

STATES OF JERSEY



HEALTH AND SOCIAL SERVICES: A NEW WAY FORWARD

Lodged au Greffe on 11th September 2012
by the Council of Ministers

STATES GREFFE

PROPOSITION

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

- (a) to approve the redesign of health and social care services in Jersey by 2021 as outlined in Sections 4 and 5 of the Report of the Council of Ministers dated 11th September 2012;
- (b) to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval –
 - (i) proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), by the end of 2014;
 - (ii) proposals to develop a new model of Primary Care (including General Medical Practitioners, Dentists, high street Optometrists and Pharmacists), by the end of 2014;
 - (iii) proposals for a sustainable funding mechanism for health and social care, by the end of 2014.

COUNCIL OF MINISTERS

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REPORT

A NEW WAY FORWARD FOR HEALTH AND SOCIAL CARE

1. INTRODUCTION

In common with jurisdictions and countries across the world, Jersey faces significant challenges in ensuring the availability of high quality health and social care within a financially affordable sum. We also have some unique challenges, for example workforce pressures, limited services in the community, clinical viability and cost pressures due to diseconomies of scale. All health and social care systems are reforming and changing to meet the challenges of demand, cost and quality. And all systems are spending increasing amounts year on year, on health and social care.

Demographic change will dramatically increase the demand for health and social care. Jersey residents are today living longer than ever before. New medicines, better ways of diagnosing and treating illnesses such as cancer, and other advances have improved life expectancy but mean that many Islanders need to visit the doctor or hospital more often. Chronic conditions such as arthritis and diabetes are rising and patients require treatment and care throughout their lives.

Technological advances are allowing efficiency and quality improvements but are also creating major new costs. Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals. Increasing regulation in health and social care is increasing quality but also reducing freedom to act outside the norm. And service ethos is shifting from treatment to prevention and promoting independence.

Health and social care services are continually developing in order to improve quality and maintain safety. However, changes will not be able to keep pace with increases in demand due to a combination of significant ongoing funding pressures and the scale of challenges which Jersey faces in the next 10 years. A system-wide view is required, with significant strategic service investment.

Health and Social Services are the largest States Department. We have over 3,000 staff, and an annual budget of £171m. Services are provided over 86 sites. Services directly provided by the Department are:

- Jersey General Hospital
- Community and rehabilitation services for adults and older adults, at Overdale Hospital plus residential and respite facilities
- Long term 'continuing care' services in States-owned nursing homes (The Limes and Sandybrook)
- Mental health services, including inpatient, outpatient, community and Child & Adolescent
- Community and Social work for children and families, adults, older adults, learning difficulties; challenging behaviours, disability and sensory impairment, safeguarding and child protection, substance misuse
- Public Health, including research, prevention and health promotion
- Environmental Health and Health Protection monitoring and regulation

Health and Social services have no direct responsibility for providing health visiting and community nursing. These services are provided by Family Nursing & Home Care, funded in part by the Department.

The Department also has no direct responsibility for either providing or funding Primary Care (GPs, Dentists and high street Pharmacists and Optometrists) – although some limited Primary Care Dentistry for children is provided at the Hospital.

Health and Social Services also holds a number of Service Level Agreements / contracts with third party organisations, to secure services to meet Islanders' needs. These include third sector organisations and off-Island care for specialist requirements.

Health, social care and Third Sector teams need to work closely with one another and with patients, service users and carers to provide evidence-based services, managing demand, promoting health and wellbeing, ensuring equality of access, protecting / safeguarding vulnerable people and enabling people to be cared for in the most appropriate place, living as productive and independent lives as possible. If the States acts now it can:

- limit the rate of increase of spend (although realistically expenditure will continue to grow in real terms due to demographic pressure)
- begin to reduce the levels of dependency of people such that Islanders are supported to live independently, receiving effective care in lower cost settings
- mitigate the effect of increasing demand because of demographic changes

Any change in service will, by necessity, be evolutionary. The timing of changes has been carefully considered in order to ensure that they are achievable, whilst also supporting the required pace. The balance between different elements of the health and social care system has been carefully considered in order to support ongoing service viability, and to support staff in continuing to provide safe, accessible, high quality services.

To enable strategic change, a number of system-wide needs have been considered – including IT support and management capacity to implement change. It is clear that these 'enablers', along with the changes identified in this report, will be required in order for future services in Jersey to be safe, sustainable and affordable.

The proposals outlined in this Report are the results of almost two years' work. The initial work that informed the Green Paper '*Caring for each other, Caring for ourselves*', published in May 2011, concluded that health and social care in Jersey is not sustainable. The Ministerial Oversight Group note the importance of:

- Fully understanding the 'case for change'; the challenges faced by health and social care services in Jersey and the reason why the current system and model of care is not sustainable
- Listening to the views of stakeholders – Islanders, Third Sector organisations and other States Departments
- Retaining what works well in Jersey, such as our strong community focus, Parish support and vibrant Third Sector
- Designing the health and social care system, and the services within it, in accordance with agreed strategic principles
- Identifying sustainable funding mechanisms for health and social care

- Addressing the challenges within our estate, most notably the size and condition of Jersey General Hospital – also other estate e.g. mental health and community services
- Starting to plan for sustainable Primary Care within the new health and social care system – this being services provided by General Practitioners (GPs), Dentists, high street Optometrists and Pharmacies
- Making changes immediately, in order to continue providing safe services into the future

The public consultation on the Green Paper and then the White Paper '*Caring for each other, Caring for ourselves*' demonstrated that Islanders understand the challenges facing health and social care; and that they agree that significant changes are required urgently. Their views, and the views of other stakeholders, have been taken into account throughout the process – and will be incorporated in the detailed planning for service changes.

Only by acting now can Jersey make preparations for a safe, sustainable and affordable health and social care system in the coming years. Countries facing the same challenges as Jersey have already begun to consider this. Strategic investment is urgently required, before the pressures start to impact on the safety of services; we cannot delay any longer.

Service redesign on this scale has never before been proposed by a States of Jersey Department. However, acceptance of it, shown by approval of the detailed proposals laid out in this document, represents a major opportunity for the States Assembly, after considered thought and debate, to work as a group of like-minded individuals, regardless of their own political differences. It offers a unique opportunity to offer Islanders a world class health and social care system for the future, which is accessible, affordable and appropriate, but, above all, safe.

The public consultation has demonstrated that Islanders agree – and are both welcoming and expecting change.

2. THE NEED TO REDESIGN HEALTH AND SOCIAL CARE IN JERSEY – WHY ‘DOING NOTHING’ IS NOT AN OPTION

2.1. AN UNSUSTAINABLE SYSTEM – CURRENT AND FUTURE CHALLENGES

Health and social services are, with some exceptions, relatively comprehensive. Key performance indicators suggest we are performing well compared with similar jurisdictions. Generally, staff are highly motivated and committed, with good levels of experience. Outcomes are good, and Islanders appreciate and value many aspects of their health and social services. However, there are a number of issues with the existing system.

The case for change in summary

The population of Jersey is growing relatively slowly but it 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 **significant increase in demand** for health and social care services.

Current services are performing generally well but they are close to capacity and could not accommodate this increase in demand. The island will **run out of capacity** in key service areas over the next five years, but within two years in many areas – and within a year in some areas. The services therefore need significant expansion and/or change to ensure that the needs of the people of Jersey can be met into the future.

Current services are also vulnerable due to **workforce pressures** with many staff approaching retirement age. Almost 60% of the medical staff are eligible to retire in the next 10 years and, due to changes in medical training and education, these consultants cannot be replaced on a like for like basis. Competition for skilled staff is increasingly hard given, in particular, high costs of living in Jersey and increasingly competitive remuneration packages for similar staff in other countries.

Jersey therefore needs a model of health and social services which can respond to the huge increase in demand while doing so in a way which enables the skills of local staff to be used to the maximum and new roles created which will attract new staff to work in the island.

Decisive action is needed now, in order to secure service changes that meet the island’s needs in the short term, and ensure services are safe, sustainable and affordable for the future.

A GLOBAL CHALLENGE

Every health and social care system is experiencing similar challenges:

- Demographic change is dramatically increasing demand
- Technological advances are enabling efficiency and quality improvements but also creating major new costs
- Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals
- Increasing regulation in health and social care is increasing standards and requirements
- Service ethos is shifting from treatment to prevention and promoting independence

- Health, social care and Third Sector partners and multi-agency teams need to work closely with one another and with patients, service users and carers to provide evidence-based services

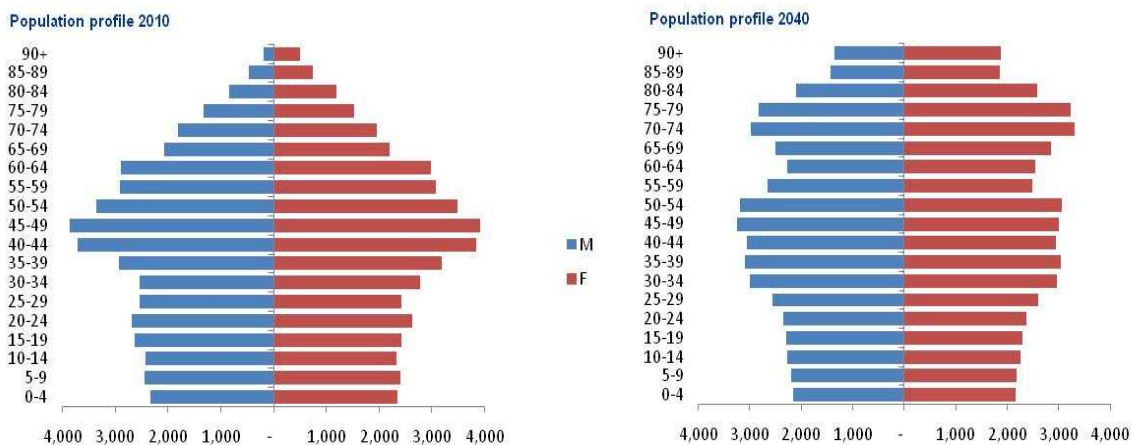
Other jurisdictions have invested heavily in health and social care over the past years, in order to alleviate pressures and prepare for the future. The strategies adopted in other countries have been considered when producing the plans contained in the Green Paper, White Paper and this Report.

THE CHALLENGE FOR HEALTH AND SOCIAL CARE IN JERSEY

Demography

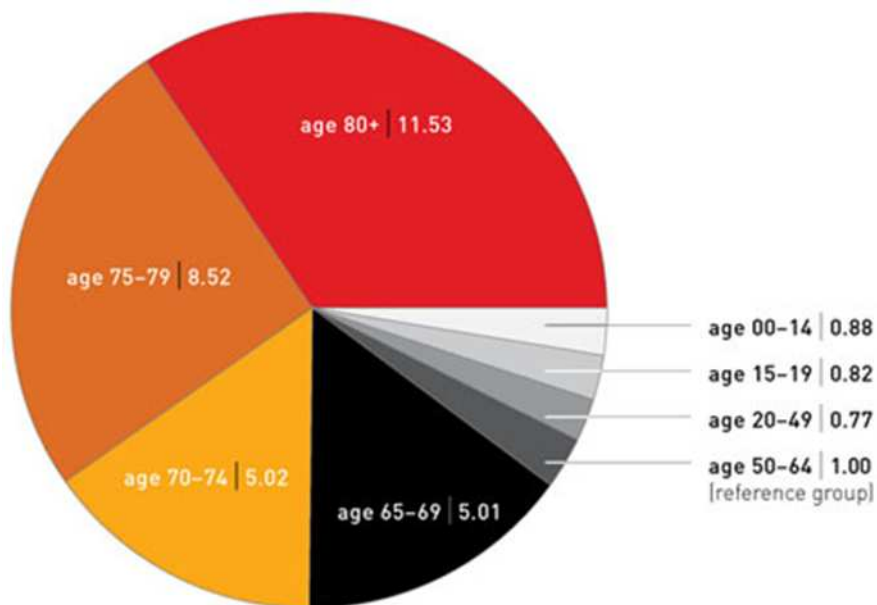
The Island's population is ageing rapidly. The numbers of people aged over 65 will rise by 35% between 2010 and 2020, with a projected increase of 75% by 2030 and 95% by 2040:

Figure 1: Projected demographic changes, 2010 - 2040



These changes will place increasing demands on services. Typically an older person (aged 65+) is estimated to use up to four times as much resource as an average adult.

Figure 2: Index of relative health care expenditure by age.¹



The challenges presented by an ageing population include increases in demand due to:

- Increased prevalence of long term conditions such as Chronic Obstructive Pulmonary Disease (COPD, or lung disease), cardiovascular disease, diabetes, back pain and rheumatological diseases
- A higher number of individuals surviving into older age following diseases such as cancer – but with additional complications and co-morbidities
- Greater demand for musculoskeletal and orthopaedic services both for trauma and emergencies, for example resulting from falls or fractured neck of femur, and for joint replacement e.g. hips and knees
- Increased demand for age-related Ophthalmology services such as cataracts and macular degeneration

In addition, the decrease in number of ‘working age’ people will produce:

- Reduced income tax
- Decreased available workforce able to support increasing care needs
- Even more pressure on carers

The demographic pressures place additional demand on both hospital and community services but also change the nature of the service, placing more emphasis on the need for prevention, long term management, developing new models of care and taking advantage of advances in technology.

¹ "Who's Going Broke? Comparing Healthcare Costs in Ten OECD Countries" Hagist, Christian and Laurence Kotlikoff

Health and wellbeing

Over 85%² of adults in Jersey rate their health as good or better. There are differences across age groups, with 91% of individuals aged between 16 to 34 rating their health as good or better, compared with 70% of those aged 65 and over. Whilst this suggests that the public in general have a positive perception of their health and wellbeing, it also highlights that the public may be unaware of how their lifestyle choices impact on their health and wellbeing³:

Alcohol

- Approximately half of men (46%) and more than a third of women (35%) exceed recommended daily levels of alcohol consumption
- There are over 250 alcohol-related emergency admissions per year; it is estimated that the hospital spends approximately £2m on alcohol attributable conditions per annum
- Approximately 11,000 people would meet the criteria for an intervention to reduce their alcohol consumption

Obesity

- 1 in 8 adults are obese and 1 in 3 are overweight
- 1 in 10 5 year olds are obese and 1 in 4 are obese or overweight
- Obesity costs the States of Jersey and other employers an estimated figure of almost £4m each year including health-care costs and sickness absence

Smoking

- An estimated 170 individuals each year die of smoking related disease
- Of approximately 17,000 smokers, 12,000 want to quit
- Approximately 400 babies leave maternity care to a home where at least one person smokes

Physical activity

- Just over half of the adult population do not achieve the recommended amount of physical activity each week
- Older adults are less likely to be participating in physical activity on a regular basis
- Young people are less likely to walk or cycle to school than in the past

Mental health and wellbeing

- Levels of suicide are higher than England and Wales. Suicide is the biggest cause of premature death
- 15% of the adult population score themselves with high levels of depression and anxiety - this equates to more than 10,000 people in 2010 rising to more than 11,000 people in 2020.
- 40% of repeat visits to GPs are by people diagnosed with depression and/or anxiety

² Jersey Annual Social Survey, 2009

³ 'Health for life', Health and Social Services, States of Jersey Health and Social Services

Long term conditions

- Excessive alcohol consumption, in addition to smoking and/or a poor diet/exercise regime can lead to a higher prevalence of long term conditions such as diabetes, COPD, CHD and dementia⁴
- There are over 3,370 patients registered as diabetic and a further 1,563 patients estimated to be unregistered or undiagnosed with the condition⁵
- By 2020 12,000 people (>13% of the total population) will have diabetes
- An estimated 3.3%⁶ of the population aged 16+ (over 2,360 individuals) are diagnosed with COPD
- Approximately 15% of smokers will develop COPD⁷
- By 2020, COPD will be the third leading cause of death and the fifth leading cause of disability
- Cardiovascular disease affects 13% of the population; the prevalence increases with age
- An increase in moderate and severe dementia of 38% by 2020 (to 1,716 people), with a 64% increase by 2025 (2,040 people) and a 154% increase by 2040 (3,167 people)

A small island

In normal circumstances our population of approximately 100,000 would be considered too small to support comprehensive hospital services and very specialist social care services – this would normally be provided for a population of over 250,000. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of hospital services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

Accordingly, the unit cost of delivering health and social services in Jersey is higher compared with systems serving larger populations. This is due to the fixed costs of key services, that are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to an additional “premium” of approximately 15 – 20%⁸.

Workforce

Staffing in health and social care is relatively light and highly reliant on very small numbers of individuals, particularly in medical staffing. This is an issue as many health and social care staff are approaching retirement age; almost 60% of senior medical staff will be eligible for retirement in the next decade. Many of these retiring professionals are generalists who can treat a range of conditions. However, new health professionals are now trained to be specialists, focusing on more narrow, specific areas of care. This means that every retiring hospital doctor may need to be replaced by a number of specialist doctors.

Jersey experiences challenges with attracting and retaining health and social care staff, particularly nurses. This is partly due to high cost of living, competitive pay packages in other countries, some rules for entry and residency and the personal profile of nurses, who are more likely to have families and are usually sole wage earners when they arrive. There are also global shortages in some skills, such as Theatre Practitioners and Neonatal Nurses.

4 World Health Organisation’s Global Status Report on Alcohol (2004)

5 Jersey Diabetes Centre, 2011

6 Jersey Public Health Intelligence, 2011

7 World Health Organisation

8 Estimated by KPMG, 2011

Due to low patient volumes, maintaining specialist skills can be difficult. Roles have not developed in line with international best practice, as there are only a limited number of expanded role practitioners. Non-medical prescribing is only now being developed, and the skill mix needs to change within teams in order to secure service sustainability and offer more attractive career options.

Estate

The buildings from which services are provided are deteriorating and in many cases are cramped and do not meet modern standards. Space allocation on wards is about half of what would now be expected for the number of beds. The configuration of six-bed bays is not consistent with the requirements of infection control and does not promote privacy and dignity for patients.

The hospital has developed over many years, and as a result, some Departments are not ideally located. This can lead to inefficiencies in the way care is delivered, for example due to the distance between areas that should work closely together. The hospital requires complete refurbishment and redesign or rebuild in the next decade, and other facilities e.g. Overdale also require refurbishment and upgrading. Some facilities have deteriorated to a point where they have required closure and complete refurbishment e.g. Clinique Pinel.

Recent years have seen growing interest in the effects of healthcare building design, and the environment more widely, on the wellbeing of patients and staff and this is supported by a growing body of evidence.

The most detailed review of healthcare facility design and specific outcomes in healthcare, examined 500 papers and reports⁹. This identified a range of positive outcomes including reductions in hospital acquired infections, patient falls, medical errors, pain, patient stress, patient depression and length of stay as well as improvements in staff 'outcomes' expressed in terms of injury and stress.

Payment systems

Where people are treated, as well as by whom, matters. Current funding arrangements do not always encourage people to seek the right help in the right place from the right health and social care professional. The current co-payment for GP services is understood to contribute to high Emergency Department attendances. It was the most frequent topic in the White Paper consultation, and the Jersey Consumer Council has recently undertaken a separate survey of Islanders. The survey is due to report in October 2012. As at 10 September 2012 Jersey Consumer Council had analysed 4,026 questionnaires. Whilst the study was not statistically representative of the entire population because respondents self-selected, an interesting set of themes emerged.

⁹ A Review of the Research Literature on Evidence-Based Healthcare Design, Ulrich et al Texas A&M University 2008

From their preliminary analysis of 4,026 questionnaires, Jersey Consumer Council has noted that:

- Approximately 29% of respondents felt that the cost of visiting a GP was 'Expensive but worth it', 12% felt that the cost was 'About right', 6% felt that it was 'So expensive that it stops members of our household from going' and 5% of respondents felt that the cost of visiting a GP represented 'Good value for money'. Approximately 48% of respondents felt that the cost of visiting a GP is expensive and therefore members of their household only go when they really have to.
- Approximately 22% of respondents felt that the cost of visiting a Dentist was 'So expensive that it stops members of our household from going' and only 4% think that the cost of visiting the Dentist was 'about right.' Approximately 44% of respondents noted that the cost of visiting the Dentist is expensive and therefore members of their household only go when they have to. Circa 28% responded that Dentist visits are expensive but worth it, and approximately 2% said that Dentists are good value for money.
- The majority (52%) of respondents would prefer to continue with the current system of funding. 15% believed in means testing, 11% in reducing general taxation and introducing private health insurance and 7.5% believed that payments should be payroll-based. 15% of respondents reported that they were not sure about the answer to this question.
- Excellent experiences of healthcare were reported
- There is a perceived lack of clarity over the availability of price lists for services and treatments in GP and Dental practices
- Concerns were raised about Optician costs, as glasses and lenses costs are reported by some as being prohibitive for older people and those on low income
- Repeat prescriptions and medication for those with long-term health problems should be considered differently, and there should be reduced GP, Dentist and prescription charges for older people
- Practice Nurses should be used more for basic procedures e.g. blood tests and vaccinations

Service models and the health and social care system

Individual services are reviewed and developed by the teams providing these services, led by the relevant Clinical and Corporate Directors. However, these service changes are often limited by available funding. The KPMG Technical Document, and *Caring for each other, Caring for ourselves* all identified challenges with the current system:

- Services are not well integrated across States Departments and with external agencies, and there is a high dependence on care provided in the hospital and other buildings (residential homes etc)
- Health services are relatively medically dominated, with correspondingly low levels of team-based practice and limited roles for other professions such as nurses
- The lack of 24-hour community services means that the system is relatively institutionalised; more care is delivered from buildings (hospital, care homes, residential services for children). It also reduces choice, e.g. at the end of life
- The limited range and availability of community services, along with the waiting lists for long term nursing care can cause people to stay in hospital for longer than is medically necessary
- Notwithstanding the diseconomies of scale from being a small, somewhat isolated island, medicalised and institutionalised care models are more costly
- As noted above, the private sector GP system is believed to contribute to a high use of hospital services. This unintended consequence of co-payment for GP appointments means that some patients access the

Emergency Department and Outpatients, rather than their GP. The Jersey Consumer Council's survey on Primary Care has made available its initial report on the impact that the Primary Care funding system has on the hospital. Of the 4,026 questionnaires analysed, Jersey Consumer Council reported that:

- Nearly 1 in 5 households who responded had used the Emergency Department for a problem that was neither an accident nor an emergency
 - 75% of respondents surveyed feel that patients attending the ED with non-urgent health problems should pay a fee
 - 65% of respondents feel that ED should charge the same amount as a GP for non-urgent care provided
- We are not taking advantage of services and technology which reduce costs and improve care, and enable individuals to be cared for in non-hospital settings
 - We have a vibrant Third Sector and a strong Parish-based system, but there is a perception from some that the Third Sector requires more support in order to fulfil its potential and be a true partner in delivering care and supporting Islanders.
 - There are insufficient respite places, particularly for children and people with dementia. This increases the pressure on carers, and can cause individuals to be admitted to costly residential care more quickly

2.2. CURRENT SERVICE PROVISION AND CHALLENGES

Public health (including health promotion)

Health promotion is delivered by the Public Health Directorate. It focuses on the priorities drawn from results of the Jersey Annual Social Survey, together with disease and mortality rates, and includes mental health, alcohol/substance misuse, obesity and smoking.

Current challenges include:

- Absence of an integrated strategy for health and wellbeing promotion
- Duplication in information and self care material, with no central point where people can access all health promotion information
- No quality assurance standards to control/approve the information which is available
- Lack of a coordinated response to promote self-help
- Lack of a comprehensive picture of population health needs - in particular for specific groups such as children, Portuguese community etc, which will allow targeted service development
- Limited ability to monitor the improvement or decline in health and social care outcomes, due to underdeveloped information systems
- Lack of coordination and integration between different services working with people who may have a similar underlying issue e.g. alcohol

Primary Care

Primary Care should be the first port of call for a patient, apart from in an emergency. Primary Care comprises:

- General Practitioners (GPs) and practice staff
- Dentists
- Pharmacists
- High street Optometrists

At present, patients can choose which GP they would like to see, but have to pay a charge (generally c£35) for seeing them. Dentists and Optometrists also operate on a fee-for-service basis (although Primary Care dentistry for children up to age 12 is available at the hospital).

This model of privately delivered Primary Care alongside other States-provided services has benefits but also creates perverse incentives which skew natural patterns of service usage. There is a high number of GPs (relative to the size of the population) but very low levels of supporting nursing and allied health professional staff in primary and community care settings, and limited integration with social care and Third Sector provision. As a result the skills of GPs are deployed on tasks that, elsewhere, would be delegated safely to other professionals, such as ear syringing and blood pressure monitoring. It also contributes to a higher use of (free) Emergency Department services relative to other jurisdictions, especially for under 5's and people with long term conditions.

Primary Care information systems are variably developed, with a mixture of systems for recording, monitoring and sharing information. The ability to register with more than one practice increases the risk of data duplication and creates governance concerns.

Hospital care

The majority of hospital care is provided free at the point of delivery. Almost 50% of the population has private health insurance but the coverage of insurance policies varies and many people still opt for States-provided care.

Jersey General Hospital provides a comprehensive range of hospital services including emergency care and Emergency Admissions Unit, medical and surgical specialties, anaesthetics, ITU, obstetrics, paediatrics and therapies. Its facilities include:

- 245 beds in total – 217 public and 28 private
- 4 main theatres (one is a ring-fenced emergency theatre)
- 2 day case theatres
- 2 endoscopy theatres
- 1 maternity theatre

Some specialist treatments are provided in UK hospitals, where there is insufficient volume of patients in Jersey, or where there is a need for highly specialised personnel and/or equipment.

The key challenges within the hospital are due to workforce, estates and low volumes – all of which have already been outlined in this Report.

There are low numbers of middle grade medical staff, challenges with recruiting and retaining nurses and the nurse to bed ratio (including all nursing staff grades) is lower in Jersey compared with English peers.

Jersey General Hospital's bed occupancy is normally much higher than best practice of 85%, with more than 95% occupancy in some acute areas. This may be due to adoption of a more medicalised model of care, with fewer nurse-led services compared to other organisations. Without service changes, Jersey General Hospital will start to run out of beds by 2017.

The buildings from which services are provided are deteriorating and in many cases are cramped and do not meet modern standards. Departments which would need to work closely together are not always located together, and this can contribute to inefficiency and to fragmented patient care, for example due to the need to travel or transport patients between Departments. The hospital itself requires complete refurbishment and redesign or rebuild in the next decade.

Standards and requirements are increasing year-on-year. This impacts the hospital in terms of training and on insurance payments for medical staff – for example, the insurance quote has increased by £1.5m between 2011 and 2012.

The hospital has invested in a new patient information system, TrakCare, but this is not yet comprehensive. Further development and technical support is needed to build a fully functional electronic patient record system that will support patient care and provide data for audit, reporting outcomes and accreditation and will link across service providers. Lack of consistent clinical coding also hampers outcome reporting, benchmarking and strategic planning.

Adult Mental Health

Adult Mental Health Services are predominantly provided by the Adult Services Division of Community & Social Services (Health and Social Services) and by GPs. There are a range of Third Sector organisations providing high quality care, including MIND Jersey, Silkworth Lodge and The Shelter Trust.

The level of service provision available for mild to moderate conditions is low as services are mainly provided within Primary Care and are not universally accessed.

States Departments are working jointly to improve their planning, response and ongoing support to people with complex needs in the community. This includes close liaison between Health and Social Services and the Police, Social Security, Housing and Home Affairs. Further progress is required in order to continuing improving services and to improve the experience for the individual receiving the service, in particular in regards to establishing an appropriate 'place of safety' other than a police cell.

The main challenge in Jersey is to continue to develop models of care as alternatives to medical and/or institutional models. Over the last ten years there has been significant progress in moving services into the community. This includes:

- Specialist community multidisciplinary teams, comprising social work, nursing, occupational therapy, physiotherapy, speech & language therapy, psychology, psychiatry and positive behaviour support services, with specialisms in both mental health and learning disability / autism
- A Psychiatric Liaison Service, which achieved accreditation from the Royal College of Psychiatry in recognition of the high standards and quality of work
- The 'Recovery Lounge' at Clairvale Road, which is designed to reduce the need for inpatient admission.

Key challenges include:

- Supporting a range of providers (including Third Sector and Primary Care) to work in partnership with health and social services
- establishing more appropriate early intervention, identifying people who are at risk within the community
- developing a robust rapid intervention / crisis resolution service
- reducing the rate of risk of self harm and/or suicide

Older Adults Mental Health

Dementia services are currently provided by:

- Community and Social Services teams
- The memory clinic based at the Poplars
- The 14 bedded assessment unit
- 52 continuing nursing care beds
- The Jersey Alzheimer's Association, which has an active membership and provides support to carers and tailored activities to people living with dementia
- The independent sector, who provide a number of residential beds, and more recently specialised nursing beds specifically for people with dementia.

Challenges include:

- Coping with the significant projected increase in moderate and severe dementia (projected to increase by 38% by 2020)
- Supporting carers with information, support and respite services
- Early identification of people living with dementia
- Raising public awareness of dementia
- Supporting the Third Sector in developing services
- Providing appropriate lifetime housing

Community services (health and social care)

Adults and Older Adults

Community nursing and home care is currently provided by Family Nursing and Home Care (FNHC), with Community & Social Services providing social work for all age groups. FNHC provide District Nurses, Health Visitors and School Nurses, as well as home care assistants. Help at home is currently available to support independent living, and includes home care to support basic needs such as shopping, laundry and meal preparation. However, services are not available 24 hours, and benchmarking indicates that Jersey has a relatively low number of registered community nursing staff.

Currently, care for people with long term conditions is mostly provided by the hospital, by GPs supported by a small number of practice nurses and by FNHC. Support for specific groups of patients with long term conditions is also provided by a range of Third Sector organisations, such as Breathing Space, Diabetes Jersey and the Jersey Heart Support Group. Integration of services, however, is limited.

Emergency hospital admissions are driven by general medical patients and other than the Samares Rehabilitation Ward, there are no intermediate care ("step-up" and "step-down" facilities) in Jersey. These facilities would help to prevent individuals being admitted to hospital ("step-up") or support discharge ("step-down"). Jersey also has no specific model for self-care or telehealth or telecare infrastructure, which can help individuals manage their own condition more effectively.

Limited choice exists for end of life care, other than for cancer and motor neurone disease, where Jersey Hospice Care provides excellent services. As a result of fixed term funding from several charitable

organisations one Palliative Care Nurse Specialist has been employed, with a further Liverpool Care Pathway Nurse employed for a period of 1 year in January 2012. In addition, charitable funding has supported the appointment of a Specialist Registrar in Palliative Care, which is shared between the Hospital and Jersey Hospice Care.

As a result of the service availability as outlined above, high use is made of institutional models of care and lower numbers of older adults are living independently in the community. It is estimated that c1,000 older people are cared for in residential settings currently, although this includes private sector as well as States-provided and funded care.

With no changes to the service model, the increasing demand expected with an ageing population will create unsustainable pressure on the hospital and on the whole health and social care system.

Carers

As with all countries, it is difficult to estimate the number of unpaid carers in Jersey. However, the pressure on unpaid carers is immense, and is compounded by the high cost of living, which results in one of the highest proportions of female workforce. The Carers Strategy “*Caring for life, a life for Carers*” was jointly developed following a workshop in October 2008. It is due for renewal in 2012. Following discussions with Jersey Association of Carers Incorporated we are proposing that this is developed by the Carers Partnership Group.

Children

A range of services for children are currently provided in the Island. These services provide preventive, protective, clinical and emotional support to children and their families across different levels of need and are provided by Health and Social Services and Third Sector providers such as Brighter Futures.

The traditional model of reactive services is no longer appropriate. 20% more children are cared for in residential settings rather than by foster carers, when compared to the UK. Children’s services are under pressure because of very high referral rates and the difficulty of securing a good supply of foster carers, and the current institutionalised model had led to increasing and unsustainable demands being placed on Statutory Services, including Residential and Fostering Services. In addition, there are high levels of Emergency Department activity for children which could be more appropriately seen within Primary Care.

At an operational level there is much passion and energy. However, greater coordination is required between the key statutory and voluntary agency partners in order that the right child gets the right intervention at the right time. Joint planning and interagency planning with common goals are vital.

A number of important forums bring together key service providers. For example the Jersey Child Protection Committee, Early Years Childcare Partnership and most recently the Children’s Policy Group which has produced the Children and Young Peoples Framework.

There is an absence of published local outcome measures, although anecdotal evidence from colleagues working in the education system note a significant variance in children’s school readiness at age five.

Other challenges include:

- Low thresholds for referral to Service for Children, as common assessment tools do not exist
- Limited capacity for early intervention in universal services
- The majority of antenatal care delivered in hospital
- High risk of disjointed and duplication of services
- Absence of robust health intelligence about children's needs

Third Sector

Jersey has a vibrant Third Sector, providing information, support and services for particular groups of patients, service users and carers. There are almost 300 registered charities in Jersey, with c70 focusing on different aspects of health and social care.

Community support groups exist in some Parishes, e.g. in St Clement. These are run by volunteers, and provide support to enable individuals to live more independently. Despite offering a quality service for a proportion of the population, other parts of the island population are unable to access this support or equivalent creating an inequity across Jersey.

There is limited integration between Third Sector providers, and between Third Sector and States-provided health and social care. This may lead to duplication or gaps in services, and opportunities to work jointly with care designed and delivered for individuals may be lost.

Many Third Sector organisations are keen to engage more fully with health and social care; whether this is to advocate on behalf of their members, to contribute to service planning or to provide health and social care services in the future. However, capacity and capability challenges exist and there is a lack of co-ordination and understanding within the Sector regarding the services offered by each organisation.

Previous Service Level Agreements have been short term and vary in their robustness and in terms of the information produced in order to assess outcomes and value for money. The short term planning cycles compounded this, and have led to some Third Sector organisations feeling unsupported and uncertain about their future.

2.3. THE IMPLICATIONS OF DOING NOTHING

Continuing to deliver services as they are at present is both **unaffordable** and **unsustainable**. Due to demographic pressure caused by the elderly population, capacity will start to be exceeded within the next year, but there are severe limitations on increasing capacity due to staffing availability and the pressure on buildings as activity increases.

Older adult services will quickly reach capacity. This will require significant additional funding and facilities, or will lead to overspill into other care settings e.g. the hospital, causing operations to be cancelled and waiting lists to grow. Increased spot purchasing of independent sector capacity will be required. The current ‘institutionalised’ model will continue, which impacts people’s ability to live productive and independent lives in the community, supported by a range of care professionals. It also reduces choice and increases pressure on carers.

Pressure on **staff** will increase significantly as caseloads and workloads increase. This is compounded by the retirement profile, which will lead to increased stress and sickness absence and a further exacerbation of the current vacancy and locum situation – which further increases costs and clinical risk, and impacts quality and safety. As community staff will become more stretched, so the amount of time available for each patient / service user decreases. This has two effects:

- The length of stay in hospital will increase as services to support people at home reduce further
- An individual’s condition can worsen if it is not being well managed. The numbers of Islanders presenting at the Emergency Department and/or requiring unplanned care will increase, and more people will need to be admitted to hospital

The **hospital** will quickly cease to be sustainable:

- As emergency or unplanned admissions increase and lengths of stay increase, hospital beds start to become full
- As hospital beds become full, operations will be cancelled more often. Waiting times will increase, and people’s health will suffer as their condition worsens whilst they are waiting for surgery
- A model based predominantly on emergency and unplanned care will reduce the attractiveness of a career in health and social services in Jersey. Skilled and experienced staff will start to leave the Island, and it will be even more difficult to recruit replacements. Eventually, some services will become unsustainable because there will not be enough staff to run them
- The wrong balance of planned and unplanned services will mean that some services may have to close because volumes may fall below safe levels (because staff are focusing on unplanned care and so do not have the capacity to provide planned care as well). Jersey residents will then have to travel abroad to receive services
- Closing services may mean that emergencies have to be stabilised and flown off island – subject to flight availability – instead of being treated in our general hospital
- With this scenario, the hospital will eventually cease to be a hospital as we currently know it and will become a “stabilise and send off island” emergency centre with some simple day surgery, outpatients and diagnostics services only.

If **Primary Care** continues to be delivered by a medically-led model, the opportunity to enhance and expand the Primary Care team will be lost, with co-payments continuing to deter some patients from accessing their GP or Dentist, health inequalities will increase as patients remain undiagnosed/untreated, and/or the pressure on unplanned care will increase as they continue to present at the Emergency Department.

Access to Dentistry and Optometry, particularly for those on low incomes, will be severely limited, and Pharmacists may be under-utilised in terms of their skills and range of services.

Significant opportunities for improving the health and wellbeing of the population are also lost as self care remains underdeveloped, leading to increased demand and cost in later years. Conflicting information and duplication in resources will continue to exist. Pockets of good practice will continue, but Third Sector and other organisations will soon become swamped by the increasing elderly population with long term conditions.

Public health intelligence will continue to remain a challenge, and undertaking robust health needs assessment of the population will be severely limited. As a result, the health and social care needs of the population may not be accurately assessed, and the most effective and appropriate care provided.

The challenges relating to services for **children** will continue; more children will be in residential care rather than with foster carers and families. Social, behavioural and psychological issues will continue into later life and may prevent children from becoming active members of society and becoming good parents themselves.

Stigma for **mental health** will continue, and more individuals with low level mental health issues will be untreated. This will lead to an increase in sickness and absence and incapacity claims due to mental health issues, and will impact not only on health and social care, but also on economic productivity, social security payments and on families and society as a whole.

3. OPTIONS FOR THE FUTURE OF HEALTH AND SOCIAL CARE

3.1. HOW THE PLANS WERE DEVELOPED

Health and Social Services embarked on its review of health and social care in Jersey in late 2010. The aim was to:

- Clearly identify the challenges, both current and future, through analysis, benchmarking and engagement
- Identify international best practice and consider how these could be applied in Jersey
- Plan, design and deliver a set of scenarios for consultation, through engaging with political, clinical, professional and managerial leaders from across the health and social care system and stakeholder representatives from key Third Sector partners

KPMG, who were working with Health and Social Services at that time, concluded that health and social care in Jersey is not sustainable. The challenges pertaining to the current system and potential care models were identified in their Technical Document.

3.2. THE GREEN PAPER

The Ministerial Oversight Group and Steering Group agreed three scenarios for consultation in the Green Paper. These were developed as a result of analysis, benchmarking, stakeholder interviews and discussions, reviewing best practice and workshops:

1	‘Business as usual’	<ul style="list-style-type: none"> ■ Services are delivered in the same way as in 2010. The demographic changes place pressure on capacity and costs
2	‘Live within our current means’	<ul style="list-style-type: none"> ■ Funding remains the same as in 2010, with an uplift of inflation + 2% p.a. for three years, then inflation only for the remaining period. ■ Some service changes are implemented, but only where this is possible within funding constraints. Significant restrictions are introduced and only the most essential services are provided to patients with the highest need
3	‘A new model of health and social care’	<ul style="list-style-type: none"> ■ A revised strategic service model, with more care out of hospital, integration, choice and evidence-based services which will relieve pressure on hospital beds

3.3. GREEN PAPER CONSULTATION

Public consultation on the Green Paper ‘Caring for each other, Caring for ourselves’ took place between May and August 2011. Consultation activities were designed to reach a range and broad spread of:

- Age groups
- Parishes
- Staff
- Vulnerable and hard to reach groups
- Interest groups
- Service providers / partners

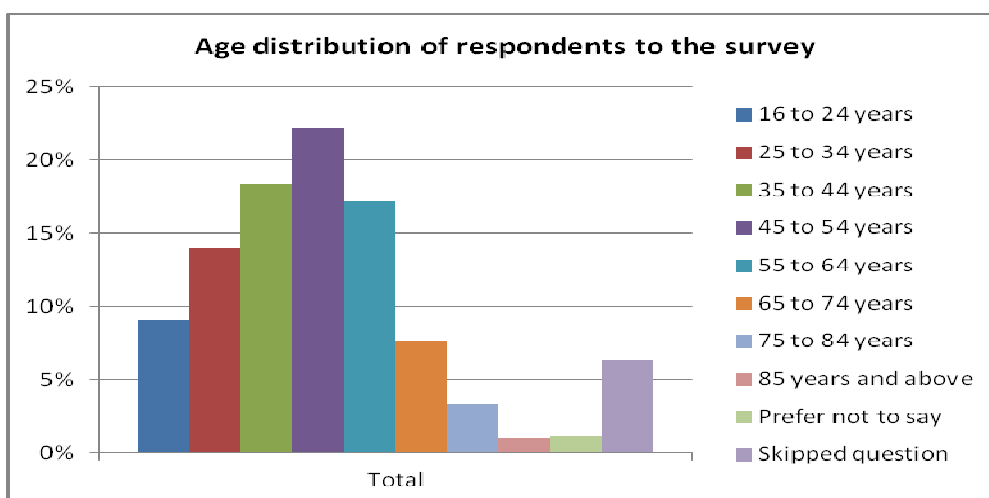
Activities included public meetings, focus groups with schools and high profile media coverage. Staff ‘drop-in’ sessions were held from 7am to 9pm on three days, in order to be accessible to night staff as well as those working during normal office hours. Focus groups were also held with Islanders with sensory impairment, in order to consider their specific views regarding access and equality.

More than 1,300 Islanders responded to the consultation. The response was overwhelmingly (86%) in favour of redesigning health and social services so that they continue to be safe and affordable for the future, and many respondents included detailed comments and viewpoints.

Responses were received from across all age groups. 69% of responses were received from individuals; 17% from organisations, such as Family Nursing and Home Care, dDeaf Awareness Group and MIND Jersey. More women than men responded.

It should be noted that the Green Paper and White Paper consultations do not provide a demographically robust sample of public opinion. People chose to take part of their own free will and therefore, the views expressed cannot be taken as representative of the views of Islanders or all organisations as a whole. However, every effort was made to engage with as wide a range of people as possible through the various mechanisms to try and capture the diversity of Islanders’ views.

Figure 3: Age profile of respondents to the Green Paper



RESPONSES

Values about health and social care

The overwhelming message from the Green Paper consultation was the positive views of Islanders about their health and social services. The results of the survey show that the majority of the respondents believe it is very (81%) or fairly important (16%) to continue providing a wide range of health and social care services on island.

The majority find it very important (82%) or fairly important (16%) that in future these services are free, or affordable, and available to all.

Several respondents added comments relating to valuing health and social services. Some say that good health and social services are one of the main duties of the States of Jersey, that health and education should take priority over other budgetary demands and that if cuts need to be taken from elsewhere to pay for this then this should happen.

Should we change services in Jersey and, if so, how?

86% of respondents agreed with Scenario 3 (a new model of health and social care). The consultation concluded that:

- To be fit for the future challenges the island faces, the health and social care system needs to change. Responses indicated that the way we provide health and social services now is not sustainable or affordable in the long term, and “doing nothing is not an option”.
- There is an understanding that simply raising revenue or controlling spending will not address the issues.

While the majority of people expressed these thoughts, there were some who believe that services should continue as they are, or should be reduced so that we live within the current budget for the next 30 years. However, very few Islanders expressed a view that the system could not be improved.

What is important?

The vast majority of respondents (90%) agreed that “The States should ensure that preventing ill health is as important as curing ill health”. Some people felt that a large benefit could be gained from this area in the long term, whilst others were not sure whether this would be possible.

Islanders indicated that mental health is just as important as physical health. They also agreed that disadvantaged children and younger people should have better access to health and social care services.

What is the individual’s role in their own health?

There were mixed views on having “responsibility for your own health”. In particular, there were concerns about “self-inflicted” injuries or illnesses. Some people argued that it was not always possible for everyone to look after themselves and that vulnerable, ill or disabled individuals should not be disadvantaged.

Where should care be delivered?

Most respondents agreed that “People should be able to live in their own home for as long as possible, providing they have the right health and social care support from the States of Jersey, the Third Sector and Parishes”.

The vast majority of people (90%) agreed that “Instead of going to a hospital doctor or GP, I would be happy to be seen by a nurse, a pharmacist or other care professional, for appropriate minor procedures such as measuring blood pressure or monitoring my diabetes.”

Most Islanders said they would welcome qualified nurses working with GPs to free up their time, but others were not in favour of nurses doing what they considered to be the work of a GP. Some people commented that the GP system in Jersey was already very efficient and they were concerned about damaging patient-GP relations, and others were concerned about the cost of visiting a GP.

Respondents also indicated that off-island travel was acceptable for some treatments. Some Islanders would rather not have off-island treatment, whilst others felt that going away for care to be inevitable on a small island like Jersey. Respondents also expressed views on whether patients should travel off island to see a doctor, or whether doctors should visit Jersey to treat patients.

Professionals working together to deliver better integrated care was important, and some people noted that Jersey’s charities should receive more funding and support.

Paying for health and social care

The vast majority of respondents thought that health and social care should be accessible and affordable, if not free, to all. However, there was a range of views about who should fund this care, and how.

Fairness – who should pay?

The need for affordable care was often stressed, and many people felt payment and funding needed to be explored in more depth.

Most Islanders said that those who cannot pay should still enjoy high quality health and social care. Opinion was then split about whether the amount of free care available for each person should be capped, with some respondents expressing concern about the costs of care for people with long term illnesses.

Some Islanders commented that if health and social care was capped, for some conditions or for all, this should be means tested. However, others disagreed with means testing and felt that if someone had worked all their lives, they should have as much right to free care as others.

Some felt it would be fair that those who had lived in Jersey all their lives received free access to treatment – but that people who have not paid into the system should not enjoy the same benefits.

Payment for treatment

According to many respondents, significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, whereas a visit to the Emergency Department is free. The majority agreed that if a charge applied to visit the Emergency Department for treatment of a minor condition, they would be more likely to go to see their GP. Many also suggested that GP consultation costs should be reviewed at the same time as Emergency Department costs.

Opinion was split about whether individuals would pay to wait a shorter time for a hospital appointment.

Efficiency

Many people felt that there are opportunities to improve the current system. Suggested ways to improve efficiency included reducing bureaucracy in health and social services, improving communication between organisations and bringing in more Third Sector and private sector organisations to provide care.

CONCLUSIONS

The vast majority of Islanders who responded agreed that health and social services should be redesigned to make them fit for the future and ready to deal with the challenges we will face. However, many were concerned about the actual implementation of these plans, the costs and associated risks.

3.4. WHITE PAPER

A ten-year timescale

The White Paper outlines proposed changes to health and social care in the next 10 years. This timescale was selected (rather than the 30-year timescale in the Green Paper) because:

- Services must change in the period to 2021 in order to cope with the increased demand in that period and simultaneously to prepare for the much larger increase in demand in the period from 2021 - 2030.
- It is extremely difficult to make detailed plans for periods longer than 10 years
- A 'new' hospital is required within 10 years
- The States' planning cycle runs for 3 years; the Service Workstreams cover three 'Phases': 2013 – 15, 2016 – 18 and 2019 – 2021. This helps to ensure that financial and service plans can be consistently developed and co-ordinated to link in with States timescales.

Identifying the service areas

Following the Green Paper consultation eight service areas, and priority areas within these, were identified, based on:

- Current / imminent capacity pressures
- Green Paper feedback
- Strategic importance
- Whether the service change is a 'critical path' building block for future service changes

Eight 'crosscutting' enablers were also identified, these being the essential elements that support change.

Considering the previously agreed prioritisation criteria and understanding the current and future challenges for each area, priority schemes were identified in each Service Workstream:

- Healthy Lifestyles - Alcohol
- Services for Children – Early Intervention (0-5 years)
- Hospital Services – Strategic Partnerships for Renal and Oncology
- Adult Mental Health – Improving Access to Psychological Therapies
- Older Adult Mental Health - Dementia
- Intermediate Care
- Long Term Conditions – Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Disease (CHD), Diabetes
- End of Life Care

The 'Crosscutting Workstreams' are:

- Workforce
- Estates
- Primary Care
- Technology
- Informatics
- Commissioning
- Funding
- Legal and Regulatory

Producing plans

Lead officers, known as Senior Responsible Officers (SROs) within Health and Social Services were identified for each of these 'Service Workstreams' and 'Crosscutting Workstreams', and high level workstream plans were developed, through working groups and workshops with a range of stakeholders, for the next 10 years. Outline Business Cases were also produced for each priority area, for Phase 1 (2013 – 15).

Producing the White Paper

The Service Workstreams, Outline Business Cases and Crosscutting Workstreams were incorporated into the White Paper.

The White Paper developed the key themes from the Green Paper feedback:

- 'Doing nothing is not an option'
- A wide range of health and social care should continue to be provided on-island, with off-island care for specialist treatments where appropriate
- Services should be free, or affordable, and available to all residents – regardless of the ability to pay
- People should be able to live at home as long as possible
- The role of nurses and other health and social care staff need to be enhanced
- Integrated care is important, with professionals working closely together
- Preventing ill health is as important as curing ill health
- Mental health is as important as physical health
- Jersey's Third Sector should be supported to take a larger role
- Co-payments for GPs need to be considered
- Services should continue to become more efficient, and bureaucracy should reduce

Rather than a questionnaire, Islanders were invited to state and outline their views.

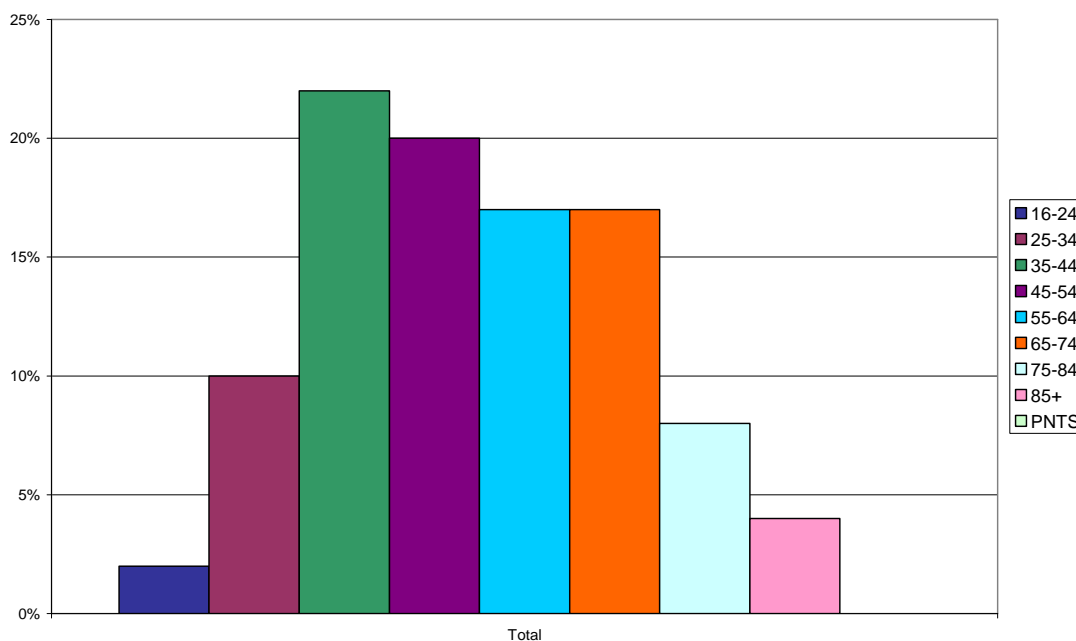
3.5. THE WHITE PAPER CONSULTATION

The White Paper consultation took place between May and July 2012.

Building on lessons from the Green Paper consultation, engagement activities included public consultation sessions, individual meetings, focus groups, discussion forums and ‘drop-in’ sessions for staff, held in different locations and at different times of the day. In addition, mainstream media routes were used to raise awareness and inform Islanders e.g. JEP, Channel TV, BBC Radio Jersey, 103Fm, www.channelonline.tv, Parish magazines, the Public Consultation Register, Facebook and Twitter.

Over 1,000 Islanders were engaged in the White Paper through face-to-face discussions. More than 20 formal responses were received from organisations, the majority of which were from Third Sector organisations. There were over 1,500 hits on the White Paper consultation page on the gov.je website, and over 130 responses were received from individuals, with a good age distribution:

Figure 4: Age profile of respondents to the White Paper



RESPONSES

Overall the vast majority of feedback received confirmed that Islanders remain positive and supportive of the proposed future direction for health and social services. Wider political / social policy issues regarding fairness and access to services for all Islanders, but in particular for the vulnerable members of society, were discussed in a number of forums. Key themes pertaining to health and social care included:

Primary Care

The majority of responses received across all consultation formats related to Primary Care, with the most common feedback relating to GP fees. Many of those that responded thought that fees were too high and can act as a deterrent to accessing care, particularly to those on low incomes or with children.

Improved access to Primary Care for under 5's was presented in the White Paper. This was frequently commented upon in the responses received, with strong support for this concept, either as subsidised or free GP appointments. Some people felt this should apply to all children under the age of 16 and those in full-time education, and some were of the view that these principles should also apply to the elderly and those with long term conditions.

Similar concerns were raised regarding access to dental care, which some felt was a specific element of Primary Care missing from the White Paper. Some respondents noted that dental services should be more accessible, through either free or subsidised care.

Many respondents were supportive of potential changes in delivery of Primary Care, with people stating that more nurses in GP practices was a good concept and should be explored further.

Some people suggested an expansion in the role of GPs, including GP clinics in the hospital and more out-of-hours access. It was suggested that this, along with changes to GP fees, would help to alleviate the pressure and the inappropriate use of the Emergency Department.

Staffing and Capacity

The majority of responses relating to staffing were focused on recruitment and retention, particularly of nursing staff. Islanders were concerned about the ability to recruit the large increase in nursing staff required to provide new services, with concerns about where skilled staff would be drawn from. People wanted to know what skills were needed, the existing gaps and what training opportunities were available for Jersey to both 'grow its own' nurses and up-skill the current workforce.

Respondents suggested that nurse pay should be reviewed and that affordable and appropriate accommodation should be available.

Alongside some of these reservations there were some very positive comments and recognition of the quality and hard work of staff currently working in health and social care, particularly at the hospital.

Funding

Respondents were anxious about the source of funding and whether enough money had been identified to deliver the White Paper. There were some mixed opinions about future funding sources, with numerous questions regarding tax and user-pays. Overall Islanders would like a fair mechanism that doesn't penalise people who have contributed to the system their whole lives, with some stating that tax relief should be available for those with private health insurance. Means testing was often discussed at meetings, and those people who offered a view on this mechanism felt that it would not be a fair or favourable way forward.

Conversely, a small number of responses took the opposite stance around paying for care and services. Some people felt that small charges for health and social care were acceptable in order to fund the required increase in services. Some responses suggested that a charge should be applied to those who misuse services, particularly the Emergency Department.

In relation to longer-term care, there was strong feeling expressed by many that individuals who have paid into the social security system during their lifetime should not have to sell their homes in order to pay for care, particularly in their old age.

Some of the feedback questioned how the money would flow around the system and which service areas and providers would receive the money. This was often raised during discussions with Third Sector organisations and GPs.

New Hospital

There was overall agreement within the consultation that investment is urgently required as current facilities are not fit-for-purpose. Opinion was divided as to whether, for the hospital, this should be a new build or a redevelopment of existing facilities. However, these comments were often linked to concerns about funding.

Carers

Support and recognition for carers was a recurring theme, with very strong views expressed throughout the consultation. Respondents felt that more recognition needs to be given to the important role of carers, and that a wider and increased amount of support, advice and training should be made available. Interestingly, these conversations often highlighted a lack of awareness of the current services and support mechanisms that are already available.

There was recognition that failure to support carers could result in carers becoming patients themselves. Islanders expressed strong views that more respite services are urgently required.

Other responses suggested the need for more support both financially and in terms of providing advice, training and recognition for carers. The important role of young carers was also noted, along with the need for continued cross-departmental working to support individuals.

Third Sector

The Third Sector is frequently referred to throughout the White Paper as a potential provider of services in the new vision for health and social care. The importance of the sector as both a partner and provider was recognised from an early stage in the development of the proposed new approach.

The majority, though not all, of the feedback received about Third Sector issues and the White Paper came from the Third Sector itself.

Overall, Third Sector groups are supportive of the proposals with some slight nervousness regarding the impact on their organisations. Many organisations were in agreement with the concept of working with the States in partnership to deliver services, and many expressed the need for this relationship to be as equals and in a collaborative and integrated model. It was noted that this would require a culture change and development of additional capacity and capability.

Care in the community

Respondents were strongly in favour of providing more care in individuals' homes, to enable people to maintain their independence for as long as possible. The concept of choice was overwhelmingly supported, along with appropriate mechanisms to limit social isolation and the need to ensure that care in the community allows people 'to live, not just exist'.

In particular, the concept of an Active Ageing and Wellbeing Centre was strongly supported by those who responded, and many Third Sector organisations expressed an interest in being involved in this.

A few respondents expressed the view that that community care won't be appropriate for everyone, and regulation and monitoring the quality of care was identified as a concern, with some people noting the need to carefully select service providers, especially those involved in care in an individuals' home. In addition, comments on the move to care in the community were often linked with concerns about funding and staffing capacity.

Mental Health

Islanders who participated in the consultation were generally very positive about the outline plans for Improving Access to Psychological Therapies (IAPT) and the inclusion of mental health in the White Paper. Some people noted the need to remove the stigma associated with mental health issues and supported service delivery in a multi-purpose setting. Others commented on the need to change perceptions of mental health and that a more positive approach around mental health and wellbeing should be promoted.

In public meetings, a view was expressed that traditionally mental health services have been perceived as a "Cinderella Service" and that this needs to change. Some mental health services also need to be prioritised, in particular for individuals in crisis. It was hoped that the changes proposed in the White Paper would act as a catalyst for this.

Equality and access

Issues of social equality and fairness were often mentioned in relation to the key themes, in particular around access to Primary Care and funding. These issues were most acutely expressed by those groups who currently find access to services more difficult due to hearing and visual impairment. These groups urged Health and Social Services (and the States) to be mindful of their needs in the design of new services and facilities.

Adult Special Needs Services

A small number of responses from staff currently working in adult Special Needs services expressed disappointment and concerns about the lack of prominence of, and funding for, these services in the White Paper. Respondents commented on poor state of current facilities and accommodation as well as the lack of resources.

Services for Children

Third Sector organisations involved in the delivery of services for children strongly supported the prioritisation of Early Intervention, with strong views expressed regarding the range of alternative service models for meeting the needs of this client group.

CONCLUSIONS

The White Paper outlined a vision of health and social care in Jersey in the next 10 years. It presented outline plans for achieving the vision, but did not present detailed plans for the full ten years of implementation. This Report gives clear information about likely changes in the first three year Phase, and work is now underway to develop Phases 2 and 3.

Over 1,000 Islanders were engaged with as part of the eight-week consultation, and engagement with a range of Third Sector organisations was prioritised. Feedback on the White Paper was overwhelmingly positive, and identified a need to prioritise and/or consider further:

- Payment mechanisms for Primary Care
- Workforce, particularly nursing
- Funding for health and social care following Phase 1 (2013 – 2015)
- Support to carers
- The role, relationship and continued involvement of the Third Sector - including capability development
- The Active Ageing and Wellbeing Centre
- Existing services for acute / crisis mental health
- Access, especially for those with special needs, physical and sensory impairment
- The detailed models of care for services for children

4. THE PROPOSED NEW WAY FORWARD FOR HEALTH AND SOCIAL CARE

The proposed new way forward for health and social care identifies the strategic investments that are required in order to continue to deliver safe, sustainable, affordable services now and into the future.

It should be noted that this does not replace the ongoing service developments that are already planned and that have already commenced, nor is it intended to replace the need for services to be continually monitored and reviewed, and operational changes made as required in the future.

One example of this would be the Special Needs Service, where significant changes are already being developed, and services increased to meet identified needs – particularly in relation to estates.

As each of the outline plans are developed into detailed plans, access and equalities impact must be considered, in order to endeavour to incorporate the particular needs of individuals with physical disability and/or sensory impairment.

4.1. STRATEGIC VISION PRINCIPLES

The vision of services which are safe, sustainable and affordable was distilled into a set of strategic design principles in late 2010. These were developed by stakeholders across health and social care, and ratified by the Ministerial Oversight Group:

- Safe
 - Clinical/service viability – overcoming the challenges of low patient volumes, delivering high quality care and minimising risk
 - Sustaining a culture of clinical governance, safety, learning and transparency
- Sustainable
 - Services that are efficient, effective and evidence-based
 - Optimising estate utilisation and ensuring the estate is fit-for-purpose
 - Supporting and utilising the workforce to the best of their abilities
 - Engaging the public in self-care and with consistent access and thresholds
 - Using robust data to support decision making based on fact, and including patients and the public in service design
- Affordable
 - Ensuring financial viability and reducing the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
 - Establishing funding streams and developing funding models that incentivise care and cooperation

4.2. THE NEW WAY FORWARD – WORKING ACROSS SERVICE PROVIDERS AND INTEGRATING CARE

The proposed model of health and social care services will support and enhance the elements of the current system that are positive and will, over the next 10 years, transform the system so that it continues to meet the needs of Islanders.

Care will be **integrated** as seamlessly as possible, with the individual patient or service user at the centre. Teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff will work together with the Third Sector and private sector providers to achieve this.

Frontline service integration will be supported by a professional mindset that seeks the individual's views, choices and decisions about their care package, and ensures that needs drive services and not the reverse.

Organisationally, teams will be integrated and clear **partnership** arrangements will be developed across service providers. Multidisciplinary teams will be introduced, with integrated care pathways that clearly define roles and responsibilities – including with hospital, Primary Care and Third Sector / Parish services.

Systems to improve **communication** will be introduced, through improving and sharing information systems. This will include multidisciplinary notes that can be shared by all professionals involved in an individual's care. Single assessment and care planning will ensure the individual's holistic needs are identified, and care navigators will ensure co-ordination and access to the right range of services.

Where appropriate, service provision should move away from residential care and institutionalisation towards an increase in **community** provision to allow service users to integrate and lead independent and productive lives as much as possible. This will relieve pressure on hospital beds, and will help the hospital to manage within its current facility until the 'new' hospital is available. It will also support more children to be cared for in family settings.

The drive to improve **efficiency, effectiveness and productivity** will continue. The Jersey Lean System (a service redesign approach) will have been introduced into health and social care by early 2013, with a number of staff in a range of settings / services trained to identify and deliver service improvements utilising the 'Lean' service improvement methodology.

Awareness and information will increase, and will be streamlined with improved accessibility. Consideration will be made particularly of the needs of sensory impairment. Individuals who are at risk of developing certain conditions will be identified through increased screening, case finding and risk stratification. This will support proactive care to delay the onset or progression of long term conditions.

Proven, cost effective **technology** will enhance services where appropriate, for example telehealth and telecare to enable individuals to be cared for in their own homes, and telemedicine to support clinicians working with off-Island colleagues.

The new system will be underpinned by robust **Commissioning**. This will ensure that the health and social care needs of Islanders are understood and services are available to meet these needs. It will also ensure

visibility over quality and outcomes and improved value for money. Commissioning will also support a range of providers, including those in the Third Sector and private sector, to deliver services.

The vision outlined above is ambitious; this will be a programme of change that is unprecedented in Jersey, and will lead to a health and social care system that will be a model of best practice for isolated, rural and island communities.

In order to achieve this, changes must be introduced in the right order and at the right pace. The majority of changes which have been prioritised for Phase 1 relate to Community services. As these begin to have impact, the strategy for services within hospital and Primary Care settings will be developed. These will then be implemented during Phase 2 (2016 – 18).

5. SERVICE WORKSTREAMS

This section presents each of the Service Workstreams in turn, and outlines the proposals for developing services, within the strategic vision for health and social care. Further detail for Phase 1 (2013 – 15) is available within the Outline Business Cases (OBCs). The feedback from the Green Paper and White Paper consultation has been used to develop our thinking regarding prioritisation and service models:

5.1. HEALTHY LIFESTYLES (STARTING WITH ALCOHOL PATHWAY)

THE VISION FOR HEALTHY LIFESTYLES

To promote healthier lifestyles and behaviours, delay the onset or progression of poor health and social care, and improve an individual's health, wellbeing, independence and quality of life. This will contribute towards a community that values, protects and takes responsibility for its own health and wellbeing, and as a result depends less on institutionalised health and social care.

WHY THIS HAS BEEN PRIORITISED

Over 85% of adults in Jersey rate their health as good or better, however, Jersey faces some significant public health challenges, in particular regarding alcohol and smoking. We need to improve health and wellbeing and reduce pressure on health and social care services. However, at present there is:

- Insufficient awareness of how lifestyle choices impact on health and wellbeing
- No integrated prevention strategy
- Very limited coordinated promotion of self-help
- No comprehensive picture of population health needs
- Limited coordination and integration between different services working with people who may have a similar underlying issue

OUTCOMES TO BE ACHIEVED

- Reduction in unwanted variation in health and social care outcomes
- Increased early identification of disease
- Improved health and wellbeing, including improvements in access and equality
- Demonstrable behaviour change, with more Islanders adopting healthy behaviours around tobacco, alcohol, exercise and diet
- Increased early diagnosis of cancer
- Increased public awareness and empowerment for informed choices about risk factors such as tobacco, alcohol, exercise and diet
- Increased awareness across key stakeholders e.g. teachers, police
- Increased numbers of individuals identified as 'at risk' as a result of screening - with brief and extended interventions provided
- Reduced pressure on hospital
- Greater integration of services, particularly with Primary Care and Third Sector
- Leadership and operational guidance from professional champions

FEEDBACK FROM CONSULTATION

The Green Paper consultation reported that 90% of respondents believed that prevention is as important as cure; some felt that this was an area where the States of Jersey need to focus their attention for long term gain.

73% agreed that individuals have a responsibility to care for themselves, once provided with the tools and skills to do so. Some respondents noted that keeping fit and healthy is the responsibility of the individual and should be encouraged as widely as possible. Others feel that everyone should have equal access to medical support, regardless of whether they look after themselves.

Feedback from the White Paper consultation supported the prioritisation of alcohol as the key priority. Islanders openly recognised the impact that alcohol dependency has on the hospital, especially the Emergency Department. They also recognised the interdependence with wider social policy, including housing, education, criminal justice and the potential impact on risks, particularly for young women.

Feedback from the White Paper also highlighted the importance of encouraging healthy lifestyles for children and young people, particularly around the importance of play and leisure time involving physical activity.

The need to streamline and simplify the multiplicity of information sources, whilst continuing to support Third Sector organisations, was identified.

SERVICE DEVELOPMENTS

The focus of this workstream is to design prevention programmes that successfully address the key determinants of poor health and wellbeing.

A rolling programme of Jersey Strategic Needs Assessments (JSNA) will be undertaken across States Departments, led by the Health Intelligence Team in the Public Health department. This will help to develop an understanding of how the determinants of health, including lifestyle risk factors, contribute to morbidity. It will also provide a clear picture of the current health status of Islanders, and identify and project their health and social care needs for the coming three to five years. The JSNA will:

- Incorporate the wider determinants of health (e.g. housing, employment, education) to provide a comprehensive view of the population's health and social care needs. It is well known that poor housing and education can have a detrimental effect on health; it is important that these underpinning foundations for health are identified and addressed as part of wider social policy at the same time as lifestyle issues
- Develop population profiles for the key risk factors (including diet, exercise, tobacco and alcohol consumption) to the main chronic disease conditions which contribute to levels of morbidity (obesity, cardiovascular and respiratory disease, and diabetes). These profiles will form the basis for commissioning population-based preventative services such as smoking cessation, as well as informing social marketing campaigns

- Consider the specific communities whose health may be worse than others, and identify equality and access issues, for example relating to sensory impairment, physical disability and/or special needs
- Develop pathways for conditions that are associated with individual behaviours and lifestyle, for example alcohol and sexual health. The pathway approach will improve the integration of services and encourage an increased role for Community and Primary Care services, which will in turn reduce the pressure on hospital services and improve outcomes.

2013 - 2015

The lead OBC is focussed on the alcohol pathway. The revised alcohol pathway will be based on NICE guidance¹⁰¹¹ and other key documents. It will support a consistent approach to addressing alcohol misuse, through a pathway developed in consultation with clinicians, the Third Sector and service users. The aim is to:

- Improve the identification and treatment of alcohol misuse
- Increase access to alcohol services toward 20% in three years
- Encourage more people to proactively seek information to help themselves and others to drink sensibly
- Improve the timely use of health services to reduce harmful patterns of alcohol consumption
- Increase the number of people being supported sooner to reduce their alcohol consumption before any crisis or long lasting damage
- Increase the number of severely dependent drinkers taking up non-hospital detoxification and relapse prevention programmes.

The future Alcohol Strategy and revision of the Alcohol Licensing Law will underpin these service changes.

The pathway comprises:

- **Self Care / Guidance** - Media campaigns and targeted social marketing, with evidence-based programmes targeting those at risk to complement the existing generic information currently provided as part of the local PSHE Curriculum in schools
- **Screening and Case Finding** - Validated tools to screen for alcohol misuse, delivered in Primary Care (GPs and Pharmacists) to provide early detection of alcohol related problems. This will be supported by a regular review of practice populations to identify high risk individuals. Key gateways into the hospital (Emergency Department, Day Surgery, Outpatients, Emergency Admissions Unit and Gastroenterology) will screen opportunistically in key target audiences. A care bundle approach will be used to ensure patients are not repeatedly assessed but are offered appropriate interventions
- **Brief and Extended Interventions** - once screening has been completed practitioners will offer brief advice and / or will refer to specialist services. Rapid response to referrals post-screening will be achieved through increasing the capacity of the Hospital Alcohol Liaison Service and ensuring expertise is built into future mental health services
- **Non-hospital Detoxification / Relapse Prevention** - Increasing the amount of screening will lead to an increase in the number of alcohol dependent patients identified for non-hospital detoxification. A

10 Guidelines on Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence Volume 1 -3: NICE

11 Public Health Guidance 24: (2010): Alcohol-Use Disorders; Preventing the Development of Hazardous and Harmful Drinking: NICE

consistent referral route will be implemented, which will enable capacity to be better utilised and will increase the amount of detoxification completed in the community. On completion of a detoxification, relapse prevention programmes will help support the client and family to adapt and to maintain abstinence, thereby reducing the risk of readmissions and alcohol-related morbidity

2016 - 2018

The focus will be on developing a comprehensive and co-ordinated approach to screening, continuing to collate information to assess health and social care needs, and increasing awareness and services for diet, exercise, tobacco and sexual health.

The approach and methodology for population **screening** will be developed from 2016 onwards. This will be a coherent and coordinated approach, initially focusing on key risk factors for chronic conditions such as tobacco, alcohol, obesity. The results of screening will enable prevention programmes ('prescriptions for health') to be focused on key groups according to the known profiles. In addition, age-related health screening at 50 – 55 years old for common conditions such as type 2 diabetes and high blood pressure will be developed, as similar programmes have been shown to have a positive impact in reducing the level of disability caused by these conditions later in life.

'**Prescriptions for health**' will allow clinicians to 'prescribe' health promoting interventions, such as exercise, weight management and smoking cessation in addition to traditional prescriptions e.g. for antibiotics and other medicines. There is good evidence to support this type of approach from the National Institute of Clinical Excellence.

Developing **pathways** for prevention, diagnosis, treatment and recovery for conditions associated with individual behaviours and lifestyles such as sexual health and illegal drugs will ensure patients access the correct services at appropriate times. The Alcohol Pathway will serve as a 'proof of concept' in terms of resource requirements for risk profiling, awareness, screening and care pathway co-ordination across sectors and agencies. Future pathways will incorporate:

- Social marketing and public awareness
- Improved access to information
- Developing the role and capacity of Primary Care
- Expert leadership across the pathway
- Clear commissioning priorities to inform third / private sector involvement
- Robust indicators based on JSNA and population risk profiles.

A coordinated **cancer strategy** will ensure prevention and earlier interventions give greater opportunity for care to be delivered in the community with the support of telehealth and telecare. The cancer strategy would encompass the complete care pathway including:

- Primary prevention, ensuring cancer prevention messages are included in the messages around smoking, alcohol, diet and exercise
- Population screening, focusing on improving uptake and monitoring new developments in current and emerging screening programmes
- Early intervention and treatment, providing quick and timely advice, guidance and treatment
- Recovery, providing appropriate community-based support to individuals and family members.

In practice, investment in promoting cancer awareness and improving early diagnosis may not reduce the number of cancer patients but will significantly reduce the costly treatment of advanced cancer, commonly undertaken off-Island.

2019 - 2021

The model for healthy lifestyles will continue to be expanded in Phase 3, including:

- **Mental Health** – Focusing on community-based programmes that support and promote mental health and reduce stigma associated with mental illness. A number of national programmes have been implemented which have had a positive impact on reducing the stigma associated with mental illness, and best practice will be incorporated from these programmes
- **Illegal Drugs** – A repeat of the Imperial College survey which described drug-taking activity in the Island, with services reviewed and developed as a result
- **Healthy Ageing** – Focusing on key factors which reduce independence, including:
 - A comprehensive falls prevention programme
 - Reducing morbidity due to seasonal flu
 - Maintaining health and independence by increasing the uptake of health promoting initiatives which provide social as well as physical benefit

5.2. REFOCUSING SERVICES FOR CHILDREN (STARTING WITH EARLY INTERVENTION)

THE VISION FOR SERVICES FOR CHILDREN

To improve outcomes for children measured in terms of their health, social wellbeing and educational attainment. This applies to all services provided to children and will be achieved by close working between States Departments and the independent and Third Sectors.

A fully integrated service delivery model will be implemented with services “wrapped around” the child and family, with respite care, a professional fostering service and a range of choices for services from a network of providers.

Service developments commence with early intervention, focusing on pre-birth to aged five. The principles and lesson learned will be incorporated into planning for each of the age groups as appropriate. In 2016-2018 the focus will be on children aged 5 – 11 years, whilst in 2018-2021 the focus will be on children aged between 12 and 18 years.

WHY THIS HAS BEEN PRIORITISED

Children and their families receive health and social care from a wide range of departments and agencies. This diversity is essential, but integration and co-ordination is required.

Referral rates into Services for Children are higher than in English authorities, and Jersey has a large number of children placed in residential care as opposed to foster care. It is acknowledged that we have less fostering and adoption than we would like, for example because we have a very high number of families where both parents work.

Over the past decade evidence has emerged that the quality of experiences in the first five years of life can have a profound impact on a child’s future development, learning, behaviour, health and the ability to build positive, secure attachments, and on truancy, conduct disorder and risk-taking behaviours such as substance misuse and mental illness. Potential economic implications include an estimated cost for each child with untreated behavioural problems of £70,000 a year by the time they reach 28 years old – 10 times the cost of children without behavioural problems, an average estimated cost of £430,000 for an individual spending a lifetime on benefits.

‘Early Intervention’ improves a child’s social and emotional capability to help break intergenerational cycle of disadvantage and underachievement. Health economists have calculated that a return of up to three to seven times the original investment could be achievable by the time the young person is 21 years.

OUTCOMES TO BE ACHIEVED

Outcomes for children will be improved, with a reduction in the need for (higher cost) reactive services later in both childhood and adulthood and:

- Reduced number of children requiring off-island residential placements
- Reduced volume of mental health referrals
- Reduced need for residential care
- Holistic, health and wellbeing needs met, through a Common Assessment Framework that is appropriate to Jersey
- Improved integration of services and joint working / staff morale
- Improved health outcomes of Looked After Children
- Diversified provision by working collaboratively with Third Sector and private providers
- Reduced obstetric complications as a result of pre-birth support given to vulnerable families
- Improved maternal / child relationship
- Reduced postnatal mental health issues
- Improved joint working in relation to child protection and safeguarding
- Reduced inappropriate Emergency Department activity
- Longer term reductions in antisocial behaviour and crime
- Integrated policy development

FEEDBACK FROM CONSULTATION

The Green Paper consultation reported that 81% of respondents agreed with increased investment in children and young people.

The White Paper consultation engaged specifically with a number of Third Sector organisations involved with children and families. The prioritisation of the 0-5 age group was supported, and respondents favoured improving access to Primary Care through a fixed number of free or subsidised GP visits. It was also suggested that a Head of Early Years for Health and Social Services should be appointed, to work closely with the Head of Early Years at Education, Sports & Culture to ensure an integrated strategic approach.

The principles underpinning the proposed changes to services for children were supported. However, the exact service model contained within the White Paper was challenged. This will continue to be discussed and developed, based on evidence and best practice applied to Jersey, and in accordance with our health and social care needs. These discussions will continue as the detailed plans for service delivery from 2013 are developed, and will be held with a range of stakeholders and experts in the field.

SERVICE DEVELOPMENTS

Services for Children will be developed in three phases, relating to the age of the child:

2013 – 2015 - EARLY INTERVENTION FOR CHILDREN (FROM PREGNANCY TO THE AGE OF FIVE YEARS)

- Additional support and financial payment for **professional fostering**, to support children with challenging behaviours
- Significantly enhanced Children's **respite** services; buildings will be modernised, and additional staffing capacity secured in order to provide more flexible respite which can be adapted to fit different families' needs. The overall aim is to enable children and their families to gain early access to the right support and enable those families to stay together for longer
- **Increased awareness and self help**. Easily accessible self-help materials to assist individuals in developing their skills and knowledge about parenting. There will be particular focus on the antenatal period with specific programmes delivered in conjunction with existing midwifery services. In addition there will be improved signposting towards existing local community groups to assist parents in sharing and supporting each other in caring for and supporting a healthy, thriving child
- Improved access to **Primary Care** for children under five years' olds whose parents require rapid access to health advice or assessment when hospital is not appropriate
- Increased **Community Midwifery**, to offer choice of service and location for ante-natal care
- **Care co-ordination**. National guidance for working effectively with families with children who have complex needs stress the importance of a key worker system. The key worker would work in partnership with the family to co-ordinate service provision and provide ongoing support
- **Early intervention**. Increasing evidence indicates the need to identify and intervene early in order to achieve the best health and wellbeing outcomes for families who have additional needs. Focused on those families assessed as having additional needs during the antenatal period, a two-year programme will provide integrated support across care settings and across organisations. A multi-agency network would be formed around the family, and the family would be encouraged to access a range of support services, drawing on both existing and new services provided by a range of organisations including the Third Sector. This approach will provide both parent and child the best chance of developing resilient, positive relationships which enable the child to thrive during the early years of life and lay the foundations for a healthy life.

2016 – 2018

Following the focus on early intervention (for children from pre-birth to age five), in the period from 2013 to 2015, the focus in 2016 – 2018 will be on children aged 5-11. Children and their families can expect to receive care from a network of practitioners, with appropriate services ‘wrapped around the child’, based on an assessment of all the child’s needs. This will include:

- **Mapping and reviewing** existing universal and tiered service provision, with a view to identifying unmet need, service duplication and overlap and areas which require improvement and scope for innovation. The development of a sustainable model for service provision will be prioritised, including the extent to which existing Multi Agency Service Teams – already established in secondary schools - can support similar functions in primary schools
- **Improving Access to Psychological Therapies (IAPT)** for children, based on learning from the first IAPT for children pilot sites in the UK. This will result in a more comprehensive range of services for children and adolescents with mental health issues. Evidence-based therapeutic interventions such as cognitive behavioural therapy, systemic family therapy, interpersonal therapy and parenting strategies will be delivered for a range of difficulties such as anxiety, low mood, parenting difficulties and conduct problems
- Continuing to invest in **respite services** and **professional fostering**
- Developing a **child health profile** based on existing and future surveys and other data sources such as the child health database

2019 – 2021

Key strategic service developments will include:

- **Mapping and reviewing** services for young people aged 11 – 19, using similar approaches to those introduced for other age groups
- Aligning services for children via multi agency **care pathways**
- Reviewing and enhancing the **Children’s and Young People’s Plan**, including the possibility of pooled budgets and joint commissioning arrangements between States of Jersey Departments.

5.3. ADULT MENTAL HEALTH SERVICES (STARTING WITH IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT))

THE VISION FOR MENTAL HEALTH SERVICES

To deliver person-centred services in safe, flexible and appropriate environments, with a range of providers supported and standardised, high quality delivery of services in a single care pathway by 2021.

WHY THIS HAS BEEN PRIORITISED

Mental health problems are common, and are a major source of suffering for individuals and their families. This can lead to social exclusion and costs to the economy. The Jersey Annual Social Survey (2010) found 18% of the adult population suffer with moderate depression and a further 2% revealed they were extremely anxious or depressed. In addition, increasing rates of death from suicide and undetermined injury was identified as a key concern.

Depression and anxiety make it much more difficult for a person to work and increase the likelihood of sickness absence, and the economic cost of mental health is significant - 46.8% of all claims made for short-term and long-term incapacity allowance in Jersey in 2009 were for mental health problems. Over 2,600 claims on average were made by people on benefits due to depression, anxiety and other mental health issues, and between 2006 and 2009 it is estimated that an average of more than £4.5m p.a. was paid in short and long term Incapacity Benefit for people with all mental health issues.

The current lack of psychological therapies in community settings can deter individuals from seeking help. There is no single point for health promotion information, and stigma associated with mental health issues are a common barrier which prevent people from accessing help. Long waiting lists for psychological interventions have a major impact on people who require support.

OUTCOMES TO BE ACHIEVED

- Early, quick, easy, equitable access to all adults over the age of 18 years for the treatment of common mental health issues, in order to:
 - reduce the impact of common mental health issues for individuals and improve general wellbeing
 - improve access to psychological therapies through a single pathway
 - reduce exclusion from work through the provision of timely, evidence-based treatment provided by a number of specifically trained staff
 - reduce inappropriate prescribing of benzodiazepines and antidepressants
- Enhanced partnership working with GPs, professionals and other voluntary and Third Sector organisations
- Improved range of care provided to people experiencing poor mental health and wellbeing
- Reduced pressure on mental health inpatient facilities
- Improved Advocacy services
- Development of additional support for carers, including peer support. This will be outlined in the Carers Strategy, which will be produced through discussions with carers
- Improved systems for engagement with people who require services and/or their relatives/carers

FEEDBACK FROM CONSULTATION

Comments on the importance of the provision of mental health services featured strongly in both the Green Paper and White Paper feedback.

In the Green Paper consultation, 90% of Islanders agreed that mental health is as important as physical health. Some respondents felt that the current mental health services could be improved, with some respondents suggesting that appropriate funding be made available to ensure this happens.

The White Paper consultation continued this theme; Islanders were extremely supportive of the IAPT model and in particular the principles of reducing stigma, increasing accessibility and making 'talking therapies' available in a wide range of settings such as GP surgeries. Strong views were expressed regarding the current range of mental health services provided and, in particular, the service models for individuals in crisis.

Islanders also indicated that support for carers should be prioritised, and many described personal experiences. The needs of carers were discussed, and the need to urgently review and amend the Carers Strategy was agreed.

SERVICE DEVELOPMENTS

Improved Access the Psychological Therapy (IAPT) services will be introduced from 2013, making 'talking therapies' more widely available for individuals with low level mental health problems, such as anxiety and depression, in non-stigmatising environments and locations.

Concurrently, the Adult Mental Health Service Users Strategy will continue to be developed in partnership with key representatives, including Third Sector (including MIND Jersey), Primary Care and Hospital representatives and, through active engagement and inclusion of people who use services and their relatives / carers.

By 2019, each individual element of mental health services will have been reviewed and improved. The individual elements will work together more closely, providing integrated, seamless care for service users and supporting carers. This will include the processes and systems required to support joint working, such as single assessment, integrated care planning, multidisciplinary notes, multidisciplinary team meetings, liaison with hospital services, partnership working and shared care with GPs and sharing of data and information.

2013–15 - IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

Following NICE guidelines, a Stepped Care Model Service is proposed¹². **IAPT** will comprise therapists working at either high intensity or low intensity, depending on the needs of the individual.

Services will be supported by **self care**, with strengthened personal responsibility, and the role of Primary Care will be developed beyond to encompass the prevention and treatment of disease and the promotion of wellbeing and independence.

¹² Department of Health (2011) The economic case for improving efficiency and quality in mental health. Crown Copyright.

Services will be developed with a range of stakeholders, based on new models of **collaborative working**, with clearly defined and safe care pathways and a distribution of responsibilities between primary, secondary, mental health, social care and the Third Sector – and the patient / service user and carer.

2016-18

Phase 2 will focus on improving:

- **Community Services** will include integrated adult mental health support as a part of a wider multidisciplinary ‘adult’ service (spanning both mental health and physical health needs). The service will incorporate specialist expertise for individuals with alcohol and/or drug dependency (‘dual diagnosis’), learning disability and autism
- **Inpatient Services.** New, flexible inpatient mental health services to replace services previously delivered at Orchard House. Inpatient assessment and treatment services will be reviewed, including the option to co-locate a low - medium secure unit and a specialist assessment and treatment unit for people with dual diagnosis
- **Residential facilities.** A modernised and improved estate. Residential services for adults with Special Needs will be reviewed and services will be reorganised and/or relocated:
 - Fit-for-purpose long term homes for adults with complex needs, including enduring mental health needs, severe learning disabilities and/or on the autistic spectrum
 - Relocation of day services for adults with a learning disability to smaller, community-based facilities
 - Centre of Excellence for Autism
 - Specialist assessment and treatment unit for adults with complex needs and dual diagnosis
- **Rehabilitation services.** Partnership arrangements are being developed with South Essex Partnership Trust (SEPT), as a leading UK Mental Health Trust, informed by work with MIND Jersey to enhance shared learning and service development and ensure services meet Islanders’ needs
- **Single Point of Access.** A Single Point of Access for assessment, diagnosis, care planning and intervention, which will focus on need rather than diagnosis, and will be supported by a robust care management system. This will improve both rapid response and the management of long term care, in line with best practice. The service model will comprise:
 1. Point of access for all referrals to a comprehensive specialist assessment service, including:
 - Social work
 - Community Nursing
 - Occupational Therapy
 - Specialist assessment such as Speech & Language Therapy, Physiotherapy, Psychology, Positive Behaviour Support
 2. Care Management for long term care, to enable individuals to maintain control of their own lives, facilitate decision making, and ensure that service providers are providing the right support, in the right place, at the right time
 3. Service provision to meet the complex range of needs of vulnerable adults living in the community, provided by a mix of Health and Social Services, Primary Care, Third Sector and other providers

2019–21

Phase 3 is a **consolidation** phase, where the service developments introduced in Phases 1 and 2 have time to stabilise. The services will remain under review, with lessons being shared and services continuing to develop operationally. Importantly, individuals and their relatives /carers will be routinely involved in reviewing services as a consequence to the implementation plan for the Adult Mental Health Service Users Strategy.

During 2019 – 21 awareness of mental health issues will be raised, with the aim of reducing stigma and increasing the understanding of Islanders. This is included within the ‘Healthy Lifestyles’ Service Workstream.

5.4. ADULTS AND OLDER ADULTS SERVICES IN THE COMMUNITY

THE VISION FOR INTEGRATED COMMUNITY SERVICES

To provide 24 hour support in a range of settings, including the individual's home, enabled where appropriate by assistive technology such as telecare and telehealth.

This will be delivered through an integrated pathway with a single point of access, starting with a single holistic assessment which takes into account the needs and preferences of the individual. The Active Ageing and Wellbeing Centre will act as a hub (with 'spokes' in the Parishes), and will be a one-stop-shop for information, advice and activities to improve independence and reduce social isolation. This will also support an expert patients programme.

Services will be provided by a multidisciplinary team, looking after both physical and mental health needs. This team is supported and enhanced by specialists such as dementia, COPD and Community Physicians who will work with GPs to support Primary Care in screening and delivering ongoing care.

WHY THIS HAS BEEN PRIORITISED

As outlined previously, services face a number of challenges. If this is not addressed urgently, services will become unsustainable as demand increases. Services are currently not available 24-hours in community settings. In addition to the overall gaps in service, lack of integration and impact on the hospital there are a number of condition-specific challenges that arise from an ageing population:

Chronic Obstructive Pulmonary Disease (COPD)

There are an estimated 3,000 individuals with COPD in Jersey. The prevalence and severity of COPD increases with age, and according to the World Health Organisation, approximately 15% of smokers will develop COPD. COPD accounts for a significant number of Emergency Department attendances and unplanned admissions because, if the condition is not well managed, exacerbation frequently occur.

By 2020, COPD will be the third leading cause of death and the fifth leading cause of disability. The prevalence COPD could reach 10% of those aged over 70 and between 5% to 7% of the population aged between 35 and 70¹³. This could equate to 5,300 people with COPD in 2040.

Coronary Heart Disease (CHD)

Cardiovascular disease affects 13% of the population. Whereas mortality from CHD is falling, morbidity from is rising, especially in older age groups. Like COPD, the prevalence of CHD increase with age - more than 1 in 3 men and around 1 in 4 women aged 75 and over live with the condition.

Diabetes

Jersey is in the grip of an epidemic of diabetes, predominantly Type 2 but to a lesser extent Type 1. Approximately 4,000 Islanders are currently diagnosed with diabetes and it is estimated that, at least, a further 2,000-3,000 cases are undiagnosed.

The prevalence of diagnosed diabetes in Jersey has been doubling every 6-8 years for the past 2 decades with no sign of any change to this trend. International data suggests this is likely to continue for at least the next 10 years and diagnosed patient numbers may well exceed 9,000 by 2020.

Approximately 1 in 5 hospital inpatients have diabetes, although people with diabetes tend to be admitted to hospital for reasons other than their diabetes e.g. because of co-morbidities such as obesity, vascular, cardiac or renal disease.

Dementia

Dementia predominantly affects people aged over 65. The prevalence for over 65's is 1.6%; this increases to 21.2% for people over the age of 85.

It is estimated that over 1,200 individuals in Jersey may have had moderate to severe dementia, but only just over 800 are known to the memory clinic. It is also estimated that approximately 65 individuals aged 30 – 64 have a moderate to severe dementia.

In addition to medical costs, the societal cost of dementia is enormous as many people with dementia require round-the-clock care. There is also increasing evidence of the service impact of dementia -hospitalisation rates can be 41% higher for patients with dementia, and the Alzheimer's Research Trust suggests that dementia costs the UK twice as much as cancer, three times as much as heart disease and four times as much as stroke.

Because Jersey's population is ageing exponentially, there is an estimated projected increase in moderate and severe dementia of 38% by 2020 (to over 1,700 people), with a 64% increase by 2025 (2,040 people) and a 154% increase by 2040 (almost 3,200 people).

End of Life Care

Jersey has an average total of 765 adult deaths per annum. 675 deaths are associated with cancer and/or other life limiting illnesses. This is predicted to rise by 26% by 2029 taking the total number of deaths per annum to circa 845. There are approximately 2-3 child deaths per annum with 20 children at any one time having life limiting conditions.

50% of current services for End of Life are delivered from hospital, within a medical model of care. This is not the most appropriate setting to manage this group of patients, and is also not sustainable as the ageing population increases; by 2029 the number of deaths is projected to increase by 26%. In the current service model, this would increase the demand for hospital beds from 14,145 in 2010 to 17,823 by 2029.

Only 10% of patients at end of life are able to die within the Hospice. Access to these services is limited to cancer and motor neurone patients only. Marie Curie estimate that 62% of people prefer to die in a place of their choice and not a hospital environment.

Conversations with families after death and from formal complaints demonstrate the need to change. The issues raised often relate to relatives left shocked at what they see as a sudden loss of a loved one, when there was actually a clear decline but the difficult conversation had not taken place. Issues are also raised regarding symptom control and the poor environment in which their loved one died, often in a ward bay surrounded by other patients.

OUTCOMES TO BE ACHIEVED

- Increased independence, confidence and quality of life - for both service users and their carers
- Personalised services, which offer choice to individuals
- Reduced confusion and duplication of services
- Increased carer support
- Flexible, integrated care
- Improved rapid response to crises or emergencies, provided by flexible services
- Reduced isolation
- More appropriate housing stock
- Increased access to services, through the provision of public transport and the extension of communications and information technology
- Reduced hospital admissions and readmissions
- Reduced hospital length of stay
- Delayed need for institutional care
- More healthy lifestyles, though increased access to leisure, recreational and community facilities
- Increased employment for the workforce beyond the existing retirement age, through increased access to training and development opportunities
- Increased number of service users/patients being cared for outside a hospital or residential care setting
- More diverse and better supported providers
- Increased earlier diagnosis
- Increase in the number of individuals providing and receiving mutual support
- Improved staff morale, through positive relationships and team working
- Reduced Social Security costs from benefit payments
- Continued support to Primary Care
- Improved patient and family experience in relation to End of Life care
- Improved care planning, which supports integration and co-ordination and improves quality and experience
- Reduced prescribing
- Improved assessment of spiritual care needs

FEEDBACK FROM CONSULTATION

The Green Paper feedback demonstrated that 93% of respondents agreed with additional support people to live in their own homes for as long as possible, and 90% agreed that teams and roles should be expanded.

White Paper feedback noted the need to support access to Primary Care for individuals with long term conditions, who often find the costs prohibitive due to the number of appointments they require to manage their condition. Respondents also supported the concept of expanding teams e.g. through expanded roles for nurses.

The prioritisation and focus on community services was strongly supported along with people being given the choice of where they receive care and being able to maintain their independence for as long as possible.

A number of Islanders noted that the Active Ageing and Wellbeing Centre is a particularly positive development, and that Third Sector organisations should be prominent in this. The role of the Third Sector was also praised, and Islanders are keen that Third Sector organisations continue to be supported and, where appropriate, their roles enhanced.

Again support for carers was raised a concern; the refreshed Carers Strategy needs to be expanded and prioritised.

SERVICE DEVELOPMENTS

People generally wish to remain in their own homes for as long it is practicable and safe to do so. This relieves pressure on the hospital but can place significant pressure on carers. Therefore, services from 2013 must incorporate both the needs of the individual and support for carers:

201 – 2015

- **Awareness and information** –consolidating and co-ordinating information, healthy lifestyle promotion and self care. Awareness raising campaigns will be scheduled, using the range of media available. Third Sector organisations will be supported and encouraged to work in partnership to provide services and information
- An '**Active Ageing and Wellbeing Centre**', providing a 'one stop shop' for information, support and advice, including:
 - Improved information and awareness
 - Patient advocacy
 - Training and support for service providers, including Primary Care and the Third Sector
 - Outreach to Parishes
 - Specialist professional expertise in dementia, COPD, CHD and diabetes
 - Carers support and networks
 - Peer support, including the expert patients programme
- **Early Diagnosis**, to ensure people receive the right support, at the right time, in the right place, thereby reducing the need for crisis intervention. This will include screening for smokers or ex-smokers aged 35 years and for dementia. Screening also includes 'case finding' and 'risk stratification' – all health and social care professionals will be encouraged to identify patients who may require screening and/or who may be at risk of hospitalisation due to an already diagnosed condition
- Enhanced **Memory assessment**, provided by an increased and expanded team. Assessments need to be undertaken in the individual's own home, as removing them from familiar surroundings can be confusing and distressing for both the individual and the carer
- **Carers support** – providing support, information, advice and training. The work on the current Carers' Strategy commenced in October 2008 when 60 delegates from across States of Jersey Departments, the Third Sector and individual carers developed an Island-wide strategy for carers. This strategy is now due to be refreshed, and a similarly inclusive process will be used. Work is currently underway in partnership with Jersey Association of Carers Incorporated, the Carers Partnership Group and the Third Sector to review the existing Carers Strategy with the aim of publishing a new 3 year strategy from 2013. It is intended that carers support will include:
 - **Training** for carers in first aid, moving and handling etc (which is currently provided by St John Ambulance)
 - Support for **young carers** (currently provided by St John Ambulance)

- Peer support (currently provided by a number of Third Sector organisations e.g. Alzheimer’s Association, Triumph Over Phobia)
- **Carers Support Budget**, ringfenced to meet carers’ needs, once these needs are identified via a carers assessment. Carers eligible to access the budget would be residing in the same property as the cared for person and providing a ‘substantial’ amount of care. In exceptional circumstances carers who are not residing with the cared for person would be able to access the carers budget
- **Carers Support Workers** to assess emotional, psychological and social needs. Support would then be identified in a care plan, e.g. promote the carer’s social inclusion – particularly where there are one-off needs or a need for respite. The Carers Support Workers would also:
 - Provide advice on available peer support
 - Offer specialist advice and information on dementia-specific services
 - Identify and develop a range of social activities to be jointly available to the individual and their carer
 - Offer or signpost access to specific carer education programmes relevant to different points in the progression of the individual’s condition (where appropriate)
 - Promote the inclusion of carers in planning and decision-making and support individual carers to participate as required
 - Offer advice and practical support to help the carer maintain employment
 - Promote access to additional support services for carers who may be hard to reach or reluctant to seek or accept advice or support
- Structured care in **Primary Care**. Once identified through screening or through case finding, individuals with certain long term conditions will be offered subsidised General Practice care to confirm the diagnosis, to exclude other conditions and initiate treatment.
- A **Single Point of Access**, to accept and allocate all referrals. Once allocated, all referrals will have a named Care Co-ordinator, who will undertake assessment of need and will work with the individual to understand their preferences. The Care Co-ordinator will then produce a holistic care plan, and will ensure the individual accesses appropriate services at the right time. They will tailor a package to meet their needs, and where longer-term support is required, this will be arranged by the Care Co-ordinator in collaboration with the person and their carer. They will also monitor the service user’s progress through the care pathway
- **Enhanced community services** – 24 hour care in an individual's home, provided by a multidisciplinary team. This will include increasing domiciliary care and developing specialised home care services. ‘Assistive technology’ such as telehealth and telecare will be available as appropriate - telehealth enables professionals to monitor the individual’s vital signs, readings and responses to health questions whilst telecare enables professionals to be alerted if a problem arises. Met Office Healthy Outlook® Alerts will also be provided to assist individuals in understanding and managing their condition
- **Specialist staff**, supported by the Ambulance Service to support GPs and the multidisciplinary community team in helping individuals to remain in their own homes and as well as possible. Increased pulmonary rehabilitation and Community-based cardiac rehabilitation will also be available
- **Intermediate care**, incorporating short term community beds in order to avoid an admission to hospital or residential care (Step-up Unit) and to support rehabilitation and recovery (Step-down Unit)
- **Hospital liaison** - providing support to staff in the hospital and residential homes to shorten length of stay in hospital and reduce admissions to hospital from residential homes. There will also be Ward Champions for COPD, CHD and diabetes to provide advice, access specialist services and supporting discharge planning

- A focus on **end of life care**, introducing a standardised and consistent approach, following the Gold Standards Framework and the Liverpool Care Pathway, across service providers. This will be supported by island-wide policies, guidelines and standards, to support strong governance
- **Condition Registers** and an End of Life Register, to assist with planning and management of conditions and to record the patient's preferred priorities of care and provide information to the multidisciplinary team
- During 2014 the **Long Term Care Benefit** is planned to commence. Health and Social Services will work with Social Security colleagues to ensure that appropriate resources and services are in place for individuals with ongoing long term care needs

2016 – 2018

Some of the services that will be introduced in Phase 1 will be further expanded, to continue to be able to provide appropriate interventions as the older adult population increases. In addition, the following will be progressed:

- Developing a policy for **housing** for an ageing society within Planning, Housing and Social Policy colleagues. Extra Care sheltered housing places will also be available from 2016.
- **Rapid Response Team** - for urgent (but not emergency) care. The Team will be available from 7.30 am – 9 pm, 7 days a week, and will monitor and respond to telehealth and telecare alerts and alarms, assess and arrange care for the individual in their own home to stabilise them and work towards preventing admission to hospital
- **Reablement Team**. The multidisciplinary team will care for patients in their own homes in the early days following discharge from hospital for up to a maximum of 8 weeks. The focus will be on supporting individuals in caring for themselves rather than undertaking tasks for them, thereby increasing independence and increasing the likelihood that the individual can continue to live in the community rather than in long term care
- **Intergenerational schemes**. Schemes will be developed with Education to involve the older population in schools and Highlands College, for example, older people visiting schools to support reading programmes. Schemes will also be developed with Social Security in partnership with the Third Sector to involve the young people and / adults in the care of the elderly, for example, children visiting day centres and residential care homes
- Integrated pathways for **Musculo-Skeletal (MSK)** conditions and chronic pain and **Stroke / Transitory Ischaemic Attack (TIA)**. As these conditions are generally not degenerative, the focus will be on maintenance and enabling the patient to live as productive and fulfilling a life as possible
- **Changing society's views** on death and dying, and the ways in which all people can think through and record their preferences at End of Life, through a public awareness campaign
- An annual **End of Life audit** tool, to combine and share data to inform the assessment of the effectiveness of the End of Life Care Pathway.

2019 – 2021

By 2019 the majority of services within the OBCs will have been introduced and **mainstreamed**. This is critical because, by the end of 2020 there will be 35% more older adults in Jersey than in 2010.

5.5. SUSTAINING HOSPITAL SERVICES (PROPOSITION BI)

Proposition bi) asks States Members to decide whether they are of opinion to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), by the end of 2014. Work on the Acute Services Strategy, led by Health and Social Services, has commenced with key stakeholders across the hospital. This will continue throughout 2013 and 2014 in order to simultaneously progress the service changes required in Phase 1 and to identify, prioritise and plan for the strategic investments required from 2015 onwards.

THE VISION FOR THE HOSPITAL

To deliver a new hospital, built to modern standards, within the next 10 years. The hospital will continue to be integral to the health and social care system, and will be supported by that system. The workforce will be skilled, motivated, modernised and supported by IT and a fit-for-purpose estate – with services developed in the right priority order to meet the needs of Islanders.

Integrated working with non-hospital organisations and settings will be supported by clinical leadership, particularly with community settings - for example by developing nurse-led services, consultant-led outreach services and, potentially, GP-led hospital based services where there is clinical evidence to support these models.

Demand for unplanned care will be more appropriate, through a combination of service and behavioural changes, facilitated by funding for GP appointments for key patient groups, triage and streaming appropriate, minor attendances to a co-located GP service.

Core inpatient services will be prioritised and sustained, in order to support emergency provision. As such, Islanders will continue to be cared for on-Island where this is clinically appropriate, and the range of services will expand where this is clinically viable.

Clinical Support Services will remain central to the delivery of high quality, patient-centred healthcare. At least 70% of clinical decisions are made on the basis of test results, and the hospital of the future will place an increasing emphasis on its entire range of diagnostic services to support rapid diagnosis and assessment, treatment and longer term management.

Hospital resources will be used effectively and efficiently, providing excellent, integrated care - length of stay will continue to reduce, with discharge planning improving and an increase in alternatives to hospital care available to relieve the pressure on beds.

Income for the hospital will be optimised to ensure that the right balance of publicly-funded and privately-funded care continues to be delivered.

WHY THIS HAS BEEN PRIORITISED

The hospital is central to a sustainable system of health and social care. Modern, state of the art hospital services and facilities and a 'new' hospital are therefore vital, but there is also an urgent need to build primary and community services to offer alternatives, relieve pressure on the hospital and create that sustainable system. This will include initiatives to manage long terms conditions such as COPD, diabetes and coronary heart disease more effectively and intermediate care services to promote independence, reduce avoidable hospital admission and support safe, timely discharge of patients who no longer need the level of medical care provided by the acute hospital.

Sustainability and viability of hospital services within an integrated health and social care model is the overarching objective and the outcome to be achieved – both for hospital services and for the health and social care system as a whole.

SERVICE DEVELOPMENTS

Hospital services need to continue to develop in the next 10 years. In particular, legacy issues and business as usual issues must continue to be addressed. Investment is required in:

- The fabric of hospital buildings and the space available for patient care
- Essential infrastructure such as information technology and patient information systems
- Staff, new ways of working, structures and organisational change.

2013 – 2015

During this period the hospital feasibility study will be progressed. This is due to identify a preferred solution by 2013, with detailed plans by 2014. States Members will be updated and informed through this period, with their views sought in accordance with States procedures.

A number of operational service changes are already underway, and strategic investments are required in the first Phase (2013 – 15). These service changes and investments are in addition to the capital investments outlined in section 5.6.4:

- Emergency and unplanned care
 - Better **integration in the Emergency Department** with GP colleagues, with enhanced triage to assess patients and direct them to the most appropriate practitioner, which would include a co-located GP service
 - Revising the **Emergency pathway**, following a review using 'lean' service improvement principles
- Elective / planned care
 - Increased **theatre** capacity, including day case theatres – through reviewing efficiency and providing additional theatre space. This includes maternity theatre.
 - Improving the Special Care Baby Unit (SCBU)
 - Enhanced recovery, which **reduces length of stay**
 - Improved inpatient pathways, with a focus particularly on **discharge planning** and flows

- Continued development in practice, to take advantage of International developments, e.g. through improvements in **technology**
- Forming stronger **strategic partnerships** with off-Island providers to improve patient safety and outcomes. This would initially be for **renal** and **oncology** services, and would facilitate:
 - Improved communication between consultants and improved links with clinical teams to ensure that clinical competence can be maintained to meet evolving clinical guidance and standards
 - Improved governance arrangements
 - Access to outcome data to monitor performance and demonstrate quality and effectiveness
- Smooth patient transfer and clinical handover

- **Supporting Community services:**
 - More specialist input into Community services, and review of Care of the Elderly provision in the hospital
 - Integrated pathways with Community and Primary Care providers
 - The impact on hospital services from the OBC developments

- Supporting care delivery
 - Review of **Pathology**
 - Changes to **workforce** models, including:
 - changing the medical staffing skill mix, moving towards Consultant-delivered / led services and redesigning Middle Grade roles
 - enhanced role practitioners, nurse prescribing and expanded nursing roles, e.g. direct access helplines, drug monitoring, assessment clinics, patient education and counselling
 - virtual clinics
 - visiting Specialists
 - retaining existing staff, e.g. retraining a specialist nurse to be an orthodontic therapist
 - An expanded Emergency Admissions Unit, incorporating surgical as well as medical patients, and increasing the unit's size

- Supporting safe care and **clinical governance**, and providing evidence for appraisal and revalidation, insurance and demonstration of achievement against standards and regulatory requirements, by commencing work on:
 - Developing a fully functioning Patient Administration System
 - Integration with non-hospital systems, particularly the GP Central Server, which may also be used by FNHC and Hospice), and Community, mental health and social care systems
 - Improved coding
 - Moving away from paper-based referrals
 - Multidisciplinary, integrated patient notes and electronic patient records
 - Supporting outcomes audits

2016 – 2018

Subject to the outcome of States Debate, the detailed plans for hospital services in the period from 2016 will continue to be developed with key stakeholders. These will be submitted for approval in 2014. Strategic investments will include:

- **Point of care testing** in Emergency Department and Emergency Assessment Unit, providing test results quickly
- A model of **ambulatory care**, including direct GP access to diagnostic and therapeutic services
- A **Clinical Decisions Unit**, including nurse-led diagnosis and closer working with medical colleagues
- A **Paediatric ambulatory suite**
- A **Cardiac care unit**
- A wide range of services available **on-Island**, to ensure the viability and sustainability of general surgical services. This may involve extending the range of procedures available to ensure more patients are treated in Jersey and decreasing the number of transfers off-Island

5.6. CROSS-CUTTING WORKSTREAMS

This Report has outlined the challenges facing health and social care, and how these challenges will compound in future years. Through the Green Paper and White Paper consultations Islanders demonstrated their understanding of these challenges and expressed their concern regarding sustainability, particularly regarding workforce, estates (the ‘new’ hospital), Primary Care and funding.

5.6.1. PRIMARY CARE (PROPOSITION BII)

Proposition bii) asks States Members to decide whether they are of opinion to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval proposals to develop a new model of Primary Care, by the end of 2014. Work on reviewing the model for Primary Care will be led by Health & Social Services, working closely with Social Security and Treasury & Resources. Work will commence in early 2013, working with key stakeholders. This will continue throughout 2013 and 2014 in order to simultaneously progress the service changes required in Phase 1 and to identify, prioritise and plan for the strategic investments required from 2015 onwards.

VISION

To maintain people in optimal health and wellbeing, both physical and mental. This will involve health promotion, health education, vaccination and screening for illness. Primary care also acts as a safe conduit to secondary care where appropriate and focuses on an individual’s holistic, ongoing needs.

Sustainable Primary Care will involve a significantly enhanced workforce, with Primary Care practitioners that are at the heart of an individual’s care and have a significant role in integrated care pathways.

Funding mechanisms will support the provision of care in out-of-hospital settings, and a high quality estate, with robust IT to support reporting and integration of patient care.

FEEDBACK FROM CONSULTATION

Islanders continue to be concerned about payment for GP appointments, particularly for children and people with long terms conditions (including long term mental health conditions).

Some respondents were supportive of potential changes in delivery of Primary Care, with people stating that more nurses in GP practices was a good concept which should be explored further.

Some Islanders suggested an expansion in the role of GPs, including GP clinics in the hospital and more out-of-hours access. It was suggested this, along with changes to GP fees, would help to alleviate the pressure on, and inappropriate use of the Emergency Department.

REQUIREMENT

Primary Care should be the first point of contact for people who are ill or believe themselves to be ill, other than for emergencies. It should be inclusive, ensuring equal access to people of all ages and socioeconomic class.

The current system of Primary Care must be reviewed and developed in line with the wider health and social care system. The perverse incentives which do not support desired behaviours (e.g. high use of the Emergency Department) must be addressed. Above all, it is essential that the role of Primary Care is supported and enhanced, that the pace of change is correct and that Primary Care practitioners (GPs, Practice Nurses and other Practice staff, Dentists, Optometrists, Pharmacists) are fully involved.

Primary Care must continue to:

- Deliver excellent health outcomes
- Provide the best possible patient (and carer) experience
- Be accessible to all
- Be efficient and effective
- Work as an integral part of a sustainable model of health and social services
- Be clinically viable, with sustainable patient volumes, delivering high quality care and minimising risk
- Be financially viable, providing value for money for the States and for Islanders, with appropriate financial rewards for staff
- Have sustainable funding, with a charging model that incentivises care and cooperation, optimises access and equality, supports the right behaviours and offers value for money
- Optimise estate utilisation, with estate that is fit for purpose and utilised to maximum efficiency
- Support workforce utilisation and development, with the right staff and teams providing modern, accessible care in the right locations
- Champion clinical governance, sustaining a culture of safety, learning and transparency
- Provide robust data to support decision making and assessment of quality – including patient-reported quality measures

PRIORITY DEVELOPMENTS

By the end of 2012 the Primary Care Governance Team will be established. Led by the Primary Care Medical Director this team will work closely with GPs and other Primary Care professionals, building mature, trusted relationships. By the end of 2014 the Primary Care Strategy will have been produced.

More immediately, the team will improve the governance of Primary Care, by supporting GPs in revalidation, appraisal and the 'Performers List', which improve the visibility over quality and safety, and by introducing the Quality Improvement Framework (QIF), which provides funding and incentivisation for certain clinical activities for identified patient groups which should be undertaken in a Primary Care setting.

The Primary Care Strategy is likely to incorporate:

- Staff-mix and skill mix - additional non-medical staff who can undertake appropriate roles to release GP time and enable GPs to focus on more specialist / medical matters. This can provide improved value for money and can also help to improve retention, particularly of non-GP staff, through providing more interesting and varied careers with greater opportunity to develop skills
- Integrated teams. As services move out of hospital settings and into Community settings, the role of Primary Care will expand. Primary Care practitioners will need to be an integral part of a number of teams, particularly the community multidisciplinary teams
- Integrated pathways, agreed across different organisations and professionals to encourage working together, and reduce duplication
- Clinical and professional leadership
- The impact of the detailed service plans, including a greater role for GPs in screening, risk stratification and case finding, assessment, care planning, agreeing responsibilities, shared care, monitoring and referral
- Training and support, to upskill and provide ongoing support to Primary Care, and to clarify the new services, care pathways, systems and processes and the Primary Care role in these. This will include awareness raising and ongoing support for specific conditions, e.g. dementia, and increasing skills in, for example, screening and managing long term conditions
- Improved communication, including newsletters, GP and Practice Manager meetings, multi-disciplinary forums and involvement in multidisciplinary teams
- Estates improvements
- The use of technology to support care in Primary and Community settings
- IT-enabling joint working, e.g. through common assessment frameworks and shared patient records, easy access to test results and integrated care planning
- Appropriate long term funding flows and payment and incentivisation mechanisms

5.6.2. FUNDING (PROPOSITION BIII)

Proposition biii) asks States Members to decide whether they are of opinion to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval proposals for a sustainable funding mechanism for health and social care, by the end of 2014. Work to review and develop proposal for sustainable funding mechanisms will be led by Treasury & Resources, working closely with Social Security and Health & Social Services during 2013 and 2014.

FEEDBACK FROM CONSULTATION

The public consultation demonstrated the level of anxiety amongst Islanders regarding future funding for health and social care. There remain mixed views regarding payment for services, means testing and payment for inappropriate use of services.

In relation to longer-term care, many Islanders expressed strong feelings that individuals who, having paid into the social security system during their lifetime, should not have to sell their homes in order to pay for care, particularly in their old age.

Some of the feedback questioned how funding would flow through the system and which service areas and providers would receive funding. This was often raised during discussions with Third Sector organisations and GPs.

REQUIREMENT

Providing health and social care will inevitably cost more money over the next 20 years. Jersey spends c£240m on health and social care. c£170m of this was spent directly by the Health and Social Services Department, more than £40m by the States Social Security Department and more than £30m by other groups and individuals including the payments for GP consultations.

Implementing the proposed new system for health and social services will require significant investment on both a one-off and recurring basis.

MEDIUM TERM FINANCIAL PLAN 2013 - 2015

The proposed new system for health and social care will require significant additional funding. Bids for growth from Health and Social Services have been made as part of the MTFP. These estimates reflect the cost of redesigning and reconfiguring key services in 2013 - 15 and are within the forecasts prepared as part of the Green Paper.

In the following planning periods (2016-2021) further business cases, including detailed plans and costings, will be developed as part of future States Medium Term Financial Plans.

The proposed service developments underpinning the funding bids have been outlined in this Report. Following the submission of initial bids to the MTFP, all Departments were required to reduce their 2013 growth by 10% based on the level of funding that was affordable in 2013:

Reform Health and Social Services	£'000	£'000	£'000
Healthy Lifestyles (starting with Alcohol)	300	440	530
Children's Services (starting with Early Intervention)	620	740	860
Adult Mental Health (starting with IAPT)	340	740	1,130
Intermediate Care	1330	2,340	2,890
Long Term Conditions (starting with COPD)	700	1,340	1,630
Older Person's Mental Health (starting with Dementia)	740	1,810	2,440
End of Life Care	400	810	830
Phasing of White Paper Implementation	-502		
Crosscutting workstreams	590	670	710
Total	4,518	8,890	11,020

Substantial capital investment is also required for the 'new' hospital (in the order of £300 million). A pre-feasibility study is underway to establish whether this will be a complete refurbishment or a new build. Notwithstanding this, our estate is deteriorating and ongoing investment is required to enhance current facilities in order to maintain patient safety and comfort.

Health and Social Services have made the following bids the Capital Programme:

2013 – £10.6 million

2014 – £6 million

2015 – £3.8 million.

For 2013 to 2015 the Council of Ministers plans to accommodate the increased Health and Social Services budget allocations within the total States spending envelope required, therefore no increases in charges or taxes are envisaged in Phase 1.

2012 BUSINESS PLAN COMMITMENTS

In 2011 it was evident that some key services were facing financial pressure. These pressures were identified in the 2012 Business Plan and commitments were made by the Council of Ministers, and subsequently endorsed by the States, to make growth provision for these priority areas:

H&SS Growth Commitments from the 2012 Business Plan				
	2012	2013	2014	2015
	£'000	£'000	£'000	£'000
Health Growth @ 2%	3,320	3,470	6,920	10,550
Medical Staff Sub Specialisation	-	300	610	920
Nursing Establishment	-	1,000	2,030	2,080
Nursing Terms and Conditions	800	600	620	630
Total	4,120	5,370	10,180	14,180

In addition to the above, additional funding has been included in the MTFP for:

Reform Health and Social Services	Dept	£'000	£'000	£'000
Vehicle Replacement	HSS	90	200	300
Health Maintenance (JPH)	TSY	630	700	700
HR HSS – 2 additional posts arising from Verita report	CMD	180	200	200
Total		900	1,100	1,200

Health growth. The recurring consequences of existing commitments, drugs cost inflation and emerging pressures account for the majority of the 2% growth provision, which equates to c£3.4m p.a.

Medical Sub-specialisation. The cost of planned replacement for retiring consultant medical staff, reflecting the difficulty in recruiting generalists and the need to manage single practitioner specialties. Initial indications for renal and cancer services estimated the cost at approximately £2 million p.a. This is being treated as a 'Business As Usual' issue and the specific funding identified in the 2013/14 cash limits together with the '2% growth funding' will be used to progress this.

Nursing Establishment. Recent studies indicate a strong correlation between nursing staffing levels, patient safety and quality of care. Shorter length of stay is strongly correlated to higher staff levels.

Following a nurse staffing review there has been investment in staffing levels across areas of Health and Social Services, particularly within the Hospital. However, staffing levels are still lower than recommended and additional investment is required. On a day-to-day basis staffing is managed by moving staff around the organisation and topping up staffing levels with temporary cover provided by nurses either employed on the nurse bank or agency. This is not a sustainable solution and in the long term is a relatively expensive solution.

Nursing Terms and Conditions. Even after Nursing Pay scales were introduced, recruitment and retention of appropriate qualified nursing staff remains problematic. Having a high number of staffing vacancies creates a significant risk for essential service delivery and patient safety. During 2011 and 2012 a number of initiatives were introduced to address nursing recruitment and retention. These include a recruitment supplement, revisions to pay structure, nurse staffing investment and recruitment in Older Adults Mental Health and Infection Control.

In practice the growth bids for the nursing establishment and nursing terms and conditions will need to be considered together. There is limited value in recruiting more nurses if we cannot adequately reward and retain the nurses that we already have. Health and Social Services are currently negotiating with trade unions to consider terms, conditions and equal pay for equal value. Further updates on progress will be provided to the States Employment Board for consideration and action as appropriate.

Reconfiguration of funding for vehicle replacement. Vehicles currently on the asset register will now be replaced by Jersey Fleet Management and leased to Health and Social Services. Additional revenue budget is required to cover these new charges.

Planned Property Maintenance. Additional base budget is required to provide planned, preventative and reactive property maintenance at an appropriate level for non-hospital buildings.

2 additional posts arising from Verita report. The Verita report recommended the establishment of a specialist Director of HR and a dedicated Medical Staffing Manager in order to improve the controls over the appointment of locum medical staff and their subsequent management, and the continuing professional development of permanent staff in the interests of patient safety. In 2011, the posts were funded by the CSR restructuring provision. Permanent appointments have been made which now need to be permanently funded.

FUTURE FUNDING PROPOSALS

Work will now continue to develop a long term sustainable funding mechanism for Health and Social Services by 2014. This work will consider all the current funding elements, including contributions made to the Health Insurance Fund, co-payment arrangements and base budget allocations. It will also take account of the proposed Long Term Care Fund and the provision of contracts with General Practitioners and other healthcare providers.

All these elements will be reviewed in order that proposals can be developed for a comprehensive but simple method of ensuring sustainable funding to the Health and Social Services Department in the coming years.

5.6.3. WORKFORCE

THE VISION FOR WORKFORCE

To create a sustainable work environment in which our diverse workforce is valued, motivated, developed and rewarded for excellent customer-focused service, ensuring States of Jersey becomes an employer of choice whilst meeting patient/client needs in an effective, safe, high quality, cost effective manner.

FEEDBACK FROM CONSULTATION

As noted previously, Islanders expressed strong support for the service developments outlined in the White Paper, but expressed concern regarding the current challenges in recruitment and retention of nurses and the ability to recruit the required numbers and skills for the future. Views were also noted about 'growing our own' and supporting Islanders, balanced with the need to secure input from off-Island specialists where appropriate.

Alongside some of these reservations there were some very positive comments and recognition of the quality and hard work of staff currently working in health and social care, particularly at the hospital.

REQUIREMENT

We need:

- The right staff, in the right place, with the right skills ,doing the right thing, at the right price
- Flexible working and skills transferability
- An appropriate, fit-for purpose working environment and tools to support modern practice
- To attract, develop and retain the right talent for each role with well planned and executed recruitment
- Staff and teams working jointly, with shared processes and systems such as assessment and care pathways
- People to feel valued, motivated and developed
- Good opportunities for career progression and ongoing personal / professional development to ensure interesting and varied careers
- Effective support systems, including access to childcare, accommodation and flexible working
- A culture of leadership which responds to feedback and creates a caring atmosphere not just for clients but for staff as well

PRIORITY DEVELOPMENTS

Recruitment

Existing recruitment activities will continue, including:

- Regular and targeted recruitment campaigns
- Return to Practice (RTP) nursing course for any Islander whose registration has lapsed
- Local adaptation for overseas trained nurses
- Local pre-registration nurse training
- Planned and phased mix of academic and competency based up-skilling of the non-registered workforce - Assistant/Associate Practitioner roles
- Partnership working with Education to feed BTEC Health and Social Care students into the non-registered workforce ahead of applications for non-registered posts and /or pre-registration nurse training
- Immediate interviews for all registered nurses visiting Jersey ahead of relocating with spouse/partners
- HSSD nurses and midwives receiving job alerts from the 'Talentlink' recruitment system
- Relocation Agreement for registered staff
- Help with private sector rental deposits and Accommodation Team support during relocation

In addition, workforce redesign will support each of the service developments as they progress through detailed planning. This will focus on:

- Increased development and use of support/generic staff
- Redesigning current roles and developing new roles and ways of working
- Agreeing new job descriptions and person specifications for all new roles
- Promoting multidisciplinary working across health and social care
- Developing competency frameworks to allow career progression and development
- Job evaluation
- Promoting and attracting more people into a health and social care career, including the development of a pre-employment program
- Improving public awareness
- Recruiting staff from a much wider community
- Streamlined application and selection processes
- Induction and 'on boarding' of appointees e.g. assistance with finding accommodation and other social support

Training and development

- Scoping current training resources and identifying the potential for expansion
- Providing clear information about the funding availability for skills development and training
- An outcomes and appraisals framework for training
- Developing appropriate training packages for existing and staff in new methods of service delivery
- Moving towards a competency-based workforce
- Exploring the use of a variety of training models including apprenticeships, on the job training and skills development

- Considering methods of delivering training in order to minimise the time requirements placed on staff to attend training. E.g. web-based training so activities can be completed in the workplace, and ‘train the trainer’ concepts and training ‘champions’ to more quickly reach a greater number of staff
- Developing a Continued Professional Development (CPD) strategy, with a framework to help managers ensure their staff can access training at different stages of their career development
- Clinical staff development, including accreditation, supervision, honorary contracts, clinical network and governance arrangements
- Broadening the availability of training to include Primary Care, Third Sector and private sector colleagues

Organisation Development

- Cultural change: Developing an open and responsive culture both internally and externally
- Developing the workforce: Providing an environment, leadership and support at all levels to enable staff to achieve their potential and to gain the skills and confidence to contribute fully to planning, delivery, evaluation and service improvement
- Effective Team working: Developing teams, team working and shared leadership
- Maximising technical and knowledge management: Gaining maximum benefit from the use of appropriate technology to enable improvement and change
- Developing Business Skills: Equipping managers with the skills to use information effectively and to develop their awareness of financial, quality, risk and stakeholder issues
- Strengthening our customer/client focus: Involving the community and workforce and build a culture of social partnership and accountability

5.6.4. ESTATES AND FACILITIES

VISION

A more sustainable, 'fit for purpose' estate.

The delivery of the estates strategy will require an extensive programme of capital projects in order to provide buildings that support modern working practices. The programme will be delivered with the aim of minimising disruption and ensuring service continuity.

FEEDBACK FROM CONSULTATION

Islanders recognised the critical need to invest in estates and strongly supported the need for a 'new' hospital.

REQUIREMENT

Buildings and facilities from which health and social care is delivered require investment. Many have significant issues with backlog maintenance due to chronic historical underinvestment – some have had to be closed for complete refurbishment. Many of our other buildings are also no longer fit-for-purpose and require significant upgrade or replacement and ongoing maintenance.

The hospital requires refurbishment, redesign or rebuild in the next decade. Notwithstanding this, many areas within the hospital require improvement now, in order to continue providing care that is safe and high quality.

There are a number of particular challenges where facilities and space allocations fall well below modern standards:

- Space allocation in the hospital wards, which is about half of what would now be expected for the number of beds
- Facilities for children's services within the hospital, where the inpatient ward has significant problems in terms of space
- Current facilities for outpatients and ambulatory care are limited. The current design does not promote efficient, effective care and treatment of patients, nor does it support privacy and dignity
- Operating theatres are below required standards in terms of space for modern equipment and clinical practice and there is insufficient capacity overall to meet anticipated demand
- SCBU, maternity (in particular the delivery suite), endoscopy and the facilities for private patients and medical education are also in urgent need of upgrade
- Some residential homes for children are in need of refurbishment
- The Limes and Sandybrook, Health and Social services-run continuing care homes, were built in the 1980s to a very high standard but have not been refurbished since
- Clinique Pinel provided 17 beds for the assessment, treatment and respite for people suffering from organic mental health problems (the dementias) in Beech Ward and 17 beds for the assessment and treatment of functional mental health problems (depression, psychosis and anxiety etc) in Cedar Ward.

Clinique Pinel also provided a further 10 beds for people who have had long term mental health conditions and are unable to cope with residential care away from a hospital setting in Lavender Ward. It is in urgent need of complete refurbishment, and has been closed to enable this to happen

- Adult care homes for individuals with special needs require refurbishment and upgrade
- Facilities at Overdale need to be reviewed

The ongoing development and management of the Long Term Capital Plan (LTCP) is a key financial planning tool for the States of Jersey. It aims to ensure that capital expenditure is approved and delivered in an optimum way, prioritised towards the delivery of key Strategic Aims, at the appropriate time, based on best available information and delivering best value from constrained States financial resources. It allows funding solutions to be developed and implemented in a co-ordinated and timely basis.

The LTCP covers the period 2012-2032.

PRIORITY DEVELOPMENTS

The Long Term Capital Plan includes:

- A 'new' hospital
- Infection Control – revising the layout of several wards within the Hospital
- The Limes Upgrade. This project will replace all floors, wall and ceiling finishes in all bedrooms, shower rooms, corridors and communal areas. In addition, there will be three new assisted bathrooms, a modernisation of sluice rooms and a complete redecoration of the building inside and out
- Clinique Pinel. This project will ensure that the building is fully compliant with fire regulations, environmentally compliant with Infection Control Recommendations and will address issues of patient dignity and safety
- Maternity Theatre and SCBU. The current obstetric theatre in the maternity unit is too small for purposes of infection control and maintaining privacy and dignity. There is no suitable area to designate for laying up instruments and no recovery area
- Upgrade of Main Theatres. The work includes reconfiguring and refurbishing theatres, replacement of air handling plant and reception area for patients for surgery and centralising and expanding the storage space available for main theatres
- Adult Care Homes. Redevelopment of Special Needs facilities to deliver:
 - Fit for purpose homes for life for people with significant and complex needs
 - Appropriate day services for people with learning disabilities, integrated in to the community
 - Appropriate day services for people on the autistic spectrum
 - Appropriate residential setting for specialist assessment and treatment
- Overdale redevelopment. An initial concept paper for the redevelopment of Overdale considers the opportunity of constructing a new facility for the provision of mental health services. This initial work will be updated and a feasibility study will provide a review of the desired service provision and the suitability of the Overdale site
- Redevelopment of Children's Homes - to develop fit for purpose homes for children who require residential care, including the acquisition and development of a new home; the provision of suitable accommodation for children with complex and challenging behaviours who would otherwise be placed in UK specialist placements; and the development of short break facilities, including day service and residential services

- Intermediate Care - the establishment of an integrated Intermediate Care Centre which will serve as the base for the new service
- Sandybrook refurbishment. Sandybrook provides residential nursing care for older people who have been assessed as needing continuing care. It currently provides 28 beds and is adjacent to the Sandybrook day centre. It has not been refurbished since it was constructed in 1999
- Ambulance Station. In the 2013 - 2015 period a feasibility study will determine whether to co-locate blue light services on one site. The project to relocate the Ambulance Station is planned to commence in 2016 but is subject to the relocation of the police and the outcome of the review of blue light services
- General Replacement Assets. Example replacement assets for the period 2013 to 2015 include:
 - CCU Monitoring System and Telemetry
 - Echocardiography equipment
 - X Ray Equipment in a number of wards
 - Gastrosopes
 - Ultrasound machines
 - Digital Image Reader
 - MRI Scanner

5.6.5. TECHNOLOGY

VISION

An IT infrastructure which enables timely installation, testing and implementation of new technologies. The application architecture is flexible and responsive and enables rapid implementation of changes to health and social care processes

REQUIREMENT

By 2021 we need:

- Comprehensive, robust information systems in place across health and social care services
- An appropriate level of integration and sharing of data across services
- Data which is stored efficiently and securely
- The Citizens Portal, providing high quality information for professionals and patients / service users / carers
- Innovative technologies, such as telehealth, which are embedded in the care delivery infrastructure

PRIORITY DEVELOPMENTS

- Continued development of the hospital ICR systems to support the development of strategic partnerships and the hospital services work stream
- A comprehensive information system(s) for community based services
- Integration and sharing of data across primary, secondary, tertiary and community care settings
- The introduction and support of new technologies
- A Citizens portal, providing advice, guidance and access to key information on care pathways etc for specific issues and conditions
- Condition Registers and an End of Life register

5.6.6. DATA AND INFORMATICS

VISION

A more integrated, functional information system which links the key elements of service provision and produces high quality data and information for clinical, operational and strategic purposes.

REQUIREMENT

Knowledge, skills and tools need to be further developed in order to enable information to be collected, managed, used and shared to support the delivery of health and social care and promote health and wellbeing. Further support is required for strategic and management level planning and decision making, including providing evidence on the progress and impact of changes and evidence to support clinical quality.

PRIORITY DEVELOPMENTS

An Informatics team is urgently required. The team will:

- Provide skills, advice and guidance on the analysis, reporting, and presentation of local data
- Agree and produce core indicators, datasets, dashboards, profiles and analyses
- Support the development of the Jersey Strategic Needs Assessment
- Support the development of the Citizens Portal
- Establish processes and procedures to monitor contracts with providers and strategic partners both locally and off-Island
- Support the development and use of key registers, such as an End of Life Register
- Develop benchmarking across health and social care services
- Embed information management into the organisation
- Improve data quality across all data sources
- Support the development of Service Line Reporting

5.6.7. COMMISSIONING

VISION

To secure the best health and social care outcomes for Islanders, based on population need, as translated into strategy. This will include supporting a range of providers, including the Third Sector, and understanding the evidence base for service delivery. Processes will be transparent and fair, and Islanders will have visibility over outcomes and value for money.

REQUIREMENT

Commissioning helps to ensure that:

- high quality, consistent outcomes are achieved
- services are value for money
- decisions are based on information, evidence and best practice
- stakeholders (including Primary Care, Third Sector, Health and Social Services providers and patients / service users / carers) are engaged
- processes are fair and transparent, and provide visibility over the services that are delivered

In order to deliver effective Commissioning, the following are required:

- clear leadership
- an agreed vision for the shape of the system
- effective governance
- an understanding of the commissioning cycle
- clarity about the difference between the commissioning and provider functions at all levels, with a shared understanding of responsibilities and expectations
- an understanding of the elements of system balance and sustainability
- systems that enable change
- a commitment to provider development

PRIORITY DEVELOPMENTS

- Agreeing the vision and strategic direction. This commenced with the 'Strategic Roadmap' work in 2010, and has developed through the Green Paper and White Paper, culminating in this Report
- Integrating strategic planning and performance monitoring – making it link and making it meaningful
- Integrating system redesign and delivery – one programme of change, including the changes outlined herein, the Comprehensive Spending Review and the Jersey Lean System (JLS)
- Commissioning based on needs – based on the Jersey Strategic Needs Assessment (JSNA), improved data collection and condition registers
- Specifying requirements. This will be developed through the detailed planning for the services contained in this Report. It will be undertaken jointly with stakeholders, including Third Sector and Primary Care

- Increasing visibility over existing service provision, including agreeing Service Level Agreements / contracts and outcome measures / metrics – which will include patient-reported outcomes and staff satisfaction
- Listening to Islanders and involving them in service planning
- Working closely with the Third Sector and Primary Care to support their capability and ensure organisations understand and are able to respond to new opportunities. Developing a partnership approach, with longer term, trusted relationships.

5.6.8. LEGISLATION AND POLICY

VISION

Legislation and policy will be developed to enable effective, efficient and responsive health and social services – both for an ageing society and for a society which is primarily focused upon prevention and wellbeing as opposed to a reactive ‘sickness’ model of care.

Children, those with special needs, the elderly and incapacitated will have their rights and best interests enshrined in legislation and policy, protecting choice and the ability of individuals to retain control of their care. Legislation and policy will also provide clarity around how the States of Jersey can protect individuals and make appropriate decisions on their behalf should this be required.

Care providers will be regulated and incentivised, through set standards and regular assessment, to provide an ever increasing quality of care. The public will be assured that the care they receive is appropriate, of a high standard and provided by care professionals that have adequate training and the right skills.

Overall, legislation and policy will encourage the public to be proactive in their own care and take responsibility for their own health and wellbeing within a system that seeks to ensure high quality and efficient services.

REQUIREMENT

The new model of health and social services must be enabled by specific legislative focus and support. Cohesive planning across States Departments is required, in order to ensure that the approach taken by Health and Social Services is considered and linked in with the States Strategic Plan.

PRIORITY DEVELOPMENTS

The development of legislation and policy will be an ongoing process. Health and Social Services will continue to inform, assist and shape the development of relevant legislation and policy. The progress of legislation and policy will be dictated by the States of Jersey and other stakeholders:

Medical Practitioners (Registration) (General Provisions) Order	Order to be made in 2012
Medical Practitioners (Registration) (Responsible Officer) Order	Order to be made in 2012
Health Insurance (Performers List) Regulations	To be lodged in 2012
Mental Health Law, including Mental Capacity	Project Initiation Q3 2012
Regulation of Care Law	To be lodged in 2013
Health Insurance Law	Orders to be made in 2013
Long Term Care Law	Orders to be made in 2014

6. ROBUST GOVERNANCE

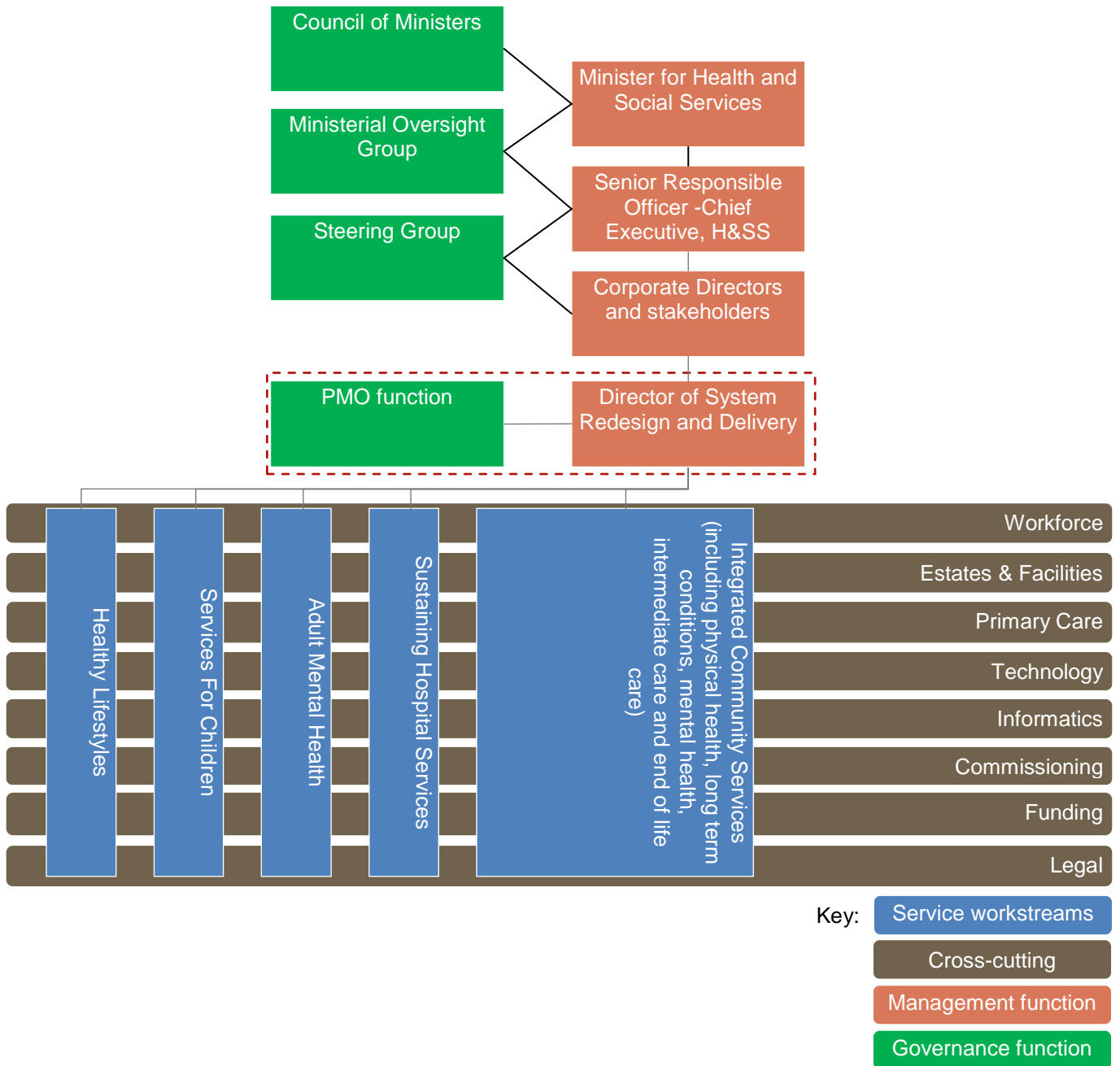
The proposed new way forwards for health and social care is a whole system transformation programme. Its scale is unprecedented, but the changes are urgently required. As such, Health and Social Services are a key priority within the States Strategic Plan.

The new system must be sequenced into a manageable series of projects, and the entire programme must be professionally managed.

Governance for this work will be consistent with the governance arrangements for the States Strategic Plan. Oversight at Ministerial and at Corporate Director level is essential; roles and responsibilities must be clear and the changes must be clinically-led.

Robust programme management has been employed since November 2010, providing:

- Strong and visible leadership from the Minister and the Chief Executive of Health and Social Services
- Input from key Ministers on strategic direction
- Ownership from Health and Social Services Corporate Directors and other key individuals
- Visibility over progress, risks and issues
- A forum for discussion and support with Treasury, Social Security and clinical representation
- Clear responsibility for identifying service changes
- Wide engagement in devising service changes, with clinical, professional and Third Sector input
- Specific professional finance input to ensure assumptions and calculations are robust
- Ongoing monitoring and a focus on risks to ensure the work progresses to time and produces quality outputs



The governance of the implementation will build on the structure and processes used in the development of the Green Paper and White Paper. The Director of System Redesign and Delivery will provide oversight and will report to Health and Social Services' Chief Executive. The Steering Group, Ministerial Oversight Group (MOG), and ultimately the Council of Ministers will continue to provide the programme governance function; testing, challenging and ensuring that the programme delivers in line with plans.

Robust processes will be followed for the production of detailed plans and business cases and for the management of this complex programme of change.

Ministerial Oversight Group (MOG)

The MOG is chaired by the Chief Minister with political membership including the Ministers for Health & Social Services, Social Security and Treasury & Resources. Officers in attendance include the Chief Executive of the Chief Minister's Department, the Treasurer, a representative of the Comité des Connétables, the Chief Officer of the Social Security Department, the Assistant Ministers for Health & Social Services and Treasury & Resources and the Health & Social Services Chief Executive. During the implementation, MOG will continue to meet once every quarter to provide:

- High level challenge against the States' Strategic Plan
- Consideration of the wider implications of change on Departments other than Health and Social Services
- A view on the system redesign and delivery work within Jersey's political cycles
- Facilitation of cross-Departmental work in support of the transformation programme

Steering Group

The Steering Group comprises Health and Social Services Chief Executive and Corporate Directors, Medical Directors for the hospital, Community & Social services and Primary Care, the Treasurer of the States and Chief Officer, Social Security.

Steering Group will continue to meet regularly. The Steering Group will receive a progress report, risks and issues and variance from plans - this reporting will be by exception.

Every six months an extended Steering Group will be held to review and reassessment the enablers and to identify lessons from the past 6 months

Steering Group members will act as champions for the system redesign and delivery work, liaising and communicating within their own Department and professional group and feeding back information and opinion.

Programme Management Office (PMO) function

The PMO will provide effective planning, co-ordination and monitoring / reporting, to monitor progress and risks and to co-ordinate communication and engagement. This will be led by the Director of System Redesign and Delivery, and will incorporate Commissioning staff, Programme Managers and a nominated communications link person.

SROs and their teams will remain responsible for:

- Progressing the actions identified in their Service Workstreams and/or Crosscutting Workstreams
- Progressing the detailed service planning, developing the Outline Business Cases into Full Business Cases, which will act as service specifications / commissioning plans and implementation plans
- Communicating with their areas of responsibility, with the individuals and organisations on their Working Group and with other relevant internal and external stakeholders
- Liaising with their fellow SROs to ensure that interdependencies are identified, managed and de-conflicted
- Ensuring that the voice of patients and carers is actively sought in the planning and implementation processes, and coordinating
- Managing risks and issues
- Submitting regular progress updates, risks and issues to the PMO function for inclusion in the weekly report
- Reporting through the Director of System Redesign and Delivery to Corporate Directors the Programme SRO and Steering Group.

7. CONCLUSIONS

Community services must be enhanced and expanded immediately in order to provide care for the increasing older adult population and to relieve pressure on the hospital. The hospital is already operating at an occupancy level which is above best practice; increasing this further will impact on patient safety and will quickly lead to increases in waiting lists and operations being cancelled.

If the pressure on hospital services is not relieved, the hospital will become an emergency-only facility. This will then undermine its ability to function as a hospital. Staff morale will decrease and retention will be even more difficult; vacancies will increase as careers in Jersey become increasingly less attractive.

Stigma associated with mental health will increase; sickness levels and incapacity benefit claims will increase. This will impact across States Departments.

More children will need to be cared for in residential settings, and children with behavioural problems will not be identified and treated early. This will impact for the rest of their lives, and will reduce their ability to lead productive, satisfying lives – including being able to work, form relationships and be good parents themselves.

If changes to health and social care are not introduced in the next 3 years, there is a real possibility that funding will not be sufficient to provide the range of services that Islanders deserve. This will mean that either services will need to be rationed or closed, taxation will need to increase, Islanders will have to pay for services as they use them or mandatory health insurance will be required. None of these options will be palatable for Islanders – especially those who have paid tax and social security contributions their whole lives.

The Council of Ministers has concluded that Jersey needs to:

- implement the redesign of health and social care services in Jersey by 2021 as outlined in this Report, and
- develop, by 2014:
 - proposals to develop a new model of Primary Care
 - proposals for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site)
 - proposals for a sustainable funding mechanism for health and social care

Service redesign on this scale has never before been proposed by a States of Jersey Department. It offers a unique opportunity to offer Islanders a world class health and social care system for the future, which is accessible, affordable and appropriate, but, above all, safe.

8. THE NEXT STEPS

Detailed planning will continue for the remainder of 2012. This will be achieved through working groups and workshops, to ensure wide stakeholder engagement and involvement, including Third Sector, clinical and professional staff, GPs, HR and Finance experts.

Amendments and feedback from this Report and the subsequent States Debate will be incorporated into the detailed plans, and into adjusting and adapting the programme as a whole.

Full Business Cases / implementation plans will be produced by December 2012, in order to support the commissioning of new services in early 2013, where appropriate.

Communication and engagement will be prioritised in 2013. It is imperative that stakeholders, including Primary Care and Third Sector, are fully engaged. It is also imperative that the views of Islanders are sought and considered as services are developed, and also as services are delivered. The views of staff are also important, as these will help to identify any issues with morale which may impact service delivery and retention.

During 2013 and 2014 the system plans for Phase 2 (2016 – 18) will start to be considered. In particular, three major elements must be progressed, in order for the changes to be prioritised in Phase 2 and the health and social care system to remain sustainable:

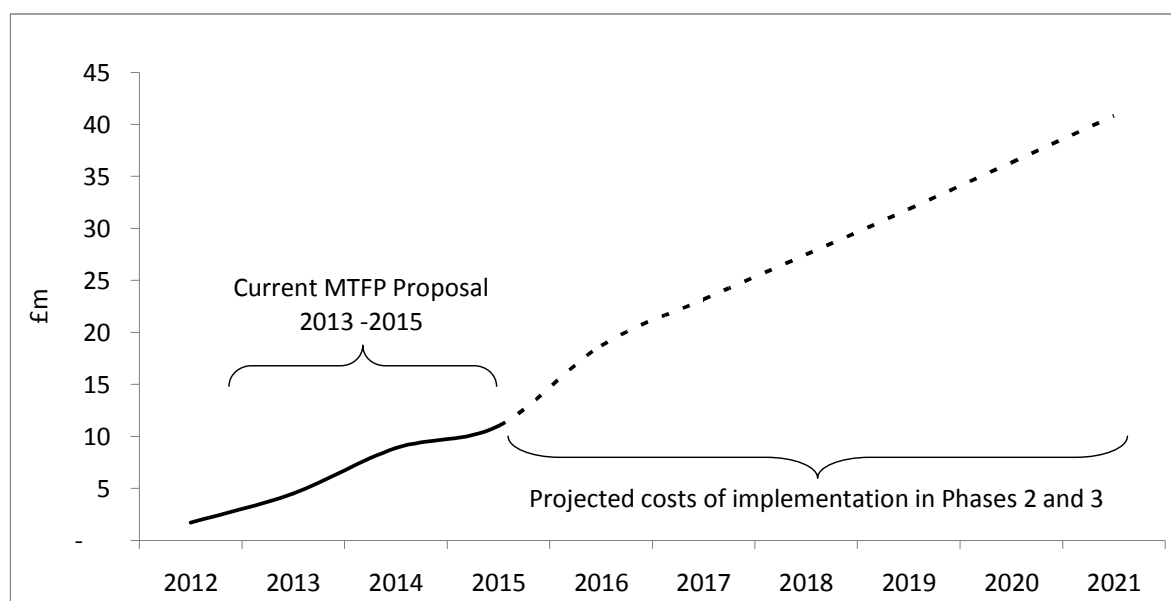
- **Primary Care.** A Primary Care Strategy will be produced. This will consider the sustainability of Primary Care within the new health and social care system. It will be produced jointly with Primary Care practitioners, in order to ensure the impacts and unintended consequences are fully considered.
- **Hospital services.** The feasibility study for the 'new' hospital will be progressed through 2013 and 14.
- **Sustainable funding.** Proposals for a sustainable funding mechanism for health and social care will be produced, with Treasury & Resources working closely with Social Security and Health & Social Services. This will consider a range of existing and proposed future funding mechanisms, including the Health Insurance Fund, and Long Term Care Benefit.

9. FINANCIAL AND MANPOWER IMPLICATIONS

9.1. FINANCIAL IMPLICATIONS

The changes contained within this report will require a recurrent increase in funding, by 2015, of over £11m p.a, as identified in the Medium Term Financial Plan. This is in addition to the additional £14m p.a. growth monies, also identified in the Medium Term Financial Plan.

Further additional investment in the period 2016-2021 will be required to implement the work streams described in this document. This was estimated as part of the development of the Green and White Papers and is illustrated in the graph below.



Source: Green Paper Technical Document and Outline Business Cases, figures shown at 2012 prices

Further business cases including detailed plans and costings will be developed as part of future States Medium Term Financial Plans.

Substantial capital investment is also required in the hospital (in the order of £300 million), and for other essential capital schemes. Health and Social Services are making the following bids in the Capital Programme for phase 1; £10.6 million in 2013, £6 million in 2014 and £3.8 million in 2015.

The Council of Ministers plans to accommodate the increased Health and Social Services budget allocations within the total States spending envelope, therefore no increases in charges or taxes are envisaged in Phase 1.

By the end of 2014, proposals for sustainable funding for health and social services will have been produced.

9.2. MANPOWER IMPLICATIONS

The proposed new system for health and social care comprises a set of service developments, investments and enhancements. These are required in order to deliver health and social care in a sustainable, safe way and to meet the increasing demands in the next 10 years.

OBCs have been produced for the proposed changes in Phase 1 (2013 – 15). Indicatively, these will require in the region of an additional 134 fte by December 2015. These figures have been included in the Medium Term Financial Plan, and include staff of all grades and types, including additional staff working within Third Sector organisations.