Analysis of the Jersey Care Model Briefing Paper – October 2019

This analysis is based on the Jersey Care Model Briefing Paper of October 2019 ("the Briefing Paper") and the Health and Community Services ("HCS") presentation and discussion at the St Peter's Parish Hall Meeting of 4 December 2019 ("the Meeting").

One of the attendees at the St Peter's Parish Hall Meeting described the Care Model as "aspirational", a description accepted by the HCS Panel. There remain practical problems relating to the non-existent infrastructure required for the Care Model (IT; new acute hospital). This note aims to identify significant, practical issues arising from current proposals on the information available within the public domain.

Three Practical Issues

1. **Lack of Infrastructure:** The Care Model requires collaborative working to ensure continuity of care; without investment in collaborative working and communication, any efficiency (financial or otherwise) will be lost with effort spent on co-ordination and communication within the system. This may lead to increased clinical risk to patients (early discharge/ ineffective communication to community providers/ readmission). The Care Model cannot work without the necessary IT infrastructure with all parts of the contributors to the model (GPs, hospital, mental health workers, carers) accessing the same record keeping system. Health and Social Care Information governance regimes will need to support access by a variety of professionals from a variety of HCS sites.
2. **GP Involvement:** The Care Model is heavily reliant on GPs and their engagement and support is essential:
    a) GPs will be expected to take on some Out Patient appointments. Some referrals may be within their current expertise, but it is unclear whether specialist training may be required for selected GPs. There was some reference to dermatology and respiratory referrals to GP surgeries, presumably requiring specialist training for nominated GPs.
    b) There may be resistance from the patient if Consultant led management is transferred to a local GP. Reassurance may be required regarding clinical competency and what financial impact, if any, transfer from hospitals to GPs will have.
    c) Rob Sainsbury suggested that GPs would monitor care regimes in the community with support from (newly recruited) Geriatricians. In the UK, care plan monitoring/ case management is undertaken through a community matron based in a commissioner body supervising the regime coupled with a key nurse in a provider district nursing team responsible for liaising with agencies and obtaining feedback. A nurse is considered

to have the relevant skill set at running day-to-day care/nursing regimes. A GP may be brought in to provide medical input but will be less experienced in terms of what is required in terms of shifts/ equipment/ staffing levels. Will HCS take some of the nurses from hospital to undertake the community tasks? They may have difficulty in persuading hospital nurses to leave the ward given the different skill set. When asked about this on 4 December, HCS described the significant numbers of nurses with prescribing rights within the Jersey. This is less of an issue given the number of GPs in Jersey; the key skill set required will be managing community regimes.

d) GPs are expected to lead within the Urgent Treatment Centre (UTC) in the hospital as an alternative to treatment within the Emergency Department. How will that support GP Out of Hours arrangements? There is a significant issue of care being free at the point of delivery within hospital but not at a GP surgery. GP practices will be unhappy about the UTC potentially undercutting their patient base by providing free treatment. Why would a patient attend a GP surgery if they can see a GP for free within the UTC? This will quickly lead to an oversubscribed UTC. Alternatively, if you charge for treatment in the UTC, patients may present at the free, Emergency Department. An effective triage system for the UTC and ED may lead to patient dissatisfaction if those conducting the triage effectively determine whether the patient is charged for the treatment or not.

3. **Lack of detail about community provision:** There is a lack of clarity regarding community provision following discharge from the hospital. Rob Sainsbury at the Meeting described step down facilities (with less expensive beds as discharge arrangements finalised often used within the UK – but there is no description of such a facility in the Briefing Paper.) There is also a clear issue with care agency support and if GPs are to take on more in terms of managing community regimes, they are going to have to develop relationships with nursing and care agencies.

Acute / Secondary Care Proposals

It is understood that HCS wishes to reduce acute/ care home beds and ensure more patients are treated in the community or within their own homes. It is also clear that Jersey does not want to follow a district hospital model, wishing to expand by developing some tertiary services such as oncology and pain management within the Island. The proposals raise a number of issues some of which are detailed below:

1. UTCs in the UK were introduced as a method of providing out of hours care when EDs were closed or downgraded. The Care Model proposal is different as the ED will continue but it raises practical issues regarding charging for treatment of care and to the extent it will divert patients from their local GP surgeries and into hospital as discussed above.
2. The co-location of mental health services within the hospital is a laudable aim; there was no mention of the role of mental health services within either the UTC or ED despite recognition that a number of admissions through ED

included management of homeless with substance misuse/ mental health problems. Is there a plan to have Psychiatric nurses in ED or will the Crisis team be contacted when required?

3. The development of a Special Care Baby Unit (SCBU) will also be strongly supported. It would be helpful to have further information regarding the recruitment of a neonatologist. In the UK, neonatologists work in Tertiary Centres and have the support of paediatric radiologists who play a vital role in the early stages of the newborn's life. How many cots will be in SCBU? The number may impact on the recruitment of a neonatologist. Is this a service Jersey may wish to share with Guernsey?
4. It is also sensible to co-ordinate with Guernsey over resources. It would be helpful to have further information about which specialities HCS considers can work between the two islands. If Jersey is to develop its oncology services, what can Guernsey offer in return?
5. The Briefing Paper also rightly recognises that work will need to be undertaken on clinical governance regimes (p12 and 24). Again, access to arrangements for referrals to specialist clinicians, clinical pathways and assessments will assist other professionals working within the Care Model and are freely available on the web within the UK. Policy Publication is considered to encourage good practice and should include Incident Reporting and other Risk Management Strategies policies.

Mental Health Proposals

1. The Briefing Paper describes a mental health inpatient ward co-located within the Hospital. Where is it anticipated mental health outpatient appointments will take place? Will Psychiatrists have to travel across the Island to meet clinical commitments?
2. Will there be recruitment of Psychologists? The IAPT programme in the UK has received international recognition (see https://www.england.nhs.uk/mental-health/adults/iapt/) as a successful way of managing mental health in the community without the need for formal mental health team referral. It also would work very well within the Parish system as it part of primary care often operating out of community halls/ GP surgeries. Psychological assessment at a primary care stage could supplement the Listening Lounge, which has proved a valued service even at its trial stage.
3. The Briefing Paper refers to a Mental Health Crisis Team, which does what it says on the tin; the team assesses whether someone requires urgent admission to hospital as they pose such a risk to themselves/ others as a result of their mental condition. Those with chronic conditions are managed by Community Mental Health Teams (CMHTs) which are not described within the Briefing Paper and are fundamental to community mental health care. Will the States actively recruit more mental health professionals to man the proposed teams?
4. Mental Health Services are always chronically underfunded. Is there a big enough budget to change this Service? It is a high risk area, as when things

go wrong it leads to suicides and homicides with the related press attention and reputational damage to HCS and providers.

5. The Briefing Paper fails to mention anything about mental health services within prison. A high percentage of offenders suffer from mental health conditions and it can be a key to preventing reoffending and reducing risk within prison (https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/400/400.pdf)
6. Mental Health teams are multi-disciplinary teams with social workers providing a key role in assessment and case management and reducing the risk of readmission in terms of care package in the community. This is a significant factor for the joint commissioning proposals contained within the Briefing Paper as keeping mental health patients stable in the community will require social care support.

Community Care

1. It would be helpful to have more information as to what HCS anticipates in the form of step down facilities. A small community hospital? If so, how many beds? How many geriatricians do HCS wish to recruit? It is recognised that care in the community is better for patient outcomes but it is also recognised that without adequate communication and care co-ordination, patients fall within silos and there is an increase in preventable readmissions (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278805/)
2. What is the view of GPs on the Care Model proposals? Are they fully supportive of the proposed Care Model? What are their concerns? Sensibly, HCS is conducting a consultation process; GPs are a vital part of the proposed regime and it would be helpful to have formal feedback of their views.
3. Has there been any consideration given to the community matron role. He/she would sit between those providing the care and the commissioner as funder of the care and act as liaison with social care commissioners.
4. At the Meeting of 4 December, care agencies clearly articulated how they felt unsupported by the current system and how things will need to change if further care is to be pushed to the communities. A community matron/ specialist commissioner could play a vital role in this post and also undertake a necessary overview of clinical competency of the competing providers.
5. There is no suggestion of replicating the Care Quality Commission ("CQC,") the UK's external regulator for Health and Social Care Providers. Aspects the CQC grading / assessment system may prove useful in internal auditing and assessing the clinical competence of health and social care providers (private, public or voluntary) in the community sector.
6. HCS suggested at the Meeting that Parish Halls could be used for physio/ occupational therapy sessions. Reassurance may be required in relation to whether such venues can accommodate the necessary equipment and maintain patient confidentiality. Has an analysis been undertaken as to the extent to which the private providers of physio and OT will work within the proposed Care Model?

Commissioning and Person Centred Care

The Briefing Paper provides limited detail about how resources will be allocated by the States, albeit there is recognition that providers and GPs will need to be incentivised. The Care Model raises a number of issues regarding how the States will undertake commissioning in a system reliant upon both public and private funding.

1. Does HCS have specialist commissioners who can lead the way in developing the new Care Model? How will they interact with other components of the model?
2. Chronic conditions require long term, consistent planning and joint commissioning. The Briefing Paper and HCS presentation at the Meeting understandably focused on the care of the elderly. It is acknowledged a significant percentage of those who require community care, but it is not the entire picture. Person centred care/ personalisation is valued and pursued by those who wish to take control of a care package for those with lifelong disabilities: parents of disabled children, adults with a disability and mental health patients in the community. Children's packages require close liaison with social care given the educational element.
3. True personalisation requires trained commissioners and education of staff involved in the working and development of care packages.

Children

The Briefing Paper refers to the Children and Young People's Plan 2019-23 focusing on outcomes for children and young people.

1. Yet, the Briefing Paper is silent on the role of the school nurse. If resourced sufficiently, school nurses can be important links between children, school, GP and social care where needed. They are already effective in relation to public health initiatives regarding immunisation but could also be used in obesity and sexual health campaigns. School nurses could also be linked up to Child and Adolescent Mental Health Services in Jersey.
2. There is also limited reference to Health Visitors. They already work with Parish facilities through their clinics and may provide helpful input into how Parish facilities can be further used.

The UK requires the public sector to consult and engage with service users regarding change of service by way of statutory duty. HCS is following good practice by circulating the Briefing Paper and by holding its series of Parish meetings. It may well be holding separate meetings with key stakeholders which

will provide valuable insight into the proposed Care Model. Reassurance will be provided to Jersey's residents by publicised support of the clinicians and carers who will operate within the future Care Model and by establishing the appropriate infrastructure.

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