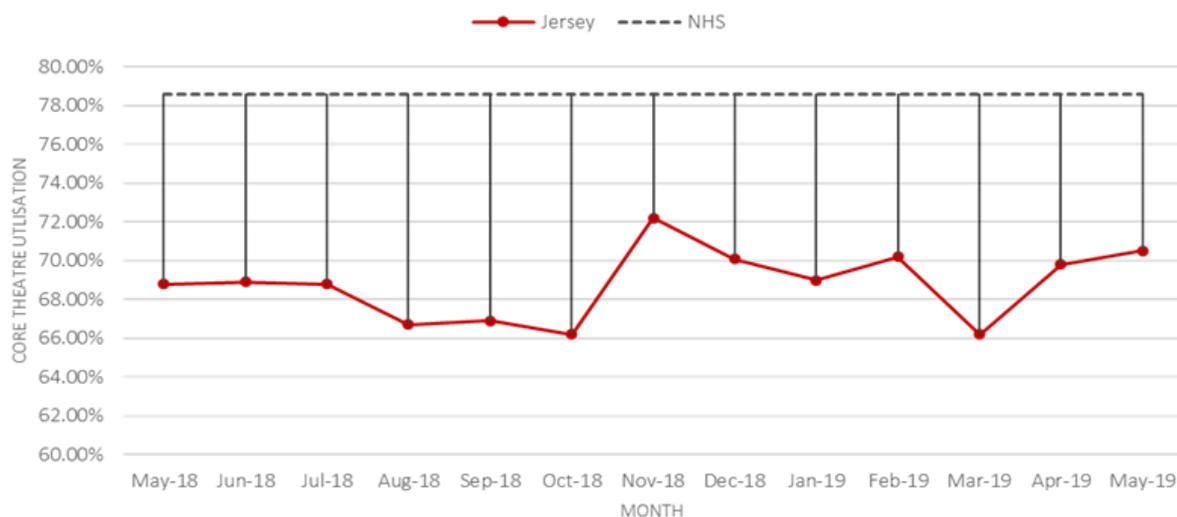
[>>> Click here to return to Secondary Care section](#)

Analysis of 2017 data suggests that we are not maximising the opportunity to perform day case procedures. In 2017, 1,824 out of 2,792 procedures were completed as a day case; this equates to 65%. The overall BADS target for day case surgery is 86%. It is recognised that where clinically appropriate, patient experience and outcome is enhanced when surgical procedures are delivered as day case wherever possible, reducing patient's length of stay and exposure to Hospital acquired infections.

THEATRE UTILISATION

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

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



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

APPENDIX 11: STEP DOWN CARE AND INTERMEDIATE CARE

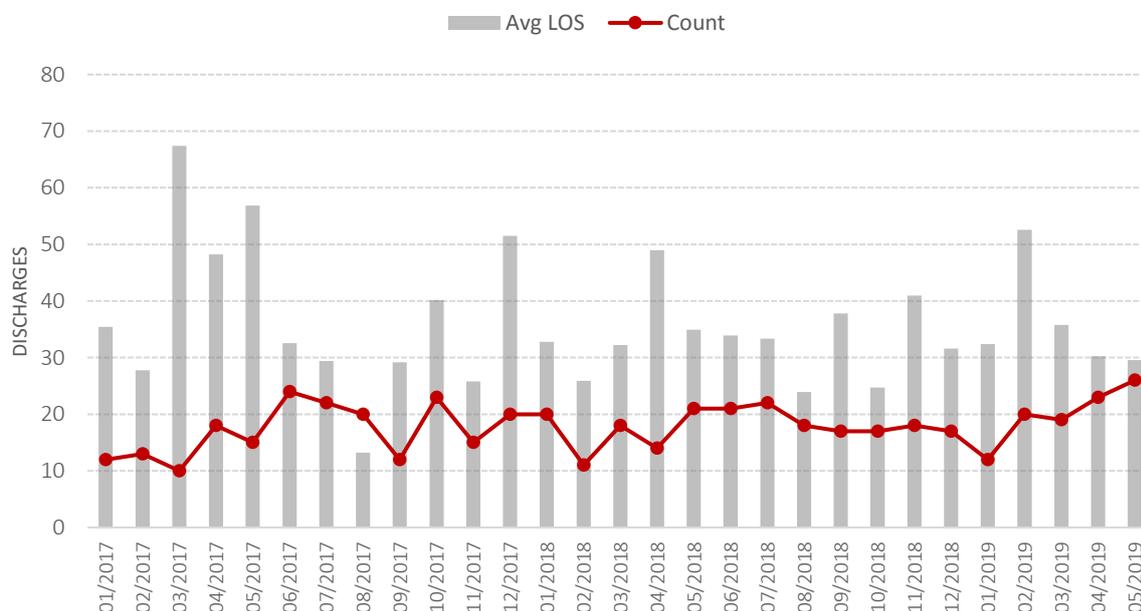
[>>> Click here to return to Secondary Care section](#)

Analysis of Samares ward has been completed for the period 2012-2018.

In 2017, Samares discharged 204 patients with an average LOS of 37.1 days at a cost of £5,868,757.52 (average cost per discharge = £28,768.42). Our rehabilitation resource across therapies is significant but care is predominantly protocol driven and patients are treated according to rota treatment, not necessarily need.

The significant resource available for therapeutic rehabilitation does not seem to result in a corresponding reduction in length of stay as a result of therapeutic input.

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



APPENDIX 12: HOSPITAL SERVICE ANALYSIS

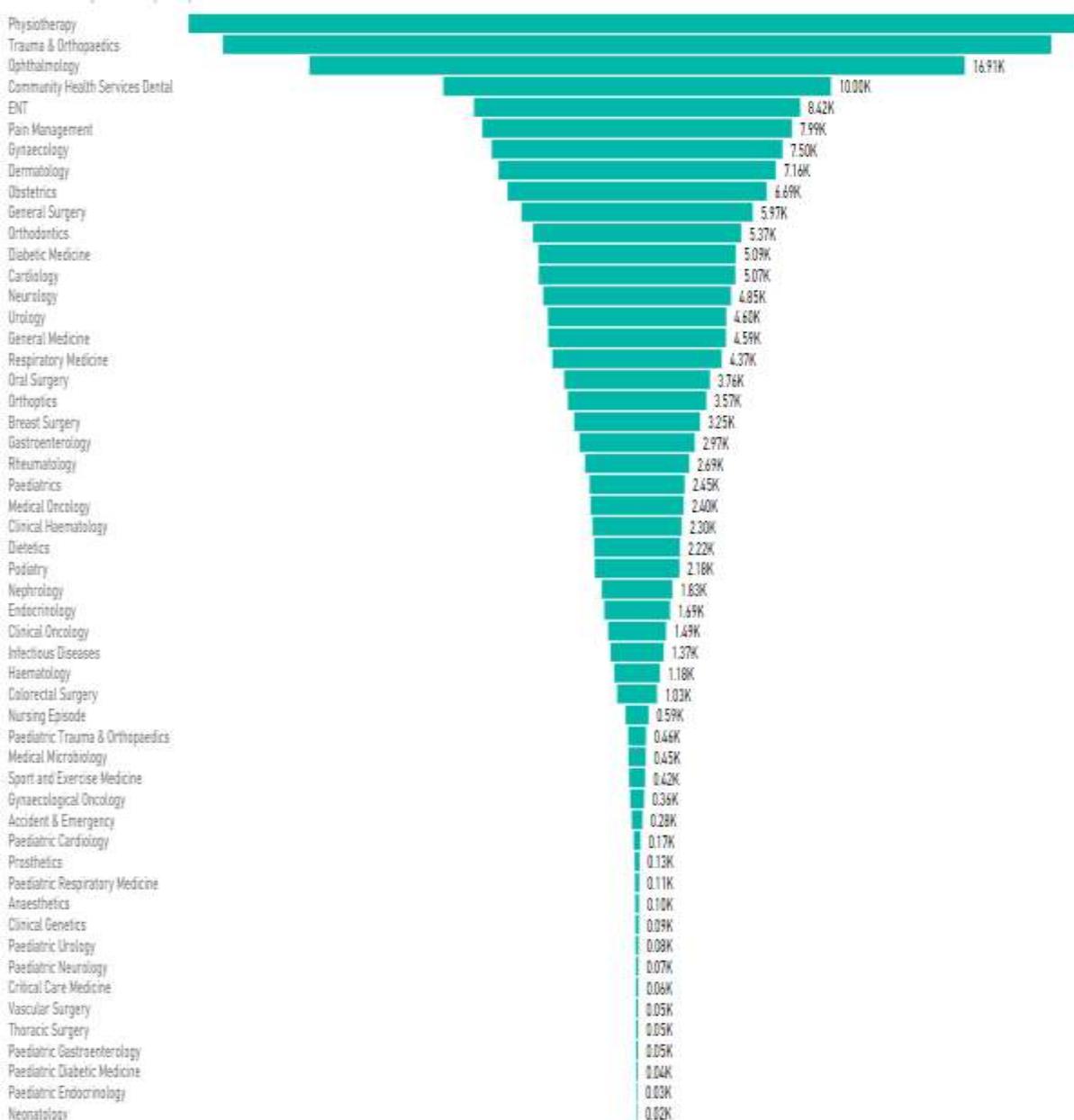
[>>> Click here to return to Secondary Care section](#)

INTRODUCTION

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

Figure 1 below demonstrates this activity split by speciality.

Figure 1: 2018 Total Outpatient Activity at JCH and Overdale Split by Speciality



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

TOP FIVE SERVICE REVIEW

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

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

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

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

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

Overall the opportunity above would see a 23.1% reduction in Trauma and Orthopaedics outpatient activity totalling 4,929 appointments.

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

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

Community Health Services Dental: Community Health Services Dental represents 5.3% of all outpatient activity with 10,000 appointment in 2018. The bulk of this activity is routine dental appointments and procedures for children aged 12 or below. The review of this activity with the AMD demonstrated that 90% of all the outpatient activity can be provided by community dental practice outside of the hospital setting.

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

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

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



TRAUMA & ORTHOPAEDICS

TOTAL ACTIVITY 21373 / 189071 (11.3%)

SERVICE TO MOVE OUT

1. DRESSING CLINICS	TOTAL	75%
Orthopaedic Dressings Clinic	740	555
Orthopaedic Dressings	1358	1019
A&E Nurse Led Dressings Clinic	1190	893
Grand Total	3288	2466

SERVICE OPTOMISATION

1. PRE-ASSESSMENT (One Stop)	TOTAL	90%
Orthopaedic Pre-Admission Clinic	1271	1144
DSU Orthopaedic Pre-Admission Clinic	241	217
Grand Total	7005	4929.3 (23.1%)



COMMUNITY HEALTH SERVICES DENTAL

TOTAL ACTIVITY 10,000 / 189071 (5.3%)

SERVICE TO MOVE OUT

1. DENTAL SERVICE	TOTAL	90%
90% of all outpatient activity	10,000	9,000
Grand Total	10,000	9,000



EAR, NOSE & THROAT

TOTAL ACTIVITY 8,420 / 189071 (4.6%)

SERVICE TO MOVE OUT

1. Suction Clinic	TOTAL	100%
ENT Microsuction Clinic	790	790
Grand Total	790	790

SERVICE OPTOMISATION

1. PRE-ASSESSMENT (One Stop)	TOTAL	90%
Nurse Led ENT Pre-assessment Clinic	117	105
ENT Nurse Pre-Op Assessment Clinic	80	72
ENT Pre-Admission Clinic	13	12
Grand Total	210	189
Grand Total	1000	979 (11.6%)



GENERAL SURGERY

TOTAL ACTIVITY 5969 / 189071 (3.2%)

SERVICE TO MOVE OUT

1. DRESSING CLINICS	TOTAL	75%
Nurse led wound dressing clinic	258	194
Grand Total	258	194

SERVICE OPTOMISATION

1. PRE-ASSESSMENT (One Stop)	TOTAL	90%
1. PRE-ASSESSMENT (One Stop)	814	733
Grand Total	1072	927 (15.5%)



OPHTHALMOLOGY

TOTAL ACTIVITY 16912 / 189071 (8.94%)

SERVICE TO MOVE OUT

1. SCREENING	TOTAL	100%
Eye Screening Clinic	730	730
Grand Total	730	730

SERVICE OPTOMISATION

1. PRE-ASSESSMENT (One Stop)	TOTAL	90%
Ophthalmology Pre-Admission Clinic	580	522
Grand Total	580	522
Grand Total	1310	1252 (7.4%)



PHYSIOTHERAPY

TOTAL ACTIVITY 23145 / 189071 (12.2%)

SERVICE TO MOVE OUT

MEDICINE SERVICE REVIEW

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

Each specialty presented guided by the following format:

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

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

PATHWAY DESIGN, REFERRAL MANAGEMENT AND EDUCATION WITH GENERAL PRACTICE

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

Gastroenterology identified Dyspepsia, Reflux, Change of Bowel Habit and Irritable Bowel Syndrome as the top referred conditions within the service. The Wolverhampton NHS Trust introduced a clinical triage of all patients referred into the Gastroenterology service in 2014 which saw a 27% reduction in new outpatient attendances.

Based on that model, the Gastroenterology service at Jersey General Hospital has identified this practice as an area for development estimating a more conservative 15-20% however realistic reduction in referrals by adopting this scheme. In 2018, there were 1927 referrals into the Gastroenterology Service, the estimated impact would be a reduction of at least 290-385 referrals per annum.

Dermatology completed an audit on their urgent referrals of which only 10 resulted in a cancer diagnosis of 42 (the rest were discharged). G.P Education, virtual clinics and quarterly MDT's with GPs could reduce the number of referrals by 20%.

This is significant when comparing the prevalence of dermatology speciality referral with the UK. In the UK 31 referrals per 1,000 of the population per week are made into the specialist; in Jersey it is 50 referrals per 1,000 of the population per week.

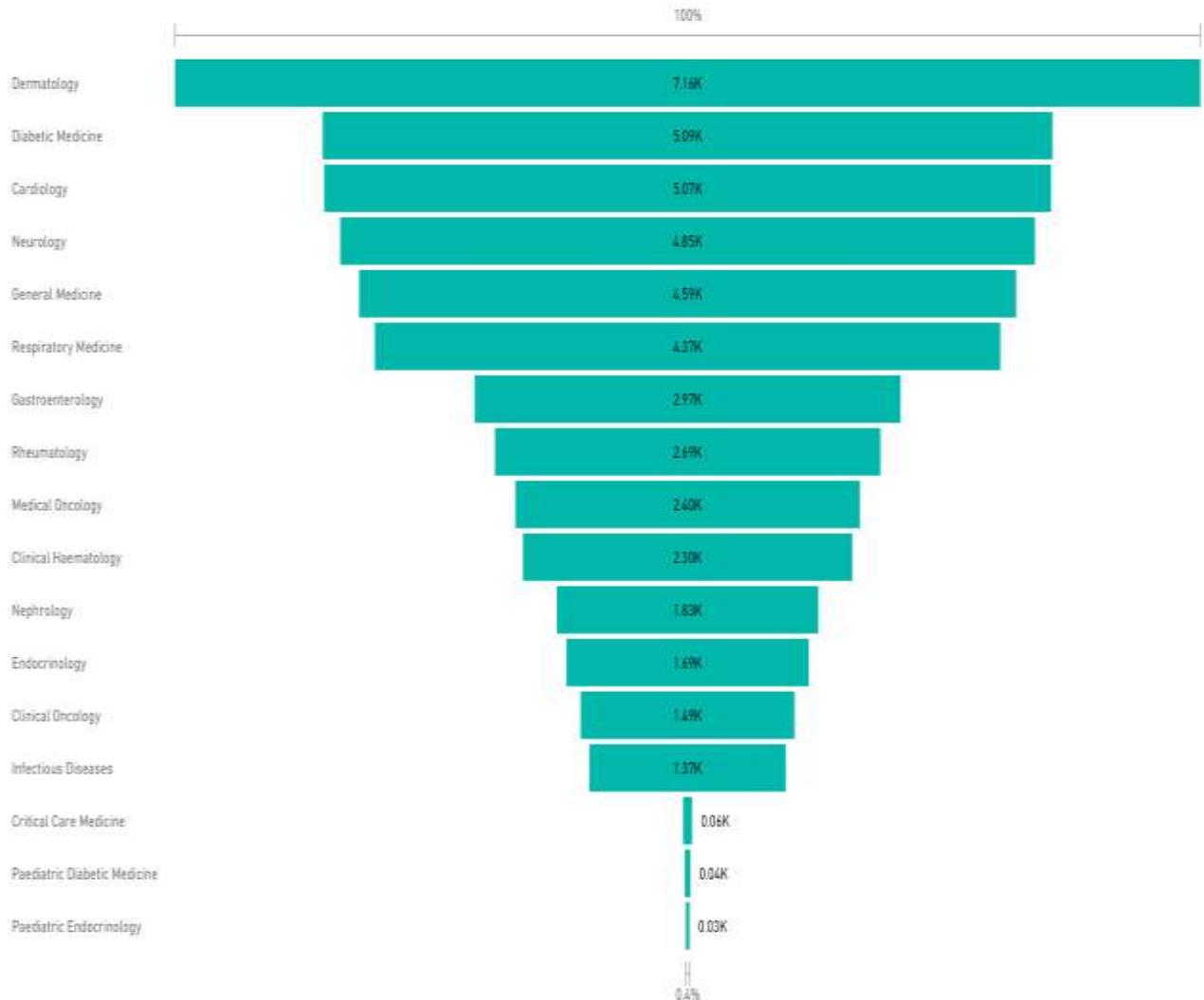
Similarly, Cardiology (Hypertension and Lipid Management), Respiratory (Chronic Obstructive Pulmonary Disease) and Endocrine (Diabetes, foot and retinal screening, prevention and remission) all identified opportunities within referral management and the education of General Practitioners to manage long term and chronic conditions outside of the acute setting.

The extent as to how much activity can be managed in an alternative setting is yet to be confirmed and fully worked up by the division.

Regulated access to modern diagnostics (blood sciences, molecular and different forms of imaging) is essential for the success of this approach.

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

Figure 4: 2018 Medical Division outpatient activity



FREQUENCY OF PHARMACY/PRESCRIPTIONS AND DIAGNOSTICS

Almost all specialties treating long term/chronic conditions identified the frequency of prescriptions as a reason for following up patients more frequently than expected as the hospital represents a free service for repeat testing (e.g. Bloods) informing prescription of medication when compared to primary care.

There would be an estimated 5-8% reduction in follow-up appointments across Medicine if the catalysts driving this behaviour between Primary and Secondary Care were overcome.

A 5-8% reduction in follow-up appointments would see an estimated 1980 – 3170 reduction in follow-up attendances across all medical specialties.

In addition to this maximising the digital opportunity via integrated reporting systems and modern technology could impact on services in the future even reducing the activity and cost of off-island activity. For example efficient use of currently existing equipment (PCR, other analysers),

Calprotectin (biochemistry) in Gastroenterology and confocal imaging (vivascope) reducing the number of samples going off island and improving turnaround times for diagnostics.

ACCESS TO SPECIALIST ADVICE AND GUIDANCE

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

MEDICAL SUPPORT FOR RAPID RESPONSE (in Reach)

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

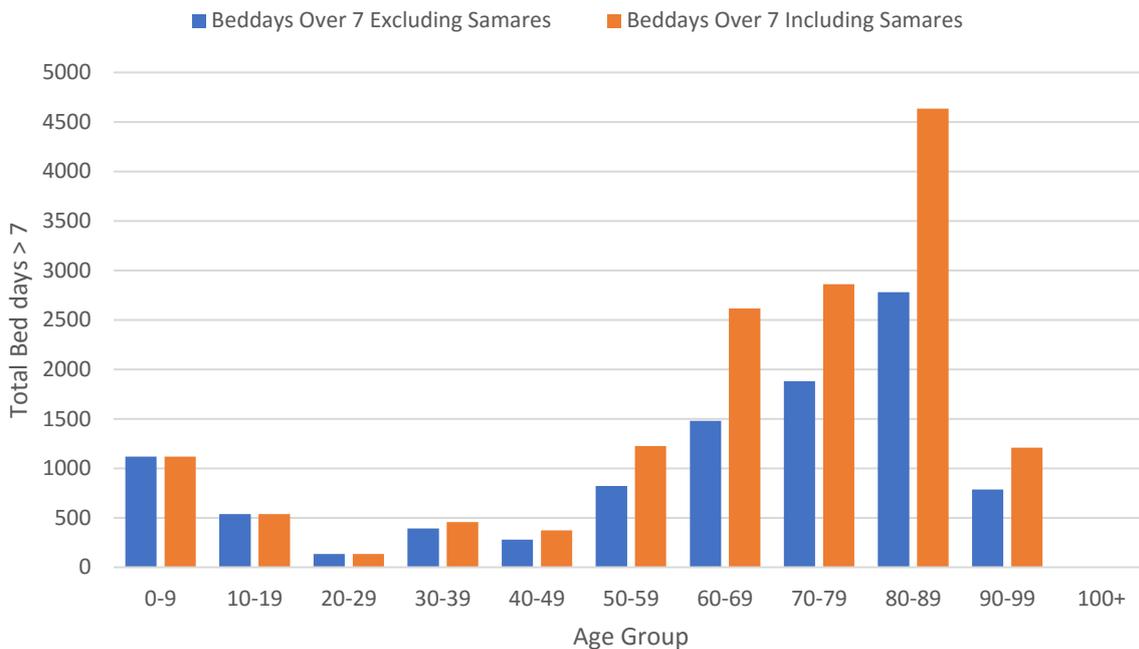
CARE OF THE ELDERLY AND FRAILTY

The Division of Medicine proposes to define the remits of this specialist activity within a 'whole island' context.

The aim of Care of the Elderly is to support patients in living independently, preferably in their own homes. At present Care of the Elderly is predominantly an inpatient function and the current care model has a significant impact on the effectiveness of the service.

Figure 5 below highlights the stranded patients (patient with a length of Stay > 7 days) and the associated bed days in hospital > 7 days; this demonstrates the current models in ability to move patients out of the acute as predominantly the only option is waiting for space in another institutionalised care setting.

Figure 5: Total bed days > 7 split by Age Group (2018)



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

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

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

APPENDIX 13: GOVERNMENT PLAN 2020-23 BUSINESS CASES

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

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

SUMMARY OF BUSINESS CASES

CRISIS PREVENTION AND INTERVENTION SERVICE

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

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

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

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

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

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

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

The size and structure of the crisis team has been based around a population size of 150,000. While Jersey's population is 105,500 the unique circumstances of the Islands location and availability of workforce resource to sustain quality and effectiveness during period of sickness, holidays, training leave needs to be scaled up to ensure services remain wrapped around the individual and sustainable so that the outcome of crisis resolution is achieved.

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

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

THE LISTENING LOUNGE AND PLACE OF SAFETY SCHEMES

During an extensive consultation exercise with service users (via a citizens panel), staff working in mental health services and a range of external stakeholders a body of evidence emerged that showed people experiencing a mental health crisis had limited options for timely and relevant support which as a result exacerbated the crisis situation and resulted in contact with the emergency services (including contact with the emergency department).

Evidence gathered relating to activity at the Emergency Department and Police service showed that some of the support needs could not be met at these locations or otherwise due to a lack of alternative 24/7 support. Contact with these services was often inappropriate to address need and could have been avoided if a more effective, proportionate and responsive support model was available at the time.

The Mental Health Strategy (2016-20) outlined a new direction of travel for mental health services which included plans for (i) developing prevention and early intervention based mental health services, (ii) improving access to mental health support over a 24/7 period and (iii) optimising opportunities for recovery, all of which are underpinned by a model of coproduction and redesign.

The proposal contributes to defining 'what good looks like' and draws comparisons with other similar UK based developments to present the case for need.

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

COMPLEX TRAUMA PATHWAY

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

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

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

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

CAMHS (CHILD AND ADOLESCENT MENTAL HEALTH SERVICES)

In the Target Operating Model of the Government of Jersey the Child Development Centre and CAMHS are to transfer from Health and Community Services into the Children and Young People's Services directorate.

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

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

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

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

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

MENTAL HEALTH LAW

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

The recommendation is made with consideration of:

- (a) projected analysis of need
- (b) review of current provision
- (c) provision mapping to identified need
- (d) reorganising/funding to meet identified need

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

[>>> Click here to return to Mental Health section](#)

[>>> Click here to return to Social Care and External Partner section](#)

APPENDIX 14: BACKGROUND AND CONTEXT

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

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

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

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

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

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

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

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

- Keeping people out of hospital will require increased community services and a new system of health and social care for the 21st century
- System to move from an acute focus to one embedded in the community delivered in partnership with the voluntary sector and the private sector with a focus on self-help and prevention
- Reduce preventable disease where possible

- Support carers through the Carers Partnership Forum
- Current system is not sustainable when considering pressures on budgets and the workforce
- Delivery of intermediate care
- Developing services for Children and Young People with Complex Needs
- Delivery of community Mental Health services
- System to embrace technology to support the delivery of quality services

Current state assessment (positive/negative)

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

A KPMG report in 2016: *The Jersey Charity Survey*¹¹ highlighted the following;

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

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

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

¹¹ 197 Organisations participated

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

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

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

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

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

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

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

Key issues

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

- Duplication of offer across sector and wider health economy without joined working
- Duplication of back office functionality across sector and health economy
- Funding pressures across sector
- Care regulations and the possible reduction in service delivery
- Workforce challenges and future proofing sector
- Workforce models
- Modes of care delivery

- Organised representation of sector and collaborative agendas
- Value for money, outcomes against investment
- Governance and risk frameworks
- Access to training
- Discrepancy in fund raising and retention of volunteers
- Lack of a JSNA, data and statistics does not lead to good commissioning

Objectives for Community Services

The key objectives are as follows:

- Reduced reliance on acute services
- Services delivered closer to people's home
- Increased choice and control for customers
- Increase in providers sharing resources/assets
- Reduction in the use of the residential estate
- Ensuring value for money
- Aligned strategy and funding
- Robust commissioning framework
- Increased use of technology in service delivery
- Improve/introduce market development and evidence based decision making
- Improved communications and relationships with the sector
- Labour market planning across the model

APPENDIX 15: FRAMEWORK FOR PARTNERSHIPS WITH THE VOLUNTARY SECTOR, PRIVATE SECTOR AND SOCIAL ENTERPRISES

[>>> Click here to return to Social Care and External Partner section](#)

Overview

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

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

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

Framework

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

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

Delivering services to an agreed common purpose will require the development and commitment of organisations to work to an overarching *Partnership of Purpose* this would be the core to all areas of service delivery and would provide the focus and structure for a framework. This in turn would be supported by an outcome-based commissioning approach

in addition to developing personalisation on the island. This would see services commissioned for health and social care outcomes not simply measuring throughput of a service.

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



A Partnership of Purpose

HCS will develop a Partnership of Purpose which would be an agreement between all parties delivering services directly or indirectly linked to the care model. The following principles provides an overview of what could be developed¹²:

Prevention: supporting islanders to live longer and healthier lives

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

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

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

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

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

¹² <https://www.gov.gg/article/162629/A-Partnership-of-Purpose-Transforming-Health-and-Care>

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

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

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

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

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

Traditional outcomes-based commissioning

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

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

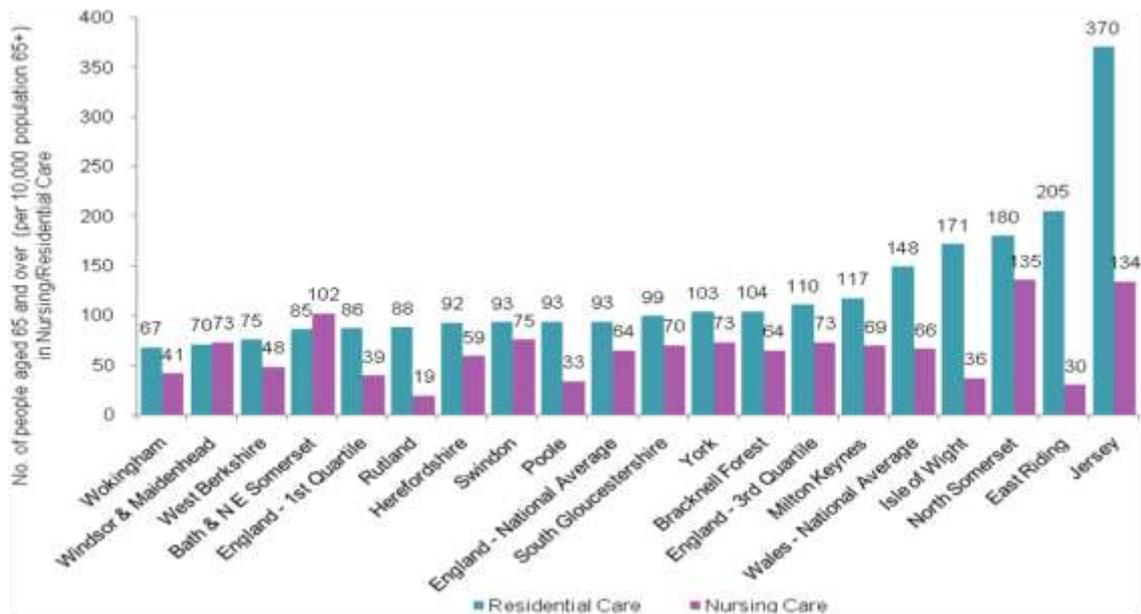
- Needs assessment
- Annual planning
- Design and contracting services
- Shaping the structure of supply/market
- Managing performance
- Evaluation

Personalisation

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

The lack of personalisation in Jersey contributes to the high levels of occupancy in the residential estate (below) which is far higher than other jurisdictions.

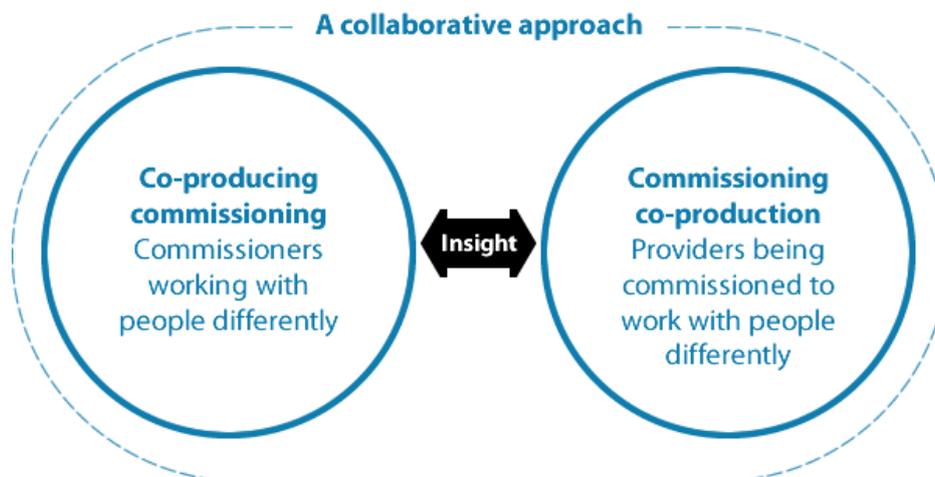
Personal budgets can be used to support independence and safely support people in their own homes while crucially developing a wider market place for providers of services and making better use of technology.



Co-production

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

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



Governance and funding

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

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

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

Market development

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

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

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

PARTNERSHIP OF PURPOSE

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

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

- **Prevention:** supporting Islanders to live healthier lives
- **Person-centred care:** joined-up services, where people are valued, listened to, informed, respected and involved throughout their health and care journey
- **Fair access to care:** ensuring that low income is not a barrier to health, through proportionate funding processes based on identified needs
- **Proportionate governance:** ensuring clear boundaries exist between commissioning, provision and regulation
- **Direct access to services:** enabling people to self-refer to services where appropriate

- **Effective community care:** improving out-of-hospital services through the development of Community Hubs (both physical and virtual) for health and wellbeing
- **Focus on quality:** measuring and monitoring the impact of interventions on health outcomes, patient safety and patient experience
- **A universal offering:** giving Islanders clarity about the range of services they can expect to receive, and the criteria for accessing them
- **Partnership approach:** recognising the value of public, private and voluntary sector organisations, and ensuring people can access the right provider
- **Empowered providers and integrated teams:** supporting staff to work across organisational boundaries, with a focus on outcomes.

COMMISSIONING PRACTICE: COLLABORATIVE WORKING

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

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

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

Responsibilities, governance and partnership

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

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

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

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

Mapping local structures

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

what operational policies they have in place and what role they play in assessing risks and, where relevant, delivering services to individuals.

Joint strategy

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

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

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

Pooling Government of Jersey budgets

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

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

Advisory group

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

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

Assessing need

Services must be commissioned according to need, ensuring individuals receiving support are at the centre of delivery. Commissioners must understand the need to directly inform

future service specification and delivery. The following provides guidance for the method of undertaking a comprehensive and effective needs assessment for services.

Compile existing sources of information

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

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

Map existing services against need

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

Key tips for mapping services

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

Involve experts by experience and service providers in the process

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

Analysis and interpretation

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

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

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

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

Transition pathways

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

Outcomes

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

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

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

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

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

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

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

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

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

To do this, commissioners must:

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

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

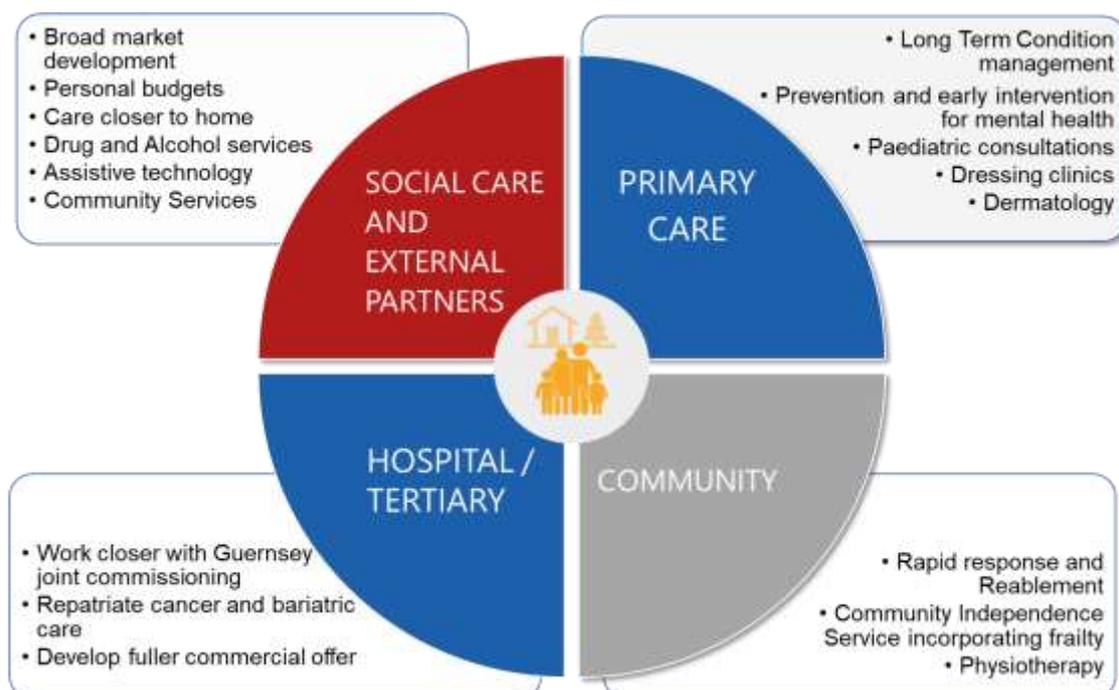
HCS is keen to ensure this framework has been utilised by commissioners and has had a positive effect on the commissioning environment. The publication is intended to be a living document which can continue to be used for the future, developing in line with the sector.

HCS will commit to:

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

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

Figure 3: Jersey Care Model Commissioning intentions (outline)



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

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

Our model will stimulate market development and reward positive outcomes for patients/customers through sharing rewards. The overarching theme of our approach will be

place-based systems¹³ of care in which HCS work together with partners to improve health and care for the population. This means organisations collaborating to manage the common resources available to them.

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

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

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

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

The following design principles will be considered when developing services;

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

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

Transactional

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

¹³ <https://www.kingsfund.org.uk/publications/place-based-systems-care>

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

This approach will also allow HCS to commission bespoke services targeted at specific groups for a finite period of time.

Strategic partnerships (SP)

To deliver the Jersey model of care will require organisations to work in partnership to deliver key services such as intermediate care for example. To endear the transformational change required to deliver a quality and sustainable model of care will in practice mean different parts of the health and social care system working together to provide more co-ordinated services to patients – for example, by GPs working more closely with hospital specialists, district nurses and social workers to improve care for people with long-term conditions.

It is anticipated that HCS will work with partner organisations to develop SP which will blend traditional commissioning with accountable organisations agreements to share rewards and risks. This approach can also be adopted with Primary Care providers as well as all external providers. Services such as intermediate care could be developed and delivered through SP.

SP will be responsible for improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services.

SP will be central to driving a change in behaviours, improving quality, access and affordability of services.

Collaborative commissioning of bespoke services

HCS has a number of bespoke services targeted at vulnerable groups. While these arrangements do have a health and social care component, customers and providers would benefit from a cross OneGov approach. For these services HCS will work collaboratively to jointly develop and fund services to ensure optimising outcomes.

In addition to this HCS does have a number of specialist off-island placements and we will work with other jurisdictions such as Guernsey to explore potential joint commissioning.

Joint or integrated commissioning at a local level

Jersey has a unique Parish system that is central to island life. Each Parish has its own individuality and to meet Parishioners needs a flexible approach to commissioning and delivering services is required. HCS will work in partnership to commission services at a micro level with partners to meet current and emerging needs. This will link with the Closer to Home agenda as well as specific local evidence-based commissioning.

Personalisation

To support choice and control for individuals, HCS will work with partners to develop personalisation. This will see individual budgets based on an assessment, allow people to have control over their care and provide a real alternative to institutional care.

APPENDIX 16: DEFINITIONS, ACRONYMS AND ABBREVIATIONS

Term	Definition
Agreement	A document that describes a formal understanding between two or more parties
Escalation	An activity that obtains additional resources when these are needed to meet service level targets or customer expectations
HCS	Health and Community Services
Impact	A measure of the effect of an incident, problem or change on business processes
Incident	An unplanned interruption to a service or reduction in the quality of a service
Priority	A category used to identify the relative importance of an incident, problem or change.
Process	A structured set of activities designed to accomplish a specific objective.
Resolution	Action taken to repair the root cause of an incident or problem, or to implement a workaround.
Role	A set of responsibilities, activities and authorities assigned to a person or team
Service Hours	An agreed time period when a particular service should be available
Service Level	Measured and reported achievement against one or more service level targets
Service Level Agreement (SLA)	An agreement between a service provider and a customer
Service Level Target	A commitment that is documented in a service level agreement.
TOM	Target Operating Model