JERSEY CARE MODEL UPDATE REPORT 2021

HOW THE DELIVERY OF HEALTH AND CARE SERVICES IN JERSEY IS CHANGING **TO PROVIDE THE RIGHT CARE, BY THE RIGHT PEOPLE, IN THE RIGHT PLACE, AT THE RIGHT TIME.**

R.192/2021

Jersey Care Model

Government of JERSEY

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Foreword from the Minister

It has been a challenging year for all of us, but particularly for our colleagues in the health and care sector. As the Jersey Care Model ("JCM") nears its first twelve months of activity, I would like to thank and commend all those who have been involved with delivering the programme this year, and to States Members for having the foresight to put your full support behind this important Island initiative.

This report has been drafted to provide an update on the progress we and our partners have made during this first year on the implementation of the Jersey Care Model. The report includes details of the year's programme highlights.

I am proud to report that we have made sound progress with the JCM this year. Key deliverables for the first year of the five year programme have included co-designing strategies with our health and care partners in the Island, including an Island-wide workforce strategy for health and care professionals; establishing the programme governance and starting the Intermediate Care programme, which supports Islanders in their homes and aims to avoid unnecessary hospital stays.

Bringing together health and care service providers across the Island has fostered good relationship building and created trust between professional partners. This has resulted in better outcomes for Islanders - for example, they are already benefiting from additional health and care support during the night from the new Overnight Community Care service.

I am pleased that we have invested in the creation of a Public Health team, headed by a new Director of Public Health. From early next year, this team will play a crucial role in understanding our specific health and care needs in Jersey which is important for prioritising interventions to help improve health and prevent disease across our entire population. As well as boosting quality of life, investment in Public Health can also lead to reduced pressure on health and care systems in the longer term.

When accessing health and care services, creating the effective means for health and care professionals and Islanders to share health and care information safely, is crucial for the delivery of patient-centred care across the Island. Key to this is our Digital programme, which has made good progress on technological initiatives this year - for example, the digitisation of our medical records.

During the pandemic some of the traditionally hospital-based services, which we had been planning to re-locate into the community later in the programme, have been brought forward in 2021. These included post-operative support and Overnight Community Care and these have provided strong evidence that the JCM concept of taking care to Islanders, rather than moving Islanders to their care, both works and delivers positive outcomes.

We are all well aware that the financial challenges facing Jersey's health and care system are not unique - economies globally are all trying to wrestle with escalating health and care costs, even without the additional burden of COVID-19. Between 2019 and 2030 the Island expects its population to have grown by 13%. By 2036 one in five Islanders will be over the age of 65. As our population grows and ages, demand and costs for health and care will inevitably increase.

We know that reducing expenditure is therefore not feasible and so the Jersey Care Model aims to reduce the growth of additional health and care costs, whilst re-designing our health system to be more person-centred, supporting Islanders in the community. This will, as you will see in this report, become increasingly achievable through the JCM's re-organisation of our health and care provision.

To address the long-term sustainability of health and care funding, a wider health economic review will be undertaken during 2022 to inform funding options for increased health and care costs and for any potential new health access schemes. The options will be brought forward in 2023 for the Government Plan 2024-27.

I hope that you feel as confident as I do about the progress the JCM has made this year and the promise that the future now holds for our Island's health and care system.

Deputy Richard Renouf
Minister for Health and Social Services

Introduction

- The **Jersey Care Model (“JCM”)** was approved by the **States Assembly** in November 2020 (P.114/2020), as a five year programme. It officially started on 1st January 2021, with funding as agreed in the **Government Plan** (P.130/2020). This has been the first year of this programme, which has been designed to improve the way that health and care services are delivered in Jersey.

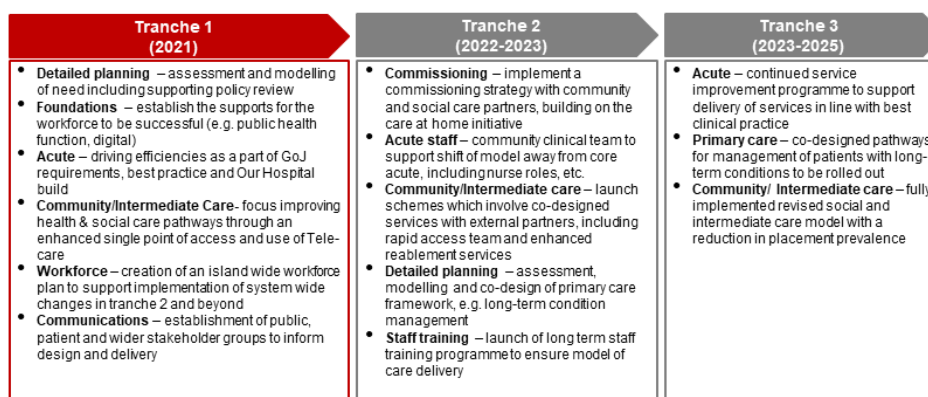
- The fundamental aim of the **JCM** is to keep people in Jersey living healthy and independent lives, for as long as possible.

- When people do need access to health and care services, the goal is for these to be delivered ‘person-centred’ in the community, where clinically appropriate. The **JCM** is re-structuring health and care services to improve outcomes and experiences for Islanders, by ensuring they are able to access the right care, by the right people, in the right place, at the right time.

- The **JCM** programme has three underpinning objectives, which are aligned with the Government strategic ambitions. These are to:-

    - Ensure care is person-centred with a focus on prevention and self-care, for both physical and mental health.
    - Reduce dependency on secondary care services by expanding primary and community services, working closely with all partners to deliver more care in the community and at home.
    - Redesign health and community services so that they are structured **to** meet the current and future needs of Islanders.

- This first year of the **JCM** programme (Tranche 1) has, despite the challenges of COVID-19, been successful in laying solid foundations on which to base the re-design of our health and care services in Jersey. We have now completed and achieved the deliverables set for the first year of the programme and are in a position to begin delivery of Tranche 2.



I recently arrived at the home of a patient in a great deal of discomfort from a blocked catheter. They were irate and distressed when I arrived. The problem was swiftly dealt with and minutes later they were feeling better, smiling and joking. With no disruption, their problem had been solved and they were able to return to sleep – there was no need to drag them out into the middle of the night; no sitting around in hospital waiting rooms and minimal stress. It's this patient-centred care that epitomises what the **JERSEY CARE MODEL** is all about.

NURSE,
FAMILY NURSING & HOME CARE

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- Dedicated **JCM** programme personnel resources have been put in place, bringing on board professionals with the key skillsets to provide the infrastructure and support to deliver our integrated health and care system. Emphasis has been on recruiting on-Island and using local expertise from across clinical, technical and operational backgrounds.

- COVID-19 became a driving factor for rapid change in many of our ***Immediate Care*** practices during 2021. Services which had been traditionally based in **Health and Community Services** buildings (such as physiotherapy) were re-designed to be delivered in the community (normally in people's homes) to ensure continuity of care, safely away from infection risk. This provided us with valuable insights and experiences for some of the ***Intermediate Care*** services that the **JCM** had been planning to roll-out later in the programme. These initiatives have been very successful and some are now being routinely delivered in the community – such as physiotherapy, occupational therapy and ***Overnight Community Care***.

- 2021 has also seen improved collaboration and co-ordination between **HCS** and other Island health and care organisations such as:- primary care providers, including general practice; charities; support groups; associations; health and care businesses; volunteers and other Governmental departments. Led by the ***Commissioning*** team in ***Health and Community Services***, health and care professionals have been working together to begin to look at how **HCS** can better commission services, to optimise patient access to the right health and care expertise, where and when they need it.

- This year has seen Jersey increase its capacity in ***Public Health.*** During 2021 a new *Director of Public Health* was appointed and a supporting team of public health professionals will be in place by the end of the year. This team will be adopting strategies to both prevent and identify disease at an earlier stage, in order to keep Islanders healthier for longer, needing fewer health and care interventions. The intention is that this will reduce the longer-term impact on health and care resources.

- Over the next few months, the newly established ***Public Health*** team is set to begin planning a comprehensive research programme regarding Islanders' health needs, called the *Jersey Strategic Needs Assessment (JSNA).* This will provide an evidence-base to underpin health and care policy and service decision-making.

- An important facilitator for improving health and care services is digital support. Following a tender process during 2021, an **Electronic Patient Record (EPR)** system has now been procured and the team will begin migrating existing patient data onto this new platform, starting early in 2022. This will mean that all patient information will be safely stored yet available electronically, to clinicians at any time when treating a patient. 2022 will see the beginning of the integration of Islanders' historical paper medical records into the **EPR** system using intelligent scanning software, improving access and the information security of patients' medical records.

- The **JCM**'s aim to ensure care is patient-centred and delivered in the community, where feasible, will affect where and how health and care professionals work across the system. During 2021 a *Workforce Strategy* has been co-designed with health and care partners across the Island and going forward into 2022 the programme is looking to formulate recruitment; training and retention strategies to help build and strengthen the Island's health and care workforce.

- Where 2021 was a year of setting the foundations for the design and delivery of the second tranche of programme activity, 2022 will see new and improved services come together more visibly to Islanders. Jersey will begin to see a more integrated system making access to health and care easier and more consistent.

- This improved access will be made possible by the creation of 'care pathways'. During 2021 a multi-disciplinary team of local health professionals (the *Clinical & Professional Advisory Forum*, chaired by the Medical Director) has begun forming and throughout 2022 they will work with the Island's first *Health and Care Partnership Group* and the newly established *User Experience Panel,* alongside health and care systems design experts to create these new pathways.

- The financial aim of the **JCM** is to manage the Island's increasing costs of health and care effectively and sustainably - it is not about attempting to cut costs or services. During this financial year the programme management team has overseen the detailed funding allocations from the Government Plan, to each of the programme development areas and work is now beginning on a wider health economic review to provide options for sustainable funding mechanisms in the future.

- During 2021 we have built a strong governance structure for the **JCM**. This has been co-designed with our partners and agreed by the *Health and Community Services Board* to ensure that the programme is clinically led and is delivering on its strategic intentions. All intentions have been met for 2021.

The remainder of this report provides an update on each of the key working elements of the **JCM** programme in more detail.

Intermediate Care

The right health and care professionals providing the right care, in the right place, at the right time

Intermediate care refers to services provided to people after leaving hospital, or when they are at risk of being sent to hospital because of their health condition. ***Intermediate Care*** helps people to avoid going into hospital or residential care unnecessarily and keeps them living at home independently, for longer.

Intermediate Care can be provided in different places (for example, in a residential home or in people's own homes).

The **JCM** ***Intermediate Care*** programme is designed to***:-***

- Sustain independence for people in their own homes for as long as possible
- Expand the scope and size of the current intermediate care provision, in collaboration with other health and care providers across the Island
- Prevent unnecessary hospital attendances and admissions
- Centralise and provide 24 hour provision of health advice and care
- Accelerate the discharge process from hospital, when this is safe and best for the patient need
- Deliver patient care closer to home
- Reduce the need for care packages

In order to work towards achieving these objectives over the next four years the ***Intermediate Care*** team has spent much of 2021 in the preparation and planning stages. Despite being in such an early phase of development, many areas of ***Intermediate Care*** have progressed well this year.

During lockdown, some areas of historically hospital-based support care, such as post-operative care, was undertaken in the community, as access to the hospital was limited. One of the unexpected results of these unprecedented circumstances was that we commenced community care provision earlier for some of the ***Intermediate Care*** practices that the **JCM** programme had been planning.

They proved to be successful and, as a result, some services have already become embedded in our ***Intermediate Care*** provision.

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To improve our service for our patients, we engaged a nurse with a community and neurology background to make home visits and seconded our assistant practitioner from the department, for one and a half days a week. The team has not only been able to review each patient's condition but, whilst in their homes, has had the time to assess the person as a whole and take a broader look at their individual needs, within the context of their circumstances.

In addition to their condition management, we've been able to assess and co-ordinate additional services to support these Islanders to help them in their everyday lives. Things like organising occupational therapy visits to put equipment and physiotherapies in place to make movement around the house much easier; mental health support and counselling to help manage their well-being or a Night Sitting Service to give them the confidence to sleep. In addition to this, we've been able to assist with engaging help needed from wider services, such as Citizen's Advice or Customer and Local Services, to enable these Islanders to enjoy better all-round quality of life.

Whilst the premise of these home consultations is very simple, the benefits have proved to be enormous and often life-altering for these patients. It's also resulted in less need for further hospital Consultant intervention. This is what the **JERSEY CARE MODEL** is all about – providing tailored health and care support for each and every Islander's needs.

SARAH KEAN,
CLINICAL NURSE SPECIALIST NEUROSCIENCE/MANAGER

The skills sharing across multi-disciplinary, multi-location, multi-organisational teams means that, in some areas, such as occupational therapy and physiotherapy, our community health and care staffing resources are now more flexible. We will continue to monitor the impact of the changes to inform the delivery of services.

The ***Intermediate Care*** programme has developed new services to help people remain independent; to stay at home or to get home quicker. Five of the ten planned workstreams have started to develop new services.

In 2021, the following services were developed in partnership with general practice; *Family Nursing & Home Care*; the *Ambulance Service*; external providers and clinicians from within *Health and Community Services*:-

- ***Overnight Community Care*** (originally launched as a pilot called the *Night Nursing Service*) - Services that will support people to remain at home when a crisis occurs and will prevent an unnecessary hospital attendance.

- ***Telecare and Teleguidance*** - ***Telecare*** is the use of technologies such as a community alarm system or remote monitoring to enable individuals to receive care at home and remain independent. It can additionally provide artificial intelligence support within an individuals' home environment. ***Teleguidance*** will enable

phoneline staff to offer callers guidance on self-care and make referrals to health and care services when necessary.

- ***HCS24*** - A multi-professional hub that will include a single point of referral and ***Telecare*** and ***Teleguidance.***

- ***Help at Home*** scheme - This project aims to create an environment in which providers of registered home care can grow through employment of new recruits; training of existing employees and providing guaranteed demand into the local market, to match new employment with commissioned packages of care.

- ***Discharge Support*** - Current teams are to be merged into one designated team to promote good and efficient discharge practices and support people at home when discharged.

Particular progress has been made during 2021 in the following areas of ***Intermediate Care***:-

- ***Overnight Community Care*** is a new overnight service, for Islanders and health care professionals alike, launched in April 2021 to ensure people are supported at home and any unnecessary visits and admissions to hospital are avoided. It has been commissioned from, and provisioned by, our colleagues from *Family Nursing & Home Care* and facilitates overnight home-based treatments for patients in need, when it is safe to do so.

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THE NIGHT NURSING SERVICE is an overnight ‘crisis management’ provision for Islanders, providing advanced clinical nursing and care assistance in their own homes, when it is safe to do so. This means that there is no need for a GP call out; an ambulance to be despatched or an admission to the ED - which can all add to a distressing situation, especially in the middle of the night. Response to this service from Islanders – even in its very early stages of roll out – has been incredibly positive and, as a practitioner, it is a humbling privilege to be able to make such a huge difference to people’s lives when they are in need.

CLARE STEWART, OPERATIONAL / CLINICAL LEAD FOR OUT OF HOSPITAL SERVICES, FAMILY NURSING & HOME CARE

- ***HCS24*** went live at the end of November 2021. The aim is for this multi-professional hotline to become the single point of referral for all community-based care, including adult and social care; adult safeguarding; community occupational therapy; physiotherapy and, by 2024, to include mental health support.

  The ***HCS24*** team is staffed by multi-disciplinary health and care professionals, based in one central office hub, who handle calls together, to signpost and refer patients directly to the treatments, therapies and support they need.

  This 'one stop shop' will provide better access to all health and care services for Islanders; their carers and their GPs and supports them in receiving the right health care without making endless phone calls; sending emails and chasing multiple agencies.

  Calls for the ***Out of Hours*** GP service will be handled by the ***HCS24*** team by the end of 2021, which will begin the roll-out of a wider ***Teleguidance*** service.

- ***Telecare*** or 'assistive technologies' do not replace human contact, which will remain integral to our health and care system**,** but they give Islanders the support to live at home, for as long as possible (see more in ***Digital Projects***). A replacement Community Alarm System has been implemented in 2021 with further assistive technologies being introduced in 2022.

- ***Teleguidance*** is due to go live in 2022. Based on algorithms, modelled specifically for Jersey, this evidence based, data hub of health and social care expertise will enable phoneline staff to offer callers guidance on self-care and make referrals to pharmacies; GPs or the Emergency Department, where necessary.

- In anticipation of this winter's COVID-19 and flu pressures on our health and care services, the launch of the remodelled ***Discharge Support Team*** is being brought forward 12 months to January 2022. The aim of this integrated unit, pooling resources from the social care discharge teams and the hospital discharge team, is to help patients who are hindered by a lack of domiciliary support, to get home in a timely manner, rather than stay in hospital, risking infection and depriving them of their home comforts.

- The ***Help at Home*** scheme is a financial stimulus initiative for which the Government has provided additional funding to support the local economy. The aim is to support the Island's home care providers in their recruitment, training and retention of care workers. The campaign aims to recruit 100 part-time carers, across the Island to help keep people, who need help with domestic tasks, in their own homes. This simple but life-altering initiative has been facilitated by the **JCM** team and designed with substantial input from professionals from commercial home care agencies, demonstrating further collaboration across our health and care organisations on-Island.

Further services will be implemented in 2022 in the following areas of ***Intermediate Care***:-

- The ***Care and Re-ablement Team*** will work closely together with the ***Discharge Support Team*** to provide 24/7 provision of a multi-professional, advanced nursing care and therapy service, based in patients' homes, as soon as it is safe for them to be discharged from hospital. This will include existing services of ***Rapid Response, Re-ablement*** and ***Supported Discharge.***

- The new ***Night Sitting Service*** is a simple, but effective initiative to enable patients to return to/remain in their own homes, during periods of convalescence, rather than stay in hospital or be admitted to a care home unnecessarily. In collaboration with our partner organisations, this service will begin during 2022.

- ***Rapid Access/Frailty Team*** will also go live during 2022. It will be a community focussed, urgent referral service to undertake assessments, using a multi-disciplinary team approach, aiming to prevent unnecessary hospital admissions or, if urgent treatment is required, provisioning acute care.

The ***Therapies*** team (which includes occupational therapy; physiotherapy; speech and language therapy; podiatry and dietetics) has built solutions over the period of the pandemic to ensure access to and continuity of care for patients. The team is currently analysing patient treatment and outcome data, in order to optimise staff capacity to continue to meet Islanders' therapy needs, in the location where they are most needed.

The different demands on therapy provision, as a result of the pandemic, have led to our health and care professionals upskilling, cross-skilling and moving locations between hospital and community settings. Virtual appointments have also been used to bolster this service, where appropriate and this has been a successful and popular means of maintaining contact with patients.

These cross-working activities have extended beyond **HCS** staff and have been undertaken in collaboration with colleagues at *Family Nursing & Home Care*. This is helping to build a more expansive, flexible workforce that can provide hospital clinics and community provision more effectively.

Fit for Life is a trial initiative that was set up at Le Squez, for Islanders who had been identified as needing support for musculoskeletal issues and has been rolled out during 2021. Led by physiotherapists, these regular community gym training sessions have proved both popular and incredibly successful with patients - 136 patients attended ***Fit for Life*** sessions during 2021. Plans to expand these fitness support sessions and establish an additional group, in the west of the Island, are in progress for 2022.

“ ” Keeping up my weights keeps me out of hospital!

80 YEAR OLD ISLANDER AT FITNESS SESSION

Outpatient Review - We plan to spend next year improving our outpatient services to ensure they are linked to a multi-disciplinary team triage, which ensures patients are seen by the most appropriate health and care professional. We will be focusing on implementing e-referrals to streamline the process. This will benefit both the patient and general practice, as e-referrals will enable advice and guidance options to exist in a formal, documented manner. We will also be reviewing whether we can introduce a better appointment booking system. Diagnostics are important and we are reviewing how these can be added to the patient's referral prior to seeing a consultant, to help inform decision-making. Could some of our outpatient appointments be undertaken in community clinics or within GP surgeries? Could we make some virtual, to save people having to travel to a follow up consultation that could be dealt with just as effectively by telephone or video call?

The aim is to spend the first half of 2022 continuing to look at the current processes and working with the ***Intermediate Care*** and ***Pathways*** teams (including the *User Experience Panel*) to ascertain how we can transform our outpatient services and do things better. In some areas we have already started the review and will be trialling the implementation of the new pathways in early 2022.

Working Together

Optimising our health and care resources through collaboration, to provide the right care, by the right people, in the right place, at the right time

In times of need, Islanders have traditionally been well supported in the community, by a number of health and care 'partners' to ***HCS***:- primary care providers, including general practice; charities; support groups; associations; health and care businesses; volunteers and other Governmental departments. However, sometimes, navigating and accessing these health and care services has not always been easy for Islanders.

Setting up a structure to formally commission services from our health and care partners, to create a more co-ordinated and effective collaboration of health and care support to Islanders, is one of the cornerstones of the **JCM** and the commissioning strategy has been a key deliverable for 2021. Throughout 2021 we have worked closely together with our colleagues from *Children, Young People, Education & Skills (CYPES)*; *Chief Operating Office (COO)*; *Strategic Policy Planning & Performance (SPPP)*; *Health & Community Services (HCS)*; and the *Jersey Care Commission (JCC)* and invited more than 90 partners to join workshops to design the principles for patient-centred and collaborative working practices going forward.

Co-ordinated by the **HCS *Commissioning*** team there has been substantial engagement and enthusiasm from these partners across the health and care support sector. They have demonstrated a strong commitment to co-producing a strategy for future collaborative working, which is now in its final stages of drafting.

> Along with many other professional partners, we have been involved with the **JERSEY CARE MODEL** from the very outset. We have been consulted every step of the way and have helped to design its structure - so we know that it is going to provide Islanders with the expert care services that they actually need, in a setting which is best for them.
>
> For so long, the Island has been entrenched in short term fixes and old routines of delivering health and care. I am genuinely excited about how Islandwide care is transforming under the **JCM**. We are designing long-term solutions for providing Islanders with a health care system that is fit for purpose and tailor made for Jersey and its unique needs
>
> **JASON WYSE, CEO,**
> **SILKWORTH CHARITY GROUP**

The ***Commissioning*** team has spent the last few months collaborating with our health and care partners to compile a joint *Partnership Strategy*, as well as best practice for all participating organisations to work towards. We have agreed to generate innovative, flexible, comprehensive and consistent health and care strategies together and to work creatively to move resources to deliver health and care provision for Islanders where and when needed.

> The **JERSEY CARE MODEL** is supporting us to work more closely with all our [health care] partners, in order to deliver more care in the community and at home. I believe that care will be more 'joined up'....[and] overlap of provision should be reduced, as there is more understanding and trust between providers of care.
>
> **ROSEMARIE FINLEY,**
> **CEO OF FAMILY NURSING & HOME CARE**

Going forward into 2022 the ***Commissioning*** team and its professional partners will commence the delivery of this agreed joint strategy and begin to re-allocate resources to meet Islanders' needs.

An overview of some of our partners engaged to date is provided in Appendix 1 at the end of this report.

Public Health

Understanding Islanders' health needs is important to improve quality of life, for everyone

During 2021 a new ***Public Health*** team was established. Last summer, we appointed the Island's first *Director of Public Health* to head up a new team focussed on health improvement, disease prevention and reducing avoidable health inequalities.

Central to the **JCM** programme is investment in our ***Public Health*** function, because it plays a crucial role in understanding our specific health and care needs in Jersey. If we can understand the health issues Islanders are facing, we can prioritise interventions to help improve health and prevent ill health, across our entire population.

As well as boosting quality of life, investment in ***Public Health*** can also lead to reduced pressure on health and care systems in the longer term, through disease prevention and early intervention. This in turn can reduce the growth of health and care costs because disease identified at an earlier stage can be better managed, with fewer interventions. With an ageing population, investment in keeping us healthy for as long as possible is beneficial for us all and crucial for managing health and care budgets.

Over the next few months, the newly established ***Public Health*** team is set to begin planning a comprehensive research programme regarding Islanders' health called the *Jersey Strategic Needs Assessment (JSNA)*. This will, over time, provide the evidence-base to underpin health and care decisions. Throughout 2022, this research initiative will collect both data and insights from Islanders to identify what our priority physical and mental health needs are and help our understanding of what people want from their health and care services.

Reviewing population evidence and intelligence is a core part of ***Public Health***. As well as tracking interventions and making sure they are giving us the desired health outcomes, the ability to continuously collect patient health data will help to inform, shape and fine-tune health and care policy as a whole.

HCS is currently being supported by the ***Public Health*** team to assess the *oral healthcare* provision for the Island's children. A survey has been distributed over the last few weeks, through schools and social media. This new research evidence will drive our oral health strategy, to address the priority areas, highlighted by Islanders.

Maintaining our health isn't just about medicines and treatments. In addition to diet and physical activity, our physical and mental health is determined by many social factors, including our education, employment and living conditions, as well as socioeconomic, cultural and environmental factors. ***Public Health*** has started developing cross-departmental collaborations to look at tackling some of the causes of poor physical and mental health so that together, we can all contribute to the sustainable health and well-being of all Islanders and reduce health inequalities.

Digital Projects

Using patient-centred technologies to support Islanders and health and care professionals

Creating the effective means for health and care professionals and Islanders to share information safely with one another when needed, is crucial for the delivery of patient-centred care across the Island. One of the key areas that is changing under the **JCM** is the centralisation and digitalisation of medical records for each Islander, so that they are easily accessible for people and for those who care for them. Whether in the GP surgery; in the hospital or in our own homes, the medical record we choose to share will be available to health professionals, so that they can provide us with appropriate, timely and safe care.

In addition, the methods through which we communicate with our health carers is changing. Face-to-face consultations are not always the most convenient or appropriate way to talk to our care givers. Thanks to technological advances – many of which were successfully deployed during the pandemic and have become embedded practice – we now have the ability to communicate through telephone; email; video call or even via remote artificial intelligence devices.

Driving these important changes, which are all well underway, is the ***Digital Projects*** team, which has been working throughout this year on a series of new digital initiatives to transform the way we deliver our health and care on- and off-Island.

There are currently more than 200 separate information system applications across **HCS** and most of these don't talk to each other. But that is all about to change as the ***Digital Projects*** team begins to converge; rationalise; consolidate; store and enable access to centralised health and care data.

An important enabler for the success of our changing health and care provision will be an **Electronic Patient Record (EPR)** system. This will mean that all patient information will be held in one, centralised database. If required, patient information can be accessed electronically by clinicians at any time, for example in an emergency in the Emergency Department. This will support patients when seeking health and care services and avoid the need for paper records. Following a tender process during 2021, the **EPR** system has now been procured and the team will begin migrating all of our existing patient data onto this new platform, starting early in 2022.

Medical records and personal information will be highly protected and Islanders can choose whether they want to share their records with their clinician.

In terms of our historical medical records, the hospital currently still works with paper files. In the first quarter of 2022 an **Electronic Document Management System** (**EDMS**) will be procured, to begin the 18 months process of using an intelligent scanning system to digitise Islanders' paper patient records, so they can be incorporated into our **EPR**s.

The ***Electronic Prescribing and Medication Administration*** (***EPMA***) system is now embedded within many of the *Jersey General Hospital* wards and during 2021, was rolled out across mental health services; maternity; paediatrics and *Sandybrook Nursing Home*. The ***EPMA*** facilitates and enhances the process of medicine prescriptions, assisting choice, administration and supply, through intelligent system decision support and also provides a robust audit trail of prescribing, which ultimately leads to better outcomes for patients.

It reduces the risk of human error; improves safety, service quality and clinical governance; improves productivity and assists with health informatics and research. The ***EPMA*** has already prevented 16,000 significant drug interactions; stopped 19,000 duplicate prescriptions and prevented 600 allergy conflicts. During 2022 we will see further roll-out to outpatients and critical care departments.

2021 has also seen the ***Digital Projects*** team deliver a ***VNA*** (***Vendor Neutral Archive***) which is effectively a cloud storage facility, designed for **HCS**. Currently, all clinical images (such as those captured through MRI, ultrasound, XRay & CT) are held on a number of local servers and cannot always be shared between Jersey based clinicians or support professionals, let alone with specialists off-Island. This new, centralised system will mean that patients' care teams can access clinical images instantaneously.

During the first quarter of 2022, the new ***VNA*** will go live for radiology meaning clinicians will soon be able to access and assess images, no matter where they are located in Jersey or beyond. As well as streamlining pathways for treatment, the ***VNA*** can enable referrals to an extended body of clinicians, easing the resource burden on-Island. Furthermore, a new, upgraded ***Picture Archive and Communication System*** (***PACS***) for the collation, storage and transfer of radiology images has been procured and is due to go live in 2022.

Running simultaneously with these digital initiatives, the beginning of 2022 will see the development of a ***Health Demographic Service*** (which will eventually dovetail with the government-wide ***Jersey Demographic Service).*** This system will create *Unique Patient Identifier* numbers, making it easier and more accurate to identify and register patients against verified demographics (therefore avoiding mix-ups between patients with the same name, for example).

Implemented during 2021 and now live, ***My mHealth*** is a digital app to support Islanders at home, with their long-term condition management. It provides a link to the respiratory, cardiac and diabetes community teams, with a self-referral option and is already being used by more than 500 Islanders.

It is important to note in this section that patient confidentiality is paramount. The **JCM *Information Sharing*** team is working closely with the ***Pathways*** and ***Digital Projects*** teams to ensure that information sharing is entered into with the strictest of guidelines. We are currently undertaking a public consultation to examine how we access personal data, based on the well-defined *Caldicott Principles.*

Care Pathways

Standardising the ways in which Islanders access the right care, by the right people, in the right place, at the right time

A 'care pathway' is effectively a best practice process or plan for a health and care system, which can be deployed when someone is in need of a health or care intervention. These standardised plans are being developed by multi-disciplinary teams and are structured according to guidance and/or evidence of best practice within the relevant local setting. Pathways aim to make access to health and care services easy and consistent for patients.

Developing standardised joint care pathways with key stakeholders means that we can structure, plan, co-ordinate and deploy the multi-disciplinary teams of health and care experts we need, to the areas in which they are needed, resulting in better patient outcomes.

This area will see substantial development and standardisation during 2022, as the *Clinical and Professional Advisory Forum* (*CPAF*); *User Experience Panel* (*UEP*) and the Island-wide *Health and Care Partnership Group* (*PG*) will begin to review the health and care needs of Islanders in detail and start to design targeted pathways of care. These defined pathways will provide the frame, around which much of the new shape of our health and care services will be structured.

The *CPAF* is a multi-disciplinary group of health and care professionals representing their professions and not their organisations. It consists of representatives from eleven disciplines, including:- primary and secondary care; mental health; social work; neuro development; pharmacy; oral health; public health; children's care; allied health professionals and community nursing.

One of the nurses from the **NIGHT NURSING TEAM** was called out in the early hours to an end-of-life patient needing a clinical intervention. The patient was frightened, uncomfortable and agitated and this was causing substantial upset for them and their family around them. Instead of a GP callout and having to be admitted to the ED by ambulance, the nurse administered the necessary treatment in the patient's home, before it became clear that the situation needed more than just her clinical input.

She remained with the patient and their family for over four hours, to help settle the patient into a comfortable state, helping to reduce the upset for those around them. Sadly, the patient later passed away, but in circumstances which were calm and peaceful rather than in the midst of a highly distressing state of crisis. The family took the trouble to subsequently contact the nurse concerned to thank her for making an awful experience so much more positive than it could have been, because of her thoughtful and compassionate care.

NURSE,
FAMILY NURSING & HOME CARE

The *CPAF*'s aim in 2022 is to fully recruit to the *Forum* and begin to make evidence-based decisions on key pathways. ***Public Health*** will provide the relevant *Needs Assessments* at the outset of each pathway, along with the evidence and information required for its design. From here, the team can then begin to develop the structure of these pathways, with input from community partners and important feedback on existing patient journeys and experiences from the *User Experience Panel.*

It is intended that *Forum* sub-groups, consisting of relevant professional specialists, will be established to focus on specific pathways within their area of expertise, for example end-of-life care pathways, which are being designed in close collaboration with the team at *Jersey Hospice Care*.

> " "
> I am committed to the concept of the **JERSEY CARE MODEL** and genuinely believe it will improve patient care and re-direct services to the community rather than secondary care.
>
> **GAIL CADDELL, DIRECTOR OF CLINICAL STRATEGY, JERSEY HOSPICE CARE**

With specialist guidance from external experts, who are currently being procured, the **JCM** team aims to create a network of care pathways, tailor-made to Jersey. The emphasis will be on maintaining individual Islander needs and quality of life considerations at the centre of their care, rather than continuing to place patients into homogenous, one-size fits all services.

Workforce Strategy

Developing an Island-wide health and care workforce to deliver the right care, in the right place, at the right time

The **JCM** programme is changing the way we work and where we work, but will build on the skills and experience of the staff that we already have in Jersey.

With the focus on patient-centred care, we are beginning to deploy our health and care teams in patients' homes and in community settings. In order to achieve this effectively, we need to alter, optimise, train and expand our teams of health and care professionals.

The ***Workforce*** project team is working closely with the other **JCM** programme teams to assess staffing needs. During 2022 the ***Workforce*** and ***Pathways*** teams will plan staffing across the health and care system, in order to meet our changing needs.

Firstly, we are addressing these needs by collaborating with the existing resources of expertise based within our partner organisations on-Island. Our ***Commissioning*** and ***Partnership*** team is working hand-in-hand with the Island's health and care organisations, associations, businesses and charities, to co-ordinate this capacity. This strategy enables us to optimise the professional workforce resources that we already have in Jersey and ensures that Islanders receive care from the most appropriate source of expertise.

Secondly, we know that we need to change our health and care workforce to fulfil newly formed roles – such as for the ***Night Sitting Service*** and ***Help at Home*** carers – and source specialist professional expertise, to some of the clinical areas - such as ***Public Health*** and physical therapies.

As recruiting within and to Jersey becomes more challenging, we are focusing on developing our own workforce through identifying and developing skills on-Island, plus creating a framework for professionals to work across organisational boundaries. We are also looking to enhance job satisfaction and career opportunities and allow for more flexibility and resilience across all health and care sectors in Jersey. Nevertheless, we will need to attract and recruit professionals from off-Island and we will aim to do this as one health and care system to highlight the advantages of working in an integrated system.

These challenges are going to be addressed in the *Workforce Strategy*. At the beginning of December we held our first strategy workshop with interested health and care providers across the Island, sharing ideas and solutions for the challenges we all face fulfilling our workforce needs. Going forward into 2022 we are looking to collaborate with our professional partners and colleagues in other governmental departments – such as Education, Immigration policy and Housing – to formulate a recruitment; training and retention strategy to enable us to deliver the right care, by the right people, in the right place, at the right time.

Financial Planning

Funding our health and care sustainably, so that it can provision the right care, by the right people, in the right place, at the right time

The unequivocal financial aim of the **JCM** is to reduce the growth in the Island's health and care expenditure – it is not about cutting costs or cutting services.

As has been previously discussed, it is clear that the 'do-nothing' and 'carry on as we are' approach would see us facing the same exponential costs that health care systems around the world are currently struggling to address. Health and care expenditure continues to outpace economic growth globally and the current system of providing health and social care will simply be unsustainable in light of population and disease projections. We also now know that the long-term legacy of COVID-19 and the implications of trying to prevent and deal with highly infectious diseases in the future, will inevitably have an additional impact on our health and care expenditure.

The **JCM** has been designed, first and foremost, to improve the long-term quality of life and the overall sustainable well-being of Islanders. Historically, our health and care system has not prioritised enough the early interventions of disease prevention or health improvements and has, instead, faced ever escalating crisis intervention costs. This is now being addressed with the programme's investment in a strong ***Public Health*** team.

Early ***Public Health*** interventions, such as screening, promise to reduce the need for expensive long-term and hospital care, as we strive for children to grow up healthily and to keep people well, in their own homes, for longer when they become older. A healthy Island community has many benefits and is a key contributor to overall well-being of the individual and the population. Research has shown that investment in ***Public Health*** is a key contributor to overall health and care cost management and so the **JCM** will continue to emphasise the role of this area.

The **JCM** programme management team has been recruited and set up during 2021 and has supported the first tranche of the programme implementation, by overseeing the detailed funding allocations from the *Government Plan* to each of the workstreams that you have been reading about in this report.

The programme's financial position has been kept in check and balance throughout the year. The focus is now on planning the allocation of funds for the workstreams being undertaken during 2022 and for the remainder of the programme.

There is an expectation that the **JCM** programme will deliver financial and operational benefits from 2022 onwards. In order to monitor and report on these, systems have been put in place to identify, quantify and track the service level benefits that are being achieved from the investment in the new programme initiatives – i.e. provide robust evidence that the **JCM** is beginning to show a return on investment long-term.

Another important aspect of efforts commencing early in 2022, will be developing the analytical tools to look at the cost inputs and activity outputs across the Island's health and care system, throughout the **JCM** programme implementation and beyond. This will be to extract the appropriate, high quality data needed to support the effective, evidence-based planning, monitoring and evaluation of the programme on an on-going basis.

Whilst the **JCM** is being designed to support more effective use of public funds, it is clear that additional on-going funding will be needed to maintain high quality health services to a growing older population and to cover increasing costs due to advances in medical treatment and new medicines. Additional costs are also expected over the next decade to cover pandemic recovery and increasing public health, primary and preventative services.

The Health and Social Services Minister will undertake a wider health economic review during 2022 to inform funding options for increased health and care costs and for any potential new health access schemes, to be brought forward in 2023 for the Government Plan 2024-27.

The current health system is undergoing a major transformation as part of the **Jersey Care Model** and the fees for accessing health and care services are not equal for all Islanders. It is therefore important to include in the health economic review a range of options on health access schemes and their related costs and potential funding solutions.

Currently, a key barrier to long-term progress is the split funding and responsibility between the Health Insurance Fund and the **Health and Community Services** departmental budget. This split funding will also be addressed in the wider health cost and funding model review.

Programme Governance

Continuously checking we are appropriately delivering the right care, by the right people, in the right place, at the right time

To ensure it is in line with **HCS** governance principles and that it is both fit for purpose and accountable, the governance structure for the **Jersey Care Model** has been developed during 2021 through engagement with professional health and care partners; the Health and Social Security Scrutiny Panel; the Legal Department; the Chief Executive Officer and the Minister for Health and Social Services.

The governance structure, which is now in place, provides both internal and external review systems, with reporting on programme progress occurring on an on-going basis. This structure now comprises:-

- ***JCM Programme Board*** – chaired by the Director General for **HCS** this Board is responsible for monitoring monthly progress of the programme roll-out. The *Digital Strategy* and **JCM *Digital Project*** also report progress into this board. Key dependencies, like the *Our Hospital* project are being monitored through this Board.

- ***Independent Oversight Board*** – the independent chair has now been appointed for this Board and during 2022 it will be responsible for keeping the programme under continuous review and for reporting monthly to the Minister and the Scrutiny Panel for Health and Social Services, on the quality and robustness of the delivery of the programme.

- ***Health and Care Partnership Group (PG)*** – the chair has now been appointed and the inaugural meeting for this group of representatives from health and care organisations across the Island, is scheduled for Q1 2022. The Group will engender further co-operation and collaboration between all agencies and support the development of care pathways.

- ***Clinical and Professional Advisory Forum (CPAF)*** - this group of professionals, representing a wide range of clinical disciplines (rather than organisations) is chaired by the Medical Director. Throughout 2022 it will provide a critical source of independent, strategic, clinical and professional health and care advice and guidance to the development of care pathways, in close association with the *Health and Care Partnership Group* and the *User Experience Panel*.

- ***User Experience Panel (UEP)*** – chaired by the Chief Nurse, this panel is currently being recruited and will seek to gather and provide overall input to service development projects and pathways, from a lay person perspective. The *Panel* will cover patient, client, carer, family and wider community experiences regarding health and care services.

Appendix 1

Professional Partners

JCM Professional Partners will be continuously expanded as part of the programme. Below is a selection of partners that have been involved thus far:-

- *Primary Care Board*
- *Jersey Doctors On Call*
- *Silkworth Charity Group*
- *Tutela*
- *Family Nursing & Home Care*
- *Jersey Hospice Care*
- *Call & Check Jersey*
- *Les Amis*
- *Dementia Jersey*
- *Jersey Recovery College*
- *Jersey Focus on Mental Health*
- *Mind Jersey*
- *Jersey Women's Refuge*
- *MyVoice*
- *LV Care Homes*
- *CI Home Care*
- *Tranquil Homecare*
- *Cheval Roc Residential and Nursing Home*
- *Enable Jersey*
- *Cambrette Care*
- *Listening Lounge*
- *Macmillan Cancer Support Jersey*
- *Les Hoûmets Care Home*
- *Jersey Care Federation*
- *Jersey Care Commission*
- *Brighter Kind*
- *Methodist Homes*
- *Personal Touch Care Service*
- *Jersey Cheshire Homes*
- *Chestnut Farm*
- *Jersey Disability Partnership*
- *4Health Home Care Agency*
- *Stroke Association*
- *1:2:1 Care*
- *Day Centres*
- *Lavender Villa Residential Home*
- *Island Dentists*

Appendix 2

Financial Overview

Government Plan 2021-25 allocated budget for Jersey Care Model

Revenue Funding	2021	2022	2023	2024
Jersey Care Model	6,600	8,326	6,101	4,136

CSP Priority	Sub-priority	CSP Ref	Programme	2021 Allocation (£000)	2022 Allocation (£000)	2023 Allocation (£000)	2024 Allocation (£000)
	Support Islanders to live healthier, active, longer lives	CSP2-1-05	Jersey Care Model	6,600	8,300	6,100	4,100

Figure 1 - Extract of Table 46 New Revenue Initiatives, Government Plan 2021 to 2025, page 195

Jersey Care Model – Expenditure and Forecast for 2021

Description	Year to 30/11/21 Actual £000	Full Year Forecast £000
Programme Office	**1,429**	**1,782**
Staff Costs	1,297	1,641
Non-Pay	132	142
Intermediate Care	**1,092**	**1,308**
Staff Costs	309	450
Non-Pay	816	891
Income	(33)	(33)
Primary Care & Prevention	**229**	**1,313**
Staff Costs	140	153
Non-Pay	89	1,160
Acute, MH & Social Care	**596**	**657**
Staff Costs	584	620
Non-Pay	12	37
Grand Total	**3,346**	**5,061**

Year to Date Spend £3,346k

The year to 30th November spend largely relates to the recruitment of staff and set up of the Programme Management Office and Intermediate Care Services teams. These teams have been the key resources to deliver the programme and to set up the new services. The new Public Health is coded under the Primary Care and Prevention. The Acute, Mental Health

and Social Care spend relates to operational and clinical team resources dedicated to progressing the described Jersey Care Model strategies and projects.

Forecast outturn £5,061k

The full year forecast will result in a £1.5m underspend against the original Government Plan funding for the year. Within the original allocation was a contingency fund of £500k which remains unspent. The remaining £1m underspend relates in part to the recruitment phase of the Programme Office team as an on-island team was recruited and new starters only started mid-year. This then incurred capacity constraints in executing other activities planned for the year. Due to the pandemic and significant planning phase, recruitment to the intermediate care services has also slipped to later than anticipated. Appointments have significantly increased in the last quarter of the year, resulting in a larger spend for December than in previous months. Accounted for within the non-staff forecast of Primary Care & Prevention are the final payments of contracts to engage dedicated capacity from this sector for the JCM implementation.

The unused funding has been requested to be made available in 2022.

Government Plan 2021-25 allocated budget for Jersey Care Model Digital and Digital Care Strategy

Capital Funding	2021	2022	2023	2024
Jersey Care Model	1,300	800	500	400
Digital Care Strategy	3,400	3,900	5,560	3,325
Total	**4,700**	**4,700**	**6,060**	**3,725**

	Department	CSP	2021 (£000)	2022 (£000)	2023 (£000)	2024 (£000)	Total 2021-2024 (£000)
Jersey Care Model	HCS	OI3	1,300	800	500	400	3,000
Digital Care Strategy (Major Project)	HCS	OI3	3,400	3,900	5,560	3,325	16,185

Figure 2 - Extract of Table 17 Detailed Capital Programme, Government Plan 2021 to 2025, page 143

Digital Programme (Capital Programme) – Expenditure and Forecast for 2021

Description	Year to 30/11/21 Actual £000	Full Year Forecast £000
JCM Digital	130	200
Digital Strategy	939	1,020
Grand Total	1,069	1,220

The pandemic has significantly disrupted the implementation of the digital strategy programme as digital staff were involved in creating and maintaining the digital platforms for case and vaccination reporting, contact tracing, travel registrations, vaccination booking systems and vaccination certificates. These were major constraints to initiate this programme as dependent resources were diverted to address COVID-19 priorities. This resulted in an overall underspend of £3.5m against the allocated budget.

The majority of the £3.4m budget was allocated to the Electronic patient record (EPR) programme, however, the procurement for the new electronic record system has taken longer than anticipated which resulted in delayed expenditure in 2021 that is now expected for 2022.

The expenditure for the JCM digital project in 2021 is in relation to the Jersey Demographic Service (£30,000), the Health Integration layer with info repositories (£40,000) and the Core Record System (£130,000). The underspend of £1.1m was mainly due to the detail and priority of the activities in the Jersey Care Model (Digital) project to be still in the planning phase in 2021 – digital is a key part of community services and Intermediate Care, as these will be designed and implemented next year, more digital deliverables are expected.

The unused funding has been requested to be made available in 2022.