States of Jersey

Health and Community Services

One Health and Community Services: Playing our part within One Government

December 2018

1. Introduction

Public services in Jersey are changing. As part of the One Government approach, we are modernising our services to meet long-term goals for islanders, businesses, our economy, and our island. Our plans are being designed to meet the opportunities and challenges of today, as well as those we will face over the next 30 years.

As the biggest government department in the States of Jersey, Health and Community Services (HCS) is also changing as we modernise to serve islanders better in order to play our part in the success of One Government. Working in close collaboration with partners in the private, voluntary and community sectors, we are modernising the way we deliver services in order to meet the needs of our growing and aging population, not only today, but well into the future.

While modernising is essential, it is equally important that we build on the good work that we are already doing and the strategies and plans that are already in place. Many of our strategies are sound, and it would be wrong of us to start our strategic work again from scratch. We simply need to revisit our strategies in light of the new One Government plans, update them as appropriate and then get on with the important task of implementing the changes that our strategies say we should make.

In short, we must move away from planning, and focus much more of our efforts on making change happen.

Against that backdrop, this document explains:

- HCS's plans for change and how they fit in with our new government's strategic priorities and the wider One Government approach
- How we propose to organise services as an overall Jersey Health and Community System in order to support the changes that are required
- At a high level, how we propose to organise HCS teams in a new operating model through which we can lead services across the island and deliver those services for which we are the provider.

To put the proposed changes into context, the document also describes:

- Our overall ambition for health and community services on the island
- The guiding principles we are using to design how we will deliver care and organise ourselves to achieve our ambition
- The care model we propose to implement and how that care model will benefit our service users
- Early priorities presented by the care model.

Although HCS has a responsibility to develop the island's overall strategy for health and community services and to act as the system leader, we know that success comes through close collaborative working with our own staff, our external delivery partners, other States departments and elected officials.

Perhaps, most importantly, success comes through listening to the views, needs and aspirations of the people we serve and acting on their feedback. We want input on our proposed changes from all of these stakeholders and others, so this document also invites feedback about our proposed care model and the organisational structures we believe will be required to support it.

2. Our plans for change

2.1 Our ambition for Jersey's health and community services

In launching the One Government vision for one island, one community, one government, one future, the States set out a very clear ambition for public services:

Our ambition as the public service is for all islanders to enjoy a good quality of life, in a fair and balanced society, sustained by a prosperous economy and outstanding, modern public services.

HCS has a vitally important role to play in achieving that ambition. We deliver services that touch the lives of all islanders and many of our visitors. Our work directly contributes to improving the island's quality of life, the fairness and balance of our society, and the health of our economy.

Within HCS, we are clear about what delivering the One Government ambition means for us:

Our ambition for Health and Community Services is to create a healthy island with safe, high-quality, affordable care that is accessible when and where our service users need it.

Our ambition is fully aligned to the Council of Minister's Common Strategic Policy, in which improving islanders' wellbeing and mental and physical health is one of their five strategic priorities. Our ambition also builds on the long-term strategic direction set out in the 2012 white paper 'Health and Social Services: A New Way Forward' (often referred to as P82) and supports the Future Jersey health and wellbeing vision that Islanders enjoy long, healthy, active lives.

In developing our ambition, we have chosen our words carefully:

- **Healthy island** – We recognise that supporting and promoting good health is just as important as providing services to help people get better when they are unwell. In everything we do as a team and with others, we must strive to make Jersey a healthy place to live and visit.

- **Safe** – It goes without saying that all of the care we deliver should be safe for our service users. However, because safety is so critical in HCS, we believe it is right to make it an explicit part of our stated ambition.

- **High-quality** – The services we deliver should provide the kind of care that we would each want for ourselves and our loved ones. We should strive to meet or exceed the standards and achievements of comparable health and care systems around the world, while recognising the constraints that inevitably come with living on a small island with a relatively small population.

- **Affordable care** – We aim to have a system where financial barriers do not prevent our citizens from getting the services they need. At the same time, as a society we have decided that it is right for service users to make a financial contribution to some of the services they receive. We do recognise that not everyone can make the same level of financial contribution, so our challenge is to create a system that is affordable and equitable for our users individually and as a whole, while balancing ability to pay with fair access to services.

- **Accessible when and where our services users need it** – We should deliver our services at times of day and in locations that suit the busy lives of our service users, their families and carers. However, we also have to recognise that we can't be everything to everyone at all times and that some services need to be delivered in a limited number of locations due to economies of scale and workforce constraints. As such, the assessment of 'need' will involve a balance of users' need for convenience, professionals' assessment of clinical and operational need, and HCS's requirement to live within our means.

Achieving all aspects of our ambition won't be easy. It will require us to put a much greater focus on prevention, well-being and health promotion and to be much more transparent about the quality standards we strive to achieve and how we measure up against them. It will also require us to tackle some of the longstanding issues of funding mechanisms and user-pay arrangements that have long acted as barriers to change on the island.

Perhaps most importantly, it will require us to work in a much more agile way across teams and across locations. We must reduce our reliance on hospital-based care delivered during the working week and create new options for care closer to home with more flexible working hours.

2.2 Our objectives

To achieve our ambition, we will:

- Support individuals to prevent ill health and adopt self-care as part of their commitment to maintaining a healthy lifestyle
- Ensure services provided by HCS and external partners are high-quality, efficient and effective, working to recognised standards shared by professionals in health and social care
- Harness the experience, ambitions and insights of professionals involved in delivering care when planning and organising services around our service users' needs and circumstances
- Make best use of the resources available for the development and delivery of publicly funded services, and help ensure that service users secure value for money when paying for services
- Ensure HCS is business-like in the way it works, encouraging staff to exhibit the behaviours and values that underpin the One Government approach.

2.3 Our guiding principles

We know we need to change to achieve our ambition. However, we want to make sure we go about change in the right way.

Our proposals for change need to be grounded in HCS's organisational values, as set out in Our Values Our Actions. They also need to be aligned to the design principles that the States has adopted for the overall work on One Government. Finally, they need to set challenging but realistic goals, recognising opportunities and constraints that are unique to the island.

With that in mind, when designing the changes we propose to make, we are adopting the One Government guiding principles as set out in the 'One island, one community, one government, one future' document. We are also adding some specific additional principles that are appropriate for HCS. As such, our guiding principles for HCS are:

Customer-focused – all islanders and key stakeholders will benefit from, see and feel what the government is doing for them. HCS will ensure that:

- Services are co-designed and quality assured by those receiving care, their families and carers, so we know and understand their needs and behaviours
- Service users understand what services exist, what those services do and how they can access them
- We support islanders to live healthier lives, focusing more of our efforts on prevention and early identification, while also recognising the need to maintain strong diagnosis and treatment services
- The changes we make are innovative, modern, based on best practice evidence and affordable.

One government – we will design the organisation as one government, facilitating and necessitating collaborative working to a common purpose. HCS will ensure that we:

- Work not only as 'one government' but also as 'one island', recognising that services are delivered by diverse mix of public, private, charity, voluntary sector and parish-based providers
- Ensure HCS undertakes a strong role as system leader, working closely with external partners to join up services, with a consistent, professional approach
- Work with services outside of HCS (e.g. sports, housing) to help build the conditions for improved the wellbeing and mental and physical health of our islanders.

Simple structures – we will simplify structures so they are easier to understand and navigate, are connected at all levels and provide sufficient flexibility. HCS will:

- Streamline management structures and arrangements to give clinical and professional leaders across the island more say in the way their services develop and operate
- Take specific action to respond to the recommendations made in the Comptroller and Auditor General's (C&AG's) report 'Governance arrangements for Health and Social Care', published in September 2018
- Put in place governance structures that reduce the complexity of administrative and managerial processes and enable professionals to spend more time focusing on their patients and service users.

Cross-cutting and agile – we will consolidate activities and teams where these can support or underpin multiple activities, such as through shared services to achieve economies of scale and minimise duplication. Where appropriate, we will also look at cross-island arrangements, where they are in the interests of residents, business and are value for money. We will have the capability and flexibility to respond at pace to changing demands and priorities. For HCS, that means:

- The system will work together such that the default location for many services will be the community or the home, not the hospital
- Services will be delivered by diverse groups of care professionals and support staff, recognising the range of capabilities different professions can bring to services and helping to compensate for the challenges of recruiting certain professions to the island
- Projects to improve services will involve individuals from across HCS and our partners, making use of specialist knowledge and experience as needed.

Digital – we will use cutting-edge technology to help simplify internal processes and speed up how customers access our services. For HCS, that means:

- Service users and patients will be supported by technology at home, in the community and in hospital
- Information will be appropriately shared with our HCS partners to improve service user experience and outcomes
- Paper records will be reduced, replacing them with intuitive, secure electronic systems that enable safer, more cost-effective and efficient care.

Integrated financial control – we will integrate finance, business planning and risk management, ensuring clear visibility, control and measurement of all finances against planned outcomes. HCS will:

- Recognise that we have to deliver a wide range of services with a limited budget
- Use evidence to allocate expenditure to areas of priority
- Develop long-term, sustainable and rigorous financial planning and management processes
- Devolve budgetary decisions to clinical and professional leaders, giving them increasing levels of freedom to design services but also holding them to account for delivering agreed outcomes
- Ensure overall funding and payment structures are as fair and equitable as possible and address some of the longstanding funding and payment anomalies that have acted as barriers to change.

Clear, transparent and accountable – we will simplify, clarify and embed a better understanding of governance, decision-making, use of information, to improve performance and accountability. We will benchmark our service performance against other services, as well as against those in other countries to whose standards we aspire, and we will regularly measure, monitor and report on key aspects of our performance. In HCS, we will:

- Use data to measure the quality and performance of services, enabling us to build on our many strengths and focus efforts on areas we need to improve
- Be ambitious about the services we can deliver in Jersey, while also being realistic about what we can and cannot do on the island.

Commercial – we will be much more business-like in the way we work, challenging our suppliers' pricing models at the same time as developing our own commercial behaviours as an organisation, to drive efficiency and value for money, and to eliminate unnecessary duplication. We will also identify what opportunities exist for the States to provide commercial services to generate income to benefit the island. In HCS, we will:

- Recognise the benefits that private services bring to our overall system – especially our hospital – and support the development of a vibrant private sector that is fully aligned to the public, charity and voluntary sectors
- In our role as a commissioner of services, promote frameworks that require providers to collaborate and create service offers that are integrated from the service user's standpoint
- Be innovative and adopt best practice approaches from other jurisdictions where these can help us accelerate or improve our developments.

2.4 Our proposed care model

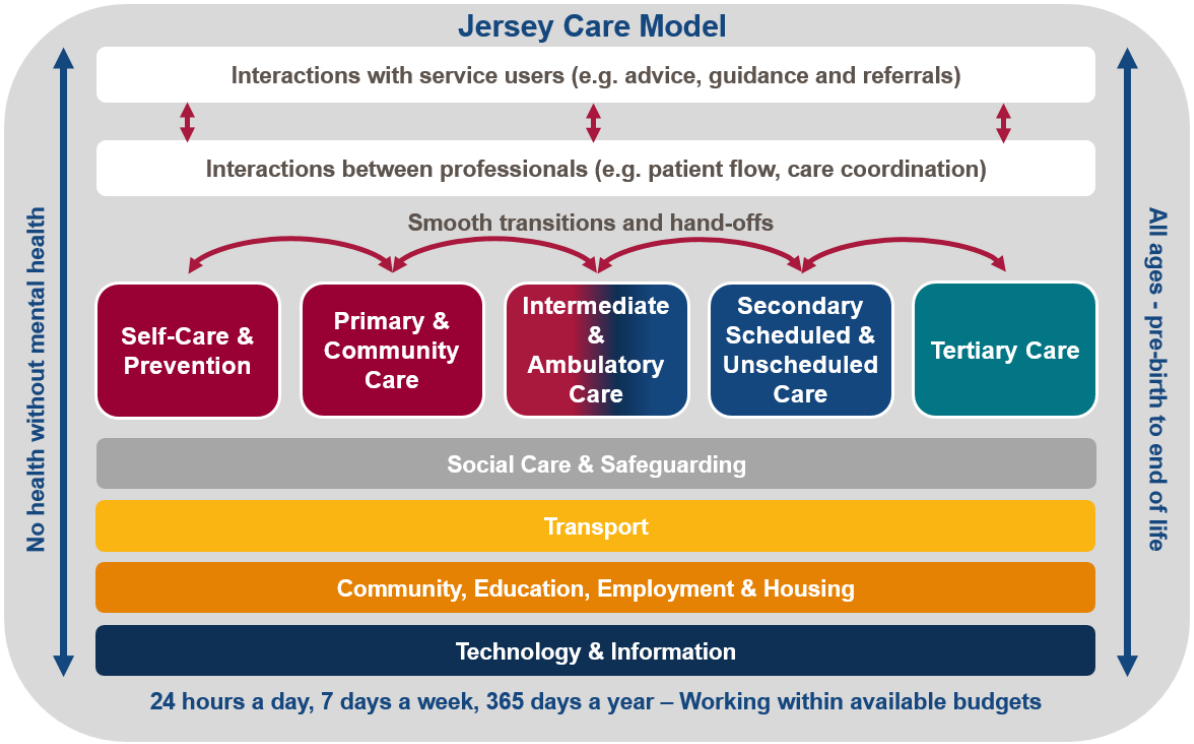
To deliver truly customer-focused care on a one island, one government approach, we need a clear understanding of the building blocks required to meet Jersey's overall health and care system needs. In short, we need to have a clear picture of Jersey's care model.

Having a clear picture of our overall model allows us to:

- Understand how different services should fit together to support our service users
- Spot service gaps and start identifying ways to fill them
- Design organisational structures and build teams that support the way we want to deliver care
- Align our governance structures, financial planning processes, and service funding mechanisms to the model.

Recognising the need for a clear care model, the HCS Management Executive (MEX) asked a group of health and care professionals from across the island to work together during summer 2018 to develop a care model that we could use to underpin all of our change initiatives. The group included both junior and senior colleagues from HCS and partner organisations in the private and community sectors, who worked together over a series of workshops to design the model and test it using a number of scenarios.

The output of the group's work is our proposed care model, shown below:



This is a model which aims to improve the customer experience for our service users, their families and carers by joining up high-quality care and making it easier to access that care. It also aims to create a great working environment for staff, by allowing them to deliver the type of services that brought them into health and care delivery in the first place.

It emphasises the need for prevention and self-care delivered through services in the community and or in people's own homes. These services help reduce our reliance on hospital-based care by delaying or completely avoiding the need for admissions to hospital, nursing or residential care. At the same time, the model recognises the important role of a strong general hospital and the need to provide excellent secondary care when it is needed.

Perhaps, most importantly, it recognises that Jersey's health and community services do not exist in isolation and go well beyond what is publicly funded or provided by Health and

Community Services. HCS is but one part of an overall system that includes services provided by private businesses, charities, voluntary sector partners and other States departments, all of which have key roles to play and need to have a strong voice in the system.

At the centre of the model are the core care types included in any health and community system:

- **Self-care** – includes the actions that people take to look after, treat and manage their own health. They may do this independently or with the support of the health and community system
- **Primary care** – usually the first point of contact for people in need of health and care support. It is provided by a range of professionals, including GPs, nurses, dentists, pharmacists and others
- **Intermediate care** – services that provide support for a short time to help people prevent problems from getting worse, recover from an episode of care or increase their independence. Ambulatory care includes services provided on an outpatient basis
- **Secondary care** – treatment for a limited period of time for a more serious illness, injury, or other health condition. Sometimes the care is planned (e.g. a hip replacement) and sometimes it is unplanned (e.g. treatment for a stroke)
- **Tertiary care** – highly specialised treatment, which for Jersey is provided off island.

Good health isn't just about physical health, so the model shows that mental health needs to be a fundamental part of all services. It also emphasises that we need to care for people of all ages, from before birth until the end of life.

The model recognises that good health and community services must be underpinned by strong social care and safeguarding services. They must also be able to rely on effective emergency and non-emergency transport services and have strong links to community services, education, employment and housing. Finally, they need to be built on technology and information platforms that enable efficient working and evidence-based decision making.

Because the overall model involves services delivered by many different types of professionals and support staff working in multiple locations, it must also include mechanisms for ensuring service users have smooth transitions and hand-offs from one type of care to another. To accomplish that, the model needs to provide ways of ensuring smooth interactions among professionals working within the health and care system and between the system and its service users.

The model recognises that appropriate services need to be available all day every day. This includes on holidays, when it can often be difficult for users to access the care they need. Finally, it recognises that we have to live within our limited means, making choices about how we deliver services and asking our service users to play their role in helping us to work within available budgets.

2.5 Building blocks to support the model

The working group that developed the care model also helped identify the key building blocks that need to be in place to support it. The group highlighted the need for:

- **Agreed and transparent standards** that should be achieved in each type of care, coupled with the publication of performance data, so we know when we're achieving those standards and when we need to improve.

- **Changes to funding structures** to address longstanding issues that have created inequalities of care and acted as barriers to change. As an example, the group highlighted that some services are free if accessed through the hospital but charged to the user if accessed elsewhere. The group felt that we cannot create a system that reduces reliance on hospital care unless we tackle that kind of distortion.
- **Transparent and efficient governance structures** that make it easier to get things done. These structures need to make it clear who is accountable for what, how decisions get made and the role each of us plays in making good governance part of our culture.
- **Organisational structures that are clinically and professionally led**, built around a care model that breaks down the organisational and professional silos that exist within many areas of our current system.
- **Strong clinical and professional leadership** and adequate resources to support change. When we talk about 'clinical leadership', we mean 'the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation, which itself recognises this commitment in supporting and encouraging high quality care'[1]. We need clinicians and other professionals to be at the forefront of leading change, and they need to be given time and support to take that leadership role. They also need to be supported by people who are experienced in implementing change and managing projects.
- **A planned programme of investment in all our staff** to support their development and enable them to contribute to their full potential to our services.

2.6 Benefits of the care model

We should only change our care model if doing so will benefit the people we serve and the staff who work in our services. We believe the proposed model does just that.

For our service users, the new model will:

- Give them more support in maintaining good mental and physical health, which will reduce or even prevent the need to access services in the first place and help reduce recovery times when they do
- Make it easier for service users to interact with services when they do need help
- Reduce waiting times and improve access to services
- Ensure they don't stay in hospital or other inpatient settings any longer than is absolutely required or necessary
- Improve service quality by establishing clear standards and creating processes for ensuring we are meeting those standards
- Ensure our services are more joined up so that service users have more seamless pathways and improved outcomes.

For our staff, the model will:

- Create opportunities to use their skills across a wider range of services and in collaboration with colleagues who have a more diverse range of skills and experiences
- Give them greater autonomy in deciding how to design and deliver services, with clinical and professional leaders in charge of those decisions
- Allow them to spend more time focusing on their patients and service users and less time navigating clunky administrative and managerial processes
- Ensure better use of our valuable resources
- Deliver a care system that is sustainable and effective.

[1] Spurgeon P, Mazelan PM, Barwell F. Medical engagement: a crucial underpinning to organizational performance. Health Serv Manage Res 2011;4:114–20. http://hsm.sagepub.com/content/24/3/114.short

3. Organising ourselves to support the care model

To deliver care in line with our proposed care model, we need to be organised in a way that reflects that model. We need teams that bring together professionals and organisations that are involved in each different type of care, and we need to put clinical and professional leadership at the helm of those teams.

When organising care, we need to bring together not only people who work in HCS and other States departments, but also our partners from across the island's private, community and voluntary sectors. Within HCS, we then need to create organisational structures that reflect an island-wide system.

No organisational structure is ever perfect, and designing a structure requires choices. There is always a risk that a new structure will create new silos that replace the ones they are trying to break down or that particular services will feel that they have not been put in quite the right place.

It is impossible to get away from those challenges, especially for services that are complex by nature and involve many different people and organisations. We simply have to recognise the challenges, build on the good things that a particular structure can provide and ensure any weaknesses do not get in the way of day-to-day operations.

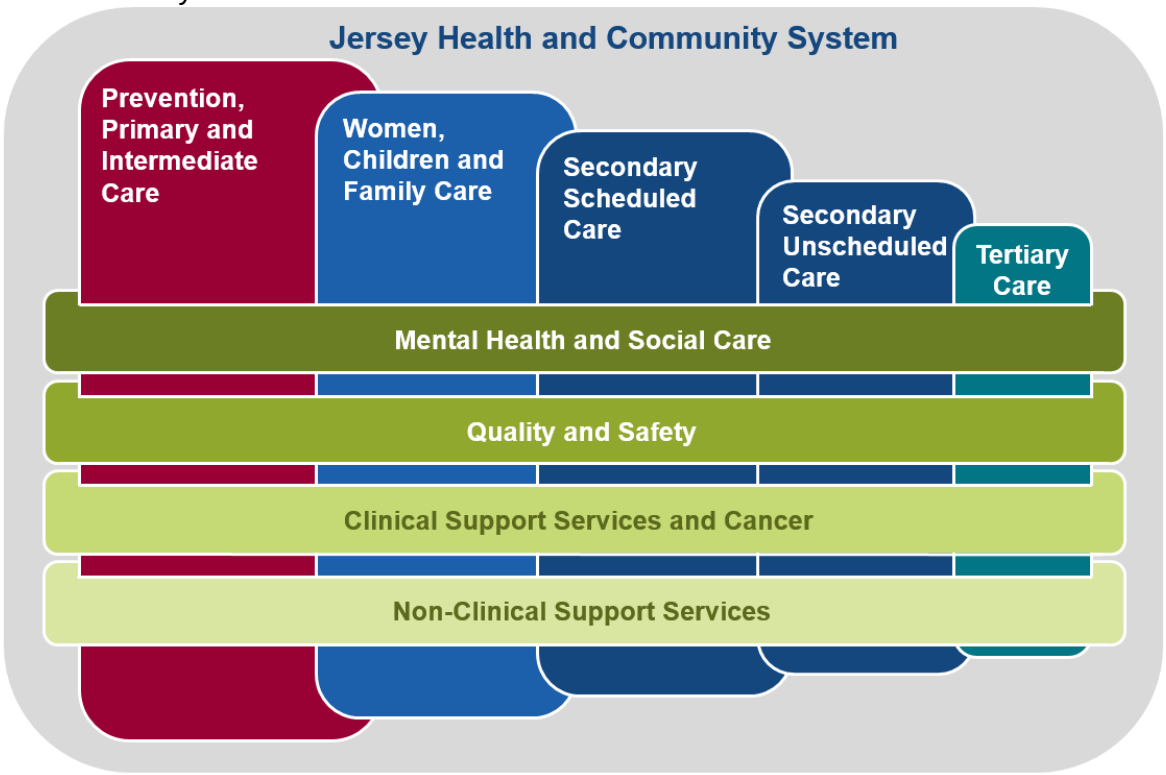
With all that in mind, our proposed structure for the overall Jersey health and community system is built around five care groups and four cross-cutting service groups:

Care Groups

- Prevention, Primary and Intermediate Care
- Women, Children and Family Care
- Secondary Scheduled Care
- Secondary Unscheduled Care
- Tertiary Care

Cross-Cutting Service Groups

- Mental Health and Social Care
- Quality and Safety
- Clinical Support Services and Cancer
- Non-Clinical Support Services



Each group will be directly accountable for delivering a specific set of services. It will also be responsible for working collaboratively with other groups for the benefit of the whole system.

The HCS Management Executive Team has done an initial mapping of all health and community services into the groups. That mapping – which is based on MEX's own considered views as well as initial input from engagement with teams from across HCS – is shown in the appendix to this document. The mapping is not fixed in stone, and we will be taking feedback as part of the consultation on our proposed restructure.

There are some important points to note about the group structure and the mapping that underpins it:

- As stated previously, not all services provided through the groups are delivered by HCS. For example, many of the island's primary care services are delivered by independent GP practices. Many children's services are provided by the States' Children, Young People, Education and Skills Department. Nevertheless, those services are included in our groups because the structure represents the totality of Jersey's health and community system.
- Although women's, children's and family care services are not separated out in the care model, we have created a group dedicated to them. We have done this because these services work with a very specific segment of our population and involve a level of specialism and risk that merits specific attention.
- Similarly, cancer services are given specific attention within the group structure, because of the need for them to be interlinked across all care groups and because of the level of specialism and risk they involve.
- Although some mental health services are specialist in nature and therefore akin to work that would be done in a care group, we have deliberately chosen to represent mental health as a cross-cutting service group. Doing so emphases our commitment to 'no health without mental health'. We will embed mental health support into all care groups, just as we will do with other cross-cutting services, such as therapies.
- Tertiary services are not currently provided in Jersey. For completeness, we have shown them as part of the Jersey health and community system on the structure diagram, but they will not be a care group in our proposed HCS organisational structure. These services will be managed under the non-clinical support services group for administration and co-ordination purposes. Clinical pathways will be managed (as they are presently) within clinical and operational functions as determined by the needs of the episode of care.

HCS will align our organisational structures to these groups. In line with our commitment to a professionally-led leadership model, we expect to mandate that most groups will be led by a doctor, nurse, allied health professional or social worker. More information about our proposed leadership structures is set out in the accompanying 'Health & Community Services Reorganisation' document that can been found on the One HCS intranet page.

From January 2019, where possible, we will start to implement our proposed group structure in shadow form, recognising that full transition to the new structure cannot happen until consultation is complete, feedback has been incorporated and individual members of staff have been appointed into specific roles.

We know that the proposed group structure and leadership model are very different from what is currently in place across the island and within HCS. We believe it is the right model for the services we aspire to provide and the ways of working we want to engender, but we also recognise that it will be challenging to implement it.

We will need to invest in helping individuals and teams work and think differently, and we will need to genuinely support colleagues to develop and thrive in a new environment. The Team Jersey culture change programme is designed to help with precisely that type of change across the States, and we look forward to having HCS colleagues and our partners heavily involved in that work.

4. Opportunities and early priorities for our proposed groups

In our work over the summer developing the care model, we started to identify a clear set of priorities that need to be tackled within specific service areas and across health and community more generally. Our proposed group structure – combined with work we are doing to improve governance and make it easier to get things done – will give us the mechanisms we need to organise and lead the work that is required to address those priorities and to implement services improvements.

As the groups start to make plans for change, it is important that we do not lose sight of our existing strengths. This section sets out some of those strengths, followed by the high-level priorities we see for each of the groups. It also explains priorities that need to be addressed across health and community services as a whole (i.e. things that affect all the groups or that need to be in place for the groups to be able to function effectively).

4.1 Building on our strengths

Jersey has many strengths in our existing health and community services, and we need to build on them when designing change. Among our strengths are:

- **Our workforce** – We have a committed workforce that has proven over and over again that it will go above and beyond and is prepared to adapt and change, even when that is difficult. We are fortunate to have highly-skilled and highly-professional staff delivering excellent care to our islanders.
- The **breadth and depth of our services** – As a health and care system, Jersey is small. Despite the small size of our population and our island, our citizens and visitors have access to a range and quality of services that would be unheard of in most jurisdictions of similar size.
- **Timeliness of services** – The speed at which islanders can access services is very fast compared with many jurisdictions, especially England. Diagnostic tests are carried out quickly, and it is almost always possible to see a GP within a day. We must acknowledge that there are some services that have unacceptably long waiting times, and access to general practice and dentistry is limited for some islanders by their ability to pay. However, overall, Islanders enjoy access and the universal benefits as they would do from a much larger system of care, such as in the UK.
- **Our parish system and wider community assets** – As we look to reduce our reliance on hospital-based care and deliver more services closer to or in people's homes, our parishes and community organisations give us a local infrastructure that would be the envy of most jurisdictions. It is fair to say that we have not used these assets as well as we could have in the past, but our local communities stand ready to play a strong role in supporting their residents to live healthy lives.
- **Access to investment** – Health remains a strong political priority in Jersey, and States Members have continued to demonstrate their commitment to investing in our services. The challenge for us in HCS is to ensure we are using all of that investment to best effect and turning it into tangible benefits for the people we serve.
- **Our long-term care benefit** – Jersey has been extremely forward thinking in putting in place a long-term care benefit scheme that helps islanders cope with the significant costs that can arise when residents need long-term care. This benefit not only helps

individual citizens but also helps protect the overall health and community system by helping avoid the need for bedded healthcare facilities to act as de facto providers of non-medical care needs.

- **Our voluntary and community sector** – We have a vibrant voluntary and community sector in Jersey, and we need to ensure we continue to work closely with third organisations to maximise the benefits for service users.
- **Primary care** – Our primary care system is resilient, and the prevalence of GPs in the island compares favourably to other jurisdictions.
- **Commercial Opportunity** – The unique blend of private and public secondary care presents a greater opportunity for sustainable recruitment and creates the conditions for improved financial and operational efficiency.

These are but a few of the strengths that will help make our care and service groups' work easier as they start to look at how they address their priorities.

4.2 Priorities for our proposed groups

This section sets out a few of the key priorities that each of the proposed groups will need to work on. These are by no means the only focus areas, and we will welcome feedback on them as part of the consultation process. We will ultimately look to group leaders and their colleagues to build on these and set their own priorities for helping us to achieve our ambition and meet the aims of the Common Strategic Policy.

In **Prevention, Primary and Intermediate Care,** we will:

- Begin to shift more resources – both staff and money – into preventative and primary care services to support islanders to live healthier, more independent lives and reduce reliance on secondary care services. We will encourage all providers across the health and care system to create healthier environments and take every opportunity in their contact with service users and families to promote and support healthier behaviours.
- Develop and promote resources that help citizens with self-care for themselves, their families and loved ones. These could include, for example, service guides, educational materials and signposting services that are available online, by phone or in community centres and GP practices.
- Give community-based professionals (including GPs, pharmacists and others) a greater role in designing the way care is delivered across primary, intermediate and secondary care and increased opportunities to deliver services that might have traditionally been delivered in a hospital setting. This work will have the dual benefit of improving access to services for patients and reducing workforce pressures in areas where it is difficult to recruit.
- Take urgent steps to address gaps in our intermediate care services, both in terms of the types of services offered and the capacity of those services to meet the island's needs. This work will enable our service users to avoid unnecessary secondary care admissions, and it will help those who do need hospital-based treatment to get home sooner and recover more quickly.
- Continue to increase service users' access to safe, cost-effective screening services that are in line with international best practice while also focusing on the specific risks faced by some parts of Jersey's population.
- Identify and implement opportunities to increase the support we provide to carers with their own needs and those of the people they look after.

In **Women, Children and Family Care**, we will:

- Review all of our children's services and identify specific steps that can to be taken in order to make them the exemplar of how we realise our ambition to create 'a healthy island with safe, high-quality, affordable care that is accessible when and where our service users need it.' For example, there is a need for an early review of children's dental services, one of the specific priorities mentioned in the Common Strategic Policy.
- Define our ambition and strategy for maternity care in Jersey and a programme of work for areas we need to improve. By doing this work, we will be able to give our service users a clearer picture of what services they can expect in the community and in hospital and also what we will only deliver off island.
- Improve access to women's services, such as emergency contraception and menopause clinics, by delivering more of them through primary and community services and reducing reliance on our specialist secondary care workforce.
- Develop new ways of working in areas such as CAMHS, which will be a priority to ensure physical and mental health care is working seamlessly with other States departments such as Children, Young People, Education and Skills.
- Seek to improve breast feeding rates.
- Further build on our pathways of care for women's and children's services, with closer working across community and hospital services.
- Develop a sustainable medical model of care for obstetric services, ensuring we are less reliant on temporary staff. We will also further develop enhanced roles within midwifery.
- Continue to work closely with our tertiary partners for children's acute care and build on the success of our resilient and well-established medical workforce.

In **Secondary Scheduled Care**, we will:

- Accelerate our work on increasing productivity and giving our patients a better experience. We will make services available during longer, more appropriate hours (including evenings and weekends) and will improve coordination of appointments, procedures and post-discharge support. By working more efficiently, our goal will be for the hospital to be able to undertake more work with the same resources and for our patients to have reduced waiting times and shorter stays in secondary care.
- For a range of long-term conditions, increase the role of community-based practitioners (e.g. GPs, practice nurses, pharmacists and therapists) in delivering care. This will make it easier for patients to access services and will reduce waiting times for those services that genuinely require specialist secondary care expertise.
- Work closely with colleagues in Secondary Unscheduled Care and other groups to ensure we are sharing resources (e.g. facilities, equipment and staff) and supporting each other's services effectively.
- Address services that have longer waits for access and take advantage of opportunities to reduce unnecessary processes in care pathways. An example of this will be improved specialist advice and guidance for GPs with direct access to specialists so that patients don't always have to attend an outpatient appointment.
- As part of our job planning and demand/capacity work, ensure that all of our planned care services from outpatients to theatres and wards are operating at their optimum ability.

In **Secondary Unscheduled Care**, we will:

- Finalise phase 1 of our 'acute floor' model in early 2019 and accelerate the implementation of subsequent phases 2 and 3. Through this model, we will provide patients with a single point of access for acute unplanned care needs, which are most often urgent or emergency situations. We will also be able to ensure that patients are prioritised consistently and get access to the right professionals 24/7/365.

- Seek to reduce the number of admissions to the hospital following the implementation of the acute floor model. We also anticipate this will result in shorter lengths of stay for patients who do require hospital based care.
- Through better coordination, provide patients with access to our most specialised professionals for longer hours each day, with better access on weekends and bank holidays. We will also safely reduce hospital admissions and inappropriate diagnostics, and we will shorten the length of stay for those who do need to be admitted.
- Make it easier for non-secondary care professionals to understand what services are available, when they can be most appropriately accessed and how their service users can access them. Similarly, we will ensure patients have a better understanding of what services are available and which are most appropriate for different kinds of needs.

In **Mental Health and Social Care**, we will:

- Take urgent action to improve our child and adolescent mental health (CAMHS) services, ensuring the services have appropriate levels of clinical and non-clinical professional resources, appropriate inpatient facilities and places of safety when these are required. We will also ensure we establish and adhere to clear protocols for off-island placements.
- Through the newly-established Mental Health Improvement Board, ensure we fully implement our mental health strategy, with a particular focus on establishing a 24/7 service with prevention and early intervention, crisis intervention, improved patient safety and improved outcomes.
- Address issues with our mental health estates, including those that were identified in recent health and safety reviews, and develop a clear plan for mental health estates for the future.
- Make it easier for people to get assessed for social care services and to access those services when they are deemed appropriate. We will ensure service users have a strong voice in deciding which services are most appropriate for their needs, and we will focus our services on increasing service users' independence.
- Ensure we are fully prepared to meet our obligations under the Regulation of Care (Jersey) Law 2014, which comes into force for these services in January 2019 and will have implications for all other groups over time.
- Ensure the availability of appropriate advocacy services to provide support and a voice for those without capacity or confidence or who are unable to speak for themselves for other reasons. We will also engage with young people, adults with a learning disability and family carers to ensure they understand the Capacity and Self-Determination (Jersey) Law 2016 and can access appropriate services in line with the law.
- Create more holistic health and wellbeing services, by creating opportunities for voluntary and community-based organisations to play a bigger role and by building even stronger links between HCS's services and those provided by the police, our schools and Social Security. This will provide service users with access to local services that are tailored to their circumstances and needs and reduce waiting times.
- Ensure that our mental health services are well supported with a sustainable and experienced workforce.

In **Quality and Safety**, we will:

- Develop a quality framework that all services can use to ensure they are providing services that are safe, effective, efficient, timely, patient-centred and equitable. By operating within a clear and consistent framework, we will be confident that our service users benefit from ongoing improvements in the quality and safety of the services they receive.

- Design a culture change and leadership development programme that will help us to get better at some of the key things that make an organisation succeed when it comes to quality (e.g. making it safe for individuals and teams to be transparent about and learn from incidents; improving teamwork and communications; holding people to account for their actions).
- Support the care and cross-cutting service groups to identify the key quality indicators that they should use in monitoring, managing and improving their services. We will then support them to get the necessary data and reports in place to track those indicators. Doing this will give our service users better visibility of our performance, including both our strengths and our areas for improvement.
- Improve our processes and systems for obtaining and addressing feedback, complaints and compliments from our service users. We will implement short-term improvements and will ultimately invest in a comprehensive patient advice and liaison service with appropriate systems to underpin it. We will also create other opportunities – for example, through events and community-based forums – for our service users to give feedback and help co-design services.

In **Clinical Support Services and Cancer**, we will:

- Improve access to appropriate diagnostics and work to become self-sufficient in the vast majority of investigations. Although we recognise that resource limitations will require some specialist diagnostics to be conducted in a limited number of locations and at specific times of day, our overall aim is that service users can access consistent, appropriate tests in GP practices, hospital and other care settings at times that are convenient.
- Complete the implementation of e-prescribing in the hospital and extend it into other care settings. This work will enhance patient safety by reducing medication error risks, improving hand-offs between care providers, driving down costs and reducing waste.
- Identify and implement opportunities for therapy professionals to expand their scope of practice and work as an integral part of multidisciplinary teams across care settings. By expanding our therapists' roles and skills, our patients will receive increased continuity of care and have a better customer experience, with fewer hand-offs.
- Enhance our multidisciplinary team approach to cancer management. This will speed up diagnosis and help ensure that patients consistently receive more effective and appropriate treatments.

In **Non-Clinical Support Services**, we will:

- Review our commissioned services (including off-island contracts) to ensure that the services we are buying are fully aligned to the needs of our new care model and the priorities of each group.
- Further develop access to diagnostics and effective cancer pathways and work with tertiary partners to further develop and explore remote care and digital health opportunities.
- Consolidate the work of our transformation and digital teams into a single transformation programme and focus those teams' efforts on implementation of concrete change proejcts with tangible service user, clinical, operational and financial benefits. We will also give clinical and business leaders increased influence in leading change and digital efforts and will in turn hold them accountable for delivery of results for our service users.
- Focus our technology investments on projects that are fully aligned to each group's priority improvement initiatives, ensuring alignment with our overall digital strategy while focusing on incremental changes that will deliver specific near-term benefits.
- Deploy a range of assistive technology solutions that will increase service users' independence and help them get home sooner if they've needed a stay in hospital.

- Ensure that our estates and facilities are well maintained and operate within the remit of an HCS estates and facilities strategy.

For **Tertiary Care Services**, which are delivered off-island, we will:

- Implement increased consistency in how we refer planned care interventions to off-island tertiary centres and work to increase the benefits that Jersey gains through having access to specialist expertise in the UK. We will continue to ensure that urgent care pathways to tertiary centres are well co-ordinated.
- Identify and implement opportunities to improve the customer experience with our travel office services.
- Work with patients and their families to find ways of minimising the impact of the travel and separation they face when off-island tertiary care is required.
- Provide service users with improved and clearer information about which specialist services can be provided in Jersey, which cannot and the reasons why it is best for our patients to have some of their specialist care provided by an off-island tertiary care provider.
- Where possible, continue to seek opportunities to enhance the services that can be delivered in Jersey rather than off island. We will work closer with Guernsey in scoping these opportunities.

4.3 Priorities to be addressed across services

While we believe that the group structure will provide an ideal mechanism for designing and driving many aspects of service change, we also recognise that there are some high-priority opportunities and challenges that can best be addressed across the health and community system as a whole. Some of the early priorities we intend to address as a whole system include:

- **Clinical and professional leadership development –** To support our clinicians and professionals to succeed in new leadership roles, we will invest in a sustained programme of clinical and professional leadership development.
- **Workforce planning and development –** Delivering different types of care in a different care model will require a different type of workforce. We will be asking colleagues to work differently, and we will also need new roles and skills on the island. To make sure we are prepared for our future workforce needs, we will create and publish a plan that explains our future workforce requirements and how we will develop, train and recruit staff to meet them.
- **Culture change –** We recognise that fully implementing our new care model and proposed group structure will require a significant culture change within HCS and across our partner organisations. We will continue our work on Our Values Our Actions and will actively participate in the Team Jersey culture change programme. We will also ensure that our partners are included in our work on culture change.
- **Service user involvement –** We will take tangible and visible steps to give service users a greater voice in providing feedback on and helping design the services we provide across the health and community system.
- **Care coordination capabilities –** Building on significant design work that has already been done, we will implement clinically-led care coordination capabilities that will help professionals coordinate care more effective across care settings and help service users navigate the health and care system with greater ease.
- **Clarity of 'the offer' –** We will work to ensure that service users, citizens, staff, delivery partners and elected representatives fully understand our overall health and community service offer and what they should be able to expect from our services. We will clearly explain, for example, what we can and should do on island, what services can and will

be delivered off island, what services will be funded via the government and where service users will be expected to make a direct financial contribution.

- **Safety and sustainability –** We will continue identifying and addressing any areas of our services where there are clear opportunities or requirements to improve safety and sustainability of care. We will also redouble our efforts on health and safety and risk management more generally. We will work under the philosophy that 'safeguarding is everyone's business' and will fully implement the recommendations of the Jersey Safeguarding Partnership Board in response to the two recently published independent reviews of safeguarding adults in Jersey.
- **Governance –** We accept and will act on all the recommendations set out in the C&AG's September 2018 report on governance in health and social care. Our plans for doing this are set out in our response to the report, published in November 2018.
- **Clinical, operational and financial performance management –** We will establish and publish the standards and processes that we will use for managing our performance. We will use data and evidence to identify and celebrate areas where we are performing well and to learn about and improve areas where we can do better.
- **Funding flows and payment mechanisms –** We recognise that in order to achieve the outcomes we want for our service users and get all providers aligned around common objectives, we will need to change some aspects of how we pay for care. We are committed to addressing issues of funding and payments – many of which are a longstanding source of frustration for providers, service users and politicians – in a way that supports the priorities of the Common Strategic Policy.

5. Implications of the care model for how we restructure HCS

Like all other departments, HCS will be reorganising to enable us to work differently and achieve our ambitions. We will also be working with partner organisations to ensure that the island's overall health and community system is organised around our proposed care model, our ambition and the Common Strategic Policy priorities.

We currently anticipate that the future HCS organisational structure will be strongly linked to the group model described in section 3 of this document. It will place senior clinicians and professionals in leadership roles, supported by strong managerial capabilities.

We expect to have 'heads of' roles for each of the care groups and cross-cutting services. These will sit alongside more general professional leadership roles. We will also have a modernisation function that will bring together our transformation and digital teams to support priority change initiatives across the island.

We expect the structure to be much flatter than our current organisation. This will streamline our operations and reduce the layers between our leadership team and our more junior colleagues.

6. Conclusion

The proposed changes have the potential to significantly improve services for islanders and to create new opportunities for those of us who work in health and community system. Some of them will be relatively easy to implement; others will be quite hard and will take time. But, if we rally ourselves around the new care model and create an environment where frontline teams are empowered to create the services they would want for themselves and their families, all of the changes are achievable.

The HCS Management Executive team hopes this document will start a conversation about our future and the way we organise ourselves to deliver it. We genuinely welcome feedback

as part of the reorganisation consultation process, and we also welcome informal dialogue about how we can improve our proposed plans and make them the best they can be.

A summary of this document and the accompanying reorganisation consultation document can be found on the One HCS intranet page, along with details about how to provide feedback. We invite you to send your feedback, comments or questions to OneHCS@gov.je or to speak to a MEX member at any time. MEX members are Anthony (Mac) McKeever, Robert Sainsbury, Rose Naylor, Sarah Whiteman, John McInerney, Darren Skinner, John Howard, Steve Mair and Derek Law.

Appendix 1 – Details of proposed care group and cross-cutting service groups

The tables below contain our initial proposed mapping of current services into the care groups and cross-cutting service groups. There are several points that should be noted about this initial mapping:

- In allocating services into specific groups, we do not wish to create silos. Instead, we are simply trying to create a sensible way of organising the many services we deliver.
- Almost all services will have interactions across multiple groups. So, we encourage you to think of the proposed service mappings as the organisational 'homes' for specific services rather than as hard organisational boundaries.
- Some of the services listed in the groups are provided by external partners or other States departments. However, they are included here because the group structure is designed to reflect the overall health and community system in Jersey.
- Although we have done our best to capture all services, it is almost inevitable that we will have missed some. If you spot something that is missing, please let us know.
- We welcome feedback on the proposed mapping. While it will be impossible to reach a point where all of our staff and stakeholders agree on the mapping, we want to make sure that it is as good as it can possibly be.

Prevention, Primary and Intermediate, Care	**Women, Children and Family Care**
• Bereavement services • CAMHS preventative pathways (shared and interface service with CYPES) • Community eye services • Community pharmacy • Community dentistry and orthodontics • Contraceptive and family planning services • COPD • Diabetes • District nursing • Frailty • GP services • Oxygen service • Palliative care • Preventative health • Primary care mental health • Pulmonary rehab • Rapid response • Reablement • Retinal screening • Rheumatology • Sexual Health	• Assisted reproductive unit • CAMHS (Mental Health and CYPES Shared Care pathways) • Child development services • Children's short break services • Early pregnancy unit • Gynaecology • Health visiting • Maternity • Obstetrics • Paediatrics • SCBU • School nurses • Tertiary pathways

Secondary Scheduled Care • Anaesthetics • General medicine and specialities • General surgery/theatres (including day surgery and minor operations) • Inpatient wards • Pain service • Private patients • Surgery pre-assessment • Surgical specialities • Tertiary pathways	**Secondary Unscheduled Care** • Care of the elderly and older people's rapid access (to be developed) • Critical care ICU • Emergency and acute medicine and surgery • GP out-of-hours • JETS and tertiary pathways • Medical HDU • Paramedic and ambulance services • Plaster technicians • Trauma
Mental Health and Social Care • Acute CAMHS • Adult mental health (crisis services, inpatient and community based services, acute and rehabilitation/recovery services, liaison services) • Adult safeguarding (tactical and preventative) • Adult social care (assessment and provision) • Autism services • Counselling • Drugs and alcohol • Falls prevention • Jersey Talking Therapies • Learning disabilities (including supported living and respite services) • Older adult mental health (day services, community and inpatient services, memory service, dementia, acute rehabilitation and long-term care, functional and organic illness) • Positive behaviour support services • Preventing isolation and loneliness • Psychological services • Tertiary pathways	**Quality and Safety** • Clinical and social care governance • Clinical audit • Clinical quality and performance management • Compliments and complaints • Designated safeguarding roles (Adult and Children working with the Chief Nurse and Group Medical Director) • Education • Incident, accident and near miss reporting • Infection prevention and control • Communicable disease control • Interpreting and translation service • Litigation • Patient advisory support service (to be developed as a replacement to the complaints service) • Professional standards and registration • Resuscitation service

Clinical Support Services and Cancer	Non-Clinical Support
• Audiology • Biochemistry • Blood transfusion • Cancer • Clinical investigations • Dermatology • Dietetics • Haematology • Microbiology and virology • Mortuary • Oncology • Orthotics • Pathology • Pharmacy • Podiatry and chiropody • Radiology • Sterile services • Tertiary pathways • Therapies • Tissue viability	• Business continuity • Care coordination • Catering • Chaplaincy • Cleaning and laundry • Coding and information • Commissioning and off-island contracts • Corporate governance • Crematorium • Estates • Facilities management • Health and safety • HR • Income • Medical records • Medical secretaries • Porters • Stores • Tertiary pathway co-ordination • Transport • Travel office