Proposals that can be achieved in the short term
1. Review operational hours for core services including, but not restricted to, District Nursing Service, Home Care, Community Adult Therapies Service and Social Work. Currently District Nurses work 8:30 to 17:00 seven days a week, Home Care work from approximately 7:00 to approximately 21:00 seven days a week, Therapies work 9:00 to 17:00 Monday to Friday, and Social Workers work 9:00 to 17:30 Monday to Friday, with an out of hours service covering hours outside of that period. District Nurses and Home Care have a reduced capacity at the weekends. Both staff and the public have suggested it would be beneficial, and make access to services easier, if core hours were extended. The suggested outcome is that a rota is introduced to cover early evening visits and that operational hours for some services should more closely, but not completely, mirror that of Home Care so that, for example, where people require evening medication it can be covered, to cover palliative care, there is an opportunity to do visits when informal carers are present, and that there is no strict demarcation between service availability and lack of availability.
2. Tailor directories of services and adapt it to reflect services available in the West. The Project Team has found that there are lots of services, both statutory and third sector, plus community activities in the West but awareness of them is very low. The proposal is to put together a directory that is themed (including health care services, well being, social and leisure activities, mental health and so on) rather than alphabetical, uses a loose leaf format that can be readily updated and be available online. The physical copy would be available in multiple venues such as local pharmacy, town hall, team offices and anywhere that people access services. At least once a year it would be updated to ensure accuracy.
3. Streamline referral process to improve it and enable self referral to services where appropriate. Separate, but closely linked to a single assessment, feedback has demonstrated a frustration with referral processes as being time consuming and restrictive, often only accessible via other professionals or service providers. One such service is the Older Peoples Day Service which requires a Social Work referral followed by a day service assessment by the provider. This represents a duplication of effort by services and a delay in accessing services to the potential client. Therefore, the Project Team propose to map referral processes to a wide range of services and subject them to a lean analysis with a view to eliminating any unnecessary steps. This may result in enabling self referral to some services.
4. Establish a single point of access to the integrated care team including a 'front desk' and single phone number for the West to access all health and social care services, including contracted or grant aided services. Currently the Adult Services Access Team provide this facility for adult social care across the Island. The proposal is to establish an access facility for all adult health and social care services in the West, locality based, and accessible both by phone, and in person.

5. **Foster and support intergenerational work.** Intergenerational work is a simple concept, bringing young and old people together to participate in social activities or mentoring schemes, that has been demonstrated to have a significant impact on well being and bring benefit to young and old alike. It can help de-stigmatise the process of ageing and increase the life experiences of young people, and address social isolation. It will also foster future volunteering and vocational career choices. As a by product it can also raise awareness of health and social care vocations. The third sector have, and are, leading in this. Live at Home are running one currently in the West in conjunction with Queen Elizabeth II High School. The Belfast Care Trust ran a scheme in their Dementia Care Supported Housing Schemes with great success. The Project Team propose to promote this and encourage other schools to get involved, and support third sector organisations to expand the process.
6. **Ensure all practitioners are aware of the costs, and availability, of respite care** (short term care) in the West. During consultation and engagement it became apparent that some people were not aware that there is a cost associated with respite care and they experienced a shock upon receipt of an invoice, and that some professions were not aware that the facility existed. All details will be included in the proposed directory of services.
7. **Recruit additional Dementia Home Support Workers** to provide service cover in the West. The Dementia Home Support service has proved very popular and effective in maintaining people in their own home but so far the service is only provided in the East of the Island. Posts already exist to extend cover but recruitment has proved difficult, particularly since the introduction of Public Service new terms and conditions. There is a separate workstream on the harmonisation of terms and conditions.
8. **Continue to develop Older Peoples Mental Health Services, including the Memory Clinic, and group work currently provided in Douglas, and associated contracted services are delivered in the West.** Currently service users from the West usually are required to travel to Douglas to receive services. This is particularly difficult for carers supporting people with dementia and the person with dementia. While there may not be sufficient demand to base resources permanently in the West it should be possible to run clinics, group activities, and support groups in the West on a regular basis.
9. **Undertake regular audits and review of service delivery** and **extend the remit of the Review Officer role.** During consultation there was a perception, mainly from the public, that service users retain services, and equipment, when the need for them has passed. The Reviewing Officer role was introduced to ensure regular reviews are undertaken to ensure that services provided are still meeting the needs of the service user, including recognising when that need has diminished. The remit of the team has, so far, been contained to reviewing Home Care and, while it was available, services provided under the Cleaning Contract. The proposal is that the Reviewing Officer should extend the reviewing role to all Department funded care and support, and possibly care funded through the benefits system, to assess whether support is still needed, sufficient or appropriate. With regard to equipment it is accepted that they will not be the appropriate agency to assess that but they if they think it is no longer appropriate or insufficient they can raise an alert with the appropriate agency. To effectively monitor equipment an effective registration and tracking system would be need to be introduced.
10. **Enable EMIS and RiO users to access each other's record systems.** Currently the Department operates a variety of recording systems but the main systems are EMIS used by Community Nursing and RiO used by Social Care, Mental Health and Community Adult Therapy Service. Access is restricted to these user groups, however it is proposed to offer access to other external agencies. As a short term measure to improve communication and avoid duplication where possible it is the intention to open access to both systems to all members of the integrated care team. Members will still record in their primary system but at least the other will be available to read by all team members. This will require an updated data sharing agreement and the drafting of new role templates for RiO and EMIS.
11. **Supply all staff with appropriate mobile technology.** Access to mobile technology can prevent the need for practitioners to keep returning to an office base, enable contemporaneous record keeping, be used as a control method to manage risk for lone working, and enable service

users to more fully participate, and be partners, in their support and support planning.
12. Implement daily integrated care team meetings to discuss shared caseload. From research, and seeing an integrated care team in action, this is the single most important change that will drive forward integrated care. Regular meetings can be short and focussed. They build up trust and team identity, and enable shared decision making and risk sharing. As the process develops it can incorporate the hospital and Accident and Emergency Department to speed up hospital discharge or prevent admission. This proposal also addresses themes around staff culture and communication.
13. Liaise with hospital services with regard to outpatient appointments to ensure they meet the needs of people using the services and look at the possibility of clinics being held in locality. A strong theme running through feedback during consultation was the scheduling of outpatient appointments that made it very difficult to get to hospital in time, or the difficulty in getting to hospital at all. Some of the issues were around practical things like appointments scheduled in the morning where the person using a service is required to leave home before the time a Home Care visit is scheduled to support them to get up. Alternatively, having to stay in the hospital while waiting for the bus back to the West. Many people expressed the view that it would feel more comfortable if they could be seen in the local area. The proposal is to put a system in place whereby the staff making outpatient appointments are aware of any issues that may restrict someone's ability to attend and encouraging the holding of clinics in the West on a regular basis.
14. Incorporate a focus on an enabling approach in all job descriptions. During the research phase, and looking at other organisations, it has become apparent that there is reason to significantly change job descriptions or roles. The only change the Project Team is suggesting is that all job descriptions incorporate the adoption of an enabling approach which will promote ageing well, empowerment and a focus on achieving, or maintaining, independence. This process has already been started for Older Peoples Services social care job descriptions for staff working in the community and residential settings.
15. Implement a shadowing scheme for members of the integrated care team. By shadowing different practitioners members of the team will gain a greater insight into the roles and challenges faced by other team members, which in turn will improve the appropriateness of internal referrals within the team and lead to less duplication of effort and more co-ordination. It will also help to build trust within the team.
16. Co-location of a core group of practitioners including representatives of the third sector. It is proposed that a core group is brought together to form the nucleus of a team, based in the same building or in close proximity. As the team develops other practitioners may be able to join the group. Co-location is not integrated care, but it can underpin integrated working. In the first instance there would be significant benefit in bringing together the Access facility/officer (as proposed above), District Nursing, Social Work, and Home Care, with a view to adding, at a later date, a Long Term Conditions Nurse, Community Pharmacist role (as described below) and a third sector representative (related to wellbeing/self care proposal outlined below).
17. Create a data sharing agreement between all service areas participating in the integrated care team including third sector providers. This will facilitate the sharing of all data while remaining within the General Data Protection Regulations.
18. Create a common consent form for people accessing services to share data. Currently, each service provider requires a service user to sign a consent form when accessing a service. This means, based on data collected by the Project Team, that a service user could end up going through a consent form and signing up to six times. The common consent form will cover all services provided by the integrated care team, statutory and third sector, covered by the data sharing agreement proposed above.

Proposals that can be achieved in the long term
19. Support recommendations from the Urgent Care Review 2016. Both staff and the public have raised the desire to have 24 hour access to services. However, neither capacity nor demand would make this a cost effective measure to implement, especially in individual localities. However, there are a range of services available out of hours, including services operated by other Departments, that offer 24 hour accessibility such as Police Service, Ambulance, Accident and Emergency Department, Manx Emergency Doctors Service, Crisis Response and Home Treatment Team and Out of Hours Social Work service. In 2016 a report was produced called "Transforming Urgent Care in the Isle of Man" (see appendix x) following research into the Isle of Wight experience of implementing an integrated, multi-disciplinary and agency, control room service for the Island. The Project Team believes implementing the recommendations of this report would address the aspiration for easier 24 hour access to services.
20. Introduce a Local Area Co-ordinator role. Local Area Co-ordination is an approach to building community resilience that focus on local relationships and assistance rather than accessing statutory services (see appendix xi for more detail). It is a strengths based approach focussing on assets rather than needs. The Project Team propose to bring forward a business case to implement this role with funding from the Department and other contributions from other agencies. While this role would liaise with the integrated care team it would not form part of the team. This proposal also addresses issues relating to resource issues, adopting a person centred approach, and staff culture and communication.
21. Develop, or extend, the role of Community pharmacist and introduction of a pharmacy technician role. Medication is a key element in managing health but it can have detrimental side effects, and there are issues with complex poly pharmacy where medications interact with each other causing a negative impact. Many people remain on medications, or use outdated ones, long after their therapeutic benefit is passed. There are two elements to an enhanced community pharmacist role, one is to be available to offer advice to people and avoid unnecessary General Practitioner appointments, one is to review medications for people. It should also be a resource for General Practitioners with regard to medication advice.
22. Implement effective person centred training for staff. Consultation suggests that some people have come away from trying to access services feeling like they are asking for a favour, or disrespected. This should never be the case. Older Peoples Services residential providers have undertaken person centred training called Eden Alternatives. This training will be adapted to a local version for community team members, focusses on attitude and communication, and comes with a registration scheme that encourages reflection on performance. The Project Team recommend using this training with the integrated care team, including making it available to third sector providers. This proposal also addresses issues around person centred care and staff culture and communication.
23. Set up a 'pop up' – 'drop in' shop. During consultation several people said they felt the voice of the community was not heard and the theme running through much of the feedback is that attention needs to be given to building community resilience. While visiting Torbay and South Devon NHS Foundation Trust the Project Team came across a pop up shop set up by one a third sector organisation that brought in other third sector and community organisations to share the space. As well as selling products it ran activities, both in the shop and in the broader community (it was publicising a music festival at the time), and succeeded in getting people to engage. It directly addressed issues of social isolation in a positive, 'non service' orientated way. It would provide an excellent resource for a Local Area Co-ordinator. The proposal is not that the Department set up such a venue but that it encourages, supports and does everything it can to foster its development. It will also address

resource issues, especially around releasing capacity in statutory services.
24. Further develop a co-ordinated volunteer recruitment service. Nearly all third sector organisations have expressed concerns around their ability to attract and retain volunteers. Volunteers are an essential element of building community resilience, addressing social isolation, and preventing people accessing statutory services when that might not represent the optimum outcome desired. At the moment, as in staff recruitment for the Department, third sector organisations are more often than not in competition to recruit volunteers. The Project Team propose that the third sector are encouraged and supported to form an alliance around the recruitment of volunteers, directing potential volunteers, based on their interests and identified skills, to the most appropriate third sector organisation.
25. Make addressing social isolation everyone's business. The most commonly reported issue raised by staff, service users and the public has been social isolation. Social isolation leads to poor health outcomes, increased contacts with primary, mental and acute health care services, as well as social care. It can lead to admission into long term residential facilities. There is no single measure, alone, that the Project Team can propose to address social isolation but several measures such as introduction of a Local Area Co-ordinator role, 'pop up – drop in' facility, the directory of services, intergenerational work and volunteering will go some way to addressing it. This will build upon the work already being done by the third sector. In addition, as part of the commitment to put enabling as a focus in job descriptions it will be coupled with addressing social isolation and it will be top of the agenda in the review of day service provision.
26. Extend the remit of the Shared Lives scheme. The public, in particular, and staff have suggested that a more flexible approach to the provision of respite care is available that is not based in residential care settings. While Crossroads Caring for Carers and day services provide some options the Shared Lives scheme being developed by Learning Disability Services may provide an opportunity. The Project Team propose that following a successful launch of the scheme it is monitored with a view to extending it to provide support for other groups.
27. Review business support services requirements, including administrative support. It is the perception that practitioners are spending significant amounts of time undertaking business support or administrative tasks that could be better utilised providing direct support with clients. The Project Team propose that an Administrative Officer is placed in the integrated care team in the first instance with a remit to identify administrative tasks that are required and undertake a lean analysis to see how they are best achieved and what, if any, administrative or business support is required on an ongoing basis.
28. Work with Community Stores and the Housing Division to improve access to aids and adaptations. The supply of aids, including what on the face of are very minor pieces such as raised toilet seats, can have a significant impact on a person's ability to maintain independence in their own home. In addition, building adaptations can prevent someone from requiring residential care. It is accepted that some adaptations can be very expensive and a cost benefit analysis for some adaptations may produce borderline results with regard to value for money. The Project Team propose working with Community Stores to open access to their equipment by increasing the number of people with the Trusted Assessors status who have undergone the prescriber training and support the implementing of an equipment registration and tracking system. In addition, as part of the process of holding well being events in the local area some items could be taken to events to demonstrate to people. With regard to adaptations the Project Team will engage with the Housing Division to look at how the process of application could be streamlined, within a means tested framework, and incorporating an element of cost benefit analysis to contrast the cost of an adaptation against the potential cost of long term care. The latter is a much longer term objective.
29. Develop an assistive technology strategy and implementation plan. Assistive technology can enable people to maintain their independence, improve service user safety, and remove dependence from statutory services. In addition, individual items of assistive technology are not expensive but can provide great piece of mind. Devices readily available include pendant and falls alarms, medication dispensers, key safes, gas monitors and tracking devices. This was a workstream carried forward from the Home Care Recommendations Implementation Group

and there was a previous Departmental working group looking at this. Assistive technology also has links with tele health and tele medicine.

30. Develop options for intermediate care. The Department operates a very successful home based Reablement Service but staff have identified a need for an intermediate bed based step up step down facility for people who are either medically fit for discharge from hospital but not quite ready to maintain independence at home, or for those at home but experiencing some difficulty but for who going to hospital would not provide the optimum outcome. It is often the case that such people are offered a residential respite care stay but this often results in deskilling the individual and creating dependency. A step up step down facility would focus on maintaining independence and rehabilitation. The Project Team consider there are two options to address this need:

A– Enter into a partnership arrangement with a care home provider in the West. The main support and rehabilitation process would be led by the integrated care team in concert with the General Practice or the proposed Community Geriatric Service. The care home would provide night time cover and peace of mind during the day, plus some hotel services if they are not part of the rehabilitation programme. We would start the process with two beds but monitor demand carefully to assess future required capacity.

Or

B – Utilise Ramsey District Cottage Hospital to provide the service.

Preferred Option – *The Project Team, while recognising that more development work would be required, recommend that option A, entering into a partnership arrangement with a care home provider in the West, to provide intermediate care best meets the need of the community in the West and the aims of integrated care.*

31. Support the Department of Infrastructure to set up a 'dial a ride' service. Transport has been a recurrent theme during the consultation response. While the Isle of Man has a very good public transport service there are still issues of accessibility and flexibility, particularly for older people. The Project Team support the proposed introduction of a 'dial a ride service' and will offer any assistance requested by the Department of Infrastructure, including inclusion in the proposed directory of services

32. Consider a pooled budget for all community services based on locality. In the United Kingdom Community Care and NHS Act (1991) there was a facility under Section 28 for health services and local authorities to pool their budgets which had the effect of delivering the opportunity to fund services in a flexible and person centred way. In the Isle of Man the setting up of a locality based budget may function to ring fence money to the locality and facilitate more creative use of funding. However, it would then create a need for a locality based budget holder and with the creation of a Community Care Directorate services are now all sharing a common bottom line. This is possibly a concept to consider when integrated care has cascaded to all localities.

33. Develop an integrated care record. The Project Team are represented on the Digital Strategy Group, which is a cross Department group looking at developing a single record, or the architecture to make disparate systems communicate with each other. The Project Team's role will be to ensure that any record system is appropriate to support community care, including functionality on mobile devices.

34. Develop a Single Assessment Process. During consultation staff, service and the public expressed frustration with the number of times they have to tell the same story repeatedly, while staff are frustrated at duplicating work that other practitioners have already collected. This results in dissatisfaction for all participants in the process and is very time consuming. The Project Team propose the development of a Single Assessment Process where all relevant core data is collected on first contact, that avoids use of jargon, and focusses on the service users desired outcome from contact with services, rather than being service led.

35. Introduce a care co-ordinator role. The complexity of service provision was raised in consultation both by service users and staff. Even

practitioners with many years experience find it difficult to navigate the care and support system if something happens in their personal life leading them, or a family member, to need such services. Therefore, for people without this experience it must be doubly difficult, especially if they have complex needs. The Project Team propose the establishment of a care co-ordinator role, a person who is identified as the first point of call for a service user to help them navigate through the system. The Project Team consider there are two options to address this need:

A – Create a new role, or team, to support people with complex needs to navigate the care and support system. The role, or team, would be based within the integrated care team and would function as a first point of call, for service users already receiving services, to support them to access different services as need fluctuates.

Or

B – Introduce a community keyworker role and allocate keyworking responsibility to the practitioner who is addressing the primary support need. Service users with complex needs, or accessing multiple services, will generally have a primary support need. The proposal is that the practitioner addressing the primary care need becomes the allocated community keyworker responsible for co-ordinating all services received, and is the first point of contact for the service user to provide advice, or support, and assist them to manage their way through the care system. For example, if the service user required a hospital admission the keyworker would be the person the hospital liaise with, would be the integrated care team point of contact for the hospital, and would ensure services are notified and in place for their discharge. If the primary need of the service user changes the keyworker would be responsible for handing over all relevant information to a new keyworker, and introducing the new keyworker to the person. The keyworker could be drawn from any member of the integrated care team, including the third sector. For example if the primary need is around personal care and independence it would be a member of the Home Care Team who take this role on, if it around a chronic illness it may well be the Long Term Condition Nurse, if the need is around social issues or isolation it would be a social worker, or possibly a day service team member, and so on.

Preferred Option – *The Project Team recommend that option B, introducing a community keyworker role best meets the objective of achieving a more co-ordinated delivery of service and ensuring continuity of care and support provision. It meets the criteria for achieving successful integrated care for those with complex needs or receiving services from multiple agencies.*

36. Remove the practice of closing cases (or develop a team, or dormant, caseload process). During consultation one issue raised was the frustration felt when someone has accessed a service, received an input, but at a later time require a further service and they are back to the start of the process to gain access to services. This results in duplication of effort by practitioners, lack of continuity of care for the service user, and delay in accessing services. For example, a person can be open to the Older Peoples Community Social Work Team, be admitted to hospital, then on discharge transferred to the Older Peoples Hospital Social Team, and then following a period of time require some support requiring going through the Adult Services Access Team and then allocated a Social Worker from the Older Persons Community Social Work Team. This is far from a lean process for the organisation, and frustrating for the potential service user. A similar scenario exists for other services. The Project Team propose that either practitioners keep cases open so that if need re-arises the original practitioners involved can pick up the case without having to undertake the preliminary processes involved in accessing the service, or the creation of a new definition of a case that is pending, or dormant, or on a team caseload, but may become live at a future date. A criteria could be adopted based on risk, or complexity, so that cases that are clearly resolved are closed. The community practitioner would retain the service user on their caseload in the event of hospital admission.

37. Promote use of tele health and tele medicine approaches. The opportunity exists to use technology to remotely monitor long term conditions, provide advice and hold consultations with consultants by skype type technology. Along with assistive technology this can empower

service users and let them take control of managing their conditions. The Project Team propose that this type of technology is included in the development of an assistive technology strategy.
38. Set up local health and social events or drop in sessions. Currently, Social Work operate a weekly clinic in the General Practice which is well utilised and popular. The Project Team propose that similar events or sessions are held, including health promotion events attended by members of the multi-disciplinary team, and weekend drop in surgeries attended by a General Practitioner, Pharmacist and District Nurse. The weekend drop in sessions is a model successfully used in the United Kingdom that has been proven to reduce demand for early week General Practitioner appointments.
39. Implement the Patient Activation Measure (PAM) tool and Help to Overcome Problems Effectively (HOPE) course. A key theme from stakeholder feedback was the need to promote ageing well (which is also a main component of 'Delivering Longer Healthier Lives'). The PAM tool and HOPE course would be instrumental in helping to achieve this. The PAM tool assesses an individual's risk factors and awareness of any conditions they may have and helps to identify those who will manage conditions effectively, and those who have not come to terms with conditions they are living with and therefore present a higher risk. It will allow the integrated care team to effectively target their resources to where they are most required. The PAM tool also acts as a screening tool for the HOPE course. The HOPE course is a self-care, or self-management, programme that empowers people and supports them to take control of their own conditions and support requirements (see appendix xii). In the Torbay and South Devon NHS Foundation Trust this course was provided by a third sector organisation who employed a Wellbeing Co-ordinator (the organisation was called Volunteers in Health). The Wellbeing Co-ordinator sat in the integrated care team and managed the HOPE course, although the course was run by health and social care professionals and volunteers. The course also 'grew their own' volunteers from people who attended courses so it is also self-sustaining. This is a major step towards creating individual and community resilience. People who undergo the HOPE course can then be re-assessed using the PAM tool to see if their risk factors have reduced
40. Eliminate professional jargon. The use of jargon, whether consciously or not, functions to set up barriers around professionals and forms a protection for those professions. Unfortunately that leads to misunderstanding between professionals, and lack of clarity for service users. Jargon in use ranges from use of Latin to describe dose times for medications to use of abbreviations. The Project Team propose that no abbreviations, or acronyms, are used in records, or assessments, that assessments incorporate plain English at all times, and that a glossary is compiled for some language that cannot be changed, that is available in both hard and electronic copies.
41. Further develop an admission and discharge process between community and hospital services. During consultation a constant topic raised was around the admission, but particularly the discharge process from hospital, including via the Accident and Emergency department. Issues were around lack of communication, discharge late at night or over the weekend, and practical difficulties such as lack of, or insufficient, medication on discharge. This was an issue for community based staff and the public. The Project Team proposes working with hospital services to devise a process that addresses these issues. It will include making sure all agencies are aware of what is actually available, both in the community and the hospital, and at what times, providing hospital services with a single point of access and ensuring they know who is the named community keyworker where appropriate, and making sure records and care plans are accessible by hospital services.
42. Implement localised first stage on call arrangements for the integrated care team. Currently teams that work outside of normal office hours have on call arrangements in place on a service by service basis. For example, Home Care have a supervisor on call rota up to 22.00 hours during the week and at the weekend, and District Nursing have an on call lead nurse at the weekend. The Project Team propose that following changes to core hours appropriate shared on call arrangements are put in place to cover the integrated care team.