STATES OF JERSEY

RE-OPENING OF SAMARES WARD (P.115/2021): AMENDMENT

Lodged au Greffe on 11th January 2022
by the Minister for Health and Social Services
Earliest date for debate: 18th January 2022

STATES GREFFE

RE-OPENING OF SAMARES WARD (P.115/2021): AMENDMENT

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1 PAGE 2, PARAGRAPH (a) –

For the words 'to reinstate', substitute the words

"continue to restore and improve", and;

For the word 'but', substitute the words

"with a full progress report delivered"

For the words 'either at Samarès Ward at Overdale or at another suitable location, as determined by the Minister', substitute the words

"to ensure patients have a responsive rehabilitation service experience, services are clinically safe, high quality and focused on patient outcomes."

2 PAGE 2, PARAGRAPH (b) –

For the words 'purpose-built rehabilitation unit offering the full', substitute the word –

"comprehensive", and;

Delete the words 'formerly offered at Samarès Ward' and;

For the words 'or at another suitable location, substitute the words –

"and the development of community services"

COUNCIL OF MINISTERS

Note: After this amendment, the proposition would read as follows –

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

to request the Minister for Health and Social Services to:

(a) continue to restore and improve the full suite of stroke and injury rehabilitation services facilities and beds at the earliest opportunity, with a full progress report delivered no later than 1st March 2022, to ensure patients have a responsive rehabilitation service experience, services are clinically safe, high quality and focused on patient outcomes; and

(b) ensure that a comprehensive suite of stroke and injury rehabilitation services facilities and beds is delivered as part of the

development of a new hospital campus at Overdale and the development of community services.

REPORT

In May 2020, at the beginning of the COVID-19 pandemic, a clinical and operational decision was made to change the purpose of Samarès Ward as part of the pandemic contingency planning. the professional team and the services provided at Samarès Ward transitioned to the General Hospital and later also to the community to continue to provide rehabilitation services. Staff were certainly not 'abandoned' and continue to provide rehabilitation services to Islanders.

It is recognised that, due to the different setting, the unsettling effect of the move and the impact of the on-going pandemic, the care and rehabilitation experience on Plémont Ward has not been as good as it should have been for every patient since the move.

Within HCS, multidisciplinary teams are already focusing on improving the rehabilitation service provision for stroke and injury rehabilitation taking into account patient feedback, staff feedback and clinical audit recommendations covering a wide range of areas for improvement. Waiting lists for physiotherapy have considerably improved over the last 6 months and urgent referrals are now seen without delay.

Considerable improvements are being made on Plémont, including physical improvements to the environment on the ward, the re-establishment of an Activity co-ordinator and a laundry service for patients. Ideas for new services were gathered as well and as a result, some new ways of providing a better experience are being introduced, for example a care passport has been developed and is being launched within the next three weeks. The passport is a personalised document for each patient and will be made available to patients at discharge from hospital with details of their care including appointment dates and details for rehabilitation services to be received at home or in the community.

The future of rehabilitation services, including stroke and injury rehabilitation services, needs to be person-centred with a holistic approach to provide the right service where the patient needs it most to recover from injury or illness. The programme of work currently being undertaken includes the establishment of three new consultant posts, one specialist stroke consultant and two frailty consultants. These are new posts which had not been available before at Overdale or the General Hospital and will considerably contribute to a wider rehabilitation service.

The re-instatement of Samarès Ward at Overdale by 1 March would operationally not be possible. The identification of and the move to an alternative location would distract clinical staff from the improvement work and the design of the future service, as they would need to find/assess a suitable location, contribute to and support the move and develop new operational procedures to ensure care is being provided safely in a remote location from the General Hospital. Wider impact on other services would be expected as well (clinical and non-clinical support services, such as diagnostics, pharmacy, facilities management). This would take considerable time that would otherwise be invested to look after patients and to work towards a person-centred model of rehabilitation.

The replication of Samarès Ward as part of the new hospital would, in addition to the considerable costs and workforce changes, reverse the improvements already made and planned and establish by default a rehabilitation function for the long-term that is determined by beds and a physical environment and not by a patient-centred approach that focuses on patient needs and includes clinical guidance and expertise.

Health and care services need to continuously develop based on Islanders' needs and best clinical practice and this is what this amendment focuses on.

Introduction:
In May 2020, at the beginning of the COVID-19 pandemic, a clinical and operational decision was made to change the purpose of Samarès Ward as part of the pandemic contingency planning. Based on the available Public Health modelling (number of potential cases, number of hospital beds required), there was a requirement to centralise the nursing and medical staff to the General Hospital in preparation for the anticipated admissions and to move the rehabilitation service to the General Hospital to provide a bed contingency for Covid patients.

At the time, the professional team and the services provided at Samarès Ward transitioned to the General Hospital and later also to the community to continue to provide rehabilitation services. Staff were certainly not 'abandoned'.

Plémont Ward currently offers 14 beds dedicated to rehabilitation with four of those in single bed cubicles. These beds are being used according to the number of neurological and stroke patients that are on the unit at any one time.

Rehabilitation services have not been reduced but are being delivered in different settings and in a number of different ways, and each rehabilitation plan is personalised. In relation to stroke and injury rehabilitation, we continue to maintain the capacity required for inpatient services. For those patients who require rehabilitation and support in an inpatient setting after completing the acute phase of treatment, the rehabilitation service that was previously delivered in Samarès Ward is now being delivered in Plémont Ward.

In addition, HCS staff are focusing on strengthening and improving the community rehabilitation team and services offered. This supports patients to continue their rehabilitation within their own environment. Recurring feedback on poor communication, uncertainty of next steps and poor visibility of care plans and appointments for community rehabilitation has been taken into account and a key focus of the improvement work going on is to ensure staff provide patients with a seamless transition and handover from inpatient to community teams including any interaction with social care services.

Not all stroke patients require inpatient rehabilitation after the acute phase of rehabilitation treatment[1] but many require continuing rehabilitation support in the community. This means an inpatient bed in a rehabilitation ward is inappropriate for these patients and would not provide the right support for them. For patients who do not require inpatient rehabilitation, rehabilitation and continuing support are preferably delivered in the patient's home or a community setting to support the patient to return

[1] The acute phase of rehabilitation follows as soon as possible after a stroke has occurred; this is provided on acute wards within the General Hospital.

to their normal place of living, enable them to return to work, to undertake their day-to-day duties, to reduce infection risk, and to enable them to adapt to their home environment.

However, it is important to note that rehabilitation is not just confined to Plémont Ward; rehabilitation is provided on every other ward in the General Hospital if required and the close proximity of staff across the various hospital wards supports peer-to-peer professional support and multi-disciplinary working and decision-making which ultimately benefits the patient.

Other advantages of the rehabilitation ward being in the General Hospital include but are not limited to, the ability to request diagnostics quickly without additional patient transport, the ability to collect and review prescriptions and medication in the hospital pharmacy without patient transport and the increased access and frequency of consultant visits (ward rounds) as no travel is required from the General Hospital to Overdale.

Feedback on Samarès Ward and Plémont Ward provision

Samarès Ward was close to many people's hearts in how they experienced care for themselves or loved ones. Whilst every effort was made to continue the service in Plémont Ward, it is recognised that, due to the different setting and the impact of the on-going pandemic, the care and rehabilitation experience on Plémont Ward has not been the best for every patient since the move.

Continuously improving services through patient feedback and clinical audits is part of providing health and care services and all feedback received from patients and feedback publicly shared by States Members on the rehabilitation service provision has been actively reviewed and responded to by HCS staff or the Minister.

In the period between 16 August 2020 and 10 January 2022, the following feedback was received about the provision on Plémont Ward.

7 complaints. All complaints were investigated and responded to formally with a written letter, and none progressed to 2nd stage. Outcomes and lessons learned are formally documented within the HCS Datix system and are being discussed and opportunities for improvements identified as part of the ward meetings. Only one complaint is still open but regularly followed up.

19 compliments. During this period 19 compliments were logged onto the Datix system, however this figure is likely to be higher as more positive feedback was received by the ward than documented. These were in the form of thank you cards, thanking all nursing and therapy staff for care. Also included was a letter regarding end of life care received. The themes raised in complaints have been included by staff in the rehabilitation improvement action plan and will also inform the design of the wider rehabilitation pathway that is being undertaken this year. More details on the improvement plan are described below in the section 'Improving rehabilitation services and patient experience'.

In addition to learning from complaints and patient experiences, HCS staff have also been focusing on the positive items patients and their families and carers liked about Samarès Ward. This allowed the team to identify items or services on Plémont Ward that should change or could be introduced.

Clinical Audit

As part of the rehabilitation improvement plan, clinical audit plays a key role. Jersey reports into the Sentinel Stroke National Audit Programme (SSNAP) and collects data on key multi-disciplinary indicators relating to stroke service provision. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke. The SSNAP is a recognised national healthcare quality improvement programme based in the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland.[2]

HCS will continue to monitor outcomes following the change in location of the rehabilitation service. This can be captured in a range of metrics including rehabilitation success and ongoing care needs. However, 2020 and 2021 have been challenging times to draw direct comparisons as, like all health and care providers, unscheduled and scheduled care activity has been significantly impacted by the pandemic with a reduction in emergency presentations, and fewer patients requiring inpatient emergency hospital care.

HCS will continue to contribute to the SSNAP and feed the clinical recommendations into the existing improvement plan. In addition, based on the national audit information we will conduct a clinical pathway review led by the new stroke consultant[3] and with King's College London. The review will assess and benchmark existing provision and advise upon the future direction and resource requirements of services locally. HCS will be commissioning a report from an expert in rehabilitation services to review existing provision and advise upon the future direction and resource requirements of services locally.

To provide further assurance on improvement of stroke and injury rehabilitation services, an update report on service provision and improvements including the progress of the improvement plan, the clinical audit and patient experience will be provided to the States Assembly by 1st March.

Jersey Care Model

The States Assembly has given its approval to the implementation of the Jersey Care Model (JCM)[4] which recognises and emphasises the importance of stroke preventative and rehabilitation services as stroke is a significant cause of morbidity worldwide. Stroke care and rehabilitation is therefore a key area for improvement in the JCM and the following objectives were included:

- Risk stratification and preventative medicine
- Reduction in morbidity & mortality using improved stroke care
- Reduction in length of stay using appropriate community rehabilitation services
- Reduction in reliance on long term care

[2] https://www.strokeaudit.org/About-SSNAP.aspx
[3] post is currently being recruited (see section Jersey Care Model)
[4] https://statesassembly.gov.je/AssemblyPropositions/2020/P.114-2020.pdf

The Jersey Care Model has just started the second year of its five-year programme. The development of clinical stroke and rehabilitation pathways starting with prevention, and improvement of stroke and rehabilitation services are key deliverables in 2022 and will therefore address any current gaps and inform the future provision of stroke and rehabilitation services.
In developing better services and improved or new pathways, HCS staff will continue to listen and engage with patients and are keen to engage and consult with local charities working with patients using rehabilitation services, in particular stroke patients.

Previous recommendations from the national stroke audit programme included the establishment of a stroke consultant post. The JCM programme has invested into and is currently recruiting to three new consultant posts with a particular focus on stroke and frailty across inpatient and community facilities to enhance the rehabilitation provision further: a dedicated stroke consultant post (for which a locum is in place since January 2022 for six months to cover the recruitment period) and two frailty consultant posts which will cover visits on hospital wards and in the community including residential care and nursing homes. The stroke consultant will provide specialist expertise that was previously not available in Jersey (and therefore not available in Samarès Ward).

The Our Hospital project
Whilst Samarès Ward provided a very pleasant environment, its rehabilitation services and clinical oversight were not state of the art as maybe perceived by patients. The detached location of Samarès Ward from the General Hospital caused many issues, such as patients had to be transported down to the General Hospital for diagnostics or had to wait longer for a consultant visit due to the consultant having to divide their time between two locations, or had to be transported down to the General Hospital for an outpatient-clinic to see the consultant. As described above, a specialist stroke consultant post had not been part of the HCS workforce but is now under recruitment and the post currently filled by a locum consultant.

The co-location of rehabilitation services in the hospital will ensure that hospital doctors including specialist consultants are available at short notice and also during out-of-hours.

In addition, Samarès Ward only provided services for certain groups of patients who needed rehabilitation, often this excluded those with more complex needs. Having an integrated rehabilitation service in the new hospital available to all patients will ensure that rehabilitation services are provided based on patient-needs and in whatever way required, starting with admission and throughout acute care whilst also supporting a smooth transition to home or a community setting with appropriate follow-ups.

The new hospital will provide stroke and injury rehabilitation, including acute and inpatient facilities with the latest supportive equipment, provided by expert staff according to patient needs. Services need to be designed to provide the best health outcomes and this is currently being addressed in the improvement plan and as part of the Jersey Care Model programme. Both will result in ensuring the new hospital is designed with appropriate capacity and provision of rehabilitation services to accommodate Jersey's future needs. The new hospital design puts emphasis on a bright, spacious and pleasant environment that will address the current suboptimal environment experienced in the General Hospital.

The number of beds required for acute rehabilitation is accommodated within the bed base of the proposed new hospital at Overdale, and importantly as described earlier, these services are required to function on more than one ward where patients in different specialist areas also require inpatient rehabilitation. This will mean inpatient rehabilitation will be wrapped around the patient rather than the patient being moved to one single ward or a separate facility to access rehabilitation services. Support services such as occupational therapists, physiotherapists, speech and language therapists and mental health practitioners will provide support to all inpatient areas of the new hospital where there is a designated need.

Rehabilitation covers the whole of health services, including preventative services, and the service should be measured by clinical standards and patient outcomes rather than by the look and feel of a building or the number of beds within it.

The provision of rehabilitation services

Rehabilitation is defined by the World Health Organisation as *"a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment"*[5].

Practically, this means rehabilitation helps a child, adult or older person to be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful life roles such as taking care of family. It does so by addressing underlying conditions (such as pain) and improving the way an individual functions in everyday life, supporting them to overcome difficulties with thinking, seeing, hearing, communicating, eating or moving around.

These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

This wide range of services cannot be provided solely by a dedicated facility or a fixed number of beds. Jersey needs to review its current rehabilitation service provision, inpatient and in the community, to improve the current experience and provision, identify gaps and develop the future provision as already planned as part of the Jersey Care Model and the Our Hospital projects.

Anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age. Rehabilitation is not restricted by age.

Some examples of rehabilitation include[6]:

- Exercises to improve a person's speech, language and communication after a brain injury.
- Modifying an older person's home environment to improve their safety and independence at home and to reduce their risk of falls.
- Exercise training and education on healthy living for a person with a heart disease.

[5] https://www.who.int/news-room/fact-sheets/detail/rehabilitation
[6] WHO as above

- Making, fitting and educating an individual to use a prosthesis after a leg amputation.
- Positioning and splinting techniques to assist with skin healing, reduce swelling, and to regain movement after burn surgery.
- Prescribing medicine to reduce muscle stiffness for a child with cerebral palsy.
- Psychological support for a person with depression.
- Training in the use of a white cane, for a person with vision loss.

Rehabilitation is highly person-centred, meaning that the interventions and approach selected for each individual depends on their goals and preferences. Rehabilitation can be provided in many different settings, from inpatient or outpatient hospital settings, to GP surgeries, or community settings such as an individual's home.

The WHO details that a rehabilitation workforce is made up of different health workers, including but not limited to physiotherapists, occupational therapists, speech and language therapists and audiologists, orthotists and prosthetists, clinical psychologists, physical medicine and rehabilitation doctors, and rehabilitation nurses.

Rather than concentrate on establishing a building and a number of beds without improved clinical pathways, it is important that we review and improve all rehabilitation services and ensure that services are providing high quality care and a responsive patient experience for now and in the future.

Improving rehabilitation services and patient experience on Plémont Ward and in the community

HCS staff are committed and focused on improving the rehabilitation service provision across the General Hospital with particular focus on Plémont Ward and community physiotherapy provision. Items for improvement are regularly discussed in each service, however, in areas where a wider range of topics needs to be covered or a whole service, improvement plans are being created and improvement opportunities are being identified and tracked in a 6 to 8 week Task and Finish multidisciplinary working group. The outpatient waiting list for physiotherapy had been the focus of a physiotherapy task and finish group in 2021. The waiting list has improved considerably and there is currently no delay for any urgent referrals to receive physiotherapy in the community.

In addition, a specific rehabilitation improvement group (Task & Finish Group) has been established within HCS, consisting of a multidisciplinary team including the Head of Therapies, General Manager for Medicine, General Manager for Rehab improvement, Consultant Geriatrician. The group has been scheduled for a period up to end of February and will report back on progress made by 1st March on the following areas:

- Quality and Safety including
    - review of complaints and feedback
    - review of policies and procedures
    - review of clinical pathways
    - review and develop key indicators and metrics
    - review criteria for off-island patients
    - conduct JNAAS[7] review

[7] Jersey Nursing Assessment and Accreditation System allows nurses to measure the quality of care they deliver

- carry out a medication audit by the Chief Pharmacist

- Environment (Plémont Ward)
  - improve the aesthetics to create a friendly and light environment
  - improve storage space
  - create a dining area to reflect a similar provision in Samarès Ward
  - conduct a gap analysis between provision in Samarès and Plémont Wards and address gaps (e.g. treadmill placed in Samarès being transferred to Plémont Ward)
  - review and develop the therapy area

- Operational Review
  - conduct an initial review of Plémont Ward and implement rapid improvement
  - review the operations and processes of Plémont Ward and provide recommendations for improvement
  - review therapy provision on Plémont Ward
  - review therapy provision in the community
  - review discharge processes
  - review mental health/psychological provision for rehabilitation services

- Workforce review
  - to review the workforce and medical model to ensure sufficient capacity and the right capabilities are available
  - to align with the JCM programme and Intermediate care to ensure staff providing a seamless service across specialities

- Information material for stroke patients
  - review and develop information material
  - liaise and engage with charities

- Patient Experience
  - Review patient feedback and include users/patients in the improvement plan
  - Improve the ward to make patient experience better and increase engagement between staff, patients and family (e.g. re-establishment of the activities co-ordinator; creating a laundry service for patients' own clothes)

- Wider communication
  - develop information material on rehabilitation and stroke related services
  - communication strategy to support the improvement initiatives

Behind each item, a number of actions are being undertaken by the staff on Plémont Ward and the wider rehabilitation and community staff. A summary overview of progress against actions is provided below:

https://www.gov.je/health/hospitals/hospitaldepartments/jerseyprivatepatients/patientservice/pages/healthcarestandards.aspx

Table 1: Overview of actions in the rehabilitation improvement plan and their current status (as at 10/01/2022). Completed = task is completed, Green = on track, A = slight delay, Red = key issues.

	Total Actions	Completed	Green	Amber	Red	Not started yet
Quality and Safety	30	7	15	2	0	6
Physical Environment	26	8	14	0	0	4
Operational Review	38	6	29	1	0	2
Workforce Review	2	0	1	0	0	1
Stroke Information Material	7	0	2	0	0	5
Patient Experience	9	0	8	0	0	1
Wider Communications	2	0	2	0	0	0
Total	114	21	71	3	0	19
Percentage of total actions		**18%**	**62%**	**3%**	**0%**	**17%**

The majority of actions are to be completed or considerably progressed by end of February 2022 and will be reported back by 1st March.

One of the first items in the improvement plan addressed, was the gap in effective communication between staff and patients and their families/carers. The very personal and visible approach led by the ward manager has already been noted by patients and families as having a very positive impact.

Samarès Ward patients had benefited from an Activity Co-ordinator who provided different activities to encourage patients' independence and social connection. The post is now being re-established and will be recruited to. In the meantime, staff on the ward are being supported to fill this gap until the post is filled.

The nutritional offer on Samarès Ward was reviewed by the hospital chef and assurance has been provided that the same nutritional service is available on Plémont Ward. Specific dietary requirements will continue to be reviewed and feedback sought from patients.

The consultant oversight and ward rounds have been reviewed and a senior doctor is on Plémont Ward five days a week supported by a weekly consultant ward round. The additional stroke consultant post that has been created as part of the JCM, provides clinical expertise on island that had not been available before on Samarès Ward.

The hospital laundry service now provides a laundry service to Plémont Ward patients so that they can have their own clothes washed regularly. Staff support and encourage patients in wearing their own day clothes during the day to create a sense of independence.

New items to be introduced will include a rehabilitation passport for patients that they can take home after discharge which provides information about their care, their rehabilitation programme, their next appointments and key telephone numbers.

Patients on discharge can expect to be followed up based on clinical need. This might include off island placement, rapid response or reablement, community therapy,

outpatient therapy or referral into community charity providers. We are undertaking a workforce review of therapies to ensure that capacity meets the demand and the skill mix is adequate.

From January 2022, improved discharge support services have been put in place in conjunction with HCS and FN&HC. This will improve timely access to care in the community and improve communication with the multidisciplinary team. The overall aim is to improve the discharge to home process with appropriate community input.
As part of the JCM, the current rapid response, supported discharge and reablement service will be developed to provide 24-hour care and a rehabilitation model in 2022. This work has been in the planning since 2020 and is now actively being progressed to implementation. The service will provide an urgent response service, including rehabilitation and personal care. The overall aim is to provide patient-centred care in a timely manner in an environment that is suitable for the patient individual needs.

Many families suffer financial strain as well as a strain on their health and emotional resources. It was recognised that information around social services and benefits has sometimes been difficult to obtain and understand by those who need it, with the result that decisions made around this area might occasionally seem arbitrary. We recognise that there is clear room for improvement and will include support to patients for social services, benefits and psychological support into the pathway development for stroke and frailty.

Impact of re-instating Samarès Ward or a separate facility at another location:
The financial implications in the proposition are only high level and indicative without reference to wider implications on health and community services, the timeline of the new hospital or how costs will be funded. The indicated costs are considerable but would need further verification and wider analysis as there is a wider impact on the Our Hospital project. The re-instatement of Samarès Ward at Overdale by 1 March would not be possible. Staff are currently working on re-locating services from Overdale to Les Quennevais and Overdale will see the first demolition work to start this year.

The replication of Samarès Ward as part of the new hospital would, in addition to the considerable costs and workforce changes, reverse the improvements already made and planned and establish by default a rehabilitation function for the long-term that is determined by beds and a physical environment and not by a patient-centred approach that focuses on patient needs and includes clinical guidance and expertise.

Conclusion
Rehabilitation services exist to help a person to regain physical, mental and/or cognitive (thinking and learning) abilities that have been lost as a result of disease, injury or treatment. They aim to return a person to a normal or nearly normal way of life. They may include services such as physical therapy, occupational therapy, cognitive therapy, speech and language therapy and mental health rehabilitation services. There are many more services that are rehabilitation services and it very much depends on the person's rehabilitation needs.

Rehabilitation services can in general be used in the areas of prevention, restoration, support and palliation. They are therefore very broad in their scope and application and need to be flexible and responsive in order to be most effective. Traditionally in Jersey they have focused on the areas of neurological impairment particularly stroke and post-injury. It is therefore timely in the context of the Jersey Care Model that we look at how

and where these services are delivered moving from them being centred from within a particular unit to being available in a much broader range of settings, for a much broader range of conditions. In particular we need to think how they can play a greater role in terms of prevention in its broadest sense and also restore peoples' mental health after health events. It is logical when considering how these services look in the future to think about the people involved first, both patients and practitioners, before thinking about facilities. Since the objective is to return to a normal or near normal way of life it is also logical to expect that services where possible need to be delivered in the community and as close to Islanders' homes as possible.

Regaining physical, mental and cognitive function is often hard work for both patients and practitioners. It should also begin as soon as possible in a patient's journey be it for an acute or chronic condition. It is not something that begins when a patient is ready for discharge from an acute hospital bed but should be seen as a continuum of treatment that begins as soon as a health condition is identified. Rehabilitation services need to be integrated with other services whether they are within a secondary care facility or if services are provided in the community. A stand-alone unit is unlikely to be the most effective way of delivering rehabilitation services in the 21st century and particularly in the context of Jersey.

Financial and manpower implications

None as a consequence of this Amendment.