# Making Waves

March 2024

## FUTURE PAGET

# BUILDING A HEALTHIER FUTURE TOGETHER


BUILDING FOR THE FUTURE P3-7

LATEST TECHNOLOGY P8-15

PARTNERSHIP WORKING P16-19

JOIN OUR TEAM P20

NHS
James Paget
University Hospitals
NHS Foundation Trust

# Jo's Overview

JOANNE SEGASBY
CHIEF EXECUTIVE


## DEVELOPING TOMORROW'S HEALTHCARE TODAY

**Our vision for the future of healthcare at the Paget is taking shape before our eyes.**

With our place on the national New Hospital Programme formally agreed, we've got the green light to progress our plans for a new hospital, with a target date of 2030.

While that may seem some time away, the first buildings that will sit alongside the hospital to form a new health campus are taking shape and - in the case of our Concept Ward - are already providing the most modern patient care currently available in the country.

The northern part of our site is a hive of activity - so to keep you up to speed with these developments, we've produced this special edition of Making Waves.

It's entitled 'Future Paget' - and takes its name from the 'Future Paget Programme' which is our vision of building a new hospital on the James Paget estate to serve current and future communities in our area.

But our future vision is not just bricks and mortar: we need to harness technology so that it works for our patients and staff.

So, while the majority of the edition is focussed on the buildings, we have also included a section on technology, including how we are using the latest equipment to provide virtual ward care in a patient's own home, and an update on Electronic Patient Record - the biggest IT project ever undertaken by the NHS in Norfolk and Waveney.

And to put it in context, there is also a section on the work of the Great Yarmouth and Waveney Place Board, which oversees the development of healthcare for our local community.

These are challenging but exciting times for the local NHS as we look to the future; if you have any feedback on our plans, please do let us know by emailing communications@jpaget.nhs.uk

## WORKING TOGETHER FOR OUR PATIENTS

**Partnership and collaboration are key to developing plans for the future of healthcare in our community.**

The James Paget is part of the Norfolk and Waveney Integrated Care System (ICS), a partnership which brings together NHS organisations, councils, to deliver more joined-up approaches to improving health and care outcomes.

There is also a partnership between Norfolk's three acute hospitals - the Norfolk and Waveney Acute Hospital Collaborative.

The collaborative has developed a clinical strategy outlining how hospital clinical services will be developed and delivered in the future, to support local people's healthcare.

The strategy outlines how the three hospitals will work together to provide sustainable services to patients through making the best use of our available resources, ensuring standardisation of procedures and using the latest technology.

A prime example of this is the development of a Specialty Clinical Network. The three trusts have worked together to create a comprehensive toolkit to agree the network configuration, to help move to standard clinical pathways, policies and procedures.

# WARD OF THE FUTURE - HERE AND NOW

**Hundreds of James Paget patients have now experienced the healthcare of the future after staying on our new Concept Ward.**


The Concept Ward opened last summer and features a unique mix of single en-suite rooms and two four-bedded bays, as well as the latest design and technology.

Several of our teams have already experienced working in the new facility, as it is currently being used as a 'decant' ward so that we can complete a rolling programme of precautionary maintenance work to our hospital roof **(see 'Paget Prioritised on Programme' - page 4)**.

Their experience of working on the ward - coupled with the thoughts of those who have received care there - will be crucial in helping us understand the impact of this innovative environment on both patients and staff.

It's feedback that ultimately will inform modern ward design in our new hospital.

To help with this work, we have joined forces with Staffordshire University in a research project which will explore how both patients and staff respond to the Concept Ward environment - and the effect of a physical environment on health outcomes.

Using quantative data (such as infection control and falls statistics) alongside qualitative information (including staff and patient feedback), the aim of the research will provide an in-depth comparison between a traditional acute hospital ward and the new Concept Ward - and then use the findings to inform the design of wards on our new hospital.

Already, the Concept Ward, designed and built by Health Spaces, has received an accolade from construction world after taking the honours in the Best Modular/Mobile Healthcare Facility category in the 2023 Building Better Healthcare Awards, beating competition from 10 other projects nationwide.

Looking to the future, once its role as a decant unit has come to an end, the Concept Ward will be used to care for patients who have undergone operations in our new Orthopaedic Elective Hub **(see 'Final Piece of Jigsaw' - page 7).**

# GREEN SPACE

**While the Concept Ward opened in the summer, work in one key area is still on-going.**

Garden areas for patients and staff are already well-progressed, with pathways, planters, beds and a pergola already in place. They are designed to be quiet spaces where both patients and staff can relax while enjoying the benefits of fresh air.

Now, the first trees have been planted after the Trust joined a partnership which aims to promote best use of green spaces at healthcare sites nationwide.

The Trust is now part of NHS Forest, an alliance of health sites which are working to transform their green space to realise its full potential for health, wellbeing and biodiversity, and to encourage engagement with nature.

As part of this partnership, we have received 50 trees for planting on our site, with the first of these being planted in the Concept Ward garden.

The trees will help us contribute to the NHS goal of net zero carbon by 2040 and increasing biodiversity across our estates.

# PAGET PRIORITISED ON PROGRAMME

**Construction of a new hospital at the James Paget has been prioritised in a national building programme taking place over the next six years.**

The New Hospital Programme (NHP) is due to deliver 40 hospitals across the country by 2030, costing more than £20 billion.

Our place on the programme was formally agreed last year - and, in addition, the government announced that a new hospital at Gorleston would be among seven schemes which would be prioritised in the construction timetable.

James Paget Director of Strategic Projects Mark Flynn said: "To have our place on the New Hospital Programme formally agreed, and then prioritised, is great news for our patients, staff and local community.

"It means we can progress with our preliminary work - land acquisition and planning - with confidence, secure in the knowledge that we have been given the green light to progress along the road to the construction of a new hospital.

"Once completed, the new hospital will be the centrepiece of our new health campus, which is already taking shape with three new buildings at the northern end of our site."

The priority schemes will see seven hospitals, including the James Paget, replaced by 2030 as their existing buildings were constructed using reinforced autoclaved aerated concrete (RAAC) a lightweight type of concrete used to construct parts of the NHS estate in the past but which has a limited lifespan, after which it deteriorates.

At the Paget, to keep our patients and staff safe, we have been conducting a continuous programme of surveying and remedial works on the RAAC panels, since new national guidance was issued back in 2019.

The on-going specialist surveys have found nothing that would warrant the closure of any areas of the hospital. A programme of installing precautionary 'end bearing' supports to RAAC planks in the hospital roof has been underway since 2021.

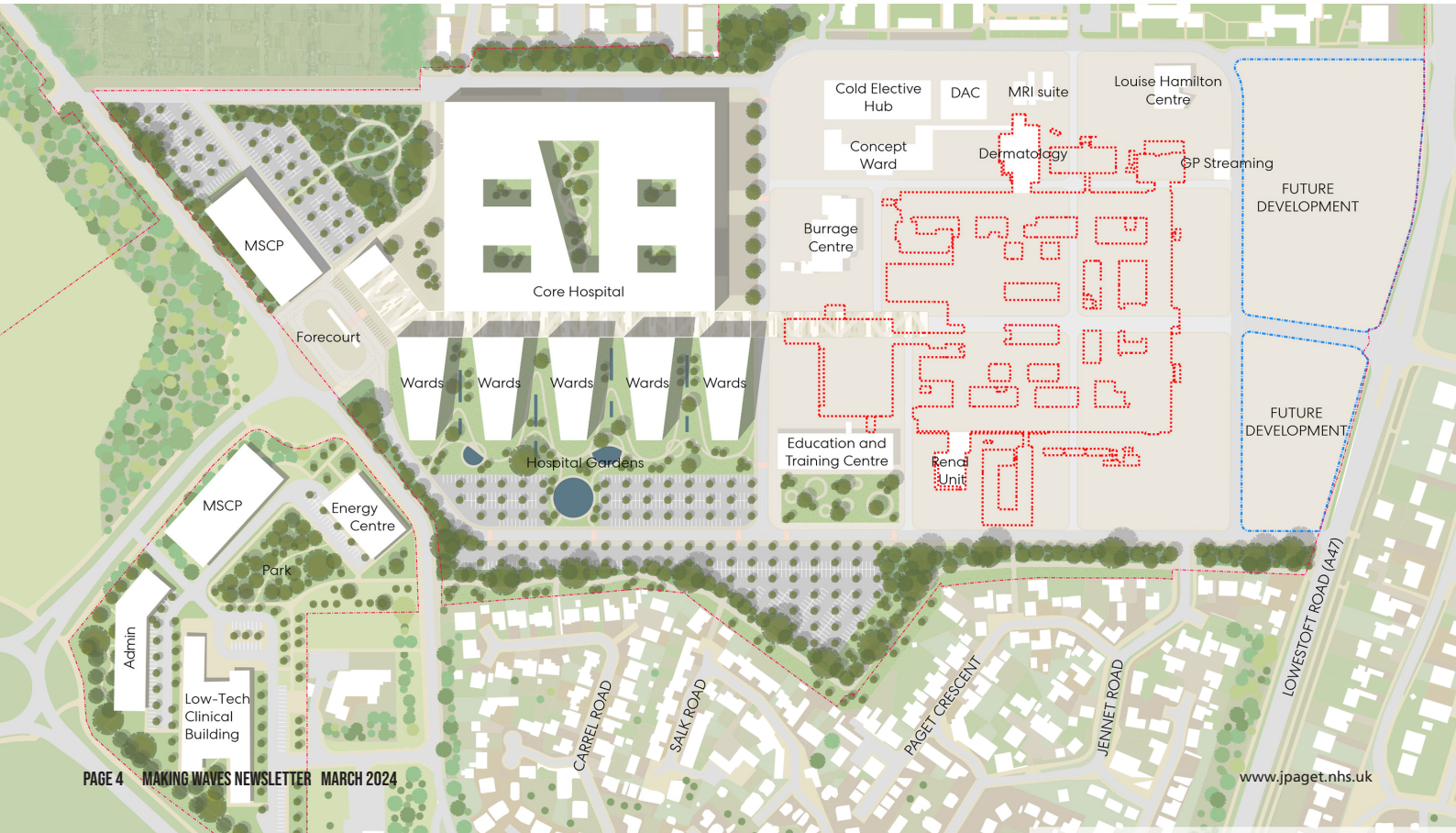
To facilitate this work, we are using our brand new 'Concept Ward' as a 'decant' space, which allows us to move entire ward teams and their patients temporarily to a new home while these precautionary supports are fitted.

"So our focus over the next few years is clear," added Mark. "Not only will we be working hard to keep our existing hospital building safe for our patients and staff but also developing the healthcare facilities of the future for our local community."

In the months ahead, we will continue to work with local planning authorities and partners on the acquisition of land for our new hospital to the rear (west) of our current estate.

The map below shows an indicative 'masterplan' of where our new hospital and related buildings could be located on the land we are working to acquire. The map also shows where our current hospital resides, and includes the new buildings on our estate which will remain as part of our long-term estates strategy.

Over the next year, we will work closely with our communities, patients, stakeholders, and local health and care partners to develop a more detailed business case for our Future Paget Programme, alongside the national New Hospital Programme.



# ‘HOSPITAL 2.0’

**The New Hospital Programme will deploy a systematic approach to developing hospitals, including developing a common set of design principles incorporating modern methods of construction.**

The James Paget’s pioneering Concept Ward has applied many of these design and construction methods in its delivery **(see Ward of the Future - page 3)**.

This approach is called ‘Hospital 2.0’, a standardised design for future hospitals which will benefit patients through digital solutions and optimised hospital layout.

It will also decrease the average time to develop and build the hospitals, enabling quicker manufacturing and assembly - and will reduce costs through economies of scale.

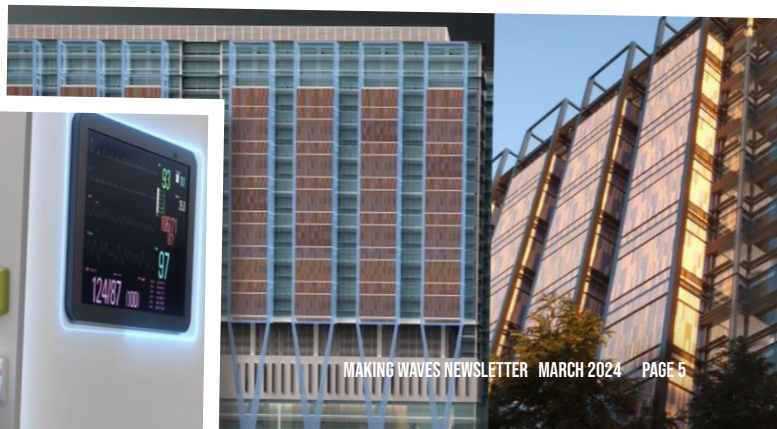
Over the past year, we have worked with the national New Hospital Programme’s workforce team to inform and develop plans for the layout and configuration of spaces for staff to work and rest within Hospital 2.0 designs.

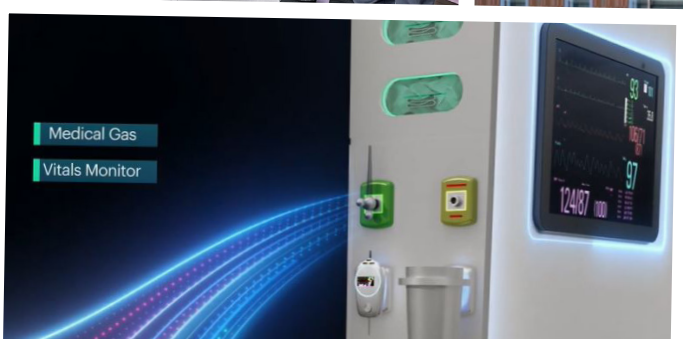
This work has complemented our ongoing engagement with clinicians regarding long-term plans for their specialties and departments, both at the James Paget, and in collaboration with the other hospitals in Norfolk and Waveney.

In September 2023, our hospital welcomed Lord Markham, Minister for the Lords and Parliamentary Under Secretary of State at the Department of Health and Social Care, and members of the national New Hospital Programme to see the progress the Trust is making ahead of developing a new hospital at its site.

Lord Markham said: *“It was great to visit James Paget hospital and meet with staff and key stakeholders to discuss their plans for the new hospital – including showcasing how their new proposed hospital will look using the standardised design and Hospital 2.0 construction.”*


Lord Markham (fifth from right) on his visit to the James Paget.



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# DIAGNOSTIC REVOLUTION

**A major boost to local diagnostic capacity is underway - meaning more appointments for patients needing scans and x-rays to progress their treatment and care.**

As part of a national drive to speed up access to treatment, the James Paget is developing new buildings to house the latest diagnostic equipment, including MRI and CT scanners.

The most visible of these is our new Diagnostic Centre, which started rising from the ground last year and will see its first patients in the summer.

The photograph above, taken in early March, shows that the main fabric of the building - its brickwork, roof and internal partitions - is in place, with contractors R G Carter now working on the interior including mechanical and electrical services, internal carpentry and flooring.

Once completed, the centre will house the latest diagnostic equipment, including new MRI and CT scanners, ultrasound imaging equipment and an x-ray room to diagnose and monitor a range of conditions including cancer, heart disease, respiratory diseases, trauma, musculoskeletal diseases and neurology.

The Centre is one of three being built at the main acute hospital sites across Norfolk and Waveney as part of a collaborative project funded by the Department of Health and Social Care.

Once opened, it will become the second building of our new healthcare campus to become fully operational, following the opening of our Concept Ward last year.

But the expansion in diagnostics doesn't stop there. There will be further diagnostic capacity created within our new Orthopaedic Elective Hub **(see 'Final Piece of Jigsaw - page 7)**, which will boost the number of operations such as hip and knee replacements when it becomes operational in the autumn.

Artist's impression courtesy of RG Carter.

In addition, a new Community Diagnostic Centre (CDC) will be developed at the Northgate Hospital site in Great Yarmouth. The Centre will be run by clinical staff and teams from the James Paget and will house a CT scanner as well as respiratory services, including spirometry and full lung function testing and 'point of care testing' such as phlebotomy and urine analysis.

NHS England has committed £19.5 million to developing the Northgate CDC, scheduled to open in March 2025, as well as the diagnostic equipment and capacity within the Orthopaedic Elective Hub - part of a government commitment to create 160 community diagnostic centres nationwide.

Artist's impression courtesy of Darwin Group.


# FINAL PIECE OF JIGSAW

**Groundworks have started on the third new building which will complete the initial phase of developing our new health campus - which ultimately will include a new hospital.**

The new Orthopaedic Elective Hub will help reduce surgical waiting lists for patients - and will operate seven days a week, providing extra theatre sessions and enough capacity for not only the hospital's annual planned orthopaedic operations but also additional cases from across the Norfolk and Waveney healthcare system.

Its development will in turn free-up theatre sessions in the hospital's main hospital theatres complex, resulting in thousands of additional procedures for other surgical specialties including urology, gynaecology, general surgery and ear, nose and throat.

The Department of Health and Social Care (DHSC) has agreed funding of £17 million for the hub, which will have its own dedicated team of staff who will oversee two operating theatres, a post-surgery four bay, stage one recovery area.

The hub is due to open in autumn 2024 and is being constructed by Darwin Group.

Artist's impression courtesy of Darwin Group.

# 'VIRTUAL' HOSPITAL CARE

**An innovative way of providing hospital care to patients in their own homes is going from strength to strength - and is receiving positive feedback from patients.**

Additional staff have been recruited to run the James Paget's 'Virtual Ward', which has seen the number of patients in its care increase over the last few months.

The ward supports patient at home so they do not have to be in a hospital bed. They receive 'in patient care' in the setting of their own home, therefore helping reduce pressure on the hospital's bed capacity.

The 'Virtual Ward' sees patients receive a daily online conversations with ward staff, with clinical observations provided remotely by medical devices.

Information from these conversations is then discussed by a multi-disciplinary team during the morning 'ward round' led by a Consultant to decide on the next steps for each patient's care - just as it would be on an actual ward in a hospital.

The 'virtual ward' opened for business in 2020, initially to provide remote care for patients with COVID.

Since then, its success has resulted in patients with a range of conditions being cared for on the ward, including those with COPD, diabetes, asthma, cellulitis, heart failure and pulmonary fibrosis. Some surgical patients are also benefiting from the service.

"The Virtual Ward is really popular with patients," said Sister Angie Crowe. "They all say how lovely it is to be able to sleep in their own bed, with their family around them and home comforts to hand.

"We find that people in general are recovering better at home, because they are away from the environmental disturbances in hospital."

The ward is harnessing the latest remote patient monitoring technology, called Feebris.

Patients receive training on how to use the technology, and take home monitoring kit in a handy case. It allows them to take observations such as temperature, blood pressure, pulse rate and oxygen levels and upload them via a phone app which provided the team back at the Paget with real time data on a computer dashboard.

"The technology is easy to use and gives us the information we need," said Angie. "We monitor patients so we can see if they are OK and if their data shows a deterioration, we can give them a call - and, if necessary, bring them back to our Ambulatory Care unit to carry out further observations, chest x-rays, whatever is needed."

Patient who no longer need hospital care are discharged as they would be from a regular ward, with their GP updated and, if necessary, on-going support provided by East Coast Community Healthcare.

Initially, the virtual ward was set up to care for a maximum of 30 patients. The aim now is to increase this to 40 patients, with an extra nurse being recently recruited.

"Facilities such as the Virtual Ward are definitely the future," said Angie. "Two years ago, we had just two nurses - now it's five. Back in 2020, the ward looked after COVID patients only - now there are 10 pathways, not just medical but surgical too."

Dr Dominic Giles, who has been instrumental in the set up of the ward, said it helped prevent re-admissions - and was also helping reduce pressure by accepting suitable patients direct from the hospital's Emergency Department, meaning they could go home with support rather than be admitted to a hospital bed **(see case study 3)**.

"It's a real bonus having the virtual ward as part of our team," said Dr Giles. "It supports patients to recover in their own homes, allows us to discharge more patients earlier and helps prevent deconditioning."

The Virtual Ward works alongside the Paget at Home initiative, which supports patients who can receive care at home but require a more 'hands on' approach, such as those who need intravenous antibiotics or wound care.

# VIRTUAL WARD

## Case study 1

**When a nasty fall resulted in a trip to A&E, Amanda O'Leary's immediate concern was: who will look after my three children?**

Amanda had suffered facial injuries and doctors wanted to keep her in overnight to check on her blood pressure, which was found to be the cause of the fall.

Fortunately, Amanda was able to organise child care for the night - but the following day, as she received on-going care on EADU, she made her concerns known to staff.

"It was a struggle to organise one night of child care, as I have no family round here, so I knew it was unsustainable," she said. "I simply needed to get home as soon as possible."

Fortunately, clinicians overseeing Amanda's care were able to come up with the perfect solution: a place on the Paget's Virtual Ward.

Amanda's condition meant she was suitable for a place on the ward as, thanks to the latest technology, her condition could be monitored remotely.

She was sent home with kit which allowed her to measure her temperature, blood pressure and heart rate, with the results sent through to the Virtual Ward team based at the hospital.

These observations were supplemented with welfare calls from ward staff, initially four times a day, until her condition improved.

"When staff at the hospital first mentioned the Virtual Ward, I said 'what's that?' - I had never heard of it," said Amanda.

"But, I am so glad that the James Paget has one. It has really helped by allowing me to receive healthcare support at home so that I can look after my children and get on with my life," she added.

## Case Study 2

**The reassurance of knowing that a dedicated clinical team is just a phone call away gives Margaret Chamberlain the confidence she needs to manage her condition away from hospital.**

Margaret was referred to the Virtual Ward team a year ago after a trip to the James Paget's Emergency Department.

She had suffered a 'flare up' of emphysema, a chronic obstructive pulmonary disease (COPD) that causes breathing difficulties.

After a stay on a respiratory ward at the hospital, 65-year-old Margaret was asked if she would like to continue her care on the Virtual Ward.

While there have been a handful of trips back to the hospital, for the large part Margaret has been able to manage her COPD at home, taking oximeter readings and speaking to ward staff on a daily basis so they can monitor her condition.

"The team try to keep me out of hospital as much as possible - and it really works and helps me," she said.

"The staff on the Virtual Ward have been brilliant. I don't know what I would do without them - especially when I have a little panic and need some reassurance!"

## Case Study 3

**Earlier this winter, a patient attended our Emergency Department, after suffering breathing difficulties due to Chronic Obstructive Pulmonary Disease (COPD).**

As the hospital was extremely busy, the patient would have waited on a trolley in the department, until a bed on a ward became available.

However, following an assessment by a doctor, it was agreed that the patient could be prescribed antibiotics and receive on-going care at home, as a virtual ward patient.

After five days of monitoring, a nurse detected that he was wheezing during a routine daily call.

As a result, a doctor carried out a remote assessment, speaking with the patient. The doctor prescribed a course of steroids which were delivered to the patient at his home by our Pharmacy Team.

The steroids helped the patient recover without having to come into hospital - with the Virtual Ward therefore giving the right treatment in the right place at the right time while helping prevent a return visit to ED and an unnecessary admission.

# DEVELOPING DIGITAL COMMUNICATION

**Our Trust continues to harness the power of the latest technology, to help us communicate more effectively with our patients.**

During the pandemic, we worked alongside national partners to introduce 'Attend Anywhere' video consultations, to help during a time when there were restrictions on hospital attendances and providing face-to-face support.

Since then, video consultations, via a secure web-based platform, have become very much business as usual and are offered to patients when clinicians think it is appropriate.

These on-line consultations are user friendly and often more convenient for patients, saving time and travel expenses.

For the hospital, online consultations have also helped reduce occasions when patients have been unable to attend an appointment, due to not being able to travel to the hospital.

The Trust has also implemented an SMS text reminder service for select outpatient appointments, as data shows that thousands of patients were accidently missing their hospital appointment each year because they forgot when it was. Each missed appointment costs the hospital money in terms of staff time unnecessarily wasted – and also means that the slot cannot be offered to another patient.

Patients receive a text message three days before their scheduled appointment, helping to significantly reduce the number of missed appointments.

At the same time, we have been developing a Patient Engagement Portal (PEP), which enables communication with patients, via their mobile phones.

The PEP has been developed over several phases, starting by giving patients the ability to view their outpatient appointment letter digitally, so they do not have to wait to receive it in the post.

We will also be developing our SMS appointment reminder service allowing patients to actively manage their appointments via the portal, with options to confirm their attendance, or request that their appointment is cancelled or re-booked coming in future releases of the PEP.

And last year, in the service's latest phase, we worked with our digital partner DrDoctor to text patients waiting for an appointment, planned procedure or operation at our hospital, to help us understand if their needs or circumstances had changed while they had been waiting. Each patient was sent a text with a link to an online survey, asking them questions about their on-going hospital care.

Looking ahead, we are planning to further develop the PEP so that patients can view their outpatient appointment letters digitally. We will roll this out by specialty, starting with urology patients this spring.

Then, we will be working with national partners to integrate the PEP to the NHS App. This significant step will allow patients to continue to access the information and features of the Portal while using the enhanced functionality of the NHS App, which is regularly updated with new services. (see **'App Provides Digital Gateway' - opposite page**).

# APP PROVIDES DIGITAL GATEWAY

The NHS App provides a simple and secure way for people to access a range of NHS services on their smartphone or tablet.

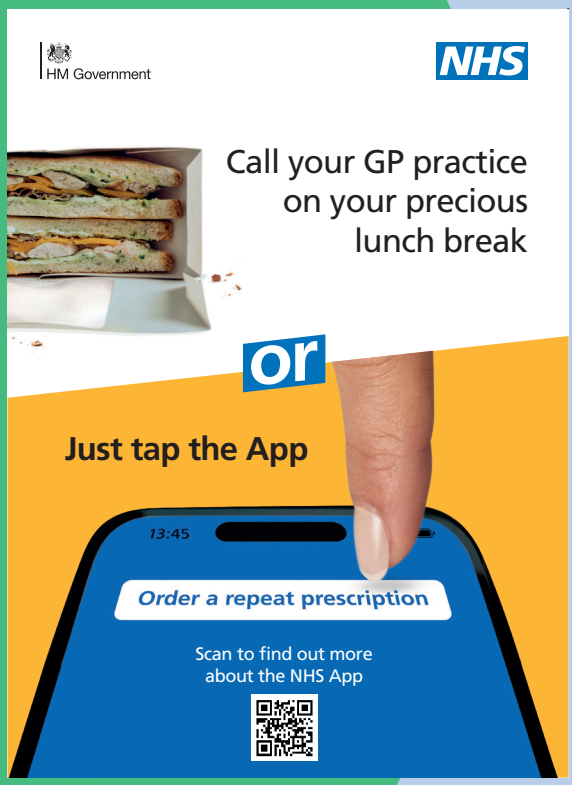
The NHS App enables patients to order repeat prescriptions, securely view their GP health record, get health advice via 111 online, find NHS services nearby, register to take part in health research and book, change and cancel hospital or clinic appointments.

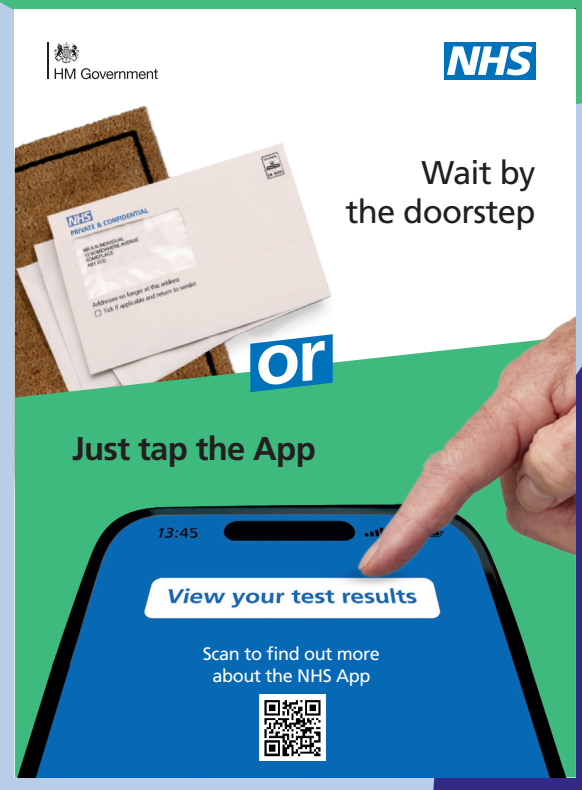
In the latest stage of its development, which took effect last month, the App can now show patients on a waiting list an estimated time for their treatment - and also a facility for people to view their prescriptions.

More functionality is expected in the future* - and to make our patients aware of its benefits, we are recruiting a team of 'NHS App ambassadors' from within the hospital.

Our NHS App ambassadors will champion the App among both colleagues and patients, promoting its many benefits and helping users to understand how to use its features.

**For more information on the NHS App, visit www.nhs.uk/nhs-app/**





*Please note that, depending on the GP surgery, not all services may be available.

# DIGITAL REVOLUTION TRANSFORMS PATIENT INFO

# NEW SYSTEM GIVES FULL PICTURE

**A new digital system is helping clinicians deliver patient care more efficiently by bringing together records from health and care providers across Norfolk.**

The Shared Care Record is providing health and social care professionals with comprehensive information at their fingertips - dramatically cutting down on the time needed to locate and access separate records from multiple organisations.

It means that relevant information about a patient's care and treatment across all services is available in one place, helping staff make more informed decisions - while patients only have to tell their story once.

Organisations involved in the creation of the system include Norfolk's three acute hospitals, including the James Paget; local GPs; Norfolk County Council; Norfolk and Suffolk NHS Foundation Trust (NSFT) and East Coast Community Healthcare (ECCH).

The system was rolled out to a limited number of front-line departments at the three hospitals last autumn. At the James Paget, the system has been successfully trialed in areas including our Emergency Department - and will now been rolled out further across the hospital in the coming months.

Peta Kerrigan, Digital Health Clinical Change Lead at the James Paget, said the system brought benefits for both patients and staff.

"It saves so much time as, by just checking one system, you can find out about all the aspects of health and social care a patient is receiving," she said.

"It is also great for the patient too, as they don't have to spend time going through their history - which may include having to repeat sensitive information - and it eradicates the chance of them missing out an important detail."

The system can also prove invaluable in helping patients get home more quickly, freeing up hospital beds by improving discharge efficiency.

"Previously, hospital staff might have to check up to 14 separate systems to get the data they needed on a patient or telephone other services to get the required information, which might not be available until the next day or after a weekend, which could delay a patient being discharged home for several days," said Peta.


The system provides a wide-range of information, in 'read-only' format, and is searchable via a patient's NHS number. It has a home page which highlights urgent information such as whether a patient has allergies, dementia or safeguarding alerts.

A series of tabs then provide more detailed information, such as:

- **GP record - from the practice, including information about medicines and immunisations.**
- **Medication - what is current and discontinued.**
- **Documents - such as referrals and discharge letters, with links to sources.**
- **Encounters - appointments, including the name of the clinician and when and where they took place.**
- **Related People - key contacts, such as mental health advocates.**
- **Social Care - details of home care plans and case workers.**

# LOOKING AHEAD

**The Share Care Record will continue to develop, to include more local organisations involved in patient care, such as the ambulance service and care homes.**

Similar projects are being rolled out across healthcare systems nationwide - with the ultimate aim of linking them together so that they cover the entire country meaning that if, for example, a holiday maker from Cornwall fell ill while in Great Yarmouth and had to attend the James Paget, their full health and social care record would be available to hospital staff at the click of a mouse.

The introduction of the Shared Care Record at the James Paget has been overseen by a project team led by Peta Kerrigan, with support from Clinical Lead Mr Alexander Leeper, who is a breast surgeon at the hospital, and Clinical Change Agents Kerry Bloomfield and Charley Middleton-Bolch.

## Case Study

**A patient recently attended A&E at the James Paget.**

The patient was assessed and it was decided that they could be discharged but only if they had the right level of support at home.

A quick check of the patient's information on the Shared Care Record showed that this support was already in place - and, as a result, they could be safely discharged.

Previously, the patient may well have had to say overnight in hospital while checks were made with the different organisations providing the support at home, usually by phone, to ensure safe discharge.

# 'FIT FOR THE 21ST CENTURY'

A consultant at the James Paget has described **how the new Shared Care Record has helped improve efficiency by putting more patient information at his fingertips.**

Alexander Leeper, who is an oncoplastic and reconstructive breast surgeon, said that paper-based systems were no longer ideal at a time when the Paget was working more and more closely with both the other two acute hospitals in Norfolk.

"The fantastic thing about SCR is that it allows me to access patient records from other sites," said Mr Leeper. "This is especially important for my patients who are under the care of the oncology team as there is tight turnaround between patients completing their chemotherapy treatment and needing surgery.

"Using this system, I can track their treatment and ensure they get their operation at the right time."

The system was also useful when speaking with patients in clinic.

"Because the system contains local GP records, it's so helpful when, for example, a patient cannot remember the medications they are taking," said Mr Leeper.

"Previously, you would be reliant on what the patient was telling you and could feel quite anxious that you did not have the full picture; in addition, a great deal of time would be spent chasing up information from other sites, which was inefficient."

Mr Leeper said that the Shared Care Record was an information system fit for the 21st century - and was a great forerunner to the Electronic Patient Record (EPR), which is due to come online in 2026.

# EPR: 'IMPROVING SAFETY, EFFICIENCY AND EXPERIENCE'

**A major digital project which will revolutionise the management of clinical information in hospitals is underway at our hospital.**

The Electronic Patient Record (EPR) is a digital patient record system to manage clinical information, making it easily available for use by health and care staff - and is being introduced across Norfolk's three acute hospitals, including the James Paget.

At the moment, many parts of our acute hospitals in Norfolk and Waveney are reliant on paper-based patient notes which can take time for staff to find and complete. The EPR programme will switch the hospitals from using paper to digital notes held in one system.

The EPR will drive improved standards of services at our acute hospitals. With secure, immediate access to live data, the new system will give clinical staff more time to deliver higher quality, and safer care. For patients, this will mean they don't have to remember their medical history or repeat the same information to different members of staff, making their care journey more joined-up.

EPR notes will only be editable and accessible for staff in the three acute hospitals.

Eventually, once the EPR is rolled out, a read-only view of a patient's acute hospital notes may be available on the Shared Care Record **(see pages 12-13)** to help give staff in the other parts of the health and care system who are directly involved in their care, a holistic view of their health and wellbeing.

The digital patient record solution is part of a national ambition the government has to revolutionise how information is stored to offer better joined-up care for patients. It is also a critical part of the Joint Acute Clinical Strategy for the Norfolk and Waveney Acute Hospital Collaborative.

Last year, the Collaborative announced that, after a rigorous procurement process, MEDITECH, a world leader in integrated digital systems, has been selected as a supplier for their new EPR system.

Vivek Chitre, Chief Medical Officer and EPR Senior Responsible Officer for the James Paget said:

*"Building one EPR system for our patients and staff will transform how we deliver care and work at all of the acute hospitals in Norfolk and Waveney. It will improve safety, efficiency, and the overall experience for our patients and their families."*

better joined-up care

## SCHEDULED TO BE INTRODUCED IN 2026, THE EPR:

- Will provide real time information available when it is needed, where it is needed.
- Will enable faster, more personalised care by enabling quicker access to patient information.
- Will mean that patients don't have to remember their medical history or repeat the same information to different members of staff, making their care journey more joined-up.
- Can help to ensure that patients are seen in the right place by the right person by providing accurate information about their needs.
- Will reduce the chance of human error by reducing the need for paper records and sharing information between health and care professionals.

# EPR Q AND A

**Why are the acute hospitals getting an EPR?**

We are getting an EPR to give people and communities across Norfolk and Waveney better joined-up care.

The digital patient record solution is part of a national ambition the government has to revolutionise how information is generated, securely stored and shared where needed to improve care.

**What does it mean for patients?**

It will improve the experience of care patients have in any of our three acute hospitals. The EPR will give staff access to important health and care information at each site so that patient interactions with services are readily available to view.

The EPR will make patients safer with digital health records flagging up things like allergies and past interventions. These changes will also allow patients to engage with their care much better and strengthen the partnership between them and clinical services.

In the future, the EPR could offer opportunities for us to explore other ways of capturing health and wellbeing information into the system already used in some settings (smart devices, patient questionnaires, at home monitoring etc).

**Will health and care data be secure on the new system?**

It will be far more secure than it is on paper. The information will be stored off site and the data will therefore be less vulnerable to cyber-attacks or to outside agencies. All patient data will be stored in the UK.

**Who will have access to the data?**

We will use a role-based access system which only allows staff who have a legitimate relationship with the patient to be able to access the information. The EPR will also allow us to track access and prevent access to information where appropriate.

**Can third party organisations access the data?**

All contracts conform to current legislation and no data is accessible to any outside agency.

better joined-up care

# ‘PARTNERSHIP AND PREVENTION’

**The health of our local community depends on the strength of partnership between organisations across Great Yarmouth and Waveney.**

Healthcare provision and meeting the unique healthcare needs of our population is the responsibility not just of the local NHS but local councils and social care, aided by voluntary organisations.

They are now working more closely together than ever before, as part of the Great Yarmouth and Waveney Place Board which focusses on addressing our community’s health and wellbeing needs both now and in the future **(see panel below)**.

For chair Jon Barber, **(pictured below left)** who is also Deputy Chief Executive of the James Paget, there are two key words which govern the Board’s work: partnership and prevention.

“We talk about health inequalities - and in Great Yarmouth and Waveney, we have some of the most pronounced inequalities in the country. For example, smoking rates are far higher in our area than anywhere else in the country.

“But healthcare organisations cannot address issues like this in isolation - there has to be a partnership approach.

“For example, at our hospital, we can support an inpatient to give up smoking - but ultimately our efforts are unlikely to be successful if they return to a home where others smoke. So, we need to make sure we are ‘joined up’ in our efforts and are supporting people to make good healthcare choices whenever and wherever they access our services.”

Already, the Place Board’s partnership approach has borne fruit, with successful initiatives launched in the last year, focusing on respiratory health (see panel).

But prevention is also key - helping people choose healthier lifestyles so that they do not need to access healthcare services so frequently.

“There are too many people with preventable conditions, such as type 2 diabetes, ending up in hospital,” said Jon. “Our focus, together, must be on helping people take more responsibility for their health, to make choices that prevent them from becoming ill and keep them out of hospital.”

But prevention goes much further. For those patients who do need to come into hospital - whether as an emergency or for planned care - every effort should be made to discharge them safely as soon as possible - and ensure they have the right support at home or in the community to prevent unnecessary readmission.

That’s where the work of Health Connect comes in, with team members known as ‘connectors’ helping people receive the support and equipment they need to self-manage their health, linking with local services that can support them to live well at home **(see page 18)**.

**“HEALTHCARE ORGANISATIONS CANNOT ADDRESS ISSUES IN ISOLATION – THERE HAS TO BE A PARTNERSHIP APPROACH”**

Jon Barber,
Deputy Chief Executive,
James Paget;
Chair, Great Yarmouth and
Waveney Place Board.

Place-based partnerships bring together the NHS, social care, local councils and voluntary organisations to lead the design and delivery of integrated services in their local areas, to improve people’s care.

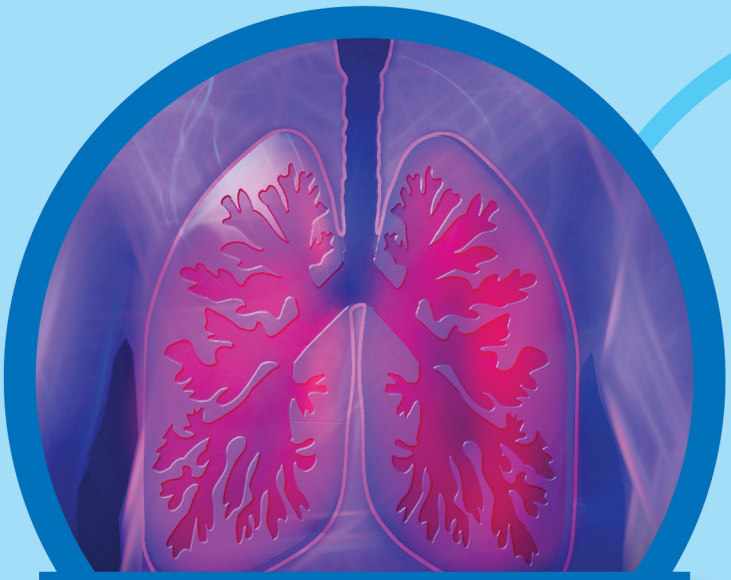
In Norfolk and Waveney, there are five Place Boards, including one for Great Yarmouth and Waveney. All five boards work closely with seven health and wellbeing partnerships, based around district council footprints.

Membership of the Great Yarmouth and Waveney Place Board includes the James Paget, Norfolk and Waveney Integrated Care Board, East Coast Community Healthcare, Norfolk and Suffolk NHS Foundation Trust, General Practice (GPs), Great Yarmouth Borough Council, East Suffolk Council, Public Health, Norfolk and Suffolk County Councils’ social care and local voluntary organisations.

# DATA DRIVES FOCUS

**Latest health data has allowed the Great Yarmouth and Waveney Place Board to identify the top five most preventable health conditions in our area - and then target resources accordingly.**

**This has resulted in a particular focus on people at risk of respiratory conditions - with the following projects moving forward in the last year:**



## WARM HOMES PROJECT

**Joint work led by Great Yarmouth Borough Council, East Suffolk Council and NHS Norfolk and Waveney identified local people with respiratory health conditions and a risk of 'financial vulnerability.'**

More than 350 households in the area were contacted and offered support and provided with general advice around staying warm and well during the winter.

As a result, 50% of residents requested a further follow-up call within four weeks, covering a range of topics such as government financial support to help with energy bills including those on pre-payment meters, local sources of financial support, information about warm rooms and support from voluntary organisations.

## ACUTE RESPIRATORY INFECTION HUBS

**These were set up to help meet additional demand from patients with respiratory conditions over the winter months.**

The service was aimed at patients needing face-to-face assessment for their symptoms, and access to a range of support to help prevent admission to hospital.

The hubs created additional capacity of 40 assessments per day.

## ASTHMA PATIENT REVIEW PROGRAMME

**GPs across the area identified and reviewed more than 1000 asthma patients with the highest clinical need, to provide them with support in managing their condition.**

This work was supported by Interface, the UK's leading independent provider of clinical pharmacists, and showcased at a national conference for healthcare leaders.

# MAKING VITAL CONNECTIONS

**A dedicated team of 'Connectors' is helping patients access the support they need when they return home after a stay in hospital.**

The Health Connect service in Great Yarmouth and Waveney works with patients, many of whom are elderly and frail, when they are discharged from hospital - with the aim of preventing readmission.

Health Connect staff, known as 'Connectors,' specialise in supporting patients who leave hospital without a package of care - but on arriving home, discover they need a helping hand to get back into a routine.

The Connectors are employed by East Coast Community Healthcare (ECCH). They work alongside ECCH's Primary Care Home teams of nurses and therapists who offer personalised care in patients' own homes. They have extensive knowledge of local groups and organisations providing support at a grass roots level. They also have established links with GPs and services provided by ECCH, including dieticians, therapists, pharmacy, and community nursing. Each of the five Connectors has their own 'patch' within Great Yarmouth and Waveney. Among them is Samantha Porter, who has been a Connector since the service was set up last year.

Samantha explained that the patients they assisted were not in need of a 'formal' package of care but needed help with, for example, their medications or to re-gain confidence and re-establish home routines after a stay in hospital.

"We are a reassuring point of contact for them and can get them the support they need quickly as we have good local contacts, both within healthcare and the voluntary sector," she said.

Notifications about patients who may need the assistance of a Connector come direct from staff providing their care on a hospital ward. They check a box on a computer system to request a welfare call - which is immediately transferred to the Connectors, who can then get in touch.

But the service isn't based on remote telephone calls, explained Samantha

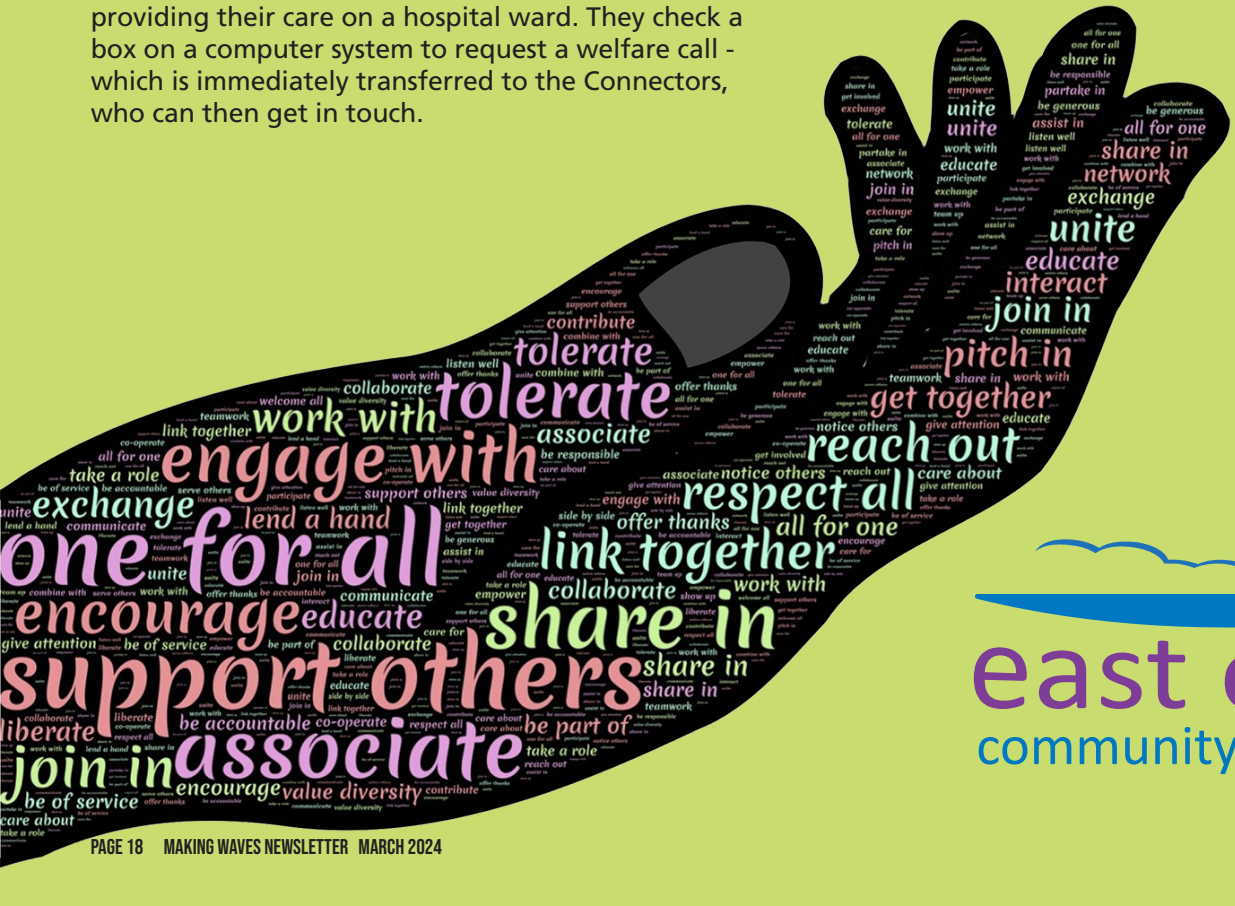
"When we make the initial call, most of the time it is to set-up a face-to-face meeting," said Samantha. "You need to meet with people to see their surroundings and circumstances and tease out what issues or obstacles they may be facing, whether physical or mental."

Connectors instigate a wide-ranging conversation to help gain a full understanding of their situation, asking questions which create a holistic picture including their routines, social interaction, physical wellbeing and mental health.

"Once we have this picture, we can use our knowledge of what support is available locally to meet their needs - and then connect them to it," said Samantha.

Feedback from patients and their families about the service, which is funded by the Norfolk and Waveney Integrated Care Board and delivered by ECCH, has been positive.

"It's an extremely satisfying role," said Samantha. "Understandably, people don't have detailed knowledge of what support is available locally or who to ring if they have a problem, so they could end up becoming isolated or possibly re-admitted to hospital. Our aim is to be a point of contact that helps prevent that from happening."




east coast
community healthcare

# HEALTH CONNECT SERVICE

## Case Study 1

A female patient who had spent time in hospital with a chest infection was discharged home at the end of November, just as the weather was beginning to turn wintry. Her stay in hospital had resulted in her losing confidence in herself and she struggled to get back into her old routine. In particular, she had been a regular at her local church group, - but was hesitant about returning.

Samantha helped her break out of this cycle by accompanying her to a church group meeting, which gave her the confidence to return in the following weeks. Samantha was also able to arrange a community transport service to give her a lift to the meeting each week throughout the winter - and, for reassurance at home, provided her with a community alarm supplied by the district council.

Without Samantha's intervention, the woman would have missed this important weekly social interaction with friends, spending the winter isolated at home to the detriment of her mental health.

## Case Study 2

A woman was discharged home after a stay in hospital due to her Chronic Obstructive Pulmonary Disease (COPD). After a conversation with Samantha, it emerged that she really was not managing well at home, struggling with issues including her medication, domestic chores and memory. Using her knowledge and contacts, Samantha was able to arrange:

- Support from ECCH's pharmacy team, to help her with her medication, including the use of new nebulisers.
- Access to support from Norfolk and Waveney Community Support, which includes staff from the local branches of Age UK and the British Red Cross, to help her keep her home tidy and access online grocery shopping.
- A referral to ECCH's memory impairment nurse, to discuss treatment and support options.

# BUILDING A HEALTHIER FUTURE TOGETHER


## "WATCH OUR RECRUITMENT FILM ON OUR YOUTUBE CHANNEL..."



## "...TO SEE WHY WE ARE PROUD OF THE PAGET"



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