Intermediate Care Strategy

Health and Community Services

December 2021

Contents

Executive Summary

A review has been undertaken following the COVID-19 pandemic waves 1 and 2, to ensure that the strategy behind the Intermediate Care Model is up to date. The review considers the most up to date practices worldwide and lessons learnt and changes in service provision since the first draft created in March 2020. Due to COVID-19 a phased approach to remodelling services will be undertaken between 2021 and 2024.

Jersey has an Intermediate Care Model already in place, but this requires modernisation in line with the Jersey Care Model (2019) recommendations. This paper provides the strategic background to inform the business case(s) for Intermediate Care Services in the future for Jersey following the agreement of the Jersey Care Model Business Case.

Jersey's ageing population is expected to increase to 19% in 2026 for over 65 year olds and, like many jurisdictions, to be able to support islander's we need to be innovative and change our current model (Jersey Care Model 2019).

Ongoing Stakeholder engagement for intermediate care services has been completed through a number of mediums including current service providers, voluntary organisations, presentations with question and answer sessions, patient surveys and road shows. Stakeholder feedback has been collated and analysed to help inform the model.

Following the work previously undertaken, it is proposed that Health and Community Services will in the future provide a centre of co-located multi professional staff members to navigate, case manage and undertake care and reablement needs assessments, named HCS24. With a number of sub services within it, HCS24 will include both statuary and voluntary sector staff members. The aim is to provide a 24 hour service, 7 days a week manned by Care Navigators who can provide telephone advice to callers whether they be professionals, voluntary sector or the public. HCS24 staff will be able to utilise Telecare, Teleguidance and databases of services provided in Jersey, through the use of triage algorithm's. We have learnt from the use of the COVID-19 Health Helpline that residents of Jersey have used this service for general health enquiries too.

The Care Navigator will offer self-referral advice to callers or, when appropriate, undertake onward referral for the caller to a multitude of services both Statutory and Voluntary sector.

An ambition will be for a Pharmacist to be available within HCS24 hub from 07:30-23:00 7 days a week. They will support the Care Navigators and the multi professional Care and Reablement Team with prescribing patient concordance and medication optimisation (Jersey Care Model 2019). This will include the introduction of a telephone medication review 10 days post discharge of hospital, which is proven to aid the public keep to medication adherence. Approximately 50% of patients within 10 days of discharge from hospital have failed in their adherence to administer their medication as prescribed for a number of reasons (Neiman et al 2017, Oswald 2018).

A small limited pharmacy service will run for patients and staff to obtain medicines with emphasis on out of community pharmacy normal hours from 2023 once the service has been

embedded. An on-going review will determine whether this service will be required to run 24 hours a day.

It is proposed that the Hospital Discharge Team from Social Care and the Discharge Coordinator is merged into one team and resources will be increased to allow for both front and back door support for patients to avoid hospital admission and promote early discharge facilitation (NICE 2015).

The Care and Reablement Team will provide supported discharge, reablement, social and nursing services to patients in their own home for up to 6 weeks. Representation of this service is expected to be based within HCS 24. This will allow for support to the Care Navigators and be a central point of access for community-based services. The team will provide a step up and step-down services, this will include from in-patient intermediate care facilities as well as Jersey General Hospital.

The Care and Reablement Team will provide a community urgent responder service, to undertake an assessment of the patient in their own home within two hours of referral. This role will work closely with Jersey Ambulance Service and General Practitioners to maintain patients in their own home whenever possible, following a full clinical assessment of their needs. Mental health colleagues will be part of this team to support patients with a crisis, cognitive impairment, delirium and those requiring supportive therapies. With this implementation quicker linkage and support to the wider mental health services, if required, will be available including crisis prevention.

The service will be able to provide short term care packages from within the team members (up to 72 hours) using a multi professional cross boundary approach. This will allow the Social Worker to undertake a full assessment of the patient and implement the formal package of care if required.

There is appetite from some clinicians to develop pathways to improve the length of stay, and with the potential to convert traditional inpatient surgery to day surgery. This is expected to take place between 2022-2024.

The Care and Reablement Team will support Care Homes with residents using its multi-professional team members. This part of the service should be in-reaching to care homes across Jersey to support them in providing care to residents and preventing admission to hospital when the person could be cared for within the home. Support for both the residents and care homes could be provided when the hospital discharges a patient. This will assist with education support on a need-by-need basis and improve the communication between care home and hospital. During the second wave of the Covid Pandemic an increased support need was identified by care homes. HCS provided this on a limited basis which received positive reviews.

A further service that could be provided by this team's remit is an outreach service to General Practitioners and HCS/charitable/voluntary day centres, to risk stratify/assess and monitor people who may be at risk of a decline in their condition (Jersey Care Model 2019). These services would work in tandem with social care using the Care Navigators and Social Workers based within HCS 24, thereby reducing duplication of multi professional contacts the patient has to interact with (Jersey Care Model 2019). This should assist with early identification of illness/decline in conditioning and support people who are not registered with a General Practitioner or do not attend their General Practitioner.

The patient will remain under the care of the General Practitioner (including JDOC out of hours if required) but with regular updates from the HCS 24 Team, and will have links into the Geriatrician/ Rehabilitation Consultants and Rapid Access Service via the use of HCS 24 (Jersey Care Model 2019).

The Rapid Access Service will undertake rapid assessment of patients who are referred by General Practitioners, Health and Community Services 24, attend the Emergency Department, or who have been admitted to the Emergency Assessment Unit. This will determine if they require secondary care or could be supported through one of the intermediate care services based in the community (NHS Benchmarking Network 2018). The Rapid Access Service will provide holistic in-depth assessment of patients including multi complex conditions, frailty and cognitive impairments with access to diagnostics.

The Plemont in-patient facility will focus on rehabilitation and care for patients who cannot be cared for within their own home environment, and who do not require care within an acute hospital setting. The in-patient facility would provide both Step Up and Step-Down provision from/to the community and Jersey General Hospital.

The Medical Care Group during the Covid Pandemic has been reviewing the current services at Sandybrook. This is ongoing and may or may not in future support intermediate care services.

Jersey is reliant on its charitable and voluntary sector providers. As part of this Strategy Paper, it is recognised that for the full potential of the Intermediate Care services to be reached it must engage with the 3rd sector to support the implementation of services (Hayes 2018, Jersey Care Model 2019).

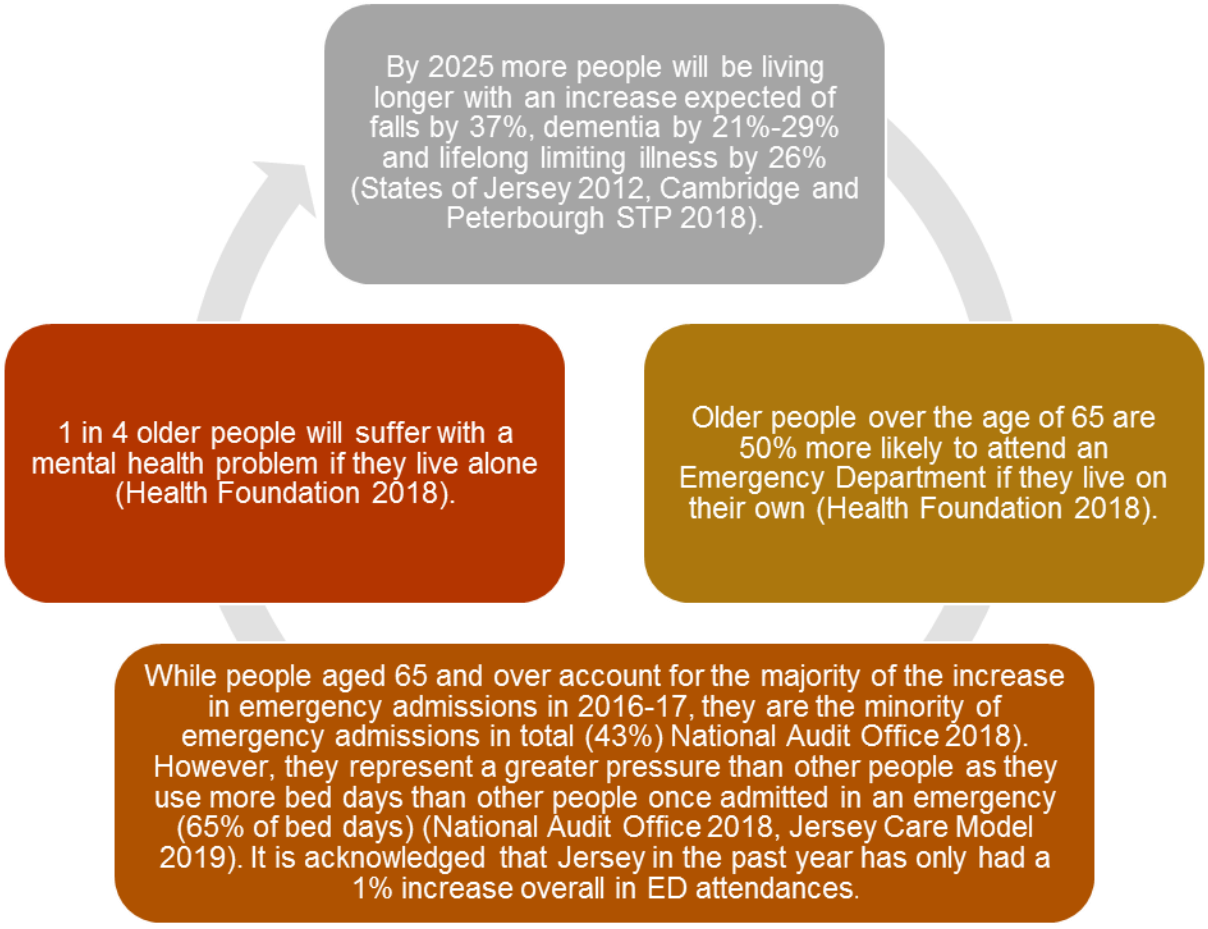
This will be done through multiple organisations to fulfil patient's needs and will engage with volunteers from the Parish's (Jersey Care Model 2019). Emphasis will be for provision when appropriate to have 7 days a week service supporting patients/service user's during and post engagement with Intermediate Care services. These services will promote independence, dignity, socialisation, safety checks and improve overall service user experience and outcomes with minimal outlay in costs to commission (Jersey Care Model 2019).

This strategy review paper supports a number of modelling options and it is recognised that an investment to save scheme is required for the model to fulfil its full potential. This has been agreed via the Business Case for the Jersey Care Model. Once fully embedded, this service model will promote independence at home with supportive services.

Reason for Change

Jersey's ageing population is expected to increase to 19% in 2026 for over 65 year olds and, like many jurisdictions, to be able to support islanders we need to be innovative and change our current model which is unsustainable. (Jersey Care Model 2019).

Expansion of the older population will create knock on effects that the Intermediate Care Service needs to take into consideration:



The below table identifies why we need to change and how this could be done:

Identified Issue	Potential Mitigation
Increase in average length of stay in hospital for patients especially over 65-year olds. This is longer than the United Kingdom National Health Service average.	• Evolvement of the role of Discharge Coordinator • Evolvement of Care and Reablement Team • Implementation of Rapid Access Service • Improved links and support to Care Homes

Patients are admitted to hospital as the current service specification is not fit for purpose.	• Evolvement of Care and Reablement Team • Closer working with Jersey Ambulance Service • Introduction of a Rapid Access Service
Peak times of older people visiting the Emergency Department is between 1600-1800 with additional peaks on a Monday morning and from 1200 on Fridays.	• Evolvement of Care and Reablement Team • Closer working with Jersey Ambulance Service • Introduction of a Rapid Access Service • Improved links and support to Care Homes • Introduction of Telecare and Teleguidance
No therapy service provided in Jersey at the weekend for intermediate care patients.	• Evolvement of Care and Reablement Team • Introduction of Rehabilitation Support Worker Role
Lack of out of hours social work support within JGH (Jersey General Hospital).	• Introduction of a hub care model that operates 7 days a week where social care evolvement is supported with the Care and Reablement Team
In 2019; • 8095 Alarm Calls made in past 12 months • Peak times of alarm calls 0900-1600 each day, with next highest peaks at 0800-0900/1800-1900/2100-2300. • Average of 23 calls per day	• Introduction of Telecare and Teleguidance • Evolvement of Care and Reablement Team • Closer working with Jersey Ambulance Service • Introduction of a Rapid Access Service
Premature admission to care homes.	• Introduction of Telecare and Teleguidance • Evolvement of Care and Reablement Team • Introduction of a Rapid Access Service • Development of Day Centre Services • Introduction of Geriatrician and Rehabilitation Consultants • Development of Plemont Ward services • Development of slow stream rehabilitation pathways

Increase mental health intermediate/community care service.	• Introduction of Mental Health workers into Care and Reablement Team • Psychologist support to CART and Plemont Ward patients
Insufficient support for care homes to help prevent admission to hospital.	• Evolvement of the role of Discharge Coordinator • Evolvement of Care and Reablement Team • Improved links and support to Care Homes
Average of 12 phone calls and 36 emails (including referrals) received for current Single Point of Referral for Adult Social Services	• Implement single point of access for all intermediate care and adult social care referrals • Co-located multi professional team • Seamless service and onward referral process
Multiple Single Point of Access services for community services	• Implement single point of access for all community referrals • Co-located multi professional team • Seamless service and onward referral process

Jersey currently offers a Rapid Response and Reablement service and the development of the Jersey Care Model provides the opportunity to enhance this with a fully integrated intermediate care offer (Jersey Care Model 2019). The Jersey Care Model (2019) recognised that the current system:

- is not delivered consistently and to its full potential to help people remain at home
- teams are not configured to manage higher-risk patients due to lack of 24/7 cover and skills mix due to the needs of JDOC support.
- reflects an institutionalised model where patients are brought in to hospital as the default option
- Lacks 24/7 Community Nursing which means that there is no nursing cover to support people at home overnight – as part of the Jersey Care Model this has been addressed and a night nursing service was implemented in April 2021.
- Mental Health Crisis prevention service requires development to support increased demand

A review of intermediate care services within Jersey and worldwide practice has been undertaken to inform this strategy, and promote best practice for the population of Jersey (Department of Health 2001, The Sainsbury Centre for Mental Health 2005, Garasen et al 2007, Robinson 2011, Holditch 2012, Johannessen et al 2013, OECD 2013, NICE 2017, World Health Organisation 2018, Intermediate Health and Social Care Services Doncaster, 2018, NHS Benchmarking Network 2018, Advantage 2019, Government of South Australia 2019,

Government of New Zealand 2019, HealthCare Denmark 2019, Ministry of Health Singapore 2020).

The voluntary sector has shown interest in developing services with Health and Community Services which has been taken forward with the commencement of scoping exercises to review how this offer can be implemented within the future model of intermediate care services (Jersey Care Model 2019).

Historically intermediate care services in Jersey have been designed and bolted on to existing services as they have developed (Black 2017). There has been no single responsible management to monitor and hold to account the overall service provision, and the new model proposed will ensure that future services are outcome-focused (Jersey Care Model 2019). In the previous 5 years some modelling of future intermediate care services have taken place though not all have been implemented (Health and Social Services 2016).

The report A New Way Forward published in 2012 (States of Jersey 2012) suggested improvements in intermediate care of which the actioned improvements can be seen in the table below (Health and Social Services 2016, Jersey Care Model 2019). At the time of the integrated community services being suggested, the economy of scale on reflection was probably not fully taken in to account and that a cultural, as well as operational change was required to provide an intermediate care service alongside the existing community services. Although some services suggested in A New Way Forward do include what may be termed intermediate care (States of Jersey 2012). This business case will build on some of the recommendations from A New Way Forward (States of Jersey 2012, Health and Community Services 2020).

Below is a breakdown of what has been achieved, partly or not achieved from A New Way Forward (States of Jersey 2012, Health and Community Services 2020):

Achieved	Partly Achieved	Not achieved
• Short term intermediate care beds • Rapid Response Service • Reablement Service	• Telecare • Single point of access • Multi professional team approach • Increased independence • Reduced Isolation • Reduction in hospital admissions and readmissions • More diverse and better supported providers • Specialist staff • Hospital liaison to community	• 24 hour support in a range of settings • Telehealth • Single assessment process • One stop shop for information • Wellbeing centre • Clarification of who provides and what services are available • Flexible rapid response service • Reduced hospital length of stay • Delay need for long term care home

		• Integrated working between providers • IT enabling joint cross organisational working

The Jersey Care Model (2019) identifies that for every £1 spent on prevention, £1.90 could be saved that would otherwise have been spent on treatment. This saving can be increased further through the reduction of care packages.

The Jersey Care Model (2019) identifies the need for a developed intermediate care service compared to the current model based on NICE guidelines (NICE 2017). This business case does not identify suppliers of future services (unless already supplied by HCS) but does set out to ensure that different service providers work collaboratively and are integrated together, with the aim of a seamless service (Health and Social Services 2016, Intermediate Health and Social Care Services Doncaster 2018, Oliver 2018, NHS Benchmarking Network 2018). Future services would provide a full seven-day service with extended hours to suit the needs of islanders. It is estimated that 50% of over 75-year olds who are admitted to hospital could be supported at home through intermediate care services, hereby preventing hospital admissions (Intermediate Health and Social Care Services Doncaster 2018, NHS Benchmarking Network 2018).

The Jersey Care Model business case now includes a stepped approach to implementation to fulfil the full potential of the future intermediate care service. The following service provision is now envisaged for implementation:

Health and Community Services 24 (HCS24)

HCS24 will deliver a high-functioning, multi-professional clinical community care centre that operates 24 hours a day, seven days a week to enable the delivery of home-based care, crisis response and reablement (Jersey Care Model 2019). The HCS24 team will include both statuary and voluntary sector staff members. This service will enable a multitude of providers to risk stratify and manage a virtual ward model to monitor patients. HCS24 will include the following services;

Telephone/care advice and Navigation of Services

A 24-hour service, 7 days a week service provided for by Care Navigators who can provide telephone advice to callers whether they be professionals, voluntary sector or the public. These staff members will be able to utilise Teleguide's database of services provided in Jersey (HealthCare Improvement Scotland 2020) to offer self-referral advice to callers or, when appropriate, undertake onward referral to a multitude of services from both the Statutory and Voluntary sectors.

All community services referrals will be received by HCS24 creating a single point of referral; through this undertaking, a reduction in duplication and multi contacts with professionals will be achieved (Jersey Care Model 2019).

HCS24 will also act as the base for Telecare, where Care Navigators will assist islander's alarm calls and enhanced monitoring, providing referral where necessary to supportive services (HealthCare Improvement 2020).

The further inclusion of a Pharmacist, available between 0800-2000, seven days a week will support the Care Navigators and the multi professional Care and Reablement Team (pg 12) with prescribing, and patient concordance and medication optimisation (Jersey Care Model 2019). The introduction of a telephone medication review ten days post discharge of hospital will improve medication adherence, as the preventative service could reduce hospital re-admission by up to 10% (Jersey Care Model 2019). It is known that approximately 50% of patients within 10 days of discharge from hospital have failed in their adherence to administer their medication as prescribed for a number of reasons (Neiman et al 2017, Oswald 2018). By resolving medication issues and providing support, islanders can remain healthier through effective, appropriate treatment (Word Health Organisation 2003, Barnett 2013, Jersey Care Model 2019).

In turn this will reduce long term costs through wasted medicines, further ill health and associated treatments required through readmission to hospital and provide health benefits for the individual (World Health Organisation 2003). It is proposed this pharmacist role will take over the Medicines Information Service, which is currently based within Jersey General Hospital, and will be available to all prescribers and community pharmacies in Jersey. This will allow current staff in the hospital to continue with their contracted role, as no one individual is allocated this role in a single post. A small limited pharmacy service will be run for patients and staff to obtain medicines with emphasis on out of community pharmacy normal hours. This will promote self-help with pharmacist support, earlier medication treatment and the ability for staff members to collect medication for patients and to support them at home. It is envisaged that this service would be provided by a community pharmacy provider. From 2024 once the service has been embedded, on-going reviews will determine whether it is feasible to run the service 24 hours a day.

It is proposed that the Hospital Discharge Team and Hospital Discharge Coordinator are merged in to one team and increased to allow for both front and back door support for patients, to avoid hospital admission and promote early discharge facilitation (NICE 2015). The Discharge Coordinator and Social Care Hospital Discharge Team will move from under Jersey General Hospital and Social Care management to HCS24, allowing for focus on community support and earlier discharge of patients whenever possible, rather than concentrating on complex discharges with their limited capacity at present. By attending the delayed discharge and bed meetings, the Discharge Coordinators will be able to review suitable patients on the wards who could benefit from intermediate care pulling them through the system and referring them to the most appropriate community service via HCS24 (Jersey Care Model 2019). This part of the service is expected to run five days a week. Placement of a Hospital Discharge Coordinator within the Emergency Department, who will cross cover with the Emergency Admissions Unit and Rapid Access Service (pg 16) 7 days a week with extended hours of 0800-2000, is advocated to promote admission avoidance, reduce multi professional input and coordinate the patient to the most appropriate service (Jersey Care Model 2019).

HCS24 will be supported by a Clinician of the Day provided by the Care and Reablement Team.

Care and Reablement Team

The Care and Reablement Team (herein known as CART) will provide supported discharge, reablement, social, mental health and nursing services to patients in their own home for up to six weeks (or in line with their service specification). A separate night nursing service commenced on 4th April 2021 which is envisaged to merge within CART in 2023.

The CART will provide a Step Up (from the community) and a Step Down (from an inpatient area) service, including in-patient intermediate care facilities as well as Jersey General Hospital. The service will promote care at home whenever it is appropriate and safe to do so, including Care Homes.

The CART will provide a community urgent responder service, 24 hours a day from 2021 (this is included in the night nursing service), to undertake a full clinical assessment of patient's in their own home within two hours of referral (Jersey Care Model 2019). This role will work closely with Jersey Ambulance Service, States of Jersey Police and General Practitioners. Whilst a full intermediate care service is not always possible overnight, the Community Urgent Responder allows for early intervention and can avert an Emergency Department attendance (Jersey Care Model 2019). A night sitting service could be provided to support the patient in these circumstances and is expected to be provided by a voluntary organisation.

Mental health colleagues will be part of this team to support patients with a crisis, cognitive impairment, delirium and those requiring supportive therapies. This implementation enables direct linkage and support to wider mental health services if required, including crisis prevention (Jersey Care Model 2019). It is proposed to continue to employ 2 RMN nurses, and enhance this with a Psychologist to support patients with anxiety, perceptual, cognitive, emotional, and social processes and behaviour (Pol et el 2019, American Psychological Association 2020, Australian Clinical Psychology Association 2020). These staff members are included within the department's Access Team, which is currently in development and is focused on increasing support in community settings and reducing hospital admissions and Emergency Department attendances (Jersey Care Model 2019). On-going reviews of the model will highlight whether staffing is sufficient against demand once the service has been embedded. The establishment and development of the Access Team through Mental Health has approved funding. Psychology is already benefitting from the funds released through the Trauma pathway increasing the number of clinical psychologists and community partners.

The CART could be up skilled to undertake further assessments such as Geriatric Depression Scoring and 6 Item Cognitive Assessment Scoring, prior to requesting mental health colleagues' involvement in support of early interventions.

It is expected that up to four times a day intravenous antibiotic could be provided and some other intravenous drugs under protocol.

The CART will be able to self-provide short-term care packages of up to 72 hours, using a multi professional cross boundary approach. This will allow the Care Navigator/Social Worker to undertake a full assessment of the patient and implement the formal package of care if required after the initial support has been provided. This would support a Discharge to Assess

pathway for both in-patients, those who are experiencing a crisis and preventing an admission into hospital (Jersey Care Model 2019, HealthCare Improvement Scotland 2020).

Long Term Care Fund has anticipated that all care packages implemented at the beginning of service entry are reassessed regularly in-line with patient's improvement and prior to the discharge of the patient, to ensure the right level of care is provided (Jersey Care Model 2019). Regular reviews will ensure care levels are adjusted to the individual's needs, and then increased to six months, then yearly afterwards to gauge if a patient is slowly improving or declining in their independence (Jersey Care Model 2019).

There is appetite from some clinicians to develop pathways to improve the length of stay and with the potential to convert traditional inpatient surgery too day surgery. One example of this is one day Hip and Knee Replacements (American Association of Hip and Knee Surgeons 2020, Care UK 2020). Currently a patient with this treatment spends 3-5 days in hospital. However, with supported discharge from the CART, for selected patients this could be reduced to day surgery with the CART supporting the patient at home with a short term care package of up to 3 days, along with therapy in the patient's own home. Using a conservative figure of a stay in hospital per bed night at £400, it is anticipated that if one surgery of this type were undertaken per week it would **save 156 bed days per year** with a minimal **cost saving of £62,400**.

The CART will support Care Home' residents through their multi-professional team members, who will be in reaching to care homes across Jersey provide care support to residents and prevent admission to hospital (Jersey Care Model 2019). This approach had had a positive effect as evidenced during the 2nd Wave of the COVID-19 Pandemic where it was identified that support was required by care homes and an in-reach approach was undertaken during this period.

In 2019 54 patients were discharged from the Emergency Department back to their care homes in Jersey, at a **cost of circa £18,900** to Jersey Ambulance Service (Emergency Department Attendance Data 2019). This could have potentially been prevented by attendance of the CART. It is proven that this approach works as an estimated 6% reduction of care home referrals to the Emergency Department has occurred where Care Home Support Teams have been implemented; this alone would **save circa £1100 per year** for Jersey Ambulance Service (Sawicka et al 2017). Support from Telecare and Teleguidance could be implemented to Care Homes in the care delivery of their residents and reduce hospital referrals and admissions further, while promoting independence and supervision of the resident. There is a potential of a **total cost saving of £20,000** through the implementation of the Telecare service.

Upon hospital discharge, the opportunity to support the care home resident, and care home, would be provided along with educational support on a need-by-need basis, this will improve the communication between care home and hospital and move the service offered from reactive to preventative through regular visits and risk stratification assessments. The support provided could include; rapid responder access, onward referral of support services (e.g. dietician, falls and dementia practitioners), staff education programmes, referral for assistive technology and ultimately hospital admission avoidance. This will aid the reduction of unnecessary call outs of the Jersey Ambulance Service (JAS) and Jersey Doctor Service (ED Data 2019).

The CART also has the facility to offer an outreach service to General Practitioners; HCS/charitable/voluntary day centres to risk stratify/assess and monitor people who may be at risk of a decline in their condition (Jersey Care Model 2019). These services would work in tandem with social care through HCS24 and the Care Navigators and Social Workers, thereby reducing duplication of multi professional contacts the patient must interact with (Jersey Care Model 2019). The outreach service will enable early identification of those who may need additional support at home, require reablement, therapy or nursing intervention which may not usually be noted until the person enters a health or social care process. Through this undertaking, it is expected that Day Centre staff from both Health and Community Services and the Voluntary Sector could alert HCS24 to engage with a client, to prevent avoidable admissions to hospital or to commence early interventions to prevent a decline in conditioning and to promote the individuals independence (Jersey Care Model 2019). The team could then monitor the person or help navigate them to the correct service if required through the Care Navigators within HCS24 (Jersey Care Model 2019). Similarly, this service could outreach to the Parishes of Jersey to undertake basic health and care screening/surveillance on a drop-in basis for over 18 year olds (Jersey Care Model 2019). There is potential with training that this part of the service could be provided by a voluntary organisation, with direct clinical support from HCS24. Referrals to General Practitioners, HCS and Voluntary organisations could be made through the Care Navigators within HCS24, improving the coordination of care (Jersey Care Model 2019). This should assist with early identification of illness/decline in conditioning and support islanders who are not registered with a General Practitioner or do not attend their General Practitioner.

The Clinical Members of this team will consist of Nurses, Physio and Occupational Therapists, Health Visitors for Older People, Psychologists, Mental Health Nurses, Pharmacists and Rehabilitation Support Workers (some of these staff members would include Advanced Care Practitioners with Advanced Clinical Assessment and Non-Medical Prescribing skills) (HealthCare Improvement Scotland 2020).

The patient will remain under the care of the General Practitioner (including JDOC out of hours) but with regular updates from the HCS24 Team, and will have links into the Geriatrician/ Rehabilitation Consultants and Rapid Access Service via the use of HCS24 (Jersey Care Model 2019).

Physician cover

Currently there are no Geriatrician or Rehabilitation Consultants in Jersey. Older people and those requiring rehabilitation medicine are currently covered by existing consultants. With the development of the intermediate care services and the acknowledgement of a rising older population in Jersey, it has been identified that there is a need of specialist support to the population within these specialities (Jersey Care Model 2019). Older peoples care is the largest specialty undertaking general medicine and providing acute medical care of patients admitted as emergencies (British Geriatrics Society 2012).

Following a review of the current position and that of the future intermediate care services it has been identified a Geriatrician and Rehabilitation/Neurological Consultant are required. It would be expected that these consultants would cross cover and provide in and outreach service across the community and HCS hospitals (HealthCare Improvement Scotland 2020). These roles may require support from staff grade medical colleagues.

The main roles and responsibilities of the Geriatricians would be as follows (British Geriatrics Society 2012, Pol et al 2019, Health Direct 2020):

- Assessment to target individuals into community-based services in lieu of hospital admission including earlier discharge to either inpatient rehabilitation services or the Care and Reablement Team.
- Support residents in care homes instead of admission to hospital alongside the Care and Reablement Team
- To lead the Rapid Access Service for older people
- To lead the medical care of older people admitted to hospital including Plemont and Sandybrook, and/or provide specialist advice to colleagues
- Early recognition and response to geriatric syndromes: delirium, falls, immobility, functional loss, incontinence, nutrition.
- Proactive identification of suitable patients for rapid follow up in specialist clinics.
- End of life care is a core medical skill but geriatricians can be expected to provide expert support.
- Provide Orthogeriatric support
- Participate in multidisciplinary rehabilitation and expert discharge planning for patients with complex needs
- Medicines Management
- Support the development of Acute Care Practitioners

The main roles and responsibilities of the Rehabilitation/Neuro Consultant would be as follows (Pol et al 2019, Health Education England 2020, Royal College of Physicians 2020):

- To be involved in the care and medical management of people aged 18+ who require rehabilitation medicine

- Assessment to target individuals into community-based services in lieu of hospital admission including earlier discharge to either inpatient rehabilitation services or the Care and Reablement Team.
- Support residents in care homes instead of admission to hospital alongside the Care and Reablement Team and care home staff
- To assess and provide interventions to individuals with complex disabling conditions and to optimise recovery following severe injuries including neurological and muscular skeletal specialist support both in the community and in hospital
- Improve the patients function and promote participation in society in the longer term for all people with conditions which give rise to disability.
- Support the earlier return of patients to Jersey who have required treatment off island (within the remit of this role)
- Treat and manage Chronic pain conditions
- Support people through the use and referral of assistive technologies
- Support neurologically impaired patients

Rapid Access Service

The Rapid Access Service (herein known as RAS) will undertake rapid assessment of patients who are referred by General Practitioners, HCS24, attend the Emergency Department or who have been admitted to the Emergency Assessment Unit (Jersey Care Model 2019). This will determine if they require secondary care or could be supported through one of the intermediate care services based in the community (NHS Benchmarking Network 2018).

The RAS will provide holistic, in-depth assessment of patients including multi complex conditions, frailty and cognitive impairments with access to diagnostics. In 2019, 338 patients attended the Emergency Department 4 or more times (Emergency Department attendance data 2019). The RAS would be able to identify and risk stratify these patients and through the Care Navigators in HCS 24 provide case management of these attendees.

Whenever possible patients within the Emergency Department will be seen within two hours of arrival in the department. It has been identified that one third of patients who attend the Emergency Department of an age group of 85+ can be discharged home the same day (Conroy and Taupin 2016). It is expected that all other patients who are referred will be provided an appointment time within 24 hours of referral via HCS24, 7 days a week.

In 2019 there were 8,888 attendances by patients aged 65+ made up of 5,484 individuals. Of these, 677 attendances were due to a fall, 1051 could have been seen by a primary care service and 2,124 had been involved in a non-road traffic collision accident. These attendances combined demonstrate a potential of 3,852 (43%) of patients who could have been seen in the RAS rather than ED. These cases have a high chance of being discharged home with supportive services. Though it must be accepted that 3,095 (35%) patients were admitted to hospital in 2019 and 1,945 patient's required ED treatment (all figures from ED Attendance Data 2019).

On average there are 24 ED attendances for 65+ per day, 47% of these are triaged as minor whilst 17% of minors were admitted indicating their need was social reason rather than medical condition. Between 08:00 and 20:00 there are an average of 19 attendances, half of these would be triaged to majors.

Of the 1,051 patients that could have been cared for by primary care professionals only 66 patients were referred for Rapid Response or Reablement.

Once the service has been embedded and knowledge has been further gained as to the potential of the RAS's development, it is expected that the Jersey Ambulance Service could make direct referrals to the RAS. This would be undertaken through strict protocols and is not expected to start before October 2021.

The RAS is a specialist team consisting of a Geriatrician and junior doctors, Clinical Nurse Specialist for older people with in-depth experience of Older People's care including falls and cogitative impairment/dementia, a physiotherapist and occupational therapist (HealthCare Improvement 2020). The team will work seven days a week 08:00-20:00, with limited service provision on bank holidays. Onward referral will be available to the Mental Health teams, Clinical Specialities and Social Care if required via HCS24.

Pharmacy support will be provided by Jersey General Hospital Monday – Friday and via the HCS24 Pharmacy at weekends and bank holidays. No further investment is required in the Jersey General Hospital Pharmacy Department as the Medicines Information Services will transfer to HCS24. The Pharmacy Department will provide advice, support and medicines optimisation for staff and patients on an ad-hoc requirement Monday- Friday 09:00-17:00. A telephone support service will be provided outside of these hours by the pharmacy service based within HCS24 (World Health Organisation 2003, Barnett 2013, Neiman et al 2017, Oswald 2018).

A Social Worker will be based in Jersey General Hospital, and they will support the team with any social care needs on an ad-hoc basis. They will be available to create new care plans or update existing ones. Any required investigations will be provided on site at Jersey General Hospital prior to discharge/transfer of care on to another service via HCS 24, or internally consultant to consultant.

Plemont Rehabilitation Unit

The Plemont in-patient facility will focus on rehabilitation and care for patients who cannot be cared for within their own home environment, and who do not require care within an acute hospital setting. The in-patient facility would provide both Step Up and Step-Down provision from/to the community and Jersey General Hospital. This may be due to the need to have 24 hours supervision or ongoing clinical need that does not require an acute bed stay (Garasen et al 2007, Olejaz et al 2012, Ministry of Health Singapore 2020). It is anticipated that patients will require less than 6 weeks rehabilitation and care from a multi professional team including advanced care practitioners, nursing, occupational and physio therapists, Rehabilitation Support Workers, and a Clinical Fellow. A Psychologist will be available to support the team from CART (Garasen et al 2007, Madaras and Hilton 2010, Olejaz et al 2012). To provide wrap-around care, an Acute Care Practitioner can support the team at night and at weekends, enable advanced clinical assessment and non-medical prescribing to take place due to the

shift in some patients' conditions (Hill 2019). To support patient interaction, hand eye coordination, cognition, and social wellbeing it is proposed to support the current staffing with an Activities Coordinator (Skills for Care 2020). This role will link with the occupational therapists to ensure that activities support cognition and hand eye coordination with the current patient caseload.

The Geriatricians will provide specialist advice to the ward to support the Clinical Fellow and Acute Care Practitioners (Garasen et al 2007, Jersey Care Model 2019). The Rehabilitation/Neurological Consultant is expected to provide input on a need-by-need basis and cover the geriatrician at times of sickness or annual leave, and vice-versa.

It is envisaged that the Jersey Ambulance Service would initially be able to make referrals to the Rapid Access Service, and in the future make direct referrals (following a protocol) for those patients that do not require an acute hospital attendance but require support and assessment of their needs who are not safe to be maintained at home. This may be a short stay of 1-2 days and the patient may be referred on to Social Care, CART or secondary care once fully assessed. This is not expected to be implemented until 2022.

Neuro rehabilitation (currently an average of 8 patients at any time) would continue to be provided for and this is normally a slower stream of rehabilitation. Through this initiative, as patient's progress in their abilities they too could be discharged under the CART to continue their rehabilitation at home when suitable and safe to do so, which is not currently available to them (Hill 2019, Guy's and St. Thomas' NHS Foundation Trust 2020, Community Neuro-rehab 2020, My Rehab Team 2020).

Investment in staff development and upskilling is required e.g. advanced clinical assessment skills, non-medical prescribing, rehabilitation and competencies across nursing and therapy interventions (McMahon and White 2016, Health and Community Services 2020).

Supportive services from charitable organisations and voluntary services

Jersey is reliant on its charitable and voluntary sector providers and it is recognised that for the full potential of the Intermediate Care services to be reached, engagement is required to support the implementation of services (Hayes 2018, Jersey Care Model 2019).

This will be done through multiple organisations to fulfil islander's needs and will engage with volunteers from Jersey Parishes (Jersey Care Model 2019). Emphasis will be for provision when appropriate to have seven days a week service. The following breakdown of services have been identified as supporting patients/service users during and post engagement with Intermediate Care services. These services will promote independence, dignity, socialisation, safety checks and improve overall service user experience and outcomes, with minimal outlay in costs to commission (Jersey Care Model 2019).

<u>Handyperson</u>

This service will undertake small tasks from changing a light bulb, setting up a TV, putting up a shelf/curtain rails, undertaking minor repairs/plumbing, locksmith, basic gardening, and minor redecorations to someone's home. This will allow an individual to be able to live at home

within a safe and appropriate environment. Admission to care homes should be delayed as the person's independence will be supported.

It is expected this service would be implemented in 2022.

Meals at home

Hot or ready to microwave meals provided to an individual's home who is unable to purchase or prepare their own meals, will improve diet quality, increase nutrient intake, reduce food insecurity and improve quality-of-life (Huichen and Ruopeng 2014).

This service has the potential to reduce care package reliance during the middle of the day (30-minute visit) for meal preparation 7 days a week, equivalent to £5,800 per year per person (Huichen and Ruopeng 2014). The current cost of a Meals on Wheels for 2 courses with daily delivery is £3.00 per day or an annual cost is £1,095 (Meals on Wheels Jersey 2020). This would **save £4,705 per person per year** in receipt of a midday care package call for food preparation. It is expected that a total saving per year on average by replacing meal preparation visits with Meals on Wheels would be **£282,000** in addition to those already receiving Meals on Wheels. It is estimated that for a 5 day a week service for 7 years, is equivalent to the average cost of 1 month in a care home (Huichen and Ruopeng 2014).

Currently the Meals on Wheels service is only available 4 days a week and food must be consumed on the same day. A frozen meals service is available through Age Concern but is only delivered 2 times a week and is known to have some limitations with capacity. This business case supports hot meal delivery being extended to 7 days a week.

Closer working of current service providers is required, and this work will commence in 2022 to implement an improved provision during 2023.

Shopping Service

One of the many things that's individuals who are house bound, or have limited walking ability, find difficult is to undertake their own food and domestic shopping. These individuals may be able to self-support in their own home otherwise, and this would prevent the need for services like Meals on Wheels or a care package for food preparation, thereby promoting dignity and independence of the person. While shopping services are available online some people do not like to or are unable to shop in this way. A shopping service could be provided through a voluntary organisation following the creation of a shopping list, and the volunteer undertaking the shopping. Alternatively, it may be possible for the volunteer to take an individual to the supermarket and assist them with the shopping i.e. use of wheelchair and modified shopping trolley.

It is expected this service will commence in 2021.

Call and Check

Regular visits are made to registered individuals by their postal worker (daily, weekly or ad hoc, as required). When they "Call&Check", the postal worker asks five short questions to find out how the service user is and if they need anything. Responses are sent for action via the Call&Check Engine on the postal worker's digital handset to the customer's approved contacts (family, carers, GP etc.) for action. The service helps reduce isolation and promotes wellbeing. The cost of each visit is £6.75 compared to a daily safety visit of £14 for 15 minutes. Call and Check further offer for a cost independent living packs, that service users can purchase.

As this is a current service, it is expected this service provision remains unchanged.

Night sitting

The aim of implementing a night sitting service alongside the CART is to support people for a short period of up to 2 nights consecutively, to be secure and supported overnight within their own home. The roles that may be required to be undertaken are to provide a supervisory and assistance provision to people who may require extra support at night. This could include, walking someone to the toilet, assisting the person with eating and drinking, assisting someone to change position (no lifting), assistance with medication administration and provide respite care for the main informal carer to allow them to have a period of rest from their day time activities.

Planning for this service has already commenced with an aim date of implementation of 2021.

Befriending

There are different types of befriending services available. For the purpose of this business case it will concentrate on services available within the individual person's own home. These services aim to provide support, companionship, creating a social link and provide an interest. Additionally, these services provide an opportunity for the service user to alert someone of any potential difficulties or health concerns who can then inform HCS24.

Telephone befriending has multiple opportunities from help and advice, befriending and group calls for discussion forums. Some service providers can be used from as little as once per week to 24 hours a day. The only requirement for this service is the ability to telephone into the dedicated phone number.

Befriending in the persons own home is another popular service. Volunteers visit an individual to provide friendship and activities like playing cards or reading a paper to the service user. Dependant on the voluntary organisation they may additionally provide light duties as shopping for a few items. Volunteers may accompany an individual to the cinema or to the bank. Normally in-home visits are on a weekly basis.

Planning for this service has already commenced with an aim date of implementation of 2021.

Cleaning

Care Packages may include cleaning services, or could be through a paid service that the individual commissions themselves. Voluntary organisations could be engaged with providing this service alongside befriending and safety type visits. This would reduce the reliance on care packages, promote socialisation and reduce multiple visits from different providers (Jersey Care Model 2019).

Laundry

There is an opportunity, for a small fee to individuals to cover washing detergent materials and electricity, to provide a laundry service to people in the community. This would be of support to those who have limited mobility or do not have their own washing machine. The service should be provided by a voluntary organisation through the collection, washing and ironing of appropriate laundry and returning it to the service user. The volunteer could additionally undertake light tasks for example putting the clothing away in wardrobes/draws and making

beds. This would reduce the reliance on care packages and promote socialisation (Jersey Care Model 2019).

This service may be incorporated into the Call and Check service or another provider in 2022.

Pet sitting

A concern for many people when they are taken ill or/and hospitalised or requiring care at home is who will look after their pet. The HCS24 database will hold a list of suitable volunteers who can "foster" an animal during this period or who if suitable can go in to feed and provide water for the animal. This may be in association with an animal welfare charity in Jersey. Additional services that may be of benefit to the service user is dog walking during their period of rehabilitation by the voluntary organisation.

This service we will aim to implement during 2022/23.

Information Technology and Support

There are many Non-Government Organisations in Jersey that have in house training on Information Technology (IT). HCS could work with one of the many organisations to develop individual training packages for people with limited IT skills and experience. This would support individuals in their own home to gain confidence in using IT to undertake online shopping, use of telecare and teleguidance and promote their independence and reduce their fears and anxieties of IT (Jersey Care Model 2019).

This service we will aim to implement during 2022/23.

Outreach Health Checks

Health Checks in the Parishes are already being undertaken in a limited form through some voluntary organisations, which can potentially be developed further to include risk stratification and early identification of people with deconditioning who may be supported through early interventions (Jersey Care Model 2019). It is expected that this service model would link in with HCS24 to ensure care coordination is maintained. Islanders who require onward referral would receive this via HCS24 preliminary back to their General Practitioner or alternative service provider including the intermediate care services.

It is expected that planning for this service would commence in 2023 with potential implementation in 2023/4.

Access to Mobility Checks

There are charitable organisations in Jersey that provide mobility aids such as electric scooters, wheelchairs, walking sticks, tri and quad walkers (including ones with seats) and zimmer frames. Equipment is available on a hire basis and some bariatric service users will be able to be catered for. This service may be of particular interest to service users who wish to access some equipment post intermediate care input to maintain their independence.

There are currently providers of this service on island and we will review if this needs further integration.

Conclusion

While the COVID-19 Pandemic has changed some timelines from the original strategy the programme of works remains on track for implementation over the next 3 years. COVID-19 has allowed some closer working between organisations and this in the last year has been encouraging to see. Additionally, implementation of the night nursing service early is proving a positive effect on cross boundary working. Evidence has further been supplied during the last year, to promote some of the initiatives within the strategy and this review paper which now reflects these changes.

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