1 Ambition 1
Deliver outstanding care for our patients

2 Ambition 2
Work with and support our people to deliver the best for our patients

3 Ambition 3
Make the best use of our physical and financial resources

4 Ambition 4
Be a leader of collaboration and partnership working locally and across the system

NHS
James Paget University Hospitals
NHS Foundation Trust

Clinical Strategy 2021-2026

Version Control

1.0	First Draft – Vision & themes signed off by HMB	LJ
2.0	Addition of: Updated Foreword by DG Updated Strategic Context LG Updated Groupings: E&EC –signed off by PW Therapies – provided by BC (has offered to do more) Maternity & Neonatal – updated by KC	Updated by LJ
3.0	With JB comments included and tracked changes accepted	Updated by LJ
4.0	With Board Workshop comments included and some of JB comments accepted Updated Groupings: Diagnostics – provided by CT Elective – provided by Mr H Deo 2 comments by PW included Critical Care updated by BI / Josip	Updated by LJ
5.0	Executive Summary added by LJ ICS Section updated by LJ Monitoring Section updated by LJ Trust Strategic Ambitions updated by LJ Quality Priorities added by LJ	Updated by LJ
6.0	Formatting	Updated by LG
7.0	Minor amendments to sections 8 and 9	Updated by LG
8.0	Formatting and Graphics	Updated by OC / CR
9.0	Inclusion of principles, pandemic learning and additional linkage to ICS clinical strategy	Updated by LG, DG,WB JB
10.0	Updating of finance section – provided by ET	Updated by DG
11.0	Updates following internal review	Updated by DG and LG

Foreword

We are pleased to present our refreshed Clinical Strategy for the James Paget University Hospitals NHS Foundation Trust (JPUH).

Our strategy has been updated at this time to re-set our vision following learning from the COVID pandemic, taking into account the NHS Long Term Plan, and to inform the planning for a new James Paget University Hospital as part of the national New Hospitals Programme (NHP).

The NHP (formally Health Infrastructure Plan or HIP2) was announced in September 2019 by the Department of Health and Social Care, a major capital investment in the nation's health infrastructure. This will deliver a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, modernise our primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate.

The JPUH was informed in May 2020 that it had been successful in its application for seed funding to develop a Health and Social Care Campus to replace the existing James Paget Hospital site. An up to date Clinical Strategy is an important first step to working up these plans, and will provide the guiding principles for the business case process.

This Clinical Strategy has been developed within the context of the Norfolk and Waveney Health and Care Partnership, which has recently become an Integrated Care System (ICS), and the emerging Norfolk and Waveney system-wide Clinical Strategy. It will continue to evolve in light of the ongoing development of these strategies and further engagement with stakeholders, although the broad direction of travel outlined in this strategy is not expected to change.

It is clear that a District General Hospital will be required in the Great Yarmouth and Waveney area. Urgent and emergency care, maternity, stroke and ambulatory services will continue to be required at the JPUH to meet the needs of the local population. However, to ensure clinical and financial sustainability, and to maximise the opportunity of a new hospital build, significant transformation of how we provide services will be required, not just in how we deliver services but the whole patient pathway across JPUH and other health and care providers.

This will mean increased partnership working for all services, with an unwavering focus on the implementation of a fully integrated health and care system within Norfolk and Waveney. Our aim is keep our services person centred and fully inclusive, tackling health inequalities locally and in line with the national priorities, using the enablers of digital technology, modern adaptable infrastructure, an engaged and evolved workforce and contribute towards our research ambitions. The COVID pandemic has shown us what is possible in terms of successful rapid transformation of services, including virtual clinics, to enable patients to access our services from home or within the community. We have the opportunity to embed and progress these developments and ensure they become business as usual.

Delivery of our Clinical Strategy will require closer collaboration with neighbouring hospitals, particularly the Norfolk and Norwich University Hospitals NHS Foundation Trust, to further develop networks for secondary and tertiary hospital services. Developing our partnership working with GP's, East Coast Community Health (ECCH) and County Councils is key to achieving our vision. We already have an effective Great Yarmouth and Waveney Locality Board where we work in partnership with these partners. It will also require closer working with academic partners such as the UEA to transform health and social care for the next generation of patients, and professionals to support recruitment and retention.

This strategy has been developed through a programme of engagement with our clinical teams and external stakeholders, and we would like to thank everyone involved for their valuable input and support. Oversight has been provided through our Medical Director and with membership from our senior clinicians. In addition, there has been consultation with Norfolk and Waveney CCG, local Primary Care Networks, ECCH, NNUH, QEHKL, Norfolk and Suffolk County Councils and Healthwatch Norfolk.

The Clinical Strategy was approved by JPUH Trust Board on 28 May 2021 with an ambition of further developing the strategy with input from all specialties, as part of their annual specialty development planning. This version of the Clinical Strategy now reflects this. Engagement will be ongoing with clinicians, partner organisations and patients to further inform this strategy, support the development and delivery of the Norfolk and Waveney Clinical Strategy and inform the business case for the new hospital build. This is an exciting time for the Trust and a great opportunity to deliver real benefits for our patients and our staff - we look forward to continuing to work with all our stakeholders to support this.

Contents

1. Executive Summary

The JPUH Clinical Strategy has been established to think creatively with partners about how we are going to provide local acute services as the local system continues its journey of becoming an Integrated Care System (ICS) and to support the development of a new hospital for JPUH under the NHS' New Hospitals Programme.

This is the second iteration of the Clinical Strategy which now includes the outputs from workshops held with each of the specialities and further details of the alignment with the draft Norfolk and Waveney ICS Clinical Strategy. The Clinical Strategy will continue to be developed to reflect engagement with partners, staff and patients.

The Clinical Strategy has been developed using a bottom up approach of working with the local clinicians, who identified an initial set of eleven specialties which would provide the biggest opportunity for delivering services for patients differently ('function' and 'form' i.e. where, what and how), and there would be a larger than expected increase or decrease in acute activity.

1.1 Challenges and opportunities for health and care services

The JPUH Clinical Strategy is set within national and local context, and the draft Norfolk & Waveney Clinical Strategy, as well as being cognisant of the draft clinical strategies from the other acute providers within our ICS.

JPUH, and the local ICS system, continues to face substantial increases in the demand for acute healthcare services, due to:

- Growth in the local population - there will be an overall growth of 11.7% from the period between 2017 and 2037
- An ageing population meaning a population with increased frailty and complexity - people aged 85+ in Norfolk & Waveney make up c. 4% of the population but account for 16% of all emergency admissions to hospital
- Inequalities in healthy lifestyles e.g. obesity, smoking, causing poor health resulting in high emergency admissions and deaths from preventable causes
- About 1 in 7 people experience a common mental health disorder with long term mental ill health being higher than the national average

The NHS' 'Long Term Plan' (LTP) provides the overarching strategic direction for a new service model. The LTP focus is twofold: firstly, it emphases a move towards the prevention of ill-health, for example to reduce the number of people who smoke, reduce obesity etc., and to reduce health inequalities and unwarranted variation in care, including the need to address inequalities associated with those people with mental health conditions; and secondly, it focuses on the treatment of illness through joined-up care across a broad range of organisations. The LTP supports a step change in the provision of out of hospital care realising a significant shift in the provision of outpatient appointments and non-acute care away from an acute hospital setting. The JPUH Clinical Strategy is entirely consistent with the LTP.

The opportunity for acute healthcare services is the national New Hospitals Programme (NHP), which is a long-term programme of investment in health infrastructure, including capital for new

hospital buildings, investment in the latest technology, and funding to make improvements to existing buildings. JPUH has been successful is being one of the 40 hospitals identified for inclusion in the NHP which provides a significant opportunity for both JPUH and the Norfolk and Waveney ICS.

1.2 Our vision: Putting patients first - providing high quality acute clinical services to support our communities to live a healthier life

The changing needs of our population coupled with advances in technology and workforce, research and education allow us to think more innovatively about who is best placed to provide high quality clinical services for our local population, and how we do that in partnership.

JPUH strives to support the local population to live well independently, and provide high quality clinical services at our hospital when the population needs to access them. JPUH is clear that it has a role to continuously improve local health equality.

1.3 Clinical Themes

Following engagement across all our specialties, we have developed a Vision and three themes which are set out below, that underpin our Clinical Strategy. The three themes were transposed back into identified groups of clinical services, so we could understand what the themes mean on the ground for transformation of service delivery with partners, and the New Hospitals Programme. Under each clinical grouping those transformation opportunities are set out, together with the benefits for staff and patients.

Theme 1 – Working with partners on alternatives to hospital care

This theme is about supporting the population to live well at home, avoiding unnecessary hospital attendances and admissions. This theme will see:

- Partnership working leading to improved patient care and outcomes
- Prevention of ill-health
- Maximised use of digital technology
- Promotion of vertical integration, through partnership working with other health and care sectors, and horizontal integration, through increased working with other acute providers in the Norfolk and Waveney ICS

Theme 2 – Person centred care with a focus on quality outcomes and user experience

If you do need to receive NHS care at the hospital or in the community, we want this this be a positive experience and for it to be centred on you. This theme will see:

- Reduced waiting times
- Holistic care wrapped around the person and their mental and physical health and their wellbeing needs
- 7 day service provision
- Separation of elective and unplanned care to minimise the number of elective operation cancellations
- Single waiting list across the ICS supporting patient choice

Theme 3 – Coming home, and living well in the community

Once you have received your care, we want you to be able to return home to your community, with support to recover and live well. This theme will see:

- Seamless transition between hospital care and care provided in the community
- Improved self-management approach for patients with long term conditions
- Promoting care at home, in the community or remotely, to support the reduction of unnecessary acute hospital attendances
- Reduced lengths of stay through reablement and therapy input
- Increased access to diagnostics

1.4 Principles

Three underlying principles have been developed which span the vision and themes. The principles are to:

- Improve integration and partnership working
- Reduce unwarranted variation of service provision
- Reduce health inequalities

1.5 Enablers

The three themes and underlying principles developed to support the successful transformation of clinical services as detailed within this Clinical Strategy are supported by critical enablers which are estate, digital, workforce and research.

2.0 Strategic Context

2.1 National and Regional Strategic Context

Published in 2019, the **'NHS 'Long Term Plan'** (LTP) is a national strategy building on the foundations of the previous strategy, the 'Five Year Forward View'. The LTP provides the overarching strategic direction for a new service model which focusses on the treatment of illness through joined-up care across a broad range of organisations and agencies in the optimal care setting. There will be a step change in the provision of out of hospital care realising a significant shift in the provision of outpatient appointments and non-acute care away from an acute hospital setting and the JPUH Clinical Strategy is entirely consistent with this. Care quality and outcomes improvement plans are established in the LTP in terms of improvements to cancer detection and treatment, mental health, diabetes, dementia and sets ambitions for children's health, cardiovascular and respiratory conditions etc. The LTP emphases a move towards the prevention of ill-health, for example to reduce the number of people who smoke, reduce obesity etc., and reduction in health inequalities and unwarranted variation in care, including the need to address inequalities associated with those people with mental health conditions.

The LTP supports a shift in emphasis in the provision of emergency care in an acute setting towards seeing patients in urgent care, rather than A&E, and supporting treatment models based on same day emergency care (SDEC), reducing the need for emergency admissions. This has been reinforced in the NHS 2021/22 Priorities and Operational Guidance document where systems are being asked to progress the work underway through the NHS 111 First and SDEC programmes which includes the use of booked time slots in A&E and acute frailty services. For those patients where admission as an inpatient is a requirement the LTP supports the reduction in delayed hospital discharges.

The role of primary care is key in our Clinical Strategy as we seek to work in collaboration closely with primary and community care and change the way we deliver some of our services for patients in line with the Vision and the three themes. Delivery of our three themes will ensure patients only attend an acute hospital when that is most appropriate place for the care to be provided from.

Primary care will support place-based provision of care and extend the range of local services, providing an integrated service with community health and social care. Greater support will be given by out of hospital teams to people within their own homes, including care home settings. Primary care networks (PCNs) are groups of GP practices covering on average a population of 30-50,000 working closely with community, mental health and social care staff. PCNs have the potential to benefit patients by offering improved access to an extended range of services through multi-agencies and through new roles, e.g. clinical pharmacist, physiotherapists, paramedics, social prescribers etc.

The LTP recognises the significant issues with regards to recruitment and retention of a healthcare workforce across the health sector. There are insufficient staff to meet the current and future demands of health sector. Action is already being taken with regards to developing new roles e.g. apprenticeships, nursing associates etc. The workforce ambitions as set out in the LTP are supported and further developed in the NHS's '**We are the NHS: People Plan for 2020/2021 – action for us all**'. The strategic direction recognises the need to address nursing shortages through increase clinical capacity including the provision of the necessary infrastructure to increase placement capacity. Together with increased training is the need to improve recruitment and retention of staff partly through evolving workforce roles across all sectors of health care suitable for the delivery of 21st century care models.

In October 2019, the second phase of the Health Infrastructure Plan (since renamed the **New Hospital Programme** or NHP) was announced by the Government. It is a long-term programme of investment in health infrastructure, including capital for new hospital buildings, investment in the latest technology, and funding to make improvements to existing buildings. JPUH has been successful is being one of the 40 hospitals identified for inclusion in the NHP, which will be subject to a successful business case process which the Trust is currently commencing.

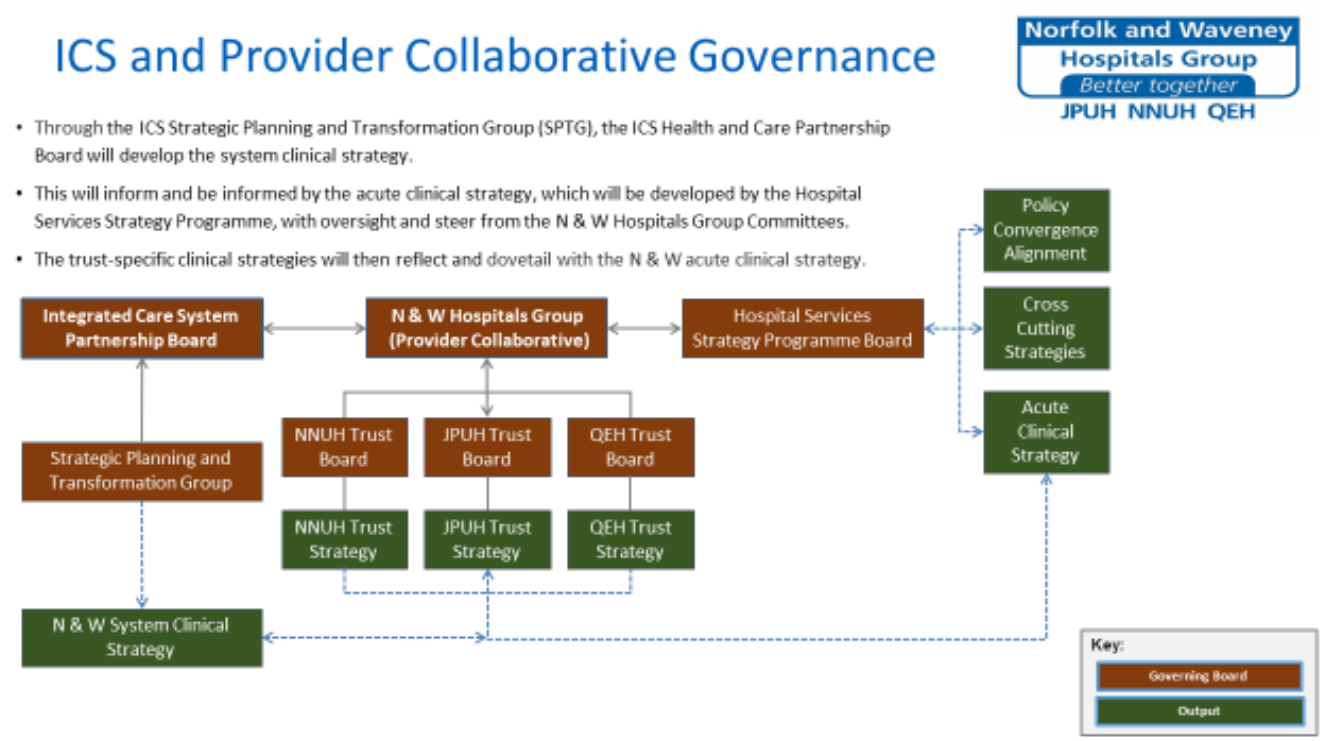
A core theme of the LTP and NHP is the importance of technology to the future provision of the new model of health and care services across organisational and geographical boundaries. The LTP sets out the critical priorities that will support digital transformation and provide a step change in the way the NHS cares for citizens. The National Information Board (NIB) in its report '**Personalised Health and Care 2020'** sets out how better use of data and technology has the power to improve health thereby transforming the quality and cost of health and care services. It will give patients and citizens more control over their health and wellbeing, allow real-time digital information to be accessible, reduce the administrative burden for care professionals, transform productivity of staff and contribute towards treatments, innovation, research and growth.

2.2 Norfolk and Waveney Strategic Context – Integrated Care Systems (ICS)

In February 2021 the White Paper "**Integration and innovation:working together to improve health and social care for all**" was published. This builds on the proposal set out in the LTP and all the experience of delivering care during the COVID pandemic. The paper sets out legislative proposals for a Health and Care Bill based on integration, collaboration and reducing bureacracy. At the time of writing this strategy it is anticipated that it will become statutory legislation from July 2022 and will be the most significant change proposed to health and social care for a number of years.

The ICS Health and Care Partnership will be responsible for developing a plan that addresses the wider health, public health and social care needs of the system. This has been set up as an interim Board pending the legislation and membership and governance is set out below:

Interim ICS Partnership Board Membership
NHS Norfolk and Waveney CCG
James Paget University Hospitals NHS Foundation Trust
Queen Elizabeth Hospitals King's Lynn NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk County Council
Suffolk County Council
Norfolk and Suffolk NHS Foundation Trust
Norfolk Community Health and Care NHS Trust
East Coast Community Healthcare CIC
East of England Ambulance Service NHS Trust



N&W ICS has developed a five year plan for improving health and care **'A healthier Norfolk and Waveney 2019-2024'**. The goals of the strategy and overarching purpose of the ICS, are set out below and are consistent with the aims of the Trust's Clinical Strategy.

Goals from Norfolk and Waveney system wide 5-year plan: A Healthier Norfolk and Waveney

1. To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health – how healthy you are should not depend on where you live.

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

ICS Overarching Purpose from Norfolk and Waveney system wide 5-year plan: A Healthier Norfolk and Waveney

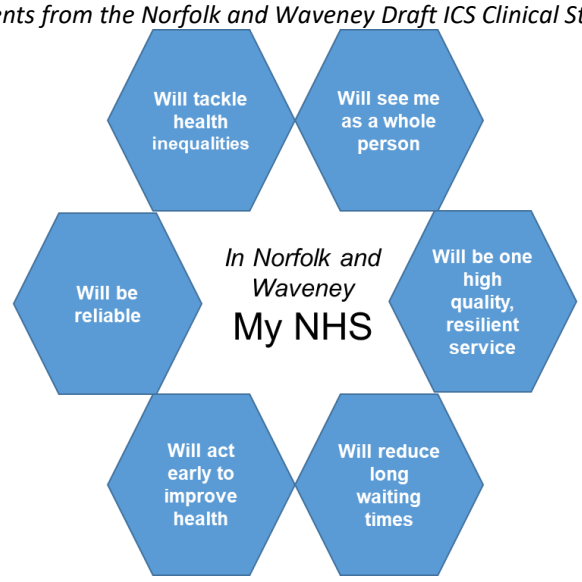
The draft ICS Clinical Strategy is one of a number of enabling strategies designed to deliver the ICS vision of Norfolk and Waveney being 'in good health' through achieving three agreed goals:

1. To make sure that people can live as healthy a life as possible.
2. To make sure that you only have to tell your story once.
3. To make Norfolk and Waveney the best place to work in health and care.

The strategy outlines two types of integration, one is within the NHS to ensure that NHS services consist of the right things, and work together in the right way, to help improve the care and treatment of people to enable everyone in Norfolk and Waveney to live longer, healthier and happier lives; the second type is integration between the NHS and local government and others. Both of these integration ambitions have been reflected in this refreshed Trust Clinical Strategy, including within the underlying principle to "Improve integration and partnership working".

The draft ICS clinical strategy contains six statements that describe what the plan will try to achieve. The statements have three key aims: To describe the expectations that patients and staff have said they want from their NHS in Norfolk and Waveney; they explain how we plan to help improve certain areas of health within our population; and they detail how NHS services will work together to achieve our goals. The statements (see below) are further defined by detailed clinical objectives.

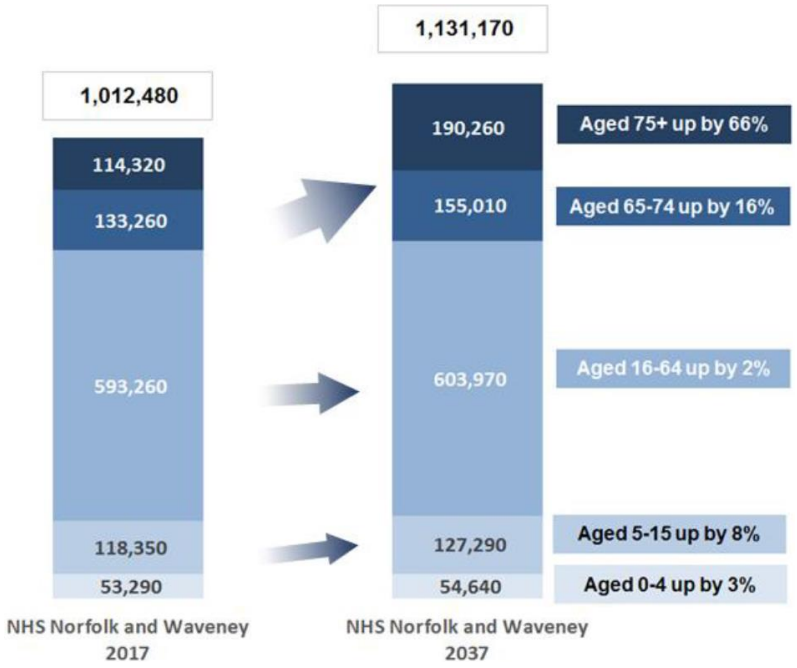
ICS Clinical Strategy Statements from the Norfolk and Waveney Draft ICS Clinical Strategy



2.3 Norfolk and Waveney Population Growth, Demographics and Health Needs

The population covered by the N&W ICS is currently 1.01m (2017 figures). The overall N&W population is generally older than the rest of England with the number of people below 49 conversely being fewer than the England average.

In terms of the predicted population it is anticipated that there will be an overall growth of 11.7% from the period between 2017 and 2037. This projected growth is expected to be primarily in older age groups (75 years plus), an age band who frequently have greater frailty and complex health and care needs.



These projected changes in the N&W population will increase the need for health and social care support as the likelihood of developing long-term conditions, frailty and the risk of emergency admissions increase with age.

The Joint Strategic Needs Assessments (JSNAs) for Norfolk and Suffolk (to capture the Waveney population) review the current health of the population and are used to inform future health and care provision, and the wider determinants of health. Key statistics of the current status of the Norfolk and Waveney population include:

- The health and wellbeing of children is consistent with the England average
- One in seven adults in Norfolk smoke
- Two-thirds of adults are overweight
- Inequalities in healthy lifestyles contribute to childhood obesity (currently c. 25%); emergency admissions in older people (currently over 3,800 admissions); and deaths from preventable causes
- 14,000 people live with dementia
- About 1 in 7 people experience a common mental health disorder with long term mental ill health being higher than the national average
- Of the c 250k people over 65 in Norfolk & Waveney, around 50% are fit; of the remaining 50%, 3.5% have severe frailty
- People aged 85+ make up c. 4% of the population but account for 16% of all emergency admissions to hospital

The outputs of the JSNAs have been used to inform the **'Joint Health and Wellbeing Strategy for Norfolk & Waveney 2018-2022'**. The vision of the strategy is to create a single sustainable system and the key priorities strategy are:

1. Prioritising prevention by supporting people to be healthy, independent and resilient
    i. Embedding prevention across all strategies and policies
    ii. Providing joint accountability to prevent, reduce and delay needs and costs
    iii. Promoting and supporting healthy lifestyles
2. Tackling inequalities in communities by providing most support for those who are most in need
    i. Improving locality working
    ii. Using evidence to address needs and inequalities
    iii. Addressing wider determinants of health
    iv. Joining up development planning
3. Integrating ways of working by collaborating in the delivery of people-centred care
    i. Making sure services are joined up and consistent
    ii. Promoting the role of carers and their support needs
    iii. Embedding integrated approaches in policy, strategy and commissioning plans

2.4 National and Regional Strategic Alignment: What this means for the JPUH Clinical Strategy

- Meeting the needs for the local population including Covid-19 pandemic response and recovery
- Supporting the care of patients in the wider ICS, and with the support of voluntary and third sector organisations
- Building upon capital investments – e.g. the NHP and the Diagnostic Assessment Centre (DAC)
- Building upon the digital programme – Electronic Patient Record and other digital enablers
- Designing new ways of delivering care, building upon best practice and reducing unwarranted variation highlighted by GIRFT etc
- Building on the ICS elective recovery e.g. adding elctive capacity and developing a single Patient Treatment List for elective surgery, across the system area.

N&W Draft Clinical Strategy Statements and Alignment to JPUH Clinical Strategy (see 5.0 for description of themes and underlying principles)

Will act early to improve health	**THEME 2** **UNDERLYING PRINCIPLE 1 & 3:** *Improving Integration and Partnership Working; Reducing unwarranted variation*
Will tackle health inequalities	**THEME 1, 2 & 3** **UNDERLYING PRINCIPLE 1, 2 & 3:** *Improving Integration and Partnership Working; Reducing health inequalities*; *Reducing unwarranted variation*
Will reduce long waiting times	**THEME 2** **UNDERLYING PRINCIPLE 1, 2 & 3:** *Improving Integration and Partnership Working; Reducing health inequalities*; *Reducing unwarranted variation*
Will be one high quality, resilient service	**THEMES 1 & 3** **UNDERLYING PRINCIPLE 1:** *Improving Integration and Partnership Working*
Will see me as a whole person	**THEME 1, 2 & 3** **UNDERLYING PRINCIPLE 2:** *Reducing health inequalities*
Will provide reliable and resilient services	**THEME 2 & 3** **UNDERLYING PRINCIPLE 1 & 3:** *Improving Integration and Partnership Working; Reducing unwarranted variation*

3.0 About JPUH

3.1 About Us

JPUH is a District General Hospital located in the coastal town of Gorleston-on-Sea on the Norfolk / Suffolk border. It serves a population of approximately 250,000 people.

The hospital has an emergency department, maternity department, a neonatial intensive care unit, a hyper acute stroke unit, a critical care unit and it hosts a hyperbaric oxygen therapy chamber, as well providing more than twenty different surgical and medical specialties and diagnostics.

The JPUH is not only a hospital building, it is part of the fabric of the local community where more than 3,000 people work, and are 'Proud of the Paget'. The community paediatrics service is provided from a separate location called the Newberry Clinic.

3.2 Activity

In 2019/20 JPUH (pre-COVID) key activity numbers were as follows:

> 102,043 A&E attendances
> 39,372 non-elective admissions
> 290,885 outpatient appointments
> 42,264 elective day case procedures
> 5,895 elective admissions
> 3,679 maternity deliveries

3.3 JPUH Ambitions

The overarching JPUH Strategy has four Ambitions, aligned to the development of the ICS and system working in collaboration with partners. Our Clinical Strategy is consistent with each of the four Ambitions. Each Ambition has a number of measurable objectives, and progress is monitored via the Trust Board.

- Ambition 1 - **Deliver outstanding care for our patients**
- Ambition 2 - **Work with, and support, our people to deliver the best for our patients**
- Ambition 3 - **Make the best use of our physical and financial resources**
- Ambition 4 - **Be a leader of collaboration and partnership working locally and across the system**

3.4 JPUH Quality Priorities 2021-2022

JPUH also has nine Quality Priorities which are set out below. They can be linked to the Trust Ambitions and all three of the Clinical Strategy themes as they carry through the principles of collaboration with partners and holistic patient centred care.

QP1 – Reduce the number of inpatient falls resulting in harm

QP2 – Eliminate Never Events and, using the most effective Quality Improvement (QI) approach or human factors methodology to embed the learning to implement new ways of working into business as usual.

QP3 - Embed the Ward Accreditation process initiated as a Trust Quality Priority in 2020/21

QP4 - Reduce the level of clinical harm as a result of long elective waiting times. Ensure timely and responsive communication to the patients.

QP5 - Embed the Quality Improvement (QI) approach across the Trust

QP6 - Improve the completion of mental health documents for patients in our care

QP7 - Ensure the best patient experience is achieved by reducing health inequalities in the local community and among Trust employees

QP8 - Develop and deliver a Patient Voice and Engagement Strategy

QP9 - Reduce the length of stay for patients and those patients who have a right to discharge.

3.5 Commissioners

Our commissioners are NHS Norfolk and Waveney CCG and NHS England Specialised, Public Health and Secondary Dental, plus some smaller contracts with Heath Education England. 85% of our revenue income is from these commissioners with the remainder coming from inter-Trust agreements and SLA's with other parties.

This will change from July 2022 as Norfolk & Waveney ICS becomes a statutory body and the commissioning functions move into the NHS Body, specifically the provider Collaboratives.

3.6 CQC Rating

The 2019 Care Quality Commission (CQC) report of the Trust concluded that the Trust achieved a 'Good' rating, highlighted areas of outstanding practice, praised staff and, importantly, showed clear evidence of continuous improvement in the services we provide to our patients. In every area inspected against the five key criteria, we achieved either a 'Good' or 'Outstanding' rating.

The results of this inspection provide a firm platform to continue developing our services for our patients, working closely with our healthcare partners across Norfolk and Waveney, with the aspiration of becoming an 'outstanding' hospital.

3.7 JPUH Financial position

JPUH has an annual turnover of approximately £250m. The JPUH financial position in 2019/20 (pre-pandemic) was a surplus of £1.4m on a control total basis, and under the pandemic financial regime during 2020/21 the Trust reported a control total surplus of £2.7m. The 2021/22 financial position is forecast to achieve a break-even position under a largely

unchanged pandemic financial regime. As Treasury and DHSC policy gradually reverts the NHS back towards a more traditional funding model in 2022/23 and beyond, the Trust is likely to receive an income reduction and will need to refocus on cost control and waste reduction. Investments required to implement this clinical strategy will need to be made through using existing resources more efficiently to supplement the limited amounts of new funding that will be available.

It is very important to note the change of focus to a system based control total, as we have transitioned into an ICS in 2021/22. All Providers and Commissioners will need to work collectively towards a system financial control total and sign up to a System Collaboration and Financial Management Agreement. The actions of one party should not adversely affect the system position overall. All significant investment decisions will need to be aligned to system strategy and will be taken as a system collective rather than a local Trust level. The arrangements at alliance level are yet to be confirmed, but it is expected that the financial management approach will need to be aligned to partnership and integrated working.

3.8 Inter-relationship with other hospitals and partners

The relationship that the JPUH has with the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) is a critical interdependency. The NNUH is the closest tertiary unit for referrals for a wide range of services including cardiology, vascular and radiotherapy, and they are the hub for the spoke renal unit that is located on the JPUH site.

The three Acute Trusts established a Committees in Common in October 2020 and will become an Acute Provider Collaborative during 2022.

The Norfolk & Waveney Cancer Alliance works across all three hospitals and the ICS footprint. JPUH is part of the Eastern Pathology Alliance with NNUH and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH), and NNUH provides a cellular pathology diagnostic service to JPUH. JPUH and NNUH have 'visiting consultants' which contributes towards skill retention. Working across more than one site offers this opportunity. Another tertiary hospital that the Norfolk hospitals have links with is Addenbrookes; this is our closest major trauma unit and specialist maternity unit. JPUH hosts outreach clinics for other specialist hospitals such as GOSH, so that paediatric patients and their families do not have to travel and instead the consultant visits JPUH once every few months. This close working relationship needs to be underpinned further by workforce and digital as key enablers.

East Coast Community Healthcare Community Interest Company (ECCH CIC) are a social enterprise, providing NHS community health services across Norfolk and Suffolk and they are the key partner for JPUH for provision of community services. The services that ECCH provide are already structured through four of the seventeen PCNs. ECCH's services include for example specialist palliative care through a partnership with St Elizabeth's hospice, speech and language therapy for adults and children, Early Supported Discharge for stroke patients, dietetics, diabetes service, wheelchair services, podiatry, stoma care, cardiac rehabilitation and a wide range of community matron and district nursing services that provide integrated care within the community. ECCH support JPUH with the delivery of stroke services, JPUH support ECCH with the delivery of the diabetes service and the stoma pathway is shared.

These close inter-relationships between providers at 'Place' level, underlines the importance for ensuring clinical sustainability through alignment of clinical strategies, so we can deliver services to meet the needs of the local population in GY&W

3.9 Hospital Services Strategy (HSS)

In 2018, the JPUH, NNUH and QEH commenced collaborative work to integrate ENT and Urology Services with the aim of improving pathways for patients, sharing staff resources and clinical expertise. Our experiences over the last three to four years have brought invaluable learning. It is becoming clear that meaningful achievement of the originally intended Acute Service Integration goals of a single contract with commissioners, a single clinical workforce, and a single patient waiting list, requires an organisational approach across the Norfolk and Waveney Acute Hospitals Group.

HSS continues to look at services across the Acute Provider Collaborative, and is taking the learning from the previous integration work to develop a methodology for service re-design, which will see the best possible use of resources across the Collaborative. This is includes service re-design, policy alignment and shared strategic objectives.

In advance of the development of an acute clinical strategy covering all three Acute Trusts in Norfolk and Waveney (JPUH / NNUH / QEHKL) we will work with the other Trusts to develop new approaches for alignment of clinical services. This work will be overseen by the Clinical Oversight Group.

The Connected Leaders Programme will support Clinical Leaders from all three Acute Trusts in Norfolk and Waveney to support the development of integration plans for the agreed specialties. The proposed delivery will be overseen by the Hospital Services Strategy Programme Board to provide consistency of approach across the ICS for pathway redesign.

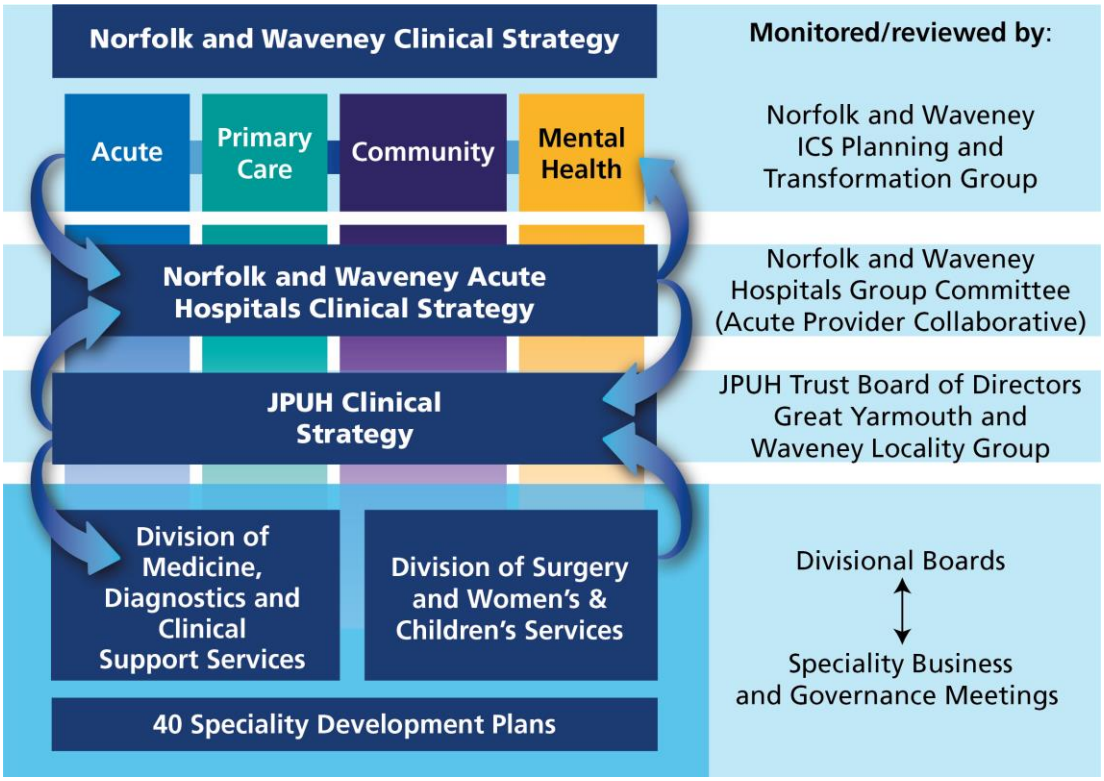
4.0 Developing the JPUH Clinical Strategy

Patients are at the forefront of the services and care that the JPUH provides for our local population. Compassionate care will remain at the centre of all that we do, but what we provide, how and where from will need to develop to meet the needs of our local community. We will embrace the opportunities of partnership working, technology, our workforce, research and education.

JPUH will continue to serve the local population providing planned and unplanned care, but a key change is that we will not be doing this on our own; it will be with partners. Some of the services we currently provide may no longer be provided by us on our site, because the patient pathway will be re-designed to better meet the needs of patients with care provided closer to home.

This Clinical Strategy significantly contributes to underpinning the delivery of the NHP programme and this second iteration of the Strategy reflects the outputs from the specialty development planning.

Below is shown the relationship of the JPUH Clinical Strategy within the wider context of the ICS.



The JPUH Clinical Strategy will support the draft Norfolk & Waveney Clinical Strategy which is due for publication in spring 2022.

The two Strategies are aligned and consistent (see 2.4). The JPUH Clinical Strategy is a sub-set of the Norfolk & Waveney system-wide Strategy, which has a wider range of partners / health and care providers.

A collaborative of representatives from Quality Management, Hospital Services Strategy and owners of the Service Development Plans will ensure that future service delivery is aligned to these principles.

4.1 JPUH Clinical Strategy: Phase 1 - The Eleven Specialties

The JPUH Clinical Strategy work commenced in 2020 with the development of Specialty Development Plans (SDPs) for all specialties, across the three clinical Divisions of Medicine, Surgery and Corporate, assessing the opportunity for collaborative working across the ICS and particularly between the three acute hospitals, be that formally through the Hospital Services Strategy, or more informally bringing the benefits of shared workforce and research.

The Hospital Management Board (HMB) identified which specialties would provide the biggest opportunity for delivering services for patients differently ('function' and 'form' i.e. where?, what? and how?), and which services are expected to provide the largest increase or decrease in acute activity. This work was signed off by the clinical divisions in December 2020. The eleven specialties that were identified are set out below:

Division of Medicine	Division of Surgery and Women's & Children's Services
Cancer Services – across both Divisions	
• Older Peoples Medicine	• Trauma & Orthopaedics
• Dermatology	• General surgery
• Cardiology	• Ophthalmology
• Stroke	• Obstetrics & Gynaecology
• Neurology	• Paediatrics

Each specialty was the subject of workshops during February 2021 which built on the SDPs, stretching the vision into the longer term whilst taking into account the needs of the patients, workforce, GIRFT reviews and findings, pathway changes, opportunities for collaboration with community, primary care and the ICS, using technology and workforce as enablers.

4.2 JPUH Clinical Strategy: Phase 2 – 42 specialties

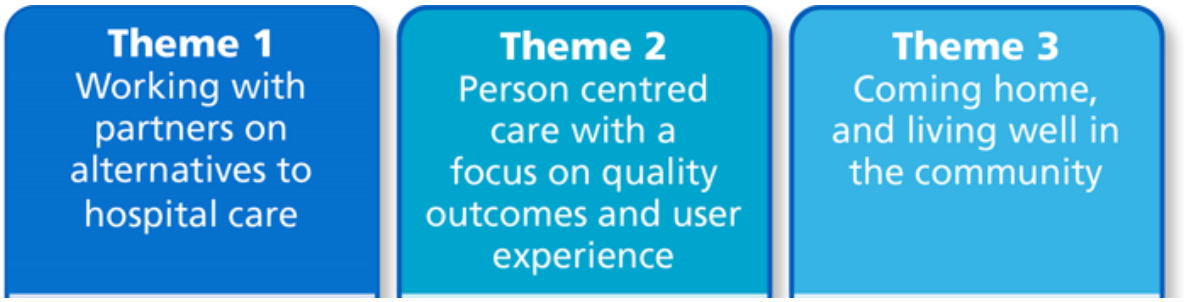
During autumn 2021 we have undertaken workshops with each of the 42 specialties (now includes Medical Examiner, ENT and Urology). The purpose of the workshops were to update the SDPs, in order to understand the future strategic direction and to inform the annual planning for each specialty, with a particular focus on learning from the Covid-19 pandemic, work to address health inequalities which became more evident during the pandemic, work to address unwarranted variation and further opportunites to achieve optimum levels of integrated working. The outputs of the specialty development planning are reflected in this updated Clinical Strategy.

4.3 Clinical Vision, Themes and Principles

The outcomes from the initial workshops identified a single Clinical Vision, and three main clinical themes, which remain unchanged in this update.

The Clinical Vision is: **Putting patients first - providing high quality clinical services to support our communities to live a healthier life**

The three clinical themes are:



Local engagement with clinicians in primary and secondary care, system partners and local Providers in the acute, community and mental health sectors to challenge the themes and secure commitment to delivery is ongoing. This is being achieved through engagement with the Great Yarmouth & Waveney Locality Group and ICS forums. We see it as essential to have our vision and subsequent themes agreed with our system partners and reviewed in line with the draft ICS Clinical Strategy.

The vision and key themes will be understood by each specialty and a set of deliverable objectives agreed for delivery. These objectives will then be shared with our system partners to ensure that these are aligned.

5.0 The overarching Clinical Vision and our three Clinical Themes with Supporting Principles

This is an exciting time for our local community as we further develop our JPUH Clinical Strategy for the next 5 years, and progress the planning to build a new hospital where we will provide some of our services in the future.

The changing needs of our population coupled with advances in technology and workforce, research and education allow us to think more innovatively about who is best placed to provide high quality clinical services for our local population, and how we do that in partnership.

JPUH strives to support the local population to live well independently, and provide high quality clinical services at our hospital when the population needs to access them. JPUH is clear that it has a role to continuously improve local health equality. This Clinical Strategy is looking to the future but is also seeking to identify what can be done now, in a transitional phase.

In support of the Clinical Strategy, the Trust has developed a Clinical Vision:

Clinical Vision: Putting patients first - providing high quality acute clinical services to support our communities to live a healthier life

The Clinical Vision is supported by three themes and include three principles that thread through the themes, as shown following.

Theme 1 – Working with partners on alternatives to hospital care

This theme is about supporting the population to live well at home, avoiding unnecessary hospital attendances and admissions.

This will involve

- Meaningful and genuine partnership working with other organisations, leading to improved patient care and outcomes
- Creating a healthcare environment without borders, ensuring the right patient contact by the right person rather than restrictive organisational / professional silos

- Promotion of self-care, prevention initiatives, social prescribing with partners, to improve the health and well-being of patients, their families and staff
- One care record that all health and social care can see, enabling care homes to have access (where consent is given) to patient records
- County Councils, Local GP's, ECCH, NSFT, NCH&C, EEAST, NNUH, QEH, Public Health England, together with the third and independent sector, as key partners in the care that is provided for patients and provide it together, in an integrated way
- Managing referrals with advice and guidance so a patient is referred only if clinically appropriate, supported through enhanced education in the primary care and community sectors and Referral Assessment Services
- Seeing patients virtually using clinicians from a range of organisations; this may be for an appointment or a treatment, including therapies
- Maximise the role of digital as an enabler where possible
- Vertical integration - JPUH will be working much more closely with primary care, high street optometrists, community care, social care, the third sector and independent providers, as well as the patients themselves especially in our ICS 'Place'
- Sharing our knowledge and skill sets with system partners, including for care homes staff, who will be supported initially by community rapid response, supplemented with digitally-enabled secondary in-reach and out-reach care
- Horizontal integration - JPUH will be working more closely together with all partners, including NNUH, QEH and other NHS and care providers across the system including ECCH and EEAST, together with 111 and GP out of hours providers (to deliver the system Clinical Strategy)
- Supporting the development of and using community diagnostic hubs, to achieve more care closer to home for our patients.
- Clear pathway for pre-habilitation and rehabilitation care accessible to all
- Ensuring where possible education is both joined up and cost is not the prohibiting factor for all to ensure there is a consistent high standard of both care and education across the locality.

Theme 2 – Person centred care with a focus on quality outcomes and user experience

If you do need to receive NHS care at the hospital or in the community, we want this this be a positive experience and for it to be centred on you.

This will mean:

- Waiting times for patients are reduced though improved clinical prioritisation
- Improved equity of access to care and maximised capacity via a single waiting list across the ICS
- Patient tells their story once and has a voice, enabled by the Electronic Patient Record (EPR)
- We all invest time with our patients, so they know what to expect before, during and after their care through improved information and communication
- Holistic patient care, wrapped around the person and their mental, physical health and well-being needs so the experience is personal to them
- Joining up the services for our complex patients, who have a range of issues and need support across a number of specialties
- Supporting patients who required adapted care e.g. bariatric patients, patients with learning difficulty, dementia, autism etc.

- Services co-designed with the patient, their carers and family, with psychological and practical support, recognising varied needs e.g. transgender patients
- Patients are at the forefront of their care, have a say in the care they receive and how they receive it, resulting in more patient choice
- Local health inequalities are understood and services are developed to reduce unwarranted variation e.g. hip fracture prevention clinic and bone health advice for older patients, community paediatric service
- Enhanced infection control measures including a larger proportion of single rooms with en-suite facilities
- Clearer stepping up and stepping down facilities, potentially with Trust partners
- Minimise the time a patient needs to stay in the hospital where clinically appropriate by, as a minimum, matching national length of stay benchmarks for elective and non-elective patients
- Expectation of more enhanced care built onto the wards care through use of technology (level 2 patient care)
- Services are consistently provided 7 days per week
- Clear separation between elective and non-elective patient flows. JPUH supporting the system by providing more elective work in a cold elective site to be distinct and separately located, remaining operational at times of extreme emergency demand for beds
- More planned care will be provided as an Out-Patient appointment or a Day Case, and less provided as an In-patient. This reduces or eliminates length of stay, improves patient experience and recovery time
- More one stop clinics
- Reduction in the number of follow up appointments, with 25% provided virtually, and introduce Patient Initiated Follow Ups (PIFU)
- Care may be provided in the hospital or in the community - services are not constrained by the hospital estate
- Paediatric services are family friendly, recognising inclusively and the complexity of modern families and their needs. Paediatric patients are transitioned into adult services seamlessly
- Enhancing our diagnostic offering by JPUH providing more of the higher volume, straightforward diagnostics for the local population, repatriating from NNUH and out of area, where appropriate, thereby reducing the need for patients to travel.
- Use of technology to monitor pts with long term conditions e.g. diabetic, cardiac, with use of AI to identify those needing intervention (could be from primary, community or secondary provider)
- Developing more robust and sustainable clinical services via linking up across the Acute Hospitals Collaborative
- JPUH continuing to champion novel and innovative pathways of care, to attract a skilled workforce and retain a unique selling point, including the introduction of robotic surgery and ‘soft landing’ surfaces for frailty wards
- Facilities for private patents that optimises the opportunities for this patient group and the benefits that brings to our workforce recruitment and retention
- Clinical services that respond and embrace the latest guidance including GIRFT.

Theme 3 – Coming home, and living well in the community

Once you have received your care, we want you to be able to return home to your community, with support to recover and live well.

This will be enabled by:

- Seamless transition between hospital care, and care provided in the community. This may be provided by the same staff as we enable staff to rotate between roles
- Improved communication between hospital staff, GP's and care homes to enable the seamless transition. This is more than a shared care record, it's a conversation
- Home First and Discharge to Assess models of care, so patients can recover well in the community without delay
- Excellent two way communication with the patient, explaining and listening, ensuring that when they are ready to go home, they have what they need to support them
- Pre-habilitation i.e. proactively support patients before their procedure so they are ready to go home afterwards, as soon as possible
- Increase the self-management approach for patients with long-term conditions, providing education to newly diagnosed patients and empowering patients to only access the service when clinically necessary
- Reducing the default of regular face to face follow up appointments. Some of this could be group based and patient initiated and virtual wherever possible
- Providing care at home or in the community where clinically appropriate, to reduce unnecessary hospital appointments. This includes monitoring of existing long term conditions through e.g. wearable devices or medication
- Reducing the length of stay in hospital through reablement and therapy input at home or virtual wards
- Improving access to diagnostics e.g. DAC programme, thereby increasing the number of one stop clinics so patients go home with a diagnosis.

Supporting Principles

The Trust has three supporting principles that supports the vision and weaves through all three themes.

1. **Improving integration and partnership working**

What we mean by this is we are committed the achieve the optimum levels of integration at speciality or pathway level, to provide patient centred, consistent, efficient and robust services at ‘place’ and ICS levels.

Examples of how the Trust is working to improve integration and partnership working include:

- Increasing links with other acute service providers within the ICS to share learning and agree common clinical pathways
- Increasing links with community, mental health and primary care for monitoring and management e.g. of some long term conditions
- Increasing links with voluntary services .e.g. Norfolk support social isolation, supporting the high intensity user etc.
- Increased multi-agency approaches e.g. case discharge meetings
- Joint roles across provider Trusts and with community services including rotation posts e.g. Occupation Therapy
- Opportunities for JPUH staff to also work at other regional provider Trusts
- Improved digital infrastructure in order to enable cross-agency working / communication

2. **Reducing health inequalities**

What we mean by this is working with our 'place' and ICS partners to identify approaches to understand, quantify and reduce the impact of health inequalities on our patients, visitors and staff.

Examples of how the Trust is working to reduce health inequalities includes:

- Raising awareness at Trust and speciality levels and identifying existing or future workstreams that address the locality priorities of mental health, obesity, hypertension, diabetes and respiratory
- Expansion of individualised care already seen in maternity and oncology for example, including accommodating needs such as mental health, frailty or bariatric requirements
- Increased accessibility of our services and convenience through 'one-stop' clinics, with more diagnostics taking place at JPUH site or in the proposed new community hubs
- Potential to move some services into primary and community care settings, and for JPUH to further support delivery of acute services in a community setting, for example:
    - Shift of some endoscopy services into a community setting
    - Engagement with primary care to assist with patient self-management / education in advance of surgery
    - Acute clinicians to work in the community i.e. visits to nursing homes to help educate staff and reduce admissions

3. Reducing unwarranted variation

- *What we mean by this is* assessing and responding to opportunities for improvement for patients, staff or Trust performance highlighted by:

    - Contract Performance Notices
    - GIRFT
    - Model Health System (was Model Hospital)
    - NHS Benchmarking Network Reports
    - Summary Emergency Department Indicator Table
    - Service Peer Reviews

Examples of how the Trust aims to reduce unwarranted variation in the services it offers include:

- Raising awareness at Trust and speciality levels and establishing a centralised log to monitor opportunities and actions to address e.g. variation in outpatient unit costs; increasing use of virtual appointments or patient imitated follow up appointment
- Taking a whole system approach to equity of access to services
- Taking action where JPUH is an outlier against national or regional service provision

5.1 Covd-19 Pandemic Learning

In addition to the themes and underlying principles, JPUH has also taken a significant amount of learning from the experiences of the Covid-19 pandemic. Some changes that were made to the delivery of services were already planned, but have been implemented in a shorter timescale. Other changes were made in order to continue to deliver services to our local community in a safe way. JPUH is taking the positive learning from these changes and planning to develop these further into the future clinical and operational delivery of services. Examples of these changes include:

- Increased use of digital technology in the delivery of care. For example:
    - Occupational therapist videos rather than face to face group sessions; electronic patient leaflets rather than paper versions etc.
    - cloud-based patient monitoring systems
    - digital provision of virtual outpatient appointments
    - electronic solutions to support activity monitoring, patient flow and discharge
    - Home reporting e.g. radiology

- Increased flexibility of workforce, including:
    - More 7 day working, remote working and flexible working
    - Increased junior doctor and nurse led roles, including criteria led discharge
    - Enhanced Multi-Disciplinary/inter department Working
    - Training to enable temporary redeployment of staff to areas of highest demand, including supporting the surge centre at NNUH
    - Increased ward based support services e.g. pharmacy
    - Participation in large staff based research trial

- Adaption of estates and facilities, including:
    - Increased infection control measures including social distancing and ventilation
    - Expansion of facilities e.g. additional MRI, Emergency Department extension
    - Enhanced piped oxygen capability

- Changes to patient pathways, to manage demand and increase patient safety, including:
    - Promotion of the Attend Anywhere principles, telephone appointments and patient initiated follow –ups (PIFU)
    - Move to day case procedures, where clinically appropriate, to reduce inpatient admissions
    - Alternatives to face to face working e.g. in the dementia service
    - Provision of service away from the main hospital site for vulnerable patient groups e.g. the chemotherapy bus
    - Temporarily movement of services to JPUH from NNUH e.g. Domiciliary NIV
    - Alternative diagnostic procedures e.g. colon capsule

During specialty engagement and reviews, we will seek to understand which changes are sustainable and can be enhanced further as part of the future clinical model for that area.

Each specialty will look to embed these changes into business as usual and be supported by the relevant enabling programme (e.g. Digital, Workforce, Clinical Pathways) to continue to build upon these and ensure any clinical, financial and quality impact on service delivery is included in future planning.

6.0 Enablers to the Clinical Strategy

The Vision of the Clinical Strategy is underpinned by enabling strategies and the four that were identified through the specialty workshops as having the most impact on the delivery of the Strategy are Estates, Digital, Workforce and Research.

6.1 Estates

The JPUH Estates Strategy sets out a vision for the future for the James Paget University Hospital site. It reflects supports and articulates the strategic objectives, key concepts and principles and key estate priorities.

The NHP scheme announced in September 2019 by the Department of Health and Social Care is a major capital investment in the nation's health infrastructure. This will deliver a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate.

The JPUH has been successful in receiving seed funding to develop a Health and Social Care Campus to replace the existing James Paget Hospital site.

The site masterplan is currently in development and will be a key enabler to the delivery of the services, and service configuration outlined in this Clinical Strategy. The estate proposals will ensure the optimum delivery of clinical services, adjacencies, circulation and facilities. The site masterplan will centre heavily on the 'user experience' - patients, visitors and staff - aiming to make their use of the site, its buildings and facilities and the journeys between them logical and simple to navigate.

The key concepts and principles that are integral and underpin the priorities within the Estates Strategy include:

- zoning of space in the Trust to improve patient flow and the adjacencies between clinical services;
- ensuring the safety of patients and to enhance patient experience;
- ensure efficiency in service delivery;
- flexibility of space; and
- the demarcation of parcels of land to be used for other developments and to exploit commercial opportunities.

In advance of the implementation of the new hospital, the Trust has also been successful in developing, or planning the implementation of key services including:

- Extension to the Emergency Department was delivered in 2020 to provide additional assessment and waiting space
- New building housing MRI facilities
- Plans are in development for a Diagnostic Assessment Centre on the JPUH site, incorporating additional imaging capacity.

6.2 Digital

The Digital vision is that every patient engagement point, every system and operational process point will become a location whereby information can be collected, accessed and modified. Digital technologies will contribute to transforming care in a sustainable, efficient and effective way. The core benefits will be to improve the efficiency and economy of the

JPUH which releases clinical and nursing time for personalised direct care; and for the new hospital to a have world-class digital capability.

Key enablers will be:

- The introduction of an ICS shared Electronic Patient Record (EPR)
- The introduction of a regional Shared Care Record (SCR)
- Expansion of whole-journey clinical pathways across the whole Health and Care sector
- All information to be integrated including data, audio, and visual services
- For information to be accessed and processed at every patient touchpoint, both within the hospital, at home, and in the community
- To replace paper with digital information
- Personalised Healthcare will be transformed with new technologies such as Artificial Intelligence and digital automation, with care tailored to the person
- Increased investment in Digital services across the whole of Health and Care will be critical to the successful adoption and benefits of new technology.

Core Digital Objectives are:

1. **Integration** of patient care pathways through EPR and SCR systems
2. **Sharing information**, electronically where possible, across organisational and geographic boundaries through EPR system
3. **Digital tools** to capture, monitor, and manage patient data
4. **Better decision making** through the adoption of AI, electronic observations and clinical decision support tools
5. **To leverage and innovate with technology**, including remote monitoring, to increase positive patient outcomes and personalised patient care

Deliverables

With the digital teams from across the health and care sector working collaboratively with a shared vision and common goals, common decisions will be made and technologies developed to benefit the local population. Systems will continue to be aligned and coordinated, delivering common tools that will improve the accessibility and familiarity of systems for both patients and care providers.

Many of these clinical tools will be delivered before the completion of the new hospital. This will enable earlier benefits to be realised, and for the new technologies to be proven and embedded, ahead of the building of the new premises. Information and governance processes will be developed in order to ensure robustness of information security.

New technologies for the new hospital will be more focused upon the efficient and sustainable operation of the new environment. These will include effective buildings management, increased amount of automated processes, and efficient utilisation to services and equipment.

- **Ahead of the new hospital (short to medium term)**
    - A shared EPR will replace a range of existing separate clinical systems
    - A Shared Care Record (SCR) will provide access to patient information from the region's Health and Care sector
    - Mobile technologies will increase rapidly as part of the e-Observations project
    - Single Sign-On will be implemented to increase the speed and reliability of access to multiple different systems.

- Automated systems e.g. Robotic Process Automation will be adopted to automate the regular high-volume processes and pathways, freeing up care-givers so they can undertake more patient facing activity or complex work
- Patient observations will become digital through medical devices or hand-held devices
- Paper will be significantly reduced with more use of electronic requesting and referrals, in both Pathology and Radiology
- Virtual consultations will be extended to enable more home-based patient engagement
- Remote monitoring & self-care – remote and home management will form part of the wider hospital, with patients' homes becoming virtual wards
- Research (AI) – Digital will be used across a range of new health treatments, research, and care.
- Patient Portal will be a feature of the EPR, with our patients able to update their own information, submit real-time care data, and book their referrals and visits.

- **Within the new hospital (medium to longer term)**
  - Active real-time building management systems will control air, power, pressure, and other conditions within the premises in order to effectively and efficiently control the environments.
  - Wards and Clinics will be fully digital, with every bed and room providing multiple opportunities for information exchange and processing. This will include electronic observations and multiple communication channels between patients and care providers.
  - Patient and equipment tracking and CCTV will be implemented to ensure the safety and security.
  - Digitally interactive – The building will be able to manage patient movement, providing directions, access control, sensing activity, self-check-in's, and presenting information ahead of a patient's arrival.
  - AI will be adopted to aid clinical care and decision making. This will include the automation of processes e.g. clinic bookings and assisting in the diagnosis of patient conditions.
  - Digital technologies will be adopted, with virtual learning being used in Education and Training, automated robotics in transportation of materials around the campus, supply chain management in procurement, to the efficient utilisation of resources and recycling.
  - Patients with smartphones will have access to building information and their own personal information on their own smart devices.

6.3 Workforce

Through the Trust's 'People Strategy' we have set out clear workforce priorities that will support delivery of the Trust's strategic ambitions, vision and objectives whilst also demonstrating our values in all that we do. We are committed to supporting our staff to deliver care at their best wherever they work and whatever their role.

We are a leading healthcare organisation within the Norfolk and Suffolk health systems, and are developing a compassionate supportive culture that makes the hospital an attractive place to work, enabling our staff to deliver the highest standard of care. We believe in

continuous development and as such ensuring we inclusively support our staff with the development they need and identify our talent for the future.

Our People Strategy is closely aligned with the national workforce strategy '**We are the NHS: People Plan for 2020/2021 – action for us all**' and we are keen to build our workforce development around looking after our staff, driving innovation, creating new roles and giving our staff the opportunity to shape and influence theirs and the organisations future.

As an organisation we strive to improve the experience of our patients by ensuring staff are appropriately trained, well equipped and performing to their best. To this end, we are creating the environment within which staff to be open about their views, have development opportunities that align with their ambitions and needs and provide them with the working conditions that allow them to be effective, caring and productive.

The delivery of high-quality patient care depends upon staff being happy in work, being appreciated and having the support they need. This is underpinned by our leadership development programme which is designed to equip managers to work alongside their staff, provide excellent leadership and promote inclusivity. In addition, the programme also ensures our workforce strategy supports our plans for integration, innovation, and modernising the delivery of care.

Our priorities are:

Short term - we will focus on leadership, management and career development, the establishment of long term workforce plans in line with our Clinical Strategy and collaboration with partner organisations. Improve how we market the Trust and ensure our attraction and onboarding arrangements are first class. We have been successful in retaining staff but will develop further plans for those areas where turnover is still high e.g. band 5 and 6 nurses. We will also extend our plans to increase access points for people to enter into healthcare careers. This will involve integration of our apprenticeship schemes and increasing the numbers of physician's associates, gateway doctors, Advanced Clinical Practitioners (ACP's), nurse associates and extended scope practice allied health professionals to support leadership and management development.

Medium term - we will continue to extend our digital workforce programme improving workforce data and supporting effective decision making. The programme also supports a more effective staff experience with access to their earned pay, the introduction of self-rostering and online training. Our plans also include opportunities for more staff to work remotely and differently and improving further the working environment. The benefits of our long term planning will align with our work towards the integration of acute services in Norfolk and Waveney and the development of new ways of working as we build our plans for a new hospital. The extension of services across 7 days will be developed across clinical and corporate services and we will work with our partners in the ICS to introduce common employment practices and opportunities for staff to move around the system and staying within it.

Longer term – we are committed to providing staff with long term career opportunities and as such will be working within the ICS to develop closer working arrangements with higher education and provider organisations. We will build upon our plans for more innovation and changing the way services can be delivered. This will mean the implementation of

technological advances that will require the development new skills new roles and will create new employment opportunities. We recognise the new hospital will present new challenges for our workforce and we aim to continue our commitment to co-designing services with our staff for the future. The number of staff we employ directly may reduce as we seek to find more innovative solutions to the workforce challenge and share staff across the ICS.

6.4 Research

There is a real passion for research at JPUH, within the clinical teams as well as good take up from patients and staff engaging in clinical trials and research projects in general.

There is a drive to make research real and relevant to all of us by integrating research into business as usual clinical service delivery, so patients and staff have a chance to take part and see the outcomes.

Evaluation, continuous improvement and innovation are key to the research agenda so we build on achievements and success.

The following areas are those that have been identified as being key enablers to the development of our Clinical Strategy:

Maximise opportunities for patients and staff to be involved in research projects

To support the development of specialty based research hubs to generate research related income to ensure the sustainability and development of research infrastructure to enable patients to benefit from taking part in the testing of innovative care pathways and new treatments.

To provide opportunities for staff to be contributors to research, both as researchers and participants, to increase awareness and understanding of research and provide development opportunities within their field.

Provide our workforce with the skills to deliver world-class research

To increase the number and range of staff groups equipped with research based knowledge by providing mentorship and training to all professions to empower staff to engage in research projects. To actively encourage staff to undertake educational opportunities via application for scholarships and fellowships to establish research based career pathways.

Embed research as business as usual

Fostering a culture where research is seen as the norm by actively encouraging staff to examine current practice and to seek solutions through research either by participating in established research programmes or developing their own in collaboration with local HEIs and NHS Partners.

Collaborating with Norfolk and Waveney partners to meet local need

To work with partners across N&W to identify local needs including submission of joint research funding applications through collaborations with UEAHSCP and UEA / Norwich Research Park.

7.0 Clinical pathway based-groupings

Our Clinical Strategy will ensure that each specialty has a sustainable future delivery plan that aligns to the patient need and complements overall service provision within the ICS. In order to achieve this each specialty has been supported to develop, deliver and maintain service provision through a robust SDP.

The SDPs have been provided by every specialty within JPUH, with additional focus and support given to the 11 priority specialties listed in section 4.1. During 2022, a review of the priority specialties will be undertaken by the three Acute Trusts and a clear methodology will be adopted by these priority specialties to ensure that objectives are measurable, achievable and aligned to ICS principles.

Each SDP addresses the following key areas:

- Learnings from Covid - including changes that can be sustained into the future;
- Health inequalities - including level of awareness and actions to address these;
- Unwarranted variation - including level of awareness and actions to address these;
- Sustainable service provision from a quality and financial perspective; and
- Enablers (and any constraints) to achieving specialty objectives, including:
    - Digital aspirations;
    - Workforce requirements;
    - Estate and Facilities considerations;
    - Integrated working – pathways, policy and governance

A set of metrics will be agreed alongside a plan for implementation that sets out the short, medium and long term objectives for each specialty. These will provide a tangible set of goals to effectively manage current demand within the service, and address the future requirements for the specialty.

The SDPs will also include all relevant actions required to achieve the delivery of the Trust's overarching clinical pathways. These pathways were identified by the specialties as integral to achieving the aims within the '3 Key Themes'. Each specialty will understand its responsibility in supporting the development, mobilisation and sustainable delivery of these clinical pathways. A high level overview of the strategy for each of these groupings is provided below:

1. **Urgent and Emergency Care**

Emergency Care, and unscheduled medical and surgical admissions

JPUH will continue to operate a type 1 Emergency Department (ED) providing a full range of Accident and Emergency services, covering both adults and children and all emergency presentations ranging from minor injuries to resuscitation, major trauma and acute mental health presentations.

In terms of the pathway, we will work with local partners towards the creation of one integrated and emergency care system, with an emphasis on prevention, and the creation of primary and community alternatives to hospital. Hospital treatment will be coordinated, with rapid turnaround and more Same Day Emergency Care (SDEC), supported by enhanced access to diagnostics, digital and workforce enablers.

The model is based on the following pathway, which takes into account the national requirements of Same Day Emergency Care (SDEC):

- **Input and arrival** – from the ambulance service, via GP streaming, ED pre-booking, Think 111 / GP First model of care. Closer working with primary care and mental health and social services will be really important through the utilisation of admission avoidance initiatives and alternative pathways to ensure patients can be fast tracked straight into the correct area
- **Throughput and flow** – 7 day services, SAFER model, diagnostics including radiology and laboratory services, in-patient specialty on-call teams and mental health are key to ensuring patients do not remain in the ED any longer than they need to and are quickly seen by the most appropriate teams
- **Outcome as either an admission or a discharge** – Holistic, person centred care provided through the Ambulatory Unit, Surgical Assessment Unit (SAU), Frailty Assessment Unit, Ward Beds across all specialties, transfers to other hospitals by ambulance, the Early Intervention Team, services in the community and out-patient clinics. Attendances at ED will not convert to an admission or hospital stay unless this is clinically necessary.

Delivery of this pathway is underpinned by:

- Adopting the Internal Professional Standards (IPS) for ED, using the nine principles advocated by the NHS Improvement Rapid Improvement Guide. This is about translating professional standards into professional behavior and embedding it as the culture of the department
- Avoiding unnecessary admissions through the establishment of more community based services at 'place' level, rapid Same Day Emergency Care (SDEC) and more use of technology as an enabler
- Improved patient and work flow when a patient is admitted to the hospital through improved 7 day working, clear decision making and escalation, a multi-specialty Frailty Unit, a Surgical Assessment Unit, Ambulatory Unit, re-designed repatriation and referral pathways with tertiary centres and strengthened network arrangements for the joint working of clinical staff
- Improving discharge through different models of care such as early supported discharge, Home First, Discharge to Assess, virtual wards, in-reach and outreach therapy and reablement services and patient monitoring aids, virtual follow ups, and community nursing teams following up the care of post-surgical patients

For patients this will mean:

- More access to, and confidence in, services closer to home, seamless pathways across all settings, less duplication, shorter waits and only needing to tell their story once, enabled by joined up digital enablers
- Increased access to services at home or closer to home, with a greater emphasis on empowering patients to self-care, with seamless pathways across all care settings.
- Timely access to point of care diagnostics and access to their health and social care information.
- Unnecessary admissions will be prevented and there will be a reduction in unnecessary transfers to tertiary centres.
- Greater coordination of care between settings with the delivery of more care closer to home, and improved primary and community care support. There will be fewer avoidable admissions for conditions that can be treated in the community, with patients receiving treatment in the right place, resulting in fewer inappropriate transfers between hospitals. Patients will also spend less time in hospital, with timely discharge as soon as they are medically fit to return to the community.

For staff this will mean:

- Better communication across the department and the system, more opportunities (as a result of new roles), and increased working across all settings as one team with shared governance, learning and approach to risk
- Better communication across services and across the system, with access to holistic information for all partners. Pathways of care will be easy to follow and there will be clear signposting to appropriate services. This will enable more agile and flexible multidisciplinary team working for staff.
- A staffing model to enable 24/7 working, a better working environment with improved facilities, and the development of new and innovative roles, as well as access to holistic, person centred information, across all care settings.

2. Elective (planned) care

We will further roll out new approaches to enable on-going care in a non-acute setting where appropriate, to increase efficiency and improve outcomes for patients. This will be underpinned by partnership working through the Norfolk and Waveney System Planning and Transformation Group Work Programme to consider the optimal configuration of services to support sustainability.

Key themes include:

- Separating 'hot' unplanned emergencies and 'cold' planned elective work, preferably situated on different sites or separate areas to ensure beds and theatres are protected from extreme bed pressures
- Redesigning outpatients pathways by reducing the number of hospital appointments and increasing value to the patient through Referral Assessment Services (RAS) for GPs (e.g. .MSK pathway)
- Use of digital technology to enable virtual appointments, self-care and remote testing; patient initiated follow up (PIFU); direct access to rapid diagnostics in the community; increased delivery by advanced, nurse and other healthcare practitioners and a one stop approach at the hospital
- Optimising surgical productivity and improved theatre utilisation with more procedures provided in outpatient settings, greater use of digital innovations, robotics and Artificial Intelligence to enhance care and increase the utilisation of JPUH to add elective capacity to the system
- Appropriate and timely discharge pathways working with system partners on enhanced recovery programmes and increased access to step-down capacity, therapies and rehabilitation services
- Pre-habilitation, plan the recovery and discharge pathway with the patient, before they have the procedure
- Acute Services Integration with neighbouring Trusts for a range of specialties
- Identification and optimisation of frail, elderly elective patients to improve outcomes and facilitate timely discharge.
- Increasing the number of theatres to increase capacity to help reduce elective backlog.
- Improved integration of IT services with primary care and the other acute Trusts to improve patient safety (e.g. medicines management)
- Increased use of hospital at home service to improve flow and patient experience
- Increased use of virtual out-patient appointments (Attend Anywhere) which reduces the footfall within the Trust and has proven to be popular with patients. Reduces the need to take time off work / school for appointments. Increased use of out-of-hours virtual out-patient appointments to improve patient choice and experience.

For patients this will mean

- Increased access to services at home or closer to home, with a greater focus on patient empowerment around self-care
- Seamless pathways in place across all care settings
- Patient-initiated follow up appointments will be in place, pre-operative care will be streamlined
- Reduced waiting times and shorter lengths of stay.

For staff this will mean

- Better communication mechanisms in place, both within the Trust and across the wider system, with staff working across different settings.
- Staff will have access to facilities to improve both effectiveness and efficiency, and surgeons will spend more time in theatre and less time in outpatient settings.
- New roles with clear expectations, training and support will be established.

3. Maternity and Neo-Natal

We will support the Norfolk and Waveney Local Maternity & Neonatal System (LMNS) with a particular focus on delivering improvements in maternity care, including responding to the recommendations of the National Maternity Review 'Better Births: improving outcomes of maternity services in England'. This includes saving babies' lives and continuity of carer, the Ockenden review, Perinatal optimisation, 'Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE) and the Maternity incentive scheme.

Key themes include:

- Making maternity care safer, more personalised and more equitable
- Improved choice and personalisation with personalised care plans for all women to enable them to choose where to have their babies and the tools to make an informed choice regarding the type of care they would like to receive
- Continuity of Carer with provision of a named midwife and team supporting each woman through her maternity journey, achieved through remodelling of midwifery teams, implementation of new models at scale and provision of an integrated model of care with community services
- Safer care through collaborative working with the LMNS, the continuation of existing models such as intrapartum training, multidisciplinary training linked to the Clinical Negligence Scheme for Trusts, Saving Babies' Lives care bundles and independent reviews of serious incidents and exploration of new models
- Improved postnatal and perinatal mental health services for parents
- Digital and data improvement and modernisation, including electronic records, use of EuroKing across all the acute sites
- Multi-professional working ensuring both in-house and cross sector multi-professional training and learning
- We will ensure strong user engagement through the Maternity Voice Partnership.
- For neonatal care, there will be a consolidation of requirements for maintaining Local Neonatal Unit status and optimising transitional care and ambulatory care; utilising technological advances for care (e.g. for respiratory and feeding care).
- 111 pathway into EADU and not ED
- Increase the number of one stop clinics by providing scans and appointments on the same day

- Increased use of video calls e.g. Attend Anywhere
- Use of patient monitoring aids e.g. Fibronectin to monitor risk of women going into pre-term labour so steroids can be administered quickly
- Obtain commissioner support to explore opportunities to deliver a higher dependency neonatal unit (level 2 service)

For patients this will mean

- Continuity of care throughout pregnancy with a familiar midwife and the provision of consistent information, both to improve confidence and to facilitate the making of informed childbirth choices.
- Right place of birth
- Transitional care
- Patients will have access to post-partum professional support for infant feeding and basic care, resulting in an improved overall experience.
- Perinatal mental health development and support
- Improved morbidity and mortality outcomes for women and their babies

For staff this will mean

- Opportunities to improve existing skillsets and to develop new skills.
- The provision of better facilities which will lead to higher levels of staff wellbeing and in turn, support recruitment and retention
- Upskilling nursing staff and midwives to enable nurse and midwifery-led clinics. This will reduce attrition and offer a career pathway at JPUH
- Research posts e.g. midwives, generate additional breadth to a job role and promotes JPUH as an attractive place to work

4. Children and Young People

The JPUH provision comprises a community and an acute paediatric service.

The vision is for the community paediatric service to be provided in the community and at the new hospital, co-located with the acute paediatric service. JPUH is the only acute hospital in the Norfolk and Waveney ICS to provide a community paediatric service, and is in a unique position to integrate pathways. The CCG is working towards using an Alliance model of care across the ICS with all partners.

The acute paediatric service is provided from the JPUH site and covers an extensive range of surgical and medical sub-specialties, with both in-patient and out-patient services. One of the challenges is to ensure children and young people can be safely and appropriately transitioned into adult services, and the team would like to extend that age to 25. There is a designated paediatric emergency department, dedicated paediatric wards and one HDU bed. The vision for this service is to develop substantially from its current position, both in the number of services it provides and the number of children and young people it sees, and demand is increasing.

Key themes include:

- Seek to provide community paediatric service in the evenings or at weekends and in a more flexible way instead of face to face, providing improved access for children, young people and their families/carers

- One stop shop type setting for assessing complex needs for community paediatrics; Advanced Practitioner roles could lead the service with Consultant input for clinical decision making
- Working in partnership with community and primary care to establish new pathways and resources, alongside education
- Greater use of digital technology for inter-agency working and shared care records – this would enable staff to see children and young people in schools and at home but have an IT link back to the acute site
- Provision of supportive services, led by primary care and provided out of hospital, to help deal with lower grade clinical presentations (e.g. constipation, enuresis)
- Provision of more physiotherapy and occupational therapy in the home environment, facilitated by technology
- Develop and deliver education for GPs to enable appropriate referrals – this could be expanded to formal Advice and Guidance and/ or the development of a Referral Assessment Service (RAS)

For children and young people this will mean:

- Shorter waits for assessment, diagnosis, treatment and discharge
- The Emergency Department will no longer be the default due to awareness and confidence in alternatives
- Everything all in one place and the environment will be purpose built
- The service becomes more accessible through the use of technology and virtual clinics
- More services are provided in the home or at school so less need to travel to an acute site
- One stop shop means children and young people come in once and go home with an outcome; this avoids multiple appointments
- Specialists are trained in that sub-specialty so children and young people get the best possible care, and pathways are integrated with children and young people seeing a number of specialists at the same appointment

For staff this will mean:

- Better communication across children and young people's services at the Trust and within the wider system
- Improved staff morale as a result of a fit for purpose working environment, having the capacity to work in new ways that will have positive benefits for patients and their families and the chance to rotate between different care models resulting in wider experience and less burn out.
- Increased staff satisfaction will support an improvement in recruitment and retention.
- Scope for expanded roles and investment in the development of Nurse Practitioner led positions in the community, provides career development and increased retention
- Review Consultant requirements with a view to increasing special interest e.g. Allergy and Cardiology sub-specialties
- Develop the role of radiographers undertaking ECHOs for children, to avoid children and young people having to travel to NNUH (linked into Great Ormond Street Hospital as the tertiary centre)
- Additional roles which could be shared posts across acute and community, Learning Disability Nurse and Mental Health Nurses – this would extend the breadth of experience and exposure to different types of patient conditions and provides further holistic care

- Aspiration to expand research e.g. orthopaedic trauma, collaboration with therapy team. This assists with recruitment and retention of staff

5. Diagnostics

Diagnostics tests, scans and procedures, and reading and reporting the results in a timely way are strategically key to the efficient and effective delivery of clinical services in the hospital and in the community. Diagnostics support all specialties and services as they enable diagnosis and the treatment pathway for the patient. Some diagnostics can only be undertaken in a hospital environment currently but the aim is that complex diagnostic capability should be shared across the system so it is fully utilised, but provision of generic capability is in the community or for the patient to use at home.

We will transform services to better support seven-day access at the hospital site. The service will make best use of innovative technologies to provide rapid access diagnostics, including point of care diagnostics linked to electronic care records and other information systems.

Key themes include:

- Right care, right time, right place, right diagnostic to ensure this does not cause a bottleneck.
- JPUH will be providing more of the higher volume, straightforward diagnostics in the future, for the local population e.g. brady pacing. This will reduce the need for our local patients to travel to Norwich.
- Using Artificial Intelligence and protocols to streamline processes and release specialist clinical capacity for more complex diagnostics.
- Increasing flexibility for reporting – e.g. from home or other locations.
- Meeting and exceeding the Faster Diagnosis Standard for Cancer - diagnosing cancer early, providing access to rapid access diagnostics for cancer services.
- Share diagnostics across the ICS footprint where possible e.g. Diagnostic and Assessment Centre (DAC) at the hospital, as part of a network approach with NNUH and QEH for Rapid Access Diagnostics.
- Seek to provide generic diagnostic testing equipment in the community e.g. ultrasound, with sharing of results
- Reducing the demand for hospital based services by keeping people well with a focus on point of care testing for those with long term conditions e.g. blood sugar monitoring.
- More one stop shop clinics, facilitated by diagnostics and phase 2 of the DAC.
- Supporting the delivery of 7-day services to improve flow in the hospital with faster access to diagnostics for in-patients and outpatients.
- Moving more care out of hospital where possible, using more remote testing and monitoring, with patients being fully involved in this.

For patients this will mean:

- Improved access to screening and treatment, speeding up the overall referral to treatment pathway and treatment to discharge.
- Investment in education for patients will lead to more appropriate and efficient use of diagnostics.
- Patients will have access to digital health technology, for example, to assist with self-monitoring.

- There will be access to more diagnostic services closer to home. This would include the repatriation of some services from the NNUH to be imaged closer to home e.g. cardiac MRI

For staff this will mean:

- Different ways of working that enhance motivation and professional development and increased productivity.
- There will be investment in workforce training and development, and staff will have access to state of the art facilities, as well as to holistic information from primary, community and secondary care across Norfolk and Waveney.
- Staff development across all four tiers to provide a multi-skilled and flexible workforce.

6. Critical Care

JPUH currently provides 12 critical care beds at Levels 2 and 3 and these have been fully utilised during the COVID pandemic. As well as care provided on the unit, the critical care clinical teams also provide outreach services as required for a range of specialties on other wards, where patients have been stepped down from critical care.

The JPUH works closely with the NNUH and QEH Kings Lynn hospital and the availability of timely and appropriate critical care transfer capability is a key interdependency of this service. There is a hyperbaric oxygen therapy chamber sited at JPUH provided by London Hyperbaric Ltd and commissioned by NHS England Specialised Services. This co-location is a real benefit to JPUH as some Critical Care patients are able to benefit from this therapy.

We will engage with the region to undertake a stock take of regional resources to develop fit for purpose facilities and increased capacity to meet future demand, subject to the commissioning of these services. Transformation opportunities include:

- Provision of all the beds in separate, single rooms
- Development and upskilling of the Critical Care outreach team for other inpatient areas
- Development of Critical Care / HDU step down/step up unit for Level 1 patients e.g. post anaesthesia care unit
- Seek to integrate critical care facilities (level 2 & 3) across the ICS and the region
- Implementation of lean electronic stock management
- Enhance use of AI/AT for patient monitoring and safety, electronic remote surveillance
- Enhanced 24/48hr recovery programme for major elective surgery
- Development of regional critical care transfer service, which is currently being procured
- Implementation of critical care enhanced patient care programme
- Provision of renal dialysis facilities within the unit
- System wide packages of care to support discharge and ICU follow up clinics, some of which could be virtual, including multidisciplinary team and psychology support.
- Facilities within the critical care complex for relatives to stay overnight
- Adequate ‘quiet’ rooms for private relative discussions
- A relatives waiting room that can accommodate multiple family members from each patient with provision of bathroom and refreshment

- Staff facilities that enable a ‘time out’ that is not the busy staff room
- Storage facilities that enable all equipment to be kept in one place within the critical care complex

For patients this will mean

- A combined intensive care unit (ICU)/high dependency unit (HDU) with psychological support for patients and staff and availability of 24/7 allied health professionals,
- An improved ICU environment with increased privacy, and timely transfers out of the ICU to an inpatient ward once it is safe to step down, with appropriate follow up to ensure continuity of rehabilitation plans.
- Improved access to ICU interventions and admission, and collaborative working between specialist teams to ensure the most appropriate intervention. In addition, there will be a reduction in cancelled surgical elective procedures and clear treatment escalation plans and end of life care plans agreed with both patients and relatives.
- Safe and timely transfers to other tertiary hospitals as required

For staff this will mean

- Better communication across the department, with staff working as one team and the introduction of new roles.
- There will be increased opportunities for upskilling and new roles e.g. introduction of Advanced Critical Care Practitioners, and structured training and development.
- Staff will have access to a state-of-the-art working environment, with the provision of psychological support and more manageable workloads.
- There will be improved support and education for staff on the wards, to support in the management of high acuity patients through nurse education and the outreach team.
- By creating additional ACCP roles in critical care and ACP roles within in outreach, these opportunities would work towards stabilising the band 5 work force

7. Cancer

The vision is to provide a cancer service that meets the needs of the local community by working in partnership across the ICS to meet the cancer national agendas of the LTP and Achieving World Class Cancer Outcomes.

We will transform the way we deliver diagnostic services for cancer. Rapid diagnostic centres (RDC) will support the faster diagnosis standard (FDS) by providing an earlier and faster cancer diagnosis by assessing patients’ symptoms holistically and providing a tailored pathway of clinically relevant diagnostic tests as quickly as possible. RDCs will mostly see patients with non-specific symptoms which could indicate cancer; as well as a cohort of patients with site-specific symptoms who are currently served by an underperforming two week wait or 62 day pathway.

Delivery of this vision is underpinned by a collaborative, regional approach to care, transformation on site at JPUH and in the community, developing the workforce and harnessing technology to transform care.

Key themes include

- An integrated approach across the hospital and community care setting, providing shared care and patient records to minimise delays and bottlenecks

- Develop and expand community based oncology and haematology services working in partnership with primary care stakeholders, to improve education and joined up working
- Develop psychological services in partnership with primary care stakeholders
- Develop health and wellbeing support and events for patients and carers by working in partnership with the Big C, Macmillan and other organisations that provide physical and psychological support
- Develop stronger links for the provision of Teenage Young Adults (TYA) service.
- The implementation of RDCs (rapid diagnostic pathway) will require support from pathology, imaging networks and investment in new equipment
- Working with partners to improve early recognition and diagnosis of cancer
- Develop more multi tests / one stop clinics
- Develop a 7 day service for both diagnostics, treatments and clinics
- Stratified follow up pathways for those patients who have completed treatment, linked into PIFU pathways (within cancer called patient centered follow up).
- Develop an Acute Oncology Service that can outreach into the community as a rapid response
- Increase digital capabilities, information sharing and information governance:
  - Wearable devices for observations
  - Use of health apps, focusing on personalised care
  - Hardware devices for remote working e.g. Smart phones/tablets for accessing patient records.

For patients this means:

- Earlier and faster diagnosis
- Timely referrals and earlier referrals to tertiary centers
- Co-ordinated testing to diagnose or exclude cancer
- Reduce the number of visits to hospital
- Providing treatments closer to home

For staff this means:

- Scope for expanded roles and investment in career development and increased retention and quality safe care responsive care – across medical, nursing and AHP workforce
- Increased job satisfaction
- Opportunity to work across 7 days
- Opportunity to work in the community
- Research will assist with recruitment and retention of staff as well as existing employee development and job satisfaction

8. Integrated Therapies Department

Integrated Therapies is similar to the diagnostics provision in that they are strategically key in enabling patient flow, and good clinical outcomes.

Integrated Therapies support patients:

- to restore or maximise their independence to the best of the patient's ability; using a holistic approach
- to remain in their home or transition into care settings in the community
- in the pre-operative and post-operative stages of enhanced recovery rehabilitation programmes. If patients can be fit and well prior to attending pre-planned surgery and

are physically active soon after surgery, this usually means a shorter length of stay and faster recovery.
- In the management of nutritional risk to ensure optimisation throughout the inpatient stay and management of short and long term conditions post discharge (dietetics)
- In outpatient clinics providing a highly specialist role within their specific field, for the assessment, treatment and management of a variety of conditions, aligning directly to enhanced recovery programmes or MDT pathways. Services include orthopaedics, pelvic health, Dietetics, Rheumatology, Pain Management, Lymphoedema

Integrated therapies includes dietetics, occupational therapy and physiotherapy and support urgent and emergency care e.g. trauma, intensive care and stroke, as well as planned care e.g. hip and knee replacement surgery. Speech and Language Therapy is provided in the acute setting by ECCH, with internal governance managed as part of the Integrated Therapy Department.

Therapies has been identified as a key enabler at all of the specialty workshops and development of the service is essential going forward.

Key themes include:

- Multi-disciplinary approach so a service can be provided based on patient pathways, with therapies provided in the community and at home with ECCH, Social Services and appropriate voluntary services
- Therapies need to be provided before, during and after the acute episode of care
- Some therapies being provided remotely, being patient-led through the provision of health and rehabilitation Applications (Apps) on phones and virtual exercises / support
- 7 day per week service supported by flexible equipment suppliers
- Embedding the Discharge to Assess (D2A) model / Hospital Discharge Plan into business as usual with the Integrated Discharge Team, with support from the community

For patients this means:

- Reduced length of stay in hospital –where appropriate, therapies can assess once patient has been discharged, wrapping the therapies input around the patient so it is holistic
- Increased therapies input provided in the community with multi-disciplinary teams
- Patients can be responsible for parts of their rehabilitation and care if they are undertaking activities at home using an App, or completing exercise programmes virtually
- Patient initiated follow ups –follow up appointments only happen if the patient feels they need it
- Equipment provided promptly when they need it, and it becomes an enabler to independence and increased physical function.

For staff this means:

- Therapies staff to work in wards, clinics and in the community as integrated teams to gain a broader breadth of experience
- More innovative career pathways e.g. Apprentices and Assistant Practitioners - develop our own staff through competency based progression
- Therapies staff to be more involved in complex patients / cases, supporting the Consultants

8.0 Monitoring of the Clinical Strategy

This Clinical Strategy will be monitored through implementation and review of Specialty Development Plans (SDPs) as detailed in section 7. They also form part of the annual cycle at Divisional Boards, reported to the Hospital Management Board of JPUH with an annual exception report to the Trust Board.

9.0 Next Steps

Our Clinical Strategy will inform the initial planning of the new hospital development including the work up of options for appraisal as part of a Strategic Outline Case during 2021/22. It is a live document that will continue to be developed, particularly in line with the Norfolk and Waveney Clinical Strategy.

Work to develop our Clinical Strategy further during 202223 will include:

- Further demand and capacity modelling through health care planners to turn the Vision and Themes into future models of care and accommodation requirements
- Continued engagement with our partners
- More detailed work at speciality level agreeing new models of care and future resource requirements, clinically led and co-produced with partners
- Further development of the enabling strategies
- The Service Development Plans are the bedrock of the Clinical Strategy. Following on from the recent 2021 SDP workshops, these will form part of the annual planning process for the Divisions within the hospital and will be kept up to date including monitoring of process to implement.

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