**WRITTEN QUESTION TO THE MINISTER FOR HEALTH AND SOCIAL SERVICES
BY DEPUTY G.J. TRUSCOTT OF ST. BRELADE
ANSWER TO BE TABLED ON TUESDAY 18TH APRIL 2017**

Question

Will the Minister list the services that will need to be transferred to the community and primary care sectors to allow the new Hospital to function effectively within its proposed capacity?

Furthermore, given the anticipated increase over the next 20 years in the number of people aged over 65, will the Minister explain how he can be confident that the proposed expansion of community and primary care facilities will be delivered on time and will be sufficient to meet any extra demand; and can he provide any indication of the annual future cost of providing these services?

Answer

The Acute Service Strategy is a key aspect of P.82/2012 'A New Way Forward for Health and Social Care'. It is clear that hospital services will be delivered on-Island where it is safe to do so. This requires the hospital to be optimally staffed, in order to provide a range of emergency and elective services. As part of the health and social care transformation work (P.82), the services that are delivered from within the hospital building are being redesigned as part of the planning for the future hospital, to ensure the hospital is the right size and to further improve pathways.

There is, and will always be, a difference between the service provided in the hospital and the services provided in a person's own home. The service changes across health and social care relate to pathways, and aim to ensure people can remain in their own homes for as long as possible – which is what Islanders told us they wanted in the P.82 consultation.. This helps to ensure the hospital focuses on the services that should be delivered in hospital and requires an increase in some community and primary care services, as it will be achieved through:

- Admission avoidance – doing all we can so that patients don't need to come to hospital in the first place
- Admission prevention – when Islanders do need to come to hospital, making early decisions and providing treatments in ways that reduce the numbers needing to be admitted
- Early discharge – ensuring that when patients have been admitted to hospital, their care is as safe and clinically effective as possible so that they can return home or to care outside hospital safely at the earliest opportunity

Admission avoidance includes initiatives such as the Care Hub, GPs accessing step-up beds rather than hospital, working with residential and nursing homes to manage fluctuations in their residents' health without sending them to hospital, improving outputs from the falls clinic and memory clinic, rolling out the Gold Standards Framework, managing long-term conditions in the home i.e. Community Respiratory team etc. Most of these services are delivered in Community and Primary Care settings.

Admission prevention includes an Ambulatory Emergency Care model, extended nursing roles in the Emergency Department, Consultant level assessment in the Emergency Assessment Unit, 'hot clinics', telephone advice for GPs and community specialist nurses, and the Rapid Response and Reablement Team and step-up beds. Most of these are services provided within the Hospital (other than Rapid Response and Reablement and step-up care).

Early discharge/transfer initiatives include implementation of the Gold Standards Framework, Rapid Response and Reablement Team, improved access to diagnostics, improved social worker provision, improved acute rehabilitation at Westmount, enhanced recovery programmes, increased day case surgery

rates, introduction of new treatments and techniques etc. Some of these services, such as step-down care, are provided by Community and /or Primary Care providers.

The proposed expansion of community and primary care services is described in the Outline Business Case. The priority investments were identified with a range of stakeholders, based on the identified gaps in service provision and international best practice in making an impact on reducing hospital demand. The Future Hospital project is refreshing its demand and capacity modelling; this will be used to inform the refresh of the Out of Hospital priorities and to target investment into services which will be able to meet the increasing demands into the future.

The ongoing planning and implementation is project managed by the Deputy Director of System Redesign and Delivery, supported by a Project Officer. The programme is overseen by a cross-system Implementation Group. The programme remains under review, with priorities being considered regularly.

In Phase 1 (2013 – 15), £3.0m has been invested recurrently in Out of Hospital services. In MTFP 2 (2016 and 2017), the additional investment totals £0.7m recurrently. Recurrent funding of £2.1m has been indicated for 2018 and 2019; this is subject to annual approval by the Treasury Minister. Funding for 2020 onwards will be identified in due course.

The KPMG projections indicated that the older adult population was set to increase by 35% between 2010 and 2020, 75% by 2020 and 95% by 2030. This, along with the need to ensure the future hospital is the appropriate size, means that investment in Community and Primary Care services must continue; both the services being provided and the ways in which the services are organised must remain under review in order to ensure the services achieve their aims of helping people remain healthy in their own homes for as long as possible.