Health and Social Services Department
Maison le Pape
The Parade
St Helier
Jersey
JE2 3PU

States of Jersey

Ann Esterson
Family Nursing and Home Care
Le Bas
St Saviour's Road
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18 December 2015

Dear Ann

Re: Health and Social Services Commissioning Intentions for 2016

Thank you for your letter (undated) following your recent Committee meeting.

I understand your concerns regarding the changes facing FNHC, but I hope you also agree that there are many opportunities to develop and integrate care in order to ensure that services remain safe, sustainable and affordable and are delivered in partnership. Both P82 and the Sustainable Primary Care Strategy are important in this regard, and FNHC have been a key partner in this journey, receiving additional funding to provide new services such as Rapid Response and Reablement, as noted in the Commissioning Intentions from 2014.

I was surprised to see your assertion that there has been a 'sudden decision' regarding the funding of home care, as it has been discussed with senior officers for FNHC since May/June 2014, when the original Commissioning Intentions were produced. You asked us not to implement the Commissioning Intentions at that time as you were producing your Strategy, and we agreed to delay their implementation whilst your strategic review was underway. The FNHC Strategy was subsequently published in March 2015. The October 2015 Commissioning Intentions are intended to clarify and re-state the Intentions from 2014; the intention remains to commission District Nursing in full, and to fund reablement home care.

At the time of the original discussions regarding Commissioning Intentions, and the development of your Strategy, new funding streams became available; these apply to some of your clients, and I have assumed that this is incorporated into your Strategy and your long term Funding Plan. We now need to utilise these funding streams by transitioning eligible clients onto Long Term Care Scheme or Income Support funding in the coming months.

In terms of HSSD funding, we are currently considering what traditional homecare we need to commission for those who are not eligible for Social Security funding – you will have heard this referred to as 'policy 1'. In order to do so, we need to identify individuals who are in receipt of Long Term Care Scheme funding and/or Income Support, and we are currently awaiting a data exchange between yourselves and SSD for this purpose.

Regarding the costs and charges for home care, I am sure you can appreciate that the Department cannot continue to subsidise this, as it is now provided in a competitive market; to do so would be unfair to the other providers. As a charity, you can of course utilise your charitable funding in order to subsidise your costs and/or provide services for those who are not eligible for States support; or you could decide to charge those clients who can afford to pay for your services. I understand that you are working to reduce your costs and increase productivity for the home care that you decide to continue providing; this was a contractual obligation in 2014/15, and I understand you are progressing this, which should significantly assist in reducing your costs closer to market levels.

In order to provide you with some additional time to transition, I am willing to agree an extension to your 2015 Agreement for a further 3 months. This will take you to 31 March 2016, which will be almost 2 years since the Commissioning Intentions were first published, and a year after your Strategy was produced.

I look forward to receiving your long term Financial Plan, which will need to be cognisant of the Commissioning Intentions. I also reiterate my offer to continue to fund John Spicer 1 day per week to work with FNHC to help improve your financial position and sustainability, up to 31 March 2016. I understand that John is meeting with Adrian this week to continue discussions regarding sustainability.

I hope this letter clarifies our position and responds to the points made in your letter; Julie Gafoor and I are due to discuss these matters further in the new year, after she returns from leave.

Yours sincerely

Rachel Williams

Director of System Redesign and Delivery
Health and Social Services
States of Jersey

cc.
Senator Green
Constable Refault
Deputy McLinton
Julie Garbutt
Susan Devlin
Jason Turner

File

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Family Nursing & Home Care

Received
24/11/2015

Rachel Williams

Director of System Redesign and Delivery

Health and Social Services

States of Jersey

Date as post marked

Dear Rachel,

Re: Health and Social Services Outline Commissioning Intentions for 2016

Your letter of Commissioning Intentions for 2016, dated 16th October, has now been considered by the FNHC Committee. We see that the Executive has already replied on the non-strategic issues, so our considerations relate to the broader principles on which we have a number of serious concerns.

First of all, thank you for stressing that from "the perspective of HSSD, it is vital that FNHC remain a sustainable and forward thinking organisation." It is always nice to get acknowledgement of the good work of the organisation. You can be assured, as you will no doubt have seen from the draft FNHC Strategic Plan which Julie discussed with you in May, that we want to remain a vibrant, independent organisation - a centre of excellence working on behalf of the community, delivering high quality, integrated nursing and social care with our partners. We also believe there is much more we are capable of doing to support the transformation.

As part of the Strategic Planning process, the Committee asked for a long term Financial Plan which you will receive shortly. Although the Plan indicates a sustainable position in five years' time, it is more pragmatic than ideal. We are poorly resourced compared to the UK and you will see that the Plan shows that more investment would be needed if we were to be staffed on a comparable basis. However, we take the view that FNHC has to be realistic at the present time given the financial constraints of the States and the amount of change taking place which may alter patient habits and demands on the service. For those reasons, we believe it is wise to continue with the current part funding arrangement for services, retaining our charitable status, so that we can respond quickly to change. We must ensure, as far as we can, that there are no gaps in provision, that care is not rationed or limited and wise investment in equipment continues whilst all this change is taking place.

There are so many "unknowns" which would make it impossible to prepare a five year project plan to "improve" sustainability as you suggest. In this context, we have to consider not only the financial implications but also the size and shape of the organisation. As with any such service, much depends on the demand and the amount of work we receive (from yourselves as well as the changes being driven by the Long Term care system etc. and how the market will respond.) The issue of critical mass of nursing and homecare staff is important to ensure sufficient cover, particularly for periods of high demand, and good governance arrangements. At the present time, we just about cope with the current levels of staffing on the mix of nursing and homecare staff now in post and are able, we believe, to keep admissions of our patients to A&E relatively low (certainly compared to the UK).

Whilst the FNHC Committee is fully aware that the Island is presently going through a huge transformation, driven by the Long Term Care Scheme and changes to the Health system which impacts on the work of FNHC, at this stage, we don't even know about any financial system that might underpin the LTC one and the timeframe for implementation. Any change of this enormity takes time to work through and bed down and requires considerable flexibility and cooperation (and, above all, trust) amongst all the key players. We believe the impact of giving people the money to buy their care and how the market may respond, is likely to take quite a few years to settle into some pattern. Our preference, therefore, would be to keep the status quo on funding at least over the next two years, allowing us to adapt and change, working with your Department to refine funding arrangements as a definite pattern emerges.

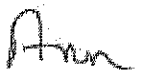
What is absolutely clear is that sudden withdrawal of all monies for homecare support next year would seriously jeopardise the operational capability of the organisation and make it financially unviable. There is a need for a five year transition arrangement on funding if you are seriously thinking of withdrawing funding for social care. As we have said before, we believe such a strategy is very high risk, as evidenced again by the recent huge impact on UK hospital services because of insufficient social care support in the community. I would remind you that we were promised that a full risk assessment would be carried out on this policy and we asked to be party to the decision making process which has not happened.

In summary, a two year agreement, within a clear five year Transition Plan would also enable us to handle changes in a more planned way and take the pressure off your staff. It goes without saying that a letter of intent for 2016 sent for comment on 16th October makes delivering change very difficult for the organisation, especially when it gives little formal notice of the withdrawal of funding for domestic only staff. Even with the "informal" notice, we had insufficient time to go through all the due processes and are forced to make staff redundant around Christmas time. This is not good for the moral of the organisation and portrays us as bad employers. It is also very unsettling for the elderly concerned and may have legal implications.

We have an excellent track record of delivery and I am sure we don't need to say that we can be trusted, given some flexibility and room to manoeuvre, to deliver the best service for the Island. We need our scant management resource focussed on dealing with this change and we are more than happy to be judged on outcomes (which a previous Commissioner indicated as the way forward) rather that divert those precious resources to detailed inputs.

We sense in your letter that there is some considerable difference between us on the way forward. The FNHC Committee is very concerned about the risk to the organisation and believes that further discussions are necessary between you and the FNHC Executive to resolve them. The Committee is also happy to make itself available for a meeting if needed.

Yours sincerely,



Ann Esterson

Chairman

FNHC

cc

Senator Green

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Family Nursing & Home Care

30th October 2015

Mr John Spicer
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Dear John,

We are writing to you in response to Rachel Williams' letter dated the 16/10/15, Re: Health and Social Services outline commissioning intentions for 2016. Rachel's letter contained two requested actions to be delivered by 5pm on 30th October 2015.

The first request is that FNHC provide information regarding its progress against contractual requirements to improve efficiency of District Nursing, Health Visiting and Invest to save projects (Electronic patient record and clinical management system). Our response to that is set out in this letter.

The second request was that we work with you in response to a request *"that FNHC refund to HSSD the monies presented in the 2015 Agreement for Service financial settlement against any posts that are vacant"*. We have responded directly to Rachel in respect of this point as well as the Commissioning Intentions letter in general.

District Nursing Service

Increased efficiency

The three District nurse team leaders are now in post and are accountable for all the care delivered in the East, Town and West in both Nursing and Social care delivered by FNHC staff. The Social Care Assessment Team (SCAT) has been moved into the District nursing team to provide core District Nursing services. One grade 6 nurse remains in Home Care, to provide complex assessments for FNHC Home Care clients, to provide Safe Guarding supervision and support to the Home Care staff.

During the year the District Nurse team have faced some difficulties attracting suitably skilled staff. The requirements of the team to function in the most effective way have been reviewed. This has resulted in the present structure, a grade 6 team leader, supported by two grade 5 deputy sisters. All of the grade 5 & 6 staff will now undertake the initial patient assessment and care planning. This is to ensure that less experienced grade 4 staff delivers the care in line with their level of competency.

The team leaders have also reviewed the skill mix of the teams resulting in an additional increase of one senior health care assistant (QCF grade 3) in each team to replace vacant RGN posts. We are also supporting one new qualified nurse through her preceptor ship year.

Each team now have a case load planning board that identifies patient dependency using a RAG system. This allows improved allocation and tracking of patients' changing care needs.

The aim of the service improvements is to ensure that the right person visits the patient at the right time and in the right place. This has presented some challenges in terms of current clinic capacity. New premises have been sourced in St Peter, through our partnership with the Co-op. Delays in completion mean that the 3 new clinic rooms will not be ready for use until Q1 of 2016 at the earliest. The increase in clinic capacity will enable us to reduce home visits to mobile patients in 2016.

Performance and quality

There have been a number of concerns about the quality of the practice delivered. This was identified through the Adult Safe Guarding Board SCR. An action plan has been completed and has resulted in one staff leaving and another being supported through a performance management process.

There has been a significant increase in the complexity and the dependency of the patients being referred to the District Nursing Service in 2015. To ensure that the Nurses have the skills to safely manage complex care they have received training and are assessed as competent by the Rapid Response team in NEWS, A-E assessment and clinical history taking. The aim of this training is to equip the team with the skills to be able to escalate to the RRRT or to take patients from the team. This will allow an improved flow and seamless care between the RRRT and DN services.

Partnership working

There is evidence of improved Multi-Disciplinary team (MDT) working with GP's and Hospice to deliver improved coordinated care to patients requiring palliative and end of life care using the Gold Standard Framework as a guide.

Health Visiting Service

Increased efficiency

The Health Visiting teams have been reorganised into 4 geographical teams that are more equally weighted in terms of complexity of families and the dependency of the caseloads. The teams are geographically based in the community at The Bridge, Pathways, Gervais le Gros in St Aubin and at Le Bas centre. Team leaders have been appointed to ensure that staff are managed, supervised and developed appropriately. The team leaders have attended a leadership skills course in 2015, as have the District Nursing team leaders, to ensure they are equipped for their role. Each team leader has a score card that she is required to complete monthly. This monitors the profile of the caseload dependencies and compliance with FNHC Governance requirements.

Team leaders have been trained as Safe Guarding supervisors and now take accountability for the supervision of children in each geographical area. The Safe Guarding of children is overseen by the Operational Lead who is the named nurse for Safe Guarding for FNHC.

Partnership working

Effective partnership working is essential to efficient working. There have been several new initiatives in 2015. Firstly, the Operational Lead meets with the GP Safe Guarding leads to improve communication about children for whom there is a Safe Guarding concern.

A joint ante-natal assessment by midwives and Health Visitors is being planned. Health Visitors now have access to Track Care to view and populate this joint assessment. The aim is to pilot this assessment in 2016. The joint assessment will provide the Health Visitors with vital information on reaching families as early as possible to offer MECSH, Early Help or Safe Guarding services.

A pilot of joint development reviews with education and Health Visiting at Pathways Children's centre has proved successful in terms of identifying children who may require additional support when they start school. The Operational Lead is working with the Head of Early Years in Education to roll out a combined assessment at 2 years old in 2016.

Performance and quality

The Team are reviewing the current uptake of the one (Q2 69%) and two year (Q2 66%) developmental reviews to improve the completion levels. A new pathway for improving the recall for children will follow from Q3, with improvements expected by Q1 2016.

An audit of the referrals to Speech & Language department identified a high level of appropriate referrals from the Health Visitor teams.

The majority of the Health Visiting service data is held on the Child Health system (Care Plus) within Public Health. This has presented FNHC with difficulty in receiving timely reports on the Health Visiting service activity. With the Health Intelligence department's cooperation a FNHC staff member is being trained to enable us to generate our own reports in a timelier manner.

The Operational Lead is identifying ways of measuring the difference group work within the Healthy Child Programme has made to children and parents. Eleven staff have now been trained in the Outcome Stars tool. This will be piloted in the East team in 2016 with a view to roll out the training to all teams thereafter.

No capability or disciplinary issues have been identified within the team. The Safe Guarding Board SCR action plan identified 4 areas for improvements in the Health Visiting Service, all of which have been completed.

The MECSH programme is now embedded into the service. A copy of the latest report has recently been sent to the Children's Commissioner.

Invest to Save project

As you are aware we have embarked on a project to change the working practices of our nursing workforce with a view to better utilise our current staffing resources. This main element of this is to introduce mobile / remote working and patient record management and will be facilitated in part by the implementation of an electronic patient record system.

The system identified is EMIS, provided by Egton Medical Information Systems. EMIS is already used in Jersey by the GPs . Due to the apparent data sharing abilities of EMIS it seemed logical for FNHC to align itself with these community based partner agencies.

The scope of the Invest to Save project covers:

- EMIS
- Change Management and Project Management
- IT Hardware Updates
- Mobile Technology
    - 4G Mobile Phones
    - Data enabled tablets
- Clinics

EMIS Quote and Contract

As of today we have an agreed quote from EMIS for the provision of the licensing and support of the system. We have not yet had sight of a draft contract for a community service in Jersey.

We are not aware of any organisation, outside of the GPs and Social Security, having signed a formal contract. We will shortly be discussing detailed time lines for the physical implementation of the system.

GPCS Quote and Contract

To enable the transfer of data between our instance of EMIS and the data hosting in Leeds we are required to utilise the GPs current infrastructure. We have had limited discussions with GPCS around this

Change Management and Project Management

As our administrative support resources are minimal we have had to engage third party resources to assist with the management of these changes. We are embarking on a change programme to ensure organisationally we are ready for the changes and understand what

the success factors of change are. From a project management perspective we have scoped the initial phase of the implementation and are now preparing detailed project initiation plans and process mapping. This will include the use of mobile technology to facilitate the mobile / remote working aspects of the change.

IT Hardware Updates

To facilitate this project an update to our IT hardware may be required. The scope and timing of this is dependent on the roll out of Windows 8 and the Medical Desktop. As we are on the HSSD network we have no control over the speed of these deployments.

EMIS is not supported in the Medical Desktop environment that HSSD are rolling out and if we chose to have the software installed locally on machines as opposed to the unsupported environment there may be an additional cost to us. This is an unknown value.

We are in the process of auditing our IT stock to ensure it is compatible with Windows 8 and if not we will be upgrading.

We are also installing WiFi in to Le Bas to enable more flexibility in the use of restricted office space.

Mobile Technology

We are investing in the region of in 4G mobile phones and in tablet devices. Annual running cost of roughly will enable all community staff to have data enabled devices with full access to the HSSD network.

This connectivity will allow mobile access to, and updating of, patient records as well as remote access to emails to ensure better communication throughout the organisation. Reducing the necessity to return to the office for routine administration tasks will mean a reduction I travel time and therefore a more productive work force. It will also help alleviate our restricted office space

Mobile technology will also be a platform for us to use mobile apps, for instance for lone worker security.

Clinics

We are investing in a new clinic in the West of the Island to double our clinic capacity and also include some office space for our teams that work in the West. The intention is to use this setting to:

a) Reduce the amount of Home Visits by transferring them to clinics;
b) Reduce the amount of travel time spent by community nurses;
c) Hold Health Visiting clinics and a facility for immunisations follow ups where they have been missed in the school setting.

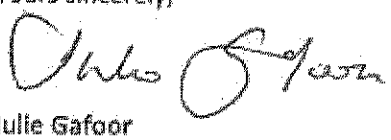
The overall cost of the clinic fit out has yet to be scoped in detail however a provisional budget of has been set aside for the internal works required, purchase of all fixtures and fittings, including bariatric couches and installation of required IT infrastructure.

As you can see, the Invest to Save project spans far more than the implementation of an electronic patient record system. FNHC is looking to invest significant sums of money to enable these changes. We have received no funding from HSSD for these despite being written in to our contract. We have applied, where possible, for funding for elements of the various projects however to date the total sum received is only

The clinic investment is being funded from a legacy that we received in 2013, without which we would not financially be in a position to make these investments without significantly eroding our reserves.

If you would like to discuss any of these points please do not hesitate to contact either myself or Adrian Blampied.

Yours sincerely,



Julie Gafoor
Chief Executive Officer