STATES OF JERSEY

HEALTH AND SOCIAL SERVICES: ACUTE SERVICE STRATEGY 2015 – 2024

Presented to the States on 21st July 2016
by the Minister for Health and Social Services

STATES GREFFE

2016 R.80

States of Jersey

Acute Service Strategy 2015-2024

Safe, Sustainable, Affordable

“Patients and their families at the heart of all we do”

Contents

Foreword from the Minister for Health and Social Services

Islanders are rightly proud of their General Hospital. Staff work extremely hard to provide the very best care they can for patients and their families. However, the Hospital is facing many challenges.

To continue delivering hospital services that are safe, sustainable and affordable for all requires the fabric of the hospital itself to be renewed and replaced.

In time, we will have a new Future Hospital of which I am sure we will be equally proud, but in the meantime we need to ensure that the high standards you expect from the services we currently provide are maintained.

While the Future Hospital will provide a modern building we must not, and cannot, wait until it is built to begin to make the changes in the way we provide the services that are essential to meet the acute healthcare needs of Islanders. That work needs to start now.

Therefore I am pleased to see in this Acute Service Strategy a recognition that a successful General Hospital depends on the delivery of equally successful services provided outside the Hospital (by Community and Social Services and Family Nursing & Home Care, for example) and in Primary Care (by colleagues including GPs, dentists, pharmacists and optometrists). For many in our increasingly elderly population, much of the care we currently provide in the General Hospital can be more effectively, and just as safely, provided either in their own homes or by community-based healthcare staff.

It is about providing the right care, at the right time, in the right place.

There are three key elements to the Acute Service Strategy for the hospital:

1. Admission avoidance – doing all we can so that patients don't need to come to Hospital in the first place
2. Admission prevention – when Islanders do need to come to hospital, making early decisions and providing treatments in ways that reduce the number needing to be admitted
3. Early discharge – when Islanders do need to be admitted making sure their care is as safe and clinically effective as possible, so that they are able to return home or to care outside hospital earlier than they do currently

These elements of the Strategy will benefit Islanders of all ages. They are based on removing steps that add little or no value to their pathways of care – whether they are for emergency care following an accident, planned care for an operation, a childhood illness, having a baby or the care people need as they get older.

Much of this Strategy describes how acute services will be provided in a safer and more clinically effective way in the coming years. Of equal importance, it sets out our commitment to patients and their families so that their experience of these services continues at all times to be compassionate and respectful.

We are setting a direction of travel for the next ten years based on our current understanding of healthcare. In that time, much will happen in healthcare that we cannot predict. However, the Strategy is written in such a way that we will be able to respond to these changes when they happen.

Whatever the future holds for acute care in Jersey, you have our commitment – as this Strategy makes clear – to keep patients and their families at the heart of all we do.

Senator Andrew Green MBE: Minister for Health and Social Services
Deputy Peter McLinton: Assistant Minister for Health and Social Services
Constable John Refault: Assistant Minister for Health and Social Services

Summary

Acute Service Strategy – Safe, Sustainable and Affordable

The term 'acute care' generally means care provided in hospital by hospital-based staff. This care is, however, best provided in partnership with General Practitioners ('primary care') and other colleagues such as district nurses, who provide 'out of hospital care'. A 'pathway of care' summarises how each of these members of the healthcare team make their contribution to the care of patients.

An Acute Service Strategy sets out a high level 'direction of travel' for Jersey General Hospital and how it will meet the challenges it faces in the coming years. In broad terms these are:

1. An ageing population that creates increasing demand for hospital care
2. A rising expectation that hospital treatment will lead to better clinical outcomes, safer care and a better patient experience
3. An increasing ability of medicine to provide these treatments
4. The increasing cost of hospital care at a time of financial challenge

This Acute Service Strategy describes why we need to change the way the General Hospital will work in the future if services are to remain safe, sustainable and affordable on our Island. It acknowledges both the opportunities and limitations in providing acute hospital care on an Island with a relatively small population.

Chief among the opportunities is the strength of our integrated health and social care system. The Strategy sets out how we must build upon this in order to provide much more care which can be delivered safely in non-hospital settings. The Vision and Strategic Principles set out in the document summarise how we can do this.

The current General Hospital has served the Island well for many years, however, it has grown in a piecemeal way. We have an opportunity with the Future Hospital to plan services and create new ways of working that will help us meet the challenges we face. The Strategic Objectives describe how services will be provided in a different way. Of course a new building does not provide all the answers. The challenges facing the General Hospital would still exist even if we were not building a new hospital. For this reason the Strategy sets out a New Model of Care which describes how we need to organise services in future years. All aspects of this Model of Care are tried and tested in other jurisdictions.

This Strategy has been developed with the help of many clinical and non-clinical colleagues. It is not without risk and these are set out in the document. Colleagues within the Hospital have developed service plans to indicate how each service can be provided to meet future challenges.

Any Acute Service Strategy sets out our best understanding of the future at a particular point in time. Services may need to change in response to this uncertain future in ways that cannot be predicted today. Whatever the future holds, this Strategy ensures that patients and their families will always remain at the heart of all we do.

Introduction

The investment being made in the Future Hospital is an enabler for the strategy set out in P82/2012 (arising from the White Paper – Caring for Each Other, Caring for Ourselves). It is a key enabler for the wholesale redesign of acute and community health services on the Island. This Acute Service Strategy would be required even in the absence of a Future Hospital development. The demographic challenges set out in P82/2012, the increase in expectations of Islanders about what they should be able to expect from their Hospital, the increase in the range of what is and will become possible in medicine, the challenges in providing a skilled workforce in a small and geographically isolated location and the inevitable concerns about how this will be financed would all need addressing regardless of the provision of a Future Hospital facility.

Many of the changes required in the way we currently provide acute services will take many years to complete. It is important therefore that the clinicians and managers responsible for these services take ownership of a change process which needs to take place.

The Future Hospital development is therefore part of the Strategy in that it provides a suitable end point – planned to be fully operational within ten years. It also provides a catalyst for much of the modernisation needed in the coming years. Demand and capacity modelling undertaken as part of the pre-feasibility work for the Future Hospital indicates that unless health care on the Island is re-designed in the ways set out in P82/2012 (particularly with respect to transferring activity from secondary to primary and community care settings and improving the efficiency of both acute and community care) there will be a requirement to build a c. 400-bed Hospital and not the c.300-bed Hospital that is thought to be safe, sustainable and affordable.

In this way, the Future Hospital becomes less about how we develop a building and more about how, from 2015, we develop the services so that the eventual building is both appropriate to house the services for the future and is of the right size and with the right facilities to provide these services safely, sustainably and affordably. Such service redesign will only work successfully through the successful integration of secondary, primary, mental health and out of hospital services, including those provided by voluntary and community organisations.

How this document was developed

This document forms a basis for discussion about the future direction of our core acute service. It sets out ways in which we can build on the many strengths of existing services. It also describes how we might re-design services so that they are better able to meet the challenges of the future. This implies no criticism of existing services. The way we provide services today in most cases has served the Island well. The standard of acute care on the Island is rightly a source of great pride and one which colleagues in the NHS would envy. However these high standards are at risk of being progressively undermined unless services are redesigned to meet *future* needs. Such processes can be unsettling in that they ask us to consider changing from the comforting certainties of the present (how we work, where we work, what our work is) to the uncertainties of the future (we will have to work differently and possibly in other locations).

This strategy is, therefore, informed by good practice illustrations of how we currently provide services and how we might build on them. It also draws on good practice nationally and internationally. However, the main source of information derives from a series of conversations in early 2014 with Lead Clinicians of current hospital services, senior managers of both hospital and non-hospital services and patient groups (see Appendix 2) . It has been a deliberate intention to develop the strategy by drawing on the thoughts of those who 'put hands on patients'. If we are to truly develop clinically-led services then clinical leaders need to have the opportunity to set out the type of services they wish to lead.

Where themes from these conversations recurred they are included as 'strategic intents'. The document does not set out how such 'strategic intents' would be operationalised in each service (with the necessary changes to in-patient pathways, development of workforce roles, investment etc.). Consultants, for example, indicated a need to redesign out-patients and other ambulatory care processes to create more of a 'one stop shop' for patients. In doing so they recognised that other services would need to be redesigned and provided in different ways in different locations, often supported by different roles. Crucially they were open and realistic in describing how they would need to change the way they worked to enable such redesign to occur. No patient pathway was off limits for redesign.

Introduction

These conversations form the starting point for the development of Service Plans for each specialty. The development of these Service Plans will need to be taken forward by the respective clinical leads and managers responsible for these services. The template for these Service Plans is included as Appendix 1.

This document also includes material that did not arise directly from the conversations but necessarily follows on from it. For example, consultants shared thoughts about the practicalities of seven day, extended day working. Although not specifically mentioned, 'Hospital at Night' as an approach to organising out of hours services is well practised elsewhere and one that has an evidence base of success.

This strategy tries, wherever possible, to emphasise the possibility of clinicians talking to fellow clinicians on and off-island (working in exemplar sites) and in time, through this network of contacts, to visit sites to see innovations that might be appropriate for our acute service.

It also contains 'best practice' reference material derived from Royal Colleges guidance, NICE, peer-reviewed journals, NHS England and other UK public bodies and literature that describes innovations in practice from which we might learn. For example, it is likely that with a growing elderly population more patients will present with a fractured neck of femur. Best practice pathways are well described, including prevention and admissions avoidance interventions. Data is available to inform and evaluate current practice and some hospitals, including our own, have a strong reputation for a high standard of delivery. It will be for the clinicians and managers in the specialty, however, to describe in their Service Plans the degree to which current practice in Jersey exceeds, meets or falls short of best practice. Inevitably such an approach employed across 30 services to inform this draft of the Acute Service Strategy necessarily simplifies what are undoubtedly more complex matters. Again, the respective clinicians and managers are better placed to add the necessary degree of sophistication and contextualisation in their Service Plans if the broad direction of travel described in this document is accepted.

Any Acute Service Strategy needs to be set against our Island context which provides both opportunities and constraints. These include:

- Diseconomies of scale that lead to high per capita expenditure
- A rich and diverse voluntary and community sector
- Workforce opportunities and constraints
- About 20% of Islanders with access to privately-funded healthcare and clinicians for whom this is critical to their total remuneration and decision to practise on the Island
- Geographical and professional isolation
- Unhealthy lifestyle choices by a significant proportion of Islanders (alcohol, smoking, over exposure to sun etc.)

The final condition this document attempts to acknowledge respect is the very special nature of health and community care in Jersey. This local context is characterised by:

- A unitary boundary circumscribed by the sea
- Health and Social Services that are integrated
- Close political oversight and scrutiny
- A relatively small population characterised by extensive personal and professional networking with a strong ethic of community responsibility
- Relatively small numbers of patients in some specialties with any given condition making continued demonstration of clinical competence challenging and pressing safety, sustainability and affordability to the margin

These and many other factors mean that innovations that work elsewhere often need sensitive local contextualisation to Jersey. Some may not be practical to implement locally. This draft respects this need for localisation, but does not revere it for its own sake. It takes as its fundamental principle that all patients, regardless of jurisdiction, need services that are safe, compassionate and clinically effective. In our island context they also need to be sustainable and affordable. The challenge to clinicians and service managers will be to agree what constitutes best practice (*their* vision for *their* services for *their* patients and patients' families) and then, instead of describing why this could not or should not work in Jersey, to focus our efforts and creativity on identifying what would need to change in the way we currently organise our services so that this best practice becomes our normal practice. Islanders should expect no less from us.

Helen O'Shea
Managing Director, Jersey General Hospital

How this document was developed

Strategy Development

A number of key issues were identified as part of the development of this Strategy

- How to balance the competing challenges created by our commitment to develop safe, sustainable and affordable services
- How to respond to the fixed upper capital cost (if specified by site) of the Future Hospital
- How to develop services irrespective of hospital site in ways that safety, sustainability and affordability could be assured
- How to develop services that enable HSSD to maintain and, where possible, exceed standards of care in other jurisdictions

Key Outputs

- A document that can be shared with stakeholders to test the acceptability and feasibility of the Strategy and its ways and means of delivery
- A description of a model of care that has the safety of patients as its paramount concern
- A series of basic Service Plans to inform the development of each clinical service in ways that support the overarching objectives of the Acute Service Strategy and capable of being interrogated by the Technical Advisors to the Future Hospital Project
- A series of questions that inform the design brief of the Future Hospital Project to ensure it is safe, sustainable and affordable

Development of the Clinical Model

- Engagement of Clinical Directors and other consultant medical staff
- Engagement of allied health profession leads
- Engagement of Ward Sisters
- Engagement with Jersey Voluntary, Community and Disability Partnerships
- Referencing against health and social care policy statements to ensure model and strategy consistent with best national and international practice
- Tested against existing HSSD operational and financial data

Key Outputs

A description of a clinical model that:

- Keeps patients and their families at the heart of all we do
- Describes best practice that is possible in Jersey where evidence of safe, sustainable and affordable practice can already be seen either on the Island or in other jurisdictions
- Is consistent with the vision and values of the Acute Service Strategy and supports wider HSSD and States Strategic Objectives

Service Improvement

The focus of internal hospital processes will be on improving:

- In-patient experience
- Outpatient experience
- Theatre utilisation
- Imaging and diagnostic provision and access

The focus of wider health community processes will be:

- Developing patient pathways that are integrated across secondary and primary care boundaries
- Ensuring that care which can be better provided outside the Hospital is delivered in primary and community care settings

Key Outputs

A Strategy and Delivery Plan that:

- Leads to significant and measurable improvements in patient safety, quality of care and patient experience of services
- Improves efficiency of bed, ambulatory, imaging and theatre capacity and patient flow in current, transitional and future hospital services such that the Future Hospital is of the correct planned size
- Sets out how each service plans to achieve the necessary capacity and capability needed to meet the strategic and demographic challenges facing the Island
- Makes explicit to patients the pathway of care they can expect to experience

Acute Service – The Case for Change

The population of Jersey is growing relatively slowly, but is ageing rapidly. Between 2010 and 2040 there will be a 95% increase in the over-65 population, with a 35% increase by 2020. This growth in the older adult population will create a **challenging increase in demand** for health and social care services.

Current services are generally performing well but they are close to capacity and could not accommodate this increase in demand. The Island will **run out of capacity** in key service areas over the next five to ten years. This will happen earlier in some areas e.g. operating theatres, emergency in-patient wards. The services therefore need significant expansion and/or change to ensure that the needs of the people of Jersey can be met into the future.

Current services are also vulnerable due to **workforce pressures** with many staff approaching retirement age. A significant number of the hospital consultants are eligible to retire in the next ten years and, due to changes in medical education and training, these consultants cannot be replaced on a like-for-like basis. Recruitment of skilled clinical *and* non-clinical staff is increasingly competitive given, in particular, high costs of living in Jersey and increasingly competitive remuneration packages for similar staff in other jurisdictions.

The overall costs of health and social care will rise significantly. Advances in medical technology and the cost of drugs creates significant upward pressure on expenditure. These are matched by understandable rises in expectations from Islanders about what services could and should be provided either on-Island or in partner jurisdictions to which all Islanders should have equitable access.

Jersey, therefore, needs an overarching model of health and social care which can respond to the challenges of increases in future demand while doing so in a way that enables the skills of local staff to be used to the maximum and new roles created that will attract new staff to work on the Island. This model cannot be based solely on increasing the capacity of the General Hospital to treat more patients. This approach will be unsafe, unsustainable and unaffordable. The Acute Service Strategy from which this model is derived is based on:

1. Preventing patients being admitted to hospital where safe and effective alternatives can be provided
2. Treating patients as effectively and efficiently as possible when they are admitted
3. Discharging or transferring them in a timely way when they are ready to go home or to an out of hospital service

The hallmark of such a system is the comprehensive integration of hospital and out of hospital health and social care. This integration can be expressed in many ways, but the key platform most relevant for this Acute Service Strategy is the development of patient pathways that cross the professional and organisational boundaries which can act as a hindrance to the quality of the experience we need to provide for patients and their families.

With its unitary boundary and its single States-wide health and social care provision and by working in partnership, where appropriate, with vibrant independent sector providers there is no reason why we cannot provide a model of integrated health and social care that other jurisdictions will seek to emulate. This Acute Service Strategy provides a 'road map' for the development of world class services for our Island. It sets out the actions needed to secure service change that meets the Island's needs in the short term and ensures services are safe, sustainable and affordable for our future.

Core Services

Definition of Current Core Services

Core services must and can only be provided in Jersey General Hospital or by acute hospital practitioners from out of hospital settings

Core Services

- Cannot be distributed economically across community settings
- Form a body of specialist skills and knowledge needed to secure effective outcomes
- Require specialist equipment or a controlled environment
- Maintain and contribute to the clinical viability of Jersey General Hospital
- Enable financial viability of total Jersey General Hospital service provision
- Are the minimum required to provide a safe emergency and urgent health care provision

Critical Mass of Core Services

- Develop core services such that there are sufficient numbers of patients for all clinical staff to maintain their competence
- Identify and mitigate risks associated with services provided within an Island health economy
- Realise opportunities to improve critical mass by providing services with Channel Islands partners and partners in other jurisdictions

Core Clinical Services

Unscheduled Care	Medical Specialties	Elective Surgery	Woman and Children's	Clinical Support Services and Therapies	Non Clinical Support Services
Emergency Department	Cardiology	General Surgery including: Breast, Vascular & Colon	Obstetrics and Gynaecology	Imaging	Cleaning
Emergency Assessment Unit	Diabetes	Urology	Children's	Radiography	Stores and logistics
Acute Medicine	Respiratory	ENT	Special Care Baby Unit	Pathology	Catering
Acute Surgery	Care of the Elderly	Ophthalmology	Maternity	Pharmacy	Portering
Trauma	Renal	Dental		Physiotherapy	Laundry
Critical Care	Rheumatology	Orthopaedics		Podiatry	CSSD
	Gastroenterology	Theatres and Anaesthesia		Clinical Investigations	Education and Training
	Neurology			Dietetics	
	Dermatology			Rehabilitation and Intermediate Care	
	Sexual Health			Ambulance Service	
	Pain Service				
	Oncology (and Cancer Services)				
	Audiology				
Private Patients					

Re-profiling Care Pathways

Rationale for Re-designing Patient Care Pathways

- Ensuring that steps that add little or no value to the patient's outcome are removed
- Supporting the further integration of Hospital and Primary and Community Care to improve outcomes and reduce cost

This Acute Service Strategy forms part of the redesign of health and social care described more fully in the White Paper *Caring for Each Other, Caring for Ourselves* (2012) which, following States Assembly approval, was set out as P82/2012. P82/2012 describes, as an essential requirement of a viable Future Hospital, the need to first develop out of hospital services:

1. To help manage the pressures on hospital in-patient beds and other services in the transitional period up to the opening of the Future Hospital
2. The continued development of these services within and beyond this transitional period to create enough out of hospital capacity and capability to create more clinically, socially and cost effective services on the Island
3. The development of health and lifestyle choices that will have a positive impact on reducing the demand on hospital services in the medium and longer term
4. The central role of primary and community care services in this re-design, building on the already extensive provision of such services on the Island

This balance of illness prevention, healthcare treatment and health promotion in an increasingly integrated system depends on:

1. The necessary re-design of patient pathways across primary and secondary care boundaries in ways that prevent admission, optimise treatment and expedite discharge from Hospital
2. Support by the required information and communication technology
3. Support by an appropriately skilled workforce
4. Being reinforced by rewards, cultural and organisational developments appropriate to incentivise the positive individual health and collective organisational and professional behaviours necessary to maximise health gain across our Island

Out of Hospital developments that will have a direct impact on the capacity needed in the Future Hospital (particularly in-patient bed numbers, out-patient attendances and operating theatres sessions) such as Pulmonary Rehabilitation, Community Intermediate Care, Rapid Response and Out of Hours General Practice Service will need to create, by 2040, services that reduce demand for acute capacity equivalent to 100 hospital beds to ensure we build a hospital of a safe, sustainable and affordable size. This gives some measure of the size of the strategic challenge to create the safe, sustainable, affordable *and integrated* health and social care system essential for the good health of our Island.

How this Strategy supports that of the States of Jersey and HSSD

The strategic direction of HSSD will be governed by:

Vision

- The vision for safe sustainable and affordable services as laid out in P82/2012 and agreed by the States Assembly
- Establishment of a locally regulated primary care system which will enable a new and integrated approach to healthcare planning, commissioning and delivery
- Implementation of the Children's and Young People's Framework under direction from the Chief Minister's Department
- Outcomes of the Public Sector Reform driven by the Chief Minister's Department

The aim of HSSD is to:
Improve the health and social wellbeing of the population

Objectives

- Redesign the health and social care system to deliver safe, sustainable and affordable health and social services
- Improved health outcomes by reducing the incidence of mortality, disease and injury in the population
- Improved consumer experience of Health and Social Services
- Promotion of an open culture based on good clinical and corporate governance with a clear emphasis on safety
- Manage the Health and Social Services budget to deliver services in accordance with the Medium Term Financial Plan

States Core Values

Values

- We put the customer at the heart of everything we do
- We take pride in delivering an effective public service for Jersey
- We relentlessly drive out waste and inefficiency
- We will be fair and honest and act with integrity
- We constantly look for ways to improve what we do and are flexible and open to change
- We will achieve success in all we do by working together

Strategy Development

Acute Service Vision, Values and Objectives

The safe, compassionate and clinically effective care of patients will be at the heart of all that we do.
We will strive to do no harm to patients and their carers and families.
We will work to meet the SoJ strategic goals: Continuous Improvement/Innovation, Pride, Working Together, Customer Focus, Fairness/Respect, Diversity/Inclusion, Delivery/ Accountability

The Strategy supports changes which are already underway

- Investment in out of hospital services
- Investment in new consultants and other clinical posts
- Extending and rewarding clinical and non-clinical roles through fundamental workforce and service modernisation
- Investment in new equipment to support safer and more clinically effective treatment
- Remodelling clinical pathways to ensure patients receive treatment in the most appropriate location by the most appropriate clinician

Purpose of the Acute Service Strategy

- Provides a direction of travel for acute services for the next ten years
- Identifies the major building blocks of safe, sustainable and affordable services
- Identifies the priorities and proposed timing for service developments
- Informs the feasibility work for the Future Hospital
- Creates a framework for the necessary service development and investment needed during the transitional period until the Future Hospital is available
- Considers the key enablers of change and the actions required to ensure clinical and financial viability and sustainability in the short and longer term

Strategic Context

National Context
- Francis, Keogh and Berwick Reports set out the core purpose of hospitals to provide safe compassionate care and the consequences for patients where they fail to do so (Appendix 3)
- Expectation that hospitals will achieve and exceed standards set nationally and these standards will be assured through external scrutiny and accreditation
- Focus on effective resource use and value for money for taxpayer

Island Context
- The challenges presented by demographic trends up to 2040 cannot be met by doing 'more of the same'
- Better integration and modernisation of all States services
- Safety driven by critical mass of services and the balance between on- and off-island service provision with drive to provide more on-Island where safe, sustainable and affordable to do so
- Regulation of Care, new Mental Health Act and other changes in the legal and regulatory framework for health and social care

Hospital Context
- The role of the acute hospital changing to become an enabler for a redesigned and better integrated health and social care system
- Need to optimise value from high cost clinical staff in scarce supply
- To develop an organisational culture that avoids the consequences of relative isolation from clinical and other networks.

Key Drivers for Strategic Investment

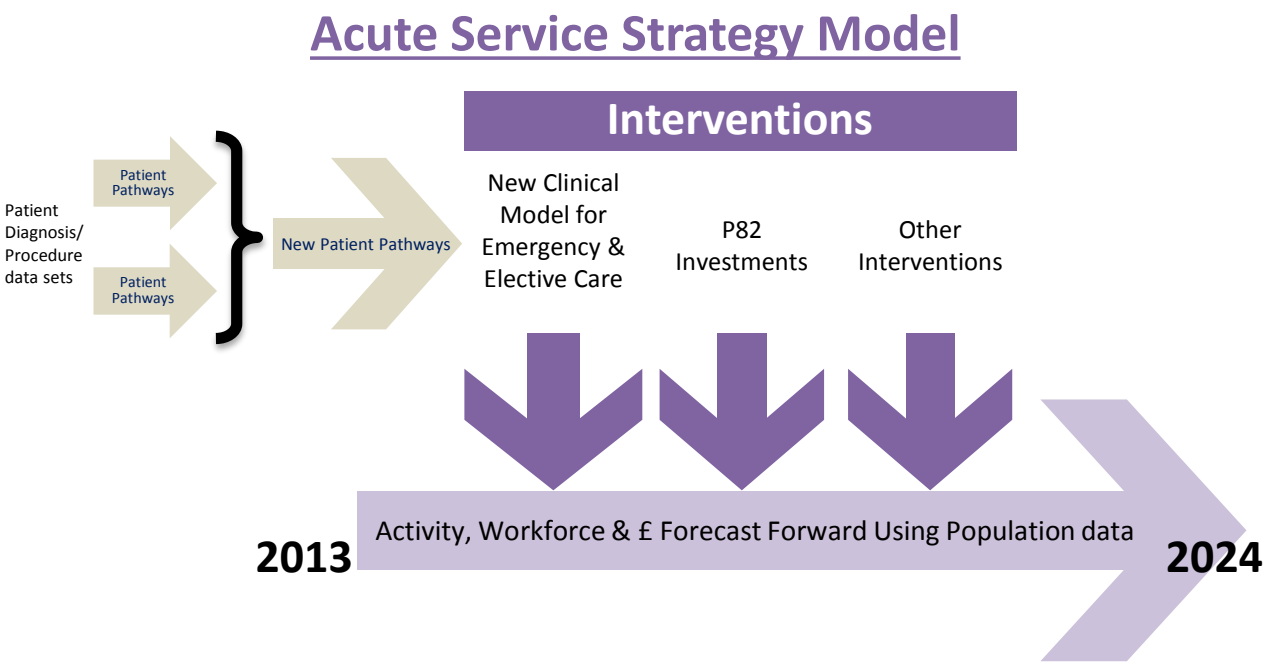
Small Island	• Per capita investment high • The 'Jersey Premium' affects all service and workforce costs
Demography	• Projected increase in number and proportion of older adults • Increasing birth rates • Immigration policy
Demand	• Demand/capacity mismatch • No on-island Hospital alternative • Clinical viability risk from small activity volumes
Workforce	• Retirement of consultant and middle grade medical staff • Single-handed practice • Recruitment and retention of nursing and allied health professionals
Clinical Governance	• Informatics to demonstrate safety, risk and clinical outcomes • Benchmarking against comparator jurisdictions
Alternatives to Hospital	• Developing most appropriate location of care and the staffing models that support the redistribution of care
Private practice and independent sector provision	• Realising the business and clinical opportunity through provision of improved facilities for private practice • Health tourism • Working in partnership with independent out of hospital care providers to encourage a mature and plural health economy
Estates	• The need for a 'fit for purpose' Acute Hospital
Primary Care Referrals	• The unintended outcomes of the current primary care funding mechanism and the need for a new system of 'sustainable primary care'
Commissioning	• The need for transparency in relation to outcome and taxpayer value for money
Legal and Regulatory Changes	• Royal Colleges accreditation • Insurance premiums • UK regulations and standards i.e. revalidation of medical staff • Jersey Regulation of Care Law

Acute Service Strategy Model

The Acute Service Strategy is underpinned by the development of a quantitative model whose objective is to produce "What If" analysis and reports from Trakcare patient management system data, financial ledger costs and population data to aid decision making in the development of the Strategy. The Model builds on, and updates, the 'Bailiwick' model developed by KPMG which provided the analytic foundation on which the White Paper and, in turn, the Future Hospital Pre-Feasibility Case was made.

In summary the model:

- Utilises actual 2013 costs, staffing and activity data and projects this forward to 2024 using States of Jersey Statistics unit population model data (2011 census data as base line). This becomes the "do nothing model".
- Uses the scenario +350 net inward migration – this being the closest scenario to SoJ migration policy
- Applies a series of interventions determined by the Acute Service Strategy and the core clinical service plans described within it



- Application of interventions are of three types which are consistent with the Acute Service Strategy:
  - A new Clinical Model for Emergency & Elective Care
  - Out of Hospital/White Paper Investments
  - Other interventions (where relevant)

- In addition, interventions can be specified by clinical specialty leads to determine the impact of these interventions on demand and capacity and unit costs (e.g. an additional consultant, different clinical pathways and so on)
- Each of the interventions can be activated or deactivated so that they can be appraised individually or collectively. The output reports are grouped into activity, full direct specialty cost (£'s) and workforce (FTE)
- For each output grouping there is a do nothing report and an interventions report. The do nothing report demonstrates the impact of not implementing an Acute Service Strategy. The interventions report demonstrates the effect of the interventions that are activated on the intervention option
- The model allows for inflation to be calculated at different annual rates up to the end of the period of the next MTFP (2016-2019)
- The financial impact of the Acute Service Strategy can therefore be predicted

The model will be an enabler for a number of work streams, which will provide high quality financial information on the quantifiable relationship between the activities described by the Acute Service Strategy and the resources required to deliver them. This will aid managers to acquire, allocate and adjust resources under their responsibility to optimise the achievement of operational and strategic objectives. The model is the foundation stone in the development of management decisions of a predictive nature, as opposed to decisions based solely on historical data. It will open up the capability of the finance team to deliver:

- Activity-based planning
- Activity-based budget setting
- Activity-based reporting
- Service line reporting
- Absorption and incremental costing

Strategy Vision

The safe, compassionate and clinically effective care of patients and their families will be at the heart of all that we do

This Strategy describes a vision for future acute services including:

1. A new hospital, built to modern standards, within the next ten years. The hospital will continue to be integral to the health and social care system and will be supported by that system. The workforce will be skilled, motivated, modernised and supported by IT and a fit-for-purpose estate – with services developed in the right order of priority to meet the needs of Islanders.
2. Integrated working across the health community supported by active clinical leadership in both secondary and primary care. This kind of working places a premium on the joint development, ownership and management of published and publically available patient pathways describing the whole patient journey unencumbered by organisational and professional boundaries.
3. Demand for unplanned care that will be more appropriate, through a combination of service and cultural changes in staff, patients and the public facilitated by modern approaches to triage, streaming and treatment of patients provided by the appropriate, skilled, practitioner. This strategic change will need to be supported by new models of primary care funding needed to incentivise optimum health behaviours on the Island.
4. Utilisation of techniques and best practice for planned care that supports progressive reductions in length of stay for all procedures
5. Where the Hospital does only those activities that only a Hospital can do. The effect of this will be that acute in-patient beds will be occupied only by those who need that bed for sound clinical reasons
6. Core in-patient services prioritised and sustained to support emergency provision for Islanders in need of urgent care with the continued expansion of these services where safe, sustainable and affordable to do so.
7. Recognition that while in-patient care is critical, the majority of contact Islanders have with the Hospital is ambulatory (i.e. out-patient, day surgical, medical day case, attendance for laboratory or imaging and so on). Increasingly, Clinical Support Services will be central to the delivery of high quality, patient-centred healthcare. At least 70% of clinical decisions are made on the basis of test results, and the hospital of the future will place an increasing emphasis on its entire range of diagnostic services to support rapid diagnosis and assessment, clinical decision making, treatment and longer term management.
8. Where Hospital resources will be used effectively and efficiently, providing excellent integrated care, with discharge planning improving and an increase in alternatives to hospital care available to relieve the pressure on beds – unnecessary waits/delay will continue to reduce.
9. Where income for the hospital will be optimised to ensure that the right balance of publicly-funded and privately-funded care continues to be delivered.
10. Where the costs of all clinical services will be understood in a way that enables clinicians and their managers to focus on reducing the unit costs of every treatment so that good value for the taxpayer can be assured
11. Finally, where the Hospital is delivering care to the highest standard and commits to demonstrating that the safe compassionate care of patients is at the heart of everything we do in the Hospital. The Hospital welcomes and is ready for the implementation of the Regulation of Care Law because it draws on appropriate external standards of care and development of evidence and data to facilitate external evaluation of acute services for the benefit of all.

Strategic Principles

Strategic Principles	What this means	What outcome this will achieve
The safe, compassionate and clinically effective care of patients will be at the heart of all that we do	All staff will be recruited through values-based processes Individual appraisals will focus on behaviour and values Organisational development that positively rewards behaviours supporting this fundamental principle Future Hospital based on patient safety, evidence-based design principles Patient safety measurement tools to make explicit standards of care Monitoring tools applied to both patient and staff experience	We will create a new kind of employee who is clear, regardless of their role, that their job is concerned with the safe, compassionate and clinically effective care of patients and their families 'Staff attitude' will not be the predominant complaint category We will create a new kind of patient – active in their care, informed about its opportunities and limitations and a responsible partner in its delivery No avoidable harm Mortality rates below 95 (HSMR) 28-day readmission rates benchmarked to top quartile
We will treat in the General and Future Hospital only those patients where is it clinically necessary to do so	Clinical processes that are clear at all times of each day 'why this patient needs to be in an acute in-patient bed?' e.g. ward round processes, detailed consultant-led patient plans, discharge processes from admission, monitoring of Estimated Day of Discharge (EDD) and Estimated Hour of Discharge (EHD) The critical importance of the pre-hospital phase of the patient's acute illness will be recognised. A single point entry for unscheduled care patients will be coordinated through a multi-agency, multidisciplinary 'Clinical Hub'	Resources (staff, beds, facilities) needed for acutely unwell patients will be focused solely on their needs Operational management processes (e.g. MCAP) that objectively evaluate need for each patient to occupy an in-patient acute bed All surgical specialities to apply enhanced recovery techniques to all patient pathways All medical and surgical specialties to apply ambulatory care pathways to patients presenting with potential zero length of stay conditions Clinically ready for discharge census always fewer than an agreed number of patients Will rank in Top 10 Dr Foster Hospital Guide Efficiency Index (see Appendix 3)
We will treat all patients on Island where clinically safe and financially viable to do so	The need to recruit and train a new and differently skilled workforce The need to identify the range of business cases that will retain or repatriate patients not currently receiving care in the General Hospital	Better value for money for each patient who continues to need off-Island care Clarity about which patients need to be treated off-Island because either we do not have the skilled staff or the equipment to treat on-Island Pan-Channel Islands services where clinically and financially viable

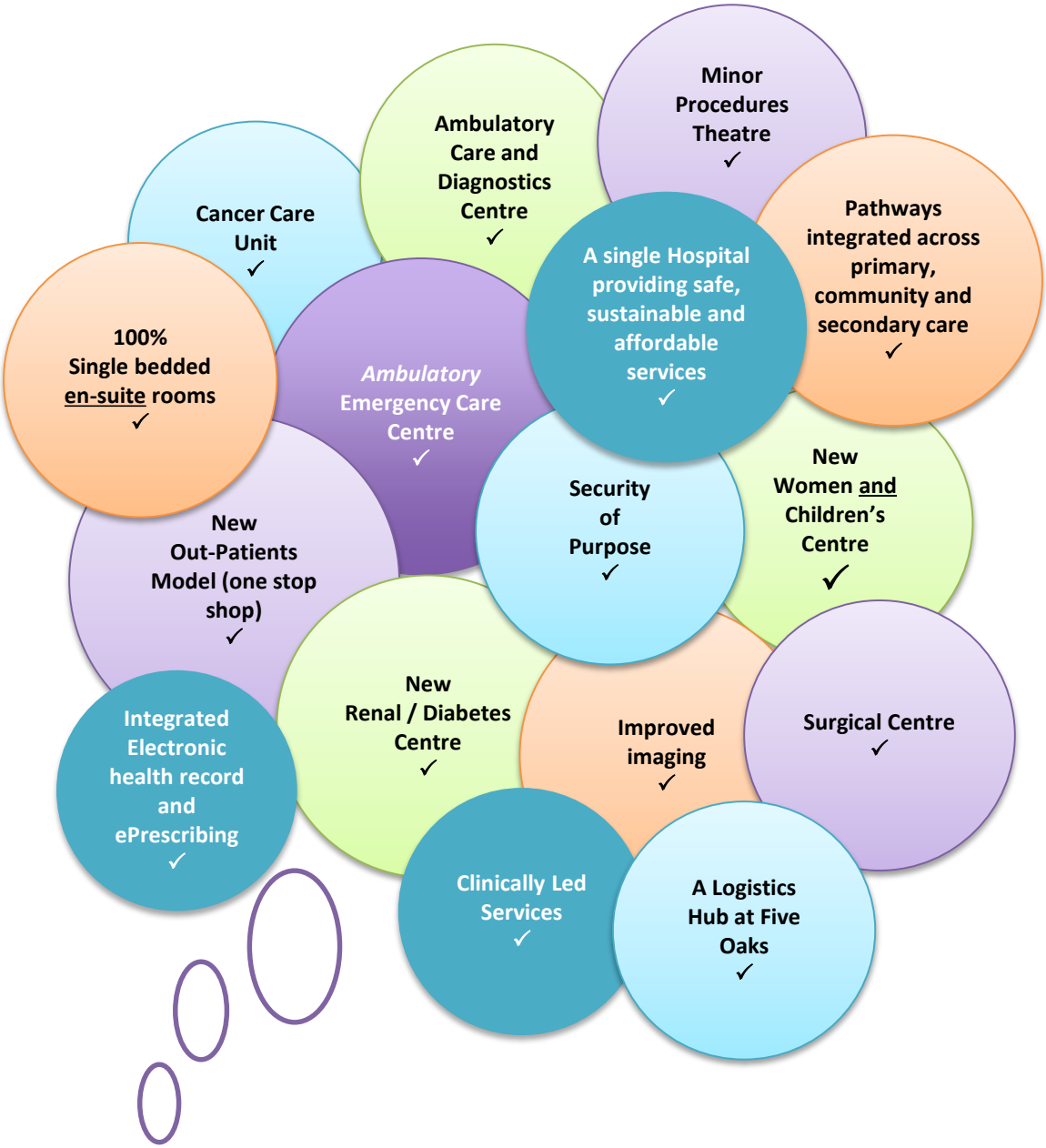
Strategic Principles

Strategic Principles	What this means	What outcome this will achieve
We will treat all patients according to best practice and this best practice will be our standard practice	Royal College guidelines will form starting point for service standards against which safety, sustainability and affordability criteria will be applied Implementation of Equality for All – Delivering Safe Care – seven days a week Seven Day Consultant Present Care, Academy of Royal Colleges http://www.aomrc.org.uk/doc_download/9728-seven-day-consultant-present-care-implementation-considerations NICE standards will inform service quality and where this is not feasible will be set out in the Hospital Risk Register	Care will be more standardised across different clinical teams with explicit evidence-based auditable pathways available for staff and patients
We will provide services that offer the best value for money	All patient pathways will be reviewed using LEAN principles Workforce strategy will ensure high cost staff (e.g. consultants, medical staff) are doing only what they can do	LEAN workforce i.e. one focused on ensuring all steps in patient care add value Clinically unnecessary waste removed Service line reporting so that patient level costs can be managed
We will be the provider of choice for private care	Repatriate off-Island private care activity when safe and profitable to do so Provide high quality private facilities to incentivise clinicians to use the Hospital as their primary base for private practice.	Increased income and market share from private practice Identifiable premium private services Respect for Islanders' choices about how and what services they wish to access and how they choose to fund these choices
Care will be integrated across secondary, primary and community sectors	Agreed patient pathways crossing secondary, primary and community care will need to be established, consistently applied and monitored The need for a new approach to Sustainable Primary Care	Organisational and funding boundaries that reflect legacy approaches developed more around the needs of professionals and organisational interests will be set aside and patients will not experience steps in their care pathway that add little value
Islanders will have access to high quality tertiary services	Greater focus on the partnerships with tertiary providers needed to support Islanders accessing appropriate elements of the tertiary pathway on Island and elements off Island	Value for money from high cost tertiary services

Strategic Objectives

- The Future Hospital will deliver safe, sustainable and affordable services
- An integrated cancer unit will be created, as a centre of excellence, that will improve cancer survival and the experience of patients and their families on their cancer journey
- An Ambulatory Care and Diagnostic Centre will be created, as a centre of excellence, that will reduce diagnostic waiting times and in doing so will improve mortality, morbidity and patient satisfaction
- An Emergency Care Centre will be created, as a centre of excellence, that will be a location for the complete integration of 'hospital' and 'out of hospital' care in ways that will lessen waiting times and transform the emergency care pathway ensuring those who need hospital care receive it safely and quickly and those whose care is best provided in non-hospital settings receive this safely and quickly
- A Women and Children's Centre will be developed as a 'unit/centre within a hospital' and a centre of excellence to provide integrated, excellent, holistic and compassionate care for women and children.
- A Surgical Centre will be created, as a centre of excellence, with the necessary operating theatre capacity and where the latest surgical techniques that can be provided safely on Island will be offered to Islanders in ways that will reduce waiting times, reduce length of stay and improve clinical outcomes
- Care will be provided in ways that will mean patients and families will not be aware of the boundaries between 'hospital' and 'non hospital' care
- The Future Hospital will be provided to the capital cost when set by the States Assembly
- Care will be delivered in ways that are supported by non paper-based health records, prescribing practices and communication across the health community
- The cost of each clinical service will be understood through a process of service line management enabling the Hospital to better organise services in ways which result in better patient care, deliver efficiencies for HSSD and provide a structure within which clinicians can take the lead on service development

Strategic Objectives



New Model of Care

To be developed further in its operational feasibility by clinicians and informed by patients, their carers and other stakeholders. This sets out a new model that from 2015 can meet the challenges of increasing demand for emergency and elective in-patient and ambulatory care and the complexity of patients needing such healthcare. Key characteristics of the new model are listed below.

Characteristic of the proposed clinical model	What this means for the current model of service provision	Logically Consequent Actions
The improved utilisation of expensive consultant medical staff to provide treatments that only they can do with a significant proportion of the work they currently do being safely undertaken by nurses and allied health professionals	Increased reliance on non-medical clinical roles for delivery of high volume activity (risk stratified out-patient appointments, direct referral from GPs to non-medical clinicians, single consultant surgeon supervising parallel operating theatres, nurse endoscopists, nurse colposcopists, extended role therapists, advanced nurse practitioners, emergency nurse practitioners, reporting radiographers etc.)	Development (internally) and recruitment (externally) of staff capable of working in expanded and extended roles Further investment in non-medical prescribing Skills escalator principles that invest, for example, Emergency Nurse Practitioners in the Emergency Department to liberate middle grades to focus on 'majors' patients and admissions avoidance and emergency care consultant to ensure ambulatory emergency care model is safe, efficient and clinically effective
The organising principle of care that all emergency admissions will be considered as 'zero length of stay' patients unless explicitly considered as not so and there will, be a single point of entry and assessment by a single consultant emergency medicine or internal medicine clinician (or their nominated deputy)	Movement away from the organisational separation of the Emergency Department and Emergency Assessment Unit Change from current Emergency Assessment Unit (EAU) model where in-patients physicians are part of a different medical team to Emergency care consultants Integration of Emergency Department medical and nursing staffing into a single team providing 7 day, 24 hour care Review service with Health Education Southwest which provides oversight of current allocation of doctors in training Review of current Divisional Management structure Integration of community nursing staff (especially rapid response and Community Intermediate Care Service) with Emergency Department staff and Ambulance Staff	Development of an Emergency Care Centre acting as a single point of entry 'Clinical Hub' for all members of the health care team (hospital and non-hospital) concerned with avoiding clinically unnecessary admissions 24/7 Co-location of GP Out of Hours Co-operative within the Emergency Department Implementation of Future Medical Division structures, roles and rotas described in the Royal College of Physicians Future Hospital Project informed by RCoP Invited Service Review With Deanery support re-organisation of trainee doctors allocations and rotas to improve training in acute assessment and general medicine Management structure aligned to Unscheduled Care and Scheduled Care Pathways Patient Pathways agreed and implemented to reduce unnecessary clinician variation in treatment

Characteristic of the proposed clinical model	What this means for the current model of service provision	Logically Consequent Actions
The organising principle of care that all elective surgical patients will be considered as day surgery patients, unless explicitly considered not, and there will be a single consultant surgeon who will validate this on a list by list basis coordinated through the Pre-Admission Clinic	Review of Pre-assessment clinic guidelines to ensure that every in-patient is admitted with respect to agreed thresholds for every condition	Increased intensity of use of Day Surgery Theatres Investment in modernised theatres Investment in minimally invasive laparoscopic equipment and training for practitioners in new surgical techniques More widespread application of enhanced recovery pathways
The development of a 'one stop shop' approach through the Ambulatory Care Centre for both surgical and medical specialties where clinical consultation, imaging and diagnostics, some procedures, clinical diagnosis and diagnosis sharing with patients and the initiation of patient counselling can all occur on a single visit	A significant re-orientation of the service to be much more 'wrapped around the patient' Stronger partnerships between GPs and Hospital clinical staff in the scheduling and communication of services to patients More explicit jointly developed patient pathways spanning primary, secondary and community care	Need to invest in technology to support efficiency of booking multiple appointments and other care contacts needed (imaging, diagnostics etc.) to ensure services can be provided on single visit with a clinically appropriately ordered schedule Agreement of standardised evidence-based patient pathways to reduce variations in treatment and improve patient engagement in their care Investment in imaging and diagnostic technologies (and associated workforces) that facilitate efficient scheduling of care in ways that are feasible for both patients and staff Extended day and extended week working
The provision of acute in-patient hospital care and ambulatory care on a 7 day, extended working day in a way that recognises this as a way of improving patient safety and clinical outcomes, reducing waiting times, matching service provision to public expectations and utilising expensive health care assets (staff and buildings) more efficiently	Review of consultant and middle grade job plans to ensure compliance with working time directive, attractiveness of jobs and enhance clinical effectiveness and safety of care for patients Review of appropriateness for the future of 'on' and 'off' wards model for physicians for future service needs Review of site management model	Clarity about what 24/7 provision means in Jersey context (practicality of more evening and weekend services, more efficient pooling of resources, focus on potential points of failure such as weekend discharge) Establishment of 'Hospital at Night Model' and of 24/7 Site Management system
The organising principle for all planned out-patient and other ambulatory patient contacts is that primary care practitioners will meet an agreed referral and treatment threshold (with appropriate imaging and diagnostics completed before patient attendance) and if this is not completed the patient will not be appointed to an Out-patient Clinic	Referral Management Centre to stream referral to consultant, middle grade, AHP or Clinic Nurse Specialist Extended roles for non-medical staff Agreement of referral processes with General Practitioners e.g. referral and treatment thresholds	Recruitment and/or development of non-medical clinical staff competent to deliver services either to direct referrals from GPs and other sources or to safely manage follow up appointments Further investment in non-medical staff competency acquisition e.g. non-medical prescribing, patient assessment etc. Agreed patient pathways that span primary and secondary care

Characteristic of the proposed clinical model	What this means for the current model of service provision	Logically Consequent Actions
The further integration of acute care with social, community and especially primary care services so that patients are accessing acute hospital services (in-patient and ambulatory) only when clinically necessary to do so	Continuing to understand the reason why patients occupy acute in-patient beds when not clinically necessary for them to do so (e.g. by use of MCAP as an operational tool (see Appendix 3), admission prevention interventions, in-patient ward processes improved e.g. EDDs, TTOs, nurse led discharge, 'Home for Lunch' etc.) 'Bed hours' not 'bed days' as the 'currency' of in-patient length of stay, discharge co-coordinator and bed manager role enhanced, 'Top 200' patients who access acute care most	Development of Emergency Care Centre model to replace Emergency Care Department Development of 'virtual wards' in the community Integration of clinical teams across secondary community care boundary e.g. rapid response team integral to Emergency Care Centre Continued investment in the out of hospital investments that are strongly associated with admission avoidance, rapid discharge and decreases in the 'periodicity' of acute hospital admission of patients with long-term conditions, such as pulmonary rehabilitation, community heart failure management etc. Progress with Sustainable Primary Care Workstream to incentivise best behaviours in service choice by patients and clinicians
The reorganisation, using LEAN methods, of both unscheduled and scheduled care pathways by introducing 'ambulatory emergency care pathways' for unscheduled patients and 'enhanced recovery pathways' for patients undergoing elective care.	Avoidance of variation in treatment through the application of agreed patient pathway consistently across all clinical specialties and consultant medical and other clinical staff Rigorous audit of adherence and clinical outcomes	'Acute Assessment' the critical discriminating and organising principle for first 23 hours not 'surgery', 'medicine' etc. 'Single point of admission' to either 'zero length of stay bed or recliner' (however that is described (e.g. Acute Assessment Unit, Clinical Decision Unit etc.) Admitting rights for Lead Clinician in that 'single point of admission' e.g. ED Consultant or named Clinical Lead Redesign of in-patient ward unscheduled care patient processes (particularly but not exclusively acute medical wards) e.g. 'Home 4 Lunch', consultant ward rounds, '12 Steps', 'supervisory' ward managers, intentional rounding etc. Written patient pathways to share with every patient and their carers to empower them and make clear the standard of care they can expect and the scheduling of that care Application of recommended processes that improves safety and efficiency of care (e.g. Royal College and RCN guidance on ward rounds, ward staffing, ward organisational structures and processes

Characteristic of the proposed clinical model	What this means for the current model of service provision	Logically Consequent Actions
The practical separation of ambulatory care from care requiring an overnight Acute Hospital stay	Need for imaging, diagnostic and other services needed to support c.160,000 patient contacts in the Ambulatory Care Centre	Ambulatory Care model is likely to see significant growth in imaging and diagnostic support. This needs to be located close to where such patient service demand arises.
	Change from current Emergency Assessment Unit (EAU) model where in-patient physicians are part of a different medical team to Emergency care consultants	Integrated medical and nursing rotas across former Emergency Department and EAU Reorganisation of trainee doctors allocations and rotas
For those who are admitted as overnight in-patients they will be cared for in a hospital environment supporting privacy and dignity and by staff committed to maximising safety and compassion	Current bed numbers allow transitional capacity demands to be met (if MCAP and other hospital and community initiatives reduce need for clinically 'non-qualified' in-patient demand). This approach commits Hospital to 6-bed bays until the Future Hospital becomes operational	Change 6-bed bays to 4-bed bays on a single 'crucible ward' to test in vivo whether the changes needed in Hospital culture, systems and processes can be made ahead of the relative reduction in bed numbers that will only be possible if these changes are made.
That public and private health care provision will exist in partnership, for the greater good of both services	Embrace private provision as a service arm of the hospital supported by appropriate managerial staff. Maximising turnover through the private wards. Maximising income through detailed pricing and activity capture. Monitoring and assurance that there is no detriment to public provision.	Greater oversight and further exploration of an independent trading arm arrangement to enable profitable trading. Improved marketing of services. Clear private practice strategy to maximise opportunities for the island to enhance income to the benefit of the public system.

All of these elements are successfully and safely in operation in other jurisdictions (with peer reviewed evidence to support their application). However, they *combine* in the new model for acute care in a way that recognises the particular circumstances of an Island health and social care community like Jersey.

In summary the new model of care improves:

- Convenience for patients (by avoiding clinically unnecessary out-patient appointments, by making more productive each in-patient episode and enhancing the possibilities of care provided with privacy and dignity)
- Clinical outcomes by avoiding clinically unnecessary admissions and in-patient surgery when peer reviewed evidence indicates day surgery or day case ambulatory emergency care can provide the means for equally safe care and reduced length of stay
- Patient satisfaction with improved outcomes
- Staff satisfaction providing more clinically effective and compassionate care and delivered with roles that maximise the potential for each member of staff from the most senior consultant doctor to the most junior health care assistant
- Value for money for each healthcare- related contact either through reduced cost or improved clinical effectiveness
- Integration of services across secondary, primary, out of hospital and community and voluntary organisations

Our Commitments to Patients and their Families

All HSSD staff, including those at the Hospital, will be encouraged to make the following commitments about how they will care for patients. These commitments are designed to communicate to patients the care they should expect when they are admitted to hospital. They also inform the basis of questions that are monitored through the annual patient survey. We will make publically available the results of this survey and the improvement plans that arise from it. This transparency – being open about where we need to improve our service to patients as well as celebrating our achievements – will be a hallmark of our maturity as a Hospital.

Our commitment to patients – Communication

- We will make sure you know who is in charge of your care at all times.
- We will discuss your care with you and take your wishes into account.
- We will keep you informed about your illness, tests, treatment and care.
- We will make sure you know who to speak to if you have any questions or concerns about your care.
- We will make sure all medical staff that review, treat and look after you are well informed about you and your illness.
- As far as possible, we will make sure that you are looked after on one ward, with one medical team in charge of your care.
- If you need to be cared for by a new team or on a new ward, we will explain the reasons for this in advance.
- We will make sure new staff introduce themselves and explain their role.

Our commitment to patients – moving beds

- We will only move you on the basis of your needs.
- We will explain to you where you are moving to and why. Where possible, we will tell you how long you are moving for.
- We will not move you at night unless your needs urgently require it.
- We will make sure you know who to speak to about your needs, treatment and care.
- We will make sure your family know where you are and why you are there (unless there are circumstances that mean this is not appropriate).
- We are committed to providing all in-patients with their own room with and en-suite bathroom and toilet.

Our commitment to patients – leaving hospital

- We will plan the care and support you need after leaving hospital in discussion with you.
- We will keep you informed about plans for when you leave hospital throughout your hospital stay.
- We will be clear about the arrangements for your care after you leave hospital.
- We will make sure you know who to contact if you become unwell after you leave hospital.
- We will make sure that any staff providing care for you outside hospital know what happened during your hospital stay.
- We will make sure arrangements are in place to get you home safely at the end of your hospital stay.

Our commitment to patients – resources devoted to your care

- We will ensure that your care is provided by the right people with the right skills in the right place at the right time, with the right behaviours and in the right numbers.
- We will display on boards outside all in-patient ward areas the staffing information needed to assure you of our commitment and to make this information publically available every six months.
- We will take the necessary action whenever staffing levels fall below the levels agreed by the Chief Nurse and Governance and Corporate Management Executive as safe.

Service Improvement

How Services Will Be Improved

- Patients will be safer as measured by infection control indices, slips, trips and falls, pressure sore incidence, medication incidents reduction
- Staff will be safer as measured by the reduction in adverse incidents relating to staff
- Standardised hospital mortality will reduce year on year

Modernisation and Quality

- Early adoption of advanced technology, therapeutics and new ways of working
- Focus on communications and information management systems to ensure the right information is present at the right time to support earlier and better decision-making
- Introduce robotics and automation where appropriate to do so (e.g. pharmacy, pathology, logistics, stores and other support services)
- Use new technologies to replace old procedures (interventional radiology, endoscopic surgery, photometry imaging, point of care testing where appropriate etc.)
- Create accredited new roles for staff through workforce redesign

Productivity and Efficiency

- Evidence-based patient pathway redesign in all specialties using LEAN principles and benchmarked against best in class in other jurisdictions
- Use Information Management System to support redesigned patient pathways (one stop shop appointment scheduling, telehealth, MDT conferencing etc.)
- Service line accounting and accountability where the unit costs of each clinical service are understood
- Improved productivity and effective use of resources
    - Beds
    - Theatres
    - Out-patients
    - Diagnostics
- Appropriately qualified staff making best quality decisions to admit, treat and 'send home' decisions 24/7
- Day care or home care as the norm

Evidence-Based Practice

- An environment where patients are treated with privacy and dignity, moving in time to 100% single rooms
- NICE guidelines and other best practice indicators (NCEPOD, CESDI, Royal Colleges etc.) will inform all clinical practice and care pathways produced (see Appendix 3)
- Integration of clinical expertise across primary and secondary care with the development of expert clinical teams delivering agreed pathways of care
- Active programme of infection prevention and control

Patient/Staff Experience

- Improved access to services (waiting times)
- All staff will make an explicit commitment to keep patients safe and compassionately cared for
- All staff will have an annual individual performance review with an appropriately resourced development plan
- Patients and staff would recommend Jersey General as their place of choice for treatment, care and employment
- The Staff Survey will indicate that staff feel valued and respected by their manager

The Role of the Future Hospital

Strategy and Rationale for the Future Hospital

- It is a critical part of the Island Strategic Plan to maintain and improve the health and well-being of Islanders into the future
- It acts as a platform for the re-profiling of care pathways across primary and secondary care
- It provides capacity and capability to meet future demands for care from an increasingly ageing and frail Island population
- It provides the facilities needed for modern healthcare
- The Future Hospital provides a platform for modernisation of all acute services and has stimulated a critical review of current practice in terms of efficiency and clinical effectiveness
- The financial discipline needed to achieve a safe, sustainable and affordable Future Hospital echoes the same discipline being applied to current 'business as usual'

Objectives of the Future Hospital

- To provide facilities that will support safe, sustainable and affordable care up to 2040
- To remedy the poor condition of the existing buildings in the General Hospital to meet modern day standards
- To create sufficient capacity to meet the needs of Islanders for the foreseeable future
- To enable the clinical adjacencies which are consistent with efficient and clinically effective care
- To realise a series of benefits including the provision of care in 100% single en-suite patient accommodation, new ambulatory care facilities, improved imaging and diagnostic facilities including additional CT and MRI, a new pharmacy, modern laboratories, new renal dialysis and diabetes centres, a new emergency care centre, a women and children's centre and new operating theatres with the necessary critical care facilities to support these services
- To support the repatriation of services where it is safe to do so from mainland providers
- To act as a platform for wider States of Jersey public sector reform and other modernisation initiatives

Why the Future Hospital is essential for the delivery of the Strategy

The Future Hospital:

- is a key driver for change – the incentive of investment in new hospital infrastructure, services and equipment will encourage greater flexibility and change to existing working practices particularly in response to the need to provide services in the new hospital that are safe, sustainable and affordable and can support greater net efficiencies in acute services
- will embody a new model of care with the development of an Ambulatory Care and Diagnostic Centre as a distinct area within the Hospital (which is providing emergency care, operating theatres and overnight in-patient accommodation for surgical and acute medicine patients)
- will provide the physical capacity to accommodate services needed to support an increasingly elderly and frail population as well as providing services in ways that are innovative and progressive - for example, the development of a cancer unit, a women and children's centre, an emergency care centre etc.
- has supported and further catalysed the agenda for reprofiling activity between acute primary care and community care settings in ways that support better integration of care, improved outcomes and will enhance efficiency
- requires an acute service strategy supported by new ways of working, organisational and cultural change, retraining and the creation of new skills to deliver acute care in different ways
- will improve the recruitment and retention of high-quality staff who want to work in modern facilities providing treatments in innovative ways that help them fully realise their potential and career aspirations

Governance and Risk

Implementation and Operation of the Strategy

- The key risks associated with the implementation and ongoing operation of the acute service strategy are identified, mitigated and will be subject to regular review
- The acute service strategy sets out an ambitious plan for HSSD which requires strong governance arrangements to ensure project management is subject to appropriate oversight and scrutiny

Key Risks Themes (see Top 10 Key Risks and Barriers)

- Poor planning and project execution could lead to expensive errors, delayed delivery, failure to achieve critical mass required for safe services and Future Hospital business case failure
- Under performance against financial, clinical quality and access standards
- If the pace of change is not consistent between primary and secondary care services, expensive duplication of gaps in services may occur
- Community and primary care services may prove unable to accommodate planned activity transfer from acute facilities within the required timeframe
- The acute management of acute patients in a community setting and through enhanced primary care provision will require the workforce to be developed and appropriate governance and risk management processes to be put in place
- Continued clinical leadership, ownership and engagement, management capacity and organisational leadership
- Failure to maintain support from States Assembly and other political stakeholders

Governance

- **Oversight and scrutiny** – the implementation and ongoing operation of the acute service strategy must be subject to oversight and scrutiny by the HSSD Corporate Management Executive and implemented by the Hospital Operational Management Group
- **Leadership** – the acute service strategy implementation will be led initially by the Hospital Managing Director.
- **Performance and risk management** – the development of the acute service strategy and its implementation will be subject to regular review against performance targets and agreed risk management activities
- **Stakeholder engagement** – the project led by the Hospital Managing Director and supported by HSSD corporate communications will ensure targeted involvement with primary care colleagues, lead hospital and primary care clinicians, operational managers and patient stakeholder groups and the wider public and political stakeholders
- **Strategic fit** – the development and implementation of the acute service strategy and its associated strategies (Finance, Estates, Workforce, ICT and so on) will be subject to ongoing review and iteration to ensure an integrated and unified overall strategic direction

Top 10 Key Risks and Barriers

Risk	Likelihood	Impact	Mitigation
P82/2012 developments do not realise intended benefits	M	H	Project management Metrics to track progress
Acute Service Strategy assumptions and clinical model do not deliver required scale of change in required timescale	M	H	Incentives to change practice Manage risks associated with eventual site choice (see below)
Recruitment and retention of required workforce	M	H	Workforce strategy finding optimum balance between on- and off-Island workforce Investment in developing skills escalator (non-medical prescribing, specialist nurse and AHP practitioners, non-registered staff etc.)
Sustainable Primary Care does not incentivise optimum behaviour by clinicians and the public	L	H	Referral thresholds established Patient Pathways redesigned to support improved integration and demand management Tariff for attenders with needs best met in primary care (minor illnesses, diagnostics and imaging)
Capacity of Project Team	M	M	Resource plan Integrated Project Team (with Technical, Legal and Finance Advisors)
Affordability of Future Hospital at FBC	L	H	Detailed OBC Clarity about choices at service level to ensure safety of eventual services is assured Realisation of risk capital and other contingencies in funding
Site-Specific Risk	L	H	Service by service risk assessment MTFP 2016-19 investments Pathway redesign Staff engagement Site-specific operational policies for clinical and non-clinical services Transitional Maintenance Capital Plan
Regulation and insurance standards are unachievable therefore undermining clinical viability	M	H	Evidence-based clinical pathways Peer reviewed and externally assured standards (NHSLA, NICE etc.) External networks with partner organisations Improved information systems
Public behaviour does not change in ways that support the strategy and clinical model	M	M	Communications and engagement strategy Act on public and patient feedback Engagement with primary care colleagues to amplify messages
Loss of political confidence in achievability of safe, sustainable and affordable services in return for substantial investment in HSSD	L	H	Regular ministerial briefing and comprehensive Scrutiny response Communications and engagement strategy with public and other stakeholders Delivery of P82/2012 and Future Hospital Programme to time and budget Clear benefits realisation plan and risk management of plan Site choice supported by Ministers

Next Steps

Implementation and Next Steps

Profile of activities to deliver the Strategy and the action to develop and embed the thinking

1. Development of a management structure best able to meet the challenges presented in the next ten years
2. A series of workshops to help develop this document
3. A consultation process with stakeholders inside and outside the Hospital
4. The development of the following strategies to support the Acute Service Strategy:

- Financial
- Estates
- Workforce and Organisational Development
- IM&T
- Mental Health
- Community Services
- Primary and Community Care
- Education and Training

The development of clinical service plans, operational policies and financial models to inform an outline business case and ultimately a Future Hospital Full Business Case that detail the acute service plan and support the delivery of the strategy.

The prioritisation and implementation of elements of these service plans that are not critically dependent on new buildings provided as part of the Future Hospital Project.

Create a critical path linking all the investments and service changes needed across the whole health and social care economy to ensure these activities occur in the order that enables both the delivery of the Acute Service Strategy (including the Future Hospital) and realises the transformation of health and social care described in P82/2012.

The development of a benefits realisation plan that is based both on the provision of the whole Future Hospital Project and one which is able to respond to the risk that not all elements of the Future Hospital Project proceed.

Programme of Delivery

The delivery of this Acute Service Strategy depends on ownership at local level. This strategy intentionally does not present anything that is 'experimental'. All of its elements are safely and successfully in operation in other jurisdictions. They all derive from a period of engagement in early 2014 with those who provide care directly for patients and their carers. The distinguishing feature of the Strategy is that it combines these elements in ways that are innovative for Jersey, reflects and responds to the context of our Island and reflects a fundamental commitment to integrate secondary, primary and community care in ways that create the possibility of Jersey becoming a world leader in creating the kind of health and social care provision to meet challenges facing all developed economies.

This does not mean that we cannot or will not incorporate radical enabling works (for example, through investments in state of the art medical and information technologies, innovative workforce roles, pioneering new ways to empower patients and carers, inventive ways to engage the whole community through its rich and diverse voluntary and community sector) to create a uniquely Jersey service embodying the values of our Island community.

The process through which the overarching Acute Service Strategy will become owned and delivered locally will be through the development of costed Service Plans and Operational Policies for each of the key services encompassed by the Strategy. This document will be developed in partnership with the teams responsible for each of these services (clinician, non clinical staff, manager and executives). Each document will describe:

1. The philosophy of the service
2. The activity each service supports (numbers and types of patients) and will support in the future
3. The facilities needed by each service now and in the future
4. The workforce and staffing profile needed to provide the service now and in the future
5. The key developments intended by that service to create safe, suitable and affordable care, now and in the future, the effects of which can be predictively modelled on cost, activity and workforce
6. How that service relates to other services essential for its delivery

Critically the cost of each service and the financial, workforce and operational consequences of the service plan can be modeled using 2013 costs, workforce data and activity as a baseline using the method described earlier in this document. At a time of financial challenge on the Island, each service will need to demonstrate value for money in how it benchmarks against an agreed standard.

The process of developing these costed Service Plans and Operational Policies will be completed by 2015. Key elements of each plan can then be extracted to populate the pages of the Strategy in a way that sets out the order and priority of investment and service changes required to deliver the benefits to patients, carers and staff set out in this Acute Service Strategy.

Until this work is complete, the Strategy will not be able to set out the milestones needed to take the Acute Service up to the handover of the Future Hospital.

Appendix 1 – Example of One Page Service Plan for Emergency Department

Key service risks

- Unscheduled care pathway not LEAN along whole pathway from ED presentation to ward discharge
- Admission prevention processes not as well coordinated as they could be leading to clinically unnecessary admissions
- Community services not yet all in place
- 24/7 senior clinician decision-maker not available for all unscheduled presentations
- More than one point of entry into unscheduled pathway
- Lack of standardsisation at key points in unscheduled care pathway (clinical pathways, workforce etc.)

Key service opportunities

- Evidence-based ambulatory emergency care pathways well described
- Innovative pathways already in place to build up (DVT, chest pain etc.)
- Early developments of community infrastructure to support admission avoidance and early discharge (e.g. Rapid Response, Community Intermediate Care)
- Nursing team already with experience and skills to adopt extended roles
- Common philosophy across ED and EAU multidisciplinary team (prevent admission, optimise flow, expedite discharge)
- Electronic patient record in ED
- Willingness to innovate and 'can do' team ethic

Five year developments for Emergency Department

Top Priorities	Milestones include…
Resolve 'exit block'	• Acute Medicine ward rounds standardised to provide opportunities for early discharge (RCoM and RCN ward round guidelines) **(2015)** • Nurse coordinated discharge (using agreed discharge thresholds) **(2015)** • 'Home for Lunch' ward discharge processes **(2015)** • Standardised in-patient ward operational policy **(2015)** • Implement 'Map of Medicine' to support integration of primary, secondary and community patient pathway **(2016)** • Establish MDT Emergency 'Hub' to reduce demand for in-patient beds **(2016)**
Implement Emergency Nurse Practitioner Service	• Critical mass nurse prescribers in both ED and EAU **(2016)** • ENP Business Case **(2015 for implementation 2016)**
Implement Clinical Decision Unit	• Business Case CDU (integrated staffing, creation of recliner area, equipment needed, imaging and diagnostics resource, electronic patient record etc.) **(2015 for implementation 2016)** • Single point of entry into unscheduled care pathway (senior clinician decision making 24/7) **(2015)** • Establish Ambulatory Emergency Care Pathways for Top 20 'zero length of stay conditions' **(by 2016)** • Ambulatory Care and Diagnostics Centre at Overdale to create additional unscheduled care imaging and diagnostic capacity at Jersey General **(2019)**

Appendix 2 – Contributors to developing this Strategy

This Acute Service Strategy has been informed by a process of engagement through 2014 with the following people/groups:

- Minister for Health and Social Services
- Chief Executive Officer for Health and HSSD Corporate Management Executive

Health & Social Services Clinical and Management Teams

- Medical Director
- Clinical Directors
- Director of Operations and Hospital Divisional Leads
- Clinical Leads and their teams in General Surgery, Operating Theatres, Endoscopy, Vascular, Colorectal, and Breast Surgery, Ophthalmology, Ear Nose and Throat, Urology, Trauma and Orthopaedics, Anaesthesia and Critical Care, Maternity, Gynaecology,, Paediatrics, Outpatients, Sexual Health, In-Patient Ward Sisters and Charge Nurses, Private Patients Service, Pathology Team in Histopathology, Haematology, Chemical Pathology, Mortuary and their respective Laboratory Scientists, Radiology, Clinical Investigations, Emergency Department and Emergency Admissions, Oncology, Renal, Physiotherapy, Neurology, Cardiology, Respiratory , Audiology, Dermatology, Rheumatology, Diabetes, Gastroenterology, Pain, Podiatry, Dietetics, Occupational Therapy and Rehabilitation.
- HSSD Estates and Facilities Team Leaders
- HSSD Finance Team
- HSSD Medical Staff Committee
- HSSD Clinical Nurse Specialists
- HSSD Senior Nurses
- HSSD Operational Management Group Senior Managers
- Director of System Redesign & Delivery
- Deputy Director of Commissioning
- Primary Care Board

Voluntary Organisations including:

- Joint Voluntary & Community Services Partnership
- General Hospital League of Friends
- Jersey Alzheimer's Association
- Visual and Hearing Impaired Partnerships
- Mencap
- Headway
- Jersey Blind Society
- Stroke Association
- Triumph Over Phobia

Appendix 3 – Documents informing this Strategy

1. Caring for Each Other Caring for Ourselves (2012) Health and Social Services Department White Paper
   http://www.gov.je/Government/Consultations/Pages/CaringEachOtherCaringOurselves.aspx

2. Health and Social Services: A New Way Forward - P82/2012
   http://www.statesassembly.gov.je/AssemblyPropositions/2012/P.082-2012.pdf

3. Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC
   http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

4. Keogh (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Professor Sir Bruce Keogh
   http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf

5. Berwick (2013) A promise to learn– a commitment to act. Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England
   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

6. Dr Foster (2013) Essential Reading for Smart Spending
   http://myhospitalguide.drfosterintelligence.co.uk/downloads/report/Report.pdf

7. NICE (2014) National Institute for Health and Care Excellence – Clinical Guidelines
   http://nice.org.uk/guidance

8. National Confidential Enquiry into Patient Outcome and Death – NCPOD (2014)
   http://www.ncepod.org.uk/

9. Centre for Maternal and Child Enquiries (CMACE) formerly the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)
   http://www.hqip.org.uk/cmace-reports/

10. Royal Colleges of Physicians (2013) Future Hospital Commission Report
    https://www.rcplondon.ac.uk/projects/future-hospital-commission

11. Royal College of Surgeons (2014) Clinical Guidelines
    https://www.rcseng.ac.uk/surgeons/surgical-standards/professionalism-surgery/gsp/gsp

12. Kings Fund (2014) Making our health and care systems fit for an ageing population
    http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf