Message # 13

Message Key:	0003157FBAF0DA6548C03A132FDECF7D8E4FE97F
From:	Council of Ministers [redacted]
To:	[redacted] Council of Ministers [redacted],Caroline Landon <C.Landon@health.gov.je>,Patrick Armstrong <P.Armstrong@health.gov.je>,Council of Ministers [redacted]
Cc:	Rowland Huelin <R.Huelin4@gov.je>, [redacted] Richard Buchanan <R.Buchanan2@gov.je>, Anuschka Muller <A.Muller@health.gov.je>, [redacted] Andrew Hacquoil <an.hacquoil@gov.je>, Susie Pinel <S.Pinel@gov.je>, Richard Bell <R.Bell@gov.je>, Tom Walker <T.Walker@gov.je>, [redacted] Russell Labey <R.Labey@gov.je>, "Paul Martin (CEO)" <Paul.Martin@gov.je>, [redacted] Carolyn Labey <C.Labey@gov.je>, John Le Fondré <J.LeF@gov.je>, Gregory Guida <G.Guida@gov.je>, Ian Gorst <I.Gorst@gov.je>, [redacted], John Young <J.Young@gov.je>, [redacted], Kevin Lewis <K.Lewis@gov.je>, Judith Martin <J.Martin3@gov.je>, Scott Wickenden <S.Wickenden@gov.je>, [redacted]
Subject:	Council of Ministers: P.115 Re-opening of Samares Ward
Date:	Tuesday, January 18, 2022 15:03 UTC

Please hold time this evening to discuss the Council of Ministers approach to P.115: Re-opening of Samares Ward

Message # 15

Message Key:	0003157FA39172F81A2CBB7D75952B8C6AB3FA92
From:	[redacted]
To:	Council of Ministers [redacted],Patrick Armstrong <P.Armstrong@health.gov.je>,Caroline Landon <C.Landon@health.gov.je>
Cc:	[redacted] Richard Bell <R.Bell@gov.je>, Susie Pinel <S.Pinel@gov.je>, Andrew Hacquoil <an.hacquoil@gov.je>, Tom Walker <T.Walker@gov.je>, [redacted] Richard Buchanan <R.Buchanan2@gov.je>, "Paul Martin (CEO)" <Paul.Martin@gov.je>, Russell Labey <R.Labey@gov.je>, Carolyn Labey <C.Labey@gov.je>, Gregory Guida <G.Guida@gov.je>, John Le Fondré <J.LeF@gov.je>, Ian Gorst <I.Gorst@gov.je>, [redacted] Rowland Huelin <R.Huelin4@gov.je>, [redacted] Kevin Lewis <K.Lewis@gov.je>, Judith Martin <J.Martin3@gov.je>, Scott Wickenden <S.Wickenden@gov.je>, [redacted]
Subject:	Council of Ministers: P.115 Re-opening of Samares Ward
Date:	Tuesday, January 18, 2022 15:24 UTC
Attachments:	Order of Business .pdf (16.8 KB), P.115-2021.pdf (334.1 KB), P.115-2021 Amd.pdf (426.6 KB), 20220117 MDCN letter to States Members.docx (84.7 KB)

Good afternoon Ministers,

Please see attached for ease the relevant lodged proposition and amendment for discussion this evening, along with the open letter written by the Medical Director to States Members.

Please also see attached the agenda for tonight's meeting.

Kind Regards,

[redacted]

[redacted] | Ministerial Support Unit

Government of Jersey
Ministerial Offices | Office of the Chief Executive
19-21 Broad Street | St Helier | Jersey | JE2 3RR

COUNCIL OF MINISTERS

Meeting to be held at 18:00 on Tuesday 18th January 2022
Teams only

18:00 (1 hour)	**B1**	**FORTHCOMING BUSINESS** Caroline Landon (Director General, HCS) & Patrick Armstrong (Medical Director, HCS) invited to attend.
19:00		**CLOSE OF MEETING**

Declarations of Conflicts of Interest

Where a discussion at the Council relates to a matter on which a Minister considers they may have a real or perceived conflict of interest, they should declare this in advance. The Chief Minister will also provide opportunity at the meeting for any such declarations, and if appropriate, the Minister will be asked to leave the meeting for the discussion. Attending officials should adopt the same approach. The advice of the Ministerial Office can be obtained on any such matter, or the Greffier of the States, and in doing so, they shall aim to mirror the approach adopted in Standing Orders and the Assembly to support consistency.

Note to support effective time management of each item:

To support an effective process, for each item the allocated time be should be divided approximately one third for officials presenting, and two thirds for Ministers discussing and determining. Within this, the role of officials is to advise, and so will be expected to contribute across the whole of the item, but this should not involve presentations taking up the substantial proportion of the time.

STATES OF JERSEY

RE-OPENING OF SAMARES WARD

Lodged au Greffe on 10th December 2021
by Senator S.W. Pallett
Earliest date for debate: 18th January 2021

STATES GREFFE

PROPOSITION

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

to request the Minister for Health and Social Services to:

(a) to reinstate the full suite of stroke and injury rehabilitation services facilities and beds at the earliest opportunity, but no later than 1st March 2022, either at Samarès Ward at Overdale or at another suitable location, as determined by the Minister; and

(b) ensure that a purpose-built rehabilitation unit offering the full suite of stroke and injury rehabilitation service facilities and beds formerly offered at Samarès Ward is delivered as part of the development of a new hospital campus at Overdale, or at another suitable location.

SENATOR S.W. PALLETT

REPORT

Introduction

In May 2020 the Samarès Ward rehabilitation centre was closed to offer a rehabilitation centre for recovering Covid patients coming off ventilators in the Nightingale Ward of the General Hospital. Later,[1] the reason given was that there is no piped oxygen available in the Samarès Ward. However, in the government's financial report for FY 2020 Samarès Ward's closure was shown as a £1.8 million HCS cost saving.

Consequently, the 17 patients in Samarès Ward were returned to their homes, or to nursing homes, or to complete their rehabilitation in Plémont Ward, which had been altered to accommodate up to six male and six female rehabilitation patients in two bays of this general medical ward. There was no gym, or specialised equipment available for the accompanying physiotherapy and occupational therapy that is an essential part of rehabilitation from serious injury, such as a stroke or major surgery affecting the ambulatory capabilities of a rehabilitating patients, although another bay in Plémont Ward has recently been converted into a form of temporary rehabilitation gym, as a development resulting from patient and family complaints about the standard of rehabilitation being offered.

Samarès Ward

The construction of the Rehabilitation Centre at Overdale (Samarès Ward) was completed in September 2004 at a cost of £ 6.8 million and underwent a refurbishment costing £815K that was finished in May 2016, only 5 years ago. Until it was closed, it was Jersey's only purpose-built facility and was designed to rehabilitate islanders suffering from severe strokes or severe injury. On completion of its refurbishment in 2016 it was able to provide the very latest in treatment practices and equipment for those who required specialist rehabilitation, particularly those from our older generation, having suffered a stroke. At the time of its closure Samarès Ward was compliant with the National Institute of Health and Care Excellence (NICE) guidelines for rehabilitation after critical illness guidelines[2].

Samarès Ward was and is a state-of-the-art, 27-bed rehabilitation centre delivering patients the privacy of their own rooms, support from nursing staff to assist and develop their mobility, specialist dietary meals from its own kitchen, specialist equipment to support the physiotherapy and occupational staff delivering the personal and individual rehabilitation needed for successful rehabilitation. It was also a calm and quiet place. Above all it operated as a community with rehabilitating patients supporting others through their journey with the aim of restoring the patient to a condition where he or she can support themselves in their own homes. At that stage the patient was discharged together with a follow-up rehabilitation programme.

Plémont Ward

All that was lost when Samarès Ward was closed, and Plémont Ward rehabilitation bays substituted. Today, despite Mr Sainsbury's comment to the H&SS Scrutiny Panel on 18th November 2021, this rehabilitation facility is certainly not in full compliance with

[1] In a statement by Mr Robert Sainsbury, at the time the Managing Director of the Hospital and Health Services to the Health & Social Services Scrutiny Panel on Thursday 18th November 2021.
[2] https://www.nice.org.uk/guidance/cg83

the updated NICE guidelines from 2017[3] Worse is the fact that a patient's time in Plémont Ward is restricted to a maximum of 13 weeks, irrespective of their recovery at that stage. The intention was that, in accordance with the doctrine of the Jersey Care Model[4], patients would be discharged with a rehabilitation plan involving ongoing physio and occupational therapy 'Closer to Home'. However, not only did the home-therapy service not materialise, but patients that need home-based nursing care have been discharged at a very high personal cost, in the worst case an annual £72,000 in care costs, plus a further £40,000 in modification costs to a home and the purchase of a second-hand mobility vehicle to move them to the Jersey Cheshire Home for hydrotherapy.

As a part of investigating the current rehabilitation situation a set of eight case studies relating to past and present rehabilitation in both Samarès Ward and today in Plémont Ward has been put together, from which four are quoted.

Case Study One

At a relatively young age, Mr. G collapsed with stroke like symptoms caused by a brain tumour while awaiting treatment at Southampton Hospital. He was stabilised in Southampton and returned to Jersey to start his physiotherapy and rehabilitation treatment with the expert staff in Samarès Ward. Without the skills and environment offered in Samarès Ward, G would not have been able to regain his strength or physical mobility essential to enjoy life as a young man. Mr. G felt that he had a small window of time to retrain his body to overcome his paralysis. The family have said that that he understood the value of the help he was receiving and worked long and hard with staff to achieve his goals. Samarès Ward was not a hospital environment; it was an environment where the person being cared for had gardens, private rooms, wide corridors enabling room to walk easily. It was light, airy, and equal to any gold standard rehabilitation centre in the UK. To quote the mother of Mr. G: "I would like to support by voicing my concerns, that every islander be it a son, daughter, mother, or father deserves better than what is on offer now"

Case Study Two

In late 2020 Mrs. X suffered a serious stroke and spent the following 13 weeks in the 'replacement', rehabilitation unit on Plémont Ward. The family do not believe that she has had the level of care that she would have received on Samarès Ward had it remained open. Mrs X has now been back home for 9 months and is still unable to walk or even stand up.

With some difficulty the family were able to put together a care package that was acceptable to authorities. They had to make alterations to their home and purchase a second-hand disability vehicle. After 3 weeks at home and with no physiotherapy provided by Health and Community Services, Mrs. X said that: "I really feel as if I have been neglected and I am worse now than the day I left hospital". Without considerable physiotherapy and occupational therapy, progress is not possible.

[3] https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwic9tmGzMD0AhXj4IUKHe4uBCgQFnoECAQQAQ&url=https%3A%2F%2Fwww.nice.org.uk%2Fguidance%2Fqs158%2Fresources%2Frehabilitation-after-critical-illness-in-adults-pdf-75545546693317&usg=AOvVaw2EvHmamoin91itiWS0ZnWT

[4] See P114/2020 report debated in the States Assembly on 3rd November 2020

After several weeks without the necessary support the husband of Mrs. X contacted the hospital who offered his wife one hour per week of physiotherapy at Overdale. When he asked how long this treatment would last, the response was: "we have no idea". After 6 weeks of one hour's treatment per week the following 3 weeks were cancelled at short notice because there was no physiotherapist available.

HCS then encouraged the family to organise private physiotherapy, which they did via two one-hour sessions per week. In addition, they made private arrangements for Mrs. X to have two half hour sessions in the hydropool at the Jersey Cheshire Home along with a massage and reflexology for one hour. Their home care package is costing the family £72K per year.

To add insult to injury, the costs of private physiotherapy, the Cheshire Home, massage, and reflexology are not considered to be, 'care costs' and therefore do not count towards the Long-Term Care threshold of £58K that needs to be met before the Long-Term Care payments begin. To quote the husband of Mrs X: "As far as we are concerned, every part of the care package that we have put in place is very much a care cost, as each one is essential for my wife's well-being and recovery and would have been available had she been in Samarès Ward."

Case Study Three

Mr. K suffered a significant stroke whilst in the operating theatre at the General Hospital in late 2019. When he awoke, he found that he was hooked up to several tubes and pipes and did not understand what was going on. He could barely move, speak, or eat. In his own words he has said that: "the hospital had neither the facilities nor the professionals to assist him" and that as he became more discouraged and depressed had it not been for the support of his wife and family, he would have simply lain in his hospital bed and vegetated.

He is clear that the day he was transferred to Samarès Ward at Overdale, was the day of his rebirth. From day one in a clean and private room equipped with a hoist, the medical and support staff were wonderful, and he was treated as an individual and encouraged and motivated in every possible way to make a start on rehabilitating himself. All the highly professional speech and occupational therapists together with the physiotherapist teams in the gym were exceptional and over time gave him the encouragement to meet his physical goals which included getting back on his feet and walking again. The staff harnessed his determination to achieve every step of the journey, including the catering staff who supported him in relearning his eating ability. Importantly, communal breakfast and lunch were social events where patients could share experiences and be supportive for those in a similar position to theirs.

To quote Mr. K: "I can never speak highly enough about the professional and dedicated team of medical and therapist staff in Samarès Ward. It was with disbelief that I learned that the world-class rehabilitation ward had been closed and that the incredible and dedicated team been disbanded. What a tragic loss to the people of Jersey – but **why** was this done? I have been forced to conclude that the closure of Samarès Ward was decided on purely economic grounds, as though the wellbeing of Jersey residents is counted in pounds and pence!"

Mr K. goes on to say that he is aware of people who have suffered strokes, accidents, and other issues since his own stay in Samarès who were left to languish in the General

Hospital, or in nursing homes without equipment, or facilities, or the dedicated health professionals that gave Mr K his life back. He finishes by saying that: "our short-sighted politicians will appreciate the importance of immediately restoring the rehabilitation centre somewhere on the island for the enormous benefit of unfortunate Jersey people who now, and in the future, need these vital rehabilitation services. They should be readily available for all who need them when they need them".

Case Study Four

This case sets out clearly the lack of rehabilitation currently available and what should be readily available for those who are severely ill of injured

In late September 2021 Mr H fell and broke his hip. He was admitted to the Beauport Ward in the General Hospital and was operated on successfully two days after admission. Unfortunately, he contracted an infection and was bed bound for a two of weeks, with no physiotherapy until the third week, apart from an occasional visit from physiotherapists who gradually got him out of bed and into a chair for short periods. At this stage he was unable to stand without help or walk. At weekends there was no physiotherapy so any small progress he made during the week was lost by Monday.

It had been hoped to move H to Plémont Ward where there would have been more physiotherapy. However, there were two more men in the same bay as H on Beauport Ward who were also waiting for beds in Plémont Ward and who were well enough medically, but not mobile enough to go home.

After four weeks Mr H had the added complication of a further infection caused of being on antibiotics for a long period. As a result, he was moved to a private room on Portelet Ward which made him for more isolated, as he is blind had no way to ask for help, instead having to wait for someone to come.

His wife said: "At the end of five weeks, we agreed he would discharge himself and I would care for him at home. They were not happy with this but, as they were unable to provide any rehabilitation, I felt we had no choice."

"In summary, it seems to me that there is no coherent rehabilitation service currently in the General Hospital, other than a few beds in Plémont Ward. Had Samarès Ward been open, with its 27 beds, I am sure that my husband would have been sent there to be rehabilitated. As it is, I am the reality of 'Closer to Home'. Fortunately, I can communicate, but I am really concerned that rehabilitation is so limited following the closure of Samarès Ward that there are people less fortunate than my husband who are simply being left to rot."

The Current Situation

The above statement from the wife of Mr. H says it all. I would also bring to Member's attention the letter to the Jersey Evening Post from Brigadier Bruce Willing CBE who set out some very pertinent questions about the Health Minister's letter to the JEP of the 30th October 2021 about the Jersey Care Model.

He asked why, given that the island has an ageing demographic, is it planned to provide only 12 rehabilitation beds in the new hospital and no specialist rehabilitation ward? He

asked why there is no hydrotherapy pool in the new hospital, why the organisation and delivery of rehabilitation at home is so poor and in some cases non–existent, and why do rehabilitation patients having to pay for their own post–hospital rehabilitation when the Director General of HCS made it clear in the Parish presentations on the JCM in November and December of 2019 that "where a service delivered in the hospital is passed into the community, the cost of that service will go from the hospital into the community"?

The response from Deputy Renouf has been met with derision by many in our local community. In his response the Minister stated: "it has been recognised that there has been a positive impact for patients of the changing model" yet he gave no evidence of such an impact and I and others suspect that it would be impossible to do so. Indeed, the oft made statement from HCS management of bed blocking in Samarès Ward as a reason for closing it is simply not true. There was one woman there for 42 weeks because no suitable alternative accommodation could be found for her. That is not 'bed blocking'; that is management incompetence.

The Our Hospital

In the UK NHS there are specialist rehabilitation hospitals and wards and of course there is an understandable emphasis on rehabilitation at home due to the distances involved. There is also a National Rehabilitation Centre in Nottingham. By comparison Jersey is a tiny island a hundred miles south of the nearest NHS rehabilitation facility. This was the reason the States Assembly had the wisdom and foresight to build and operate the Samarès Ward from 2004 onwards. Now, in the Our Hospital, we propose to replicate the current situation in Plémont Ward in the new hospital except this time they will be in single rooms and remote from any chance of assisting their rehabilitation in a Samarès Ward type of community. This is simply unacceptable.

Successful rehabilitation is dependent on a recognition of the extreme fatigue suffered by those recovering from a stroke or serious head injury, which in turn makes them very sensitive to coping with everyday noise, let alone those experienced routinely in a medical ward like Plémont Ward.

A further consideration, which seems currently to be missing in the management and leadership of HCS, is a recognition the unsuitability of some people's homes and the staff-intensive nature of a home service, as opposed to a centralised, expert, and consistent service where staff do not need to be spending time travelling to patients but are actually helping the patient recover in order that they can go home and survive.

It seems that the leadership in HCS too often believes that second best will do; I suggest that islanders are not prepared to accept second best when it comes to family members recovering from an accident or serious illness and want the best for their loved ones. If we accept this current situation, I believe we are shirking our responsibility to those who elected us. We need Samarès Ward now, an interim facility while the Our Hospital is being built (which looks unlikely to be before 2023) and a new Samarès Ward on the Overdale Our Hospital medical campus.

Is what is happening now in Plémont Ward and is planned for Our Hospital what we expected when we listened to and voted for the Jersey Care Model on 3rd November 2020?

Financial and manpower implications

Part (a): In terms of the financial implications of reinstating Samarès Ward, an estimate of £550,000 is suggested. This figure is based upon the difference between the running costs for Samarès Ward in 2019, its last full year of opening (£2,382,939) and the running costs of Plémont Ward from June 2020 (£2,227,811) which is £155,128, combined with an uplift of £200,000 for the running cost of Samarès Ward in 2020 and 2021 = £550,000. This figure includes staffing costs.

If the Minister determined that another location (such as Le Bas Centre, for example) could be suitably re-purposed or refurbished to accommodate a rehabilitation unit in place of Samarès Ward, this could incur costs to ensure the alternative site was fit for purpose. Equipment that had previously been in use on Samarès Ward could be transferred to this site to reduce additional expenditure.

Part (c): the cost of building Samarès Ward in 2004 was approximately £7,923,000. Updated in line with inflation, this produces a figure of £11.13million as an estimated capital cost of constructing a replacement rehabilitation facility.

STATES OF JERSEY

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

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

STATES GREFFE

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

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1 PAGE 2, PARAGRAPH (a) –

For the words 'to reinstate', substitute the words

"continue to restore and improve", and;

For the word 'but', substitute the words

"with a full progress report delivered"

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

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

2 PAGE 2, PARAGRAPH (b) –

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

"comprehensive", and;

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

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

"and the development of community services"

COUNCIL OF MINISTERS

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

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

to request the Minister for Health and Social Services to:

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

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

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

REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Feedback on Samarès Ward and Plémont Ward provision

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

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

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

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

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

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

Clinical Audit

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

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

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

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

Jersey Care Model

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

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

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

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

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

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

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

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

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

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

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

The provision of rehabilitation services

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

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

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

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

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

Some examples of rehabilitation include[6]:

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

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

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

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

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

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

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

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

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

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

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

- carry out a medication audit by the Chief Pharmacist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial and manpower implications

None as a consequence of this Amendment.

Health and Community Services
General Hospital
Peter Crill House, Gloucester Street
St Helier, Jersey, JE1 3QS

17th January 2022

To: All States Members

An Open Letter to States Members from Jersey's Medical Director and Chief Nurse

Dear States Members,

At the beginning of the pandemic the modelling suggested we could face a situation where we would need to accommodate 3-4 times as many patients as we had beds for, 10-20 times more patients requiring intensive care than we had capacity for and a need to provide oxygen to these patients at a rate that was massively in excess than we could have provided at that point.

The modelling also suggested that we might have had to face the death of 500 islanders in the first wave. Like our colleagues across the world, we had no direct experience to draw on or text-book to turn to in order to respond to this daunting situation.

Some of our responses are well documented such as the building of the Nightingale wing, however it is safe to say that the pandemic has and continues to turn the way we deliver healthcare on its head. Now nearly two years on we are still affected every day by the pandemic in some form or another whilst we continue to manage and deliver our usual services. During this time, we have continued to develop plans for 'Our Hospital' and have started to deliver changes within the remit of the Jersey Care Model. New services such as Overnight Community Care, HCS24, Help at Home, My mHealth, Night Sitting, Teleguidance, Telecare and many changes to our community therapy services are already beginning to have an impact and we expect other projects to gather pace over the coming year.

We are therefore so very proud and grateful to all our staff who have had to work through these exceptional times and in some instances, suboptimal healthcare environments. Delivering healthcare is challenging but never in the way it has been over the last 2 years. We know as a leadership team we have asked our staff on many occasions to step up above and beyond what is normally expected of them and we know that it is likely that we may have to again in the future. This is part of delivering healthcare whether in a clinical or support role and we do not underestimate the sacrifices our staff have made and the dedication they have shown during this particular time of need.

Many of our services have been affected by the changes we have had to make during the pandemic, our rehabilitation services being an example. These services were relocated early in the pandemic to the General Hospital and to the Community. More recently, we have been able to refocus on our usual business. We need to look at each service and work out how it should best be delivered within the context of the Jersey Care Model and the New Hospital. Two years can be a long time in healthcare. How and what we deliver always changes over time, sometimes rapidly, sometimes more slowly as we learn more about what works best for patients. The evidence base expands and we gain more knowledge.

There is no doubt having moved our rehabilitation services, there were aspects which were not being delivered to the standard we aspire to and that is why we have, are and will continue to make improvements to the service which were shared at the States Members' Briefing last Thursday 13th of January 2022. Whilst undoubtably some issues are related to the environment most relate to issues with communication and how services are being delivered, rather than simply the building. We are aware of some very emotive accounts from patients and families who feel let down and it is right and proper that we listen to those accounts and to you our elected representatives so we can understand how best to improve. It is our view and our clinical judgement, supported by having an overview of all our services and staff, that simply moving this service back to its original site at Overdale would be a mistake.

Apart from the fact that this service has already moved twice, once to the General Hospital and once within the General Hospital, it would have to be moved within months to accommodate the building of the new hospital, causing even more disruption to the service and staff. It would be a missed opportunity not to allow a broader conversation amongst staff and islanders to develop a modern and much broader rehabilitation offer, fit for the 21st Century.

Traditionally, the rehabilitation services at Samares ward have been focused on neurological conditions, particularly stroke and post injury, for example following fragility fractures affecting hips. Rehabilitation Services exist to help individuals regain physical, mental and cognitive abilities, lost as a result of disease, injury or treatment in order that individuals can return to normal, or as near normal as possible, life. They should broadly cover the areas of Prevention, Restoration, Support and Palliation and therefore need to be broad in their scope and application whilst being delivered in a wider range of locations and for a wider range of conditions than we have done so up until now. As with most clinical services, they are becoming more and more multidisciplinary requiring the input of increasingly sub-specialist knowledge and guidance. In the context of Jersey this would be difficult to deliver in a separate and stand-alone unit.

We are in full agreement that our rehabilitation services need to be considered and reviewed, so that we provide the best for all islanders for all conditions. As proposition P115 is currently written, it would force us to look at only one approach, a specialised stand-alone unit. We do not believe this will deliver the quality and scope of services islanders deserve. We believe that there needs to be a much broader discussion involving all clinicians (therapists, doctors, nurses) who deliver rehabilitation services, considering the voices of all patients' groups and not just a few subsets before we make any firm decisions about the future. Basing clinical decisions on testament alone, no matter how emotive that testament is does not facilitate safe clinical decision making.

This proposition, along with the threat of a further proposition to reverse our decision to restrict visiting in the hospital causes us great concern that clinical voices may be ignored. The decision to restrict visiting was not taken lightly. We, as the responsible and accountable officers for clinical safety based our decision to restrict visiting on advice provided to us by our Infection Prevention and Control team, along with advice from our Deputy Medical Officer for Health in his role as Director for Infection Prevention and Control. This advice followed strong evidence of COVID-19 infection being transmitted to patients in our care by visitors. We have put in place systems which will consider the balance of harm on those wards where the restrictions have been implemented. These are the wards accommodating our most vulnerable patients.

Where we are providing end of life care we will of course facilitate visiting as best we can. Where our patients may come to significant harm for whatever reason by denying visiting, we will do our best to facilitate exemptions. We continue to look for ways in which we could implement a testing regime that would facilitate safer visiting but so far have not seen or found a suggestion that we believe is safe enough or that would avoid impacting and distracting our staff whilst they deliver the care they are there to provide. We will continue to review this decision on an at least weekly basis and given the falling numbers of COVID-19 cases on the island do not foresee this measure being in place for long.

To be forced to reverse any clinical decision taken to protect and keep our patients safe or which impacts our ability to provide the highest quality care we can is in our opinion both dangerous and unsafe.

This coming week you have within your power to take significant decisions affecting how we deliver health care in Jersey. We would implore you to think long and hard about those decisions as they will have an impact far beyond the site where a service is delivered or how and when people visit the hospital. We as public servants must listen to and seek out views from you the people's representatives in addition to our patients, the people we serve. We have a duty to do this and it is our job to come up with solutions to those concerns. We are, along with all our colleagues, the experts in this area. We need to be wary of the danger of non-expert advice, no matter how well intentioned, driving decision making which in turn can lead to those decisions being clinically unsafe.

Thank you for taking time to consider our views and as always, we are happy to talk to any member in relation to the services we provide. We very much hope we can continue to work collaboratively and constructively in the future in the way that we have done so often in the past.

Yours sincerely

Patrick Armstrong MBE
Medical Director

Rose Naylor
Chief Nurse