

Delivering Longer

Healthier Lives



**HEALTH AND  
SOCIAL CARE IN  
THE ISLE OF MAN  
2016 - 2021  
5 YEARS. 5 GOALS.**

**Our vision:**  
the best small-island  
health and care system.



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# 1. Foreword



Hon David Ashford MHK  
Minister for Health and Social Care

The Isle of Man has a historic opportunity to provide world-leading integrated health and care services so that we can deliver longer, healthier lives for all of our residents; one of the core aims of our Programme for Government.

Our vision is to become the best small island-based health and care system; to provide the right care, at the right time, in the right way, as close to home as possible.

But we are a long way off achieving this vision.

We face the same pressures as all other health and care economies. Thanks to advances in healthcare people are living longer, which is a good thing; but as our population continues to get older, we are faced with managing more complicated health and social care needs, and the accompanying pull on resources.

Integration offers the best chance to address this. Integration stops people falling through the gaps between organisations. Integration reduces inefficiencies. Integration is good because it allows us to design services based around the needs of the individual, rather than the organisation; involving, supporting and trusting people to help them lead independent lives and take control of their own health and care.

In practice, this is about keeping people out of hospital wherever possible, so that care is provided within the community, in a real partnership with all the health and care providers we work with.

In turn, this approach will ease the pressure on hospital, residential and nursing care so that we can focus our efforts on how we support the most vulnerable.

Joined-up, co-ordinated services that put people at the heart of everything we do, will help us achieve the best outcomes for our people and communities; and gives us a way forward to meet the aspirations set out in our five-year 'Health and Care Strategy'.

I look forward to working with all of you to turn this into reality.

Hon David Ashford MHK  
Minister for Health and Social Care



[Click here to visit the 'Health and Care Strategy'](#)

# 2. Introduction

**Our vision is to deliver longer, healthier lives by becoming the best small island-based health and care system** - on the journey to achieve this vision we have set an aim that by December 2021 we will have collaborated with all stakeholders to co-design and to, in most part, have implemented a people-centred health and care system that always provides timely, best practice care in the most appropriate setting; delivered by colleagues and partners who are skilled, caring and find joy in their work.

An integrated care system built around the needs of our residents and led from community or primary care. We want all our residents no matter what age to feel more in control of their lives and able to draw upon their own personal resources, and those of the community, not only when health and care problems arise but to prevent these problems happening.

**We know that this means we will need to focus more on prevention, early intervention, shared decision making and self-care. When problems occur that need the intervention of health and care services, our response will be co-ordinated and targeted.**

We recognise that we need to do much more to support people to be well and independent so that they do not require the intervention of services. In health, we know that the current model, where the overwhelming majority of funding is spent on acute hospital services here on the Island or in the UK, which is the most expensive part of the system, is unsustainable and has to change. Similarly, to make sure that we get the best value for public money, and so we need to prevent or delay admissions to nursing and residential care, and to reduce the cost of dependence for adults of working age.

At the moment, we know that there is a lack of those health and care services based in the community that could prevent individuals having to be treated at hospital or needing some social care intervention. Moreover, the services that are available are not co-ordinated across the system, leading to both gaps and on occasion duplication. It is essential to improve the experience of health, care and support for our residents, and also to create a sustainable system that these services are delivered in a much more integrated way, taking a life course approach and, where appropriate, is available seven days a week.

Our plans for integrated, increased community-based care reflect the feedback from our residents that care needs to be more joined-up (Southern Community Partnership focus groups held between January and March 2017 and Western focus groups held in December 2017). These plans will require large-scale transformation of the way that care is delivered in the Isle of Man, and include a significant shift of resources out of the hospital setting to care provided in the community setting in 'hub' locations across the Island. We do not underestimate the scale of the challenge, which will require the commitment of all our colleagues and health and care professionals and community third-sector partners and a wide-ranging communication and engagement with all of our 83,000 residents.

# 3. Our Vision

## 'To become the best small island-based health and care system'

### What this will mean for our residents

We see a local environment where all our residents feel more in control of their lives and more confident to draw on their own personalised resources, and those of their families and communities, not only when problems arise but to prevent them from happening. We know that this means we will need to give greater priority to prevention, early intervention, shared decision making and self-care. When problems occur that need the intervention of health and social care services our response should be integrated and targeted.

We want a truly integrated health and care system for the Isle of Man, one that incorporates our definition of Integrated Care:

## 'Where our teams offer a person and their carer a co-ordinated personal and flexible response to their health and care needs so that best outcomes are achieved.'

Our residents tell us that they want a more joined-up service available in their communities. At the same time, our analysis shows us that we cannot sustain the current proportion of expenditure that is currently spent on hospital services here at Noble's hospital and the specialist hospitals in the UK. Nor can the Isle of Man Government continue to afford, if the system were to remain unchanged, to fund the benefit support required for the projected future need of placement in future Residential Nursing and Care Homes due to the expected rise in elderly resident population.

Therefore, we want to support people to be well and independent and to take control, with support as needed, for their own care. When intervention is required, we want this to be provided in people's own homes, in primary care or community facilities. Only when there is an urgent or emergency need should care be provided at Noble's hospital, or in the case of the elderly, if a person can no longer be supported to remain independent in their own home, a residential or nursing home. All services should be delivered in an integrated way, led by community-based colleagues and primary care professionals where appropriate, in partnership with people and their carers and to the highest standards of safety and quality. They should be focused on early intervention and prevention with the aim of reducing, as far as possible, reactive and unplanned care.

## The central pillars of our vision can be summarised as follows:

That health and care services should enable supported people to be well and independent and to take control of their own care to achieve the best outcomes, drawing on all the assets available in the community.

That health and care support and services should be provided at home, in the community or in primary care, unless there is a good reason why this should not be the case.

That all support and care services in the Isle of Man should be safe and of a high quality and part of an integrated system led by professionals in the community in an equal partnership with people and their carers.

We want to see a joined-up, integrated care system that puts people at the centre of the organisation of their care, with community-based professionals as a cornerstone of the co-ordination of services.

As the holder of the registered list of patients, primary care is in a unique position as the co-ordinator of care, shaping services around the person, creating a joined-up system and dramatically reducing the fragmentation of delivery. The co-operation of all colleagues is required to ensure the correct support and if needed a package of care is put in place for people. This will be led by an identified professional, someone with the understanding of the 'whole-person care needs' of that person. This could be a GP or a long-term condition nurse or social worker; anyone professional that can take up this key role in co-ordinating and leading care pathways.

Supporting all of this will be the wider care system; including pharmacists, optometrists and dentists, as well as care-based, early intervention services, all play a role in supporting people to be well and independent. The DHSC is committed to ensuring that we retain a viable, high quality, local acute and emergency service at Noble's hospital. Together with 'step-up and step-down' intermediate care beds at Ramsey Cottage District Hospital, where those that need health care for a defined period of time overseen by a consultant physician.

## The difference to our residents

We want our joined-up approach to make a difference to all our Island residents. This new approach will be designed to address the concerns of communities about the current fragmented nature of some of the care they receive.

**These include:**

### Reducing the repetition and duplication -

“I don’t want to tell people six times”

“I want my child to receive the right care by the right person and in the right place”

### No one falls through the gaps-

“We didn’t know who was responsible for what”

### An end to the revolving door syndrome -

“Dad was in and out of hospital and care homes more often than he needed to be”

### Co-ordinated home visits -

“I wanted to be there to support my mum as she was uncomfortable with strangers coming into the house, but it meant that I had to take time off work”

### Discharge from hospital at the right time with the right support -

“Dad wanted to come home and we wanted him home, but it took ages”

**We listened to what people would like to see from their health and care services**

(Feedback from the focus groups held in 2017 in the South and West of the Island):

To tell their story once.

For providers to join and co-ordinate services to create a chain of support.

To open up their world and increase their choices.

To be involved in their own care and for this to be centred on their wants and needs (and take account of those of their family carers).

**We understand the major challenges that we face in delivering more integrated care:**

Too many individuals are trapped in cycles of unnecessary and expensive emergency admissions resulting in increased dependencies on formal care.

We have fragmented and broken chains of care resulting in gaps, escalations of response, inappropriate ‘hand offs’ and limited on-going support.

Too great a reliance on hospital-based care and a need to modernise our community and primary care infrastructure; young people and their families feel the transition to adult services is a cliff edge.

## An Integrated approach for the Isle of Man will have six key elements:



## The following examples illustrate the difference that more joined-up care could make to people living within the Isle of Man:

### Juan & Ruth

Juan is 72 and lives with his wife Ruth, in Port Erin. Ruth, aged 70, has become increasingly dependent on Juan due to chronic rheumatoid arthritis. Ruth has had a number of slips and minor falls over the past year. Juan has diabetes and heart failure but doesn't visit his GP very often because he doesn't like leaving Ruth alone and doesn't like to trouble his doctor. He relies on a neighbour to care for Ruth when he has to go out. Juan has recently had increased problems with his breathing and on two occasions the symptoms were so bad he phoned an ambulance to take him to Emergency Department (ED) at Noble's. The neighbour cared for Ruth while Juan was in hospital.

Juan has attended ED on two occasions recently, and his GP has asked colleagues to arrange for the team of health and care professionals to come together with Juan to see how they can best support his need taking into full account what matters to him. Juan is found to have a chest infection and cellulitis (a bacterial infection that causes swelling in his legs). The team treat Juan's chest infection and cellulitis and arrange for Care Companion Carol, to meet with Juan and Ruth to find out what support they need. Together, they agree on a plan of care and support which includes:

- ✓ **Additional support for Juan via the local Care Centre (Southlands) including respite care.**
- ✓ **Adaptations to the house including the installation of grab rails and a walk-in shower for Ruth.**
- ✓ **Use of tele-health so that Juan can be monitored regularly without him having to attend his GP practice.**

Juan now contacts Carol if there are any problems with his health.

## Voirrey

Voirrey aged 85 lives alone and is recently bereaved with no family. She feels socially isolated and frequently attends ED (she regularly phones for ambulances for minor illnesses). She often visits her GP in Douglas, sitting in the waiting area (up to four times a week) simply because she is lonely. Her anxiety impacts on her ability to cope with daily living tasks and other practical needs. A number of professionals (occupational therapists, physiotherapists, community nurse) have tried to intervene with little success and there is a feeling that all options have been exhausted. She has attended a couple of community groups in the past with a professional but does not continue when left to her own devices; Voirrey has also paid for companionship through a private care agency for an expensive monthly fee. By focusing on questions to help understand Voirrey's background and determine the cause of her problems, the Douglas North community team learned about her life and priorities. Working together, they identified that Voirrey had a number of concerns that were causing her anxiety, including sorting out her late husband's and her own will. She also did not consider the companionship she received from the agency to be value for money, but did not feel able to address this with the agency.

The Douglas North Patch team worked with Voirrey to focus on the root cause of these issues. Together, they took the following actions:

- ✓ **The team advocated on Voirrey's behalf with the care agency so that she now pays a reduced amount and the care is more specific to her needs.**
- ✓ **As a number of professionals are involved, the Douglas North community team leader has called a case conference to agree a common approach and avoid duplication.**
- ✓ **The community team are also linking with a voluntary organisation to identify a volunteer buddy through a scheme which embodies 'it's better together'.**

Once the underlying causes of her anxiety are addressed, Voirrey can be supported to connect to the community and pursue her creative interests with the support of a buddy.

## Mohammed (Mo)

Mo is 69, lives alone in Ramsey and has some mobility problems. He relies on his electronic scooter to go into town to do his shopping. Sometimes Mo has problems breathing. He has an inhaler to help him but isn't always sure when he should use it and sometimes it doesn't seem to work very well.

Mo recently lost the keys to his scooter and now feels trapped in his home and lonely. He doesn't know who to contact for help. Mo's breathing difficulties have started to get worse, and when his inhaler doesn't work, he calls an ambulance. This happens frequently over a six-month period, and Mo's GP is advised by the Emergency Department of the fact that he may be having problems.

A team of health and care professionals meet with Mo to discuss his support needs. Together they develop a plan that includes:

- ✓ **A named co-ordinator whom Mo can contact with any problems.**
- ✓ **Time with a Ramsey group practice nurse to help Mo to use his inhaler properly.**
- ✓ **Access to a self-management course which helps Mo to better understand his condition.**
- ✓ **Information about local activities in his community (such as Men in Sheds) to combat Mo's loneliness.**

Most importantly the team got a set of replacement keys for his scooter so he can get out and about again.



# Kate

Kate is a 24-year-old Mum, pregnant with her second child. Her first child is now 20 months and is at home with her. Her partner, Tim, frequently works away from the Island, often away for numerous days at a time and they have no family on the Island. Kate's pregnancy is around 30 weeks advanced, and she worries that she will have a need to attend hospital unexpectedly, possible in labour, without the support of her partner due to his work commitments off the Island.

Their first child, Jimmy was born in Ireland close to where Kate's parents live. She had a fairly rapid labour for a first-time mum and delivered a good-sized baby boy, despite him arriving a few weeks earlier than expected.

Kate is aware that second labours can be quicker than the first and she is developing anxiety that perhaps this next time things could get underway when Tim is away. How would she manage to look after Jimmy while in labour without Tim close at hand? She is a protective mum to Jimmy, who is often very uneasy around other small children and pets, so she tends to keep young Jimmy to herself and does not have an established group of friends or other mums locally that she knows well.

Kate's GP and midwife at her local surgery have been monitoring her pregnancy and all appears to be progressing well, but at her last visit the midwife picked up from Kate that she was getting worried about her second child's arrival even though it was expected to be a few months yet. She had begun to express her concerns about who could look after Jimmy (and her) if Tim was away when her labour started? The midwife suggested that she would arrange for herself and the health visitor to visit Kate at home and together they would all work out a plan to help reduce her anxiety and plan for some informal channels of support and friendship from some of the experienced local women.

Together at the meeting organised at Kate's home, Kate, the midwife and the health visitor all work up an agreed plan of care and support which includes:

- ✓ **An opportunity for the HV to meet with Kate and Tim together so that Tim could be helped to understand Kate's anxiety and an attempt to adjust his work commitments away in the weeks approaching her due date.**
- ✓ **Kate agreed for the professionals to identify a couple of experienced mums in the area who could help to provide some friendship support and socialisation help for Jimmy and Kate, to reduce her isolation and anxiety.**
- ✓ **The hospital Maternity team were fully updated to ensure that should Kate's fear be realised (and her labour was swift and earlier than expected) a plan for her midwife to visit at home when in labour, (if Tim was away) for assessment to be made and in case of urgent need the Children and Families Team made aware that a very urgent plan for Jimmy may be needed as a precautionary measure, just whilst Kate was in labour.**





# 4. Why We Need To Change

This section describes the reasons why we need to bring about radical change in the way that health and care services are provided in the Isle of Man. It describes this from the perspective of the demographic change that is happening, our progress against the delivery of health and care outcomes and the financial challenge we are facing. We want to Deliver Care in the Right Setting for people as an underlying principle of this vision.

## 4.1 Demographic change

Our ambition is to see integrated services for all parts of our population. In the Isle of Man the birth rate is declining, around 750 births occur every year. A particular driver for reform is that older people use health and care services proportionately more than other age groups and that the number of people aged over 65 is increasing rapidly.

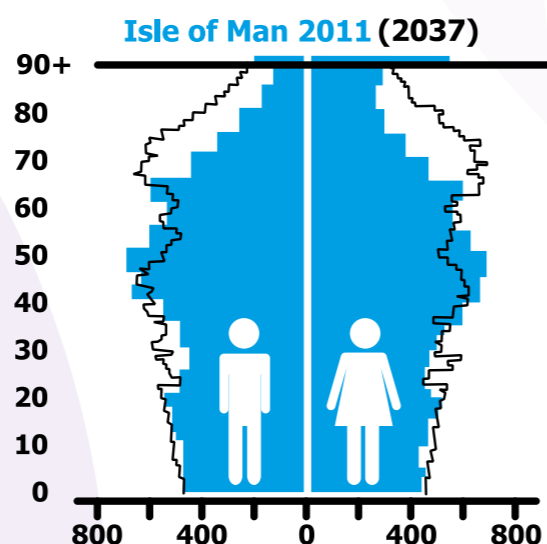
According to the Isle of Man Census (2016) there were 18,265 people of retirement age or over compared to 14,725 in 2001. A decline is noted in people less than 16 years of age 14,233, reduced from 14,509 in 2001.

A dependency ratio over all of 63.95% increased from 62.10% in 2001, the aged dependency\* ratio 35.9 compared to 31.3 in 2001 (\*the number of persons of retirement age and over as a percentage of the number of working age).

Age demographic profile projections for the future (2037) suggest that our Island population will be heavily increased in 65-85 year olds with further decline in residents below 20 years.

Whilst we should welcome the fact that people are living longer, our challenge is to make sure that our residents have a long and healthy old age. Although major gains have been made in terms of life expectancy, this has not been matched by a similar increase in healthy life expectancy. The result is that people tend to live longer with a limiting long-term condition(s). Often when over 65 years of age people are prone to have up to two ailments/conditions, in general terms most over 75s are diagnosed with three or more conditions.

The diagram represents the shift from the population demographic of 2011 in blue shading to the predicted demographic that by 2037 (the black line) a much greater number of people on the Isle of Man will be aged 70-90 years.



## 4.2 Health outcomes

Health outcomes amongst our population are mixed. Life expectancy at birth (the average number of years a newborn baby would live) is 4 years lower for men than women - 79.6 years and 83.6 years (both similar rates to England based on data for 2013-2015). The Director of Public Health published her first Annual Report in late 2017, which provides an independent overview of the health and wellbeing of the population of the Isle of Man. It shows where we need to drive improvement in health outcomes and provides a baseline against which we can monitor our success in doing so. By improving the way we work together across government, the private sector, voluntary sector and communities will mean we can drive system change that will be sustainable into the future.

### Public health data – life courses

A selection of the current factors relating to three distinct stages in life to illustrate where an impact could be made

Isle of Man Director of Public Health Annual Report 2017 (Image extracts from Annual Report)

#### Children aged 0-5 years



#### Working Age People



#### Elderly People



Icons in orange or red identify areas where preventative actions of residents and integrated working of care colleagues and communities can be targeted to support a change to improve health outcomes from their current worse or similar to the England average, to better than the England average.

One of the red icons shows a low proportion of people currently facilitated, to die with support at home rather than in strange hospital surroundings, when their time comes. An end of life pathway is an example of integrated teams working collaboratively across all sectors to facilitate a compassionate death in familiar, comfortable surroundings.

## 4.3 Fragmented services

People have told us that too often services do not feel joined-up. Residents and patients have to give the same information a number of times, services appear to not talk to each other and people do not feel in control of how those services work together. We also appreciate that, currently, the way services are delivered, often appears to be more about the convenience of the organisation, where health or social care colleagues may be based, and not about the convenience of the person. We want to see a real transformation: for people to be in greater control of the care they receive, their own information and the way in which organisations work together. We will, wherever possible strive to remove this fragmentation and duplication in services.

## 4.4 Financial position

The need to improve outcomes and the experience of care is a fundamental part of why we are pursuing this programme of change. We understand that we must change to address the scale of the financial challenge that is facing our health and care economy.

We cannot preserve the quality of services provided to our residents if we continue to deliver them as we currently do. In order to maintain and improve the quality of services we must radically transform the system in which they are delivered. This means supporting people to be well and independent and building an integrated system of services that are targeted and preventative rather than unplanned and reactive.

The review of funding for the health service (agreed in Tynwald January 2018, to report no later than March 2019) together with options for the funding of nursing and residential care for the elderly (reporting to Tynwald in July 2019) are key to the future implementation of this strategy.

Services both in Noble's Hospital and in the community across all aspects of health and care must begin their reconfiguration. Funding currently provided to the hospital will be partly reassigned to ensure that a greater share is provided for the community teams in order for there to be an increased workforce delivering health and care closer to people's homes. Preventative elements must also be resourced appropriately to ensure their impact is realised.



# 5. Delivering Our Vision

## To become the best small island-based health and care system

Our approach will be characterised by the need for services to be provided in an integrated way (the right care), at the right time, in the right setting. We must start with the person at the centre of the care - a move to more personalised and targeted to the specifics of what really matters to that person, quite different and a big improvement from the way the current system operates. Integrated care within the Isle of Man must span the wide range of issues that our population faces, from social isolation through to acute medical care. For our residents, integrated care will mean the following:

- An identified first point of contact for their health and care needs and for the coordination of their care and support
- An integrated care plan, built around the individual and their carer, covering health and care, and drawing on all of the assets available in the community
- Full involvement in the development of this care plan, including self-care elements and planning ahead to record choices and decisions about future care.

To achieve our vision of integrated care, health and care providers will need to deliver services in new ways and the key components of this system are set out in Appendix A.

The Health and Care economy stakeholders are committed to transforming the system, colleagues within the Department of Health and Social Care, together with the various contracted Primary Care professionals and very importantly our partners in third sector voluntary organisations, who are to be embraced by the DHSC into the system as equal partners.

This overarching vision for integrated care will be implemented by recognising while the principles of good quality integrated care are as above, the needs of children, of adults below retirement age and of older people aged 65 years and over are different, we should be clear that we want to follow the natural life cycle approach of:

Start Well,  
Live Well,  
Age Well,  
Die Well.

The strategic aims allow the co-ordination of work programmes to be integrated across the full range of public service functions in order to tackle a well-documented issue (Marmot Report, Department of Health, 2010 UK): that disadvantage starts before birth and accumulates throughout life.

This means that action to reduce health inequalities must start before birth and be followed through the life of an individual to:

1

Ensure that they reach their full potential through getting the best start in life

(Start Well = pregnancy through to end of formal education/training)

2

Ensure that they have healthy productive working lives and are empowered to be fully engaged citizens and parents - reducing risk of premature avoidable deaths & long-term limiting illness

(Live Well = working age adults)

3

Ensure that the older people are empowered to maximise their health, well-being & independence and in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities

(Age Well = retirement age to end of life)



## Safeguarding people

At any stage in a person's life certain vulnerabilities may become evident often requiring some form of intervention for a period of time, short or sometimes long-term to keep them safe.

Safeguarding people is set to become a statutory function of the DHSC and a key priority for the Isle of Man Government. It is **everyone's responsibility** and a key thread requiring collaboration and integrated working across services. The statutory Safeguarding Board brings together leaders and stakeholders across all agencies to work with mutual understanding and commitment.

# 6. Understanding Our Population

## 6.1 A healthy Island?

The first annual report from the Director of Public Health, published in October 2017 is the first report to use local data to give an overview of health and how it compares to England.

The Public Health directorate held workshops in the early part of 2018 with stakeholders from across government, the third sector and private sector to discuss the challenges faced in improving health and wellbeing and, how, across the Island we need to work differently together to achieve this.

Core to the delivery of integrated care is a detailed understanding of those residents at risk of future lost independence. This allows us to group the needs of the population in order that partners can work together to target expertise effectively.

A designated subcommittee of the Council of Ministers, the Social Policy and Children's Committee will decide on the prioritisation of the programme for future Joint Strategic Needs Assessments (JSNA). The programme will then be drawn up, resourced, commissioned and undertaken. It is vital that the focus of future strategies is aligned to address those in most need.

## 6.2 Listening and working with island residents

We want to involve and engage the residents of the Isle of Man in the planning and shaping of future services, ensuring they have a clear voice in the development and delivery of the integrated care programmes, for children, for adults and for older people. There is already evidence of a willingness to engage with the DHSC, the pilot Southern Community Partnership took place successfully in the South of the Island during the first quarter of 2017 and has plans to establish itself formally in the Summer, 2018. In December 2017 DHSC also sought the views of residents and stakeholders in the West of the Island with two focus groups held in Peel.

In December 2017, January and March 2018, six focus groups were held in Douglas to ascertain people's views of the current mechanisms for funding Nursing and Residential Care Homes within the Island; specifically to ask their views regarding the direction the government should move towards in preparation for a policy position to be put before Tynwald (July 2018) on the future sustainable funding arrangements for residents requiring placement in either Nursing or Residential Care Homes throughout the Island.

We are seeking to strengthen and further develop this engagement work so that residents are asked not only about individual services, but how those services work together and in a way that supports people to be in control of their lives as far as possible.

# 7. Change Across The System

We are developing a number of cross-cutting plans that will play a vital part in the delivery of a system of Integrated Care for our residents. We need to make sure that all parts of the system are playing their roles in this transformation programme as each section of our economy must move towards a more integrated model at pace.

## 7.1 Children's integrated care - Start Well

### Breastfeeding

Breast milk is a great start for an infant, and so, further encouragement is to be given to more mothers to help them understand the life-long benefits for their child, and immediate benefit to themselves when feeding is initiated at birth. Presently only 70% of Island mothers initiate breastfeeding with a steep drop to 41% of those mothers after 6-8 weeks. Giving every child the best start in life is crucial to reducing health inequalities across the course of a lifetime and what happens during the early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status.

### Health visiting and school nursing service

Health visitors and school nurses deliver both a universal and targeted service to children aged 0-19 years and their families. The teams work closely with professional colleagues from this Department and also from Education, Sports and Culture as well as the voluntary sector to identify vulnerable children, reduce inequalities and improve the future health outcomes for children and their families across the Island. Health visitors and school nurses within the teams have a public health role and are committed to the concepts of prevention, early intervention, protection and promotion.

Colleagues within this service lead on the delivery of the Healthy Child Programme (HCP) which offers every family a programme of screening assessment, the opportunity to receive the national immunisation programme, developmental reviews, and information and guidance to support parenting and healthy choices. The HCP for both 0 – 4 and 4 – 19 years focuses on early intervention, prevention and the promotion of health for children, young people and families. The HCP is not carried out in isolation but forms part of a wider process of ensuring children's health and safety is optimised through the Island's Strategy for Children and Young People (2015 – 2020).

## 7.2 Integrated care for adults of working age – Live Well

For adults of working age, we will need to empower people to have confidence to self-care where appropriate, to signpost, educate and communicate the range of support available through the Directory of Services available on the web prior to engaging with public service interventions. Some residents and patients can currently 'bounce' between a range of different services (primary care, benefits payments, criminal justice, Emergency Department, mental health and social care) without improving their outcomes and at a cost to the system. A coordinated integrated approach will significantly reduce this unsettling 'bounce' effect.

## 7.3 Integrated care for older people - Age Well

Our work in this part of the system will aim to reduce hospital activity and improve the quality of care provided to patients through a more co-ordinated approach based on multi-disciplinary care plans a single assessment process and shared decision making.

We will build the extended programme from integrated hubs across the Island, a number of which are already established in Port Erin and Port St Mary at the Thie Roisen facility where (Dental, Physiotherapy, Reablement, District Nursing, Family Planning, Men in Sheds, Bridge Club and other group activities that can help to combat loneliness) and in the North at Ramsey Cottage District Hospital campus, (Men in Sheds, Social Care Team, Mental Health Community Team, Renal Dialysis Satellite, Minor Injuries Unit, Out Patients, Tissue Viability Service, Physiotherapy and Occupational Therapy, District Nursing, Respite Beds and Intermediate Care) both Integrated Hub sites are situated very close to GP practices, sheltered accommodation and residential care home facilities.

Developments to establish integrated hub facilities in the West and develop further in the East of the Island are to gather pace in the coming year. We will build the extended programme from Community Care around clusters of GP practices or Community facilities (known as Hubs) and will draw upon the resources of all major partners, including the third sector. The model will contribute to the development of the model of 'out of hospital care' and test whether it will run at a lower cost than the existing system whilst ensuring that the quality of care is continually improved. This will provide an opportunity for the enhanced testing of concepts such as virtual wards, shared decision making, self-management and motivational interviewing.

# 8. Supporting Strategies



This is an ambitious strategy for the Isle of Man and is dependent on a number of other key strategic frameworks and programmes making a contribution to its achievement. Leaders across the department are committed to ensuring all partners are involved in and sighted on the developing strategies that together will determine our ability to deliver integrated care at scale and pace. Amongst these the following are particularly important.

## 8.1 Out of hospital care

### (Integrated health and care implementation plans in development)

In January 2018 three services, Adult Social Care, Mental Health and Community Health, previously each managed separately were combined to bring together a newly designed Community Care Directorate, led by one Director supported by an expert team of professionals. The integration of the teams brings about a cultural change and the opportunity for all to share in bringing about one unified vision.

The scale of this transformation is significant and will require a fundamentally different way of doing business. Central to this will be an integrated approach where health and care delivery is built around the person.

The programme will include testing the potential to reduce hospital beds by examining how the appropriate accelerated discharge of people who no longer require medical care from hospital colleagues yet for a range of reasons, are currently impeded from timely discharge from a hospital bed.

We will also explore the potential for making better use of the beds in the department's care homes considering the use of some of them to be used as a virtual hospital in order to reduce beds currently provided on hospital premises.

Part of our planning to deliver this change will be a pathways group, comprised of a range of health professionals including GPs and hospital doctors to agree for each main care pathway, how to bring about the appropriate transfer of some aspects of clinical care from secondary care to the local setting in primary and community care. We will look at different methodologies to achieve this, including for example following up on the work undertaken globally where local GPs and a range of health professionals come together to agree what the patient pathway for a particular condition should be.

This will be an economy-wide programme to deliver this change in a phased way over the lifetime of this strategy. We will test the outcomes of this work and how people experience this through the development of our own Out of Hospital Quality Care Standards. We will draw on work done elsewhere (e.g. Greater Manchester) to inform the development of these standards.

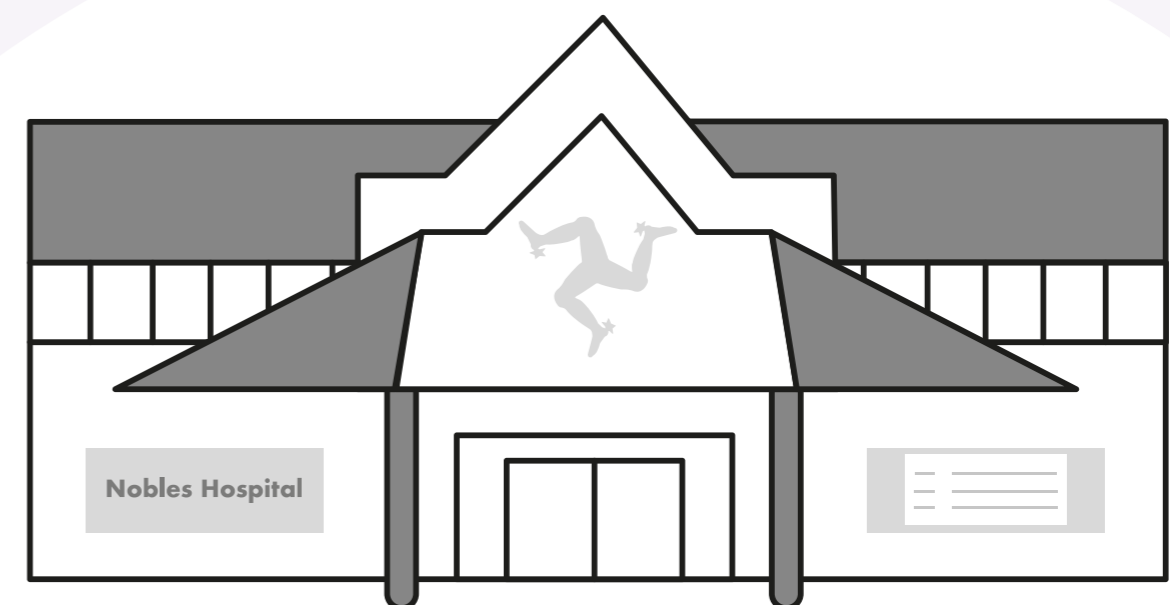
In parallel with this strategic work, it is incumbent upon us to ensure that we have a clear and agreed plan to determine services we want to be provided within our Island hospital and what services we want to be provided in the North West of England or Northern Ireland / Scotland at a regional level.

## 8.2 Hospital services at Noble's and tertiary care

In line with the DHSC's five-year strategy (2016-2021) a major quality improvement project has been initiated to ensure that the care provided in the hospital and across the whole health and care system is of the highest standard and delivered in a timely and efficient manner.

As an important element of the integrated care model, Noble's will be a key facility for healthcare as a centre of excellence providing core services that are only required to be delivered in a hospital setting. This will include elements already in place (e.g. scheduled inpatient and outpatient care that requires specialist consultation, and in large part unscheduled inpatient care) as well as a range of new pathways that will incorporate proven contemporary models such as rapid access speciality clinics, hospital in the home and enhanced Emergency Department capability that will include an observation ward for patients requiring a maximum of 23 hours hospital care.

There will continue to be a requirement for those hospital services not able to be provided in a clinically and financially sustainable manner to best practice standards on the Island. Newly agreed service agreements and pathways developed with suitable providers of excellent care in the UK will be established. Some specialised care may be delivered on Island by visiting Consultants when appropriate or otherwise off-Island where access will be facilitated by efficient and timely transport services.



## 8.3 Intermediate care model at Ramsey Cottage Hospital

In February 2018, the model of care at the Ramsey and District Cottage Hospital changed, medical supervision of patients cared for in the intermediate care setting is provided by a hospital-based physician and a community elderly care consultant. The intermediate care model for Island-wide residents also increases capacity for this type of step down care from 21 up to 31 beds. Intermediate care may have the potential to be provided in a person's home in the future.

## 8.4 Primary care strategic plans

### (To be developed)

As holders of the registered list of patients, GPs are in the best position to lead the co-ordination of patients' care. This covers the range of inputs from support for self-management and shared decision making to ensuring that patients with complex needs have robust care plans with all agencies contributing to the person staying well, independent and out of health and care institutions.

We recognise that there must be transformation in primary care for it to fulfil this role. Survey information shows that patients are largely satisfied with the quality of general practice on the Isle of Man. However, the demographic change outlined in Section 3.1 and difficulties in recruiting and retaining GPs means that the primary care system is under significant pressure at a time when it needs to be a core component of the Island's vision for integrated care. Exhaustion and fatigue and disengagement of the GP workforce could be a major barrier to GP led integrated care models. In so far as this model relies on GP leadership, it requires GPs to want increased responsibility for the organisation and delivery of health care and to have the capacity to expand into this role. GPs will need time to plan, improved premises and infrastructure to be able to take on these roles.

The Department will work with GP representatives to produce a primary care strategy that will consider how the Island has a sustainable primary care service which will play a leading role in the delivery of an integrated system. During 2018/19, the key focus for primary care development will be on prescribing (both to improve the quality of prescribing and to ensure that prescribing is cost effective) and the development of shared care. The Department will need to decide what services can be better provided mainly or wholly in primary care, and we are considering services like diabetes and sexual health at present.

## 8.5 Strategic plan for mental health and wellbeing (2015 - 2025)

We want people in the Isle of Man to live healthy, fulfilling lives. We also want to support the development of a fairer community where everyone is able to make the most of themselves and be as independent as possible.

Improving mental health and mental wellbeing is part of this approach because it will contribute to:

- Addressing health and other inequalities
- Increasing levels of education, gaining qualifications and employment opportunities
- Tackling poverty, drug and alcohol misuse, and homelessness
- Reducing the number of people entering the Criminal Justice System.

We also strive for parity by valuing mental health equally with physical health.

The overarching principle of the parity of movement is equality in access to care, improving the quality of care, and the way resources are allocated. If we stay true to the principle of treating each person with dignity and respect in our health care system, then we should make no distinction between illnesses of the mind and illnesses of other bodily systems.

## 8.6 Strategy for children and young people (2015 - 2020)

The plan for 2015-2020 focuses on joint activity which extends beyond departmental and agency boundaries and is underpinned by the following key principles:

- Provision of high-quality services and clearly defined outcomes for children and young people
- To work in partnership with families to help them achieve the best they can for their children
- Ensuring children and young people are safe from harm and are able to build resilience to overcome inequalities
- Promote the wellbeing of children and young people.

For some children and young people, the outcomes they experience are different to the outcomes experienced by the majority of other children and young people. For some children and young people, these experiences challenge efforts to get the best out of life's opportunities. Resources are targeted towards those that need it most and where there is a likely positive impact in the longer term for individuals and the wider community.

## 8.7 Transforming children's social care

The Children and Families service has been transforming services and improving outcomes for children over the past five years.

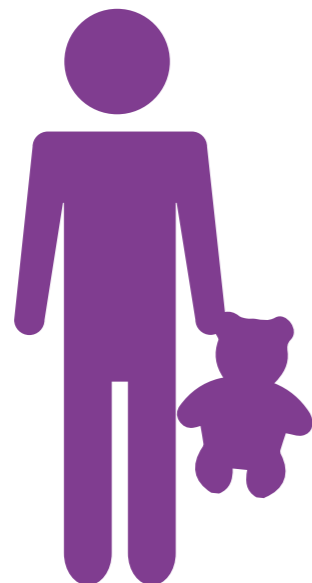
Its core statutory function – safeguarding children is undertaken in a collaborative approach with other agencies. Through the work with the Safeguarding Children Board it has established integrated thresholds and risk analysis approaches with all relevant Departments and services. The Safeguarding Bill will strengthen these collaborative arrangements.

The Children and Families service has established an early help and support service in collaboration with other partner departments and agencies to provide combined help and support before a problem becomes acute or chronic for children and their families. This is now an established source of support for up to 250 families per year, who previously would not have had support.

The Children and Families service have, after consultation with families and colleagues reconfigured two resource centres for children with disabilities. One has remained, focused on providing over-night respite care and the other has become a community support hub, providing support and guidance to children and young people with disabilities and complex medical illnesses to access services and activities they would otherwise be excluded from. It also serves as a point of contact for all agencies with a family. It has increased the use of its capacity significantly from 35% take up to 70%.

The next phase of change for Children and Families is a planned move to introduce an integrated pathway for children with disabilities. With agreement from both the Department of Education, Sport and Culture and the DHSC, through a pilot approach which has been tried and tested in other developments, the initiative being called "moving closer together" will be a proposal for an integrated approach to referral, assessment, planning and delivery of services to children with disabilities.

Other big changes for Children and Families services include a number of legislative amendments that will improve collaboration and integrate responsibility with other Departments. These will include legislative proposals for the concept of Government as "corporate parent" for children who are looked after and establishing a legal footing for the Youth Justice responsibilities of the DHSC, alongside the Department of Home Affairs (DHA) and its criminal justice strategy.



## 8.8 Self-management and self-care

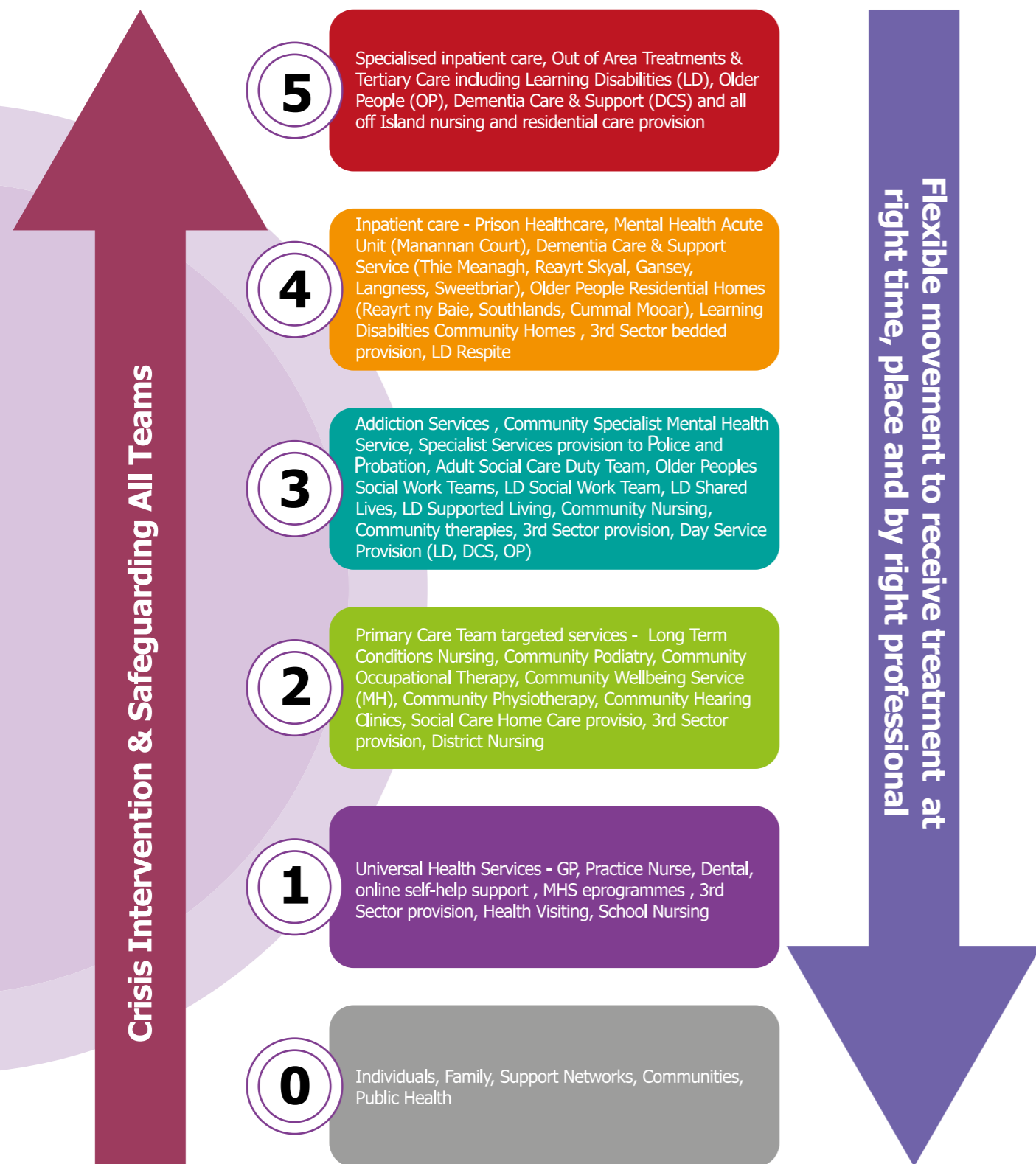
Self-management support will be a key feature of the Island's integrated care programme in order to support the aim of empowering people to become more informed about their conditions and to take an active role in their own care. A range of techniques, tools and activities that enable a person to develop confidence, knowledge and skills to be able to manage their condition and to make informed decisions where there are choices to be made about treatments and care.

The components of self-management will ensure that people and their carers:

- Have increased knowledge and understanding of the condition
- Have increased knowledge and understanding of their treatment
- Develop greater understanding of how to live a healthier lifestyle and know where to access support
- Gain better access to self-management information through patient education
- Are fully involved in decisions about their treatment and care through Shared Decision Making
- Have increased awareness and access to appropriate self-care devices through schemes such as the introduction of tele-health.



The following tiered model illustrates how tiers below the second tier (i.e. Tier 1 and 0) encompass self-management and self-care within the context of all services available to Island residents:



## 8.9 Integrated palliative and end of life care

Hospice Isle of Man is leading a cross-sector group that will develop and implement an ambitious, affordable and sustainable Integrated Palliative and End of Life Care Plan. The plan will be based on what matters to local people and their families, drawing on themes explored by people from all sectors who took part in a seminar and workshop in December 2017. The key themes in the plan will support the three pillars of the wider health and care strategy

- Nurturing a Compassionate Isle of Man, drawing on the assets of individuals and communities and supporting them to fulfil their vital role in the health and wellbeing of people and families – recognising that caring for one another at times of health crisis and personal loss is not just the responsibility for health and care services, but is everyone’s business.
- Improving continuity, communication and coordination of care across professionals and across teams with a focus on identifying people who need palliative care support earlier so that more people and families can benefit from information, advice, support and palliative care towards, at and after end of life, for a good life, good death and good grief.
- Providing more specialist palliative care services in the community and reaching out from the hospice so that more people will be supported to have the best possible end of life care at home and closer to home.

The vision for a compassionate Isle of Man is a future in which we all have a role to play in supporting each other in times of crisis and loss, and where people are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

To enable this vision to become a reality we will take forward a creative approach with local communities to raise awareness, engage and support citizens in caring for people at the end of their lives, and better support family carers. These community connections and networks will strengthen the natural support systems of family, friends and neighbours and build a dynamic network of volunteers that can offer care and companionship at the end of life, complementing the valued support from health and care professionals and services. We will also invest in new ways of learning and improving together so that patients, families, volunteers, communities and professionals learn with and from each other, enhance their knowledge, skills and confidence, build trusting relationships, and deliver the best possible palliative care to all who need it, when it is required, where it matters, and in ways that achieve the best possible outcomes for people.



## 8.10 Digital strategy - Delivering integrated care

The Department of Health and Social Care is introducing a technology-driven change which will improve care, reduce paper-based administration and eliminate the need for people to repeatedly explain the same information to each person who treats them. General Practitioners and other community health and care providers across the Island will work with joined-up information.

Using the Island's GP software system, the first phase of the change will see patient information shared between surgeries and the Hospice, adding to the network which includes the Island-wide Manx Emergency Doctors Service (MEDS) for out of hours GP contact. The next phase will extend the programme to include community nursing teams, with health visitors and school nurses, district nurses, long-term condition nurses and specialist nurses all being able to share data with the relevant doctor.

The initiative forms part of the Island-wide Digital Strategy and is a key component of the Programme for Government, with its commitment to "digitally transform the hospital and health and care services more generally".

The rules governing what information is shared, and who it is shared with, have been set to make sure that each person remains in control at all times. Consent to share their information will need to be given by the individual at each and every point of contact with a health and care professional. Patients will not be obliged to share their data. The main patient record only will be shared.



## 9. Enabling Frameworks

There are a number of building blocks already in place that can provide a strong foundation to the development of integrated health and care in the Isle of Man, and these can act as a catalyst to this development.

### 9.1 Finance

The DHSC has an allocation of budget for both health and social aspects of care which since 2014 have been part of the same system; unlike some other jurisdictions where health and social care do not fall within the same alignment of the same senior leadership. An independent review of Health and Care Funding has been commissioned to report in early 2019.

### 9.2 Governance

The vision to bring about integrated care is to be implemented by a wide range of individuals, DHSC professional and support colleagues, GPs and voluntary sector partners.

Transparent and efficient governance is essential to delivering this transformational change. A DHSC Programme Board chaired by the DHSC Chief Executive has been established to ensure the planning, prioritisation and implementation project streams are coordinated, monitored and reported upon to the Board, Minister and delegated political members.

### 9.3 Estates and community assets

The DHSC has vast array of assets in various forms which, with some adaptation, will be able to support the development of integrated care. We should also aim to work with those in the various localities such as our third sector partners and Local Authorities, some of whom have already confirmed a willingness to support our access to the wealth of buildings designated for community use.

## 9.4 Data sharing

Data Protection is not a barrier to share information, merely a framework to follow to ensure lawful sharing. Ultimately it is the person's decision to decide who their information is shared with based on three pre-set options;

1. individuals to give consent for a professional to see their record every time they come into contact with care services; or
2. give on-going consent to anyone involved in their care so they do not have to be asked again; or
3. opt out of sharing their information altogether via the integrated care record.

The integrated care record is governed by an information sharing protocol and an information sharing agreement which details what the signatory organisations are allowed to do with information once they have accessed it.

There are some statutory functions, such as child protection and adult safeguarding, where information can be lawfully shared without consent.

Only those organisations that are signatories to the information sharing agreement will have direct access to the data. That access will only be to those organisations and individuals that have a direct care relationship.

What we must not lose sight of is that appropriate information sharing is an essential part of the provision of safe and effective care. People may be put at risk if those who provide their care do not have access to relevant, accurate and up-to-date information about them.

Multi-disciplinary and multi-agency teamwork is also placing increasing emphasis on integrated care and partnership working, and information sharing is central to this, but information must be shared within the framework provided by law and ethics.



## 9.5 Engagement

Engagement is key to the success of this vision. A communications plan which outlines the vision and the objectives for the delivery of the communication and engagement activities of integrated care and how collectively we can attain the vision to become the best small island-based health and care system.

Consistent engagement with our population, listening to, and acting upon the views and concerns of the residents will be integral to our work. We want to empower residents, through enhancing their understanding of health and care services, to become more independent and take control of their lives. In an island community, virtually all our health and care colleagues are residents of the Island too, their engagement and empowerment is critical to the system working collaboratively in teams also.

We recognise that understanding the person, their experiences and their journey through the health and care system are as important as understanding their clinical needs. These same individuals and their carers have a better understanding of how the system works on the ground and what needs improving. Involving the public and giving them an active role in the system change, allows us to build the system more readily around the person and consequently, future users can understand, navigate and use easily and appropriately.

## 9.6 Workforce

Our people and their use of CARE values amongst our teams are key to making our vision come to fruition. There are opportunities to create new and different forms of working to deliver genuinely integrated care. We need to assess and take action to minimise the impact of transformational service change on staff leaving and turn this on its head so that personnel are attracted to being part of a future where island-based health and care is attractive to those with the value base to flourish.

Our values-based CARE Qualities, introduced in 2017, help set expectations, standards and encourage all colleagues to abide by the same type of behaviour throughout the DHSC.



## 9.8 Technology

We must utilise the opportunities that developing technologies offer to support people to stay independent and to manage their conditions.

Tele-health offers real potential for people to take more control of the monitoring of their condition in their own homes. For example, a GP could work in conjunction with a hospital consultant to care jointly for a diabetic patient in the community. Remote blood pressure monitors and remote blood gas monitoring are some of the more rudimentary forms of technology yet to be in widespread use across the Island.

Innovative use of IT also offers us opportunities for appointments currently provided in a hospital building to be delivered via a link direct to the person's own home. We have implemented a text message based reminder to help people comply better with appointments; similarly, this technology can also be used to gain better compliance with prescribed medications.

## 9.9 Third sector partners

The Island has an active and diverse third sector of voluntary, community and faith groups which also embraces social enterprise companies. Its size is perhaps best illustrated in that it has a turnover in excess of £85 million per annum, employs almost 1,000 staff, 10,000 volunteers and engages across every aspect of island life.

It has demonstrated over recent years that it has the capacity, ability, vision and enthusiasm to significantly support and contribute to the department's journey along which it would see itself as an essential travelling companion and strategic partner.

The Department acknowledges this valuable contribution which the third sector partners make to improving outcomes and changing lives. The third sector can and does contribute to integrated health and care in many ways:

- As organisations that deliver health and/or social care support and preventative early interventions to help people to live well and manage their health conditions
- Support for carers to remain well and continue in their role
- Engaging people who use services in co-producing care and support services
- Expertise and good practice on inclusion, equality and diversity
- Listening to the needs of local citizens and facilitating dialogue with communities
- Providing intelligence useful for planning, monitoring and evaluation.

The task is to harness this vital capacity, and to support it to grow in order to achieve the best outcomes for, and, with our people and communities. However there have been some challenges in engaging and building capacity with such a diverse group of people, interests and organisations. This document provides opportunity to develop a supportive framework and collaborative infrastructure that builds long-term sustainable capacity in the third sector and helps the wide range of organisations and community groups maximise their individual and collective contribution to integrated health and care in the Isle of Man. This will bring together the scale and expertise of the large 'providers' with the diversity of support available at a very local level.

The sector looks to engage and work with the Department to produce a Third Sector Strategy which will consider how together we can ensure that we have a sustainable third sector which will play a leading role in the delivery of integrated care. We can then together explore which services can be better provided, in whole or in part, by the third sector acting as consortia or by individual arms.

To this end during 2018/19, all parties will work together to scope and move to establish a true Health and Care Alliance to amplify the voice of third sector organisations build capacity and capability to make the shift towards outcomes-based commissioning, facilitate research and innovation on prevention, early intervention and support for self-management, and to demonstrate public value from investment in the sector.

The Health and Care Alliance will:

- Ensure people are at the centre, that their voices, expertise and rights inform policy and shape the design, delivery and improvement of our support and services.
- Support radical change towards assets-based approaches that work with individuals and communities, reducing loneliness and isolation, helping people to stay well, manage their health conditions and remain independent for longer.
- Champion and support the third sector as a vital partner in integrated care and raise awareness of their role in ensuring an inclusive, co-production and human rights-based approach to care and support.
- Strengthen the relationships between third sector organisations, and with other health and care professionals, commissioners and funders.

## The following case studies illustrate the contribution which the third sector can make to all tiers of services.

### Sarah

Sarah is in her early 30's with two children aged 11 and 5 years and her husband works off-island for long periods of time. During Sarah's third pregnancy she was diagnosed with cancer and had to have the baby early to undergo surgical treatment followed by chemotherapy.

Shortly after the birth of their son, Sarah's husband had to return to work due to the financial strain, leaving Sarah to look after 3 young children and receive chemotherapy.

EHAS (Early Help and Support) were involved and co-ordinated the provision of services between Crossroads Care, school and community nursing to meet the needs of all the family members.

Crossroads Care provided support to all three children as young carers. Crossroads Young Carers sessions provide social and emotional support to the 11 and 5-year-old. Crossroads also provided nursery provision to enable Sarah to attend her chemotherapy sessions and other medical appointments without having the responsibility of caring for a young baby at the same time.

- ✓ Community Nursing ensures Sarah's after care needs were met at home.
- ✓ EHAS contacted services needed for the children
- ✓ School ensured the two older children continued to achieve and receive an education.
- ✓ Crossroads provided Young Carers to support all 3 children through the nursery and Young Carers Scheme.
- ✓ Crossroads Care provided nursery provision for Sarah to attend her hospital appointments and treatment.



### Betty & Alfie

Betty and Alfie moved to Port Erin to enjoy their retirement. They have two grown-up children who live off-Island and have their own families that they enjoyed visiting.

Plans for their retirement alter when Alfie suffers a stroke and is left with weakness, an inability to manage his own personal care and a difficulty in communicating. Despite medical treatment and rehabilitation, Alfie is now reliant on Betty to care for him and the plans they shared for retirement had to be reconsidered.

Betty, who enjoyed a Sunday job working as a sales assistant now finds herself constricted to the house and can no longer come and go as she pleases. Alfie is struggling to deal with the fact he's lost his own independence and is reliant on Betty for everything including his personal care.

Betty has daily assistance from a private care agency to assist with Alfie each morning, getting him up and dressed. Betty needs this support as she is often tired and frustrated with Alfie, but also misses the husband she had before his stroke.

Alfie's social worker and friends have ensured she has regular respite sessions each week through day services and community outreach support from third sector organisations, and a block residential stay at Ramsey Cottage Hospital to allow Betty to have time to herself and visit her children in the UK.

- ✓ Third Sector provision for day services allowing Alfie to socialise without Betty.
- ✓ Third Sector provision for community outreach support for Alfie to enjoy being part of his community.
- ✓ Statutory provision of block respite at Ramsey Cottage Hospital.
- ✓ Private domiciliary care to help Alfie get up and dressed in the morning.

# Sebastian

Sebastian is a young gentleman with severe and complex health needs and presents with a learning disability. Sebastian lives at home with his mum who is his main carer, however, mum has also had health concerns and recently has been hospitalised following a fall which resulted in her having her hip replaced.

During Sebastian's mum's recovery period, she was unable to meet Sebastian's personal care needs for him to remain at home. Sebastian's social worker requested services from Crossroads Care and other domiciliary care agencies to reduce disruption and stress for the family and allow his mum to continue to provide the level of parental support she usually provides for him.

During this time, Sebastian was admitted to Noble's Hospital as an acute medical admission, where Crossroads Care provided one-to-one support for him on the ward, helping facilitate communication with the medical, nursing and hospital staff whilst also effectively communicating and feeding back to his mum.

- ✓ Private domiciliary care for personal care in the home.
- ✓ Respite to assist mum's recovery from Crossroads Care.
- ✓ Emotional carer support and ongoing communication with mum.
- ✓ One to one support for Sebastian from Crossroads whilst an inpatient in Noble's Hospital.

# 10. Outcomes

## What do we mean by outcomes?

Outcomes are the benefits that are delivered as a result of a service. As our integrated model will be a new way, a change from what has been provided in the past, and anticipated to be an improved experience of care for people; we need to be able to measure the delivery of our strategy via a suite of measurable outcomes.

Outcomes can range from broad lifestyle goals to specific quality of care outcomes. Redesigning care around the delivery of outcomes requires a multi-disciplinary approach across prevention, diagnosis, treatment and follow-up and a range of interventions to improve a person's confidence and resilience to enable them to be able to look after their own needs more easily.

Improved experiences of care, improved outcomes in terms of changes to people's health and wellbeing; and better use of resources are all key.

In order to choose the right measures through which to evaluate and judge performance and progress in integrated care, we need a clear understanding of:\*

- the **core aims of integrated care** in terms of who and what the interventions involved are seeking to influence
- the **range of desired outcomes** that should result from the interventions, drawn primarily from the patient's / persons own perspective. Measures need to be relevant and focused on / aligned with outcomes
- the **timeframe over which such outcomes can reasonably be expected** to be achieved in order to understand which measurement categories actually have the potential to be improved
- **how impact can be measured** in a way that ensures attribution between the interventions developed and the outcomes observed
- the **robustness of measures**, so they can imply actions to be undertaken for quality improvement purposes by managers and professionals, and to avoid perverse incentives
- **simplicity and ease of measurement.** Considering data that is already being collected, but being open to new and innovative approaches. The more measurements are in tune with what people do, the more they are seen as meaningful and the greater the drive for improvement; and
- **time series analysis.** Measuring data over time will enable an understanding of trends, which will help us to understand changes in performance.

\*Dr. Nick Goodwin, CEO, The International Foundation for Integrated Care & Senior Associate, The King's Fund

May 2015

Better Care Fund Issue 4 May 2015

# 11. Moving Forwards



We have a real opportunity to transform the way that health and care services are provided in the Isle of Man. We want to see that all our residents get the support that they need to stay well and in control of their lives.

When people need a response from services, this will be a joined-up, targeted response built around the needs of the individual, involving them fully in decisions and drawing on their strengths and those of their community.

The interventions provided will be based much more in people's own homes and communities than is the case today. Clearly, a transformation of this scale and pace will require fundamentally different ways of working across the whole system. We call on all those involved in the delivery of services in the Isle of Man to work together to deliver our vision.



## Appendix A

	What does this mean for the people of the IOM?	Examples of what we want to implement
<b>Support for self-care and independence</b>	<ul style="list-style-type: none"> <li>I will be supported and empowered to take ownership of my own care and well-being so that I can live independently</li> <li>I will be able to make informed decisions about my care</li> <li>I will be aware of my choices and the consequences of the choices that I make</li> <li>I will be encouraged to maintain good health and an active lifestyle.</li> </ul>	<ul style="list-style-type: none"> <li>Patient education programmes</li> <li>Accessible information</li> <li>Expert patient programmes</li> <li>Shared Decision Making</li> <li>Development of a web-based Directory of Services</li> <li>Promote good health</li> <li>Build local assets to encourage healthier, active lifestyles</li> <li>Resources will be targeted to the most vulnerable.</li> </ul>
<b>Providers working together</b>	<ul style="list-style-type: none"> <li>My GP will provide access to health, care and wellbeing teams in an integrated way</li> <li>I will experience care provided in a seamless way with unnecessary duplication avoided</li> <li>I will tell my story once</li> <li>I will have a 'Care Companion' to support me in my journey.</li> </ul>	<ul style="list-style-type: none"> <li>Integrated case management across health and social care directed by GPs</li> <li>Single holistic assessment process and care planning undertaken by a multi-professional team</li> <li>Integrated teams delivering seamless health and care and wellbeing services from the right community hubs</li> <li>An integrated service model offering coordinated care with a focus on healthy lifestyles, education and prevention and care closer to home</li> <li>Investment in a system so that we have a shared record and all parts of the system has access to that.</li> </ul>
<b>Accessible &amp; Responsive (easy access-right time)</b>	<ul style="list-style-type: none"> <li>I will be able to access services in an easy and timely manner</li> <li>I will be dealt with as an individual</li> <li>My GP will act as my first port of call.</li> </ul>	<ul style="list-style-type: none"> <li>Development of the capacity and capability of Primary &amp; Community Care to provide an increased range of services</li> <li>Improved access to GP and other community services including Out of Hours services</li> <li>Enhancing services in Primary Care &amp; Community services</li> <li>Reducing variation in Primary Care.</li> </ul>
<b>Planned Pathways of Care</b>	<ul style="list-style-type: none"> <li>I will know what my care will be and where, when and how it will be delivered</li> <li>My care will be of high quality no matter who provides that care</li> <li>I will only attend hospital when absolutely necessary</li> <li>My care journey will be planned and coordinated</li> <li>My care will be built around me.</li> </ul>	<ul style="list-style-type: none"> <li>The development and implementation of evidence-based pathways of care</li> <li>Remodelled outpatient follow up services</li> <li>Community clinics staffed by integrated teams delivering a range of out of hospital care.</li> <li>A dedicated Care Coordinator and Care Companion</li> <li>Text messaging and other technological solutions to provide access for patients and professionals to appointment and waiting time information.</li> </ul>
<b>Quick response to urgent needs</b>	<ul style="list-style-type: none"> <li>I will be able to get rapid access and appropriate response when I have an urgent need.</li> </ul>	<ul style="list-style-type: none"> <li>Rapid response/intermediate care teams aligned to re-ablement</li> <li>Urgent Care provisions</li> <li>Joint urgent response services across health and social care 24/7</li> <li>Improved access to in and out of primary care services and responses to minimise the necessity to attend the Emergency Department at Noble's.</li> </ul>
<b>Appropriate specialist and hospital care only when required</b>	<ul style="list-style-type: none"> <li>I will be able to access services in an easy and timely manner</li> <li>I will be dealt with as an individual</li> <li>My GP will act as my first port of call.</li> </ul>	<ul style="list-style-type: none"> <li>Early supported discharge service with investment in step up and step down care in the right settings as part of the integrated plan</li> <li>A dedicated Care Coordinator and Care Companion</li> <li>Hospital at home teams, including re-ablement</li> <li>Integrated End of Life Care</li> <li>Planned discharge at the point of admission</li> <li>Diversion scheme from ED to 'set aside' GP appointments across all practices.</li> </ul>



