Government of JERSEY

Progress Report

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

QUARTER 4, JANUARY 2025

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.

January 2025

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				• JHC is in the process of becoming an GSF accredited organisation.	• Within the planning for the new Living Well Team and their standard operating procedure, GSF will be a core requirement of their roles in terms of advance care planning and treatment escalation. • GSF meetings are planned to take place within primary care to discuss and document patients' needs and wishes.
Develop a central, integrated IT system to facilitate the sharing of advance care plans and Gold Standards Framework recording and collate outcome performance data				• The use of the EMIS system to host an electronic palliative care register is currently being investigated.	• Further discussions with EMIS experts.
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				• Complete	• Complete
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)				• The contract for additional community nurses has been signed, and mobilisation of the new service has commenced (the Living Well Team).	• Recruitment of staff to commence before the end of January 2025 • Telephone support service to commence by the end of March 2025

Educate / develop the workforce / volunteers and increase public awareness in relation to palliative care				• Contracts have been signed for the education service • The Palliative and End of Life Care Education Forum has been meeting regularly • 1 of the 2 nurse educator posts has been recruited to • Delivery of training sessions for doctors has commenced	• Recruitment of second nurse educator post to commence before the end of January 2025 • Development of course materials
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 meeting is planned for January 2025 to discuss the challenges around Long Term Care funding and agree a way forward that will benefit palliative and end of life care patients.	• Action plan to be developed following January meeting
Collate Public Health data across all healthcare settings using a collaborative approach to IT systems and robust analysis with benchmarking				• Not started	• 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 developed for the Living Well Service and reviewed for the Specialist Palliative Care Service.	• Implementation of procedures
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				• It is anticipated that by the development of the Living Well Service, which will operate 7 days a week 8-8 and the SPCT out of hours telephone on call service, alongside the continued joint working with other community healthcare professionals and teams, that the provision of generalist and specialist palliative care services will meet the needs of islanders now and in the future.	• 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				• Complete	• Complete
Ensure hospital referrals to community services are completed in a timely manner				• The purpose of the introduction of the Living Well Service which will support with expediting rapid discharges from the hospital and the introduction of the Education Service which will support with the knowledge and competence of the hospital workforce around palliative care is to ensure hospital referrals to the community services are completed in a timely manner. Both services should be fully operational by end of Q2 2025.	• Ongoing
Improve communication across all areas of the health system				• Advanced communication skills training is a core part of the education plan across the hospital and community for all health care professionals when having difficult conversations with patients and their families. The next course is being held in February and is fully subscribed. • The intention of the integrated IT platform and palliative care register is to improve the exchange of patient information between health care professionals across the system thereby improving communication around patient wishes and preferences.	• Ongoing continuous improvement process.
Develop a transfer of care process				• The transfer of care policy between hospital and JHC inpatient unit has recently been updated and is now out for consultation with relevant stakeholders.	• Adoption of policy

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				• Contracts for education service have been signed • Delivery of training to doctors has commenced	• 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				• Not started	• 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				• Rapid discharge policy from hospital in place • Updated transfer of care policy from hospital to JHC inpatient unit- currently out for consultation.	• Ongoing
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				• Single point of referral for all Jersey Hospice Care clinical community services in development to include Living Well service.	• Ongoing
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 Care Jersey Faculty of Health Education 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.	• Education programme to be rolled out • 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				• Contracts for education service have been signed • Work has commenced on development of the education programme	• 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	• To look at what is the best way to review practice, learn from experience and improve outcomes for patients and their families.

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				• Jersey Hospice Care has a public awareness programme planned for Q1 to update on progress on the strategy. This will help inform public on new services as well as other developments.	• Ongoing
Develop a proactive approach and plan to galvanise support and spread the message across our communities				• The EOLP has decided to hold an event during Dying Matters week to update on the progress made on the strategy implementation to date • Jersey Hospice Care will attend the Jersey World Cancer Day event in February	• Working group to be set up to plan a calendar of events across EOLP members for 2025
Develop an island-wide 'Carer Strategy' to ensure we address and meet the needs of these members of our community				• Not started	• Q1 2025 establish workstream
Undertake a carer assessment in order to establish need				• Not started	• Q1 2025 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				• JHC launched a Compassionate Neighbours Service in September 2024. It offers a reliable relationship to individuals over 18 who have a life limiting illness. It also extends to family and carers. To date, twenty-two volunteers and patients have been matched successfully.	• The development of a system wide care model is ongoing. •

Palliative and End of Life Care Strategy Success Criteria

	Strategy measure	Proxy measure	Strategy baseline measure	2024 actual performance												Comments
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1	75% of patients with an expected death will have documented advance care planning which includes a treatment escalation plan and DNACPR record	75% of patients known to Jersey Hospice Care will have a documented advance care plan discussion	53%	95%	100%	100%	100%	100%	100%	100%	100%	100%				
2	100% of health and care professionals working across community, hospital and Hospice will have access to educational sessions around palliative care including GSF and end of life care on a monthly basis															Education programme to be rolled out in 2025
3	More patients will receive effective care, treatment and symptom control in the community. This will be demonstrated by ensuring that, for those patients who have a PPC within the community and an expected death, less than 30% experience an unplanned hospital admission in the last 90 days of life															267 people had an unplanned hospital admission in the last 90 days of life in 2021. The equivalent figure for 2023 was 224. Data for 2024 incomplete.
4	Services will be set up to enable more patients to achieve their wishes set put in their advance care plans. 75% of patients will achieve their preferred place of death	75% patients known to Jersey Hospice Care will achieve their preferred place of death	85%	88%	84%	67%	80%	79%	82%	82%	95%	90%				
5	75% of patients will achieve their preferred place of care	75% of patients known to Jersey Hospice Care will achieve their preferred place of care	79%	71%	61%	88%	94%	85%	76%	92%	96%	93%				
6	100% of carers will be supported throughout the palliative care experience of their loved one	% carers responding to experience survey expressing satisfaction with services provided by Jersey Hospice Care		100%	100%	100%	100%	100%	100%	100%	100%	100%				