Government of JERSEY

Update on the Palliative and End of Life Care Strategy for Adults in Jersey 2023-26 Action Plan

JULY 2024

Introduction

This document contains an update against the action plan published in the 'Palliative and End of Life Care Strategy for Adults in Jersey 2023-26.' Publication of the update was a commitment by the Minister for Health and Social Services following an Assisted Dying review panel Scrutiny recommendation

Future updates will be published on a quarterly basis.

July 2024

Progress against strategic Plan

Complete

Not started

Ongoing delivery

	2024	2025	2026	Update	Next steps
Outcome 1 - People in Jersey who need palliative and / or end of life care will be seen and treated as individuals who are encouraged to make and share advance care plans and to be involved in decision regarding their care					
Continue the development of Gold Standards Framework across health care professionals in the community and hospital				• A new education programme is being launched in September which will promote use of the Gold Standards Framework. Further detail on this to be published in the next quarterly update.	• ongoing
Develop a central, integrated IT system to facilitate the sharing of advance care plans and Gold Standards Framework recording and collate outcome performance data				• On hold. • Representatives of the partnership have contributed to updating the DNACPR (do not attempt cardiopulmonary resuscitation) policy in HCS which incorporates the sharing of resuscitation decisions with care providers.	• IT requirements for palliative and end of life care to be explored in 2025.
Outcome 2 – People in Jersey who need palliative and / or end of life care will have their needs and conditions recognised quickly and be given fair access to services regardless of their background and characteristics					
Ensure all interested parties who represent patients requiring palliative care have a voice on the End of Life Care Partnership				• Patient representatives are members of the End of Life Care Partnership Group and working groups. • Wide breadth of representation across health and community partners including various charities.	• Patient representatives from the HCS Patient and User Public Engagement Panel are members of the End of Life Care Partnership. Patient views are also expressed through other members.
Design and build a robust 24/7 model of palliative care that is accessible to, and meets the needs of, patients and families at a generalist and specialist level (see Figure 1 of the Strategy for definition of generalist and specialist)				• Plans developed for expanding specialist and generalist services. Further detail on this to be published in the next quarterly update. • Co-design workshops have taken place involving End of Life Care Partnership	• Q4 2024 implementation of first phase. • 2025 next stage of development addressing: ○ overnight care, ○ access to equipment ○ financial support.

				organisations with advice from a UK subject matter expert. • First phase to introduce new community nursing roles to support earlier identification of people at the end of life and advanced care planning. Further detail on this to be published in the next quarterly update.	
Educate / develop the workforce / volunteers and increase public awareness in relation to palliative care				• Proposals for an education programme have been approved. The education programme will be widely advertised and promoted to the workforce and the public once the details have been confirmed. • 3 key areas (symptom management, advanced care planning and communication) have been prioritised for initial roll out (phase 1). • Courses will be delivered by a partnership of HCS and Jersey Hospice education teams.	• Q3 2024 Implementation • 2025 review of phase 1 and training needs analysis • 2026 review and amend programme based on updated analysis of training needs (see Outcome 5).
Arrange access to emergency funding for end of life care and to responsive care in the community at end of life either from the Long Term Care Fund or alternative sources				• A cross government working group (involving Health and Community Services and Customer and Local Services) has been established to focus on this.	• Q3 2024 cross government working group meeting scheduled
Collate Public Health data across all healthcare settings using a collaborative approach to IT systems and robust analysis with benchmarking				• On hold	• IT requirements for palliative and end of life care to be explored in 2025.
Outcome 3 – People in Jersey who need palliative and / or end of life care will be supported to live well as long as possible taking account of their expressed wishes and maximising their comfort and wellbeing					
Develop standard operating procedures across all partnership providers				• Standard operating procedures are currently being drafted by partnership providers.	• 2024/5 Implementation

Improve and build on these community services (see page 33 of the Strategy) and initiatives as we face an ageing demographic and therefore an increased need for these services				• Current services have been reviewed and gaps identified. • Improvements to address the gaps will be made through service changes to be implemented at the end of 2024. Further detail on this to be published in the next quarterly update.	• Ongoing improvement process. • Changes to be implemented at the end of 2024 • Changes to be reviewed at the end of 2025 by the End of Life Care Partnership through assessment of performance measures which will be set for service providers. These performance measures will be linked to achievement of the Strategy outcomes. • 2026 further improvements made as necessary.
Differentiate between specialist / generalist provision to ensure the most cost-effective model is designed with patient preferences built in				• Completed as part of the current service review. • Service specifications are clear on the role of specialist and generalist provision. • The service review and service changes have been jointly developed and agreed by the End of Life Care Partnership, including patients, and have been informed by independent peer review and UK benchmarking information.	• Changes to be implemented at the end of 2024 • Changes to be reviewed at the end of 2025 by the End of Life Care Partnership through assessment of performance measures which will be set for service providers. These performance measures will be linked to achievement of the Strategy outcomes. • 2026 further improvements made as necessary.
Ensure hospital referrals to community services are completed in a timely manner				• Ongoing progress. • The standard operating procedures currently being drafted, and the new education programme will support this action.	• Ongoing
Improve communication across all areas of the health system				• Built into education programme	• Ongoing continuous improvement process.

Develop a transfer of care process				• Standard operating procedures are currently being drafted by partnership providers.	• Q4 2024 implementation
Develop an educational focus for GPs and care homes around advance care planning and end of life care to seek to and prevent avoidable admission to hospital				• Built into education programme.	• Ongoing continuous improvement process.
Outcome 4 – People in Jersey who need palliative and / or end of life care will receive care that is well coordinated					
Ensure the right information is available at the right time to minimise duplication through the development of an integrated IT system across the whole health system in Jersey				• On hold	• IT requirements for palliative and end of life care to be explored in 2025.
Expand / realign hospital discharge processes to present the opportunity to enable more people to transfer from inpatient settings to their preferred place of care with the care they require to support them as appropriate				• Specialist palliative care team will retain responsibility for Gold Standards Framework and will provide in reach to inpatient areas to facilitate discharge.	
Ensure people receive the right care, at the right time, in the place consistent with their wishes and preferences avoiding the disruption of non-value-added hospital admissions				• Ongoing. • The service changes (see Outcome 3) will support advanced care planning and ensure that people receive support earlier.	• Ongoing continuous improvement process.
Develop a single point of access for referrals to help ensure patients have timely access to the most appropriate care in the most efficient way possible				• Addressed through the service changes (see Outcome 3). Further detail on this to be published in the next quarterly update.	• 2025 Implementation
Develop an agreed pathway for access to anticipatory medicines / equipment out of hours				• Initial scoping work completed to identify what the issues are and potential solutions.	• 2025 next stage of development which will address overnight care, access to equipment and financial support.
Address care needs to support people to remain in their own home				• Initial scoping work completed to identify what the issues are and potential solutions.	• 2025 next stage of development which will address overnight care, access to equipment and financial support.

Outcome 5 - People in Jersey who need palliative and/or end of life care will have their care provided by people who are well trained to do so and are receiving ongoing training to maintain their skills and competencies					
Undertake a needs analysis of the health and care workforce in terms of their knowledge and competence in palliative and end of life care				• Initial priorities for education have been identified through incident and mortality reviews.	• A more comprehensive training needs analysis will be conducted by the End of Life Education Forum through 2025. The End of Life Education Forum is a partnership between Jersey Hospice Care and the Health and Community Services Post Graduate Education Centre to oversee and deliver the new education programme.
Develop an island wide training plan and competency framework to support the entire workforce				• Initial training plan developed.	• Q3 2024 Implementation • 2025 competency framework developed
Develop consistent measurable standards and robust evaluation methods for quality education and training and ensure it is delivered by skilled and qualified providers				• Key performance indicators identified within education plan. • A variety of methods to evaluate the quality of training identified, including approved assessment tools and trainee surveys. • Approved providers, appropriately skilled and qualified identified.	The quality of the education and training to be delivered will be reviewed on a quarterly basis.
Ensure all key staff are able, encouraged and supported to attend training programmes around core principles of palliative and end of life care				• There is agreement across the organisations involved in the End of Life Care Partnership Group that training is a priority, and a commitment to ensure staff attend.	• ongoing
Adopt a system wide approach to the provision of palliative and end of life education. This should include all training providers across the island				• The education service to be implemented is available to all across the island without charge.	• ongoing

Extend membership of the Morbidity and Mortality Meetings to encourage island-wide attendance				• Not started	Once the Morbidity and Mortality meetings re-commence in August 2024 membership will be extended.
Outcome 6 - People in Jersey who need palliative and/or end of life care will be part of communities that talk about death and dying and that are ready, willing and able to provide the support needed					
Ensure everybody's voice is heard through engagement on palliative and end of life care				• Wide range of stakeholders have been engaged at all stages of the strategy development and implementation to date, including patients/families/public, health and care organisations, third sector organisations, funeral directors, spiritual representatives, government departments	• ongoing
Develop a proactive approach and plan to galvanise support and spread the message across our communities				• Not started	• Q4 2024 establish workstream
Develop An island-wide 'Carer Strategy' to ensure we address and meet the needs of these members of our community				• Not started	• Q4 2024 establish workstream
Undertake a carer assessment in order to establish need				• Not started	• Q4 2024 establish workstream
Combine all Third Sector elements to develop a robust, multifaceted model of care delivery which is supported by members of our community who are then reinforcing the need, spreading the message and having the conversations				• Working groups to design service changes such as the education programme and expansion of community nursing services have included third sector organisations.	• The development of a system wide care model is ongoing. • Communication plan to be developed and mobilised in 2025.