Isle of Man Government

Reiltys Ellan Vannin

High Level Target Operating Model for Primary Care

March 2022

Contents

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Glossary

PHM	Population Health Management
PCN	Primary Care Network
MDT	Multi-Disciplinary Team
PDSA	Plan, Do, Study, Act
CQC	Care Quality Commission
LTC	Long-Term Condition
PCN	Primary Care Network
GP	General Practitioner
ED	Emergency Department
EMR	Electronic Medical Record
DES	Direct Enhanced Services
FCP	First Contact Practitioner
ROPA	Record of Processing Activities
DPIA	Data Protection Impact Assessment
COPD	Chronic Obstructive Pulmonary Disease
AF	Atrial Fibrillation
JSNA	Joint Strategic Needs Assessment
TOM	Target Operating Model
LAC	Local Area Coordination
PAM	Patient Activation Measure
NICE	National Institute for Health and Care Excellence
NHSE	National Health Service England

PHE	Public Health England
OECD	Organisation for Economic Cooperation and Development
HMO	Health Maintenance Organisation
ENT	Ear, Nose, Throat
SOC	Specialist Outpatient Clinic
IAPT	Improving Access to Psychological Therapies
TCLC	Transformational Change Leadership Course
CPD	Continuing Professional Development
ALS	Action Learning Set

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Executive Summary

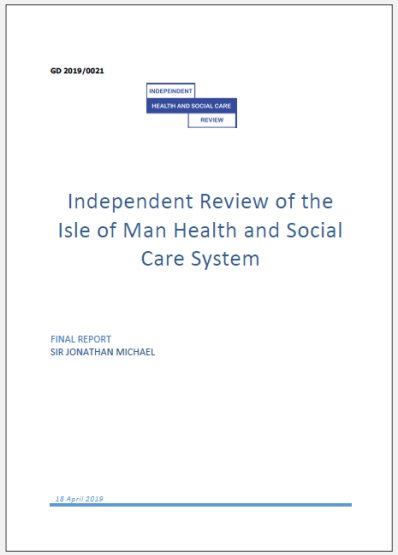
Background

High Level Target Operating Model

Next steps

Appendices

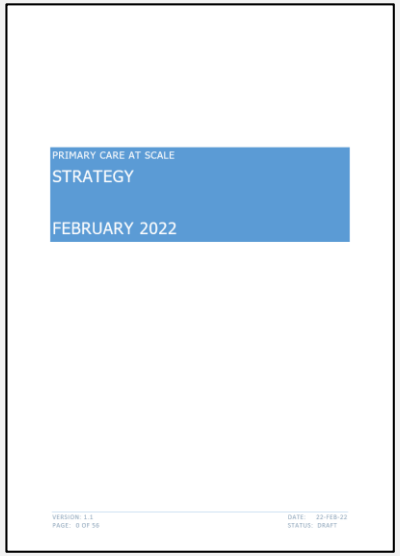
A new Target Operating Model (TOM) is required to deliver Primary Care at Scale (PCAS) on the Isle of Man



In 2019, Sir Jonathan Michael published his Independent Review of the Isle of Man Health and Social Care System, recommending:

"The Isle of Man should establish a model for delivering primary care at scale, since further and deeper collaboration within Primary Care is necessary to deliver current services and provide additional services."

(Recommendation 15)



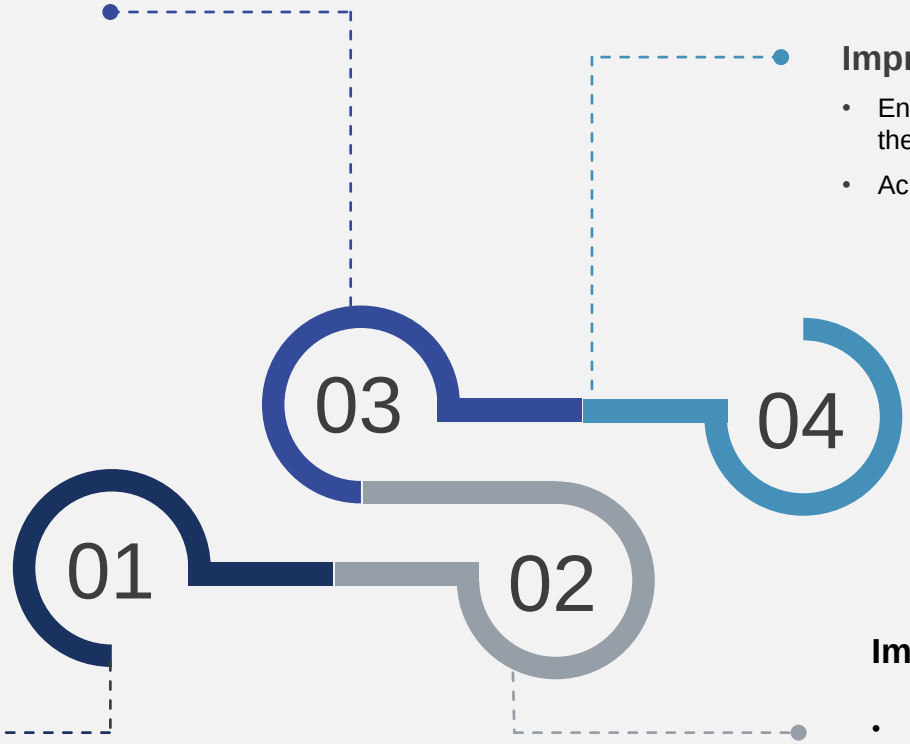
In March 2022, the Primary Care at Scale Strategy was refreshed, outlining plans to achieve its dual strategic objectives over the next 5 years:

1. Co-design of a new Target Operating Model for Primary Care at Scale
2. Implementation of a new Target Operating Model for Primary Care at Scale

Sir Jonathan Michael's report set out four principles that should underlie design of a new Target Operating Model (TOM)

Improve Quality of Care

- Provide person-centred care, treating people as individuals, and ensuring equity of care (including those with special needs)
- Deliver a well- led and safe service
- Ensure continuity of care
- Improve access to appointments and treatments
- Reduce waiting times
- Provide patients with information that enables them to make informed choices about their care
- Foster and enable strong relationships between patients/service users and professionals
- Reduce silos in the system so people only have to tell their story once and receive joined-up care
- Provide consistency of care for all patients
- Deliver the right care in the right place, at the right time (including more care closer to home)



Improve Sustainability and Value

- Ensure that the right staff are delivering care, working at the top of their license
- Achieve value for money in service delivery

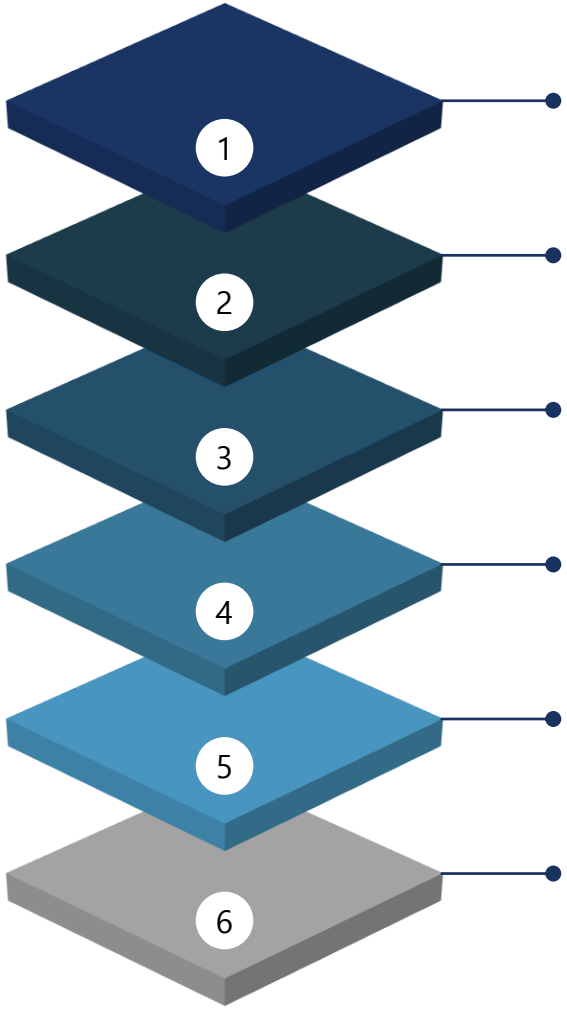
Improve Staff Experience

- Make the Isle of Man a safe and enjoyable place to work
- Provide staff with the development opportunities they want and need
- Encourage and foster strong relationships between professionals, especially between teams
- Foster hope for the future and raise morale

Improve Patient Experience

- Support people and communities to manage their own care needs and live healthier lives
- Support people's care needs early by preventing longer term needs (including preventative deaths)
- Support people to better manage long term conditions
- Support people in a way that helps them live the life they want to live
- Reduce admissions to hospital

The PCAS Strategy describes a proposed structure for the new Target Operating Model (TOM) across 6 domains:



Model of Care

- The locations and means by which all services are delivered in Primary Care

Processes

- Processes describe the activity that occurs in Primary Care from front-line services through to back-office functions and transformation

Workforce

- The workforce necessary to deliver the model of care including the reporting and accountability hierarchy, leadership, capabilities, skills, culture and performance expectations for people and organisational units

Technology

- The technology required to support the execution of processes and manage information/data

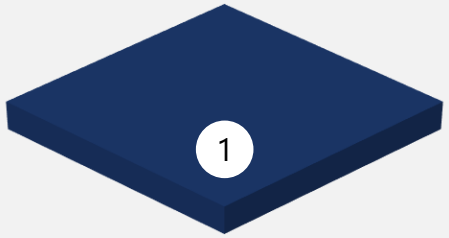
Information

- The data and analytics required to support the execution of processes and to inform business decisions

Governance

- The alignment of governance, risk and compliance processes in Primary Care to its strategy

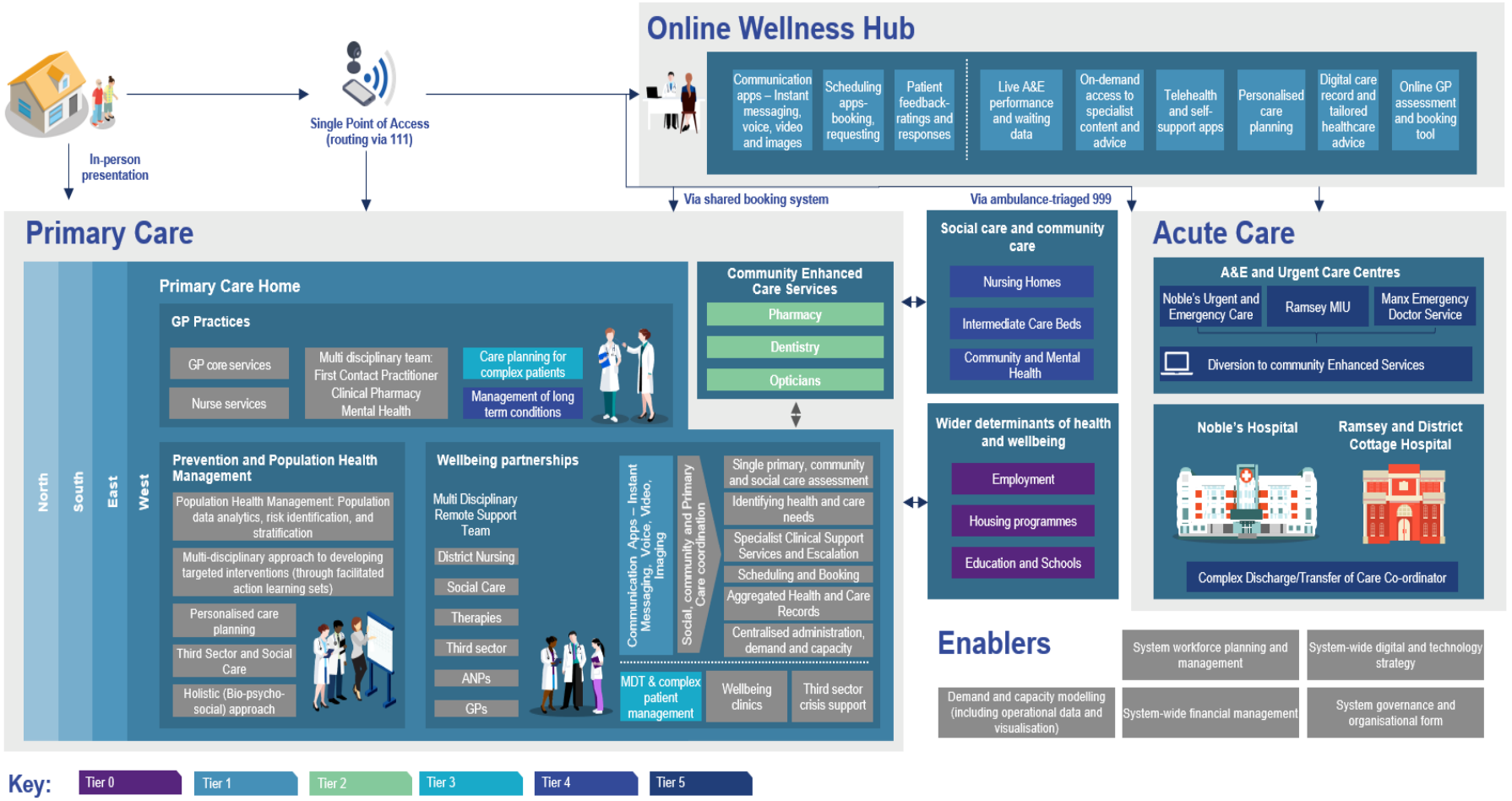
The Model of Care describes the locations and means by which all Primary and Community Care services are delivered in the future



Model of Care

The Model of Care describes the locations and means by which all Primary and Community Care services are delivered in the future.

The diagram opposite is a blueprint of the proposed Model of Care for Primary Care at Scale and was set out in the revised Primary Care at Scale Strategy in February 2022.



Building on the vision set out in the PCAS strategy, continued development of the Model of Care was achieved in 4 stages:

Step 1: Priority cohorts agreed

- While examination of international best practice is informative, it is obviously not possible (nor even desirable) to simply ‘lift and shift’ an entire operating model. Priority cohorts were agreed to ensure services were developed in line with population need and impact.
- To do this, a segmentation approach should be used in line with PHM principles. Priority cohorts should be chosen

Step 1: Priority cohorts agreed

Step 2: A list of high-impact services compiled for each priority cohort

- For each priority cohort, examples of international best practice should be sourced.
- A workshop should, bringing together colleagues across Primary, Secondary and Community Care to review the Priority Cohorts. Groups discussed: how such patients are managed currently, gaps in the current provision, and how best practice from abroad might be assimilated. A long-list of proposed services for each cohort was produced.

Step 2: High impact services compiled for each cohort

Step 3: Assessment of each service against operating model requirements, cost and dependencies

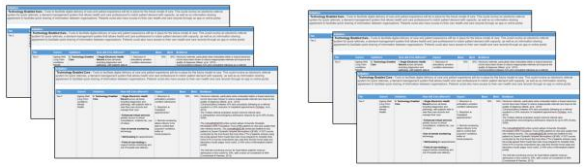
- Each proposed service was cross-referenced against the operating model requirements set out in Sir Jonathan Michael’s report
- Each service was then assessed with a view to the likely cost (high, medium or low)
- Each service was then assessed with a view to the likely dependencies (workforce, technology and estates)

Step 3: Assessment against cost and dependencies

Step 4: Consolidation of services into 7 key initiatives and impact assessment

- Services were consolidated into a list of 7 key initiatives, spanning all 4 Tiers of Primary and Community Care: 1. Prevention Initiatives to Improve Population Health, 2. Single Point of Access for the Primary Care Home, 3. First Contact Practitioners, 4. Population Health Management with Multi-disciplinary Teams, 5. Care Planning and Coordination, 6. Specialist Community Outpatients and Diagnostic services, and 7. Intermediate Care.

Step 4: Consolidation and Impact assessment



The list of consolidated initiatives and estimated impact is set out below (1/2)

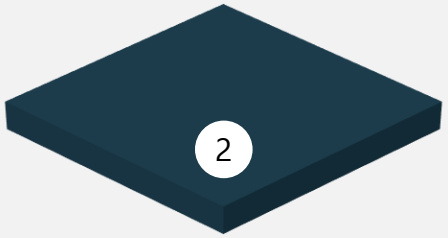
The list of consolidated initiatives with an indicative impact assessment is displayed below The initiatives include proposed service changes in General Practice, Pharmacy, Dentistry and Optometry as well as Community Services in the Wellbeing Partnership. A detailed list of services included in each initiative is set out in the main report.

Tier	Cohort	Initiative	Impact	Base	Best
Tier 0	ALL	**1. Prevention Initiatives to improve Population Health**	1. Reduction in Outpatient Appointments 2. Priority cohorts would be able to manage their conditions better at home/residence	10%	20%
Tier 0	ALL	**2. Single Point of Access**	1. Reduction in ED attendances covered in Out of Hospital model	10%	25%
Tier 1	ALL	**3. First Contact Services**	1. Reduction in ED attendances	15%	20%
Tier 2	Long Term Conditions	**4. Population Health Management (PHM) with Multidisciplinary Teams (MDT)**	1. Reduction in ambulatory sensitive condition admissions 2. Reduction in ED attendances	10% across both	30% across both
Tier 3	Complex Needs	**5. Care Planning and Coordination**	1. Reduction in ED attendances	15%	30%
			2. Reduction in Non-elective admissions	10%	25%
Tier 3	ALL	**6. Specialist Community Outpatients and Diagnostic Services**	1. Reduction in ambulatory sensitive condition admissions 2. Reduction in Outpatient appointments? 3. Remote monitoring allows citizens to be able to control their long term conditions better at home/residence	10%	30%

The list of consolidated initiatives and estimated impact was compiled (2/2)

Tier	Cohort	Initiative	Impact	Base	Best
Tier 4	Complex	**7. Intermediate Care**	1. Reduction in non-elective admissions	10%	15%
			2. Redution in ED attendances	10%	15%
			3. Reduction in OP attendances (due to patient intitiated follow-ups)	TBC 10%	TBC 25%
			4. Reduction in Hospital Bed days	TBC 10%	TBC 10%
			5. Increase in community/home visits	12%	22%
			6. Increase in community admissions (virtual wards)	TBC 10%	TBC 30%
			7. Increase in primary care contacts	5%	15%
			8. Increase in social contacts	5%	15%

2. Processes

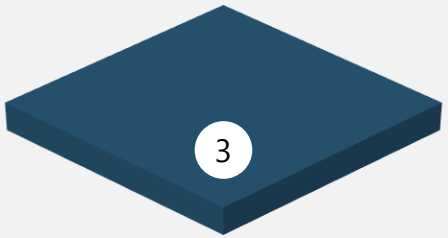


Processes

Processes describe the activity that occurs in Primary Care from front-line services through to back-office functions and transformation and also activity at the interface of other providers e.g. with Secondary and Community Care providers. These processes will need to be updated to reflect the new model of care. They should also take advantage of the ability to work ‘at-scale’ and to assure quality and performance through a standardised island-wide approach.

Process	Description	SJM Operating Model Requirement	Cost
Standard Operating Procedures (SOPs)	Describes the activity that occurs within Primary Care providers and includes both front, middle and back office functions. A standardised approach to operations across all providers ensures quality and efficiency. General Practice should devise and implement SOPs for the following: - **Front-line processes**: standardisation of approach to access and navigation, consultation, diagnosis and management - **Back office functions**: standardisation of back office functions like finance, human resources, administration and procurement. Where appropriate, these functions can be consolidated - **Transformation processes:** standardisation of approach to processes that transform service design and operations including Population Health Management, Workforce Planning, Quality Strategy and Digital Strategy. Should describe how each organisation collaborates on cross cutting issues such as these at an island level with Secondary Care, Community Care and Manx Care.	- Standardised policies and procedures - Shared approach to assessing and qualifying patient need - Capitalise on economies of scale in consolidating back end and supporting services - Organisational plans in place and updated regularly (this should be done collaboratively with Manx Care) - A collective innovation capability to ensure a process of continuous improvement; ongoing solution development to meet ever changing need - Mechanism for agreeing a single set of communication across all practices to ensure consistent messaging to all.	
Standardised Clinical Pathways	Describes activity at the interface of Primary Care and the wider health system. With Manx Care, Secondary Care and Community Care, Primary Care to agree standardised clinical pathways and clear referral criteria for common conditions and presentations. Work is already underway as part of the Care Pathways workstream. Critical policies for Primary Care include: - Direct Access to Community Diagnostics (UEIC Pathway) - Direct admission to hospital (UEIC Pathway)	- Ensuring continuity of support through effective implementation of integrated care pathways - Organisational plans in place and updated regularly (this should be done collaboratively with Manx Care)	

3. Workforce



Workforce

The workforce necessary to deliver the model of care including the reporting and accountability hierarchy, leadership, capabilities, skills, culture and performance expectations for people and organisational units

A new Model of Care for Primary Care will require an aligned and empowered workforce. To achieve this, the following will be required:

1. A baseline understanding of the current Primary Care workforce (and workforce planning capacity)

This should include an understanding of, not just the number and type of staff, but also their skillset. This includes both clinical skills (e.g. diabetes management), and non-clinical skills (e.g. digital literacy). This will inform plans to upskill the existing Primary Care workforce and recruit into it. A baseline assessment of workforce planning capacity is also required. Future workforce planning structures should include structures that coordinate planning across Primary and Secondary Care.

2. An understanding of future Primary Care workforce requirements

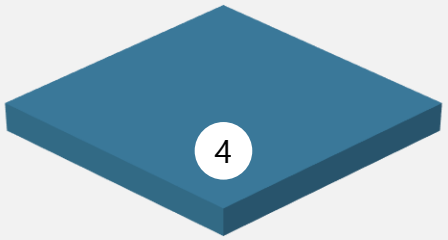
Primary Care will need to model its future workforce based on the proposed new operating model. This modelling should include assumptions about the degree of “left shift” into the community, the proposed adoption of new technologies in Primary Care, the proposed upskilling of staff in pharmacy and optometry, and any proposed new service provision within general practice (e.g. MDT working and recruitment to new roles such as care coordinators).

3. A detailed plan for how to achieve it

A workforce plan will be required to articulate how the Island plans to deliver the workforce required to staff the new operating model for Primary Care. This plan will articulate actions that can occur at a practice level and an island level, and should include sections on:

- Making Primary Care the best place to work
- Improving Leadership Culture
- Releasing Time for Care
- Workforce Re-design
    - Preparing for New Models of Care
    - Preparing for the impact of technology
    - Optimising new workforce roles
    - Supporting the third sector, other volunteers and carers
- Growing and retaining the future workforce
- A New Operating model for workforce

4. Technology

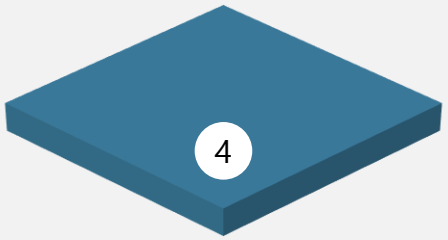


Technology

The new Target Operating Model for Primary Care will require a digital infrastructure to underpin all new services and processes. A digital strategy should include actions required at an island level as well as at a provider level. The digital strategy should align with the proposed roll-out of services in the TOM. The digital strategy should also consider, not only implementation of a new technology, but the change management piece around it – making it a part of the working lives of staff and easy to use for patients. This is exemplified by relatively poor uptake to date of Patient Access online services.

Remote Monitoring	- A flexibility in the locations in which different types of care/different interventions are delivered	- Facilitates the work of District Nurses and Intermediate Care Teams (including roll out of Virtual Wards / Hospital@Home) in Tier 4 services - Also supports self-management of LTC in the community	
PHM Platform	- Delivery of a broad set of capabilities and interventions tailored to a population's need, including the use of data and evidence to understand need (population health management capability)	- Facilitates the processes of Population Health Management including: population health needs analysis, population segmentation and risk stratification, and evaluation of interventions. - PHM is integral to the design and redesign or Primary Care at Scale services.	
Remote consultation platform	- An ability to make reasonable adjustments to care delivery to ensure effective care for those with disabilities - Increase capacity in the system (e.g. number of appointments available) - Varied mechanisms for collaboration, including digital tools - A flexibility in the locations in which different types of care/different interventions are delivered	- Partnering with offshore remote GP consultation services like Livi can address immediate clinical workforce shortages. - Other remote consultation platforms, such as Microsoft Teams, facilitate further clinical services, such as: Remote consultation for housebound patients, MDT team meetings	
Single Point of Access	- Effective triage process in place to direct patients to the right service - Online booking systems and other tools to ensure effective access to appointments for all	- A Single Point of Access could operate at an island level or it could operate at a Primary Care Home level - The purpose is to simplify access to health and care services for patients by offering one digital route in - Improved demand management as patients digitally triaged and navigated to the most appropriate service first time.	
Remote patient messaging	- Ability to flex treatment and interventions to match personalised care plans - A flexibility in the locations in which different types of care/different interventions are delivered	- Platforms that facilitate remote patient messaging such as Accuryx (already in place in most GP practices)	

4. Technology



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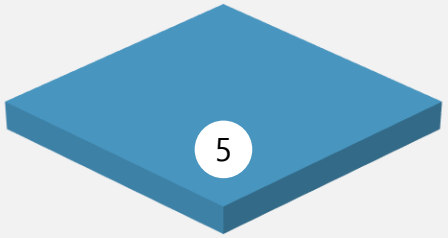
Remote patient messaging	- Ability to flex treatment and interventions to match personalised care plans	- Platforms that facilitate remote patient messaging such as Accuryx (already in place in most GP practices)	
Secure NHS Email	- Fast adoption of digital tools that improve efficiency	- Ability for other contracted services eg Pharmacy, Dentistry and Optometry to communicate with General Practice	

5. Information



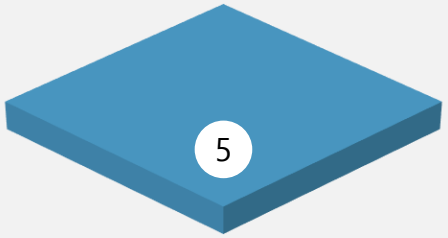
Information

The data and analytics required to support the execution of processes and to inform business decisions:

- Understand the health and social care needs of the population
- Plan services
- Compare outcomes with relevant comparators and drive improvement
- Monitor finances
- Model the workforce
- Assess staff satisfaction
- Review quality and performance metrics

Process	SJM Operating Model Requirement	Next steps	Cost
Demand and Capacity Modelling	- Effective case load management, including ability to manage capacity across general practice (not just at practice level) - this includes systems and operational staff capability.	- Data and analytics capacity is required to guide demand and capacity planning across the health and care system, including Primary Care. This is especially important given the continued imperative to shift activity out of acute hospitals and into the community where appropriate.	
Population Health Management Data	- Delivery of a broad set of capabilities and interventions tailored to a population's need, including the use of data and evidence to understand need (population health management capability) - A collective innovation capability to ensure a process of continuous improvement; ongoing solution development to meet ever changing need	- Population Health Management is predicated upon the use of available intelligence to design and deliver integrated services that meet the needs of the population. - There are a number of existing datasets on the island that could be utilised to develop a deeper understanding of population need (at both an Island and a localised level). - There are a number of notable limitations to the data that is currently in place, that will need resolving: - There are some obvious omissions (Public Health Outcomes Framework) - There is currently very little linking of data - There is currently little interrogation of data - There are issues with data quality (e.g. coding) - Information Governance issues are ongoing	

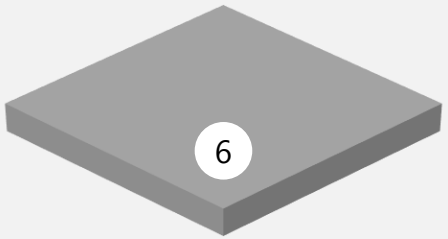
5. Information



Information

Coding	- Delivery of a broad set of capabilities and interventions tailored to a population's need, including the use of data and evidence to understand need (population health management capability)	- The quality of coding in Primary Care is essential to the assessment of need, quality and performance in primary Care. Without a clear understanding of disease prevalence, it is impossible to design appropriate services. Improving the quality of coding will be essential.	
Information Governance	- A commitment to share all relevant data (within the legal constraints) with partners across the health and care system (including off island) to support effective collaboration and delivery of services	- Resolving Information Governance issues will be essential to at-scale working and underpins all services.	
Primary Care Dashboard	- Efficiency programmes to improve process across all General Practice	- A Primary Care dashboard already exists though its scope could be broadened considerably to enable more effective tracking of quality and performance in General Practice at a Practice, Primary Care Home and also at an Island level. - For example, regarding performance, the dashboard could collate data on: number of appointments, waiting times, DNAs, referral rates, prescribing targets, patient satisfaction etc - Regarding quality, the dashboard could collect data on QOF targets, disease prevalence etc. - For internal operations, All Standard Operating Procedures should have Key Performance Indicators attached to them with mechanisms in place to monitor the information and forums in which to analyse and discuss the data.	

6. Governance



Governance

Governance describes the system by which entities are directed and controlled. It is concerned with structure and processes for decision making, accountability, control and behaviour at the top of an entity.

Governance influences how an organisation's objectives are set and achieved, how risk is monitored and addressed and how performance is optimised

Manx Care Functions

In 2020, Manx Care assumed responsibility for the provision of all health and care services on the Isle of Man. Over the next 5 years, its stated ambition is to shift activity out of Secondary Care and into Primary and Community Care. To do this, Manx Care has created an internal governance structure to:

- Set a vision for the future Model of Care on the island
- Commission providers in that new Model of Care
- Support delivery of the new Model of Care (through 'at-scale' and integrated design of the corresponding workforce, technology, policy and governance infrastructure required)
- Assure the quality, performance, and value of said services

Primary Care Provider Functions

1. Service Delivery Management / Governance

As providers of Primary Care services, General Practice, Pharmacy, Optometry and Dentistry, should be represented in many of these functions. As such, Manx Care has created a seat for Primary Care on:

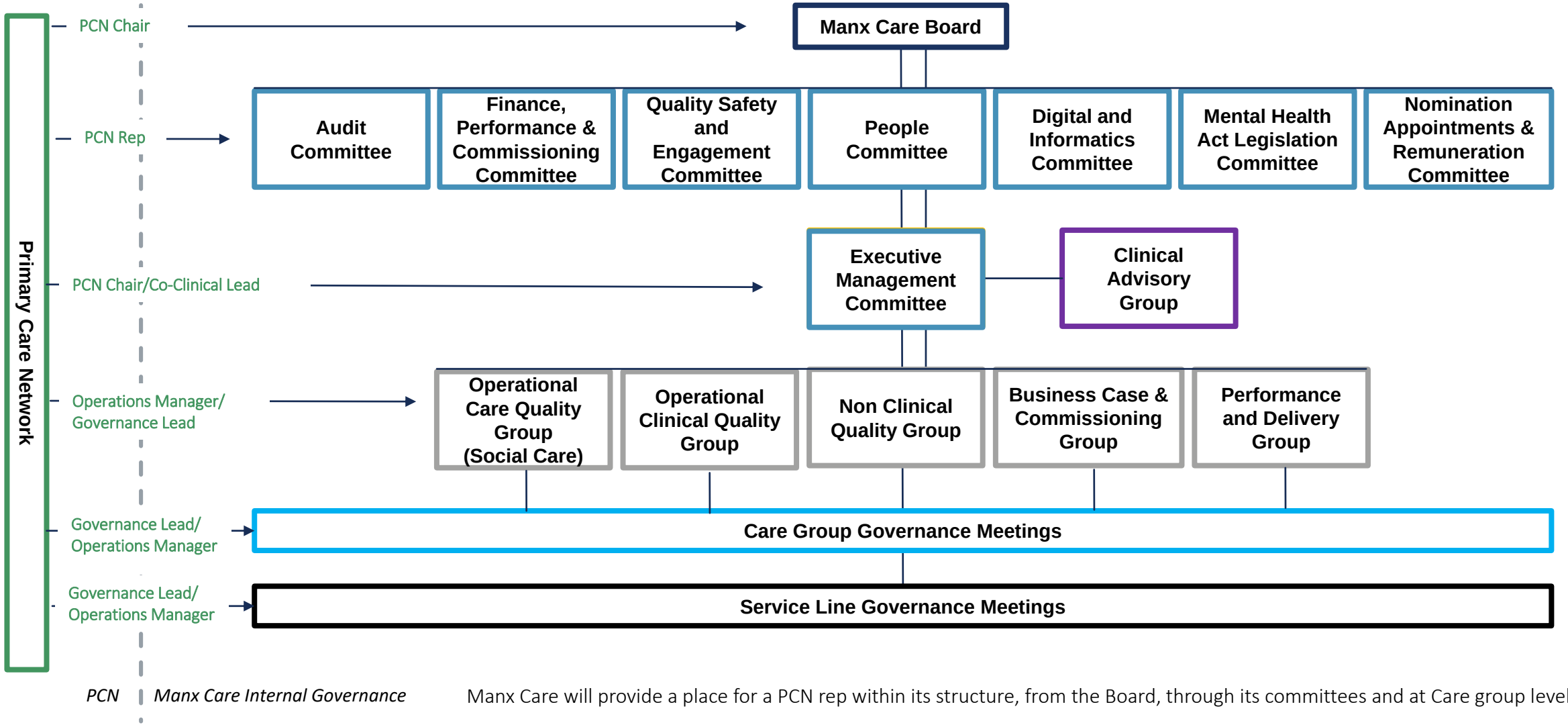
- It's Board: and
- Various sub-committees of the Board, such as the:
    - Audit Committee
    - Finance, Performance and Commissioning Committee
    - Quality, Safety and Engagement Committee
    - People Committee
    - Digital and Informatics Committee
    - Executive Management Committee
    - Operational Clinical Quality Group
    - Business Case and Commissioning Group
    - Performance and Delivery Group
    - The "Integrated Primary and Community Care" Care Group

As a representative of all 11 practices on the island, the Primary Care Network has the authority, from the 11 Practices, to represent General Practice on these Boards and Committees as confirmed in the PCN Strategy document which was approved by the PCN Board in March 2022. The PCN is recognised by Manx Care as representing General Practice and has invited the PCN to take on roles within its governance structures.

NB. Manx Care will provide suitable backfill to ensure the nominated representative from the PCN is able to attend.

It is anticipated that, within 5 years, the PCN will be seamlessly integrated within the governance and reporting structures of Manx Care, with the two organisations operating as one, enabling frictionless sharing of resources and mutual transparency.

6. Governance



Manx Care will provide a place for a PCN rep within its structure, from the Board, through its committees and at Care group level

6. Governance

2. Delivery of services

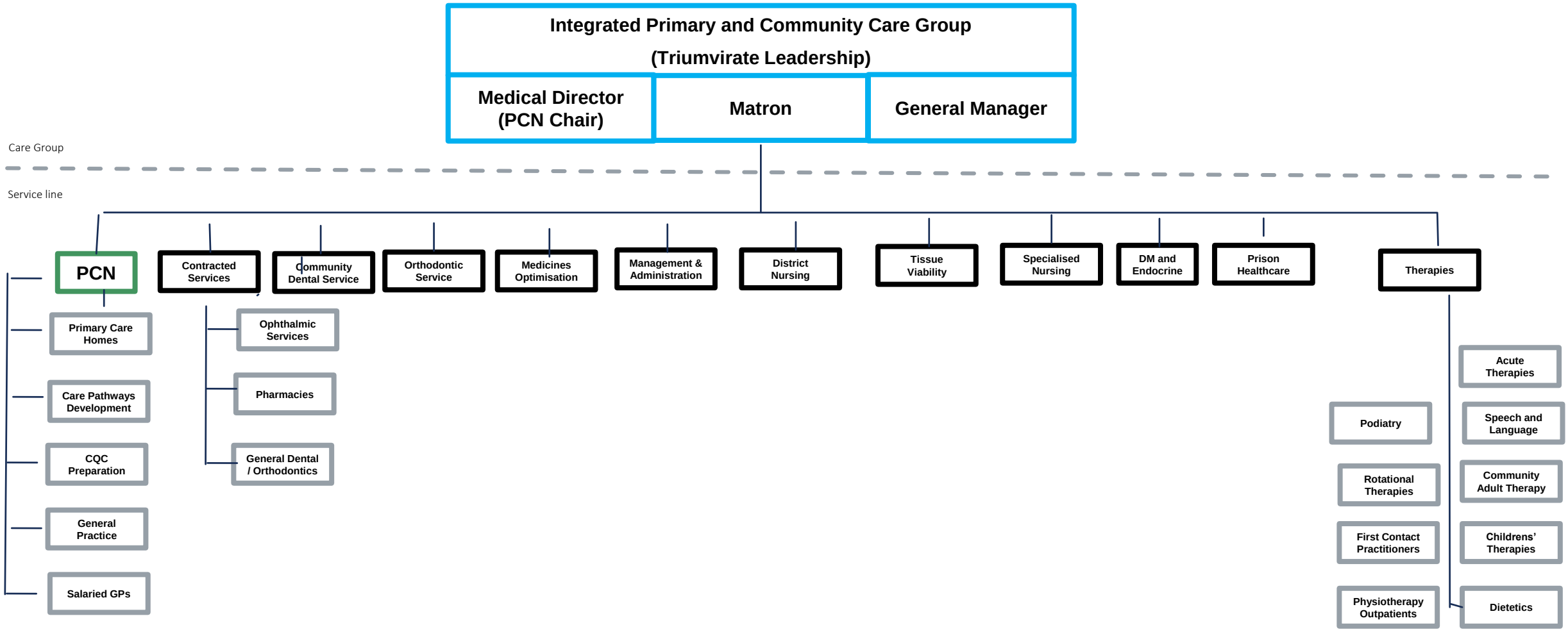
As providers of Primary Care, General Practice, Pharmacy, Optometry and Dentistry also have a role in delivering the services described in the Model of Care. Policy is defined by DHSC and included in the 'Required Outcomes Framework'. The PCN will be required to deliver the Primary Care element of the ROF and will have autonomy in terms of how those services are provided. The relationship between Manx Care and each of the Primary Care providers is defined by a contract, of which there are two types (see below). As well as defining services, such contracts also stipulate standards and processes for clinical, informational and financial governance. In each case, the provider is a *Service Line* and the department into which they report is the *"Integrated Primary and Community Care" Care Group* (see diagram overleaf).

- **Individual Practices:**
    - **Standard Clinical Services:** The General Medical Services (GMS) contract specifies the range of services that Manx Care expects each General Practice to deliver. In return, the contract specifies Manx Care's expectations in terms of quality, performance and compliance (outcomes based commissioning).
    - The same principles apply to the Dentistry contract, Pharmacy contract, and Optometry contract
    - The Individual practices will continue to be self-managing within a system of governance led by Manx Care and the PCN. Practices will be accountable via the PCN for performance, accountability and governance
- **Primary Care Network**
    - **Clinical Services:** The Direct Enhanced Services (DES) contract, will, in due course, specify Primary Care services that are not captured in the GMS contract referenced above. The Primary Care Network is accountable to the Manx Care Board for delivery of service and patient parity for the services they provide i.e. all patients have access to all services. For example, in general practice, this could be either via their individual practice, a Primary Care Home centre, a specialised clinic or a referral to a clinician with special interest within the wider PCN.
    - **Non-Clinical Services:** In some cases, Manx Care may wish to commission the Primary Care Network to deliver non-clinical services via the DES. This might include the setting up of the Primary Care Homes, and other cross cutting issues such as Clinical Pathway design, and CQC preparation.

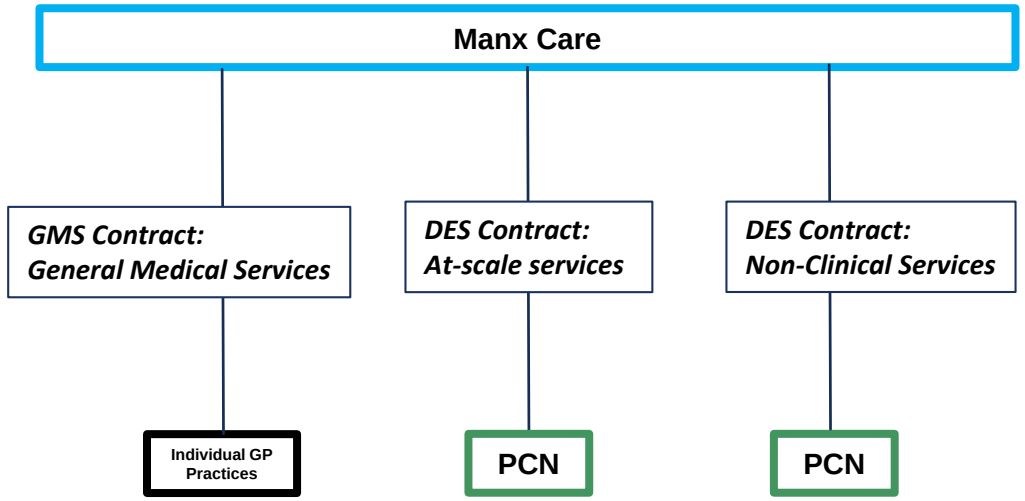
Note: It is not for this document to set out the internal governance of Primary Care Network. It is recommended that the functions of Education and Innovation sit within Manx Care, with multi-professional and cross sector (Primary, Secondary and Community Care) input.

- **Primary Care Network specifics**
    - **Primary Care Homes:** The PCN will design, pilot and shape the Primary Care Homes. The pilot will shape the evolution of the PCH which may, for example, see the Wellbeing Partnerships formally becoming part of the PCH structure.
    - **Workforce Funding** Will be made available on a case by case basis, where new roles have been agreed.

6. Governance



6. Governance



Proposed contractual relationship between Manx Care and General Practice. As presented here the use of the GMS Contract and DES remain intact. By mutual agreement the may be varied in due course.

Assurance of Clinical, Financial and Information Governance

Clinical, financial and information governance would be assured through the contractual relationship with Primary Care, as they are currently, through the GMS and DES contact. As well as defining the services required of providers, these contracts stipulate standards and processes providers are expected to comply with for clinical, informational and financial governance. Where providers of a Service Line function are direct employees of Manx Care (rather than a contractor), existing Manx Care governance arrangements require each Service Line to have accountability for their own governance and report risks regularly into Manx Care's Operational Clinical Quality Group, in a templated format. A similar process would be expected from contracted General Practice services.

Responsiveness to changing circumstances

Manx Care's expectations of General Practice are set out in the GMS and DES contract and can only be prospective. If circumstances change, and Manx Care wish a service to be rolled out through General Practice island-wide (for instance, a vaccination programme), a contract negotiation would have to take place. There is flexibility with the Care Group to move services where appropriate within the responsibility of the PCN.

Next Steps

To agree steps that can be taken in year 1 to work towards the governance shown at year 5.

NB. It should be noted that in parallel to this, the Transformation Team will be looking at incentives in the existing GP contract with a view to ensuring the contract delivers the Model of Care envisaged in the future, and this work will need to be aligned.

Next steps are for a Business Case and Detailed TOM but continued work on the Target Operating Model doesn't preclude work starting on the PCH pilots

More detailed work is required over the next 3 months to build out design of the initiatives – first for a Business Case in June 2022 and then for a detailed TOM in September 2022. This will involve intensive co-design workshops with Primary, Secondary and Community Care Services. Accompanying the Business Case in June, will be an implementation roadmap, prioritising high impact activities and services. In the meanwhile, this does not preclude work starting on existing plans for the Primary Care Home pilots, in the North, South, East and West of the Island.

PCAS Strategy	High Level TOM	Business Case for TOM	Detailed TOM
• Agreed strategic objectives over next 5 years (design and deliver a new TOM) • Agreed design principles of a new TOM based on Sir Jonathan Michael's report • Set out structure of TOM	• Describe the proposed new TOM for PCAS, covering: 1. Model of Care 2. Processes 3. Workforce 4. Technology 5. Data and Analytics 6. Governance	• Business Case for a new TOM • Each proposed new service costed • Implementation roadmap devised, prioritising high impact activities and services	• Scoping and commissioning of all Primary Care activities and services in the new TOM
9 March 2022	31 March 2022	30 June 2022	30 September 2022

Primary Care Home (PCH) pilots

As well as continuing to build out the detailed Target Operating Model, ongoing support will be required on implementation

General Practice and Wellbeing Partnerships
A critical path for development and implementation of the Primary Care Homes is set out in the PCAS strategy. The PCN is in agreement with the steps but timelines are being negotiated to fit their capacity and Manx Care expectations. The Primary Care Network have compiled a business case for the first two pilots and will be going out to the Network shortly for Practices to lead this work in each area.

Pharmacy
A critical path for development and implementation of the pharmacy model of care is set out in the PCAS strategy. Delivery of the future operating model will depend on continued engagement and negotiation between Manx Care and the Pharmacy Association to deliver the next keys steps.

Dentistry
A critical path for development and implementation of the dentistry model of care is set out in the PCAS strategy. Delivery of the future operating model will depend on continued engagement and negotiation between Manx Care and the Dental Association to deliver the next key steps.

Opticians
A critical path for development and implementation of the opticians model of care is set out in the PCAS strategy. Delivery of the future operating model will depend on continued engagement and negotiation between Manx Care and the Optometry Association to deliver the four key initiatives. At present, discussions are taking place between the optometrist community (via the Optometry Association) and Manx Care regarding their contractual arrangement, specifically the current standard eye test fee. The Optometry Association would like to adopt a remuneration schedule similar to the Scottish model for the proposed new schedule of services. If unresolved, this may impact the ability to deliver the planned changes to the service.

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Executive summary

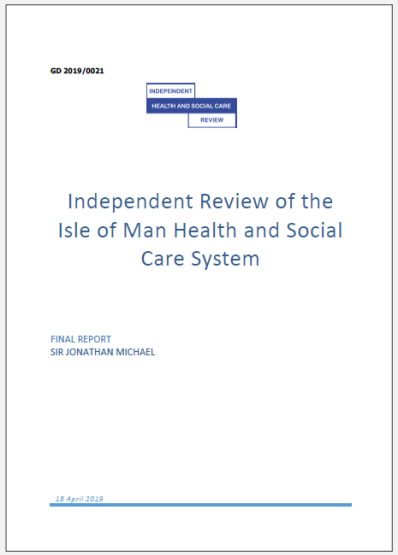
Background

High Level Target Operating Model

Next Steps

Appendices

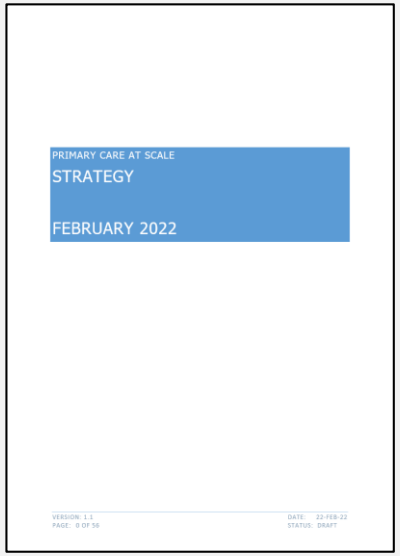
A new Target Operating Model (TOM) is required to deliver Primary Care at Scale (PCAS) on the Isle of Man



In 2019, Sir Jonathan Michael published his Independent Review of the Isle of Man Health and Social Care System, recommending:

"The Isle of Man should establish a model for delivering primary care at scale, since further and deeper collaboration within Primary Care is necessary to deliver current services and provide additional services."

(Recommendation 15)



In March 2022, the Primary Care at Scale Strategy was refreshed, outlining plans to achieve its dual strategic objectives over the next 5 years:

1. Co-design of a new Target Operating Model for Primary Care at Scale
2. Implementation of a new Target Operating Model for Primary Care at Scale

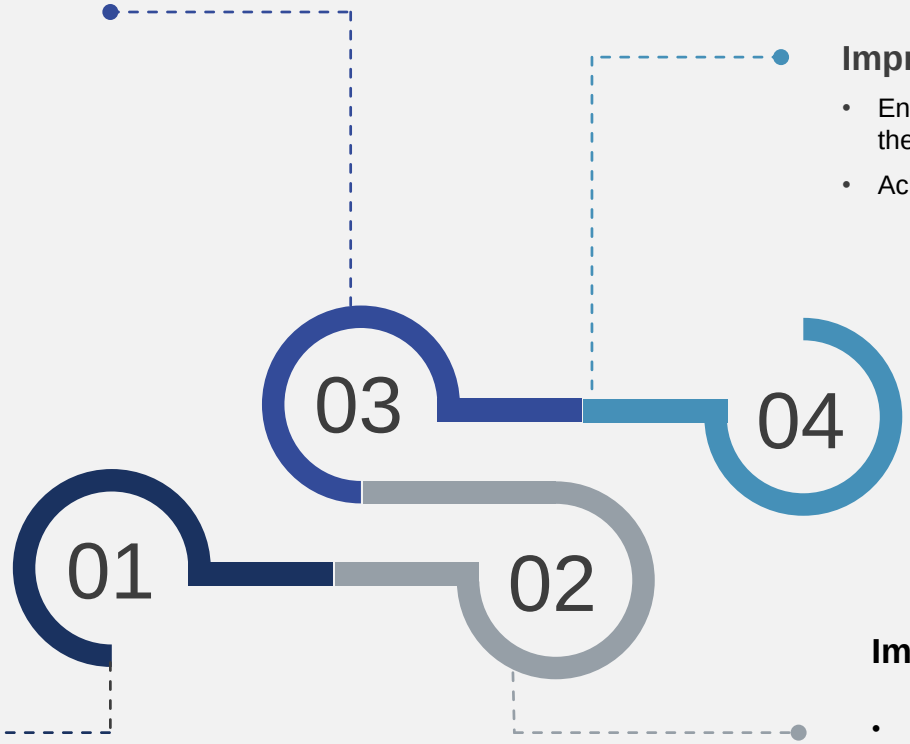
Sir Jonathan Michael's report set out four principles that should underlie design of a new Target Operating Model (TOM)

Improve Quality of Care and Patient Experience

- Provide person-centred care, treating people as individuals, and ensuring equity of care (including those with special needs)
- Deliver a well- led and safe service
- Ensure continuity of care
- Improve access to appointments and treatments
- Reduce waiting times
- Provide patients with information that enables them to make informed choices about their care
- Foster and enable strong relationships between patients/service users and professionals
- Reduce silos in the system so people only have to tell their story once and receive joined-up care
- Provide consistency of care for all patients
- Deliver the right care in the right place, at the right time (including more care closer to home)

Improve Staff Experience

- Make the Isle of Man a safe and enjoyable place to work
- Provide staff with the development opportunities they want and need
- Encourage and foster strong relationships between professionals, especially between teams
- Foster hope for the future and raise morale



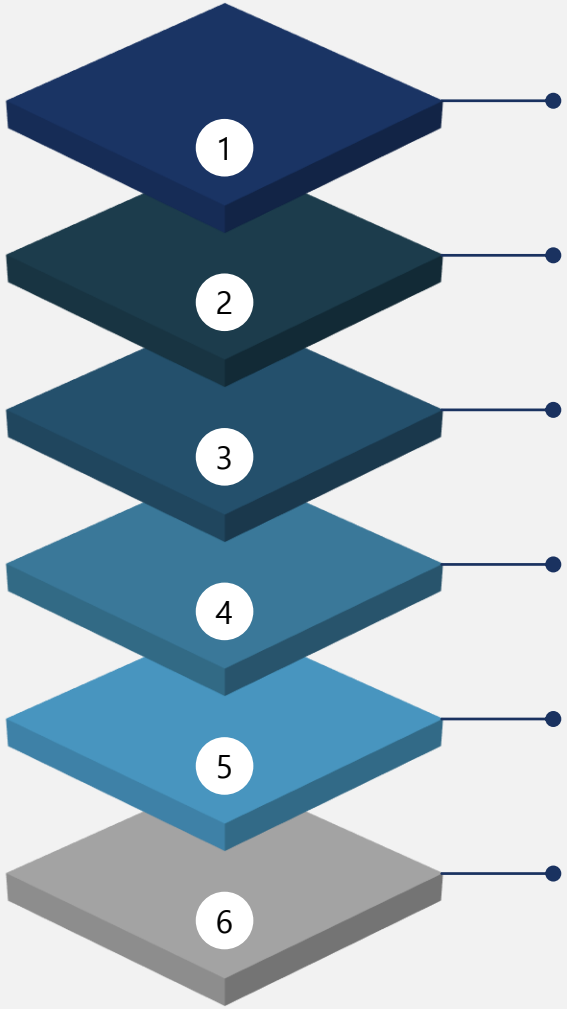
Improve Sustainability

- Ensure that the right staff are delivering care, working at the top of their license
- Achieve value for money in service delivery

Improve Quality of Life

- Support people and communities to manage their own care needs and live healthier lives
- Support people's care needs early by preventing longer term needs (including preventative deaths)
- Support people to better manage long term conditions
- Support people in a way that helps them live the life they want to live
- Reduce admissions to hospital

The PCAS Strategy describes a proposed structure for the new Target Operating Model (TOM) across 6 domains:



Model of Care

- The locations and means by which all services are delivered in Primary Care

Processes

- Processes describe the activity that occurs in Primary Care from front-line services through to back-office functions and transformation

Workforce

- The workforce necessary to deliver the model of care including the reporting and accountability hierarchy, leadership, capabilities, skills, culture and performance expectations for people and organisational units

Technology

- The technology required to support the execution of processes and manage information/data

Information

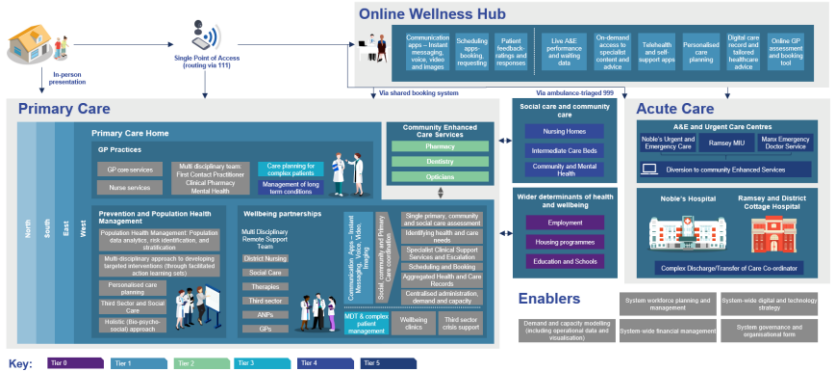
- The data and analytics required to support the execution of processes and to inform business decisions

Governance

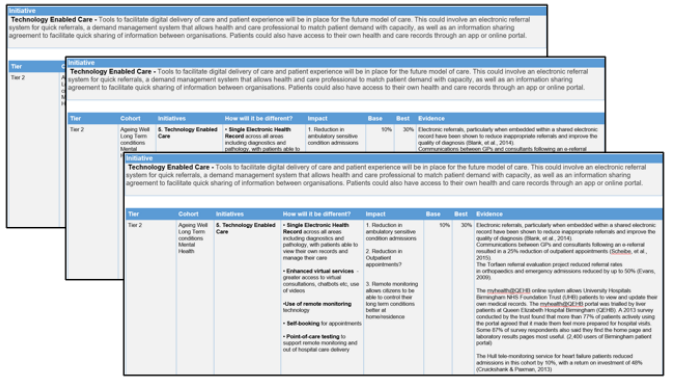
- The alignment of governance, risk and compliance processes in Primary Care to its strategy

This document sets out the High Level Target Operating Model for Primary Care including: (1/2)

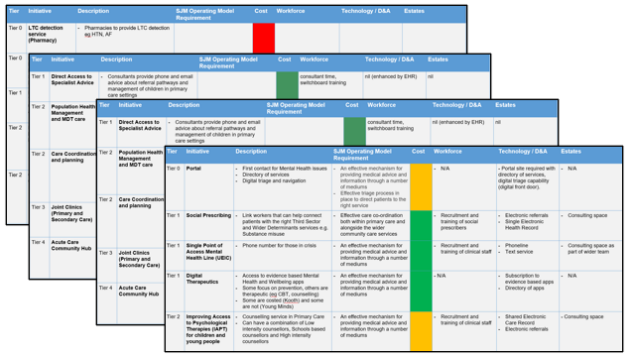
1. A Blueprint for the future Model of Care



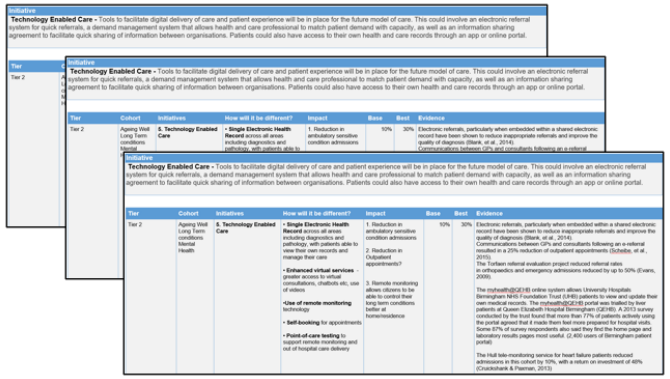
2. A Consolidated list of Initiatives for the future Model of Care



3. An assessment of the initiatives against cost and dependencies

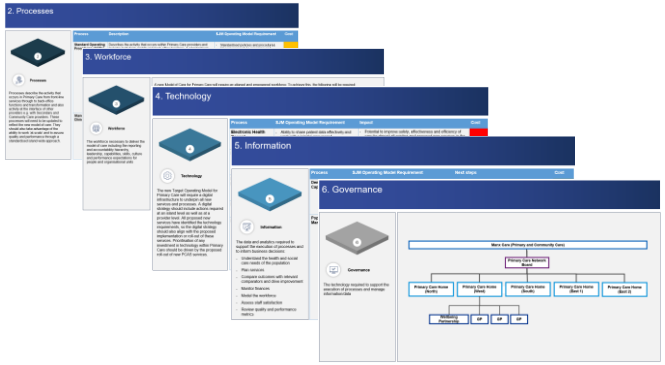


4. An assessment of the initiatives against impact



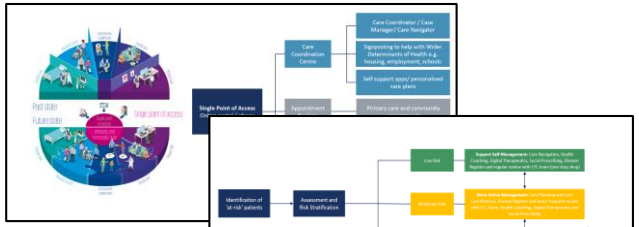
This document sets out the High Level Target Operating Model for Primary Care including: (2/2)

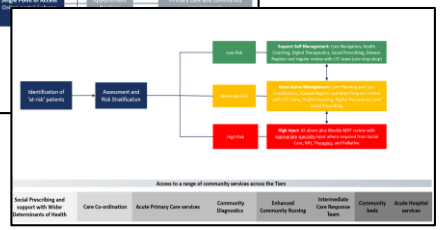
5. Priorities for the enablers of the TOM (workforce, governance, technology etc)



6. Illustrative Personas demonstrating User Journeys in the future

6. Process Maps for the key initiatives





Continued work on the Target Operating Model doesn't preclude work starting on the Primary Care Home pilots

The revised Primary Care at Scale (PCAS) strategy was submitted in February 2022. This document builds on that strategy, setting out the High-Level Target Operating Model for PCAS. Following this, more detailed work will need to be done over the next 3 months to build out design of the initiatives – first for a Business Case in June 2022 and then for a detailed TOM in September 2022. This will involve intensive co-design workshops with Primary, Secondary and Community Care Services. Accompanying the Business Case in June, will be an implementation roadmap, prioritising high impact activities and services. In the meanwhile, this does not preclude work starting on existing plans for the Primary Care Home pilots, in the North, South, East and West of the Island.

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Primary Care Home (PCH) pilots

Isle of Man Government
Reiltys Ellan Vannin

Executive summary

Background

High-Level Target Operating Model

Next Steps

Appendices

Isle of Man Government
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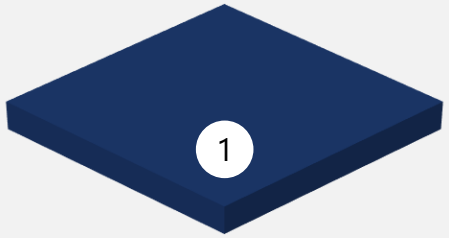
1. Model of Care

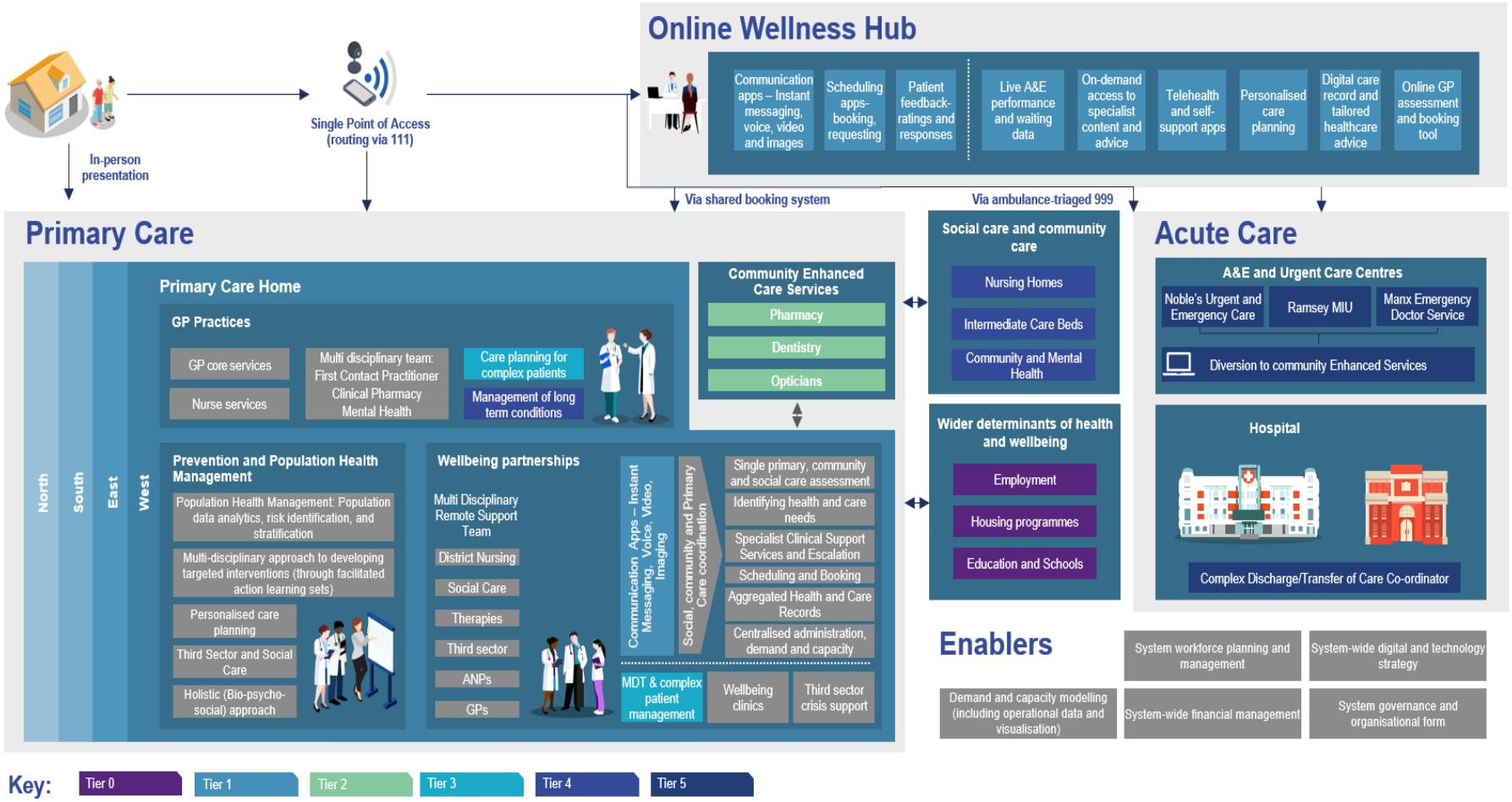
The Model of Care describes the locations and means by which all Primary and Community Care services are delivered in the future



Model of Care

The Model of Care describes the locations and means by which all Primary and Community Care services are delivered in the future.

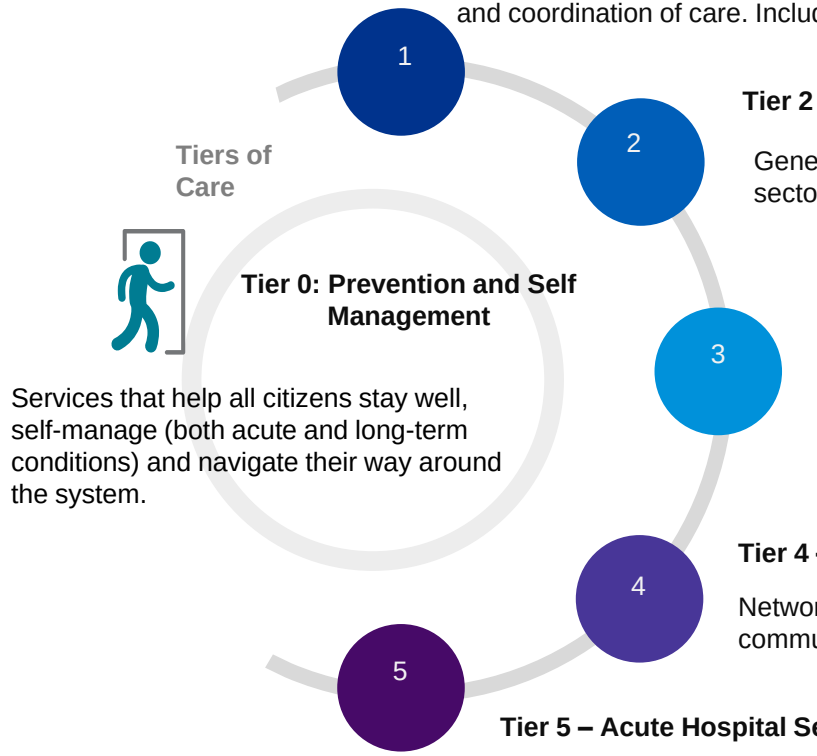
The diagram opposite is a blueprint of the proposed Model of Care for Primary Care at Scale.



PCAS services span a broad range of acuity in the new Model of Care

In the proposed new Model of Care, Primary Care services span a broad range of acuity, from health promotion and disease prevention (Tier 0 services), right through to Hospital at Home services for those at imminent risk of admission or those recently discharged.

A stated aim of the PCAS strategy was for more care to be provided in the community where appropriate and the new Model of Care builds capacity in the community to do so.



Tier 0: Prevention and Self Management

Services that help all citizens stay well, self-manage (both acute and long-term conditions) and navigate their way around the system.

Tier 1 – Population Health Management and First Contact services

Services for citizens with low-acuity care needs. Provides access, navigation, triage, management, and coordination of care. Includes both urgent and planned services, in hours and out.

Tier 2 – Integrated Primary and Community Care services for those with LTCs

General Practice at scale and integrated health, social care and voluntary sector teams working through a hub and spoke model across each locality.

Tier 3 – Community Outpatient and Diagnostic Services

Outpatients and Diagnostics services delivered from Locality Integrated Wellbeing Partnerships

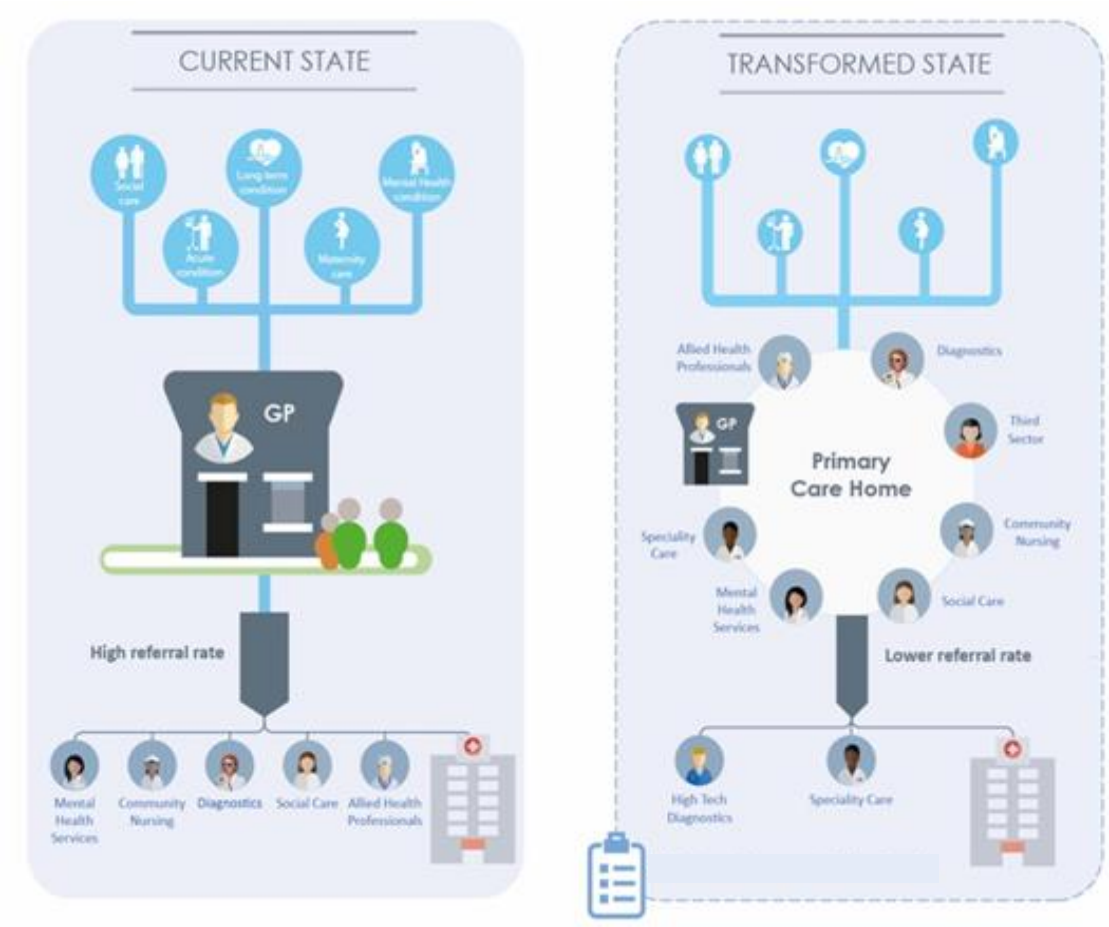
Tier 4 – Intermediate and Social Care and Unplanned care Services

Network of care (acute outreach where appropriate) delivered from community hubs and facilities, preventing unnecessary hospital admissions

Tier 5 – Acute Hospital Services

Access to high quality acute hospital services for patients when they need intervention that can only be provided on an acute site

At the heart of the new PCAS Model of Care is the Primary Care Home (PCH), of which 4 or 5 are expected to operate on the Island



The new Model of Care envisages 4 or 5 Primary Care Homes (PCH) operating on the island – one in the North, South, and West, and potentially two in the East - each consisting of one Wellbeing Partnership (at which many Community Services and Intermediate Services are currently sited) and a number of local General Practices.

Each PCH would be anticipated to serve a population of around 20,000 – 25,000, with that number defined by the registered list of the participating GP practices. The idea of the PCH is to create a local “ecosystem” of care, integrating the work of Primary, Community and Social Care services in a local area.

Working in this way, the PCH would be able to better:

- Define the needs of its local population
- Co-design interventions to help meet those needs
- Provide integrated care as part of MDTs
- Expand access to first contact practitioners
- Incorporate secondary care advice into Primary Care

It is anticipated that this way of working would reduce pressure on GPs as a first contact provider, free up GP time to work as a “Consultant in Primary Care”, provide better access for patients to GP and specialty services and reduce the referral rate to Secondary Care.

Over time, other Primary Care providers like pharmacists, dentists and opticians could be incorporated into the Primary Care Home and services may even choose to be co-located in a centralised clinic with access to onsite diagnostics and treatments.

Building on the vision set out in the PCAS strategy, continued development of the Model of Care was achieved in 4 stages:

Step 1: Priority cohorts agreed

- Wile examination of international best practice is informative, it is obviously not possible (nor even desirable) to simply 'lift and shift' an entire operating model. Priority cohorts were agreed to ensure services were developed in line with population need and impact.
- To do this, a segmentation approach was used in line with PHM principles. Eight priority cohorts were chosen

Step 1: Priority cohorts agreed

Step 2: A list of high-impact services compiled for each priority cohort

- For each priority cohort, examples of international best practice were sourced.
- A workshop was conducted, bringing together colleagues across Primary, Secondary and Community Care to review the Priority Cohorts. Groups discussed: how such patients are managed currently, gaps in the current provision, and how best practice from abroad might be assimilated on the Isle of Man. A long-list of proposed services for each cohort was produced.

Step 2: High impact services compiled for each cohort

Step 3: Assessment of each service against operating model requirements, cost and dependencies

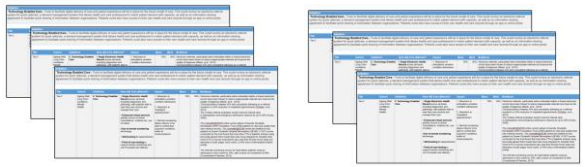
- Each proposed service was cross-referenced against the operating model requirements set out in Sir Jonathan Michael's report
- Each service was then assessed with a view to the likely cost (high, medium or low)
- Each service was then assessed with a view to the likely dependencies (workforce, technology and estates)

Step 3: Assessment against cost and dependencies

Step 4: Consolidation of services into 7 key initiatives and impact assessment

- Services were consolidated into a list of 7 key initiatives, spanning all 4 Tiers of Primary and Community Care: 1. Prevention Initiatives to Improve Population Health, 2. Single Point of Access for the Primary Care Home, 3. First Contact Practitioners, 4. Population Health Management with Multi-disciplinary Teams, 5. Care Planning and Coordination, 6. Specialist Community Outpatients and Diagnostic services, and 7. Intermediate Care.
- Each initiative was then assessed to give an indication of the impact on acute demand. This indicative assessment was based on experience of activity shifts in other systems in the UK (e.g. Lincolnshire, Derbyshire, Walsall) and relevant case studies conducted in the UK. This analysis will be refined for the Business Case in June 2022.

Step 4: Consolidation and Impact assessment



Step 1: Priority cohorts agreed

Priority Cohorts were identified using a Population Health Management approach, with methodology set out by the National Association of Primary Care (NAPC). Using this approach, the population was segmented by:

- **Age** (children, working age and older age)
- **Baseline health** (generally well, LTC and complex care needs); and
- **Acuity of Care Need** (Prevention, Routine and Urgent)

Existing services were then mapped across the segments and compared with international best practice. Priority Cohorts were chosen where there was the greatest potential for impact.

These Priority Cohorts then became the basis of eight Personas (see Appendix A):

1. Child with a LTC (Asthma)
2. Child with a Mental Health problem
3. Adult with an Acute Minor Ailment
4. Adult with a LTC (Type 2 Diabetes)
5. Adult with Cancer
6. Adult with Complex Needs
7. Older adult with Dementia and Frailty
8. Older adult in a Nursing Home

Children:

Children	Prevention	Routine Needs	Urgent Care Needs
Generally Well	**All children:** • Vaccination • Parenting advice and guidance (Wellbeing Partnerships) • Sight tests • Dental checks **Babies:** • Health Visitor • Baby checks **School age** • Mental Health (apps)		• GP clinic (on the day) • Pharmacy • Dentist • OOH GP (MEDS) • Ramsay (Minor Injuries) • Mental health support
Chronic Condition	• As above	• Personalised Care Planning • Case Management (eg Asthma clinic) • Shared Care initiatives	• As above plus • Direct access to specialty input (Nurse Specialist) • Specialist advice to GP
Complex Needs	• As above	• MDT for complex needs (Physical, social, emotional, and developmental eg LD / ASD)	• As above

Adults:

Working Age	Prevention	Routine Needs	Urgent Care Needs
Generally Well (Low Risk)	• Risk Stratification • Stop Smoking services (app, clinic etc) • Diet • Physical Activity • MH advice and support • Health Coach (app, in person) • Social Prescribing • Vaccination • Screening	• Contraception • Maternity Care • Planned Care – support to prepare for surgery and recover	• GP Clinic – Acute on the day • Nurse led clinics – acute on the day • Pharmacy (Minor Ailments) • Opticians (MECS) • Dentists • OOH GP (MEDS) • Ramsay (Minor Injuries) • SDEC (Acute) • Mental Health Services (eg IAPT)
LTC (Medium Risk)	• As above plus • Personalised Care Planning • Secondary CVD prevention	• MDT case management (including care coordination and specialist input) • Community Outpatient Clinics • Digital Therapeutics (LTC mgmt) • Shared Care initiatives	• As above plus • Direct Access Specialist Support (eg MH phone line, Cancer Nurse Specialist) • GP access to specialist advice (eg Cardiologist on call) • Care Coordinator Support
Complex Needs (Multi-morbidity) (High Risk)	• As above	• MDT for complex needs (high risk) • Intermediate Care Response Team • Virtual Wards / Hospital at Home • Palliative Care at home	• As above plus • Intermediate Care Response Team

Older Adults:

Older Adults	Prevention	Routine Needs	Urgent Care Needs
Generally Well (Low risk)	• Risk Stratification • Stop Smoking services (app, clinic etc) • Diet • Physical Activity • MH advice and support • Health Coach (app, in person) • Vaccination • Screening		• GP Clinic – Acute on the day • Nurse led clinics – acute on the day • Pharmacy (Minor Ailments) • Opticians (MECS) • Dentists • OOH GP (MEDS) • Ramsay (Minor Injuries) • SDEC (Acute)
Chronic Condition (Medium Risk)	• As above plus • Falls prevention • Personalised Care Planning • Secondary CVD prevention • Social Prescribing	• Case management (including care coordination and specialist input) • Specialist clinics • Care Coordination • Shared Care initiatives	• As above plus • Intermediate Care Response Team • Direct Access Specialist Support (eg MH phone line, Cancer Nurse Specialist) • GP access to specialist advice (eg Cardiologist on call) • Care Coordinator Support
Complex Needs (High Risk)	• As above	• MDT for complex needs (high risk) • Intermediate Care Response Team • Virtual Wards / Hospital at Home • Palliative Care at home	• As above

Eight Priority Cohorts became eight Personas:

Case 1: Child with a LTC (Asthma)

Case 2: Child with a Mental Health problem

Case 3: Adult with an Acute Minor Ailment

Case 4: Adult with a LTC (Type 2 Diabetes)

Case 5: Adult with Cancer

Case 6: Adult with Complex Needs

Case 7: Older adult with Dementia and Frailty

Case 8: Older adult in a Nursing Home

Step 2: A list of high-impact services was compiled for each Priority Cohort

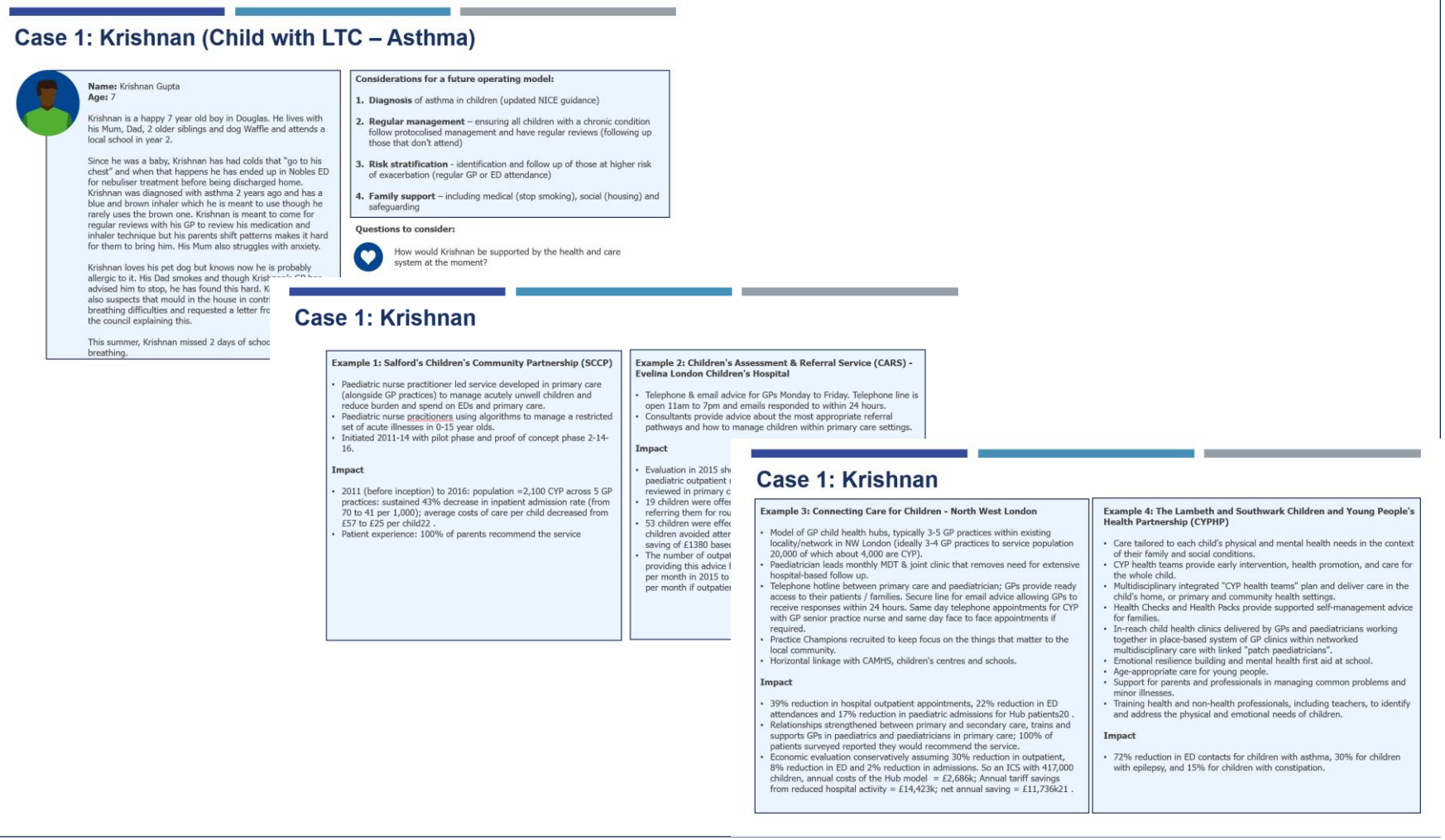
The Personas were further developed and used for a workshop with representatives across Primary, Secondary and Community Care.

Desktop research was carried out to identify international best practice and exemplar services were identified for each Persona (See Appendix A).

Workshop participants were asked to review the Personas and consider:

- how such patients are managed currently
- gaps in the current provision, and
- how best practice from abroad might be assimilated on the Isle of Man.

A long list of high-impact services was then compiled for each cohort.



Case 1: Krishnan (Child with LTC – Asthma)

Name: Krishnan Gupta
Age: 7

Krishnan is a happy 7 year old boy in Douglas. He lives with his Mum, Dad, 2 older siblings and dog Waffle and attends a local school in year 2.

Since he was a baby, Krishnan has had colds that "go to his chest" and when that happens he has ended up in Nobles ED for nebuliser treatment before being discharged home. Krishnan was diagnosed with asthma 2 years ago and has a blue and brown inhaler which he is meant to use though he rarely uses the brown one. Krishnan is meant to come for regular reviews with his GP to review his medication and inhaler technique but his parents shift patterns makes it hard for them to bring him. His Mum also struggles with anxiety.

Krishnan loves his pet dog but knows now he is probably allergic to it. His Dad smokes and though Krish[illegible] advised him to stop, he has found this hard. K[illegible] also suspects that mould in the house in contr[illegible] breathing difficulties and requested a letter fr[illegible] the council explaining this.

This summer, Krishnan missed 2 days of schoo[illegible] breathing.

Considerations for a future operating model:

1. **Diagnosis** of asthma in children (updated NICE guidance)
2. **Regular management** – ensuring all children with a chronic condition follow protocolised management and have regular reviews (following up those that don't attend)
3. **Risk stratification** - identification and follow up of those at higher risk of exacerbation (regular GP or ED attendance)
4. **Family support** – including medical (stop smoking), social (housing) and safeguarding

Questions to consider:

How would Krishnan be supported by the health and care system at the moment?

Case 1: Krishnan

Example 1: Salford's Children's Community Partnership (SCCP)

- Paediatric nurse practitioner led service developed in primary care (alongside GP practices) to manage acutely unwell children and reduce burden and spend on EDs and primary care.
- Paediatric nurse practitioners using algorithms to manage a restricted set of acute illnesses in 0-15 year olds.
- Initiated 2011-14 with pilot phase and proof of concept phase 2-14-16.

Impact

- 2011 (before inception) to 2016: population =2,100 CYP across 5 GP practices: sustained 43% decrease in inpatient admission rate (from 70 to 41 per 1,000); average costs of care per child decreased from £57 to £25 per child22 .
- Patient experience: 100% of parents recommend the service

Example 2: Children's Assessment & Referral Service (CARS) - Evelina London Children's Hospital

- Telephone & email advice for GPs Monday to Friday. Telephone line is open 11am to 7pm and emails responded to within 24 hours.
- Consultants provide advice about the most appropriate referral pathways and how to manage children within primary care settings.

Impact

- Evaluation in 2015 sh[illegible] paediatric outpatient [illegible] reviewed in primary c[illegible]
- 19 children were offe[illegible] referring them for rou[illegible]
- 53 children were effe[illegible] children avoided atte[illegible] saving of £1380 base[illegible]
- The number of outpat[illegible] providing this advice [illegible] per month in 2015 to [illegible] per month if outpatie[illegible]

Case 1: Krishnan

Example 3: Connecting Care for Children - North West London

- Model of GP child health hubs, typically 3-5 GP practices within existing locality/network in NW London (ideally 3-4 GP practices to service population 20,000 of which about 4,000 are CYP).
- Paediatrician leads monthly MDT & joint clinic that removes need for extensive hospital-based follow up.
- Telephone hotline between primary care and paediatrician; GPs provide ready access to their patients / families. Secure line for email advice allowing GPs to receive responses within 24 hours. Same day telephone appointments for CYP with GP senior practice nurse and same day face to face appointments if required.
- Practice Champions recruited to keep focus on the things that matter to the local community.
- Horizontal linkage with CAMHS, children's centres and schools.

Impact

- 39% reduction in hospital outpatient appointments, 22% reduction in ED attendances and 17% reduction in paediatric admissions for Hub patients20 .
- Relationships strengthened between primary and secondary care, trains and supports GPs in paediatrics and paediatricians in primary care; 100% of patients surveyed reported they would recommend the service.
- Economic evaluation conservatively assuming 30% reduction in outpatient, 8% reduction in ED and 2% reduction in admissions. So an ICS with 417,000 children, annual costs of the Hub model = £2,686k; Annual tariff savings from reduced hospital activity = £14,423k; net annual saving = £11,736k21 .

Example 4: The Lambeth and Southwark Children and Young People's Health Partnership (CYPHP)

- Care tailored to each child's physical and mental health needs in the context of their family and social conditions.
- CYP health teams provide early intervention, health promotion, and care for the whole child.
- Multidisciplinary integrated "CYP health teams" plan and deliver care in the child's home, or primary and community health settings.
- Health Checks and Health Packs provide supported self-management advice for families.
- In-reach child health clinics delivered by GPs and paediatricians working together in place-based system of GP clinics within networked multidisciplinary care with linked "patch paediatricians".
- Emotional resilience building and mental health first aid at school.
- Age-appropriate care for young people.
- Support for parents and professionals in managing common problems and minor illnesses.
- Training health and non-health professionals, including teachers, to identify and address the physical and emotional needs of children.

Impact

- 72% reduction in ED contacts for children with asthma, 30% for children with epilepsy, and 15% for children with constipation.

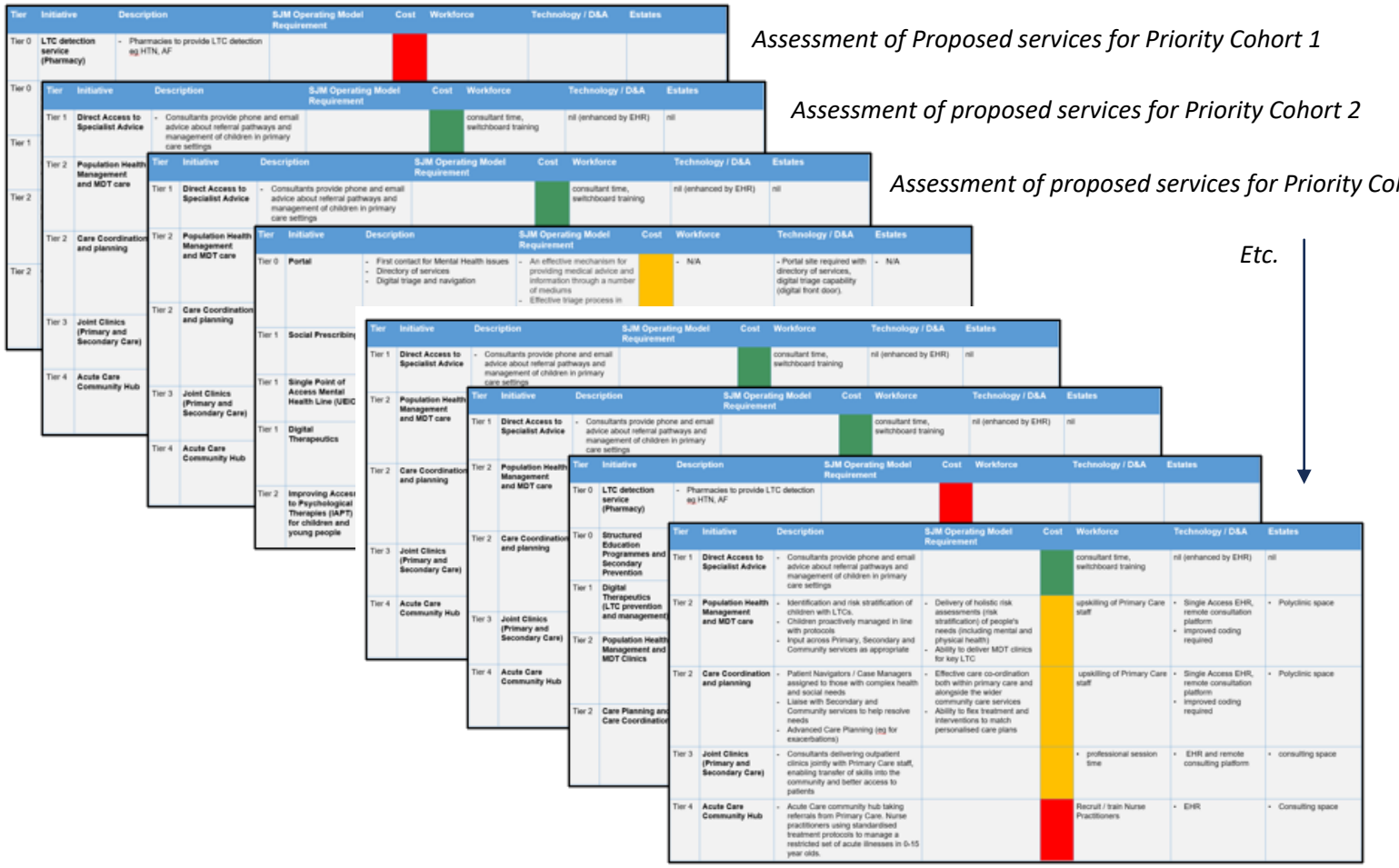
Step 3: An assessment of each proposed service was made - against operating model requirements, cost and dependencies

Based on desktop research, as well as the outputs from the workshop, the proposed services for each Priority Cohort were:

- Cross-referenced against the operating model requirements set out in Sir Jonathan Michael's report
- Assessed with a view to the likely cost (high, medium or low)
- Assessed with a view to the likely dependencies (workforce, technology and estates)

In addition to this, the proposed service changes to Pharmacy, Dentistry and Optometry (as agreed during consultation for the PCAS strategy) were similarly reviewed.

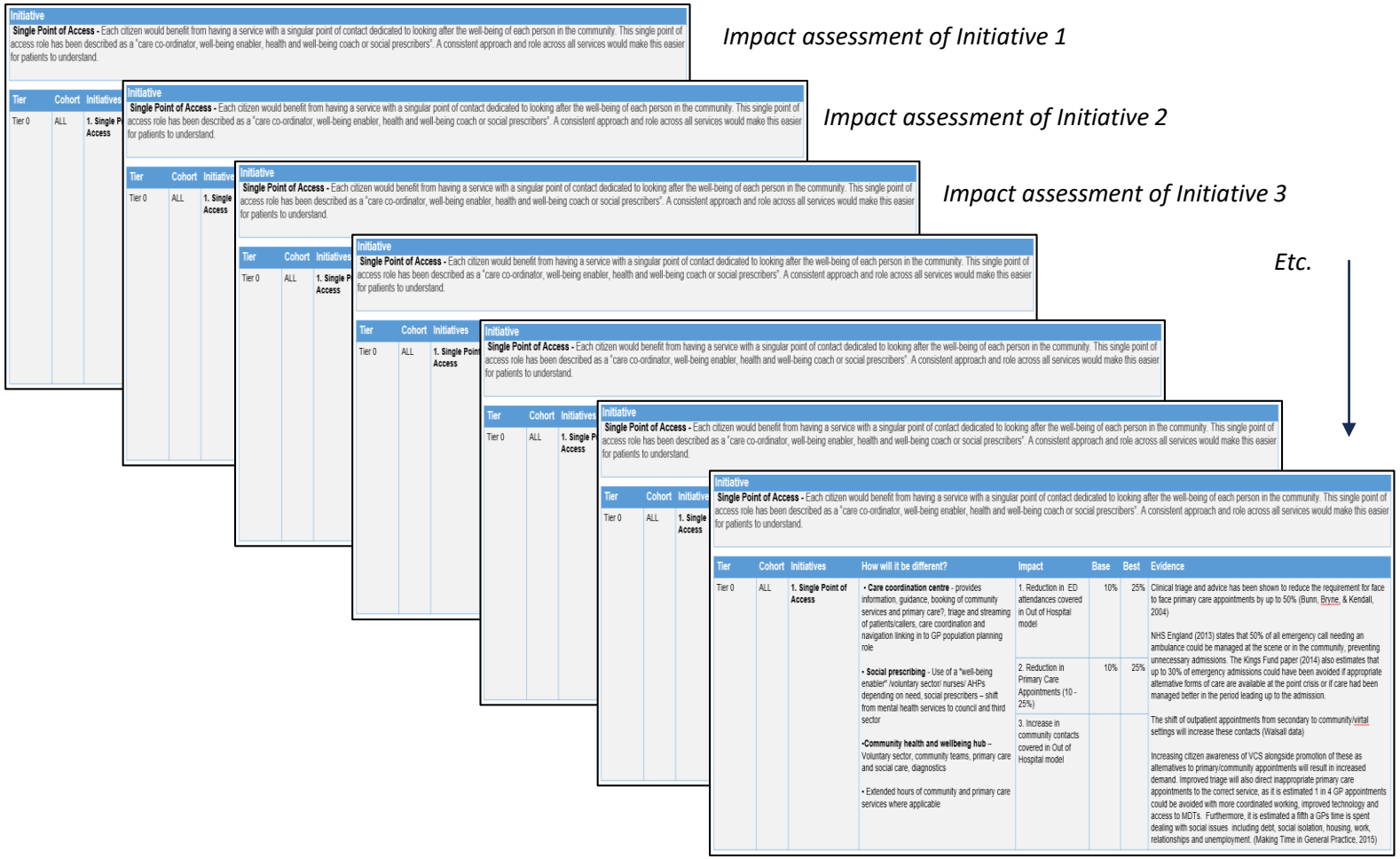
All of these analyses are contained in Appendix C.



Step 4: The long list of proposed services was consolidated into 7 key initiatives, with each initiative assessed for future impact

The long list of services was then consolidated into 7 key initiatives, these include the proposed changes to **Pharmacy, Optometry and Dentistry** services:

1. Prevention to improve Population Health
2. Single Point of Access to Primary Care Homes
3. First Contact Services
4. Population Health Management with Multi-disciplinary Teams
5. Care Planning and Coordination
6. Specialist Community Outpatients and Diagnostics
7. Intermediate Care Services



The list of consolidated initiatives and estimated impact was compiled (1/2)

Tier	Cohort	Initiative	Impact	Base	Best
Tier 0	ALL	**1. Prevention Initiatives to improve Population Health**	1. Reduction in Outpatient Appointments 2. Priority cohorts would be able to manage their conditions better at home/residence	10%	20%
Tier 0	ALL	**2. Single Point of Access to Primary Care Homes**	1. Reduction in ED attendances covered in Out of Hospital model	10%	25%
Tier 1	ALL	**3. First Contact Services**	1. Reduction in ED attendances	15%	20%
Tier 2	Long Term Conditions	**4. Population Health Management (PHM) with Multidisciplinary Teams (MDT)**	1. Reduction in ambulatory sensitive condition admissions 2. Reduction in ED attendances	10% across both	30% across both
Tier 3	Complex Needs	**5. Care Planning and Coordination**	1. Reduction in ED attendances	15%	30%
			2. Reduction in Non-elective admissions	10%	25%
Tier 3	ALL	**6. Specialist Community Outpatients and Diagnostic Services**	1. Reduction in ambulatory sensitive condition admissions 2. Reduction in Outpatient appointments? 3. Remote monitoring allows citizens to be able to control their long term conditions better at home/residence	10%	30%

The list of consolidated initiatives and estimated impact was compiled (2/2)

Tier	Cohort	Initiative	Impact	Base	Best
Tier 4	Complex	**7. Intermediate Care**	1. Reduction in non-elective admissions	10%	15%
			2. Redution in ED attendances	10%	15%
			3. Reduction in OP attendances (due to patient intitiated follow-ups)	TBC 10%	TBC 25%
			4. Reduction in Hospital Bed days	TBC 10%	TBC 10%
			5. Increase in community/home visits	12%	22%
			6. Increase in community admissions (virtual wards)	TBC 10%	TBC 30%
			7. Increase in primary care contacts	5%	15%
			8. Increase in social contacts	5%	15%

Initiative 1: Prevention Initiatives to improve Population Health

Initiative

Prevention Initiatives to improve Population Health - In addition to the prevention initiatives that already exist in Primary care (vaccination, screening, smoking cessation etc), there are many ways in which that prevention agenda can be expanded and its effect amplified by working **'at-scale'**. At an island level, Population Health Analytics can help to target those at risk more effectively, and to design more personised interventions. Working with Pharmacy to provide health checks and opportunistic screening can help expand capacity. Expanding the Primary Care workforce in the PCH to include Care Navigators and Health Coaches can help support people with healthy lifestyle choices (weight management and physical exercise for instance), and also to empower them to manage their own health (through patient activation). Digital Therapeutics can also be helpful here too. In time, the personal health data that people currently collect from their remote monitoring or wearable devices will be able to sync with a Single Electronic health record and trigger a more proactive and personalised service. Advanced care planning will also impact the prevention agenda but is included in Initiative 3.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 0	ALL	**1. Prevention Initiatives to improve Population Health**	**Population Health Analytics** • Better identification of those at-risk, more targeted prevention initiatives and a more personalised approach to prevention **Care Navigator / Health Coach** • Supporting patients with prevention of lifestyle illnesses - signposting to community prevention services e.g. smoking cessation, help with alcohol and substance misuse, weight management, mental health support, falls prevention **Patient Activation** • Primary Care Homes to train all staff in patient activation, working particularly with care navigators, case managers and care coordinators to improve patients understanding and management of their own condition. **Digital Therapeutics** • Ready access for patients to digital therapeutics – both for primary prevention (eg weight management) or Secondary Prevention (eg COPD monitoring app) **Remote Monitoring** • Wearables connected to the Electronic Care Record uploading vital statistics and monitoring health	1. Reduction in Outpatient Appointments 2. Priority cohorts would be able to manage their conditions better at home/residence	10%	20%	It can be expected that through providing clear and easy access to self-care advice and guidance that the management of self-limiting illnesses will be improved (Rosen, 2014) , with citizens also likely to seek advice and treatment from their local pharmacists. Impact analysis % based on Walsall transformation programme

Initiative 1: Prevention Initiatives to improve Population Health (2/2)

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 0	ALL	**1. Prevention Initiatives to improve Population Health**	**Pharmacy Screening** • HTN and AF Identification service **Optician Screening** • Diabetic retinopathy screening to be rolled out on island **Pharmacy Health Checks** • NHS Health Checks offered in community pharmacy on the island **Patient access to Electronic Care Record** • Patient autonomy and improved activation **Portal** • Giving patients ready access to advice and guidance on acute, self-limiting conditions and long term condition management. Part of other initiatives: **Care Planning** • See initiative 3. Especially for specific LTCs eg DM, Heart Failure, COPD, Dementia, EoL	1. Reduction in Outpatient Appointments 2. Priority cohorts would be able to manage their conditions better at home/residence	10%	20%	It can be expected that through providing clear and easy access to self-care advice and guidance that the management of self-limiting illnesses will be improved (Rosen, 2014) , with citizens also likely to seek advice and treatment from their local pharmacists. Impact analysis % based on Walsall transformation programme

Initiative 2: Single Point of Access for the Primary Care Home

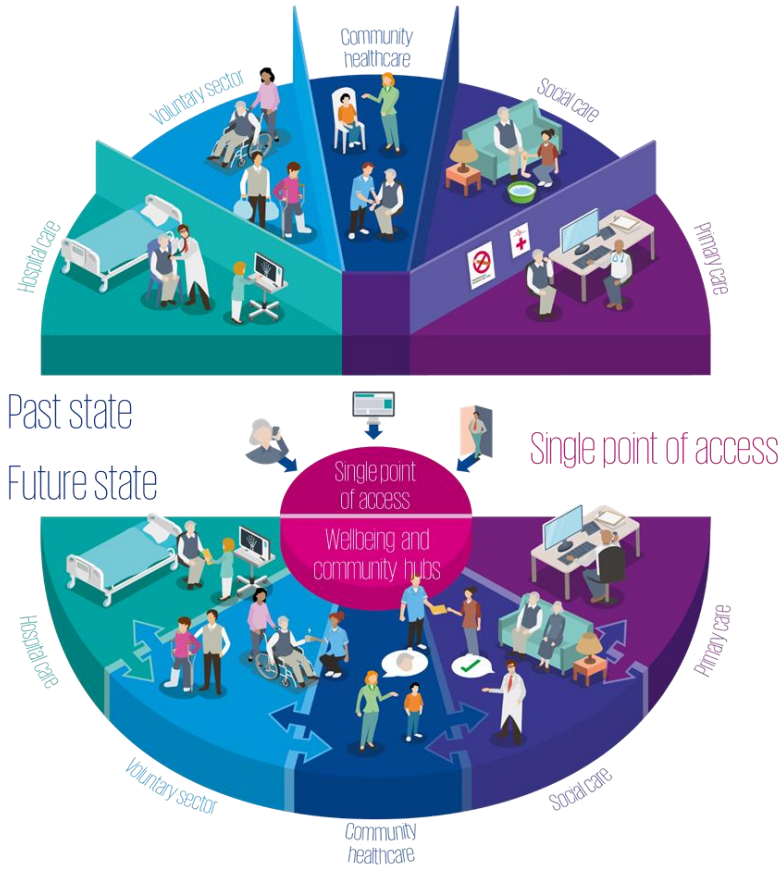
Initiative

Single Point of Access for the Primary Care Home - There is strong evidence to support a Single Point of Access for all Primary Care queries, which can effectively navigate people to the most appropriate service and where appropriate, book appointments. Not only does this simplify the process of accessing services for patients, it is safer for patients, and helps Primary Care to manage demand for its services. A Single Point of Access for Primary Care is part of existing UEIC plans for the island, with access via phone (111) and online, though with a limited remit in the first instance. This work does not preclude Primary Care Providers themselves working to improve access channels to their own services, and a Single Point of Access for the Primary Care Home is advocated here, with General Practices and the Wellbeing Partnership in that location, working **'at-scale'** to:

1. Provide AI supported triage and navigation services to those seeking first contact services
2. Book appointments for any Primary or Community Service in the PCH as required
3. Provide an access point to patients' personal Care Coordinator and team

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 1	ALL	**2. Single Point of Access for the Primary Care Home**	**Single Point of Access** • Online and telephone access • Where telephone is used, call handler uses the same AI assisted software to triage and navigate patient as used online. **Triage and Navigation** • Acute problems are prioritised and seen on the day. • Call handlers have access to personalised care plans • Patients directed to the most appropriate first contact provider in the first instance, which may be another Primary Care provider (e.g. Pharmacy, Opticians or Dentist), a Community service (MH crisis response), a Secondary Care provider (eg A+E) or a Third Sector provider **Appointment Booking** ▪ Patient able to book appointments across Primary and Community Care **Care Coordination Centre** • See initiative 3. Care Coordinators may be a nurse, Allied Health Professional (AHP) or Social Prescribing Link Worker depending on need.	1. Reduction in ED attendances covered in Out of Hospital model	10%	25%	Clinical triage and advice has been shown to reduce the requirement for face to face primary care appointments by up to 50% (Bunn, Bryne, & Kendall, 2004) NHS England (2013) states that 50% of all emergency call needing an ambulance could be managed at the scene or in the community, preventing unnecessary admissions. The Kings Fund paper (2014) also estimates that up to 30% of emergency admissions could have been avoided if appropriate alternative forms of care are available at the point crisis or if care had been managed better in the period leading up to the admission. The shift of outpatient appointments from secondary to community/virtual settings will increase these contacts (Walsall data) Increasing citizen awareness of VCS alongside promotion of these as alternatives to primary/community appointments will result in increased demand. Improved triage will also direct inappropriate primary care appointments to the correct service, as it is estimated 1 in 4 GP appointments could be avoided with more coordinated working, improved technology and access to MDTs. Furthermore, it is estimated a fifth a GPs time is spent dealing with social issues including debt, social isolation, housing, work, relationships and unemployment. (Making Time in General Practice, 2015)
				2. Reduction in Primary Care Appointments (10 - 25%)	10%	25%	
				3. Increase in community contacts covered in Out of Hospital model			

Initiative 2: Single Point of Access



Single Point of Access
Online portal / phone

- Care Coordination Centre
  - Care Coordinator / Case Manager/ Care Navigator
  - Signposting to help with Wider Determinants of Health e.g. housing, employment, schools
  - Self support apps/ personalised care plans
- Appointment Booking
  - Primary care and community appointments
- Triage and Navigation
  - No care plan → Referral to appropriate service and if required to risk identification/ stratification
  - Care plan in place → Referral to appropriate service and inform care co-ordinator

Initiative 3: First Contact Services (1/2)

Initiative

First Contact Services - Working 'at-scale' as a Primary Care Home can vastly improve First Contact services for patients. For instance, a broader range of First Contact clinicians such as First Contact Physiotherapists and Mental Health Practitioners, can reduce pressure on GP appointments and improve access to care for patients. Freeing GP time also allows for specialisation, with GPs becoming more involved in complex condition management and supervision of clinicians in other General Practice roles (eg Physicians Associates, Advanced Nurse Practitioners). Working at-scale also enables Primary Care to deliver more tailored services, with GP practice collaborating to offer a shared 'on-the-day' acute service, as well as shared access to Continuous Care Teams for Long Term Conditions. Use of digital technology can also expand access to First Contact Care for instance, through partnering with a remote consultation platform such as Livi or Babylon. On an island with recruitment and retention issues, this could quickly expand GP capacity in the immediate term. Pharmacy, Dentistry Opticians also have plans to extend their First Contact services with Pharmacy First, expansion of the Minor Ailments Scheme, and Minor Eye Conditions Service. Within the Wellbeing Partnership, access to Social Prescribing, Third Sector services and the Local Area Coordination programme, also expands first contact to community services and support with Wider Determinants of Health.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 1	ALL	**3. First Contact Services**	**First Contact Practitioners** • First contact Physiotherapists and Mental health practitioners available within the PCH **ANP and PA top of licence working** • Advanced Nurse Practitioners and Physicians Assistants taking a greater role in leading services for Long Term Condition Management **At-Scale Acute Services** • Collaboration at PCH level to offer shared access to acute 'on-the-day' appointments **Pharmacy First** • Patients navigated to community pharmacy where appropriate, avoiding GP appointment • Non-Medical Prescribers treating common conditions from an agreed formulary **Minor Eye Conditions Service** • Opticians providing first contact for minor eye conditions avoiding GP appointment	Reduced ED attendances	15%	20%	Attendances suitable for primary care account for between 15 to 20% of ED visits, with the highest proportion being children. Therefore, there are likely benefits in providing alternative urgent care services at hospitals with high standardised attendance rates such as reducing the number of patients who need to use the ED whilst providing them with a better experience (GIRFT, 2021).

Initiative 3: First Contact Services (2/2)

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 1	ALL	**First Contact Services**	**Out of Hours First Contact Care** • Plans to develop the existing MEDS service into an Urgent Treatment Centre with a Pharmacist, Doctor, Mental Health nurse and Advanced Nurse Practitioner/Paramedic (Advanced Clinical Practitioner). **Decision Support** • Decision support embedded in Single Electronic Health Record to support Primary Care clinicians to work at the top of their licence **Standardised referral pathways** • Standardised referral pathways agreed for common conditions to support community management and avoid the waits associated with referral rejection (Care Pathways work) **Access to Specialist advice** • GPs to have greater access to specialist advice on referrals and management through direct links to hospital specialists via email, and phone. **Social Prescribing** • Wellbeing Partnerships to offer first contact support with social issues, including close Third Sector working to support those with needs in wider determinants of health **Local Area Coordination** • Wellbeing Partnerships to provide insight into local issues and support those with complex needs.				

Initiative 4: Population Health Management and Multi-disciplinary Teams (1/2)

Initiative

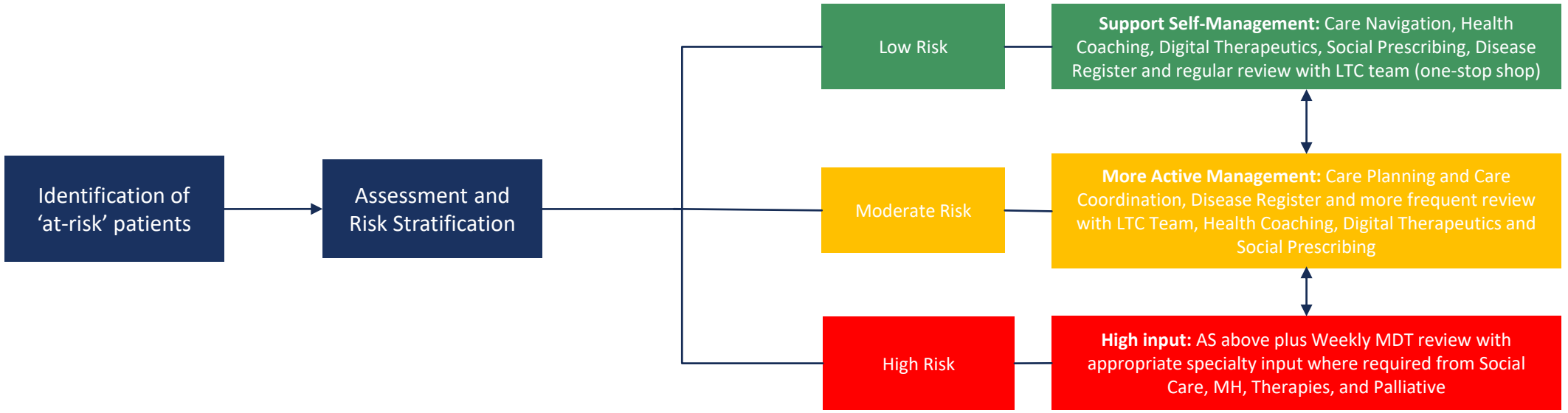
Population Health Management with Multidisciplinary Teams - Patients identified as having, or being at- risk of a LTC, are identified from existing care records and through screening. These patients are then invited to a holistic health assessment, and risk stratified according to whether they are low, medium or high risk. Based on their risk stratification, patients are managed according to standardised clinical protocols and offered appropriate levels of support. Low risk patients will most commonly require support with self management only though access to advice and guidance, care navigation and digital therapeutics. Medium risk patients require more input with a Case Manager and more detailed Care Planning (see Initiative 5). More complex or high risk patients will require MDT management with teams tailored to patient needs but often including a mix of Primary Caer, Secondary Care and Community Care staff. General Practice should keep up to date disease registers of their patients with LTCs to ensure they are recalled at appropriate intervals to review. The Population Health Management approach for LTCs is outlined in the process map overleaf.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 2	Long Term Conditions	**4. Population health management with Multidisciplinary Teams**	**Population Health Management** • **Patient Identification** - A more proactive approach to LTC management with all patients either with, or at risk from, an LTC, identified from Primary Care records / screening • **Holistic Assessment -** Patients get a holistic assessment taking a bio-psycho-social approach. • **Risk Stratification -** Patients risk stratified and managed appropriately, according to standardised protocols assuring high quality care. • **Disease Registers -** Patients condition correctly coded and patient added to disease register to ensure appropriate call and recall for review. • **Protocolised Management -** Intervention targeted to need. Those at highest risk are more frequently reviewed and receive more intensive input **Care Navigation (See Intervention 1)** • Patients with low complexity LTCs supported with self management with access to Health Coach, Digital Therapeutics, Care Navigators and Social Prescribers	1. Reduction in ambulatory sensitive condition admissions 2. Reduction in ED attendances	10% across both	30% across both	Integrated Neighbourhood Teams project (Wigan, UK) - neighbourhood teams (which involve clusters of practices), meet to discuss the top 30% of patients referred to them who are at risk of admission to hospital. The team discuss and agree how each patient can best be supported to remain independent. The project has significantly contributed to a 43% drop in A&E visits and a fall of 48% in emergency admissions. Outpatient attendance was also down by 17%.

Initiative 4: Population Health Management and Multi-disciplinary Teams (2/2)

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 2	Long Term Conditions	**4. Population health management with Multidisciplinary Teams**	**Care Planning and Coordination** (Intervention 3) • Patients at medium risk have Care Planning and Case Managers with MDT input for patients with non-complex LTCs **MDT Management** • Patients with complex needs require MDT management including Primary, Secondary and Community Care services. • Different MDTs will exist for different types of condition e.g. Frailty, Multi-morbidity, End of Life care				

Population Health Management and Multi-Disciplinary Teams for LTC management



Access to a range of community services across the Tiers

Social Prescribing and support with Wider Determinants of Health	**Care Co-ordination**	**Acute Primary Care services**	**Community Diagnostics**	**Enhanced Community Nursing**	**Intermediate Care Response Team**	**Community beds**	**Acute Hospital services**

Initiative 5: Care Planning and Coordination (1/2)

Initiative

Care Planning and Coordination - Citizens' aspirations and wishes will drive a much more personalised approach to care planning and delivery. Care will focus on 'what really matters to the person' and be characterised by care plans that are personalised towards individual assets, needs and preferences and take account of any inequalities and barriers to access.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 3	Complex	**5. Care Planning and Coordination**	**Patient Identification** • Health and Social Care staff trained to identify and refer patients who would benefit from a holistic assessment and Care Planning / Care Coordination. • This may be indicated by clinical indicators (eg NEWS score), risk indicators (eg E-frailty score), clinical diagnosis (e.g. LTC), mental health condition, social complexity or difficulties with Wider Determinants of Health (eg housing, social isolation) **Holistic Assessment** • Bio-psycho-social assessment carried out in the Wellbeing Partnership • Assessment should be in community with appropriate specialist input i.e. transition to true MDT where required **Enhanced Care Planning** • Maximising the use of care plans where appropriate to help people stay independent, healthy and in control • Use of a standardised template for Care Planning detailing each patient's care journey and pathway • Personalised care enabled by digital infrastructure and shared records, so all necessary providers can view the care plan including emergency services. • Not just about health provision. Non-medical management key	1. Reduction in ED attendances	15%	30%	A Unified Care Plan programme in Birmingham found residents that followed their care plan had a 50% reduction in accident and emergency attendance, and a 25% reduction in non-elective admissions. A Seven Day Ambulatory Emergency Care Mode by Southend Trust, UK uses data to predict surges in demand for hospital services. Separately, an 'assess to admit' model evaluates patients along their own pathways, directs them towards discharge or ambulatory care when possible. Seven-day pathways were developed for the most common acute setting conditions, mapping optimal patient paths to recovery and discharge (Southend ACE)
				2. Reduction in Non-elective admissions	10%	25%	

Initiative 5: Care Planning and Coordination (2/2)

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 3	Complex	**5. Care Planning and Coordination**	**Care Coordination** • Care Coordinators to act as the first point of contact for patients with complex care needs • Care Coordinators to specialise in certain areas eg frailty, mental health, young people, multi-morbidity. • Role to be based across multiple practices within the PCH • For patients with multi-morbidity, Care Coordinators can arrange a 'One Check' where some or all relevant specialties are present and all reviews are conducted. • Care Coordination Centre for the PCH proposed, responsible for the active management of patients with Long Term Conditions and complex needs e.g. multi-morbidity, frailty etc				

Initiative 6: Specialist Community Outpatient and Diagnostic Services (1/2)

Initiative

Specialist Community Outpatient and Diagnostic Services - Primary Care services will have greater access to community diagnostics and outpatient services, first through the implementation of urgent access pathways and potentially in the future through the introduction of a Community Diagnostic Hub. Patients should also heave greater access to specialist outpatient care through both face to face and virtual clinics in the community. Joint clinics with Primary Care would help transfer skills into the community.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 3	LTC and Complex	**6. Specialist Community Outpatient and Diagnostic Services**	**Outpatients in the community** • These should be Joint Clinics where possible to build capacity and competency in the Primary Care workforce (e.g. GPwER) **Virtual Outpatient Clinics** • Remote consulting platforms would facilitate greater access to Specialist input, especially for the housebound **Condition Specific Rehabilitation** • Services such as Cardiac Rehab and DM prevention services are well suited to the community and could be housed either in Wellbeing Partnerships or in Ramsay Hospital **Urgent access pathways to diagnostics and radiology** • Primary Care physicians to have access to urgent and same day tests and imaging (UEIC) **Community Diagnostics Hub** • Consider use of Ramsay Hospital as a cold site for rapid throughput community diagnostics e.g. CT / MRI / US / Echo / Endoscopy **Hot Clinics** • Urgent access ('hot') clinics are dedicated clinics providing emergency care for specific conditions eg Geriatrics • Hot clinics would provide a one-stop clinic for elderly patients with complex needs who require quick, comprehensive, geriatric assessment and intervention and could run out of the Wellbeing Hubs.	Reduction in outpatient appointments	20%	50%	Renal e-clinics in Tower Hamlets allowed GPs to refer patients to a virtual clinic, resulting in 50% of referrals managed without the need for an outpatient appointment. (NHS England, 2016)
				Reduction in DNAs and length of outpatient appointments	25%	50%	A virtual outpatient scheme called 'Diabetes Appointments via Webcam in Newham (DAWN)' showed an increase in patient satisfaction and a reduction in DNAs by 50% (Vijayaraghavan, et al., 2015). NICE (2021) recommend that people who visit their GP with symptoms that may suggest cancer should be sent for diagnostic tests to confirm or refute a cancer diagnosis. Enabling GPs to use direct access (through SDEC pathways) for specific tests is cost effective and will reduce the time to reach a diagnosis. All radiology services should have access to dedicated facilities to admit and discharge day case patients for interventional procedures (GIRFT Radiology, 2021). A recent audit of the effectiveness of the Bristol Hot Geriatrics clinic showed that 72% of referrals were successfully treated in the community following attendance at the clinic and avoided the need for hospitalisation. (Thorax 2008; 63: supplement VII A13).

Initiative 6: Specialist Community Outpatient and Diagnostic Services (2/2)

Initiative

Specialist Community Outpatient and Diagnostic Services - Primary Care services will have greater access to community diagnostics and outpatient services, first through the implementation of urgent access pathways and potentially in the future through the introduction of a Community Diagnostic Hub. Patients should also heave greater access to specialist outpatient care through both face to face and virtual clinics in the community. Joint clinics with Primary Care would help transfer skills into the community.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 3	LTC and Complex	**6. Specialist Community Outpatient and Diagnostic Services**	**Hub and Spoke model for specialties** • GPs participating more in complex case management, MDTs, joint clinics and specialised hub and spoke services (GPwER) eg Dermatology Hub and Spoke service				

Initiative 7: Intermediate Care Services

Initiative

Intermediate Care Services - In the future model of care, patient care will be delivered as much as possible in the community, reserving hospital capacity for the most serious cases. Intermediate Care services provide care for patients with more acute and intensive care needs – those who are housebound requiring home care services, those in residential and nursing care, those who require hospital based diagnostics and treatment but do not require ED assessment or hospital admission and those in crisis.

Tier	Cohort	Initiatives	How will it be different?	Impact	Base	Best	Evidence
Tier 4	Complex	**7. Intermediate Care Services**	**Intermediate Care Response Team** • Facilitated discharge • Hospital at Home / Virtual Wards • Reablement • Two-hour crisis response (UEIC) **Nursing Home Clinical Support Services** • Advanced Care Planning • Use of NEWS2 escalation tool • Nurse prescriber access (UEIC) **Same Day Emergency Care (SDEC)** • Outpatient service for those who require access to hospital based testing or treatment but do not require ED assessment or hospital admission (UEIC) **Crisis Teams at Scale** • Eg Mental Health Crisis Single Point of Access (UEIC) **Enhanced Community Nursing Programme** • Buurtzorg style integrated health and social care nursing in the community (UEIC)	1. Reduction in non-elective admissions	10%	15%	The impact of discharging patients from acute beds into the community will increase the demand on Social and Community Care to provide the necessary care for these patients (Walsall data) Research by the Royal College of Emergency Medicine has shown that 15% of patients presenting to A&E can be seen safely in the community (if appointments are available within 24 hours), 5% of people who attend A&E could be dealt with by a GP (Time to act – Urgent Care and A&E: the patient perspective) Based on pilot being undertaken by Robin Fackrell (Point 1, 4 and 6) Check for patient initiated follow-up impact - based on targets had by Trust (3) Front end streaming service pilots found a reduction in A&E attendance of 3.5% and non-elective admissions were reduced by an average of 5%. NHS England (2013) states that 50% of all emergency call needing an ambulance could be managed at the scene or in the community, preventing unnecessary admissions. The Kings Fund paper (2014) also estimates that up to 30% of emergency admissions could have been avoided if appropriate alternative forms of care are available at the point crisis or if care had been managed better in the period leading up to the admission.
				2. Redution in ED attendances (10-15%)	10%	15%	
				3. Reduction in OP attendances (due to patient initiated follow-ups)	TBC 10%	TBC 25%	
				4. Reduction in Hospital Bed days	TBC 10%	TBC 10%	
				5. Increase in community/home visits	12%	22%	
				6. Increase in community admissions (virtual wards)	TBC 10%	TBC 30%	
				7. Increase in primary care contacts	5%	15%	
				8. Increase in social contacts	5%	15%	

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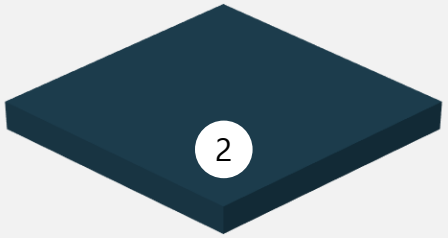
2. Processes

2. Processes



Processes

Processes describe the activity that occurs in Primary Care from front-line services through to back-office functions and transformation and also activity at the interface of other providers e.g. with Secondary and Community Care providers. These processes will need to be updated to reflect the new model of care. They should also take advantage of the ability to work ‘at-scale’ and to assure quality and performance through a standardised island-wide approach.

Process	Description	SJM Operating Model Requirement	Cost
Standard Operating Procedures (SOPs)	Describes the activity that occurs within Primary Care providers and includes both front, middle and back office functions. A standardised approach to operations across all providers ensures quality and efficiency. General Practice should devise and implement SOPs for the following: - **Front-line processes**: standardisation of approach to access and navigation, consultation, diagnosis and management - **Back office functions**: standardisation of back office functions like finance, human resources, administration and procurement. Where appropriate, these functions can be consolidated - **Transformation processes:** standardisation of approach to processes that transform service design and operations including Population Health Management, Workforce Planning, Quality Strategy and Digital Strategy. Should describe how each organisation collaborates on cross cutting issues such as these at an island level with Secondary Care, Community Care and Manx Care.	- Standardised policies and procedures - Shared approach to assessing and qualifying patient need - Capitalise on economies of scale in consolidating back end and supporting services - Organisational plans in place and updated regularly (this should be done collaboratively with Manx Care) - A collective innovation capability to ensure a process of continuous improvement; ongoing solution development to meet ever changing need - Mechanism for agreeing a single set of communication across all practices to ensure consistent messaging to all.	
Standardised Clinical Pathways	Describes activity at the interface of Primary Care and the wider health system. With Manx Care, Secondary Care and Community Care, Primary Care to agree standardised clinical pathways and clear referral criteria for common conditions and presentations. Work is already underway as part of the Care Pathways workstream. Critical policies for Primary Care include: - Direct Access to Community Diagnostics (UEIC Pathway) - Direct admission to hospital (UEIC Pathway)	- Ensuring continuity of support through effective implementation of integrated care pathways - Organisational plans in place and updated regularly (this should be done collaboratively with Manx Care)	

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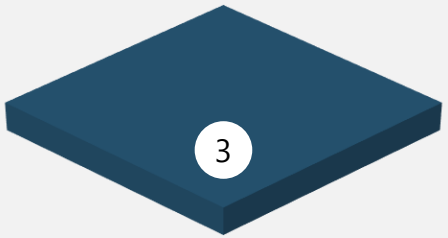
3. Workforce

3. Workforce



Workforce

The workforce necessary to deliver the model of care including the reporting and accountability hierarchy, leadership, capabilities, skills, culture and performance expectations for people and organisational units

A new Model of Care for Primary Care will require an aligned and empowered workforce. To achieve this, the following will be required:

1. A baseline understanding of the current Primary Care workforce (and workforce planning capacity)

This should include an understanding of, not just the number and type of staff, but also their skillset. This includes both clinical skills (e.g. diabetes management), and non-clinical skills (e.g. digital literacy). This will inform plans to upskill the existing Primary Care workforce and recruit into it. A baseline assessment of workforce planning capacity is also required. Future workforce planning structures should include structures that coordinate planning across Primary and Secondary Care.

2. An understanding of future Primary Care workforce requirements

Primary Care will need to model its future workforce based on the proposed new operating model. This modelling should include assumptions about the degree of “left shift” into the community, the proposed adoption of new technologies in Primary Care, the proposed upskilling of staff in pharmacy and optometry, and any proposed new service provision within general practice (e.g. MDT working and recruitment to new roles such as care coordinators).

3. A detailed plan for how to achieve it

A workforce plan will be required to articulate how the Island plans to deliver the workforce required to staff the new operating model for Primary Care. This plan will articulate actions that can occur at a practice level and an island level, and should include sections on:

- Making Primary Care the best place to work
- Improving Leadership Culture
- Releasing Time for Care
- Workforce Re-design
    - Preparing for New Models of Care
    - Preparing for the impact of technology
    - Optimising new workforce roles
    - Supporting the third sector, other volunteers and carers
- Growing and retaining the future workforce
- A New Operating model for workforce

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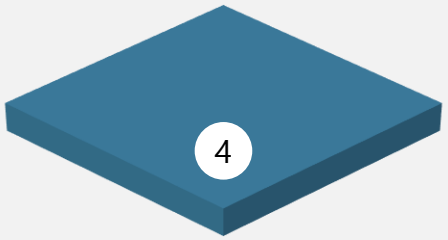
4. Technology

4. Technology (1/2)

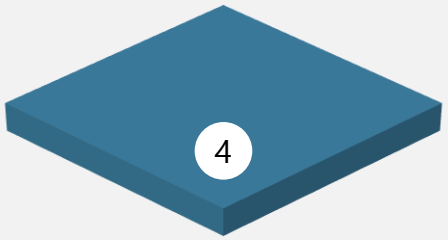


Technology

The new Target Operating Model for Primary Care will require a digital infrastructure to underpin all new services and processes. A digital strategy should include actions required at an island level as well as at a provider level. The digital strategy should align with the proposed roll-out of services in the TOM. The digital strategy should also consider, not only implementation of a new technology, but the change management piece around it – making it a part of the working lives of staff and easy to use for patients. This is exemplified by relatively poor uptake to date of Patient Access online services.

Process	SJM Operating Model Requirement	Impact	Cost
Electronic Health Record	- Ability to share patient data effectively and work with a 'single' care record - Varied mechanisms for collaboration, including digital tools	- Potential to improve safety, effectiveness and efficiency of care for almost all existing and proposed new services in the model of care, being able to view this in pharmacy also. - Procurement process already initiated	
Electronic Referrals	- Fast adoption of digital tools that improve efficiency - Varied mechanisms for collaboration, including digital tools	- Potential to embed the agreed and standardised clinical pathways into BAU activity of Primary Care, improving safety, effectiveness and efficiency of care. - Potential to significantly improve communication and coordination between Primary and Secondary Care	
Electronic Prescribing	- Fast adoption of digital tools that improve efficiency - Varied mechanisms for collaboration, including digital tools	- prescribers process prescriptions more efficiently - dispensers can reduce use of paper, have improved stock control, and provide a more efficient service to patients - patients can collect repeat prescriptions from a pharmacy without visiting their GP	
Digital Therapeutics	- An effective mechanism for providing medical advice and information through a number of mediums	- Patients are empowered to better manage their own health and Long Term Conditions. Patients with the lowest Patient Activation Measure use 20% more healthcare resource.	
Portal	- An effective mechanism for providing medical advice and information through a number of mediums - Provide patients with information that enables them to make informed choices about their care	- Existing plans under UEIC are for: expansion of the directory of services, addition of self-care advice and signposting, and addition of booking and prescription services. - In addition to this, the following could also be added: communication apps – instant messaging, voice, video and images, patient feedback – ratings and responses, live A+E performance and waiting data, on demand access to specialist content and advice, telehealth and self support apps (digital therapeutics), personalised care planning, digital care record and tailored health advice, digital triage (AI assisted assessment and booking)	

4. Technology (2/2)



Technology

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Remote Monitoring	- A flexibility in the locations in which different types of care/different interventions are delivered	- Facilitates the work of District Nurses and Intermediate Care Teams (including roll out of Virtual Wards / Hospital@Home) in Tier 4 services - Also supports self-management of LTC in the community	
PHM Platform	- Delivery of a broad set of capabilities and interventions tailored to a population's need, including the use of data and evidence to understand need (population health management capability)	- Facilitates the processes of Population Health Management including: population health needs analysis, population segmentation and risk stratification, and evaluation of interventions. - PHM is integral to the design and redesign or Primary Care at Scale services.	
Remote consultation platform	- An ability to make reasonable adjustments to care delivery to ensure effective care for those with disabilities - Increase capacity in the system (e.g. number of appointments available) - Varied mechanisms for collaboration, including digital tools - A flexibility in the locations in which different types of care/different interventions are delivered	- Partnering with offshore remote GP consultation services like Livi can address immediate clinical workforce shortages. - Other remote consultation platforms, such as Microsoft Teams, facilitate further clinical services, such as: Remote consultation for housebound patients, MDT team meetings	
Single Point of Access	- Effective triage process in place to direct patients to the right service - Online booking systems and other tools to ensure effective access to appointments for all	- A Single Point of Access could operate at an island level or it could operate at a Primary Care Home level - The purpose is to simplify access to health and care services for patients by offering one digital route in - Improved demand management as patients digitally triaged and navigated to the most appropriate service first time.	
Remote patient messaging	- Ability to flex treatment and interventions to match personalised care plans	- Platforms that facilitate remote patient messaging such as Accuryx (already in place in most GP practices)	
Secure NHS Email	- Fast adoption of digital tools that improve efficiency	- Ability for other contracted services eg Pharmacy, Dentistry and Optometry to communicate with General Practice	

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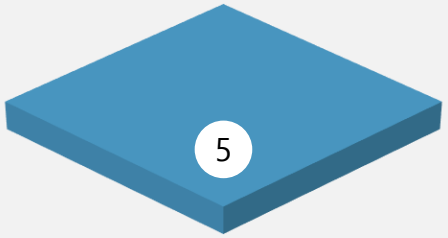
5. Information

5. Information



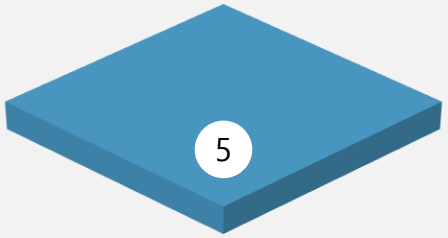
Information

The data and analytics required to support the execution of processes and to inform business decisions:

- Understand the health and social care needs of the population
- Plan services
- Compare outcomes with relevant comparators and drive improvement
- Monitor finances
- Model the workforce
- Assess staff satisfaction
- Review quality and performance metrics

Process	SJM Operating Model Requirement	Next steps	Cost
Demand and Capacity Modelling	- Effective case load management, including ability to manage capacity across general practice (not just at practice level) - this includes systems and operational staff capability.	- Data and analytics capacity is required to guide demand and capacity planning across the health and care system, including Primary Care. This is especially important given the continued imperative to shift activity out of acute hospitals and into the community where appropriate.	
Population Health Management Data	- Delivery of a broad set of capabilities and interventions tailored to a population's need, including the use of data and evidence to understand need (population health management capability) - A collective innovation capability to ensure a process of continuous improvement; ongoing solution development to meet ever changing need	- Population Health Management is predicated upon the use of available intelligence to design and deliver integrated services that meet the needs of the population. - There are a number of existing datasets on the island that could be utilised to develop a deeper understanding of population need (at both an Island and a localised level). - There are a number of notable limitations to the data that is currently in place, that will need resolving: - There are some obvious omissions (Public Health Outcomes Framework) - There is currently very little linking of data - There is currently little interrogation of data - There are issues with data quality (e.g. coding) - Information Governance issues are ongoing	

5. Information



Information

Coding	- Delivery of a broad set of capabilities and interventions tailored to a population's need, including the use of data and evidence to understand need (population health management capability)	- The quality of coding in Primary Care is essential to the assessment of need, quality and performance in primary Care. Without a clear understanding of disease prevalence, it is impossible to design appropriate services. Improving the quality of coding will be essential.	
Information Governance	- A commitment to share all relevant data (within the legal constraints) with partners across the health and care system (including off island) to support effective collaboration and delivery of services	- Resolving Information Governance issues will be essential to at-scale working and underpins all services.	
Primary Care Dashboard	- Efficiency programmes to improve process across all General Practice	- A Primary Care dashboard already exists though its scope could be broadened considerably to enable more effective tracking of quality and performance in General Practice at a Practice, Primary Care Home and also at an Island level. - For example, regarding performance, the dashboard could collate data on: number of appointments, waiting times, DNAs, referral rates, prescribing targets, patient satisfaction etc - Regarding quality, the dashboard could collect data on QOF targets, disease prevalence etc. - For internal operations, All Standard Operating Procedures should have Key Performance Indicators attached to them with mechanisms in place to monitor the information and forums in which to analyse and discuss the data.	

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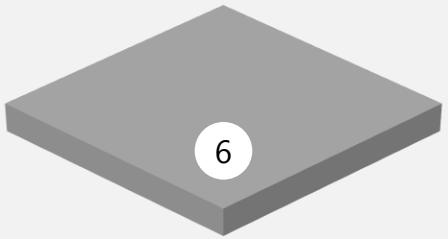
6. Governance

6. Governance



Governance

Governance describes the system by which entities are directed and controlled. It is concerned with structure and processes for decision making, accountability, control and behaviour at the top of an entity.

Governance influences how an organisation's objectives are set and achieved, how risk is monitored and addressed and how performance is optimised

Manx Care Functions

In 2020, Manx Care assumed responsibility for the provision of all health and care services on the Isle of Man. Over the next 5 years, its stated ambition is to shift activity out of Secondary Care and into Primary and Community Care. To do this, Manx Care has created an internal governance structure to:

- Set a vision for the future Model of Care on the island
- Commission providers in that new Model of Care
- Support delivery of the new Model of Care (through 'at-scale' and integrated design of the corresponding workforce, technology, policy and governance infrastructure required)
- Assure the quality, performance, and value of said services

Primary Care Provider Functions

1. Service Delivery Management / Governance

As providers of Primary Care services, General Practice, Pharmacy, Optometry and Dentistry, should be represented in many of these functions. As such, Manx Care has created a seat for Primary Care on:

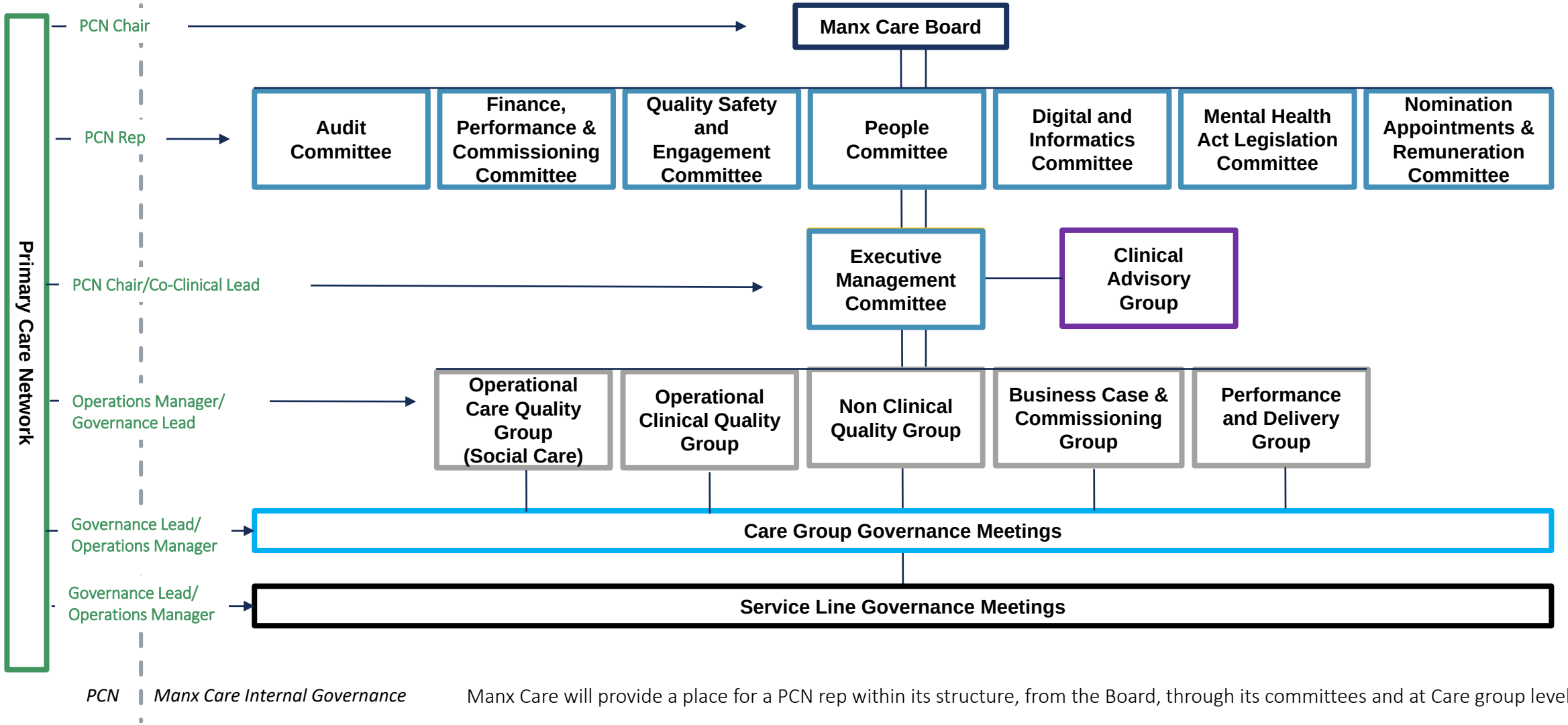
- It's Board: and
- Various sub-committees of the Board, such as the:
    - Audit Committee
    - Finance, Performance and Commissioning Committee
    - Quality, Safety and Engagement Committee
    - People Committee
    - Digital and Informatics Committee
    - Executive Management Committee
    - Operational Clinical Quality Group
    - Business Case and Commissioning Group
    - Performance and Delivery Group
    - The "Integrated Primary and Community Care" Care Group

As a representative of all 11 practices on the island, the Primary Care Network has the authority, from the 11 Practices, to represent General Practice on these Boards and Committees as confirmed in the PCN Strategy document which was approved by the PCN Board in March 2022. The PCN is recognised by Manx Care as representing General Practice and has invited the PCN to take on roles within its governance structures.

NB. Manx Care will provide suitable backfill to ensure the nominated representative from the PCN is able to attend.

It is anticipated that, within 5 years, the PCN will be seamlessly integrated within the governance and reporting structures of Manx Care, with the two organisations operating as one, enabling frictionless sharing of resources and mutual transparency.

6. Governance



Manx Care will provide a place for a PCN rep within its structure, from the Board, through its committees and at Care group level

6. Governance

2. Delivery of services

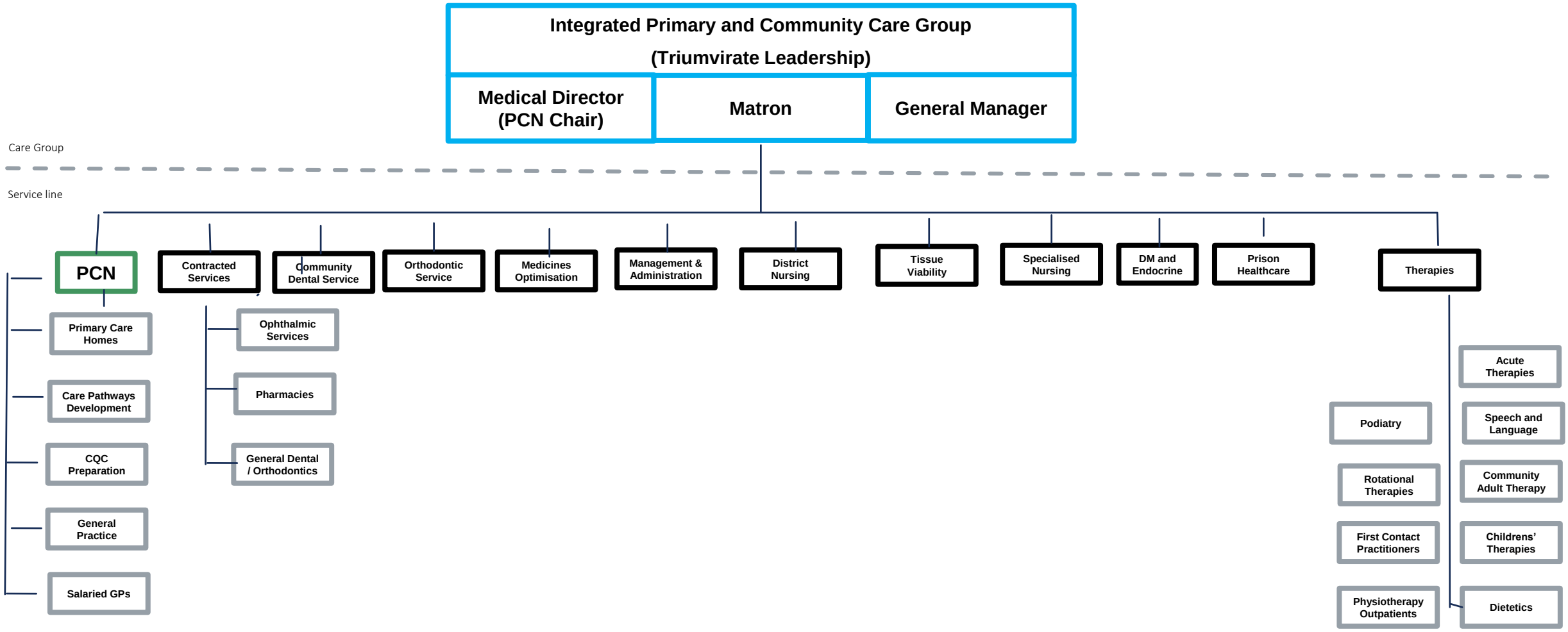
As providers of Primary Care, General Practice, Pharmacy, Optometry and Dentistry also have a role in delivering the services described in the Model of Care. Policy is defined by DHSC and included in the 'Required Outcomes Framework'. The PCN will be required to deliver the Primary Care element of the ROF and will have autonomy in terms of how those services are provided. The relationship between Manx Care and each of the Primary Care providers is defined by a contract, of which there are two types (see below). As well as defining services, such contracts also stipulate standards and processes for clinical, informational and financial governance. In each case, the provider is a *Service Line* and the department into which they report is the *"Integrated Primary and Community Care" Care Group* (see diagram overleaf).

- **Individual Practices:**
    - **Standard Clinical Services:** The General Medical Services (GMS) contract specifies the range of services that Manx Care expects each General Practice to deliver. In return, the contract specifies Manx Care's expectations in terms of quality, performance and compliance (outcomes based commissioning).
    - The same principles apply to the Dentistry contract, Pharmacy contract, and Optometry contract
    - The Individual practices will continue to be self-managing within a system of governance led by Manx Care and the PCN. Practices will be accountable via the PCN for performance, accountability and governance
- **Primary Care Network**
    - **Clinical Services:** The Direct Enhanced Services (DES) contract, will, in due course, specify Primary Care services that are not captured in the GMS contract referenced above. The Primary Care Network is accountable to the Manx Care Board for delivery of service and patient parity for the services they provide i.e. all patients have access to all services. For example, in general practice, this could be either via their individual practice, a Primary Care Home centre, a specialised clinic or a referral to a clinician with special interest within the wider PCN.
    - **Non-Clinical Services:** In some cases, Manx Care may wish to commission the Primary Care Network to deliver non-clinical services via the DES. This might include the setting up of the Primary Care Homes, and other cross cutting issues such as Clinical Pathway design, and CQC preparation.

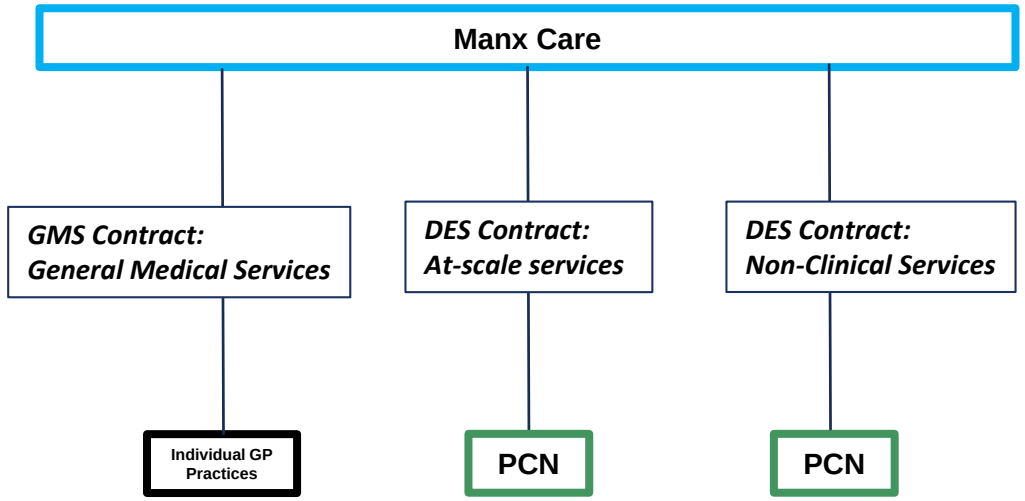
Note: It is not for this document to set out the internal governance of Primary Care Network. It is recommended that the functions of Education and Innovation sit within Manx Care, with multi-professional and cross sector (Primary, Secondary and Community Care) input.

- **Primary Care Network specifics**
    - **Primary Care Homes:** The PCN will design, pilot and shape the Primary Care Homes. The pilot will shape the evolution of the PCH which may, for example, see the Wellbeing Partnerships formally becoming part of the PCH structure.
    - **Workforce Funding** Will be made available on a case by case basis, where new roles have been agreed.

6. Governance



6. Governance



Proposed contractual relationship between Manx Care and General Practice. As presented here the use of the GMS Contract and DES remain intact. By mutual agreement the may be varied in due course.

Assurance of Clinical, Financial and Information Governance

Clinical, financial and information governance would be assured through the contractual relationship with Primary Care, as they are currently, through the GMS and DES contact. As well as defining the services required of providers, these contracts stipulate standards and processes providers are expected to comply with for clinical, informational and financial governance. Where providers of a Service Line function are direct employees of Manx Care (rather than a contractor), existing Manx Care governance arrangements require each Service Line to have accountability for their own governance and report risks regularly into Manx Care's Operational Clinical Quality Group, in a templated format. A similar process would be expected from contracted General Practice services.

Responsiveness to changing circumstances

Manx Care's expectations of General Practice are set out in the GMS and DES contract and can only be prospective. If circumstances change, and Manx Care wish a service to be rolled out through General Practice island-wide (for instance, a vaccination programme), a contract negotiation would have to take place. There is flexibility with the Care Group to move services where appropriate within the responsibility of the PCN.

Next Steps

To agree steps that can be taken in year 1 to work towards the governance shown at year 5.

NB. It should be noted that in parallel to this, the Transformation Team will be looking at incentives in the existing GP contract with a view to ensuring the contract delivers the Model of Care envisaged in the future, and this work will need to be aligned.

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Executive summary

Background

High-Level Target Operating Model

Next Steps

Appendices

Next steps are for a Business Case and Detailed TOM but continued work on the Target Operating Model doesn't preclude work starting on the PCH pilots

More detailed work is required over the next 3 months to build out design of the initiatives – first for a Business Case in June 2022 and then for a detailed TOM in September 2022. This will involve intensive co-design workshops with Primary, Secondary and Community Care Services. Accompanying the Business Case in June, will be an implementation roadmap, prioritising high impact activities and services. In the meanwhile, this does not preclude work starting on existing plans for the Primary Care Home pilots, in the North, South, East and West of the Island.

PCAS Strategy	High Level TOM	Business Case for TOM	Detailed TOM
• Agreed strategic objectives over next 5 years (design and deliver a new TOM) • Agreed design principles of a new TOM based on Sir Jonathan Michael's report • Set out structure of TOM	• Describe the proposed new TOM for PCAS, covering: 1. Model of Care 2. Processes 3. Workforce 4. Technology 5. Data and Analytics 6. Governance	• Business Case for a new TOM • Each proposed new service costed • Implementation roadmap devised, prioritising high impact activities and services	• Scoping and commissioning of all Primary Care activities and services in the new TOM
9 March 2022	31 March 2022	30 June 2022	30 September 2022

Primary Care Home (PCH) pilots

As well as continuing to build out the detailed Target Operating Model, ongoing support will be required on implementation

General Practice and Wellbeing Partnerships
A critical path for development and implementation of the Primary Care Homes is set out in the PCAS strategy. The PCN is in agreement with the steps but timelines are being negotiated to fit their capacity and Manx Care expectations. The Primary Care Network have compiled a business case for the first two pilots and will be going out to the Network shortly for Practices to lead this work in each area.

Pharmacy
A critical path for development and implementation of the pharmacy model of care is set out in the PCAS strategy. Delivery of the future operating model will depend on continued engagement and negotiation between Manx Care and the Pharmacy Association to deliver the next keys steps.

Dentistry
A critical path for development and implementation of the dentistry model of care is set out in the PCAS strategy. Delivery of the future operating model will depend on continued engagement and negotiation between Manx Care and the Dental Association to deliver the next key steps.

Opticians
A critical path for development and implementation of the opticians model of care is set out in the PCAS strategy. Delivery of the future operating model will depend on continued engagement and negotiation between Manx Care and the Optometry Association to deliver the four key initiatives. At present, discussions are taking place between the optometrist community (via the Optometry Association) and Manx Care regarding their contractual arrangement, specifically the current standard eye test fee. The Optometry Association would like to adopt a remuneration schedule similar to the Scottish model for the proposed new schedule of services. If unresolved, this may impact the ability to deliver the planned changes to the service.

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Appendix A: Sir Jonathan Michael's Design Principles and Operating Requirements

Sir Jonathan Michael's Design Principles and Operating Model Requirements

Impact	Outcome	Operating Model Requirement
IMPACT 1: Improve the quality of care for citizens	**Support people and communities to manage their own care needs and live healthier lives**	An effective mechanism for providing medical advice and information through a number of mediums
	Support people's care needs early preventing longer term needs (including preventative deaths)	Ability to deliver screening clinics for appropriate conditions
		Delivery of holistic risk assessments (risk stratification) of people's needs (including mental and physical health)
	Help people manage Long Term Conditions better	Development of MDT care plans for those with complex needs
		Ability to deliver MDT clinics for key Long Term Conditions
	Support people in a way that helps them live the life they want to live	Ability to provide treatments and interventions across settings
	Reduce admissions to hospital	Ability to work closely with community services to provide medical cover for patients at risk of admission or recently discharged
IMPACT 2: Improve the experience of care for patients	**Deliver person-centred care, treating people as individuals and ensuring an equity of care (including those with special needs)**	An ability to flex treatments and interventions to match personalised care plans
		An ability to provide a greater level of intervention and care time to those with complex care conditions
		An ability to make reasonable adjustments to care delivery to ensure effective care for those with disabilities
		Delivery of a broad set of capabilities and interventions tailored to a populations need including the use of data and evidence to understand need (PHM capability)
		An ability to co-produce service change with patients
	Deliver a well led service	Effective clinical leadership in place
		Effective system leadership, supporting system governance and leadership groups and ability to represent and make decisions for GPs at scale
		Effective public leadership with patients clear on ho the services are led and confidence in them being led effectively

Sir Jonathan Michael's Design Principles and Operating Model Requirements

Impact	Outcome	Operating Model Requirement
		Effective local leadership so patients have an ability to connect in with people operating in a leadership function within their individual neighbourhoods
		Clinical and operational leadership who are accountable to delivering the agreed outcomes
		An ability to collate and provide key performance data both within internal governance and to Manx Care
		Effective governance (both corporate and clinical) in place
	A safe service	An appropriate reporting tool for incidents and issues
		Appropriate clinical staffing to deliver services
		An ability for patients and staff to provide feedback ensuring feedback is taken in to account
	Ensure continuity of care	Ability to provide continuity of staff members providing care
		Ensure continuity of support through effective implementation of integrated care pathways
	Improve access to appointments, diagnostics and treatments	Online booking systems and other tools to ensure effective access to appointments for all
	Reduce waiting times	Increase capacity in the system (eg number of appointments available)
	Provide patients with information that enables them to make informed choices about their care	Clear communications in a number of different mediums
		Mechanism for agreeing a single set of communication across all practices to ensure consistent messaging to all
	Foster and enable strong relationships between patients/service users and professionals	Ensuring effective coordination of care
		Supporting the patient to see the same clinician/professional wherever possible
	Reduce silos in the systems so people only have to tell their story once and receive joined up care	Effective forums for teams and professionals to discuss patients (eg MDT meetings)
		Support team-based care by creating local teams across the island; including supporting integration with wider community services to operate as one team

Sir Jonathan Michael's Design Principles and Operating Model Requirements

Impact	Outcome	Operating Model Requirement
		A commitment for teams to engage positively and proactively with staff across the health and care system (including off-island), and with other relevant public sector organisations (eg education)
		A commitment to share all relevant data (within the legal constraints) with partners across the health and care system (including off island) to support effective collaboration and delivery of services
		An ability to share patient data effectively and work with a "single" care record
	Consistency of care for all	Standardised policies and procedures
	Provide care in the right place at the right time (including more care closer to home)	Shared approach to assessing and qualifying patient need
		Effective triage process in place to direct patients to the right service
		Effective case load management, including ability to manage capacity across General Practice (not just at practice level) – this includes systems and operational staff
		Effective care coordination with within Primary Care and alongside the wider community care services
		A collective innovation capability to ensure a process of continuous improvement; ongoing solution development to meet ever changing need
		Ensuring active participation of Primary Care in Integrated Care pathway design and delivery
		A flexibility in the locations in which different types of care/different interventions are delivered.
		A broad skill mix across staff (both clinical and non-clinical) to meet the range of complex needs in Primary Care; including a multi-disciplinary first contact capability that utilises the full breadth of non-medical clinical
IMPACT 3: Improve the experience of work for staff	**Make the IOM a safe and enjoyable place to work**	Ensuring that the right mix of staff are in place – effective workforce modelling and workforce plans (this should be done collaboratively with Manx Care)
		Ensure all appropriate HR policies are in place and are well understood

Sir Jonathan Michael's Design Principles and Operating Model Requirements

Impact	Outcome	Operating Model Requirement
		Create a learning organisation where all experiences across General practice feed into improvements and changes
	Provide staff with the development opportunities they want and need	Learning and development plans (this should be done collaboratively with Manx Care)
		Introduction of innovative roles that provide different opportunities for people
		Support and encourage training and broader learning alongside the structured training and development support on the island
		Provide appropriate forums for sharing experiences and knowledge
	Encourage and foster strong relationships between professionals, especially between teams	Forums for team development
		Varied mechanisms for collaboration, including digital tools
		Support the development of a 'one team culture' through structured and un-structured interventions
		Appropriate meetings and settings in place for cross team working
	Foster hope for the future and raise morale	Effective staff communications
		Organisational plans in place and updated regularly (this should be done collaboratively with Manx Care)
IMPACT 4: Improve the sustainability of services	**Ensure the right staff are delivering care**	A workforce model that allows the most appropriate and cost-effective staff to meet demand/activity, capitalising on more cost effective non-medical clinical staff wherever possible
	Achieving value for money in service delivery	Fast adoption of digital tools that improve efficiency
		Efficiency programmes to improve process across all General Practice
		Capitalise on economies of scale in consolidating back end and supporting services

Isle of Man Government
Reiltys Ellan Vannin

Appendix B: Priority Cohorts and Best Practice

Case 1: Krishnan (Child with LTC – Asthma)

Name: Krishnan Gupta
Age: 7

Krishnan is a happy 7 year old boy in Douglas. He lives with his Mum, Dad, 2 older siblings and dog Waffle and attends a local school in year 2.

Since he was a baby, Krishnan has had colds that "go to his chest" and when that happens he has ended up in Nobles ED for nebuliser treatment before being discharged home. Krishnan was diagnosed with asthma 2 years ago and has a blue and brown inhaler which he is meant to use though he rarely uses the brown one. Krishnan is meant to come for regular reviews with his GP to review his medication and inhaler technique but his parents shift patterns makes it hard for them to bring him. His Mum also struggles with anxiety.

Krishnan loves his pet dog but knows now he is probably allergic to it. His Dad smokes and though Krishnan's GP has advised him to stop, he has found this hard. Krishnan's Mum also suspects that mould in the house in contributing to his breathing difficulties and requested a letter from the GP to the council explaining this.

This summer, Krishnan missed 2 days of school due his breathing.

Considerations for a future operating model:

1. **Diagnosis** of asthma in children (updated NICE guidance)
2. **Regular management** – ensuring all children with a chronic condition follow protocolised management and have regular reviews (following up those that don't attend)
3. **Risk stratification** - identification and follow up of those at higher risk of exacerbation (regular GP or ED attendance)
4. **Family support** – including medical (stop smoking), social (housing) and safeguarding

Questions to consider:

How would Krishnan be supported by the health and care system at the moment?

How could we work together to better support Krishnan?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 1: Krishnan

Example 1: Salford's Children's Community Partnership (SCCP)

- Paediatric nurse practitioner led service developed in primary care (alongside GP practices) to manage acutely unwell children and reduce burden and spend on EDs and primary care.
- Paediatric nurse pracitioners using algorithms to manage a restricted set of acute illnesses in 0-15 year olds.
- Initiated 2011-14 with pilot phase and proof of concept phase 2-14-16.

Impact

- 2011 (before inception) to 2016: population =2,100 CYP across 5 GP practices: sustained 43% decrease in inpatient admission rate (from 70 to 41 per 1,000); average costs of care per child decreased from £57 to £25 per child22 .
- Patient experience: 100% of parents recommend the service

Example 2: Children's Assessment & Referral Service (CARS) - Evelina London Children's Hospital

- Telephone & email advice for GPs Monday to Friday. Telephone line is open 11am to 7pm and emails responded to within 24 hours.
- Consultants provide advice about the most appropriate referral pathways and how to manage children within primary care settings.

Impact

- Evaluation in 2015 showed 27 children were identified to need a paediatric outpatient review, who otherwise would have not been reviewed in primary care.
- 19 children were offered an urgent appointment instead of GPs referring them for routine review.
- 53 children were effectively managed in the primary care setting, 10 children avoided attendance to the ED as a result of CARS (potential saving of £1380 based on average ED attendance = £138).
- The number of outpatient referrals have avoided as a result of providing this advice has steadily increased from an average of 1.9 per month in 2015 to 3 per month in 2016 (potential saving of £645 per month if outpatient appointments cost £215).

Case 1: Krishnan

Example 3: Connecting Care for Children - North West London

- Model of GP child health hubs, typically 3-5 GP practices within existing locality/network in NW London (ideally 3-4 GP practices to service population 20,000 of which about 4,000 are CYP).
- Paediatrician leads monthly MDT & joint clinic that removes need for extensive hospital-based follow up.
- Telephone hotline between primary care and paediatrician; GPs provide ready access to their patients / families. Secure line for email advice allowing GPs to receive responses within 24 hours. Same day telephone appointments for CYP with GP senior practice nurse and same day face to face appointments if required.
- Practice Champions recruited to keep focus on the things that matter to the local community.
- Horizontal linkage with CAMHS, children's centres and schools.

Impact

- 39% reduction in hospital outpatient appointments, 22% reduction in ED attendances and 17% reduction in paediatric admissions for Hub patients20 .
- Relationships strengthened between primary and secondary care, trains and supports GPs in paediatrics and paediatricians in primary care; 100% of patients surveyed reported they would recommend the service.
- Economic evaluation conservatively assuming 30% reduction in outpatient, 8% reduction in ED and 2% reduction in admissions. So an ICS with 417,000 children, annual costs of the Hub model = £2,686k; Annual tariff savings from reduced hospital activity = £14,423k; net annual saving = £11,736k21 .

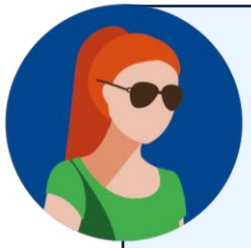
Example 4: The Lambeth and Southwark Children and Young People's Health Partnership (CYPHP)

- Care tailored to each child's physical and mental health needs in the context of their family and social conditions.
- CYP health teams provide early intervention, health promotion, and care for the whole child.
- Multidisciplinary integrated "CYP health teams" plan and deliver care in the child's home, or primary and community health settings.
- Health Checks and Health Packs provide supported self-management advice for families.
- In-reach child health clinics delivered by GPs and paediatricians working together in place-based system of GP clinics within networked multidisciplinary care with linked "patch paediatricians".
- Emotional resilience building and mental health first aid at school.
- Age-appropriate care for young people.
- Support for parents and professionals in managing common problems and minor illnesses.
- Training health and non-health professionals, including teachers, to identify and address the physical and emotional needs of children.

Impact

- 72% reduction in ED contacts for children with asthma, 30% for children with epilepsy, and 15% for children with constipation.

Case 2: Sophie (Young Person with a Mental Health problem)



Name: Sophie Crellin
Age: 17

Sophie, a student in the first year of her A-Levels, is an introvert who often finds it difficult to open up to people. Her childhood has been difficult as her parents split up when she was six years old. Her mother struggled to cope by herself, so she spent a number of years living with her grandmother in Ramsey.

Sophie had to take a lot of responsibility at a young age as her grandmother had periods of ill health and required care from Sophie. When she did live with her mother, they frequently had arguments; Sophie felt unloved and like a burden. As a result, she is underconfident and anxious, with undiagnosed depression. Whilst she has struggled to make friends at school, she has done well academically and aspired to leave the Island and go to University in the UK.

However, the combination of her loneliness and the pressure that she puts on herself at school is causing her to self-harm. She regularly feels overwhelmed and is worried that it could start to affect her grades.

Considerations for a future operating model:

1. **Identification** – Ensuring children are identified (in all settings)
2. **Management** – access to community services (digital and in-person) and to timely specialist input
3. **Support** – for young carers
4. **Signposting** – role of social prescribing and the Third Sector
5. **Liaising** – with families and schools

Questions to consider:

How would Sophie be supported by the health and care system at the moment?

How could we work together to better support Sophie?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 2: Sophie

Example 1: The Bridge PCN, Milton Keynes

Talk for Sport is an exercise-based therapy programme that provides eight weekly gym sessions for young people aged 11 to 18 with low to moderate mental health issues. The aim was to use these sports sessions as a way of providing education and support on topics such as mental health and resilience, nutrition and bullying.

The PCN developed the programme with a private enterprise, which provided most of the funding and marketing materials, and the PCN provided a clinical questionnaire for the group to measure outcomes. The cost to the PCN to support the programme was only £1,000, which meant the partnership approach was very cost effective.

The PCN engaged with local schools about this service. Schools can refer students directly to the project and, as part of their contribution, schools have provided a bus to transport young people to and from the gym. Local GP practices can also refer young people and make use of the bus service.

The pre-course questionnaire found that 72% of the young people had used CAMHS, and 46% had consulted their GP in the last six months for depression or anxiety. The post-course questionnaire found that 69% had improved their mental wellbeing, 76% made new friends and 76% enjoyed being part of a group. The Personal smile survey score of current mood was 64%.

Example 2: Well Centre, Lambeth

Early support hubs offer easy-to-access, drop-in support on a self-referral basis for young people who don't meet the threshold for Children and Young People's Mental Health Services (CYPMHS) or with emerging mental health needs, up to age 25. A mix of clinical staff, counsellors, youth workers and volunteers provide a range of support on issues related to wellbeing, while additional services can be co-located under one roof; offering wrap-around support across, for example, psychological therapies, employment advice, youth services and sexual health.

Some local areas have developed this approach to include primary care alongside mental health support. The Well Centre in Lambeth is a health hub where you can see a doctor, counsellor or Health and Wellbeing Practitioner to discuss any of your health concerns or worries in a safe and confidential space. This initially developed as a means to embed some of the principles of a youth-friendly practice, such as flexibility for appointments for young people.

in a UK study investigating Youth Information Advice and Counselling Services (YIACS), for young people who reported that advice had improved their stress or health, savings in GP costs alone (and disregarding the cost of other health services) were estimated to equate to £108,108 per 1,000 clients of youth advice agencies, or £108 per young person, exceeding the average cost of advice provision.

Case 2: Sophie

Example 3: RCPCH guidance on young carers

- **Active enquiry.** Many young carers may not recognise that they are providing caring duties at all, let alone recognise that they have specific needs. Health professionals, schools and others who potentially come into contact with young carers in their professional capacities must not only actively enquire whether their patients are carers, but also about their family circumstances in order to ascertain whether they undertake any caring duties.
- **Ensure that young carers (and their family) are told about their statutory rights** (such as the right to a needs assessment in England, and that social care must repeat this assessment every time the young carer's circumstances change including transition assessments before their 18th birthday).
- **Direct young carers to sources of support.** Professionals should be able to sensitively direct carers and their families to possible routes of financial, educational and health support, which varies across the UK.
- **Remind young carers who are aged 16 years and over that they are entitled to apply for Carer's Allowance** (and in Scotland, those who are not eligible for the Allowance may also apply to the Young Carer's Grant).
- **Helping their family members to access support** will have an indirect but important impact on the lives of the young carers themselves**.**
- **Celebrate young carers.** Young carers are often 'experts' in care, and their contribution should be valued and recognised. Most young carers find it rewarding, and feel rightly proud of their role and the skills they are developing.

Example 4: Kooth

Kooth.com is commissioned by the NHS, Local Authorities, charities and businesses to provide anonymous and personalised mental health support for Children and Young People.

Live counselling functionality allows children and young people to receive professional support through either booked or drop in sessions as and when a session is required.

The qualified practitioners are real people, not bots, with significant experience in working with children and young people.

Case 3: David (Adult with a LTC – Type 2 Diabetes)

Name: David Quayle
Age: 56

David is a business development manager who works long hours, often going between the Island and the UK. He has a wife and three children and enjoys a very stable family life. He also regularly visits his parents; his mother is in good health, but his father has had diabetes for many years.

David struggles with his weight and has a poor diet. He enjoys foods that are high in fat, and often resorts to quick and easy meals or takeaways when he's on the road. This has contributed to high levels of cholesterol, high blood pressure and a recent diagnosis of T2 Diabetes. He currently manages the condition with tablets though his blood sugar control is not good. His endocrinologist suggested he may soon have to start insulin if it does not improve but he has missed his last two outpatient appointments because he had to travel for work.

David knows he needs to prioritise his health more, but hears lots of conflicting advice online and doesn't really understand what to do. He generally avoids going to the GP unless he absolutely has to – he feels that he'll only get a lecture about his diet and lifestyle if he does.

Considerations for future operating model:

1. **Identification** – how could PCAS improve early identification of people at risk of diabetes?
2. **Prevention** - what could be done to prevent progression of pre-diabetes
3. **Routine Management** – how could PCAS ensure patients with diabetes are receiving NICE recommended care? Are able to self manage more eg digital therapeutics, education. Have more accessible services eg remote consultations, community outpatient clinics, GPs with Extended Roles
4. **Urgent care needs** – how could PCAS ensure patients with diabetes are managed in the community as far as possible? E.g. access to specialist advice on insulin dosing on "sick days"

Questions to consider:

How could services better meet David's needs?

How could we work together better to support David?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 3: David

Example 1: Foundry Healthcare, Lewes

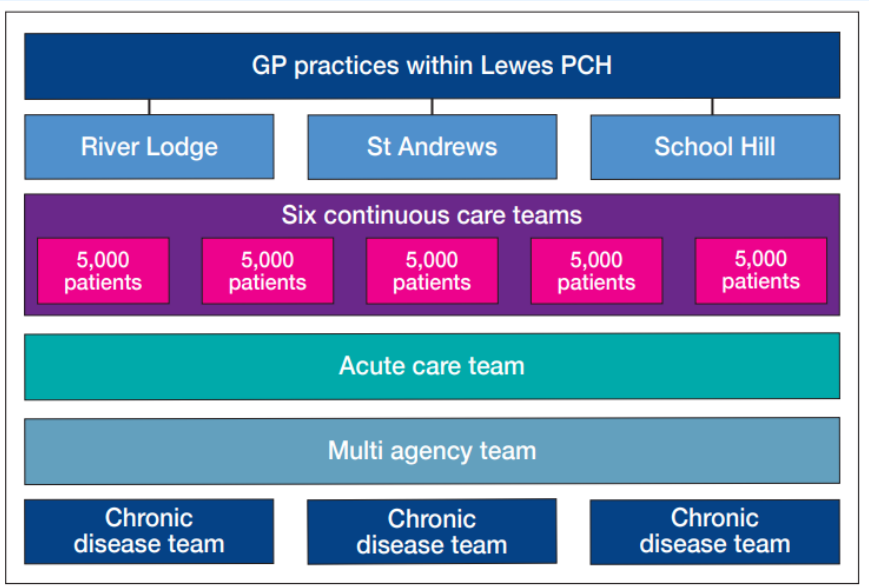
At Lewes PCH, 3 GP practices worked at scale, creating new shared teams for specific segments of the population:

1. An **"Acute Team"** - for patients who are generally well with new problems.
2. Six **"Continuous Care Teams"** - for those with chronic and complex problems.
3. A **"Multi-agency Team"** – that cares for the most complex patients who require active case management.

The Continuous Care Team provides:

- Routine follow up with proactive management
- Daily appointments for urgent problems
- Case management for complex patients with less current needs
- Practice based case management by patient navigator
- Home based patient management by visiting case manager
- Responsibility for 5000 patients with all levels of complexity
- The most complex patients supported by specialist case management
- Named team for every patient and telephone recognition software directs phone calls to case manager for complex patients
- 1 session per week for nursing home ward round

The Continuous Care Team is staffed by a small team of GP's (with at least one GP trainee and one trainer), a junior pharmacist, patient navigators and a reception prescription clerk



The practice also has a "**Long Term Condition Team"** for people with less complex long term conditions. This provides:

- A 'One stop shop' aimed at seeing patients for all their routine medication and chronic disease reviews at one appointment
- Routine blood testing and blood pressure monitoring
- Majority of prescription requests dealt with in this team
- Staffed by a senior pharmacist to provide oversight, do MURs authorise repeat prescribing and authorise simple acute prescribing and a prescribing clerk to process prescription requests

Case 3: David

Example 2: Bright Outcomes South East Hampshire and Portsmouth Super Six Model

The project defined six services to remain within an acute care setting:

- inpatient diabetes
- foot diabetes (with predefined criteria)
- poorly controlled Type 1 diabetes,
- including adolescents
- insulin pump services
- low eGFR or patients on renal dialysis
- antenatal diabetes.

All other people were managed in primary care. A combination of remote consultation and practice visits aimed to upskill the primary care workforce. A variety of modalities were used to deliver this e.g. virtual clinic, data base review and audit work review. This was supported by the community diabetes nurse specialist team.

Example 3: Patient activation

Many studies have shown that patients who are activated — i.e. have the skills, ability and willingness to manage their own health and healthcare have better health outcomes at lower costs compared with less activated patients.

Patients with the lowest activation scores, that is, people with the least skills and confidence to actively engage in their own healthcare, cost 8 to 21 percent more than patients with the highest activation levels (KPMG).

Example 4: Structured Education Programmes for DM

People learn about their condition in different ways. A useful framework for understanding diabetes education, broadly based on a model used in Scotland, is in three levels:

- **Level three**: Structured education that meets nationally-agreed criteria (defined by NICE/SIGN), including an evidence-based curriculum, quality assurance of teaching standards and regular audit.
- **Level two**: Ongoing learning that may be quite informal, perhaps through a peer group.
- **Level one:** Information and one-to-one advice.

Case 3: David

Example 4: Wigan

Service:

- Sharing risk management, decision making and advanced planning between primary and secondary care e.g. remote consultant A&G input with/without patient.Use of weekly MDT to support long-term condition management and complex frail/elderly
- Use of case manager with MDT input to support non-complex long-term conditions and frail/elderly
- Risk stratification of the population at scale to support streaming and shared access to records and care plans
- Community based acute care input e.g. Geriatrics/Specialist respiratory input
- Regular health checks over agreed age and based on risk stratification which allows higher risk individuals to be looked after by care co-ordinators

Evidence:

Integrated Neighbourhood Teams project (Wigan, UK) - neighbourhood teams (which involve clusters of practices), meet to discuss the top 30% of patients referred to them who are at risk of admission to hospital. The team discuss and agree how each patient can best be supported to remain independent. The project has significantly contributed to a 43% drop in A&E visits and a fall of 48% in emergency admissions. Outpatient attendance was also down by 17%.

Example 4: Digital Therapeutics

A total of 950 participants with a haemoglobin A_{1c} (HbA_{1c}) baseline value of at least 7.0% enrolled in the Vida Health Diabetes Management Program. The intervention included one-to-one remote sessions with a Vida provider and structured lessons and tools related to diabetes management. HbA_{1c} was the primary outcome measure. Of the 950 participants, 258 (27.2%) had a follow-up HbA_{1c} completed at least 90 days from program start.

The present study revealed clinically meaningful improvements in glycaemic control among participants enrolled in a digital diabetes management intervention. Higher program usage was associated with greater improvements in HbA1c. The findings of the present study suggest that a digital health intervention may represent an accessible, scalable, and effective solution to diabetes management and improved HbA1c.

(JMIR Diabetes 2021)

Case 3: David

Example 4: Care Coordination

- Use of "My care document"" for each patient that has their care journey and pathway
- Not just about health provision. Non-medical management key e.g. Wellbeing practitioners being employed by 3rd sector to work with families.
- Personalised care enabled by digital infrastructure and shared records
- Enhanced Care Planning – Maximising the use of care plans where appropriate to help people stay independent, healthy and in control
- 95 WTEs Mental Health practitioners to be brought into BSW incl. wellbeing – can act as a central point that collaborates together with primary / secondary care
- Support of non-medical management
- Use of 'One check' where all services feed into for a patient to be seen e.g. holistic approach using 'month of birth' recall
- Holistic Assessment – Clinical/fraility/NEWS/psychosocial/mental health at an early stage
- Trusted Assessment - Use of one assessment rather than duplication
- Wider determinants of health e.g. housing, social isolation
- Assessment should be in community with appropriate specialist input i.e. transition to true MDT
- Discharge to Assess at Scale

A Unified Care Plan programme in Birmingham found residents that followed their care plan had a 50% reduction in accident and emergency attendance, and a 25% reduction in non-elective admissions.

A Seven Day Ambulatory Emergency Care Mode by Southend Trust, UK uses data to predict surges in demand for hospital services. Separately, an ‘assess to admit’ model evaluates patients along their own pathways, directs them towards discharge or ambulatory care when possible. Seven-day pathways were developed for the most common acute setting conditions, mapping optimal patient paths to recovery and discharge (Southend ACE)

Case 4: Simon (Adult with complex needs)

Name: Simon Baker
Age: 56

Simon is currently unemployed and lives alone in his flat in Douglas. He has struggled with his health for many years. A long term smoker, Simon has peripheral vascular disease and had a below knee amputation 3 years ago. He has wheelchair for his mobility but rarely uses it to leave the house as his flat is on the first floor and his COPD makes it physically challenging.

Simon has kind neighbours that he likes. They help with his shopping and a District Nurse comes to dress his leg ulcers but he struggles with activities of daily living, like personal hygiene, and he feels embarrassed at the state of his flat. He feels very lonely. Sometimes he drinks alcohol to help him through these thoughts.

Simon has been admitted to hospital twice in the last 6 months. Once when his leg ulcers became infected and the second time when he got an exacerbation of his COPD.

Considerations for future operating model:

1. **Identification and risk stratification –** how are people with complex needs identified, risk stratified and referred for advice and help?
2. **Complex Case Management** – integrating primary care, secondary care and community care input.
3. **Care Planning**
4. **Care Coordination**

Questions to consider:

How could services better meet David's needs?

How could we work together better to support David?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 4: Simon

Example 1: Foundry Healthcare, Lewes

At Lewes PCH, 3 GP practices worked at scale, creating new shared teams for specific segments of the population:

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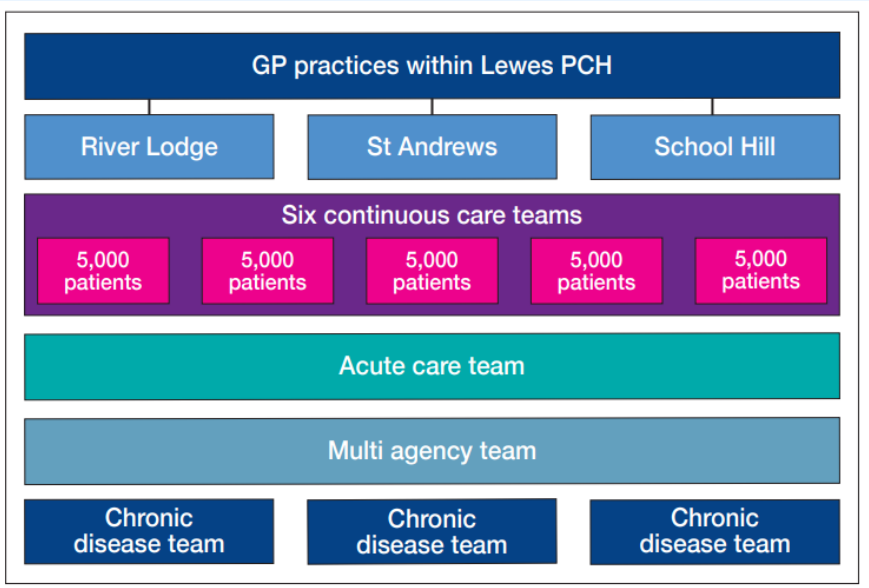

How the Multi-agency Team works with clients:

"You will be assigned a Case Manager based on your personal needs, and any existing relationships you may have with local services. Your Case Manager will be your key point of contact, getting a full picture of what matters to you, and supporting you in your journey. They will also contact you to arrange a "what matters" conversation at a time and location that is convenient to you.

The MAT will use your What Matters conversation to work out how to help you achieve your goals. Your Case Manager will talk to you about the actions they have suggested, and work with you to make a plan to move towards achieving your goals."

The Multi Agency Team is comprised of:

- GP
- Community nurse
- Palliative nurse specialist
- Community psychiatric nurse
- Social worker
- Occupational therapy/community physiotherapy
- Patient navigator
- House bound case manager/Frailty HCA

Case 4: Simon

Example 2: Montefiore, New York

Montefiore systematically identify those patients whose medical history and use of health services suggest the need for more active and co-ordinated care.

An 'initial assessment team' runs 90-minute telephone interviews to understand these patient's challenges and life goals. A team of 200 nurse case managers and social workers works with enrolled patients to surface the underlying problems that are contributing to their ill health, identify the changes that will make a difference, and pull together the medical, social and voluntary services needed to turn their lives around. Geriatricians, psychiatrists, pharmacists and other specialists give advice where needed. The nurse case managers draw in specialist teams to help with specific problems such as access to food or housing.

Nobody is simply going through the motions – ticking boxes to count the numbers of patients who got a call or received a care plan. Staff will search for a patient when they arrive in accident and emergency or are admitted into a hospital ward if that's what's needed to enrol them into care management. When the case managers identify housing as a critical issue, they don't simply 'signpost' patients to housing services or hand over a telephone number. They prepare the housing application, hound the housing department to do something, or sit with people in their interviews with housing associations if required.

Example 2: Kaiser Permanente, California

KPWA's Complex Case Management (CCM) Program is designed to serve the most vulnerable members. These clinical teams work together to carry a panel of members who have been identified with complex needs. Members are identified as eligible for CCM in two ways: 1) The John Hopkins ACG score is a tool used to identify members with complex needs who need further assessment for CCM service, 2) The KPWA Likelihood of Readmission Risk Stratification Tool is used to identify members at risk for readmission following hospital discharge and refer those who may benefit from CCM

Following enrolment, the nurse conducts a comprehensive assessment that evaluates the members physical health, behavioural health, environmental concerns, psychosocial needs, safety, medications and activities of daily living. The CCM nurse then works collaboratively with the member to develop goals that are meaningful and to translate those goals into concrete steps for the member to work on with the support of the CCM nurse. The collaboratively developed self-management care plan is then sent to the member, Primary Care Provider, and other members of the care team. Members are typically enrolled in the program for a minimum of 60 days and average between 60 and 120 days. The CCM nurses reassess members for continued use of the services at 90 days and then every 30 days thereafter.

Case 5: Anna (Adult with an Acute Minor Ailment)

Name: Anna Cowin
Age: 39

Anna is a solicitor at a prestigious legal firm in Douglas. She works long hours, supporting her clients around the Island and across in the UK. She values her time with her family, including her partner, her dog Alfie, and her parents in Peel.

Anna is generally healthy and enjoys long walks on her weekends, however she has visited her local GP on a couple of occasions over the last few years. She has found it frustrating to try to get an appointment, especially with her busy schedule during the week.

Anna has been feeling under the weather, has discomfort when urinating, and some pain lower down in her tummy. She knows this is likely an uncomplicated UTI infection but does not have time to call her GP until the end of the day.

Considerations for future operating model:

1. Access options for those with acute minor ailments
2. Triage of patients – how should this operate:
    1. At a practice level?
    2. At a Primary Care Home level?
    3. At an island level (eg 111)?

Questions to consider:

How would Anna typically present for treatment at the moment?

How can we make sure Anna is navigated to the right service in the first instance?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 5: Anna

Example 1: Manual Triage (KP on Call)

KP OnCall is the clinical advice centre in Southern California. Patients have round the clock telephone access to nurses who can direct patients to the most appropriate setting—whether the clinical condition warrants an immediate appointment in an ED, a direct referral to a specialist, or can be handled through a next day follow-up with primary or specialist care. Out of the 850,000 calls received in 2011, 34% were safely managed with primary care appointments and/or care in non-ED ambulatory settings, 15% were directed to urgent care clinics, 10% were provided advice for home care, 1% were advised to call "911," and only 18% were sent to EDs. The remainder had non-advice related calls. Kaiser has studied the effectiveness of OnCall further and found that of the members who called and indicated they would have gone to the ED otherwise, only 40% felt they needed to go to the ED after the call.

Example 2: Digital Triage (Haxby Group)

Haxby Group uses an AI powered digital triage tool to help triage and navigate patients. "A triage GP lead reviews urgent cases in the morning. If the GP feels an appointment is needed, they direct patients to the best point of care. Advanced nurse practitioners, for example, could be better suited for a particular patient's needs."
Klinik (the technology platform) captures information from patients in a consistent way – either they complete the online form themselves or if they phone through to the surgery, call handlers go through the same questions. It then uses AI techniques to analyse the information provided, indicate urgency and suggest the right type of care for each patient. This is helping staff across the practice better deal with enquiries. "Previously, admin teams might have escalated requests to a GP, and given them appointment just to be on the safe side. With this technology, admin staff have an easier path to a GP. The AI helps, because it asks sensible questions."

Case 5: Anna

Example 4: Foundry Healthcare, Lewes

At Lewes PCH, 3 GP practices worked at scale, creating new shared teams for specific segments of the population:

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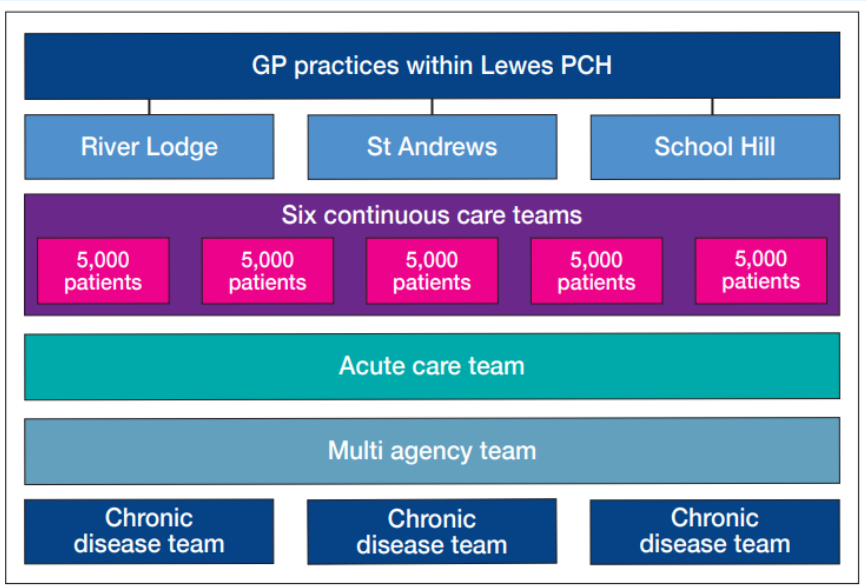
The Acute Team is comprised of:

- **Patient navigator** - directing patients to most appropriate pathway
- **GP** - telephone triage new patients, assigns patients needing face to face appointments to appropriate staff, supports other staff in acute team, sees more complex acute patients, admits patients to community beds, supports overflow from continuous care team. GP's rotate through acute team from continuous care team
- **Nurse practitioner** - extended role of current minor injuries nursing staff, able to see acute problems in generally well people
- Paramedic - visiting role for acute illness in complex patients unable to leave home to support continuous care teams, visiting role for acute illness in generally well patients unable to leave home eg, back pain
- **Physio** - direct access to physiotherapy for acute musculoskeletal problems, provides ongoing role for patients with primarily musculoskeletal problems



The Acute Team deals with:

- Generally well patients with new problems
- Emergencies
- Urgent care
- Ongoing care transferred to continuous care team
- Over flow from continuous care team

The team do a morning ward round and provide support to community beds. They have a twice daily huddle at 8am and 1pm

Case 5: Anna

Example 5: Livi app, North Tyneside CCG

In July 2020 the CCG commissioned Livi on a pilot 12-month basis to offer additional GP access. Patients have also been directly involved, via the Patient Forum, in the process of commissioning Livi.

Livi is a digital application that enables patients to book directly and see a GP by video appointment on a mobile phone or tablet. Whilst Livi brings the technology, more importantly, it also brings additional GP capacity to respond to patient's needs. This new application supports the North Tyneside health economy to offer additional capacity within the system, providing GP appointments during the day and also in evenings, weekends and on Bank Holidays.

Patients have to consent for the Livi GPs to access their records. If patients do not give their consent, they cannot be seen by the Livi GP. All consultations by Livi are recorded in the patients GP record. In the event the GP assessment identifies that a patient needs to be seen face to face by a GP, this is communicated to the practice. Similarly, where a patient requires diagnostics, e.g. a blood test, this is also communicated to the practice and the practice will undertake those diagnostics. Livi GPs follow the same clinical protocols as all North Tyneside GPs and can refer to other services, prescribe and provide fit notes.

Update – September 2021

North Tyneside CCG, following an evaluation exercise, has extended the Livi pilot contract while it procures a 'Complementary GP Video Consultation Service' for North Tyneside. The timescales for procurement have not yet been finalised given the changes in CCG's and Integrated Care System. Details of the procurement timeline will be published on the website once it has been confirmed. The approach has been supported by the Local Medical Committee (LMC) noting that this needs to happen alongside a wider piece of workforce and transformation work in general practice. Our commitment remains, to work together to ensure that the residents of North Tyneside consistently have timely access to health services seven days a week to meet their health needs. A key part of this is to ensure consistent timely access to see a GP where the majority of initial contacts in the health service happen.

Case 6: Graham (Adult with Cancer)

Name: Graham Corrin
Age: 72

A year ago, Graham started to have difficulty swallowing. His GP wanted to refer him directly for an endoscopy but this with no direct access to this diagnostic test, Graham had to wait to be seen by the hospital consultant first. His OGD showed oesophageal cancer and Graham went to Liverpool for treatment and was assigned a CNS on the island.

When Graham returned from Liverpool, it took time for his treatment plan to come back to the GP. He continued to attend regular appointments at Noble's and had new appointments with physios and dieticians, but felt like this could more joined up and worried that all this means that he has less quality time with his wife.

In the last few weeks, Graham's mobility has decreased and he is worried about relying solely on his wife for more care.

Considerations for future operating model:

1. Direct access to diagnostics from Primary Care
2. Standardised referral pathways
3. Electronic Referrals
4. Advice and guidance for referrals
5. Care coordinators for patients with cancer
6. Involving Primary and Community care in the MDT
7. Supporting carers

Questions to consider:

How would Graham be supported by the health and care system at the moment?

How could we work together to better support Graham?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 6: Graham

Example 1: Standardised referral pathways, Canterbury NZ

Developed from 2008 on, HealthPathways are in essence local agreements on best practice. They are created by bringing together hospital doctors and GPs in order to hammer out what the patient pathway for a particular condition should be. They spell out which treatments can be managed in the community; what tests GPs should carry out before a hospital referral; where and how GPs can access such resources (including referral to other GPs whose practices have particular skills – spirometry, for example, or the removal of skin lesions or the insertion of IUDs – not things that all GPs undertake).

The pathways aim to follow international best practice but where they can't - eg due to lack of resources – that is made explicit.

Referrals go through an ERMS, which means they don't get lost. There is an audit trail. GPs and specialists review referrals, rejecting those that have not followed the pathway but with a reference to it, and to what should be done instead, either to remove the need for referral or to work the patient up. GPs are given feedback on their referral rates compared to others. Rates of rejected referrals have declined over the years.

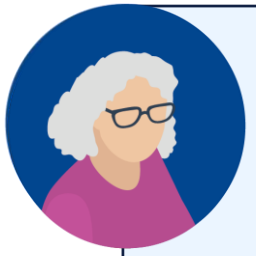
Example 2: Electronic referrals, Ribera Salud Valencia

Similarly, Ribera Salud devise integrated Primary and Secondary Care referral pathways and review them regularly. These referral pathways are embedded in the Electronic Health Record and help to support clinicians through referral process ensuring all guidelines are followed and embedded in day-to-day practice. Primary Care physicians have ready access to specialist advance and guidance to discuss anomalous cases and override the system. Exceptions are monitored and used to inform provider education.

Example 4: Direct access to diagnostics

Evidence from the UK shows that GP Direct Access testing performs as well as, and on some measures better than, consultant triaged testing on measures of disease detection, appropriateness of referrals, interval from referral to testing, and patient and GP satisfaction.

Case 7: Pamela (Older person with frailty and dementia)



Name: Pamela Hughes
Age: 85

Pamela is a retired secretary. Until last year, she lived independently in the house that she shared with her late husband. However, she was knocked over by a car whilst out walking 12 months ago and has been recovering her mobility since. She now walks with a stick, goes to regular physiotherapy and has home help once a week with cleaning and shopping. She has one son who is an accountant in London and comes over every 2-3 months to check on her.

In recent weeks, Pamela has been getting more confused. Her son called the GP to report that she had been found wandering outside her home in recent days and that the cleaner had noticed she had left the gas on.

Pamela has been to the GP surgery 3 times in the last 4 months with dizziness and worsening eyesight. She has had a number of admissions to ED – once when she accidently took too much medication and twice with dizziness and confusion. On her last admission, the geriatrician diagnosed her with Parkinson's Plus.

Considerations for operating model:

1. **Identification** – how could PCAS improve early identification?
2. **Assessment** – how could PCAS ensure holistic assessment of patients?
3. **Routine Management** – how could PCAS ensure frail patients are receiving NICE recommended care for frail patients?
4. **Secondary Prevention** – what could PCAS do to prevent crises eg Advanced Care Planning, Falls prevention service, virtual wards, medication review for poly-pharmacy
5. **Urgent care needs** – how could PCAS better respond to crisis events? GP access to specialist geriatrics advice

Questions to consider:

How could Pamela be supported by the health and care system at the moment?

How could we work together to better support Pamela?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 7: Pamela

Example 1: Bridport Frailty Hub

The Integrated Frailty Service is provided by a specialised nurse team who work closely with GPs and other professionals to improve care for older people living with complex health and domestic care needs:

- Undertakes weekly **care home ward rounds** for all care homes in West Dorset and others "at-risk" in the community
- **Assesses** needs to help people live healthily at home.
- Provides **education** for the individual and their carer about conditions and how to recognise and manage symptoms.
- Helps the individual and their carer identify if **extra services** are needed at home.
- Develops and reviews a **Personalised Care Plan** with the individual, their relatives and carers and health and social care professionals, to prevent admissions.
- **Refers** the individual to any services that may benefit them e.g. Community Matrons, Social Services, Consultant Geriatrician, Voluntary Agencies.
- Provides **specialist advice to GPs** via telephone
- Provides coordinated **rapid response** to patients in crisis
- **Plans** community services for the frail elderly
- **Holistic**, covering all aspects of care including family issues, social issues, equipment issues and lifestyle issues.

Example 2: e-frailty index

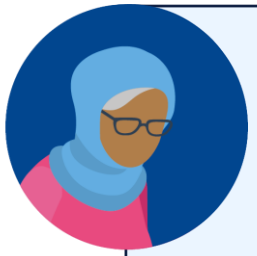
The electronic frailty index (eFI) uses the existing information within the electronic primary health care record to identify populations of people aged 65 and over who may be living with varying degrees of frailty. When applied to a local population it provides opportunity to predict who may be at greatest risk of adverse outcomes in primary care as a result of their underlying vulnerability.

The eFI uses existing electronic health records and a 'cumulative deficit' model to measure frailty on the basis of the accumulation of a range of deficits. These deficits include clinical signs (e.g. tremor), symptoms (e.g. vision problems), diseases, disabilities and abnormal test values.

It is made up of 36 deficits comprising around 2,000 Read codes. The score is strongly predictive of adverse outcomes and has been validated in around 900,000 patient records.

- For patients identified as living with severe frailty (around 3% of over 65s), GPs in the UK are asked to undertake an annual medicines review, a falls risk assessment, if clinically appropriate, and promotion of the enriched Summary Care Record (SCR);
- For patients identified as living with moderate frailty (around 12% of over 65s), consider undertaking a medicines review, a falls risk assessment if clinically appropriate, and promotion of the enriched SCR.

Case 8: Ayesha (Older person in a Nursing Home)



Name: Ayesha Shah
Age: 92

Ayesha is a former teacher with two adult children. She moved into a Nursing Home 2 years ago after she was no longer able to live independently at home.

Preceding her admission, Ayesha had become increasingly unsteady on her feet and has had a number of falls, one of which resulted in a fractured hip. Whilst in hospital, Ayesha was diagnosed with vascular dementia and now struggles to recognise her children when they visit. She is able to walk with a frame but requires a lot of help with activities of daily living.

As well as dementia, Ayesha also has a number of complex medical conditions, including heart failure and high blood pressure. Ayesha and her GP have struggled to find the right balance of medications that doesn't leave her either breathless or dizzy, as the Nursing Home have had to call an ambulance twice in the last 6 months on both accounts.

Considerations for future operating model:

1. Primary Care and Nursing Homes
2. Hospital at Home
3. Models of District Nursing
4. Palliative Care in the Nursing Home

Questions to consider:

How would Ayesha be supported by the health and care system at the moment?

How could we work together to better support Ayesha?

What do we need to make these changes a reality? (For example, using the workforce differently or a technological solution)

Case 8: Ayesha

Example 1: Havering CCG and Health 1000

In 2014, the Health 1000 pilot was established as a 'one-stop-practice' for patients with complex health needs defined as having five or more chronic conditions. A dedicated multi-disciplinary team of NHS health care and voluntary sector professionals were recruited into the practice, The organisation initially focused on supporting the long-term condition cohort, however it was agreed that the provider, Health 1000, could support a new nursing home programme in 2016. As part of this service, a geriatrician is available to support GPs and families, including supporting family members when a patient is approaching the end of life. Also included in the service is:

- Comprehensive medicines reviews.
- A named clinician and key workers as dedicated contacts for each nursing home.
- Support to the nursing homes from 8am to 8pm, seven days a week.
- Support to the nursing homes for providing end-of-life care.
- During ward rounds at the nursing homes, staff are given advice and/or are educated in more appropriate or better care techniques.
- Acute assessments are provided by Health 1000 for nursing home patients with acute presentations and are carried out while still residing in the nursing home. Responses to such assessments may be advice to send the patient to hospital, to arrange a Health 1000 clinical visit or to prescribe appropriate medication.

Example 2: Buurtzorg, Netherlands

In 2007, a small social enterprise in the Netherlands pioneered a hybrid model, providing both health and social care through a unique nurse led model that operates in small teams of up to 12. Deeply embedded in their communities, these nurses liaise regularly with patients' friends, family, GPs, specialists, social care, pharmacists, the police and other community services. Buurtzorg employs a higher proportion of Registered Nurses than other home care services but despite costing more per hour to employ, the service has remained cost neutral, because it has been able to reduce by a third, the number of care hours required per patient.

Buurtzorg now operates over 850 teams across the Netherlands and has exported its model to 24 countries. Some common features of successful implementation are described in a recent report citing a flat management structure, user friendly IT systems, consolidated back-office functions, an online peer network and expert OD coaches as central to its successful roll-out. One of the most important features was what they describe as a "heatshield" to deflect the scrutiny of performance managers in the early stages, when the service is getting into its stride.

Case 8: Ayesha

Example 3: Guys and St Thomas' Hospital at Home

The @home service is nurse-led, but includes dedicated GP and consultant sessions. The overall area served has a socially and culturally diverse population of 610,000 (2015) and over 150 languages are spoken. The service aims to take up to 300 new patients per month and focuses on reducing avoidable hospital admissions and supporting rapid and safe discharge from three London hospitals' accident and emergency (A&E) departments, acute assessment units and acute wards. Referrals are made by in-reach nurses and GPs, as well as community teams and the ambulance service. The scheme provides intensive input, with treatments, interventions and monitoring for a short period during an acute episode of ill health.

The scheme operates 365 days per year from 8 am until 11 pm. Typically patients receive visits up to four times a day during their episode of care, which on average ranges between three and seven days. The patients are assessed within two hours of referral. The most frequently occurring conditions / interventions for which patients are admitted include:

- chronic obstructive pulmonary disease
- heart failure
- IV antibiotics
- complex falls
- hyper/hypotensios
- hyper/hypoglycemia
- hyponatraemia
- palliative care
- deteriorating renal function
- post-operative care
- hyperemisis
- trial without catheter post-surgery

A summary of the staffing is:

- 1 clinical lead/deputy head nursing 8B
- 4 clinical matrons 8A
- 1 practice development matron 8A
- 1 clinical pathway matron 8A
- 10 band 7 nurses (3 of which are hospital in-reach);
- 17 band 6 nurses
- 7 band 5 nurses
- 13 rehabilitation support workers
- 1.5 pharmacists
- 4 GPs
- 8 sessions of consultant geriatrician input
- 1 band 8A physiotherapist (therapy lead), 2 band 7 physiotherapists, 4 band 6 physiotherapists;
- 2 band 6 occupational therapists;
- 2 full time social workers
- 1 business support manager
- 5 admin support staff

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Appendix C: Cost and Dependency Analysis

Cohort 1: Child with a Long Term Condition (1/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 1	**Direct Access to Specialist Advice**	- Consultants provide phone and email advice about referral pathways and management of children in primary care settings	- Effective forums for teams and professionals to discuss patients (e.g. MDT meetings)		- Professional time form specialist rotas	- Electronic Health Record beneficial	- N/A
Tier 2	**Population Health Management and MDT care**	- Identification and risk stratification of children with LTCs. - Children proactively managed in line with protocols - Input across Primary, Secondary and Community services as appropriate	- Delivery of holistic risk assessments (risk stratification) of people's needs (including mental and physical health) - Ability to deliver MDT clinics for key LTC		- Recruitment of Population Health Management team including Data Analyst - Upskilling of Primary Care staff	- Electronic Heath Record beneficial - Remote Consultation Platform beneficial - Improved coding required	- Polyclinic space beneficial
Tier 2	**Care Coordination and planning**	- Patient Navigators / Case Managers assigned to those with complex health and social needs - Liaise with Secondary and Community services to help resolve needs - Advanced Care Planning (eg for exacerbations)	- Effective care co-ordination both within primary care and alongside the wider community care services - Ability to flex treatment and interventions to match personalised care plans		- Recruitment of Care Navigators and Case Managers - Upskilling of Primary Care staff	- Electronic Health Record beneficial - Remote Consultation Platform beneficial	- Polyclinic space beneficial
Tier 3	**Joint Clinics (Primary and Secondary Care)**	- Consultants delivering outpatient clinics jointly with Primary Care staff, enabling transfer of skills into the community and better access to patients	- Effective forums for teams and professionals to discuss patients (e.g. MDT meetings)		- Professional time form specialist rotas	- Electronic Health Record beneficial - Remote Consultation Platform beneficial	- Consulting space

Cohort 1: Child with a Long Term Condition (2/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 4	**Acute Care Community Hub**	- Acute Care community hub taking referrals from Primary Care. Nurse practitioners using standardised treatment protocols to manage a restricted set of acute illnesses in 0-15 year olds.	- Support team-based care by creating 'local teams' across the island; including supporting integration with wider community services to operate as one team - Effective case load management, including ability to manage capacity across general practice (not just at practice level) - this includes systems and operational staff capability.		- Recruitment or training of Nurse Practitioners	- Electronic Health Record beneficial - Remote Consultation Platform beneficial	- Consulting space

110

Cohort 2: Young Person with a Mental Health Problem (1/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 0	**Portal**	- First contact for Mental Health issues - Directory of services - Digital triage and navigation	- An effective mechanism for providing medical advice and information through a number of mediums - Effective triage process in place to direct patients to the right service		- N/A	- Portal site required with directory of services, digital triage capability (digital front door).	- N/A
Tier 1	**Social Prescribing**	- Link workers that can help connect patients with the right Third Sector and Wider Determinants services e.g. Substance misuse	- Effective care co-ordination both within primary care and alongside the wider community care services		- Recruitment and training of social prescribers	- Electronic referrals - Single Electronic Health Record	- Consulting space
Tier 1	**Single Point of Access Mental Health Line (UEIC)**	- Phone number for those in crisis	- An effective mechanism for providing medical advice and information through a number of mediums		- Recruitment and training of clinical staff	- Phoneline - Text service	- Consulting space as part of wider team
Tier 1	**Digital Therapeutics**	- Access to evidence based Mental Health and Wellbeing apps - Some focus on prevention, others are therapeutic (eg CBT, counselling) - Some are costed (Kooth) and some are not (Young Minds)	- An effective mechanism for providing medical advice and information through a number of mediums		- N/A	- Subscription to evidence based apps - Directory of apps	- N/A
Tier 2	**Improving Access to Psychological Therapies (IAPT) for children and young people**	- Counselling service in Primary Care - Can have a combination of Low intensity counsellors, Schools based counsellors and High intensity counsellors	- An effective mechanism for providing medical advice and information through a number of mediums		- Recruitment and training of clinical staff	- Shared Electronic Care Record - Electronic referrals	- Consulting space

Cohort 2: Young Person with a Mental Health Problem (2/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 2	**Specialist advice and guidance in Primary Care**	- Advice and guidance service for Primary Care through phone or email			- Professional session time allocated in rota	- Phoneline - Text / email service	

112

Cohort 3: Adult with a LTC (1/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 0	**LTC detection service (Pharmacy)**	- Pharmacies to provide LTC detection eg HTN, AF	- Ability to deliver screening clinics for appropriate conditions		- Pharmacy Upskilling	- Secure email to contact GP - Access to Single Electronic Care Record	- N/A
Tier 0	**Structured Education Programmes and Secondary Prevention**	- Public Health interventions designed to educate patients, and help them manage their own condition eg DM	- An effective mechanism for providing medical advice and information through a number of mediums		- Recruitment and upskilling of staff to educate patients. - Possible to contract in services.	- Data collection and analysis required for evaluation - Remote consulting platform	- Consulting space
Tier 1	**Digital Therapeutics (LTC prevention and management)**	- Evidence based apps for patients that help prevent or self manage conditions such as COPD, T2DM, CCF	- An effective mechanism for providing medical advice and information through a number of mediums		- N/A	- App Library / Directory - Subscription model for some apps - Interoperability with EHR / PHM software	- N/A
Tier 2	**Population Health Management and MDT Clinics**	- Identification and risk stratification of adults with LTCs. - Patients proactively managed in line with protocols - Input across Primary, Secondary and Community services as appropriate - Joint GP/Specialist clinics	- Delivery of holistic risk assessments (risk stratification) of people's needs (including mental and physical health) - Ability to deliver MDT clinics for key LTC		- Professional time allocation in rota - Protocol adoption - PHM analysts	- PHM infrastructure - Information Governance - Coding	- Consulting space

Cohort 3: Adult with a LTC (2/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 2	**Care Planning and Care Coordination**	- Patient Navigators / Case Managers assigned to those with complex health and social needs - Liaise with Secondary and Community services to help resolve needs - Advanced Care Planning (eg for exacerbations)	- Effective care co-ordination both within primary care and alongside the wider community care services - Ability to flex treatment and interventions to match personalised care plans		- Recruitment and upskilling of staff to these roles	- Single Electronic Health Record to facilitate communication	- N/A
Tier 4	**Primary Care centres of excellence for LTC management (eg DM practice)**	- Hub and Spoke model of specialist Care where one GP practice in an area (eg Primary Care Home) provides more specialist care eg insulin initiation	- A flexibility in the locations in which different types of care/different interventions are delivered		- Upskilling of clinical staff in Primary Care - Clear referral pathways	- Single Electronic Health Record - Electronic referrals	- Consulting space

114

Cohort 4: Adult with complex medical and social needs

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 1	**Social Prescribing**	- Link workers that can help connect patients with the right Third Sector and Wider Determinants services e.g. Substance misuse	- Effective care co-ordination both within primary care and alongside the wider community care services		- Recruitment and training of social prescribers	- Electronic referrals - Single Electronic Health Record	- Consulting space
Tier 2	**Population Health Management and Multi-Disciplinary Team (MDT) care**	- Identification and risk stratification of adults with LTCs. - Patients proactively managed in line with protocols - Input across Primary, Secondary and Community services as appropriate - Joint GP/Specialist clinics	- Delivery of holistic risk assessments (risk stratification) of people's needs (including mental and physical health) - Ability to deliver MDT clinics for key LTC		- Professional time allocation in rota - Protocol adoption - PHM analysts	- PHM infrastructure - Information Governance - Coding	- Consulting space
Tier 2	**Care Planning and Care Coordination**	- Patient Navigators / Case Managers assigned to those with complex health and social needs - Liaise with Secondary and Community services to help resolve needs - Advanced Care Planning (eg for exacerbations)	- Effective care co-ordination both within primary care and alongside the wider community care services - Ability to flex treatment and interventions to match personalised care plans		- Recruitment and upskilling of staff to these roles	- Single Electronic Health Record to facilitate communication	- N/A
Tier 3	**District Nursing Services**	- Integrated Health and Social Care Nursing workforce	- An ability to provide a greater level of intervention and care time to those with complex care conditions		- Recruitment and training District Nursing workforce	- Access to Single Electronic Health Record	-N/A
Tier 4	**Virtual Wards**	- Admission avoidance / Step-down - Stabilising and enhancing reablement part of the pathway through provision of acute healthcare in people's homes	- Ability to work closely with community services to provide medical cover for patients at risk of admission or recently discharged		- Recruitment and training of workforce	- Remote monitoring technology	- N/A

115

Cohort 5: Adult with Acute Minor Ailment

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 0	**Portal**	- First contact for Mental Health issues - Directory of services - Digital triage and navigation	- An effective mechanism for providing medical advice and information through a number of mediums - Effective triage process in place to direct patients to the right service		- N/A	- Portal site required with directory of services, digital triage capability (digital front door).	- N/A
Tier 1	**Digital Assisted Triage**	- Digital front door to services - Assessment of presenting complaint and navigation to correct service, with correct degree of urgency - Software can be used when patients call surgery directly	- Effective triage process in place to direct patients to the right service		- Training and upskilling receptionists	- Digital triage platform	- N/A
Tier 1	**Minor Ailments Service (Pharmacy)**	- Pharmacists prescribe from a formulary using standardised treatment protocols to manage a restricted set of acute illnesses	- Increase capacity in the system (e.g. number of appointments available)		- Pharmacy upskilling (Non-Medical Prescribers)	- Access to Single Electronic Care Record - Secure mail to contact GPs	- N/A
Tier 1	**Remote GP consultation platform**	- Digital platform supplying remote GP consultations via email, phone, video or text - Off-island medical practitioners (eg Livi)	- Increase capacity in the system (e.g. number of appointments available)		- N/A	- Remote GP consultation platform	- N/A
Tier 2	**At Scale Acute General Practice**	- Practices collaborate to provide appointments for on-the day	- Increase capacity in the system (e.g. number of appointments available)		- Reconfiguration of working practices	- Single Electronic Care Record beneficial	- Reconfiguration of estate purpose

116

Cohort 6: Adult with Cancer

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 1	**Social Prescribing**	- Link workers that can help connect patients with the right Third Sector and Wider Determinants services e.g. Support for carers	- Effective care co-ordination both within primary care and alongside the wider community care services		- Recruitment and training of social prescribers	- Electronic referrals - Single Electronic Health Record	- Consulting space
Tier 2	**Care Planning and Care Coordination**	- Patient Navigators / Case Managers assigned to those with complex health and social needs - Liaise with Secondary and Community services to help resolve needs - Advanced Care Planning (eg for exacerbations / palliative care)	- Effective care co-ordination both within primary care and alongside the wider community care services - Ability to flex treatment and interventions to match personalised care plans		- Recruitment and upskilling of staff to these roles	- Single Electronic Health Record to facilitate communication	- N/A

Cohort 7: Adult with Frailty and Dementia

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 1	**Social Prescribing**	- Link workers that can help connect patients with the right Third Sector and Wider Determinants services e.g. Support for carers	- Effective care co-ordination both within primary care and alongside the wider community care services		- Recruitment and training of social prescribers	- Electronic referrals - Single Electronic Health Record	- Consulting space
Tier 2	**Population Health Management and Multi-Disciplinary Team (MDT) care**	- Identification and risk stratification of adults with LTCs. - Patients proactively managed in line with protocols - Input across Primary, Secondary and Community services as appropriate - Joint GP/Specialist clinics	- Delivery of holistic risk assessments (risk stratification) of people's needs (including mental and physical health) - Ability to deliver MDT clinics for key LTC		- Professional time allocation in rota - Protocol adoption - PHM analysts	- PHM infrastructure - Information Governance - Coding	- Consulting space
Tier 2	**Care Planning and Care Coordination**	- Patient Navigators / Case Managers assigned to those with complex health and social needs - Liaise with Secondary and Community services to help resolve needs - Advanced Care Planning (eg for exacerbations)	- Effective care co-ordination both within primary care and alongside the wider community care services - Ability to flex treatment and interventions to match personalised care plans		- Recruitment and upskilling of staff to these roles	- Single Electronic Health Record to facilitate communication	- N/A
Tier 3	**Intermediate Care Team**	- Admission avoidance / Step-down - Stabilising and enhancing reablement part of the pathway through provision of acute healthcare in people's homes	- Ability to work closely with community services to provide medical cover for patients at risk of admission or recently discharged		- Recruitment and training of workforce	- Remote monitoring technology	- N/A
Tier 4	**Virtual Wards**	- Admission avoidance / Step-down - Stabilising and enhancing reablement part of the pathway through provision of acute healthcare in people's homes	- Ability to work closely with community services to provide medical cover for patients at risk of admission or recently discharged		- Recruitment and training of workforce	- Remote monitoring technology	- N/A

118

Cohort 8: Adult in a Nursing Home

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates
Tier 1	**Social Prescribing**	- Link workers that can help connect patients with the right Third Sector and Wider Determinants services e.g. Support for carers	- Effective care co-ordination both within primary care and alongside the wider community care services		- Recruitment and training of social prescribers	- Electronic referrals - Single Electronic Health Record	- Consulting space
Tier 2	**Population Health Management and Multi-Disciplinary Team (MDT) care**	- Identification and risk stratification of adults with LTCs. - Patients proactively managed in line with protocols - Input across Primary, Secondary and Community services as appropriate - Joint GP/Specialist clinics	- Delivery of holistic risk assessments (risk stratification) of people's needs (including mental and physical health) - Ability to deliver MDT clinics for key LTC		- Professional time allocation in rota - Protocol adoption - PHM analysts	- PHM infrastructure - Information Governance - Coding	- Consulting space
Tier 3	**District Nursing Services**	- Integrated Health and Social Care Nursing workforce	- An ability to provide a greater level of intervention and care time to those with complex care conditions		- Recruitment and training District Nursing workforce	- Access to Single Electronic Health Record	-N/A
Tier 4	**Virtual Wards**	- Admission avoidance / Step-down - Stabilising and enhancing reablement part of the pathway through provision of acute healthcare in people's homes	- Ability to work closely with community services to provide medical cover for patients at risk of admission or recently discharged		- Recruitment and training of workforce	- Remote monitoring technology	- N/A
Tier 4	**Nursing Home Pilot**	- Nursing Home Clinical Support Services - Advanced Care Planning - Use of NEWS2 escalation tool - Nurse prescriber access (UEIC)	- An ability to provide a greater level of intervention and care time to those with complex care conditions		- Nurse Prescriber training - Nursing Home staff training	- Use of NEWS2 Escalation tool	- N/A

119

Pharmacy Services (1/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates / Facilities / Policies
Tier 0	**Hypertension and AF Identification Service**	- Opportunistic identification of HTN and AF in the community - Can be promoted as part of Public Health initiative	- Ability to deliver screening clinics for appropriate conditions		- Upskilling of pharmacy staff	- Secure mail address to communicate findings with GP - Access to Summary Care Record	- Equipment - Service Spec and SOP
Tier 0	**NHS Health Checks**	- Opportunistic provision of agreed NHS Health Checks	- Ability to deliver screening clinics for appropriate conditions		- Training of Pharmacy staff	- Secure email required to communicate with GP - Access to Summary Care Record	- Equipment - SOP and Service Spec
Tier 1	**Emergency Supply Service**	- Ability for pharmacist to supply 30 days of medication from a repeat script whilst awaiting authorisation from GP - Requires change in legislation (currently 5 days allowed)	- Ability to provide treatments and interventions across settings		- N/A	- Secure email required to communicate with GP - Access to Summary Care Record	- N/A

120

Pharmacy Services (2/2)

Tier	Initiative	Description	SJM Operating Model Requirement	Cost	Workforce	Technology / D&A	Estates / Facilities / Policies
Tier 1	**Non-Medical Prescribers (Pharmacy First Plus)**	- Provision of NMPs across the island (not in all pharmacy but some per PCH for parity of access) - Expansion of Minor Ailments Service to enable pharmacists to prescribe for a defined list of conditions - Work within restricted formulary when a GP appointment is not required	- A flexibility in the locations in which different types of care/different interventions are delivered - Increase capacity in the system (e.g. number of appointments available)		- Recruitment and training of Non-Medical Prescribers - Expansion of existing on-island training scheme with 4 places guaranteed for the scheme	- Access to Summary Care Record - Referral and booking system from GP to Pharmacy (eg EPIC pilot Brighton)	- N/A
Tier 1	**Injectables**	- Expansion of existing injectables service to include Depo Provera, Covid vaccines and others.	- Ability to provide treatments and interventions across settings - A flexibility in the locations in which different types of care/different interventions are delivered		- Ongoing training need to keep competencies up	- Access to Summary Care Record - Secure email to communicate with GP and vaccination central bookings service	- Cold Chain Facilities - Standardised Referral Pathway
Tier 1	**Night Pharmacy**	- Ability to provide services Out Of Hours taking pressure off MEDS	- A flexibility in the locations in which different types of care/different interventions are delivered		- Expansion in workforce to staff extended hours	- N/A	- Extension of opening hours
Tier 2	**Discharge Medication Reviews**	- Pharmacists to receive and review discharge paperwork from Nobles to align their Patient Medication Record (PMR) in the pharmacy and reduce errors	- Ability to provide treatments and interventions across settings - A flexibility in the locations in which different types of care/different interventions are delivered		- Training evening,	- Secure email addresses for pharmacy staff - Access to Summary Care Record	- Service spec and SOP

Dentistry services

Tier	Initiative	Description	SJM Operating Model requirement	Cost	Workforce	Technology / D&A	Estates / Facilities / Policies
Tier 0	**Universal Dental Services**	- Promotion of oral health - Wellbeing - Self Care	- Increase capacity in the system (e.g. number of appointments available)		- Review of payment schedule	- N/A	- N/A
Tier 1	**Universal Dental Services**	- Diagnosis - Treatment planning - Maintenance Dental Care - Emergency Dental Care	- Increase capacity in the system (e.g. number of appointments available)		- Review of payment schedule	- N/A	- N/A
Tier 2	**Enhanced Dental Services**	- Tooth extraction - Permanent fillings - Cyst removal - Orthodontic treatments and appliances	- Increase capacity in the system (e.g. number of appointments available)		- Review of payment schedule	- N/A	- N/A
Tier 3	**Specialist Dental Services**	- Root canal therapy - Complex periodontal services	- Increase capacity in the system (e.g. number of appointments available)		- Review of payment schedule	- N/A	- N/A
Tier 4	**In-Patient and Consultant Out-Patient Services**	- Oral Surgery Procedures - Complex Orthodontics - Oral Surgery procedures - Maxillo-Facial and complex restorations.	- N/A (describes in hospital services)	- N/A	N/A (describes in hospital services)	N/A (describes in hospital services)	N/A (describes in hospital services)

Optometry services

Tier	Initiative	SJM Operating Model requirement	Cost	Workforce	Technology / D&A	Estates / Facilities / Policies
Tier 1	**Sight Test**	- N/A		- N/A	- N/A	- N/A
Tier 1	**Minor Eye Conditions (MECS)**	- Increase capacity in the system (e.g. number of appointments available)		- N/A	- Secure email to communicate with GP desirable	- Equipment audit required
Tier 2	**Glaucoma monitoring**	- As above		- Skills audit required - Certification of staff	- As above	- As above
Tier 2	**Contact lens provision**	- As above		- Skills audit required - Certification of staff	- As above	- As above
Tier 2	**Pre-and post-cataract services,**	- As above		- Skills audit required - Certification of staff	- As above	- As above
Tier 2	**Diabetic retinopathy service**	- As above		- Workforce upskilling	- Access to platform registering results	- Premises as being conducted centrally on island
Tier 3	**Community-based support and services for people with sight loss**	- As above		- Skills audit required - Certification of staff	- Secure email to communicate with GP desirable	- Equipment audit required
Tier 3	**Provision of Eye Care Liaison Officer,**	- As above		- Recruitment to position	- As above	- As above
Tier 3	**Low vision service and Rehabilitation service**	- As above		- Skills audit required - Certification of staff	- As above	- As above

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Appendix D: User Journeys

Ageing Well - How care can be delivered for Clara

Clara

Age: 85

Job title: Retired bookkeeper

Clara has remained relatively independent despite the death of her husband 3 years ago, however she has had a number of falls in the last 5 years, and also been treated for multiple UTIs. She has fallen repeatedly at home, but wishes to remain independent. Her family would like to see her better supported.

Clara has just received acute care following a fall in her home. The **Intermediate Care Response Team** initiative has allowed Clara to return home rapidly. The **GP and Care Coordinator,** using their risk stratification tool, identify Clara as high risk and that she will require remote monitoring.

The **Care Coordinator** and social care work with Clara and her family to evaluate her home environment and develop a comprehensive care package through a **trusted assessment** between health and social care.

With some small modifications and the installation of **monitoring devices**, everyone is satisfied Clara can continue to live at home safely.

If Clara unfortunately does fall, a rapid response MDT with her Care Coordinator and social care is alerted and are able to access Clara's health data through shared care records.

Clara can be referred to a community-based clinic with enhanced **Community Frailty MDT** who understand her history, access to **community diagnostics**, and with **specialist outreach** into the community team.

If required she can be admitted to a **virtual ward**

Clara is able to attend her local community centre to meet her friends with support from the voluntary sector as part of her **well being plan**.

She is also able to attend the **community frailty clinic** at the community hub and has been offered **virtual appointments** so she does not have to rely on others

By utilising a wide range of digital monitoring devices and software, Clara and her family can be assured that she is safe and well at all times. In the event of an emergency or fall, the staff at the **Wellbeing Partnerhip** can act immediately with the appropriate course of action 24 hours a day, with full **shared access to her care record**.

Long Term Conditions – How care can be delivered for Marvin

Marvin

Age: 52

Job title: Warehouse Night Manager

Marvin is a night shift worker in a warehouse, who values the time outside of work he can spend with his family. He has poorly managed Type 2 diabetes and has been recently been diagnosed with COPD. He has a poor diet and is distrusting of health professionals so avoids visiting his GP.

The Care co-ordinator has identified Marvin as high risk through **risk stratification** with his GP. They co-develop a **Care plan** that suits his work patterns to **self-monitor** his diabetes and control its impact.

Marvin speaks to his employer about his Care Plan and how they can work together to ensure his health is prioritised and maintained. Marvin is able to access the **Wellbeing Partnership** out of hours to suit his shifts.

Marvin is provided with **diabetics group support sessions** and 1:1 virtual support from his GP to help make changes in his life sustainable

Marvin has **remote monitoring for his vitals** and access to his **diabetic nurse in primary care** through **virtual appointments**. The nurse can access **specialist input** in the GP practice if required.

In the event of an acute COPD episode, Marvin can be seen by a **respiratory nurse specialist** in his local **Community assessment and treatment** unit in an ambulatory care setting and if required admitted to a **virtual ward.**

Marvin is provided with **advice and guidance** on self care and monitoring so he can **initiate a virtual follow up** if required.

Marvin is able to better control his diabetes through self monitoring and diet. This has enabled him to stay well and out of the hospital. He is able to access a **local gym** out of hours and is able to lead an active lifestyle.

Long Term Conditions – How care can be delivered for Maria

Maria

Age: 11

School student

Maria is a quiet, anxious child and has just started secondary school. Over the course of the year Maria has become an unhealthy weight. Maria doesn't do any exercise out of school as she feels embarrassed in-front of other children and is worried what they might say.

Maria lives with her Mother who works full-time and is often exhausted when she returns home from work, so tends to buy ready meals for them to eat together.

Maria's mother is worried about her daughter who has gained a significant amount of weight and it has been a challenge to address this. There is a history of heart disease, early onset diabetes and obesity in the family which is a cause of concern. Maria's mother describes how she is finding it hard to balance looking after Maria with her full time work.

The GP recognises that Maria is at an unhealthy weight and that she and her mother require greater community and social support and raises it within the **community MDT**.

The **MDT** highlights the risk of obesity on Maria's physical and mental health, and developing long term conditions into adulthood such as diabetes.

The **GP**, with the **local family support** and **voluntary and community sector group**, agree a **personalised family care plan** with Maria's mother with the offer of care support for when she is busy with work which can be booked via the **health and wellbeing app**.

Matt from the **family support group** at the **Children's Centre** is able to arrange for Maria and her mother to join a **5 week cookery course** run by **local community and voluntary services**. This helps to get Maria involved in cooking and learn about the benefits of a healthy lifestyle. Maria's mother also gets to meet other parents in an environment that makes her feel supported.

Meal plans and recipe ideas can be accessed on an app on Maria's phone and Maria's mother is able to **chat directly to the community team 24/7** to discuss any issues.

Maria is also able to attend **local breakfast and after school clubs** when her mother has work commitments. Here she receives healthy food and is encouraged to take part in activities with other children. Maria really enjoys playing football after playing with one of her friends at the after school club.

Maria's mother is **able to access local football clubs** from the **health and wellbeing app** and encourages Maria to join one.

Maria and her mother enjoy cooking together at home and trying new recipes. Maria has also made lots of new friends playing football at the **after school club**. Her grades are improving at school and she has **much increased confidence**.

Mental Health – How care can be delivered for Peter

Peter

Age: 53

Job title: Retired carpenter

Peter was diagnosed with dementia 4 years ago and his condition has steadily deteriorated. His family have been able to support him to date, however he has frequently visited A&E over the past year and has started becoming more violent. His wife feels she is unable to easily access the local care that her husband needs.

Following another attendance at A&E caused by a violent episode, the consultant flags Peter and his wife as requiring greater **community and social support** and refers them to **Care co-ordination**.

The **Care Coordinator** sets up the **MDT** including **specialist input** and the **social worker** highlights the risk of further deterioration of Peter's dementia and the impact on those around him, while his **GP** flags that Peter's wife is suffering from mobility issues which limit her ability to care for him.

They agree a **Care Plan** together, to be led by her GP and supported by the local family support VCS group. The acute service is also able to access this plan.

The Care coordinator refers Peter's wife to a **local charity,** allowing her a safe space to speak openly about Peter's condition and **respite care** should it be required.

They also find a local boules **social club** that Peter and his wife are able to join and have made new friends together.
Peter and his wife are provided with regular **reminders for his medication** and access to the **crisis team** via her phone.

Peter's records are shared amongst all the providers involved in his care and the ambulance service, should there be an emergency, ensuring his EoL plan is followed and he remains at home where possible.

In the event of another violent episode, a **24/7 community crisis team** is able to respond immediately following a call from Peter's wife, where they can escalate to the **acute for specialist services** if required.