Isle of Wight

Better Care Fund
Part 1
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Section 1: Plan Details

Summary of Plan

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<th>Local Authority</th>
<th>Isle of Wight Council</th>
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<tr>
<td>Clinical Commissioning Groups</td>
<td>Isle of Wight CCG</td>
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<td>Boundary Differences</td>
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<td>Date agreed at Health and Wellbeing Board:</td>
<td>18/09/2014</td>
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<tr>
<td>Date submitted:</td>
<td>19/09/2014</td>
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<tr>
<td>Minimum required value of BCF pooled budget: 2014/15</td>
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<td>2015/16</td>
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<td>2015/16</td>
<td>£20,607k</td>
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Authorisation and signoff

| Signed on behalf of the Clinical Commissioning Group | [Signature] |
| By                                                   | Loretta Outhwaite |
| Position                                             | Chief Finance Officer on behalf of Chief Officer |
| Date                                                 | 18/09/14 |

| Signed on behalf of the Council | [Signature] |
| By                               | Dave Burbage  |
| Position                         | Managing Director |
| Date                             | 18/09/14 |

| Signed on behalf of the Health and Wellbeing Board | [Signature] |
| By Chair of Health and Wellbeing Board             | Cllr Ian Stephens |
| Signed on behalf of the Health and Wellbeing Board | [Signature] |
| By Vice Chair of Health and Wellbeing Board         | Dr John Rivers |
| Date                                                | 18/9/14 |
## Related documentation

<table>
<thead>
<tr>
<th>Doc Ref</th>
<th>Document or information title</th>
<th>Synopsis and links</th>
</tr>
</thead>
</table>
| IOW01   | NDTi Report: My Life a Full Life | Provides an overview of the early stages of the My Life a Full Life programme. The report:  
- sets out the rationale and evidence for integration  
- describes the MLAFL programme  
- summarises the conclusions of the three locality workshops that took place  
- suggests a set of outcomes for the programme and some ways these could be measured  
- presents a delivery plan for the programme  
| IOW02   | My Life a Full Life PID | Provides a description of the My Life a Full Life programme, its scope, expected outcomes, programme success criteria, approach, constraints, assumptions, interfaces, an outline programme plan and tolerances  
[https://secureservices.iow.gov.uk/bcf.zip](https://secureservices.iow.gov.uk/bcf.zip) |
| IOW03   | Isle of Wight Five Year Health and Social Care Vision | Provides the Island’s vision, objectives and its principles and aims of working together and with others to improve services  
[https://secureservices.iow.gov.uk/bcf.zip](https://secureservices.iow.gov.uk/bcf.zip) |
| IOW04   | Mental Health Strategy 2014 – 19 | Describes the work that is needed over the next five years to make sure that Island residents have good mental health and receive the correct support at the time and place when they need it to support them to recover.  
[https://secureservices.iow.gov.uk/bcf.zip](https://secureservices.iow.gov.uk/bcf.zip) |
| IOW05   | Suicide Prevention Strategy 2014 – 19 | Provides a framework to improve the management of suicide prevention on the Isle of Wight and to focus local suicide prevention activity ensuring it is joined up, relevant, evidence based and sustained.  
[https://secureservices.iow.gov.uk/bcf.zip](https://secureservices.iow.gov.uk/bcf.zip) |
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<tr>
<th>Reference</th>
<th>Title</th>
<th>Description</th>
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| IOW06     | Dementia Strategy 2014 – 19 | Builds upon the previous Joint Commissioning Strategy 2009 – 2013 which aimed to deliver a vision of high quality services for people living with dementia on the Isle of Wight. A revised strategy is required in order to consider service delivery in line with emerging best practice, new government guidance and agendas, economic parameters, re-alignment of health and social care services and the volume of services required to meet the needs of all those on the Island with dementia.  
https://secureservices.iow.gov.uk/bcf.zip |
| IOW07     | Isle of Wight’s LGA Integrated Care Value Case | Provides an overview of the value case for integrated care on the Island through the work of the My Life a Full Life programme.  
http://www.local.gov.uk/documents/10180/12193/Isle+of+Wight+-+Solving+the+data+sharing+problem+version+2/794bc54f-eb6a-44f6-bde2-70468ab67455 |
| IOW08     | Joint Strategic Needs Assessment (JSNA) | Joint council and CCG assessments of the health needs of the local population in order to improve the physical and mental health and well-being of individuals and communities produced in a series of factsheets.  
| IOW09     | Joint Health & Wellbeing Strategy (JHWS) | Sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for the Island.  
| IOW10     | CCG Clinical Commissioning Strategy 2014 - 2019 | Sets out priorities, vision and values for the IOW CCG for the next five years.  
https://secureservices.iow.gov.uk/bcf.zip  
Isle of Wight Health Economy Strategic Plan 2014-19:  
https://secureservices.iow.gov.uk/bcf.zip |
| IOW11     | Joint Carers Strategy | Provides the strategic direction and approach that will be taken to support carers on the Island. It brings together key legislation, as well as key priorities for delivery and how we will measure whether and how well we have delivered those priorities.  
| IOW12     | Beyond Boundaries – IOW NHS Clinical Strategy 2013/14 – 2017/18 | Describes how health care on the Island will be delivered over the next 5 years, showing the need for integrated commissioning and service delivery.  
https://secureservices.iow.gov.uk/bcf.zip |
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<tr>
<th>IOW13</th>
<th>Director of Public Health’s Report 2013/14</th>
<th>Provides Public Health’s vision for the Island. <a href="https://secureservices.iow.gov.uk/bcf.zip">https://secureservices.iow.gov.uk/bcf.zip</a></th>
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<tr>
<td>IOW14</td>
<td>Autism Strategy</td>
<td>Describes the work that is needed over the next five years to make sure that Island residents who are on the autistic spectrum receive the support they need to help them live fulfilling lives. <a href="https://secureservices.iow.gov.uk/bcf.zip">https://secureservices.iow.gov.uk/bcf.zip</a></td>
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<tr>
<td>IOW15</td>
<td>ASC 3 Year Strategy</td>
<td>Describes what ASC plans to achieve over the next 3 years. <a href="https://secureservices.iow.gov.uk/bcf.zip">https://secureservices.iow.gov.uk/bcf.zip</a></td>
</tr>
<tr>
<td>IOW17</td>
<td>CCG Operational Plan 2014-16</td>
<td>Sets out the IOW CCG Executive’s priorities and requirements in delivering the strategy. <a href="https://secureservices.iow.gov.uk/bcf.zip">https://secureservices.iow.gov.uk/bcf.zip</a></td>
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Section 2

Vision for Health and Social Care Services

Key Points:
- The Better Care Fund Programme contributes substantially to the delivery of the agreed Five Year Health and Social Care Vision of person-centred, co-ordinated health and social care and support.
- The new way of working will aim to ensure the Island health and social care provision is sustainable within the resources available despite increasing demand.
- Services will be people centred and delivered in a way which meets their individual need.
- The health and social care outcomes for people will be improved and we will ensure that this is being delivered through careful monitoring and evaluation of our plans.
- Services will be provided in an integrated way across health, social care and the independent and voluntary sector.
2.1 Vision

‘Person-centred, co-ordinated health and social care support’

We want people, including the most vulnerable in society, to enjoy fulfilling lives, good health and a sense of wellbeing. To achieve this, we are encouraging people to combine, and get the best from, the resources and support they have access to: at home, from their family and community, from the council, the NHS and a wide range of organisations and enterprises. Ensuring the right support around people creates personal solutions that maximise their choice and control.

The joint aim, consolidated through the Health and Wellbeing Board, of the Island’s health and social care organisations is to promote longer, healthier and more independent lives for the people of the Isle of Wight, whilst embracing the wider wellbeing agenda which is the ‘golden thread’ throughout the Care Act 2014. This will result in people experiencing a whole life journey approach with seamless transitions of care. Primary, secondary and social care all have individual contributions to make to this, but we recognise our overall effectiveness and efficiency is dependent upon developing a highly integrated model of care, including working closely with the third and private sectors. The people we serve need to be at the heart of all our decisions, supported by a clear mandate and priorities, and be the ultimate judge of everything we do.

We are committed to making our vision of person-centred, co-ordinated health and social care support a reality on the Island. We want to improve the outcomes and experiences of people, families and carers which will be achieved by doing things differently, to collaboratively harness the capacity of organisations, people and communities to think creatively to help us build a sustainable health, social and community economy, fit for now and for future generations.

To deliver this vision, the Island’s Five Year Health and Social Care Vision describing the integration of our services is fully supported by the Island’s Health and Wellbeing Board, the Isle of Wight (IOW) Clinical Commissioning Group’s (CCG) Governing Body and Clinical Executive, the IOW Council’s Cabinet (recently renamed Executive) and the IOW NHS Trust Board.
Vision
Person centred, co-ordinated health and social care.

Objectives
- Improved health and social care outcomes.
- People have a positive experience of care.
- Person centred provision.
- Service provision and commissioning is delivered in the most efficient and cost effective way across the whole system, leading to system sustainability.
- Our staff will be proud of the work they do, the services they provide and the organisations they work for and we will be employers of choice.

Principles and aims of working together and with others to improve services
- To work towards better integration and co-ordination of care across all sectors of health and social care provision within statutory deadlines.
- To reduce bureaucracy, improve efficiency and increase capacity to meet future demands for services.
- To work towards one Island budget for health and social care which makes the best use of resources.
- To ensure all care will be person centred, evidence based and delivered by the right person in the right place and at the right time.
- To jointly ensure that our resources are focused on prevention, recovery and continuing care in the community.
- To jointly ensure that people are supported to take more responsibility for their care and to be independent at home for as long as possible reducing the need for hospital admission and long term residential care.
- To continually improve the quality of our care and improve the experience of people in contact with our services within available resources.
- To ensure partnership working across all sectors, including the third sector and independent sector.
- To develop our workforce to enable our staff to have to have the right knowledge, skills and expertise that is appropriate to their role.
- To encourage staff to work beyond existing boundaries to support system wide innovative delivery of care.
- To work towards a fully integrated IT system across primary, secondary and social care with appropriate access for staff.
- To jointly commission services with outcome focused contracts, which incentivise positive change in providers of services.
- To recognise the importance of communities and act to ensure we listen to Island people in the planning of services and responding to their concerns.
- To share information in an open and transparent way to enable decision making across the organisations.

Putting the person at the centre of everything we do is key to the success of our vision – “I” and “We” statements underpin the philosophy of our vision for the future.

Using the “I” statements developed by National Voices and Making it Real as a basis for further development by local people, we have defined what ‘good’ will look like for our residents and communities:

- I will no longer be a patient or a client; I’ll be a person.
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I feel valued for the contribution I make to my community.
- I have access to easy to understand information about health, wellbeing, care and support which is consistent, accessible and up-to-date.
- I am able to get skilled advice to plan my care and support.
- I can plan ahead and keep control at times of crisis.
- I have considerate support delivered by competent people.

In essence, this means that people wish to be considered as unique individuals who have different characteristics and are distinct from other people. What is important to people on the Isle of Wight is: “My health, support and care is directed by me, co-ordinated, and works well together”

It is also recognised that as organisations, if we wish to deliver our vision effectively, we need to respond in a new way to how we support people. The organisational “We” statements below, developed as a response to the local “I” statements, will be how we now prioritise and respond to people we work with on the Island:

- We will enable people to promote their own health and wellbeing supported by self-care and self-management.
- We will see people as people and deliver co-ordinated support to individuals, their families and carers.
- We will support people at times of crisis to have the right support as soon as possible, to enable people to return home and to their communities.
- We will develop the infrastructure to deliver truly co-ordinated care and support.
- We will support people with long term conditions (LTCs) and the frail elderly locally, based around GP practices.

A key element of our future vision, in line with the Care Act 2014, is to design and deliver a progressive prevention strategy which will support people to look holistically at their care and support needs at an early stage, finding the low intensity support that will help to prevent the escalation of those needs. This will include a community information hub (Isle Help) which will bring together all third sector advice services within one service, providing a broad range of information and advice to enable people to be as informed as possible. To ensure this approach, the council has supported a range of partners in the third sector to submit a recently successful National Lottery bid which is designed to help rationalise and improve the availability of advice and support to Island residents through the development of Isle Help. Sitting alongside this will be an on-line community directory which will take a holistic approach to providing up-to-date information around key areas of people’s lives, rather than focusing merely on conditions or presenting need. It will provide details on the wide range of services and support groups that are available, including peer support, and will be easy to access and navigate, linking with work around digital inclusion and the implementation of the Universal Credit scheme.

The Island’s User Led Organisation, People Matter, plays a key role in our prevention strategy. It will be a key player within Isle Help, providing specialist advice to residents around personal budgets and employing Personal [care] Assistants (PAs). There is also an Independent Living Centre which enables people to look at aids and adaptations before purchasing any equipment. Uniquely, as part of our preventative approach, the centre provides Occupational Therapist (OT) support to those who do not meet Fair Access to Care Services (FACS) eligibility or do not want statutory service intervention.

Fundamental to the delivery of our vision is the need to ensure that people are safe. This requires a co-ordinated robust approach to safeguarding, whilst ensuring that the individual has a personalised experience that is focussed on delivering the right outcomes identified with them. We work on a partnership basis, ensuring that people feel listened to and are fully engaged with us in shaping their care and services. Alongside our desire to deliver an integrated approach to safeguarding vulnerable people, we will work with partner agencies, including Care Quality Commission (CQC), to ensure that there is a level of quality assurance which provides reassurance that services and organisations offer quality care and support.
2.2 Engagement

To develop our vision we engaged with people and stakeholders in the following ways, to ensure our vision is what our communities want. This has informed all our strategies, including the Better Care Fund (BCF).

- **Health and Wellbeing Strategy 2013**: Extensive consultation took place to develop our Island’s overarching strategy.
- **My Life a Full Life (MLAFL)²**: three locality workshops and a launch event were held which were attended by people from a cross section of the community, people who use services, voluntary and private sectors, GPs, Primary Care and the health and social care workforce.
- **Five Year CCG Clinical Commissioning Strategy 2014 – 2019**: three workshops were held in September 2013 to develop a strategy for the Island. Participants included representatives and professionals from healthcare providers, the third sector, primary care and a number of patient and carer groups. The IOW CCG then published a draft strategy on its website and sought further feedback from its stakeholders through advertising the consultation in the local media and directly contacting key stakeholders.
- **Isle of Wight Living Well with Dementia Strategy**: consultation has been in two phases: phase one was a consultation event and a number of meetings with key stakeholders; phase two involved raising awareness of the draft Strategy and inviting people to comment and make recommendations.
- **Isle of Wight No Health Without Mental Health – it’s everyone’s business**: the IOW CCG, LA, Public Health, Police and VSF consulted widely on the development of the No Health Without Mental Health Strategy. The consultation has been in two phases: phase one comprised of two engagement events which included service users, carer, staff, public and third sector organisations and members of the public; phase 2 involved circulating the draft strategy to all stakeholder organisations and to the wider public on the Island.
- **Isle of Wight Suicide Awareness and Prevention Strategy**: the development of this Strategy was supported by two phases of consultation: phase one consisted of a comprehensive two month consultation period; the second phase consisted of circulating the draft strategy, inviting feedback.
- **Autism Strategy**: information about the consultation was distributed widely, including: local media, GP surgeries and clinics, NHS Bulletin, schools and parish council notice boards. A workshop was held which a large range of organisations attended and two meetings were held with parent and carer groups.
- **IOW NHS Trust Clinical Strategy**: the development of this five year plan follows significant consultation with local partners, staff and patients on the Trust’s clinical strategy. The IOW NHS Trust Integrated Business Plan is aligned closely to the shared Five Year Health and Social Care Vision and has the development of integrated services at its heart.

The overall strategic direction was endorsed by stakeholders and the final strategy was amended to reflect the feedback received.

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² The My Life a Full Life programme brings together the Island’s CCG, Isle of Wight Council and Isle of Wight NHS Trust to work collaboratively to deliver a shared vision which sees us embarking on a new initiative and programme of work that will create a fundamental change in the way people experience living healthy and well on the Island. This programme aims to see the partners, including voluntary and private sectors, working together to promote innovation and the introduction of proactive integrated care and support on the Island.
- **Working Together with Carers Strategy**: developed through extensive consultation with a wide range of carers and carers groups across the Isle of Wight over a 6-week consultation period, during which 16 events were held in a range of venues.

We will hold a public awareness event in October/November of this year to consult on our BCF submission and gain the views of a wide range of people and organisations. We will use the feedback gathered at this event to help further shape our plans for integration and further development of the BCF.

In addition, we will work with our local HealthWatch to engage as many people as possible and gain their views and comments. We will also be supported, in a critical friend role, by HealthWatch who will have a part to play in monitoring the BCF work to ensure we are delivering against the schemes and targets outlined.

### 2.3 Island Context

The Joint Strategic Needs Assessment (JSNA) is the main body of work which underpins the development of our strategies. Analysis of the broad demographic and socio-economic needs has informed where we need to focus our priorities.

The population of the Isle of Wight shows an ageing demographic profile. Almost a quarter of the population is 65 plus and over the next 10 years there is likely to be a significant increase in this. The ageing profile has implications for the management of long term conditions, which is predicted to increase by 5.1% between 2011 and 2018. The ageing population enables us to predict the prevalence of dementia; we already have the highest recorded UK prevalence in 2011/12.

Mental health status and sense of wellbeing is an important determinant of overall health. It is estimated that over 16,000 Island people will have common mental health problems and improving mental health is one of our key strategic priorities.

Inequalities in health status and outcomes are associated with inequalities in the wider environment. The Island ranks among the 40% most deprived local authorities in England.

We have taken all these factors into account when developing our strategies and the resulting BCF. More detail on our demographic profile and the Case for Change is in Section 8.
2.4 Seeing the difference

One of the key delivery mechanisms for the Island’s integration agenda and thus the BCF, is the MLAFL programme. The evaluation of MLAFL seeks to establish the difference the MLAFL programme has made to individuals, their carers and families, as well as how it has affected way staff delivering health and social care work, and any changes to the systems they work with. The evaluation will be carried out over 2 years (from January 2014) using qualitative research methodology, quantifiable metrics collated locally and nationally, and financial modelling.

The Public Health Team is working with the Wessex Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in order to evaluate the effect that MLAFL has had on social networks and the capacity of an individual to care for themselves using informal networks.

It is anticipated that the schemes within the BCF programme will make the following differences, and contribute to the objectives and principles set out in the Five Year Health and Social Care Vision.
Outcomes
The MLAFL programme is using the following metrics to measure the impact of integration. Apart from the required metrics for the BCF and our local metric, we will be monitoring the following outcomes:

User experience
- Survey developed to measure any increase in satisfaction
- Reduction in people’s complaints
- Increased satisfaction with complaint resolution
- Numbers of users satisfied that their personal budget meets their needs
- Improved carer quality of life
- People are supported to take more responsibility for their care
- People will remain independent at home for as long as possible reducing the need for hospital admission and long term residential care

Front line staff experience
- Annual staff survey to measure levels of staff satisfaction
- Reduction in staff sickness and absenteeism
- Vision and reason why we need to change understood
- Measure ‘We’ statements on effectiveness of cultural change

Health and wellbeing outcomes
- Evaluation framework built on individual experience of new ways of working based on locally developed “I” statements
- Self-care and self-management supporting quality health and wellbeing outcomes
- People receiving support at times of crisis and cared for closer to home
- Focusing on personalisation and prevention
- Achievement of the relevant national outcomes in the NHS, public health and social care outcomes frameworks

Impact on performance
- Reduction in non-elective (A&E) attendances
- Reduction in non-elective admissions for conditions amenable to treatment
- Reduction in hospitalisation and readmission rates
- Reduction in the use of nursing and residential care places (increase in people living independently for as long as possible)
- Increase in reviews and the use of reablement and assistive technology
- Reduction in unnecessary face to face GP consultations by redirection where appropriate
- Improvement in discharge rates from services (unblocking)

Impact on cost
- Reducing cost and demand to the benefit of all organisations
- Quality outcomes improved, reducing need for ongoing support
- Health and social care service sustainability, despite increasing demand and fewer resources

Productivity
- Primary care and health, as well as social care staff, able to concentrate on those most in need
- Releasing capacity in statutory services, moving to better use of the voluntary sector and communities
Benefits

**IOW CCG and primary care**
- GP’s time freed up or GPs more able to actively case manage patients with the support of other professional teams
- Care closer to home for residents and locality based services
- Greater co-ordination of care resulting in care provision being given at the right place at the right time
- Reduction in demand: A&E; ambulance; non-elective admissions
- Improved health outcomes
- Effective use of commissioning resources
- Primary care integrated with other community and social services

**IOW Council**
- Reduction in referrals through greater access for residents to information and help
- Greater co-ordination ensuring right agency responds
- Reduction in admissions to long term care
- Having a community and home-based approach rather than a bed-based approach

**IOW NHS Trust**
- Reduced non-elective admissions to hospital
- Reduced readmissions to hospital
- Reduction in bureaucratic systems and enhanced case management of the most vulnerable patients
- Greater co-ordination of care and support across the organisation and within communities

**Public**
- Improved outcomes
- Greater freedom and choice
- Empowered people
- Feeling part of the local community
- Independent living
- Improved experience: right care, right time, right place

**Measures of Success**

The measures of success will be built around five key areas, with longitudinal studies being used to show how improvement is made over time. The focus will be on both qualitative and quantitative data, capturing the experience of people using services and more tangible performance indicators to understand the benefits of integration.

**Customer satisfaction**

We will track and bring together all the national surveys which measure patient/customer/carer satisfaction, in addition to identifying other key measures which are important to our local population and ensure baselines are identified this year to track our success over future years.

**Improved health and social care outcomes**

We will use the national and locally developed indicators and expect to see improvements in all indicators over time.

**Delivery of the NHS constitution**

Current performance monitoring will be used to ensure delivery of the NHS constitution.

**Staff satisfaction**

We will fully utilise national surveys, as well as developing our own specific indicators to use across staff and organisations to test the benefits of integration on staff satisfaction.
Financial sustainability

Financial sustainability across the system while meeting increasing demand will be a prerequisite to the programme. Achieving the above success measures and financial balance in all participating organisations will be an indicator of a successfully integrated system.

Health Gains

We will fully utilise national frameworks such as:

- Public Health Outcomes Framework
- Adult Social Care Outcome Framework
- NHS Outcome Framework
- Local Hospital Episodes Statistics
- GP data

These will provide quantitative data around health gains and more specifically reduction in health inequalities through mortality, morbidity and disease prevalence statistics. Qualitative data will be gathered as part of the comprehensive MLAFL evaluation and this will add to the evidence of benefits to health on the Island through both that programme and use of the BCF.

2.5 How the future will look

The Island’s Joint Health and Wellbeing Strategy, based on the JSNA, has been agreed by the council and its partners following public consultation in March 2013. It has identified the following strategic priorities which underpin the ambitions of our vision for integration:

- Ensuring children and young people have the best possible start in life
- Helping and supporting people prepare for old age and to manage long-term health conditions and disabilities
- Enabling people to make healthy choices for healthy lifestyles
- Building and sustaining economic growth and supporting employment opportunities
- Making the Island a better place to live and to visit

In order to deliver our vision of person-centred, co-ordinated health and social care over the next five years we will change the way we work and the approach the public takes to managing their own health and care in a more proactive way.

To deliver this vision, work on developing a joint commissioning approach continues. This will support the delivery of integrated care on a locality basis ensuring that care and support are co-ordinated around the needs of people and populations, putting the person, as the ‘expert by experience’, at the centre of their care and support. To ensure a whole-system response, a number of different approaches, using locality working are being considered for implementation over the next five years, with the initial phase being implemented by April 2015. The Island localities will be based around three natural geographical groupings: North and East, West and Central, and South Wight.

This will work for the benefit of residents and move away from a more fragmented delivery of care to support an integrated system that promotes independence, choice and control. This will improve services where necessary and help drive the efficiency gains required across the system. This will mean:

- There is a fully integrated, funded and delivered health and social care system which has reduced bureaucracy, improved efficiency and increased capacity to meet future demands.
- There is a culture across all health and social care services that is customer-focused and person-centred and where people report high levels of satisfaction.
- Support and services are appropriate to need and delivered when required in a co-ordinated way.
- People are supported to take more responsibility for their care and support, with improved health and social care outcomes year on year.
- Staff satisfaction is high and the Island is a place where people want to work and live.

**Mental Health Reablement**

The mental health reablement pathway is an addition to existing Payment by Results mental health pathways for people with complex mental health needs and who are accessing secondary mental health treatment and services. The pathway helps ensure the provision of holistic and comprehensive health and social services - devised through a jointly agreed service specification and dedicated workforce structure. This supports individuals to make incremental improvements in their everyday social functioning and to successfully take on increasing levels of responsibility in managing as many aspects of their own life as possible.

In addition to this work, we want to work towards building the capacity of voluntary and community sector self-help groups and support organisations for people with mental health conditions on the Island through working in partnership with the third sector. To enable this, MLAFL is working with the voluntary sector to produce a grant funding prospectus which aims to provide expert leadership to improve and expand voluntary sector mental health service capacity and delivery on the Island in line with the three priorities areas set out in the Mental Health Strategy:

1. **Prevention and early intervention for mental health and wellbeing** – by enabling people to maintain and strengthen their own mental health and providing early intervention when support is necessary.
2. **Improved recovery and access to mental health support** – by quick and easy access to recovery focussed support for those with identified needs.
3. **Reducing stigma and discrimination through stronger communities** – by supporting families and communities to become more confident and more resilient when dealing with issues that affect mental health.

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**Mr D: mental health reablement**

**Future vision**

Mr D, a 49 year old man with a history of long term schizophrenia lives at home alone. Over time, his physical health has deteriorated, developing angina and breathing difficulties. He has been neglecting his care, not always preparing meals for himself or keeping appointments with his key worker, and has lost his job.

Mr D has become very unwell and been admitted to an inpatient unit, he is reassessed and a full physical health check has been undertaken. He is identified as suitable for the enhanced mental health Reablement pathway and his key worker works out a wellness recovery action plan which includes the issues that are important to Mr D.

**Outcome**

Through his individual wellness recovery action plan Mr D is being supported to achieve his identified outcomes, which includes support from an employment support worker to be able to regain employment. His GP has worked with him to manage his angina and Chronic Obstructive Pulmonary Disease (COPD) with advice, support and medication. He has developed his skills to be able to prepare meals and maintain his personal cleanliness and keep on top of the housework. He has also been supported by a peer to reconnect with some of his old community activities, developing local relationships, whilst maintaining his independence at home.
Crisis Response

To support those people who have a greater level of need or who are in crisis we have created, and continue to build on, an integrated Urgent Care Hub which has brought together teams from Adult Social Care and Health who are able to communicate clearly and respond quickly and effectively to a wide range of needs for vulnerable Island residents.

Sitting within the Urgent Care Hub is the Crisis Response Service, a multi-disciplinary team consisting of health and social care professionals, who liaise with the ambulance service, community matrons, occupational therapists, physiotherapists, reablement and adult social care. The team also have members of the voluntary sector who ensure and facilitate a smooth transition of care, following the 72 hour crisis team intervention, into longer term support networks and services.

Mr F: crisis response

Future vision

Mr F is a 92 year old gentleman who suffers with mild dementia; he lived with his wife who had a massive stroke at home, fortunately witnessed by a neighbour. Mr F has no family on the Island but the ambulance crew, when attending his wife, asked for the crisis response team to support him.

These events occurred at 3.30pm on a Friday afternoon and the team knew from the little history given that Mr F’s main carer was his wife, and that he would not manage on his own at home and could not be left; apart from his dementia he also suffered from shortness of breath and had a history of falls.

Mr F’s wife was taken to the Emergency Department where she sadly died.

The role of the Crisis response team started at 4pm when Mr F was assessed for how severely his dementia would affect his activities of daily living. Being confused by what he had witnessed and his understanding that his wife of many years had just passed away, it became apparent that for his own safety Mr F would require some immediate care. The team spoke to the duty social worker for the Crisis response team who arranged for a duty social worker to meet Mr F and the team and discuss the best way of caring for him in the short term. In Mr F’s best interest a period of respite care in a residential home would be provided over the weekend and subsequently this allowed the team to look at ways of managing Mr F within his own home in the future. A joint meeting was held between the Crisis team and Social Services and a plan for him to return home was set up. This included Mr F having assistive technology provided in his own home that would connect with Wight Care if he was to wander out of the house at night (this being a main concern of the teams hence admission for intermediate residential care). A care package was also set up to support Mr F in remaining independently at home. Mr F was referred to the dementia liaison team and nurse specialist for follow up when he returned home. Age UK were contacted to give support from the Good Neighbour Scheme.

If the team had not existed Mr F would have had no choice to be taken from his home in the ambulance with his wife, bought into the Emergency department and then most likely admitted to hospital as a social care admission until a placement could be set up for him. He remains at home and is by all accounts doing well with a care package set up to support him.

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2 The Urgent Care Hub hosts a number of multiagency professionals, brings together a number of services, including 999, 111, community nurses, mental health workers, community physiotherapy, occupational therapy, rehabilitation, District Nurses, Wightcare (community alarm and wardens), Adult Social Care First Response Team, Hospital Transport and our out of hours GP service to deliver support in an integrated way.
Rehabilitation/Reablement

Adult residents with physical rehabilitation needs, following illness or trauma, will receive more timely and effective interventions in appropriate settings to allow them to reach their optimum levels of functional independence. The intention is that they will be enabled to remain as contributing members of their communities. It is anticipated that following an initial scoping exercise, that we will develop an integrated rehabilitation and reablement team.

**Mrs A: rehabilitation/reablement**

*Future vision*

Mrs A, an 89 year old woman, lives at home alone following the death of her husband 5 years ago. One day she falls in the garden, sustaining a fractured neck of femur. Unable to reach the phone she has to wait until her neighbour hears her calls for help.

She is admitted to an acute ward where her hip is repaired. Concerned relatives feel that she should move into a permanent care setting. Mrs A wishes to return home.

The integrated rehabilitation and reablement team work with Mrs A, first in a community rehabilitation bed in a nursing home near her house, and then with her at home to ensure she can become able to live alone again. The team liaise closely with her relatives to reassure them. A minimal care package from Age UK supports her with the tasks that she can no longer manage and ensures that she is no longer socially isolated and a Lifeline alarm ensures she can call for help should she need it.

**Outcome**

Following a period of 10 week’s gradually reducing rehabilitation and reablement interventions the team, with Mrs A, decided that she was ready to be discharged from the service.

Without the support of this service, Mrs A would have been in receipt of ongoing social care support.

Integrated Locality Working

Work is progressing with the creation of three integrated locality teams working across the Island and linking closely with Primary Care. The 17 GP practices on the Island have already formed themselves into three localities to enable them to work more closely together to deliver services. Following this model the District Nursing teams, Health Visiting and Midwifery have also arranged their services into these locality teams. The next steps will be to work with colleagues in Adult Social Care to create multi-disciplinary integrated Health and Social Care Locality Teams.

**Mr B: integrated locality working**

*Future vision*

Mr B is an 84 year old man living alone in his own home. He has recently been diagnosed with Severe Chronic Obstructive Pulmonary Disease. Along with his COPD he has diabetes, hypertension and depression. He is independent and currently does his own shopping.

Mr B was identified by the GP as at risk of social isolation, Emergency admission or long term
Mr B’s situation was discussed at the Locality Forum meeting with all agencies present. A care plan was devised to include the Community Matron, Social Care, Local COPD support group and assistive technology. All Professionals were aware of Mr B in the community and encouraged him to attend Café Clinics in his area for his long term conditions, Falls Prevention - Strength and Balance classes and to join the local activities. The longer term plan would be for Mr B to have Telehealth care installed at home to support his long term conditions.

**Outcome**
Mr B felt well supported by the locality and was able to continue to be independent. His depression was less acute. Mr B began to accept his COPD and became able to understand the condition, enabling him to monitor his own health, preventing acute admission or a rapid deterioration of his illness. Mr B continues to live alone, shopping for himself and enjoying the local activities.

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Mrs M, who is 60 years old, arrived in A&E at 3.30 on a Saturday with a badly swollen knee after multiple falls at home. She lives alone and has no family living on the Island. After being initially assessed in A&E, it was ascertained that there were no medical reasons to admit her to a ward.

The weekend duty social worker was called to carry out a social care assessment and was able to start his assessment within 15 minutes of Mrs M being admitted to A&E. The social worker worked jointly with the on-call hospital physiotherapist.

**Outcome**
Wishing to avoid a stay in hospital, and with no community rehabilitation bed being available, the social worker arranged, using his Trusted Assessor status, for Mrs M to go to a local residential home via a short-term placement. The social worker completed the paperwork immediately and Mrs M was moved from A&E to the residential home that same evening.

All of Mrs M’s outpatient medical appointments were booked prior to her leaving A&E and a plan drawn up for Occupational Therapy and reablement support to be put in place upon her return to her home in order to regain her confidence and maximise her independence.
Supporting Information, Advice and Self-Management

The culture and conditions for people to promote their own health and wellbeing will exist on the Island. Self-care and self-management support will have been made available through a variety of formats. Existing support mechanisms will have been strengthened and new methods developed.

Ongoing self-care and self-management campaigns will encourage patients to seek appropriate advice and information. An Island-wide care plan, containing personalised information, will be used to ensure people are fully informed about their health and social care needs and methods of fulfilling them.

Mrs D: self-management

New practice

Mrs D has multiple long term conditions which she has not been managing well, becoming very anxious when she feels she is becoming unwell. This lead to her calling 999 up to four times a week, leading to her being admitted into the A&E department. To support Mrs D to manage her conditions more effectively, she was given some Telehealth equipment which takes readings of her vital signs.

Outcome

Since using Telehealth Mrs D is able to manage her own condition. When she feels poorly, Mrs D takes a reading, sometimes multiple times in a day, and when she identifies that her vital signs are good this reduces her anxiety. Therefore, instead of her first reaction to feeling poorly being to dial 999, Mrs D contacts her GP surgery or community matron. Mrs D has used Telehealth for the past 18 months and has only dialled 999 three times during that period.

Critically, the relationship between Primary Care and services provided in the community will be the key to ensuring that case management is embedded in practice and communication between key professionals is enabled to the benefit of the most vulnerable people in our community. We will further develop and use good risk stratification tools to identify those residents most at risk of A&E attendances or hospital admission and a stay in a residential home, to develop a holistic response to their care needs.

Mrs J: father’s health deteriorating

Future vision

Mrs J is becoming increasingly worried about her father, Mr S, especially his ability to manage at home since the death of his wife. He is becoming very socially isolated, his general health and wellbeing is deteriorating and he is unable to think about his future, saying what will be, will be. This is out of character for her father as he is generally very confident, outgoing and has always liked meeting new people and making friends. He said he didn’t want to be a nuisance, or have anything to do with social services as he didn’t want them knowing his business.

Mrs J had heard of a new service available that could offer information, advice and support. When she discussed this with her father, he wasn’t quite sure what he would gain from this service. However, with a bit of persuasion, he agreed to go with his daughter. When they arrived, they were both amazed at the relaxed atmosphere and friendly staff, all volunteers, who stopped and talked to them. Mr S explained that since his wife had died he had lost his way in life and didn’t really know what to do or even enjoyed doing anymore. His mobility was also deteriorating and he felt, at times, unsteady on his feet and this was affecting his confidence.
A volunteer suggested that he might like to go through a “Planning for the Future” tool, either by himself or with support, which enables people to think about what is important to them in their life, what they would like to do and/or need support with. This would be a good way to identify how the service could support Mr S. In addition, it was suggested that he might want to visit the Independent Living Centre, as they have an Occupational Therapist there, who could talk to him about his mobility needs and recommend some equipment to help. Mr S decided that he wanted some time to complete the Planning for the Future tool so would complete it at home and return the following week.

**Outcome**

Mr S, following his visit to the centre, is now receiving minimal support, attending a local amateur dramatics group, using a walking aid and enjoying life to the full. His general health and wellbeing has improved and he is considering also taking up art as well as taking golf lessons.

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**Carers**

Carers across the Island will be supported and empowered by offering information, practical and emotional advice, participation in groups, activities, events and a range of services that are specifically tailored to the needs of the Islands carers. We will also work closely with other organisations across the Island who work specifically with carers, building strong relationships with partners in the statutory and voluntary sectors and carers can actively be involved in the planning, delivery and monitoring of carers’ services to ensure that their specific needs are met and that carers’ voices are heard.

Mrs C is 33 and looks after her son Owen, who is on the autistic spectrum, with her husband. As she had recently moved Mrs C to the Island, she did not have an established network of friends nor did she know what support and services were available to her and her son. Mrs C made contact with Quay Carers who provided her with information and advice about what’s available for her as a carer as well as where she could go to get support for her son.

**Outcome**

Through this service, Mrs C found her feet quickly, making contact with Carers Isle of Wight and a local Carers Support Group. This was particularly helpful when her son had not settled into his new school. As part of the support offered, Mrs C and her husband were each given a Carer’s Emergency Alert Card so that they had confidence that when their son was not with them and should they be needed they could be contacted quickly.

Because of the intensity of the caring role and the fact that they had no relatives on the Island they were also able to benefit from the respite weekends provided by Quay Carers which gives them time to switch off and unwind as a couple.

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**Care Act**
The introduction of the Care Act will ensure that the most vulnerable people in society have the opportunity to live their lives as part of their community, as independently and fulfilling as possible. It will ensure that people have more choice and control over their lives and that the support provided by unpaid, family carers fully recognised by statutory organisations. It will ensure that approaches are joined up and that services are holistic with the person at the centre of their care and support.

Mrs R: Care Act

Future vision

Mrs R is in her 80s and is starting to struggle with her mobility. She is finding it difficult to get in and out of bed and to prepare her own meals. Her husband provides a large amount of care and support to her already, but he now not able to cope on his own.

Mrs R contacts Adult Social Care duty to request an assessment. As part of this initial contact, she is given information around the financial eligibility. Mrs R has substantial savings, well above the £118,000 threshold. Her husband also requests that a carer’s assessment be carried out.

Outcome

Mrs R still had a social care assessment carried out so that she can prepare a plan to meet her increasing needs. She funds this care and support fully herself, recording what she spends on her care in her Care Account. Her husband has a carer’s assessment and, to support him his carer’s role, Mrs R is given a weekly 2 hours free sitting service so that he can go shopping without worrying about needing to take his wife with him.

Local Area Co-ordination

LAC is a unique and innovative approach to supporting people who are vulnerable through age, learning disability, physical disability, sensory impairment or mental health issues to identify and pursue their vision for a “good life”, to strengthen the capacity of communities to welcome and include people and to make services more personal, flexible and accountable

Local area co-ordination

Future vision

The Local Area Co-ordination vision is that ‘All people on the Island live in welcoming communities that provide friendship, mutual support, equality and opportunities for everyone, including people who may be isolated, excluded or vulnerable due to age, disability or mental health needs, their families and carers’. This is taken from an inclusive neighbourhood’s presentation on LAC from their work in Derby. We would hope to have a similar impact on the lives of those on the Island:

“They take time to get to know us - me, my family, and my community.”

“They help me to have a voice – to be heard and listened to”

“We have more Choices. It’s not just about services”

“There used to be so many people It’s nice to have one person I know well “

“LACs really listen – they don’t judge or assess”

“They support and challenge me to do more for myself. I feel more confident now.”

“I’m proud I don’t need services anymore! “

The success of the BCF will be the joined-up, holistic approach to the schemes included within it. The BCF helps us to look at things from an ‘Island health and social care economy’ perspective. It allows all parties
to see the impact that a proposed scheme has on all partners keeping the benefits to individuals and organisations at the forefront of what we do.

Our BCF plans reflect our strategic intentions: they are not new plans but build on work which has already commenced, therefore the schemes are at different stages of development. The BCF has created an added impetus to the development of the plans and the governance structures around them.

We recognise that there is much more work to do and that a number of uncertainties still exist in relation to our proposed investments and outcomes. Work will continue in 2014/15 in preparation for the full implementation of the BCF. The figures we share are best estimates based on work to date and will evolve and change over time. Significant amounts of work remain to be done by all partners, not least the development of a detailed Section 75 Agreement, but this work has commenced.
Section 3

The Case for Change

Key Points:

- BCF programmes and services focusing on prevention and integration are key factors in mitigating the risk of services being unsustainable on the Island due to the increasing financial and demographic pressures.
- The Island health and social care economy faces unprecedented financial challenge: reduction of £28m in IOW Council spending by 2016; IOW CCG £35m over target in resource allocation on a budget of £205m; IOW NHS Trust with a savings target of £35m over 5 years.
- The cost of health care provision is often higher on the Island due to diseconomies of scale.
- The Island has the demographic profile now that the rest of England will have in 2048.
- The Island has the second highest proportion nationally of registered patients aged 75 or over (11.48% compared to 7.63% nationally).
- 53% of people have at least one long term condition and over 3,000 people are at risk of hospitalisation in the next year.
- The ambition is to achieve a 5% reduction in emergency admissions by December 2015:
  - 3.6% reduction in 2014
  - 1.5% reduction in 2015
3.1 The drive for change

The health and social care economy on the Island faces unprecedented financial and demographic challenges and risk if it is to meet people’s expectations. The Island’s BCF provides a platform for meeting those challenges and for shaping the future direction of service delivery over the next three to five years. It starts to bring together in one place the aims and ambition for care and support for the most vulnerable people living on the Isle of Wight, much of which can only be achieved in collaboration with other agencies. Unless the whole system works together individual elements will fail.

To achieve this whole system reform, there will need to be:

- A programme of cultural change which reinforces positive behaviours.
- A focus across all sectors on self-help, prevention and people being responsible for managing their own health and social care needs, and that when support is needed it is delivered in a co-ordinated way.
- Support and services provided by multi-agency integrated teams within three localities across the Island.
- Integrated social, primary and secondary care through clear pathways for those with more complex health needs, providing joint working and shared responsibility, resulting in improved health and social care outcomes.
- Sharing of records through integrated IT with the use of paper being phased out as quickly as possible, stopping duplication, enabling real time information resulting in increased efficiencies.
- A single point of access to emergency and urgent care services across health and social care which will build on our existing integrated arrangements and Urgent Care Hub.
- Ultimately, one budget for health and social care, supported by joint commissioning which focuses on outcomes for people rather than outputs.

There is an Island-wide passion to work together to deliver the benefits sought both for individuals and their carers and partners within the BCF. To make this happen, groups and organisations, including the council, the NHS, voluntary and community organisations, the Island’s User Led Organisation (People Matter) and a wide range of public services, will work together to deliver our vision of ensuring that people have the personalised health and social care and support they need via a ‘through life’ family-centred approach, resulting in an improved experience for all.

Island challenges

The Isle of Wight is the largest offshore island in England and Wales, covering an area of 146.8 sq miles. There is no mainland fixed link which means travelling to other health and social care providers involves the use of a ferry or, in extreme emergencies, via helicopter. This makes travel fragmented and particularly challenging for families with young children or the frail and elderly.

For example, the Island’s population is and will remain less than half of that normally needed to sustain a traditional district general hospital providing a wide range of services at cost-effective levels, even taking into account the high volumes of visitors. Patient volumes for some services are too low to fully cover fixed overheads of staffing and estate. This is particularly pronounced where health services incur high levels of fixed costs in order to operate safely and meet national guidelines: clinical governance requirements
dictate the minimum configuration for certain services (often with high fixed costs), where economies of scale cannot be achieved, such as in the emergency department and maternity service. Some specialist care simply cannot be provided and patients have to travel to the mainland. As a result some innovative models of working and partnerships already exist to help minimise the impact of this, for example the provision of specialist clinical time on the Island from nearby mainland hospitals.

The same challenges affect private sector providers: it can be very difficult to encourage new providers to come to the Island as it is not viable for them on a sustainable basis to provide services here due to diseconomies of scale and set up costs.

In addition, due to its isolated location from mainland UK, there are issues around workforce: the difficulty in attracting professionals to the Island is becoming an increasingly important factor in the ability to provide services. Many young people brought up on the Island migrate to the mainland in adulthood, for education or work, only returning, if at all, when they’re ready to have families or to retire. This results in the Island losing many of its working age residents. The vast majority of Island residents work on the Island and do not commute to the mainland for work; the converse of this is also true, with it generally being more difficult to entice people living on the mainland to commute to the Island. The two major factors contributing to this are the cost and the time associated with ferry travel.

Cross border (mainland) placements are another area that cause increased issues for the Island. Although many councils and CCGs try not to place individuals in need of care across neighbouring borders, on the Island this is magnified by the isolation of the Island and the need for cross-Solent travel by both professionals and families and is referred to not as ‘cross border’ but ‘off Island’.

The Island’s main economy is tourism, with a strong tourist industry throughout the summer months, including a number of major events, such as: the Isle of Wight Festival, Bestival, cycling festival, walking festival, Cowes Week and the Scooter Rally – many of which are the largest of their type in Europe. This means that the population can increase by almost half as much again at peak times during the year putting additional pressures on limited resources (see figure 1 below).

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visitors</td>
<td>28,000</td>
<td>55,000</td>
<td>80,971</td>
<td>37,000</td>
</tr>
<tr>
<td>Isle of Wight</td>
<td>140,000</td>
<td>140,000</td>
<td>140,000</td>
<td>140,000</td>
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</tbody>
</table>

Figure 1: Average Weekly Population on the Isle of Wight
These challenges are summarised in figure 2 below.

**Location factors relevant to the Isle of Wight**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Impact on healthcare</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Socio-economic</td>
<td></td>
<td>• The Island has the same demographic profile that England will have in 2048! With &gt;25% of the population over 65, &gt;11% over 75.</td>
</tr>
<tr>
<td>2. Remoteness / travel time/</td>
<td></td>
<td>• Travel to and from the mainland for patients, carers Clinicians, supplies and waste is adding a cost and time premium.</td>
</tr>
<tr>
<td>travel cost / logistics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rural / Coastal</td>
<td></td>
<td>• Greater than average deprivation with a Gross Value Added / FTE of £29,000 compared to a national average of £41,000.</td>
</tr>
<tr>
<td>4. Population / Activity levels</td>
<td></td>
<td>• 140,000 people generate a third of the activity needed to fund at normal tariff services like trauma, maternity, etc. – but meeting the cost premium is cheaper, safer and more acceptable to island residents than moving services to the mainland</td>
</tr>
<tr>
<td>5. Geographic issues</td>
<td></td>
<td>• Island roads are single carriage way and radiate out of Newport where St Mary’s is located – the average ambulance journey time to St Mary’s is 35 minutes</td>
</tr>
<tr>
<td>6. Seasonal fluctuations</td>
<td></td>
<td>• During Q3 the average weekly population increases by 60% for holidays and festivals bringing different demographic &amp; capacity challenges</td>
</tr>
</tbody>
</table>

**Conclusion:** Account needs to be taken of the differential impact of location factors when considering the provision of healthcare for any location - they are just more ‘obvious’ on ‘the Island’

*Figure 2: source IOWPCP 2012*

**Financial challenges**

The council is facing a significant financial challenge over the next three years. Due to reducing government grants and increased service needs the budget gap is £28m across the council as a whole over the period 2014/15 to 2016/17. The total amount of savings required across the council in 2014-15 is £7.2m. The target for Adult Social Care for 2014-15 is £1.505m.

A great deal of work has already taken place to identify and implement schemes alongside those within the BCF which have already, and will in the future, help towards our savings target. The council will continue to build on this work, identifying further savings, reviewing and improving business processes, and optimising income.

A key strand of the savings strategy for Adult Social Care is to reduce the use of residential care and provide services to maintain people in their own homes. A £350k savings target has been set for 2014-15 which is based on replacing nine residential placements per month for those people with lower-end needs and providing an average of 15 hours home care per week in order to meet their needs at home rather than in a residential care setting. This is a challenging target particularly against a demographic pressure of a growing elderly population and increasing demand for residential care as more people live with multiple long term conditions.

The IOW CCG has financial challenges of its own: in December 2013 NHS England approved a new CCG allocations methodology. Under the new methodology for the IOW CCG the target allocation is £35m (21.4% lower) than the IOW CCG’s current allocation. Within the next 12 – 24 months NHS England is likely to introduce a ‘pace of change’ towards the new allocation, leading to an expected reduction in funding for the Island. The IOW CCG is actively working with the NHS England allocations team to understand why the Island is significantly impacted by the new funding formula to develop an appropriate response.
As mentioned previously, the unique nature of the Island means many of the IOW NHS Trust’s services suffer from diseconomies of scale. The IOW NHS Trust is working closely with the IOW CCG to establish local price tariff modifications and variations in line with Monitor guidance to mitigate these diseconomies and formalise funding streams. However, the local health economy is aware that the level of reductions forecast from the BCF initiatives are not expected to facilitate the level of cost reductions within the IOW NHS Trust that may be realised in a mainland Trust. With this in mind, over the next 5 years the IOW NHS Trust has a significant financial challenge. This challenge is currently estimated to be circa £34m.

The IOW CCG, IOW Council and IOW NHS IOW NHS Trust all face significant, financial challenges over the next few years. All three organisations are committed to working together to develop a financially sustainable health and social care system for the Island. To this end, and to particularly support the implementation of the BCF, the executives from each organisation will be taking part in a financial summit (15th October 2014) to ensure that the organisations understand each other’s financial positions and their interdependencies, and to develop strategies for risk sharing across the health and social care economy.

Demographic Profile

Ageing Population

The Island has a greater proportion of older residents aged 65 plus (almost a quarter of the population) and fewer younger people, those aged 0-14 years (only 15% of the population) than both the South East region and England and Wales as shown in figure 3.

![Proportion of population by broad age band]

Over the next ten years, there is likely to be a significant increase in the proportion of people aged 65 years and older living on the Island, while over the same period, the number of younger age groups will reduce, although the level of reduction is predicted to slow towards the end of this period.

In addition, projections predict that the Island will experience an average annual growth of 1,250 people over the next 22 years (2033) and the overall rate of growth will be among the older population. The following two charts provided in figure 4 show the predicted shifts in population by age band and gender, with an overlay of the same projections at a national level:
In 2013:

There is a projected growth in numbers of people on the Island, over 65 years of age, with a limiting long-term illness over the next few years. The steepest rate of increase is seen amongst the 75 to 84 age group which is projected to increase from 5,616 in 2012 to 6,994 in 2020 (an increase of 24.5%).

The Island has the second highest nationally proportion of registered patients aged 75 or over (11.48% compared to 7.63% nationally\(^1\)). See figure 5 below.

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**Residential Care**

The admission rate per 100,000 for permanent admissions to care homes on the Island for the period 2013/14 for those aged 65 and over was 840. There were three authorities with a higher (worse) rate in our ONS comparator group and 12 with lower (better) rates.

The tables below (figure 6 and figure 7) show the increasing demand for residential and nursing services on the Island; trying to halt or decrease growth in this area is part of our BCF plan.

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\(^1\) Source: 2012/13 NHS Comparators
Social Isolation
Social isolation is a key determinant of poor health and is, therefore, an important contributory factor to these figures.

This is particularly relevant to the Island as it is seen as an idyllic place to retire to, with many people moving to the Island and ageing without the direct support of family (due in part by the cost of sea travel), quite often finding themselves isolated in beautiful but remote rural locations. This isolation is further exacerbated when individuals experience the loss of a partner. A 2012/13 survey on the Island told us that almost 20% of single older people felt isolated or lonely, this rises to 50% of carers who responded, which is twice the national average.

With the growth in these figures and people living longer with one or more long term conditions, it is inevitable that the demand for health, social care and community services will increase. There is a clear consensus across organisations, people and communities on the Island, that new ways of working must be developed and delivered.

* Isle Engage run by Age UK
With this in mind, the Island, through the lead partner Age UK, has successfully bid for project funding from the National Lottery’s Fulfilling Lives, Ageing Better grant. The project aims to:

1) Develop and implement a vision across all sectors that recognises the negative impact of social isolation on community cohesion, and on the mental, emotional and physical wellbeing of older people. We will build on national learning and successful local practice in involvement, to ensure reducing social isolation is embedded in all services that affect older people.

2) Develop a culture with our partners where older people are placed at the centre of services. Staff and volunteers will be helped to develop new attitudes through leadership and training, to deliver individualised services which respond to the unique factors which lead to an individual’s social isolation. Personalisation began this process, but services are yet to be fully tailored enough to the needs of the individual.

3) Ensure services respond to the needs/aspirations of the whole person and not just the presenting problem. The joint commissioning approach and integration, developed through MLAFL, will drive change. Older people will be part of the commissioning process and service providers will have to prove they bring positive impact to local communities and support older people who are socially isolated, whether they are current service users or people who find it hard to engage with services and their local community.

4) Deliver a whole system response that can be replicated by other parts of the country working with older people, or in other areas of work: for example children and families.

**Carers**

There is a clear relationship between poor health and caring that increases with the duration and intensity of the caring role. Those providing high levels of care are twice as likely to have poor health compared to those without caring responsibilities.

The 2011 Census indicated 16,420 people on the Isle of Wight provided at least 1 hour of unpaid care per week, meaning 11.9% of the total Island population had a caring responsibility. The South East (9.8%) and England (10.2%) both had lower levels of unpaid care provision.

Of those people providing unpaid care, 4,104 provided 50+ hours of care per week (3.0% of the total population), higher than both the South east (2.0%) and England (2.4%).

The support for carers on the Island is increasing, evidenced by figures 8 and 9 below:

As a further response to the needs of carers, we have developed a joint Carers Strategy. It identifies what is important to carers and how those priorities will be delivered. We have made a commitment that carers will be:

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5 Source: ONS
- Respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.
- Able to have a life of their own alongside their caring role.
- Supported so that they are not forced into financial hardship by their caring role.
- Supported to stay mentally and physically well and treated with dignity.
- Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes.

### 3.2 Risk Stratification
The IOW CCG operates risk stratification under the s251 conditions and has completed and returned the Assurance Statement to NHS England.

The IOW CCG utilises a risk stratification tool provided by Sollis which uses the Adjusted Clinical Group (ACG) model supplied by Johns Hopkins University. GP practices are currently carrying out risk stratification to identify those patients most at risk of an unplanned hospital admission within the next twelve months. During 2014/15 the IOW CCG has also been reviewing the outputs of the ACG Risk Stratification tool in order to gain an understanding of the profile of people on the Isle of Wight. This review only profiled those people included within the data exercise and it is, therefore, an acknowledged risk that those outside of this will not be identified by practices. With this in mind, practices are advised that this is only one source of identifying patients and that local knowledge and systems must also be used to refine the lists of patients to review.

#### Multiple chronic conditions by age
Using the ACG tool the IOW CCG has identified the following (illustrated in figure 10 below):
- 53.1% of people have at least one condition
- More people have one or more condition than have none.
- More people have two or more conditions than only have one condition.
- The majority of over-65s have two or more conditions, increasing to three or more conditions for the majority of over-75s.

![Figure 10](image)

Services are reviewed, designed and integrated to be patient centred due to the high proportion of patients aged 75 and over and the likelihood of these patients having multiple chronic conditions.
The ACG tool provides an indicative total cost for each patient and this enables the costs to be analysed by the number of chronic conditions. The total cost includes secondary care, primary care and medication costs. The total cost is indicative as the tool does not use community or social care data.

The chart below (figure 11) shows the number of chronic conditions per patient and the proportion of the total costs that each band accounts for. The respective proportion of the population that each band accounts for is also included. People with three or more chronic conditions make up 15.9% of the population but account for 45.1% of the total cost.

![Figure 11: Proportion of total costs and population by number of chronic conditions.](image)

The following graph below (figure 12) demonstrates the clear impact of the number of chronic conditions on the total cost.

![Figure 12: Average cost by chronic condition band.](image)
Resource Utilisation Bands

The ACG tool stratifies the population into Resource Utilisation Bands (RUBs) (see figure 13 below). These bands range from Very High to Healthy. Additionally the tool identifies any non-users who have not accessed primary or secondary healthcare within the previous twelve months. On the Island, 8.3% of the population are in the Very High and High bands – these patients will typically have multiple chronic conditions resulting in high resource utilisation.

The activity utilisation for each of these bands was reviewed and this identified the following:

- Patients in the Very High band have 10.9 times more emergency admissions compared to the whole population.
- Patients in the High band have 3.2 times more emergency admissions compared to the whole population.
- Patients in the Very High band have 3.5 times more A&E attendances compared to the whole population.
- Patients in the High band have 1.5 times more A&E attendances compared to the whole population.

![Resource Utilisation Bands](image)

This analysis shows that the Very High and High cohort of patients account for a high proportion of unscheduled activity and could benefit from patient centred care.

Probability of emergency hospitalisation

The ACG tool provides a probability of emergency hospitalisation score for each patient within the population. For the Isle of Wight there are more than 3,000 people with a greater than 25% risk of emergency hospitalisation within the next twelve months. GP practices are utilising this report in order to review a cohort of people that are applicable for the avoiding unplanned admissions enhanced service.

The diagram below (figure 14) shows the pyramid of risk of emergency hospital admission within the next 12 months. A risk score for emergency hospitalisation is produced for each patient within the ACG Risk
Stratification tool. These scores range from a 0% to 99% risk of emergency hospitalisation. The IOW CCG has assigned these patients to the following bands:

- 25% - 99% risk
- 10% - 24% risk
- 5% - 9% risk
- 0% - 4% risk

The figure shows the bands and the number of patients that are assigned to each band. The percentages in brackets show the overall percentage of the whole population within each band. There are 3,184 patients in the top band 25% - 99% risk of emergency hospitalisation.

Frail Elderly
People in the UK are living longer, many with complex medical conditions, and a significant number of them find that advancing age brings frailty.

The Isle of Wight has the UK’s second highest concentration of over 50s (45%) with the figure set to rise to (51%) by 2019. Over 75s make up over one third (c6,000) of the total (c18,000) admissions to hospital, with pneumonia, urinary tract infections, stroke and fracture to the neck of femur as the most common conditions.

The focus will be to ‘ensure vulnerable frail older people are treated with dignity and respect in the most suitable environment, to ensure the best clinical and personal outcomes’. These are:

- Improving quality of life and care for patients
- Reducing the demand on health and social care services
- Improving access to services, to avoid delays and possible deterioration of the patient’s condition
- Providing sustainable services for the ‘frail older people,’ enabling them to maintain their independence and wellbeing

Long Term Conditions
It is estimated that LTCs consume around 70% of health and care resource expenditure. Moreover the pattern of LTCs is changing. Although great strides have been made in tackling individual conditions, increasingly individuals have to cope with multiple conditions. Society has also changed: people have
different expectations and the revolution in digital technology means the traditional role of the professional with a customer needs to be transformed.

We recognise that the system we are using was designed for the 20th century and needs to change and adapt to meet the challenges of the future. By listening to the experiences and feedback from people coping with LTCs we recognise that the individual ‘I’ needs to become central to how care is designed and implemented locally. Personalised care which understands and supports the individual is vital. We are committed to thinking systematically about the essential components to ensure this happens.

We have, therefore, utilised the House of Care as a framework to enhance the quality of life for people with long term conditions, no matter what their conditions. We acknowledge that implementing the intent of the House of Care will provide a challenge.

The Department of Health’s ‘Enhancing the quality of life for people living with long term conditions – the House of Care’ (see figure 15 below) model takes a whole system approach to LTC management. It is about aligning levers, drivers, evidence and assets to enhance the quality of life for people with long term conditions no matter what or how many conditions they have.

The House enables person-centred, co-ordinated care. The roof of the House provides best clinical and organisational processes to deliver that person-centred care, with it being supported by two walls: the first wall supports professional collaboration, particularly between specialists and generalists; the second wall is about the individual and their carers – supporting the potential for self-care with the individual being the ‘expert by experience’. The foundations for the House are commissioning enablers. Planning, securing and monitoring investment on behalf of the individual and population to secure the best possible outcomes.

Dementia
On the Isle of Wight 24% of the population are over the age of 65. Due to age being one of the highest risk factors for dementia we subsequently have one of the highest prevalence’s of dementia in the UK with 3,078 people estimated to be living with dementia. Due to the integrated work driven by the Dementia Steering Group 60% of these people have a diagnosis and access to post diagnostic support which meets
the national target. Due to an ageing population the number of people living with dementia is expected to increase by 23% over the next 10 years.

The ACG Risk Stratification tool was used to obtain a profile of people with Dementia. Below are some of the key findings from the analysis:

- The current and predicted risk scores and the probability of extended hospitalisation were higher for those people with dementia as would be expected. However, the variation between patients with dementia and those without dementia was most significant in the 65-69, 70-74 and 75-79 age bands. The variation decreased in older age bands.
- 91% of people with dementia have one or more other chronic condition.
- Overall, 35% of people with dementia also have depression. In the 65-69 age band 38.7% of people also have depression.
- The average total cost for people with dementia is 1.9 times the cost of people without dementia. Again the difference is more prominent for those aged between 65 and 79.
- 33% of people with dementia have had at least one emergency admission over the previous twelve months, compared to 7% of those people without dementia.

In response, the Isle of Wight has developed a Living Well with Dementia Strategy which identifies 4 priority areas for action:
1. Awareness and prevention
2. Diagnosis and post diagnostic support
3. Care at home
4. Specialist Care

Each priority area has an action plan in the strategy which is monitored by the Dementia Steering Group. There are a number of national, area and local targets and aspirations for dementia, which includes diagnosis rates being increased to 67% by March 2015 and 100% of appropriate frontline staff being trained in dementia level 1 by 2018. Integrated working is essential in order to drive these targets, deliver the strategy and ensure people and their carers live well with Dementia on the Island.

The prevalence rates (see figure 16 below) have been applied to the ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia up to 2020. It is predicted there will be a further 21% increase in registered dementia prevalence by 2020.

![Graph showing GP Practice Dementia Registers - Recorded Prevalence Rates](image-url)
Mental Health

Based on GP registrations, the percentage of people with a serious mental illness in England is 0.82% per registered population. The Isle of Wight has a slightly higher rate than the national average of 1%. The mental illness prevalence on the Island has increased by 8% between 2006 and 2011, which is a much slower growth than the national average of 11%.

The Island is just publishing its No Health Without Mental Health .... it’s everyone’s business strategy. This is a joint response under the Island’s Health and Wellbeing Board on what we need to do as partners to make sure that Island residents have good mental health and receive the correct support at the time and place when needed to support recovery.

The priority areas were identified as:
1. Prevention and early intervention for mental health and wellbeing
2. Improved recovery and access to mental health support
3. Reducing stigma and discrimination through stronger communities

The strategy identified that some groups of people are known to be at higher risk of developing mental health problems. On the Island, these groups have been identified as:

- **Looked after Children:** in March 2012 0.6% of the 0-17 of age population were looked after, this figure has been predicted to have increased in 2012 – 2013.
- **People with long term conditions:** people with a long term condition are two to three times more likely to experience mental health problems. Also individuals with mental health problems are twice as likely to experience a long term illness or disability. On the Island it is estimated that 20.1% of our population lives with a long term illness compared to the national average of 16.9%. It is a fact that poor mental health problems complicate physical health conditions leading to more time spent in hospital, poorer clinical outcomes, lower quality of life and a need for more intensive support from health services.
- **Older people:** adult and elderly secondary mental health services on the Island are being used at a significantly higher rate than the England and South East rate. The Island does have a higher demographic of over 65 population of 24.1% compared to England’s average of 16.6%.
- **Employment:** employment is good for a person’s health, improves their quality of life and wellbeing. Remaining in and returning to work quickly, aids recovery and people gain health benefits from being in work:
  - People with severe mental health problems have a lower rate of employment than any other disabled groups, the percentage of people in Europe with schizophrenia in employment is estimated between 10-20%.
  - The percentage of the population on the Island that are economically active aged between 16 – 74 that are long term unemployed is 1%, the average in England is 0.8% (Public Health Profiles PHE).
- **People known to the Justice System:** the Island has a higher rate of young people entering the criminal justice system than other parts of the England. This will impact on their ability to gain employment and this in turn has an impact on their mental and physical health. Crime levels are associated with both illness and poverty, increasing the burden of health on those communities least able to cope. The Bradley report (2009) highlights the need of people with mental health and learning difficulties in the Criminal Justice System. Evidence suggests there are more people with mental health problems in prison than ever before and there is growing consensus that prison may not always be the right environment for those with severe mental illness.
- **Veterans:** the Kings Centre for Military Health Research found that 20% of Veterans were above cut-offs on self-rated scale using GHQ-12. The most common diagnosis is Adjustment Disorder and Post Traumatic Stress Disorder (PTSD) with the prevalence increasing significantly in those that had been deployed. It is estimated that 11.2% of the over 16 population on the Island is a veteran.
Variation between GP practices

The probability of emergency hospitalisation scores were analysed at GP practice level. For the avoiding unplanned admissions enhanced service the practices are required to identify the top 2% of patients at risk of emergency hospitalisation. In general the top 2% of the whole Island population ranges from patients with a 27% risk of emergency hospitalisation to a 99% risk of emergency hospitalisation. However, there is variation between practices on the range of risk covered by the top 2%. The diagram below (figure 17) demonstrates the range of risk covered by the top 2% of patients for each practice. Therefore some practices will be reviewing patients with 24%-26% risk (ie below the Island minimum risk score for the Island top 2%) whereas the top 2% of patients for other practices will cover a risk range starting from 30%.

![Diagram showing variation between practices](image)

This highlighted variation between practices indicating that a locality approach to some service redesign would be more beneficial.

Acute care utilisation

- **Inpatient Admissions**: 276 patients have had five or more inpatient admissions within the last year
- **Outpatient Appointments**: 1,210 patients have had twelve or more outpatient appointments within the last year
- **A&E Attendances**: 800 patients have had five or more A&E attendances within the last year
The utilisation patterns of the top 10 patients were reviewed and are detailed in the chart below (figure 18):

![Figure 18](image)

This demonstrates that there are a variety of utilisation patterns and that integrated and specific care coordinated around the needs of the patient is vital to reduce the resource utilisation, cost and importantly improve the quality of life for the patient.

Rationale for emergency admissions metric

The revised BCF planning guidance set out the planning assumption that each Health and Wellbeing Board area would plan to reduce the total number of emergency admissions to hospital by 3.5%. The guidance also confirmed that this planning assumption did not constitute a firm target which would have to be met by all areas, and that a case could be set for a lower level of ambition in 2015. This could depend on the variation in starting point, the demography of the population, and relative performance to date, and should also meet six Principles set out in the guidance.

**Appendix A** to the BCF Plan sets out the detailed rationale for the Isle of Wight emergency reduction target setting out the ambition, the justification, the contribution to delivery by the BCF schemes, demonstration of meeting the Principles, and the methodology behind the setting of the ambition trajectory.

The Appendix also provides contextual information supporting the BCF Plan Template Part 2 trajectories, including data derived from baselines, and the contribution of BCF to aggregated achievement of the emergency admissions reduction.
Rationale Summary

The ambition above is for early achievement of a reduction in emergency admissions in excess of the national aspiration of -3.5% from a 2013 baseline, and from a starting position which is demonstrated as already showing a high level of system efficiencies in the rates of emergency admissions, despite a demography with a comparatively higher BCF target population, as follows:

- The IOW Health and Social care economy already has in place Integrated Care schemes (e.g., My Life a Full Life) which forms a part of the BCF.
- Trends predict return on these investments, including Quality, Innovation, Productivity and Prevention (QIPP) schemes outside BCF, will realise a -3.6% reduction in 2014 against 2013 levels.
- A further reduction of -1.5% is expected to be realised in 2015 by the full impact of BCF and QIPP schemes.
- This is in addition to avoiding additional emergency admission arising from predicted population growth during the period 2014 and 2015.
- The aim is ambitious but realistic given the variation in starting point for the Isle of Wight where:
  - The Marginal Rate for Emergency Admissions is not realised in the main acute provider contract as levels are below that of the baseline 2008-09 levels (adjusted for service changes)
  - Non-elective admission rates are low (7th out of 151 PCTs – 2012-13)
  - Preventable admission rates are low (834.7 compared to 1181.9 nationally – 2012-13)
  - End of Life Care in Hospital is low (45.3% versus England 50.7% - 2014)
  - The IOW had the second highest nationally proportion of registered patients aged >75 (11.48% compared to 7.63% nationally - 2012-13) which are the main target group for the BCF
  - The IOW has good performance (lower numbers) compared to the most similar Health and Wellbeing Board areas for rates of emergency admissions (see figure 19 below).

These figures corroborate the assertion that the IOW already manages a higher than average proportion of the target population (as set out in the Case for Change) in the community.

Figure 19: Source: NHS Comparators
Given the variation in starting point showing high achievement against benchmarks (illustrating that level of opportunity is significantly different from lower quintile areas set the same national ambition); the differences in population characteristics (again illustrating the need for safe ambitions), the trend in local performance (the measurable impact of schemes implemented specifically to support integrated care already being realised with 3.6% reduction planned in 2014), a further 1.5% reduction in 2015 is a realistic, stretching but reasonable ambition, set in the context of a total reduction of 5% and absorption of population growth of 1.1% overall.

See Appendix A: *Reduction in Emergency Admissions Performance Fund Ambition* (page 179) for detail on the justification for the ambition and the modelling of the trajectory.
Section 4

Plan of Action

Key Points:
- The Health and Wellbeing Board will ensure accountability for the delivery of the BCF programme to the Isle of Wight residents.
- A new Joint Adult Commissioning Board will monitor the detailed implementation of the BCF and the individual schemes.
- Project Management principles will be applied to the delivery of all schemes.
- The BCF Section 75 (pooled fund) agreement is in development with the aim of agreement by January 2015, ready for full implementation of the BCF in April 2015.
4.1 Key milestones

The table below sets out the key milestones for the Island’s BCF:

<table>
<thead>
<tr>
<th>Timescale</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>16th Sept 2014</td>
<td>Final Planning Templates to be submitted to Health and Wellbeing Board (HWB) for approval. Island’s BCF agreed by HWB.</td>
</tr>
<tr>
<td>19th Sept 2014</td>
<td>Island’s BCF submitted for assessment and approval.</td>
</tr>
<tr>
<td>15th October 2014</td>
<td>Tripartite Finance Summit meeting.</td>
</tr>
<tr>
<td>October/Nov 2014 (post BCF feedback)</td>
<td>Systems of delegation agreed across system. JACB meets and agrees any proposed fine tuning of BCF plan and individual schemes. JACB establishes two monthly cycle of activity. Ongoing commissioning intentions confirmed to providers with supporting modelling and/or change in service cost base (continuation and/or notices for nine BCF schemes). Any changes in future commissioning arrangements formally notified to providers.</td>
</tr>
<tr>
<td>27th Nov 2014</td>
<td>HWB considers any changes to BCF following assessment process.</td>
</tr>
<tr>
<td>December 2014</td>
<td>Outline expenditure plans revised for the BCF. Contractual changes in commissioner confirmed and service contract documentation drafted.</td>
</tr>
<tr>
<td>Jan 2015</td>
<td>Overarching Section 75 Partnership Agreement signed for the Island’s BCF.</td>
</tr>
<tr>
<td>12th March 2015</td>
<td>HWB Review BCF plans prior to final implementation from 1st April 2015.</td>
</tr>
<tr>
<td>1st April 2015</td>
<td>Island’s BCF live.</td>
</tr>
</tbody>
</table>

4.2 Governance arrangements

Strong joint governance arrangements are seen as fundamental as we move towards greater integration.

The IOW Health and Wellbeing Board (HWB) is well established and is giving strategic leadership on integrated working. It is made up of key organisations including the IOW Council, IOW CCG and IOW NHS Trust, police, fire, Public Health, Healthwatch, the voluntary and private sectors, economy, environment and housing. Agreement of the BCF and regular reports on implementation will be a feature of HWB agendas.

Although the Island has had effective partnership agreements in place for a number of years overseen by individual specific boards and groups, it has been agreed that a Joint Adult Commissioning Board (JACB) will be established during October 2014. The terms of reference will be formally agreed at the first meeting, setting out JACB responsibility for overseeing the development of integrated commissioning, providing direct oversight and co-ordination of the BCF. The Board will also hold individual pooled fund managers to
account. It will be necessary for new delegated powers to be sought within the IOW Council and IOW CCG to ensure that the Board has sufficient authority to transact business.

For key decisions on the BCF, agreement will also be required by the IOW CCG Governing Body and IOW Council. Regular reports will be received by the IOW CCG Clinical Executive and IOW Council Executive.

Work on the Section 75 to support the BCF commenced in April 2014 involving both IOW CCG and IOW Council lawyers. Individual pooled fund managers for each scheme have been identified as the scheme leaders and where required Section 113 arrangements will be put in place.

The performance dashboard for the BCF is in development and will be ready for full implementation in April 2015. The JACB will monitor this at each meeting. It will track expected outcomes from the agreed baselines.

The JACB’s role will include:
- Supporting the development and implementation of joint/integrated commissioning, across health, social care and public health services, where partnership adds value in terms of improved outcomes and greater efficiency.
- Proactively identify and agreeing opportunities and priorities for integrated commissioning.
- Ensuring commissioning decisions are made in line with the principles set out in the Five Year Health and Social Care Vision and the priorities in the Health and Wellbeing Strategy.
- Agreeing the development and monitoring of joint strategies and plans to ensure they meet the objectives and targets, and align commissioning arrangements with partners’ financial and business planning cycle.
- Receiving and considering reports on the management of pooled funds, service developments, audit reports etc regarding services which are part of formal partnership arrangements.
- Seeking assurance on the quality and safety of integrated services and ensuring performance is monitored and exception reports are received by the board.
- Agreeing and reviewing risk associated with any formal partnership agreement.
- Facilitating the alignment of commissioning where formal arrangements for joint commissioning are not in place.
- Ensuring appropriate contractual arrangements for all services jointly commissioned or commissioned through partnership arrangements.
- Monitoring the performance of individual schemes and directing changes in work programmes to ensure that targets are met and risks are shared.

The HWB will be the external public facing body which will be accountable for greater public scrutiny of the BCF implementation.
The MLAFL programme board will be the main vehicle to ensure full evaluation on the success of integration. A formal evaluation process has been set up, supported by the University of Southampton.

4.3 Management and oversight of BCF delivery

Each scheme has a lead officer from either the IOW CCG or the IOW Council to take accountability for delivery. Operational oversight is provided by a stakeholder Board or Group, dependant on the scheme.

Each scheme will use project management principles, having robust delivery plans, performance reports and risk logs, whilst maintaining a lessons learnt log. Through this approach, each Group will pick up any early indicators of plans going off track and ensure remedial action plans are put in place. It will seek to address issues at this level unless they are of strategic importance and need to be considered by the JACB.

The JACB will agree scheme timelines and milestones, reporting against these through highlight and exception reports, being presented to the JACB in a timely manner together with agreed performance and risk management information. Each formal Board and Group will be accountable through their lead officer for reporting to the JACB.
### 4.4 Planned BCF Schemes

The following table sets out, in summary, the planned BCF schemes.

<table>
<thead>
<tr>
<th>Ref no.</th>
<th>Scheme</th>
<th>Lead and Management Board</th>
<th>Full Implementation by</th>
<th>Target group</th>
</tr>
</thead>
</table>
| 1       | Mental Health Reablement  
- Integrated reablement pathway for people with complex mental health needs  
- Reablement bed: Ryde House Group | Sue Lightfoot  
*Mental Health and Learning Disabilities Board* | March 2015 | ✓ |
|         |        |                           |                        | Long Term Conditions | Mental Health | Dementia | Frail Older People |
| 2       | Crisis Response  
We will improve crisis response – review our use of direct access beds, develop 7 days a week working, review and deliver as appropriate urgent GP nursing beds, respite service, deliver an integrated crisis response service and improve take up of Assistive Technology. | Linda Rann  
*Crisis Response Working Group and System Resilience Board* | April 2015 | ✓ | ✓ | ✓ | ✓ |
<table>
<thead>
<tr>
<th>Ref no.</th>
<th>Scheme</th>
<th>Lead and Management Board</th>
<th>Full Implementation by:</th>
<th>Target group</th>
<th>Long Term Conditions</th>
<th>Mental Health</th>
<th>Dementia</th>
<th>Frail Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Rehabilitation/Reablement</td>
<td>Alison Geddes Rehabilitation/Reablement Steering Group (to be set up)</td>
<td>Sept 2015</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrated Locality Working</td>
<td>Rachael Hayes Integrated Locality Working Group and MLAFL Board</td>
<td>April 2017</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Enhanced Hospital Discharge</td>
<td>Martin Elliott System Resilience Group</td>
<td>April 2015</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Supporting Information, Advice and Self-management</td>
<td>Alison Geddes MLAFL Board and Self-care Working Group</td>
<td>April 2016</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>

6 SPARRCS – Single Point of Access, Referral, Review and Co-ordination Services: multi-disciplinary team comprising of senior clinicians: Nurses, Occupational Therapists, Physiotherapists working as trusted assessors with telephone triage for all referrals
<table>
<thead>
<tr>
<th>Ref no.</th>
<th>Scheme</th>
<th>Lead and Management Board</th>
<th>Full Implementation by:</th>
<th>Target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Carers</td>
<td>Jackie Raven</td>
<td>April 2016</td>
<td>Long Term Conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Careers Group</em></td>
<td></td>
<td>Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dementia</td>
</tr>
<tr>
<td>8</td>
<td>Care Act</td>
<td>Martin Elliott</td>
<td>April 2017</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Care Act Board</em></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>9</td>
<td>Local Area Co-ordination</td>
<td>Anita Cameron Smith</td>
<td>2018</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Healthy Communities Group reporting to HWB</em></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

We will invest in the Island’s carers, recognising the impact they have on the Island’s health economy. We will implement our three year strategy (2013 -16) and specifically seek to commission training and development, services/personal budgets and Continuing Healthcare respite.

We will review services to meet the requirements of the forthcoming Care Act, including: personalisation; carers; information, advice and support; quality assurance; safeguarding vulnerable adults; assessment and eligibility; veterans; law reform; IT and prisons.

We will develop our plans for Local Area Co-ordination (LAC) in a co-productive and collaborate way with all partners to ensure the programme delivers against BCF outcomes.

LAC is a unique and innovative approach to supporting people who are vulnerable through age, learning disability, physical disability, sensory impairment or mental health issues to identify and pursue their vision for a “good life”, to strengthen the capacity of communities to welcome and include people and to make services more personal, flexible and accountable.
Section 5

Risk and Contingency

Key Points:
◆ A comprehensive risk log has been developed.
◆ High risk that financial savings from reduction in non-elective admissions will not be realised as a cash releasing saving.
◆ The IOW CCG underwriting risk share in Year 1 of BCF to enable investment in services that otherwise would have been withheld in performance fund, with funding only released on achievement recurrently.
◆ Financial support for Social Care required at higher levels than BCF alone can support.
◆ Financial summit being held across public sector organisations on 15\textsuperscript{th} October 2015 to look at and address total health and social care financial risks.
# 5.1 Risk log

The JACB will have its own risk mitigation log which includes the BCF. This is in development and will ensure key risks are reviewed at each meeting. The table below provides an overview of the key risks identified through the co-design process.

<table>
<thead>
<tr>
<th>Risk No</th>
<th>There is a risk that:</th>
<th>How likely is the risk to materialise</th>
<th>Potential impact</th>
<th>Overall risk factor</th>
<th>Mitigating Actions</th>
<th>Financial Impact £000s</th>
<th>Organisational Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEGISLATIVE</td>
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</table>
| BCF1 | Legislation and/or change in Government and/or national vision may mean that the programme will need to change direction. | 3 | 4 | Medium | - Keep abreast of changes to national direction and legislation.  
- If changes to Government direction or legislation occur, consider the impact on the programme.  
- Identify which parts of the programme may need to change.  
- Using agreed processes, gain agreement for change from the Joint Adult Commissioning Board.  
- Regular updates to Board on any changes and implications for the programme. | Not applicable | IOW Council IOW CCG |
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<th>Financial Impact (£000s)</th>
<th>Organisational Impact</th>
</tr>
</thead>
</table>
| BCF2    | The overall financial benefits of the schemes are not sufficient to protect adult social care. | 4 | 5 | 20 | High | The Isle of Wight is working very closely as a health and social care system to ensure system sustainability. This is across the CCG, IOW NHS Trust and council and the transformation programmes are agreed across organisations. A financial summit is being held on 15th October and the following issues are acknowledged by all organisations:  
- Severe reduction in IOW Council allocation  
- Predicted IOW NHS Trust deficits  
- Reduction in IOW CCG allocations. These cannot be addressed through the BCF alone and therefore a much broader programme of work to deliver the Five Year Health and Social Care Vision is being developed and will be required to protect Adult Social Care sufficiently and on a recurring basis. | £3.161m Adult Social Care Funding Gap  
£2.161m non-recurrent identified for 2015/16  
£1m savings dependant on BCF delivery | IOW Council |
| BCF3    | Inability to release funds from existing sources to develop and fund new services. | 4 | 4 | 16 | High | Prioritise service development.  
- Regular updates to JACB on any changes and implications for the programme. | Dependant on scheme | IOW Council  
IOW NHS Trust  
IOW CCG |
| BCF4    | Organisations are relying on the same financial benefits leading to potential duplication in system financial plans. | 4 | 4 | 16 | High | Finance summit on 15th October 2014 to support joint financial understanding and planning.  
- Robust programme and project management, including financial reporting. | Being developed | IOW Council  
IOW CCG  
IOW NHS Trust |
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<td></td>
<td><strong>WORKFORCE AND CULTURE</strong></td>
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</table>
| BCF5    | Recruitment and retention of health and social care staff continues to be very challenging. There are national skill shortages in some professions e.g. Occupational Therapy exacerbated by being an Island. The increasing numbers of other therapists, district nurses and care managers to implement community schemes including the Care Act is of concern. | 4                                    | 4                | 16 High             | • Major workforce development programmes through the MLAFL programme involving all public sector organisations and the voluntary and independent sector.  
• Development of new types of generic workers.  
• Trusted assessment being implemented and rolled out to reduce duplication.  
• Workforce summit being held in October to have a system wide strategic plan for attracting professionals to the Island. |                        |                      |
|         |                                                                                                             |                                      |                  |                     |                                                                                                                                                                                                                       | Not applicable         |                      |
|         | **BCF6** Engagement of primary care and its ability to deliver accelerated change.                           | 4                                    | 3                | 12 Medium           | • Using formal and informal networks to discuss the job description and person specification and the ambition for the role and encouraging interest in the position.  
• Working with the Thames Valley and Wessex NHS Leadership Academy to support clinicians who do come forward with an interest in these roles to develop skills rapidly. |                        |                      |
|         |                                                                                                             |                                      |                  |                     |                                                                                                                                                                                                                       | Not applicable         |                      |
|         | **BCF7** Due to high elderly demographic profile shortages of care staff particularly during peak periods of demand and during school holidays. | 4                                    | 4                | 16 High             | • Major workforce development programmes through the MLAFL programme involving all public sector organisations and the voluntary and independent sector.  
• Workforce summit being held in October to have a system wide strategic plan for attracting professionals to the Island. |                        |                      |
<p>|         |                                                                                                             |                                      |                  |                     |                                                                                                                                                                                                                       | Not applicable         |                      |</p>
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</table>
| BCF8   | There are insufficient managers with the capability and capacity to deliver the scale of transformation required while continuing with the operational delivery of commissioning and provision.                                                                                             | 3                                   | 4                | 12 Medium         | • Strong programme and project management.  
• Clear leadership identified in each organisation for specific schemes.  
• Additional programme management and project management support as part of MLAFL programme.  
• Non-recurrent funding made available to support infrastructure and capacity in 2014-2015.                                                                                                                                                                               | Not applicable         | IOW Council IOW CCG |
| BCF9   | Changes to lead person within each organisation may lead to a change in direction for the programme.                                                                                                                                                                                                   | 3                                   | 4                | 12 Medium         | • Ensure robust management of the direction of the programme through the JACB Board.  
• Ensure robust Terms of Reference are in place for the JACB Board outlining how and who can change the programme’s direction.  
• Ensure each strategic lead within respective organisations is championing integrated working and now the Five Year Health and Social Care Vision.                                                                 | Not applicable         | IOW Council IOW CCG |
| BCF10  | Resistance of staff to new ways of working could result in integration not being achieved.                                                                                                                                                                                                                 | 3                                   | 4                | 12 Medium         | • Engagement with staff to ensure they understand what the programme outcomes and benefits are.  
• Link with communications leads for each partner organisation to ensure an effective awareness raising campaign is in place.  
• Provide training sessions where necessary to ensure staff understand any changes and possible new roles.  
• Delivery of integration to be linked to job roles, annual appraisals and work reviews.  
• Manage delivery through contracts with providers.                                                                                                                                         | Not applicable         | IOW Council IOW NHS Trust IOW CCG Independent Sector Voluntary Sector Primary Care |
<table>
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</tr>
</thead>
</table>
| BCF11   | Resistance of staff to 7/7 day working could result in shortage of key staff to enable extended working. | 3                                   | 4                | 12 Medium           | • Engagement with staff to ensure they understand what 7/7 day working benefits are.  
• Delivery of 7/7 day working linked to job roles, annual appraisals and work reviews. | Not applicable                     | IOW Council IOW NHS Trust |
| ORGANISATIONAL INTEGRATION |                                                                                     |                                     |                  |                     |                                                                                     |                        |                       |
| BCF12   | Cross organisational cultural changes will not be achieved to level required.         | 3                                   | 3                | 9 Medium            | • Cultural change programme being developed and part of workforce programme within MLAFL programme.  
• Funding set aside to support cultural change programme in 2014/15. | Not applicable                     | IOW Council IOW NHS Trust IOW CCG |
| BCF13   | Conflicting priorities from each organisation resulting in integration not being achieved. | 4                                   | 4                | 16 High             | • Five Year Health and Social Care Vision completed and signed by all three organisations.  
• Issues arising highlighted and resolved with robust monitoring and governance processes. | Not applicable                     | IOW Council IOW NHS Trust IOW CCG |
| BCF14   | Integration of other major projects and programmes within partner organisations does not happen resulting in duplication and reduced efficiencies. | 3                                   | 4                | 12 Medium           | • Prioritise all major projects and programmes across all partner organisations. | Not applicable                     | IOW Council IOW NHS Trust IOW CCG |
| IMPACTS/BENEFITS |                                                                                        |                                     |                  |                     |                                                                                     |                        |                       |
| BCF15   | That the actual anticipated benefits are lower than anticipated as demand for community services is increasing and the activity levels of people requiring services is also increasing. | 4                                   | 3                | 12 Medium           | • Each scheme will be project managed and monitored and remedial action will be taken where required.  
• Robust business cases are required prior to implementation. | Dependant on schemes                | IOW Council IOW CCG |
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<th>Financial Impact £000s</th>
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</table>
| BCF16   | There is a risk that in running the BCF schemes as a portfolio of initiatives to action the strategy, the benefits arising out of the differing schemes overlap and may not be fully realised. | 3                                    | 3                | 9 Medium            | • The portfolio of schemes will be closely monitored using robust governance and project management principles.  
• The portfolio of schemes will be modified as required depending on performance of schemes and initiatives, closing those which are not performing and identifying replacement schemes as appropriate. | Dependant on schemes and potential overlapping impact | IOW Council IOW NHS Trust IOW CCG |
| BCF17   | The actual reduction in emergency admissions is not delivered.                        | 3                                    | 5                | 15 High             | • Robust project management, monitoring and remedial action plan taken where required.  
• Robust business case required prior to long term commitment to scheme.                                                                                                                                  | £ P4P                | IOW Council IOW NHS Trust IOW CCG |
| BCF18   | Emergency admissions are reduced but overall financial savings are not realised.      | 4                                    | 5                | 20 High             | • Careful monitoring of case mix and length of stay of non-elective admissions.                                                                                                                                  | £ P4P                | IOW Council IOW NHS Trust IOW CCG |
| BCF19   | The reduction in residential demand is not delivered.                                  | 3                                    | 4                | 12 Medium           | • Robust project management, monitoring and remedial action plan taken where required.                                                                                                                          | Not yet quantified    | IOW Council IOW CCG |
| BCF20   | There is a risk that strategic consultation and person engagement has increased expectations that may not be delivered in the short term. | 3                                    | 3                | 9 Medium            | • Cohesive communication strategy that keeps everyone informed of progress, including successes and issues to be addressed.  
• Engage service users and carers in how we mitigate risk.  
• We develop a HOT (honest, open and transparent) culture across all partners including service users and carers, including what is realistic and within statutory gift. | Not applicable       | IOW Council IOW CCG |
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</thead>
<tbody>
<tr>
<td>BCF21</td>
<td>ICT systems do not enable new integrated service(s) resulting in duplication of information and potential for information to be lost/not recorded.</td>
<td>4</td>
<td>4</td>
<td>16 High • Engagement of ICT leads for each partner organisations within the development of work streams/projects within the programme. • Identify ICT systems currently in use by relevant services. • Identify what ICT systems would be needed for new integrated services. • Ensure BCF IT needs are fed into the appropriate IT Boards and systems IT planning.</td>
<td>Not applicable</td>
<td>IOW Council IOW NHS Trust Primary Care GP Practices</td>
</tr>
<tr>
<td>BCF22</td>
<td>Accurate data about existing services is not available.</td>
<td>3</td>
<td>3</td>
<td>9 Medium • Use a variety of data sources to cross-check validity where possible. • Identify gaps and ways to address these. • Identify where ‘pump priming’ funding is required.</td>
<td>Not applicable</td>
<td>IOW Council IOW NHS Trust IOW CCG</td>
</tr>
<tr>
<td>BCF23</td>
<td>There is a risk of data and information not being shared across the whole health and social care system due to incompatible systems.</td>
<td>3</td>
<td>3</td>
<td>9 Medium • Mitigation in place such as moving PARIS, PH (council) analysts now having access to ECLIPSE. • Ensure BCF IT needs are fed into the appropriate IT Boards and systems IT planning.</td>
<td>Not applicable</td>
<td>IOW Council IOW NHS Trust IOW CCG</td>
</tr>
<tr>
<td>BCF24</td>
<td>There is a risk of data and information not being shared across the whole health and social care system due to culture and staff knowledge of data sharing legislation and protocols.</td>
<td>3</td>
<td>3</td>
<td>9 Medium • Workforce development, joint working around data sharing protocols, plans for joint training for IOW CCG, NHS and council staff around data sharing. • Ensure BCF IT needs are fed into the appropriate IT Boards and systems IT planning.</td>
<td>Not applicable</td>
<td>IOW Council IOW NHS Trust IOW CCG</td>
</tr>
<tr>
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<tr>
<td>BCF25</td>
<td>PAS system does not become fully spine compliant.</td>
<td>1</td>
<td>3</td>
<td>3 Low</td>
<td>ISIS Programme board monitoring of progress and escalation to partner organisations. Paris Group set up/ to oversee Information System development and integration.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>BCF26</td>
<td>PARIS project not fully implemented or delayed.</td>
<td>2</td>
<td>3</td>
<td>6 Low</td>
<td>PARIS Project board monitoring of progress and escalation to lead to partner organisations.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>BCF27</td>
<td>GP Practice systems are not updated to enable further information sharing.</td>
<td>2</td>
<td>3</td>
<td>6 Low</td>
<td>GMSIT strategy review and review via IOW CCG IM&amp;T Strategy development.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Risk No</td>
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<td>Overall risk factor</td>
<td>Mitigating Actions</td>
<td>Financial Impact £000s</td>
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<tr>
<td>BCF28</td>
<td>Information governance (IG) breach occurs (failure to put in place and/or comply with an Information Sharing Agreement related to specific data flows).</td>
<td>2</td>
<td>2</td>
<td>4 Low</td>
<td>Privacy Impact Assessments and Information Sharing Agreements must be made for all information flows between systems and/or organisations. The NHS Standard (health care services and contract requires that there is information governance clauses contained in the contract which places obligations on providers and suppliers. During project development and business case IG controls apply and NHS IOW Trust IT Department identify against any requests for installation of equipment, whether or not there will be data slows utilising PID and require approval from the Information Governance Manager to proceed following appraisal that the flows would be IG compliant. Partner organisations Business Case Templates have section to consider IG implications.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>BCF29</td>
<td>The use of the NHS Number is not universally adopted.</td>
<td>1</td>
<td>2</td>
<td>2 Low</td>
<td>NHS procured contract require that all systems must be compatible with use of the NHS Number. This would be identified at the development stage and would only progress to implementation if compliant.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
### Risk No

<table>
<thead>
<tr>
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</table>
| CARE ACT | Implementation of the Care Act will result in a significant increase in demand for assessments from 2015 and cost of care provision from 2016 that is not yet fully quantifiable. This will impact on sustainability of social care funding and plans. | 4 | 5 | 20 High | • Impact Assessments being undertaken by the council.  
• To be discussed as part of financial summit on 15th October 2014.  
• Action Plan for delivery being prepared. | Not yet quantified | IOW Council |
5.2 Contingency plan and risk sharing

This part outlines the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place between commissioners across health and social care and with providers.

Emergency admissions performance payment contingency risk share

As part of the governance process that will be monitored by the Joint Adult Commissioning Board, the local health economy has identified the value of the Pooled Fund that is potentially at risk. This is identified in the Part 2 templates as the Emergency Admissions value which forms the Performance Payment value (£265k).

The BCF officers are currently in discussions with Bevan Britten (legal firm) and IOW Council legal team in constructing an overarching Section 75 agreement for the BCF, addressing governance issues and processes for the IOW Council and IOW CCG.

The Section 75 agreement will have a service specification for each section, with an identified lead commissioner for each project. As part of the mitigation of Risks included in Section 5 a) above; the detailed Risk management arrangements will be agreed and set out in the Section 75 Pooled Budget arrangements. The development of the local Section 75 agreement has commenced but the detail is not yet defined.

The value of the emergency admissions reduction is currently identified in contract baselines with the acute provider. The IOW is achieving emergency activity reductions due to schemes implemented under QIPP and schemes in the BCF, which contribute to the aspirational reduction agreed by the Health and Wellbeing Board (see Template 2 Non-elective reduction aspiration for further details of the IOW aspirational % reductions and the underpinning analysis and modelling in Appendix A page 181). As it is intended to invest the value of the Pooled Fund into services (both recurrently and non-recurrently) being delivered and developed from the start of the Fund, in Year 1 of the BCF, the IOW CCG will hold the acute contract budget reduction as risk contingency, whilst enabling investment of an equivalent sum in the BCF from Month 1 on a non-recurrent basis. Once it is apparent that the reductions have been achieved the IOW CCG will release the equivalent value into the BCF recurrently.

If the reductions are not realised the value of the risk contingency will be planned to be removed from BCF service costs by the following financial year, and the Fund reduced accordingly. The value of the expected reduction will have been removed from the acute activity contract recurrently and if the reductions are not realised the over-performance value will be allocated non-recurrently to the provider. This therefore assumes recurrent removal of the value from the acute contract with only non-recurrent “return” which is the provider Trust risk element.

The services on which the intended performance funding will be spent include inter alia Crisis Response, Mental Health Reablement and the Frail Elderly Locality Pathway into which health service investment is being made within the BCF, and against which the emergency care health service budget can be offset. The release of the performance funding into the BCF on a recurrent basis will be finalised by the end of Quarter 3 in Year 1, or allocated to the acute contract non-elective baseline to fund over-performance on plan non-recurrently.
In effect the IOW CCG will be under-writing, on a non-recurrent basis, the value of the risk for the health economy for one year during which time the health and social care economy will have time to review the effectiveness of delivery plans and agree Year 2 (and following years) recurrent allocation of the value. This will provide stability of investment in Year 1 and provide assurance to the acute provider that should the BCF schemes fail to deliver the anticipated reductions, funding will be available to meet the cost of delivery. Whilst effectively underwriting the management of financial risk in Year 1 of the BCF by the IOW CCG, future years’ risk sharing arrangements will be reviewed annually dependent on the performance of the Pooled Fund, in order to share risk gain/pain across the health economy and ensure that the management of activity is dependent on mutual co-operation across patient pathways. In Year 1 the financial risk borne by the provider is the recurrent reduction in expected activity reduction with non-recurrent return for under-performance. The risk borne by the BCF is the requirement to reduce costs in Year 2 in order to fund the recurrent gap.

The diagram below (figure 20) sets out the contingency management.

This arrangement is set in context of the Joint Adult Commissioning Board being able to review the scheme’s effectiveness on an ongoing basis and adjust the delivery at appropriate milestones. The activity will be separately identified and monitored in contract baselines to ensure that impact of the schemes can be reviewed regularly and progress tracked.

The rate of admissions reduction is unlikely to result in an equivalent cash releasing saving from the acute sector costs, and the impact of this will be considered as part of wider risk sharing agreements.

**Wider health and social care economy risk sharing agreements**

The BCF risk sharing arrangement for the potential non-achievement of the emergency admission reductions form part of a much wider health and social care risk share arrangements, including diseconomies of scale and transitional funding, that will be reviewed as part of budget setting and contacting for 2015-16 and beyond. The IOW Financial Summit in October will begin the process of reviewing the financial position of the partners (IOW CCG, IOW Council and IOW NHS Trust), and agreeing
the wider system risk management arrangements, in the light of the challenges facing the health and social care economy on the Island including:

- Council savings target £28m over three years
- Adult Social Care Net Budget in 2013/14 £47.6m with a savings target of £5.6m by 2015/16
- The IOW NHS Trust savings target of £34m over five years
- Following the issue of the new funding formula, the IOW CCG has been given a target allocation which is £35m (21%) lower than its current allocation. National policy for the next two years is a very slow progression towards the target, but after this period the policy is unclear.
- The council expectation is that £3.161m will be available in 2015/16 to protect Adult Social Care

Financial details have been developed at BCF Scheme level and will be part of the Section 75 agreement and included in the wider risk management discussions. The aspiration is to agree and implement, in the spirit of our jointly agreed five year health and social care vision, a fair and transparent risk sharing arrangement across the system.

**Operational Risk Management**

The level of risk in terms of impact of achievement of the reduction in emergency admissions will be reviewed and monitored monthly at both the acute provider Contract Review Meeting and, in order to take a whole systems approach at the IOW System Resilience Board and the JACB. It is not expected that a rise in emergency admissions above the plan will impact significantly on the elective capacity (RTT Admitted and Non-Admitted) if these admissions are phased in the current pattern, the risk to protected elective capacity will be if the pattern does not follow the usual distribution causing the need for elective cancellations, and how quickly the acute provider could recover any waiting list (RTT Incompletes) position. This may include agreement to outsource electives, schedule additional clinics/theatre lists etc., as well as reviewing the capacity to reduce admissions in the community.

Regular system review of the contract baseline monitoring described above, along with the pattern of admissions at the groups, should ensure that the system can take steps to respond to any pressures and mitigate impact on key targets (RTT, Cancer, Cancelled Operations, Ambulance and A&E measures).

**Quality Risk Management**

The system has already acknowledged that declining resources and rising expectations, may lead to reported patient satisfaction reducing in the short term. The system acknowledges that communication between improvement projects, health and social care professionals, the public and voluntary sector, will be essential in managing expectations; this will be considered as part of the Joint Adult Commissioning Board delivery plans.
Section 6

Alignment

Key Points:
- The Five Year Health and Social Care Vision which supports integration was agreed prior to the BCF.
- The BCF schemes therefore fully reflect the existing strategies including MLAFL which support integration.
- Where new strategy and policy is in development we will ensure it is in full alignment with the agreed vision and principles and fully supports the BCF. Examples of this include primary co-commissioning and housing strategies.
- All enabling strategies, such as data and information sharing, are aimed at supporting the integration agenda.
6.1 Alignment with other initiatives

The BCF proposals are initiatives which were already in development and therefore reflect the joint aims of the IOW CCG, IOW NHS Trust and the IOW Council in promoting longer, healthier and more independent lives for the people of the Isle of Wight. Primary, secondary, and social care, all contribute to the overall vision and the effectiveness and efficiency is dependent upon developing a highly integrated model of care. This is at the centre of our health and social care vision.

The My Life a Full Life (MLAFL) programme, which is central to the IOW CCG Commissioning Plans, IOW NHS Trust Strategy and corporate priorities of the IOW Council, has been a pivotal influence on the BCF plan, which has resulted in the BCF plan naturally aligning with these existing strategies.

As referred to in previous sections, the following strategies are reflected in and align with the BCF plans:
- IOW CCG Clinical Commissioning Strategy 2014 – 19
- IOW NHS Trust Clinical Strategy
- Health and Wellbeing Strategy
- Adult Social Care Strategy
- Mental Health Strategy
- Dementia Strategy
- Suicide Strategy
- Carers Strategy
- Autism Strategy

In preparing the BCF Plan a review of health and social care partner plans was undertaken, looking at services currently commissioned, and those planned to be commissioned, to map alignment with the Health and Wellbeing Board vision and identify which initiatives should be included in the BCF plan. From this, IOW CCG, IOW Council and IOW NHS Trust partners can confirm that BCF plans reflect elements of existing strategies and are therefore fully aligned (see table on page 75 – figure 21).

Current strategies are wider than the BCF but the BCF schemes complement other initiatives, for example:
- GP in A&E, commenced November 2013 so is already reducing admissions for 14/15 baseline 800 people (32%) discharged instead of admitted to date
- New paediatric non-elective care pathway in development
- Anticipatory Care Plans have been in place for a year and continue to be utilised
- Hospice admitting directly rather than through hospital
- 111 and Urgent Care Hub
- GP Directly Enhanced Service (DES) - Care Plans scheme started April 2014

A good example of resource sharing is clearly demonstrated in the Urgent Care Hub, based at St Mary’s hospital, from which the Island delivers aligned services incorporating:
- NHS 111 Service
- Ambulance Dispatch
- Adult First Response
- Wight Care (Emergency Response Service)
- Single Point of Access Therapy Service
- Multidisciplinary Crisis Response Service
- District Nursing Service

Also delivered in alignment, with resources shared through Section 75 agreements, are the Integrated Community Equipment Store (ICES) and Speech and Language Therapy service for both adults and children.

The Public Health review of current initiatives and programmes identified the Health Trainer service as a programme that relates to care and support. The commissioning of this service post 2015 is currently being
reviewed as part of the planning phase of Local Area Co-ordination to ensure alignment and to explore opportunities to share resources.

Personal Budgets and Personal Health Budgets form part of the Care Act and are therefore naturally aligned with the BCF.

Work will be done to ensure that all commissioning intentions align, where appropriate, with achievement of the integrated care vision, and that the sharing of resources is maximised. Where opportunities for the use of Health Act flexibilities are identified, further schemes can be added to the BCF Section 75 when agreed by all partners.

The IOW CCG, IOW NHS Trust and IOW Council have developed a System Resilience Plan which links BCF principles in the wider planning agenda. A number of the members of the System Resilience Group are also members of the JACB and therefore have a broad understanding of the principles and requirements that apply to both areas. The BCF will underpin many of the operational capacity and resilience planning requirements.

The JACB, with director level representatives from the IOW CCG and IOW Council, has clear oversight of both BCF schemes and wider local initiatives, and will facilitate ongoing communication between the various schemes and initiatives, ensuring continued alignment. The JACB will report to the Health and Wellbeing Board.

A wide range of local initiatives, strategies, work plans and delivery mechanisms sit under the umbrella of the Health and Wellbeing Board, with voluntary and community groups engaged with them. The Health and Wellbeing Board therefore has clear oversight of all local initiatives, and governance mechanisms in place will ensure that plans continue to fully align.

**Housing**

We are keen to align other areas of work with that of the BCF. One of the primary aims of the BCF is that people remain independent in their own homes for as long as possible. An excellent example of how this is happening is the Pan Meadows development. Pan Meadows is a housing and regeneration project being delivered on the outskirts of Newport in partnership between the IOW Council, Barratts and the Spectrum Housing Group. The development will eventually provide over 800 homes with around a third of these being affordable homes. Overall the site will comprise a mixture of new homes for sale on the open market, shared ownership homes and homes for affordable rent. Importanty, homes of all tenures exceed level 4+ of the Code for Sustainable Homes, Lifetime Homes and Building for Life (Gold Standard) meaning that as part of the design of these homes, doorways are wider, turning spaces for wheel chairs are provided and level access delivered as a matter of course. This means that residents living on Pan Meadows automatically reside in a home which is not only future-proofed by design to meet the needs of disabled and/or ageing tenants, but beyond this design are easily, quickly and cheaply converted into a home which is suitable for all stages of life. All of the affordable housing will have been delivered by December of this year.

**Extra Care Accommodation**

The demographic information presented in this plan highlights the high number of residents over the age of 65. The link between this ageing population and the demands for residential and nursing placements has been clearly made which in turn is creating significant financial pressures on Adult Social Care. A range of responses are in place to try and tackle the impact of this demand on the health and social care system across the Island and many of these are described elsewhere in this document. It has, however, become increasingly evident that one element of the response which is missing is an adequate supply of Extra Care accommodation.
The need for this type of accommodation, which if available can help to delay the need to make a referral to a residential or nursing facility, is demonstrated by the needs data set out below:

**Number of clients receiving services provided or commissioned by IOW Council – 1/4/13 – 31/3/14.**

<table>
<thead>
<tr>
<th></th>
<th>Total of Clients</th>
<th>Community based services</th>
<th>Residential care</th>
<th>Nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18-64 age group</strong></td>
<td>1135</td>
<td>938</td>
<td>218</td>
<td>12</td>
</tr>
<tr>
<td><strong>65 and over age group</strong></td>
<td>2860</td>
<td>2038</td>
<td>868</td>
<td>248</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3995</td>
<td>2976</td>
<td>1086</td>
<td>260</td>
</tr>
</tbody>
</table>

Out of the clients receiving community based services, the following were receiving home care:

<table>
<thead>
<tr>
<th></th>
<th>Total of Clients receiving Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18-64 age group</strong></td>
<td>178</td>
</tr>
<tr>
<td><strong>65 and over age group</strong></td>
<td>1145</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1323</td>
</tr>
</tbody>
</table>

As there is movement between the service sectors there may be some double counting across service types. The ‘Total of Clients’ column is a measure of the number of clients involved ie there were a total of 4220 clients on our books during the period. Nevertheless, the data makes the pressure inherent in the system very clear.

Currently there are two small Housing Association schemes in Newport and Ventnor which provide 44 units of Extra Care accommodation. The council is therefore currently working with the Homes and Communities Agency, Abbeyfield UK and another national housing provider in an attempt to deliver in the region of a further 180 Extra Care homes on the Island in the next two to five years. Once these homes have been constructed they will help to keep Island residents living independently, in their own community, for as long as possible. This in turn will help to alleviate some of the financial pressures on the supply.

**Care Act**

Set against all of this activity is the need to prepare for and deliver against the new Care Act 2014 due to be implemented in 2015. The Care Act is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It requires local authorities, CCGs, health and housing services, as well as other service providers, to deliver an integrated approach to the provision of care and support to ensure the best outcomes are achieved for the individual. There are also new areas of responsibility, such as social care in prisons, carer’s needs being put on a statutory footing, adult safeguarding becoming a statutory function, having a statutory responsibility for providing information and advice as well as Personal Budgets, including Personal Health Budgets, being included within a legislative framework for the first time.

**Digital Inclusion**

ICT has enormous potential to improve quality of later life and plays a crucial role in creating a fair and equitable society. It can extend services to help people retain their independence, offer access to information and advice to improve health and wellbeing, create social networks to tackle isolation and loneliness, enable community participation and empower consumers. We have begun a one year project which ensures that older Islanders have the opportunity to become digitally literate and confident users of technology. IT volunteers will provide practical support and advice on a 1:1 basis in people’s own home/care home, or through small group work at community locations.

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7 Source: Referrals, Assessments and Packages of Care (RAP), 2013/14
Assistive Technology

The government initiative ‘3 million lives’ made clear the commitment to work with industry to improve the lives of patients living with long term conditions with the integration of technology, including Telecare and other assistive technology. The use of medical telehealth monitoring, although in its infancy, is part of this progress.

The Isle of Wight’s telehealth model has spearheaded this progression. The Island model focuses on providing people living with long term conditions the use of high quality, light-weight portable equipment to transmit symptomatic metrics i.e. blood pressure, temperature and pulse oximetry, via smartphone technology, to a secure web based link to the clinician’s desktop. This information is closely monitored, involving staff from an array of backgrounds, including respiratory and cardiac specialist nursing teams, specialist physicians, ambulance services and the crisis response team within the Urgent Care Hub. This allows timely and relevant intervention and appropriate advice to enable and promote self-care and self-management within the home environment, with very positive results.

Information sharing

The IOW NHS and IOW Council ICT departments have built up good working relationships over the years and are examining all areas of ICT in partnership to see where similarities exist and where sharing of skills and resources could benefit both organisations.

A project to use a shared database for the management of patient and client records in the Community base is being implemented and will be live in October 2015. The NHS has already implemented parts of the Civica PARIS project with the Child health and Mental Health modules already live. Community Health will be live by the end of the financial year and the Social Care module will be implemented by October 2015. The implementation of this software will enable some integration of records to support patient care.

The initial phase to implement the Social Care module will then lend itself to further phases of information sharing amongst professionals. Phase 2 of the project will start to look at where there are integrated teams working together and how integrated a patient/client record can become in reality. Part of this phase will be around mapping of business processes and looking at where information can be shared within the legal boundaries of each organisation.

Once we technically have the ability to share records across social care and health then we can look at wider areas such as GP information and how we can align the systems to talk to each other. This will fit in line with the ISIS (Information Sharing, Integrated System) project being run by the IOW NHS Trust which extracts information from multiple systems to create an integrated record (see Data Sharing, Section 8c).

In the current climate both the council and the NHS are experiencing financial pressures and we are beginning to look at ICT across the three organisations and how best it can be supported. We are looking at areas of commonality and where resources can be shared. We are looking at data centres and how we can support each other in providing disaster recovery centres by housing software and hardware in each other’s data centres, so that in the event of failure or disaster systems can be accessed on each other’s sites.

Beyond the above we are also exploring the possibility to align IT support services across the three organisations. Work is currently taking place to conduct a feasibility study of an Island business hub and discussions are starting to take place as to what this would look like, what organisations could be involved and what services could be aligned.
6.2 Alignment with two year operating and five year strategic plan

The IOW CCG, IOW Council and IOW NHS Trust partners within the BCF can confirm that all the BCF schemes are included as part of both two year operating plans and aligned with five year strategic plans.

The BCF plans are reflected in the IOW CCG Strategy 2014 – 19, where the priorities are:
- Self-care and self-management
- Primary care
- Integrated care
- Mental health
- Urgent care

The IOW CCG two year Operating Plan and two year Delivery Plan set out the strategic importance of the BCF to deliver both improved health outcomes and improved performance, including reductions in preventable non-elective admissions. The delivery plan, which is the implementation document, sets out the milestones and key dates for service transformation to take place.

We can confirm that the trajectories in the Operational Plan that were required to be submitted were aligned with the strategy and original BCF and will be refreshed to take account of amendments to the Emergency Admissions activity trajectories.

The BCF plans are reflected in the vision of the Isle of Wight’s 2014 – 2017 Adult Social Care Strategy, which includes:
- Enable people to take control of their lives, make positive decisions and realise their ambitions.
- Meet statutory duties and enable and deliver services at the right quality and cost effectively within the resources available.
- Seek to protect and support the most vulnerable.
- Ensure person centred, co-ordinated health and social care.

The IOW NHS Trust’s five year strategic plan, which demonstrates how we will implement our vision, aligns closely with the BCF plans, including:
- Integrated locality working within the community services, aligning our services with other statutory and non statutory provision. This includes service redesign and capital investment.
- The development of an integrated Urgent Care Hub bringing together relevant services under a single umbrella to ensure individuals who require urgent help receive the right care at the right time.
- Wider integration including services, planning and management where it benefits people.
- Closer working with partner organisations including co-delivery of services.
- A greater focus on community provision and patient centred care.
- Hospital redesign to enable earlier discharge and to avoid admission.
- Joint work is underway through the My Life a Full Life Programme to move towards a more integrated health and social care pathway for the locality.

The BCF schemes are reflected in all these priority areas and the common theme throughout all the strategies and the BCF is integrated services regardless of client group or service issue.

The BCF schemes have all been reviewed against the health and social care system strategies described in Section 2: Vision (Page 9) to ensure that there is no disconnect with strategic direction, and similarly that the wider system workstreams under each strategy support the strategic direction of the BCF. We can confirm that no differences or discrepancies have been identified in the alignment of the BCF plans and the two year plans and five year plans as demonstrated in the table below (figure 21):
6.3 Alignment with primary care co-commissioning

The areas and projects outlined in the our BCF proposal have been widely rehearsed within primary care, with a number of the projects matters of ongoing discussion with all members, particularly regarding locality integrated working as part of the MLAFL programme and projects regarding the management of unscheduled admissions. As discussed elsewhere in this proposal, GPs regularly undertake peer review of both referrals and emergency admissions as part of the work they put into the IOW CCG. Discussion has taken place at monthly locality meetings with regular updates from project managers, particularly related to the development in locality working and changes to community nursing roles.

As part of the IOW CCG’s strategy development process earlier in the financial year, GPs were specifically consulted on the proposals emerging regarding integration and locality working and their requirement to undertake their own transformation change as providers to meet the challenge. The IOW CCG has a separate programme of work supporting this primary care transformation.

The Clinical Executive, which is elected by GP members to be the decision making body within the IOW CCG, has been fully appraised of the BCF throughout the process of its development, recommending formal delegation for decision making regarding joint adult services from the Clinical Executive to the proposed Joint Adult Commissioning Board in August 2014. This group reports monthly to locality groups with a member of the clinical executive attending each group to discuss issues.

The IOW CCG is currently seeking to appoint three GP locality champions, reflecting the three Island localities, to support the aims of the BCF and ensure membership awareness is continually improved. The shape of this BCF proposal has been discussed with the IOW CCG GP locality teams most recently at the round of locality meetings held in the first week of September 2014.

Comments have largely related to concerns regarding the management of workload during transition and the complexity of the transformation required. GPs report significant workload pressures and difficulty in recruiting.
The IOW CCG has expressed an interest in co-commissioning to NHS England and is engaged in discussions with the Wessex Local Area Team to progress these. The IOW CCG does not feel that it requires any additional powers in primary care to achieve the aims of the BCF and although primary care services are not at this stage being commissioned through the BCF, it is acknowledged that it is central to its delivery for a number of schemes.

The IOW CCG in its first year recommissioned all existing enhanced services into standard NHS contracts and has worked closely with NHS England to approve incentive schemes. All GP practices on the Island have signed up to the enhanced services supporting risk stratification and care planning. The IOW CCG is continuing to support practices to implement risk stratification and to ensure that they meet the requirements of the enhanced service, building on work undertaken on the Island with GP practices in previous years, to develop care planning and reform community services to work more closely with GPs. The IOW CCG is fully engaged with all 17 GP practices on the Island and we fully anticipate that the GP community will have met the DES requirements at the end of this financial year.
Section 7

National Conditions

Key Points:

- There is clear recognition and agreement on the need to protect adult social care services, recognising the importance in supporting prevention and patient flow through the health care system.
- Plans are being developed to ensure the Care Act is fully implemented and that the wider health and social care economy, including the NHS, recognises the partnership role it has in implementation. This is reflected in the BCF plan.
- Carers play a vital role in maintaining people’s independence at home. Our joint strategy implementation is reflected within the BCF.
- The Island already has 7 days a week to access community services where there has been a need identified. This is constantly kept under review to ensure services keep pace with demand and discharge from hospital is not delayed, or admission prevented, where appropriate.
- Agreement has already been received to ensure the Trust and Adult Social Care use the same information system. This is underpinned by data sharing agreements and further work is taking place on the strategy to include primary care. This will also ensure the NHS number is the primary identifier in correspondence.
- The GP is the lead professional for high risk individuals however, through the work of the locality management groups this will be refined to ensure other professionals are included in lead roles.
7a Protecting social care services

Adult Social Care

Protecting social care services on the Isle of Wight means ensuring that those in need within our local communities continue to receive the care and support they need, in a time of increasing demographic pressures, growing demand and budgetary pressures. Social work resource is required to be at least the existing level in order to deliver safeguarding, assessments and personal budgets. The IOW Council spend on domiciliary care and personal budgets is also key in maintaining people’s ability to continue to live at home.

Maintaining current eligibility criteria is key, particularly with this due to be set at a national level in the new Care Act. We have a number of other key priority areas, including integrated, multi disciplinary teams delivering a holistic, person-centred approach to care and support. Our approach to the integration of services across the social care and health sectors, described in our vision for integration and our BCF will minimise need and reliance on statutory services across the sector, with a shift to a proactive, preventative model which will encourage people to better manage their own health and care and increase the use of voluntary sector organisations. This will ensure that we deliver significant savings, allowing the movement of savings from IOW CCG funded services to social care. We will ensure that people will have maximum choice and control over their lives, maintaining independence and remaining in their own homes and within their local communities for as long as possible.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the council to provide timely assessment and personal budget provision as well as, where appropriate, commissioning services for individuals who have substantial or critical needs. Those people below the eligibility threshold are provided with information and advice and signposted to third sector organisations where appropriate.

With the increasing demographic pressures, it is inevitable that this will need to be sustained, if not increased, within the funding allocations for 2015/16 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and the new Care Act, where additional assessments will be undertaken for people who did not previously access Social Services, for example, carers and those in prison.

It is proposed that the additional resources mentioned above will be invested in social care to deliver enhanced preventative and rehabilitation/reablement services (including Mental Health) which will reduce hospital readmissions and admissions to residential and nursing home care.

Protecting Adult Social Care (ASC)

The eight core schemes (excluding our joint work on the implementation of the Care Act locally) are targeted at a range of preventative services at those Island residents who are most likely to make use of higher cost services such as residential and nursing home care and or require admission to hospital. By the sensitive and intelligence led application of services such as additional homecare packages, the rapid application of reablement services and the on-going development and use of the crisis response service the schemes set out in this plan should reduce the requirement for residential and nursing care. In the medium term over the next two –five years our integration programme, which is scheduled to start with the introduction of locality working in April 2015 will deliver additional savings for investment in the social care economy. The schemes set out in annex 1 to this document provide fuller details of our ongoing intentions.
BCF allocation for the protection of ASC

The tripartite approach to the development of our BCF plan has identified a requirement of £3.161 million for the protection of Adult Social Care Service in 2015/16. The IOW CCG is supporting Adult Social Care with £2.161 million on a non-recurrent basis. The remaining £1 million is generated from scheme savings and ongoing benefits from integration. As integration continues and the way we work changes, efficiencies across the system will be developed. We will focus on the prevention agenda to reduce the need for expensive care packages and hospital admissions. The ongoing requirement beyond 2015-16 to deliver £3.161 million of protection to social care will be achieved through the BCF and the wider integration agenda being delivered as part of the five year Health and Social Care Vision, which will expand over time once the locality working model has been successfully implemented.

Within the BCF we have a planned to invest £519k (£359k revenue as per our proportion of the £135 million national pot, plus £160k capital) in the implementation of the Care Act. A tripartite Financial Summit is being held on 15 October 2014 where final exemplification of this budget will be delivered.

New duties under the Care Act 2014

The Care Act represents the biggest overhaul of Social Care legislation in 60 years, putting people and their carers in control of their care and support. For the first time, the Act will put a limit on the amount anyone will have to pay towards the costs of their care.

There are a number of areas that will, for the first time, become statutory, including adult safeguarding, Personal Budgets and social care provision in custodial settings.

There will be a considerable increase in, amongst other things, our responsibility towards carers and self-funders. Eligibility criteria will also be amended (significantly), with a minimum eligibility threshold being introduced across the country. This will be a set of criteria that makes it clear when local authorities will have to provide support to people. This, together with other significant funding reforms, will mean that the cost of Adult Social Care to local authorities is likely to increase considerably.

Particular attention should be paid to the fact that the financial support provided by the council will be extended by raising the upper capital limit from £23,250 to £118,000. This will increase the number of people approaching local authorities for help with their care and support. In addition, there will be a cap on the amount people have to spend on the care they need, regardless of how much they have in savings or assets. For people of retirement age the cap is £72,000, once this is reached the state will pay their care costs. Those who turn 18 with eligible care and support needs will have their needs met for free by their local authority for the rest of their lifetime. On top of this we will have increased demands placed on us in terms of assessment, provision of information and advice and means testing.

The key duties of the Care Act are:

- Promoting wellbeing
- Prevention, reducing and delaying needs
- Information and advice
- Market shaping and commissioning adult social care and support
- Managing market failure and other service disruptions
- Assessment and eligibility
- Independent advocacy
- Charging and financial assessment
- Deferred payment agreements
- Care and support planning
- Personal budgets
- Direct payments
- Review of care and support plans
The sum of £359,000, which is the local proportion of the Government’s identified £135m, has been allocated from within the BCF in order to ensure the IOW Council is able to fulfil its new duties under the Care Act. Alongside this there is a capital allocation of £160,000.

To meet the requirements of the Care Act, the following either has been or will shortly be in place:
- Senior Responsible Officer is being recruited to lead implementation
- Care Act Implementation Board established to ensure the Act is introduced effectively
- SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) sub-regional, regional and national LGA/DASS involvement from council leads
- Financial modelling is underway
- Integration duty is being looked at alongside the MLAFL programme
- Communication of duties and engagement with partners in partner organisations, including the CCG and the IOW NHS Trust

The Care Act, by its very nature, will encompass everything that ASC does in supporting all those with social care needs, including those groups particularly identified through local risk stratification: frail elderly, long term conditions, mental heath issues and dementia. It is, therefore, implicit that all the schemes within the BCF will contribute towards the delivery, not only by the council, but its partners too (including the IOW CCG, IOW NHS Trust, and the voluntary and private sectors), of the Care Act. We are able, therefore, to say with confidence that the work around the Care Act is completely aligned with achieving the vision and benefits outlined within this submission.

Resource for carer-specific support
The IOW Council and the IOW CCG are working together to improve the lives of carers, providing them with the opportunity to be consulted about services and involved in the decision making which affect them. One of the main aims of the strategy, in line with government policy, is to provide people with genuine control and choice over how they are supported. In the last 10 years we have seen a 14 per cent increase in the numbers of carers living on the Island with figures rising above 16,500, which is over 10 per cent of the Island’s population. The Care Act offers significant opportunities to improve support for carers. A new Isle of Wight carer’s strategy has now been drafted and focuses on the things that make the most difference for carers.

This strategy potentially affects 16,500 carers (census 2011) on the Isle of Wight and is proposed to ensure that carers are supported in their caring role, through 10 key priorities, these are:
- Priority 1: Identifying and including carers
- Priority 2: Providing information, advice and training for carers
- Priority 3: Carers shaping policy and services
- Priority 4: Peer support
- Priority 5: Carers Breaks
- Priority 6: Access to work and training
• Priority 7: Access to benefits
• Priority 8: Crisis support
• Priority 9: Access to health and wellbeing
• Priority 10: Support for children and young carers

Set out below are details of the council’s current level of expected expenditure in relation to supporting Carers for 2014/15:

• Free sitting service - £196,103
• Residential/nursing crisis for carers - £6,793
• Carers UK - £3,264
• CRUSE - £1,530
• Family and carer support: Stroke Association - £58,104
• Carer’s alert cards - £1,000
• Quay Carers: carers support - £31,500
• Male carers support - £1,500
• Former carer support - £1,500
• IOW CCG Carers for Continuing Healthcare - £291,000

Part of the delivering of the Carers Strategy will be to further scope demand, which will inform the longer term financial assessment. Currently services are funded via the Adult Social Care base budget, £240,190 and £61,104 from NHS Support to Social Care funding and £291,000 from Continuing Healthcare funding.

**Effect on budget**

Provided the schemes deliver the anticipated benefits and the ongoing integration programme remains on track, we do not anticipate any change to the original forecast within the BCF, notwithstanding the massive demographic pressures which the system is already struggling to deal with which threaten the whole of the Island system.
7b 7 day services to support discharge

Implementation of 7 day services

The IOW Council, IOW CCG and IOW NHS Trust are committed to developing 7 day week working and, together with the voluntary sector on the Island, are fully engaged in the My Life a Full Life Programme which is progressing integrated working across health, social care and the third sector.

We are redesigning the way we provide care and support on the Island by introducing integrated, multi-disciplinary working on a locality basis to support the implementation of a 7 day a week approach. The Island will work in three geographical localities clustered around Primary Care practices.

Island residents already benefit from having The Beacon Centre, a 7 day a week GP walk-in centre for patients with Primary Care minor injuries and illnesses. The centre is co-located next to A&E and manages a number of conditions aimed at reducing the pressure on A&E as well as managing normal Primary Care conditions. The Centre is categorised as a class 3 A&E site and its fast access supports the overall A&E access performance times. This service is available to all Isle of Wight residents and visitors. The GP service is accessible between 8am and 8pm, 7 days per week, outside of these times the service also provides the local GP Out of Hours service. This is supported by GPs access to direct referral residential home beds, preventing hospital admission.

In order to improve discharge from hospital we provide a full 7 day a week enhanced discharge service from the Hospital Care management team. We will expand our hospital social work team to align with the working pattern of our reablement service in the community. Community nursing continues to provide 7 day cover with an on call service out of hours. The community rehabilitation team are also extending their service to provide 7 day week cover.

In addition, the Island has an integrated NHS 111/Urgent Care Hub providing 7 day services: hosted within the Urgent Care Hub are 111 and 999 call handling staff, Clinical Advisors, the community rehabilitation triage service (SPARRCS), Community Nursing, Wightcare (24/7 Community alarm, telecare and response service), the ‘Check it Out’ online advice service and members of the Social services duty team. The Integrated Care Equipment Services (ICES) out of hours service can also be accessed through the Urgent Care Hub via the community nursing team. The Urgent Care Hub is a key integrated co-ordination centre which offers significant development potential for the future.

The IOW NHS 111 service has been in operation since October 2011 as part of an early adopted pilot site. The 111 provider, the ambulance service and the acute hospital are all the same integrated Trust which insures efficiencies and shared objectives benefit the health economy.

To support this, the crisis response service delivers 72 hour crisis team intervention 8.30am – 4.30pm, 7 days a week, with out of hours support from the Urgent Care Hub, with the aim of supporting patients through crisis and providing the ongoing care required to prevent admissions to hospital and nursing and residential placements.

Mental Health services are extending their 7 day provision, for example, the mental health 111 algorithm is being utilised in the Urgent Care Hub 24 hours a day, 7 days a week, to ensure appropriate transfers of care to either A&E, the crisis mental health team for assessment or to a GP, thus supporting delivery of Mental Health Concordat 2014. The Mental Health Reablement Project now provides 11 beds and community support 7 days a week while learning disabilities respite/reablement beds will be available from October
2014 to provide access to appropriate support 7 days a week and support delivery of Winterbourne Concordat.

A local CQUIN is included within the NHS local contract with the IOW NHS Trust for 2014/15 in response to the Keogh ten new clinical standards that describe the standard of urgent and emergency care all patients should expect seven days a week. The CQUIN supports Standard Two ‘All emergency admissions must be seen and have thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital’. Milestones include audit samples for measuring compliance and triangulation of data collected to look at patient safety incidents, mortality data, length of stay and readmissions. For quarter 4 a service by service action plan is required for any reconfiguration of services during 2015/16 and/or business cases for resources timetable. There is potential to consolidate these plans into quality requirements of the NHS Standard Contract for 2015/16 – 2016/17.

One of the schemes within the Service Development and Improvement Plan within the 2014/15 NHS local contract with the IOW NHS Trust also links to Keogh and includes the requirement for a high level review of all services across the trust to determine whether 7/7 delivery is appropriate. The high level review is in progress. Milestones within the plan require development of action plans for implementation of 7/7 working in agreed appropriate services. These are monitored and reviewed through the IOW CCG Clinical Quality Review Meeting with IOW NHS Trust.

The risk to implementation of these schemes is achievement of the cultural change required to deliver 7/7 working and recruitment of key staff, where additional staff are required.
7c Data sharing

Utilisation of the NHS Number

Health and social care systems
Due to current legislation, neither the IOW CCG itself nor the IOW Council are lawfully allowed to use the NHS Number as the identifier, unless it is relevant to direct patient care and/or the patient has given express consent (Caldicott 2).

Therefore, the health economy will utilise the NHS Number for administration where it is lawful, relevant and with consent, subject to the Health and Social Care Act regulations.

The IOW CCG is currently redefining its Information Management and Technology Strategy (to be finalised by April 2015) and this will set out further the aspirations for data sharing and be agreed by the Health and Wellbeing Board as part of overall Data Sharing agreements for integrated care.

By October 2015, the IOW Council social care staff will be using the Civica PARIS case management system. The NHS has already implemented Civica PARIS for Child Health, Mental Health and, by the end of March 2015, Community Health.

The database will hold all patients/clients of the Isle of Wight and therefore Social Care and Health will be using the same patient/client demographics. The record will contain the PARIS number, the NHS number and the IOW NHS Trust number. The NHS Number can therefore be used as the primary identifier, and for communication outside the PARIS system.

As part of the rollout of PARIS for Social Care, business processes will be re-engineered and staff will be advised and trained on the use of NHS number as the primary identifier. All new forms, letters and documentation will be built within the system and therefore will carry the NHS number. All existing systems outside the PARIS system will be fed from the PARIS information so will also contain the NHS number.

The NHS have been given access to the current Social Care case management system SWIFT, and are able to populate Social Care open cases with the NHS number, so that we are in a position to map all records during migration to the new PARIS system. By October 2015, the PARIS social care system will have been fully implemented so that each client will have a PARIS number and an NHS number.

Ultimately, the project will lead to integration of services where information can be shared by professionals that work across Health and Social care. Work will begin to identify joint teams and workflow within the system will be generated from the PARIS system to users, allowing work on the same case to be recorded.

We have an overarching information sharing protocol between the IOW Council and the IOW NHS Trust and individual data sharing agreements with individual services. Information governance training is provided across both organisations and will be further developed as the implementation of the PARIS system is rolled out across both organisations.

The IOW NHS Trust has adopted a strategy to integrate information across care pathways and this is being realised by its ISIS programme (Integrated Services Information System). ISIS has utilised open APIs to integrate 10 core systems across healthcare on the Isle of Wight, including ambulance, GPs, diagnostics, acute e-prescribing and hospital PAS. The architecture will permit future integration of community, mental health and social care and potentially the third sector.
The programme links with wider data sharing model across the Isle of Wight building on the NHS spine (figures 22 and 23).
The Roadmap above (figure 24) illustrates key milestones and phases in EPR development; this has been shared with IOW NHS Trust Board and partners, and a Business Case will be prepared and submitted via the Trust’s governance structure.

The primary care (all practices) clinical system in use on the Island – VISION – already uses the NHS number as its primary identifier. All referral correspondence from primary care contains the NHS number. (The IOW number is not routinely used in all cases in primary care and a review of primary care system will be undertaken as part of GMS IT strategy).

The NHS Number would be the primary identifier for client/patient data systems within the My Life a Full Life BCF Localities.

**System Impact**

Systems are therefore in place to utilise and increase the utilisation of the NHS Number identifier across the patient pathway (and not just for payment systems).

As we increase the use of the NHS Number as the primary identifier for patients/client this will enable providers of services to improve case records and improve the effective flow of information between providers of care supporting the integration of services. The IOW CCG will seek to ensure that those providers that it contracts with are prepared and enabled to use the NHS Number as the primary identifier.

**NHS Number retrieval**

The IOW NHS Trust has a system in place whereby, until PAS is fully spine compliant, entry point users have access to the SCR prior to registering a patient as new. Active patient records with NHS Number identifier is currently 98.2% (compliance will never be 100% due to overseas patients/offender records etc). A validation is run overnight for patients admitted with no NHS number identifier and one is added manually. Further validation with PAS PMY weekly DBS Trace Service to update. Once PAS is fully spine compliant the need for batch validation will become real-time. The PAS system will feed other systems (ie ISIS systems and PARIS) and therefore the NHS Number should be compliant in case records.
Adoption of systems based on Open APIs and Open Standards

All partners adopt the principles of the use of APIs and Open Standards. In addition, we also adhere to standards around transfer of data, for example, the use of GCSX for secure emails. This is supported by the Information Sharing Protocol described below and the subsidiary Information Sharing Agreements approved by the IOW Health and Wellbeing Board. Processes have been developed using the NHS Interoperability Toolkit. We are currently developing further the integrated care plans and are committed to using Open APIs and Open Standards (ie NHS net) for transmission of care data as follows:

It is a requirement of the PARIS system described above that access to all APIs in the PARIS system would be granted. We do not currently anticipate any issues with this requirement, and are confident that where needed all interfaces can be achieved with our suppliers.

The ISIS programme described above has utilised open APIs to integrate 10 core systems across healthcare on the Isle of Wight, including ambulance, GPs, diagnostics, acute e-prescribing and hospital PAS. The architecture will permit future integration of community, mental health and social care and potentially the third sector. The Trust’s EPR solution is ITK compliant and the specification for any additional systems would include the use of open APIs.

The IOW system is currently looking at NHS Mail 2 and evaluating how this could fit in with our corporate tools, how this could be best achieved, and what advantages this will bring to our integration agenda.

Any new IT system which is mandated under GPSoC should now meet these requirements; this would cover primary care clinical systems and other clinical applications. If primary cares decide to move to a new clinical system these issues would need to be explored in detail as part of the move. Although the IOW CCG commissions GMS IT which would include email systems to GP practices, the technical detail and standards would be determined by the Commissioning Support Unit through which the IOW CCG contracts for GMS IT support, and so the IOW CCG will need to understand more about this technically to be able to ensure that these standards are considered. This will be included in the IOW CCG IM&T strategy.

The IOW CCG, IOW NHS Trust and IOW Council will work with Third Sector Partners to ensure that any new systems are compatible.

The IOW system will document and publish the interface systems where relevant. The IOW NHS Trust strategy is to integrate systems right across pathways via an ITK accredited architecture.

The IOW health and social care system policy in developing data sharing infrastructure is to avoid any unnecessary transfer of data. The following diagram (figure 25) illustrates the development of data warehousing utilising portals to deliver extracted data to access accredited front end users, from multiple data warehouses hosting patient information utilised by the systems from which the data is being extracted, rather than create any new data warehouse into which updates from system warehouses would be collected and stored in addition to the original storage. The ISIS system is a starting platform from which the local system has been developing data sharing linkages across health and social care, including not only secondary care systems but the PARIS system, the GP system and ensuring that any voluntary sector systems can link in the future.
Figure 25: Illustrating development links for Data Warehouse.

Information Governance Controls
The IOW health economy is developing Data Sharing within a set of principles:

- Confidential information about service users or patients should be treated confidentially and respected.
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.
- Information that is shared for the benefit of the community must be anonymised.
- An individual’s right to object to the sharing of confidential information about them must be respected and an opportunity to object made clear, including the requirement to gain any necessary consents to the sharing of confidential information.
- Organisations should put robust policies in place.

The IOW CCG operates risk stratification under the s251 conditions and has completed and returned the Assurance Statement to NHS England.

As part of the MLAFL integrated care programme, the IOW has developed an overarching Information Governance and Sharing Protocol which has already been signed up to by the major stakeholders including the IOW Council, the IOW CCG and the IOW NHS Trust. In addition the ISP has also been circulated to many other information sharing partners including GPs, and, as identified, additional stakeholders will also be invited to sign up to this. This Isle of Wight wide mechanism when used correctly, will ensure that information about individuals and their health and care needs can be shared lawfully, effectively and appropriately between professionals, and that the customer has the best experience possible without needing to repeat their story each time they make contact with a new professional or service, leading to reduced risk of incomplete and out of date data.

The NHS Standard (health care services) contract requires that there are information governance clauses contained in the contract which place obligations on providers and suppliers. During project and business case development, IG controls apply and when processing any requests for installation of equipment the IOW NHS Trust IT department identifies whether or not there will be data slows, utilising PID, and require approval from the Information Governance Manager to proceed following appraisal that the flows would be IG compliant.
The IOW Council is already approved under the IG toolkit requirements (Level 2) and undertakes re-assessment annually. We are confident that we will once again be approved and have no reason to believe that approval will not be given. Similarly the Authority is working towards compliance with Caldicott 2 and will be implementing over the next 12 months all recommendations.

The IOW NHS Trust is NHS IG Toolkit compliant (Level 2). The IOW CCG is Level 2 compliant with the NHS IG Toolkit. All providers of services, under Local Authority Contract and under IOW CCG contracts have contractual requirements to be NHS IG Toolkit compliant.

Contractually, GP practices are required to apply relevant IG standards, ie Level 2 IG toolkit, Caldicott 2, and NHS England are the body responsible for enforcing these requirements.
Those at high risk of hospital discharge

The IOW CCG has identified an initial cohort of 3,184 patients deemed by the Johns Hopkins Adjusted ACG Risk Stratification tool to be at greater than 25% risk of hospitalisation over the next 12 months, including those with dementia and mental health problems. This tool links patient level data from primary care and secondary care including diagnoses, activity and medications. This data is also combined with the patient age and gender profile. The information is fully anonymised at CCG level but is available at patient level to individual practices. A comprehensive IG compliance process and quality assurance process has been undertaken by South Central Commissioning Support Unit (CSU) who provide this tool to the CCG. Quality assurance continues to be undertaken at each data refresh.

Assessing risk, planning care and allocation

GP together with a multidisciplinary team have then reviewed these patients under the risk stratification and care planning DES to undertake a patient level, holistic assessment of the individuals needs and where appropriate have included the patient on the DES 2% cohort. An alternative outcome is also that the patient is placed on an Advanced Care Plan which is locally commissioned by the IOW CCG for patients who are assessed as in the last 12 months of life. Other patients who are assessed as high risk but not identified by the risk stratification tool have also been included in the multidisciplinary review with a particular emphasis on patients in nursing homes, including those with mental health problems and dementia.

The IOW CCG is addressing barriers to joint care planning through the development of locality management groups (as described elsewhere in this document). The IOW CCG has mapped the current points at which care planning occurs in the health economy and identified the opportunities for more effective planning and where the joint approach needs to work. The work that GPs are currently engaged in to formally codify care plans for the top 2% at risk of hospitalisation suggest that appropriate involvement of agencies across health and social care is currently happening, however there are few mechanisms to measure this. This will be taken forward as a priority by the Locality Management Group over the next six months.

The IOW CCG is working on the description of lead accountable professional to take into account the wide range of professionals that could be involved with a patient. Currently the GP occupies this role with those patients most at risk of hospitalisation, and for all over 75 patients on the Island, as required by the Transforming Primary Care Agenda. Further work through locality management groups is required to refine this approach so that for instance an appropriate mental health professional or social worker could be the lead professional for particular clients or patients. Mechanisms to clearly nominate and inform patients of their lead professionals will be developed alongside the processes for ensuring and measuring joint care planning processes.

The IOW CCG has invested the £5/head to support GPs in care co-ordination in the following ways:

- Increase in staffing in GP practices through the recruitment and development of Health Care Assistant (HCA) workforce to support care planning. This group supports the accountable GP to enact decisions about care plans and provides a point of contact for patient’s carers and other professionals in relation to these care plans.
- Implementing patient access to medical records across older people. This is using the ECLIPSE Patient Passport to enable access to patient friendly view of the GP record, with an ability to see key diagnoses,
test results and other information the GP wishes to communicate regarding the health status of the individual. This will support care homes in particular to interpret and implement a person’s care plan.

- GP innovation fund – we have allocated funds to our GP practices to come up with their own ideas about how to implement and improve care co-ordination. Schemes being implemented range from the development of an app to enable older people to engage with the GP practice electronically more effectively, to the development of roles for pharmacists in GP practices to support both care delivery and medicines use and optimisation to improved working with care and nursing homes, reducing the need for urgent consultations and providing regular ward rounds.

**Joint care plans for those at high risk**

Following discussion with our GP colleagues, we anticipate care plans being in place for 2% of the population by the end of September 2014.
Section 8

Engagement

Key Points:

- The BCF reflects service transformation that has been agreed and is in development following consultation on a number of strategies.
- Stakeholder, including public/patient, engagement has been instrumental in the development of these strategies and the BCF plans reflect some of the service transformation plans developed following consultation.
- Specific stakeholders are involved in the detailed planning groups as relevant to ensure a wider range of stakeholders are directly involved in the co-production of plans.
- The IOW NHS Trust has been an active stakeholder in the co-production of strategies and implementation of plans. The impact on the activity in the acute part of the Trust, as detailed in the BCF plans, has been modelled with them and the target reduction agreed.
- The financial savings from changes in acute activity is more difficult to predict as currently reductions in non-elective activity are not leading to savings. A system wide risk agreement will therefore be put in place.
8.1 Engagement

Throughout the development of the BCF and its constituent schemes, a wide range of providers have been involved, including the IOW NHS Trust, which is the biggest health provider on the Island, the council’s provider services (specialising in short-term reablement, crisis and respite services), private sector providers including those that provide both home care and residential care, as well as voluntary sector providers supported by the Island’s Community Action IOW. There has been strong engagement with GPs, as well as with staff at all levels of the IOW Council, IOW CCG and IOW NHS Trust.

Patient, service user and public

Our vision of person-centred, co-ordinated health and social care has been developed through involving local people and listening to what they say is important to them. To hear the voice of people, we have engaged directly with individuals, user groups and user representative organisations, including those people that are ‘experts by experience’, to ensure that we are fully able to capture and respond effectively to what they tell us.

Not only have people been engaged in helping to shape the vision and strategies for the Island, but they have also been able to influence the way support and services are delivered and to have a voice about how local services are developed, all of which are reflected within the BCF.

This has been achieved through the MLAFL locality workshops and launch, as well as directly involving carers, people who use services and the general public to develop a number of key strategies, previously mentioned, across all organisations. Critically, in order to ensure residents were fully engaged with developing these strategies, they were fully supported to have a voice as experts by experience.

In order to reach as many people as possible, and in addition to speaking to individuals directly, we have fully engaged People Matter, the Island’s User Led Organisation, and our local Healthwatch. Both of these organisations have a large membership consisting of people with many different perspectives and experiences and are, therefore, able to give a broad range of views and feedback.

People Matter have specific commissioned responsibilities to engage with vulnerable hard to reach individuals with the Island community and are core to any consultation, engagement or development work around health and social care approaches and services. Not only are they able to reach these communities, but they support them to fully engage by enabling effective communication with and support for those with specific needs, eg, learning disabilities, autism, blind, etc.

Our local Healthwatch have a seat on the HWB which ensure that Island residents have a strong voice at a strategic level in the development of health and social care services on the Island.

Working with our communities, we have developed “I” statements that reflect what people have told us good would look like. These “I” statements provide a clear view of what people’s experiences will be through the delivery of our vision.

To ensure continued public and stakeholder involvement with the BCF, we will hold a public awareness event in October/November of this year to consult on our BCF submission and gain the views of a wide
range of people and organisations. We will use the feedback gathered at this event to help further shape our plans for integration and the BCF. Alongside this event, MLAFL will be holding its own engagement event at which it is planned that we will share the work on the BCF. Beyond this, we will continue to engage stakeholders in the development of individual strategies, ways of working and service design.

IOW NHS Trust
The Isle of Wight has one main health provider, the IOW NHS Trust, being the biggest provider of healthcare to local residents across acute, community, mental health and ambulance services. It has been fully involved as a partner in the development of our Island-wide strategies and has been an active participant in the development of the IOW CCG strategy.

As a signatory to the shared strategic vision, the IOW NHS Trust has been engaged from the outset through its involvement in a variety of strategic, tactical and operational health and social care forums. With its partners the Trust will be instrumental in the delivery of locality objectives. The BCF plan reflects activity required to deliver against shared objectives which are aligned to the Trust’s objectives. The schemes within the plan form part of the portfolio of service developments within the Trust’s operational plans that will contribute to the delivery of improved outcomes across the Island.

The Trust has been closely involved through the BCF meetings and the development and discussion of these proposals. It has also been an active partner in the development of relevant individual schemes and has contributed in full to the design and detail of the service specifications, workforce structure and delivery models.

Primary Care Providers
A large number of primary care providers attended the MLAFL workshops and launch event, being key stakeholders in the development of a vision for the delivery of integrated health and social care support on the Island. Their participation and engagement, has ensured that their views and concerns have been heard and have been used to develop a sustainable approach to integration.

In addition, as part of the IOW CCG’s strategy development process, GPs were specifically involved in the development of the proposals regarding integration and locality working, including their requirement to undertake their own transformation change as providers to meet the challenge. The IOW CCG has a separate programme of work supporting this primary care transformation.

As mentioned previously, the shape of this BCF proposal has been discussed with the IOW CCG GP locality groups specifically at the most recent round of locality meetings in the first week of September 2014.

Social Care, Voluntary and Community Sector Providers
The Island’s Residential and Nursing Home providers and the Island’s Learning Disability providers have well established provider forums. The council’s Commissioning Manager, Head of Service and CCG Head of Continuing Healthcare regularly attend their meetings and use them as a means of staying in touch with the Island’s care market. Representatives from the forum are members of the Island’s Safeguarding Adults Board and play an important part in the formulation of sector-wide safeguarding responses.

The Executive Member who holds the Adult Social Care Portfolio, and is also the Deputy Leader of the Council, has established a regular pattern of meetings with the Chairs of each forum and engages with them on a two monthly basis.

The Isle of Wight’s BCF plan encompasses other existing programmes of work which have had, and continue to have, full stakeholder engagement. Health and social care providers have been fully participating partners in shaping, developing and now delivering our overarching vision and the programmes, strategies and plans which are in place to deliver that vision.
In order to gain key stakeholder engagement, including service providers, GPs and statutory service professionals, we held a number of locality workshops and a launch event for the MLAFL programme which were used to develop the vision for integrated care on the Island, how to deliver that vision and how to measure success. In addition to the MLAFL events, there has been wide consultation with a large number of provider organisations, with professionals participating in a number of workshops to develop a number of Island-wide strategies covering a range of areas, including: mental health, suicide prevention, carers, dementia, autism and the IOW CCG Clinical Commissioning Strategy.

Additionally, representatives from these provider groups sit on the HWB and the MLAFL Strategic Board. They also sit on the service specific Boards where they have an active interest. Two voluntary groups with very active involvement are Community Action IOW and Age UK IOW. For social care providers there is the Voluntary Sector Providers Forum which meets regularly with representatives of social care and health. Most of the Island’s planning groups have very pro-active participants from the community and voluntary sector.

Two workshops have been hosted (during 2014) specifically targeting third sector/community providers of mental health services. Views have been captured and a prospectus opportunity is being developed that will be offered to the third sector and support broader implementation of the Pathway.

8.2 Stakeholder Engagement Detail

My Life a Full Life
Three locality stakeholder workshops were held, together with a launch event, which between them involved in excess of 800 people from a cross section of the community: people who use services, voluntary and private sectors, GPs, primary care, commissioners and the health and social care workforce.

The diagram below reflects the outcome of the combined workshop.
Five Year Clinical Commissioning Strategy
Three workshops were held in September 2013 to develop a strategy for the Island. Participants included representatives and professionals from health and social care providers, the third sector, primary care and a number of patient and carer groups. The IOW CCG then published a draft strategy on its website and sought further feedback from its stakeholders through advertising the consultation in the local media and directly contacting key stakeholders. The overall strategic direction was endorsed by stakeholders and the final strategy was amended to reflect the feedback received. The BCF plan reflects the IOW CCG strategy.

Isle of Wight No Health Without Mental Health – it’s everyone’s business
A joint approach means that the IOW CCG, IOW Council, public health, police and Voluntary Sector Forum have consulted widely on the development of the No Health Without Mental Health Strategy. The consultation has been in two phases:

Phase 1: Two engagement events were designed to maximise the contribution of those attending and support individuals with mental health problems and their carers to participate. This involved facilitated market stalls, one for each of the six objectives in the national No Health Without Mental Health strategy. Participants were asked what they felt were the priority areas and the actions required to improve people’s mental health and wellbeing on the Island. 141 people attended the events. A further eight people completed the online survey which asked the same questions as the facilitation event. Participants included service users, carers, commissioners, the health and social care workforce, private and third sector organisations and members of the public.

In addition, the IOW CCG held three stakeholder events in which participants were asked if they agreed with the priorities highlighted from the engagement events and discussed how they could contribute to improving the mental health and wellbeing of Island residents.

Phase 2: This phase involved circulating the draft strategy to all stakeholder organisations and to the wider public on the Island over an 8 week period. The feedback was very supportive for the overall strategic direction of the document.

Isle of Wight Suicide Awareness and Prevention Strategy
The development of this Strategy was supported by two phases of consultation. A full report can be found in Appendix 9 of the strategy.

Phase 1: A two month consultation period which included attending workshops, interviews with stakeholders, an online questionnaire completed by 25 people and an open invitation engagement event attended by 93 people.

Phase 2: The second phase was raising awareness by circulating the draft strategy and inviting feedback and comments.

The Suicide Awareness and Prevention Steering Group received seven comments; four were from members of the public, one from the Trust’s Lesbian, Gay, Bisexual and Transgender patients and staff network, one from a Public Health colleague and one was from a media organisation.

Isle of Wight Living Well With Dementia Strategy
The IOW CCG has consulted widely on the development of the ‘Living Well with Dementia on The Isle of Wight’. Consultation has been in two phases and a full report of the consultation can be found in Appendix 6.
Phase 1: An engagement event was designed to maximise the contribution of those attending and support individuals with memory problems and their carers to participate. This involved facilitated market stalls, one for each of the six stages of the dementia journey.

Participants were asked what they felt was working well, what they felt were the challenges and what we needed to do to address these challenges. People were then asked the priority areas and the actions required to ensure people live well with Dementia.

106 people attended the events which included service users, carer, commissioners, the health and social care workforce, private and third sector organisations and members of the public.

A number of meetings with key stakeholders have been held and the Dementia Steering Group, which includes representation from Public Health, the IOW Council, the IOW NHS Trust, the IOW CCG, care homes, third sector, service users and carers has had a number of meetings to develop the strategy and action plan.

Phase 2: This phase involved raising awareness of the Draft Dementia Strategy and inviting people to comment and make recommendations over an eight week period.

The Dementia Steering Group throughout this consultation attended groups, circulated it amongst all their teams and networks and received comments via a central email account. The Dementia Steering Group was pleased to receive such a positive response to the strategy and action plan.

Autism Strategy
The consultation was launched at the end of December 2011. Advertising was placed in GP surgeries and clinics and in the NHS e-Bulletin which reaches 4,000 employees. Information regarding the consultation was circulated to schools for advertising in book bag letters and newsletters and was also placed on parish council notice boards encouraging people to complete the survey. Local media organisations were used before and during the consultation. A workshop was held at a community centre all day which 80 people attended including people representing housing, education, parent support groups, the National Autistic Society and residential and domiciliary support providers. Two meetings with parent and carer focus groups were also held, which 20 people attended. A total of 116 responses were received during the consultation.

Working Together with Carers
The Working Together with Carers Strategy has been developed based on information gathered from a wide range of individual carers and carer groups. This provided a focus point for further engagement, which was significant during the formal consultation launched at the beginning of 2013 for a six week period. In order to engage widely with carers, 16 different events were held across the Island in a variety of venues, eg, local supermarkets, libraries, St Mary’s Hospital and with carers’ groups at different times of the day in order to enable as many carers as possible to attend. People were able to discuss individual issues and obtain information on carers support and services available on the Isle of Wight.

At these events people were encouraged to submit formal responses by completing a carers’ survey which could either be filled in at the event, taken away to complete either on line or on paper to return later. Consideration of how to engage with carers was supported by the local branch of Carers UK which sent out survey information to 600 carers registered on their mailing list. Local media was used to make people aware of the carers’ survey and the local networking events across the Island.

GP practices were sent information regarding the consultation events, along with printed copies of the carers’ survey. A GP survey consisting of five questions regarding the strategy was sent to all GP practices across the Island.
The BCF plan reflects these strategies where appropriate which, as has been shown, have had extensive engagement in their development.

### 8.3 Implications for the Acute Sector

#### Impact on acute service delivery targets

The main acute provider that serves the Isle of Wight population is the IOW NHS Trust (92.5% of emergency activity is undertaken on the Isle of Wight and is considered to be in scope for the emergency admission reduction). Representatives of the Trust’s senior management have been present at the local BCF Plan Coordination Group meetings and have been fully involved in the evolving shared plans. The modelling for the Emergency Admissions reduction has been shared with the Trust prior to final approval by the partner commissioner organisations.

#### Rationale for emergency admissions ambition

The Isle of Wight economy’s ambition is to achieve a 5% reduction (6.1% including population growth) over the two years from the baseline period to end Q3 2015.

- 2014 – 3.6% reduction on 2013
- 2015 – Further 1.5% reduction on 2014

Appendix A: *Reduction in Emergency Admissions Performance Fund Ambition* sets out the rationale for the Isle of Wight emergency admission reduction, setting out the ambition, the justification, the contribution to delivery by the BCF schemes, demonstration of meeting the six principles and the methodology behind the setting of the ambition trajectory.

Given the variation in starting point showing high achievement against benchmarks (illustrating that level of opportunity is significant different from lower quintile areas set the same national ambition); the differences in population characteristics (again illustrating the need for safe ambitions), the trend in local performance (the measurable impact of schemes implemented specifically to support integrated care already being realised with 3.6% reduction planned in 2014), a further 1.5% reduction in 2015 is a realistic, stretching but reasonable ambition, set in the context of a total reduction of 5% and absorption of population growth of 1.1% overall (see figure 26 below).

See Appendix A: *Reduction in Emergency Admissions Performance Fund Ambition* (page 179) for detail.

![Figure 26: Expected reduction in elective admissions (CCG total)](image-url)
Impact on Acute Services

Financial Impact
Section 5c sets out the Risk Share arrangement (contingency) for the achievement of the Emergency Admissions Reduction. The figure above illustrates the potential impact on the IOW NHS Trust contract (from which the total -1.5% reduction will be realised). This illustrates the risk to the IOW NHS Trust where the 2014 contract reduction is removed recurrently from the contract, the planned 2015 reduction is removed recurrently from the contract baseline, and if the emergency admissions activity is above contract baseline, that the funding in year will be on a non-recurrent basis.

The figure below shows the activity impact at CCG level with the reduction in activity removed from the IOW NHS Trust contract.

Once the full modelling has been undertaken as part of the Demand Planning process for the 2015 activity baseline, with the identification of Healthcare Resource Groups (HRGs) against the -178 reduction, the breakdown of the £265k value will be removed from the contract baseline in anticipation of the planned ambition realisation.

The following illustrations show where the impact of the reduction is most likely to be achieved.

Service Impact
The illustration begins to show where the likely impact will be within acute sector specialities (see table below – figure 27). The impact is not cumulative and the patients may benefit from several schemes in reducing the likelihood of admission.
Figure 27: Illustrating service area impact and the relative contribution to the 1.5% (178) reduction in 2015.

The following table (figure 28) sets out how the BCF schemes plan to support this impact.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Mental Health Reablement      | Deliver parity of esteem to identified high risk group, to reduce current anticipated life reduction of twenty years, by ensuring that there long term health conditions are addressed via a number of initiatives including:  
  1. National Schizophrenia CQUIN.  
  2. Cluster 11 shared care agreement pilot, to ensure that individuals who are stable, are transferred into a shared care agreement with their GP to provide their support in their locality and enhance current Quality Outcomes Framework (QOF).  
  3. Ensuring the provision of an Isle of Wight enhanced and integrated (health, social care, housing and third sector) mental health Reablement pathway that achieves sustainable and improved outcomes for people with complex mental health problems and evidences quality of life improvements via Camberwell assessment.  
  Improve the availability of and enhance the provision local health and social care supports available to people with complex mental health problems, and enable the repatriation of those placed out of area, support the prevention of expatriations and reduce inpatient admissions. |
| Crisis Response               | This scheme will contribute to a reduction in emergency admissions for frequent service users and observational admissions. This scheme particularly focuses on people over 65 at risk of admission or falls, fragility and frequent service users with long term conditions and conditions amenable to prevention of admission. This scheme was implemented in Q4 2013/14 and the impact of this scheme is being observed in the reduction in non-elective admissions from Q4 2013/14 and Q1 2014/15. |
| Rehabilitation/Reablement     | This scheme will contribute to a reduction in emergency admissions/re-admissions by managing the risk of deterioration and increasing resilience in the initial post discharge period. |
| Integrated Locality Working   | This scheme will contribute to a reduction in emergency admissions of patients by preventing exacerbations of their multiple long term conditions. |
| Enhanced Hospital Discharge   | This scheme will contribute to a reduction in emergency re-admissions by managing the risk of deterioration and increasing resilience in the initial post discharge period for a high resource intensity group of patients and ensuring appropriate discharge arrangements in place such that individuals are supported at home. |
| Supporting Information, Advice and Self-Management | This scheme will contribute to a reduction in emergency admissions by enabling people to take control of their long term conditions and therefore avoid deterioration of their condition which could result in an admission. |
Table: Scheme and Comment

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers</td>
<td>This scheme will contribute to a reduction in emergency admissions by ensuring the need of carers are identified early to reduce the breakdown of home placements and therefore also reducing admissions to residential care and hospital.</td>
</tr>
<tr>
<td>Local Area Co-ordination</td>
<td>The impacts of this scheme are more long term and preventative in nature. Therefore the impact during 2015 will be minimal.</td>
</tr>
</tbody>
</table>

Figure 28: Illustrating impact of schemes

**Potential impact on health and social care economy bed configuration**

The pattern of bed utilisation is expected to move to the following potential configuration (figure 29).

Figure 29: Potential Future bed configuration (IOW)

**Impact on IOW NHS Trust**

As previously highlighted in Section 2 and 3, the Isle of Wight has a uniquely modelled health care system with one main NHS provider, council and CCG, however, as an Island we have to be self-sufficient in terms of capacity for A&E and Emergency Care generally and it is, therefore, highly co-dependent for system sustainability.

The performance of healthcare on the Island is already very good, as set out previously and in Section 3: Appendix A; with the IOW CCG in the top 25% nationally for [avoidance of] emergency admissions for acute conditions that should not usually require hospital admission. The national expectation regarding further levels of savings from non-elective admissions will be challenging to achieve when the Island system is already performing well. The IOW CCG already pays the IOW NHS Trust an “Island Premium” of £5m due to diseconomies of scale in services such as A&E where a minimum level of medical staffing is required regardless of the number of attendances.

The plan is to shift demand and services to community provision from acute services as it is in the best interest of patients, however this can often be limited or cost neutral in terms of actual cash realising savings within the Trust. The IOW CCG, IOW NHS Trust and IOW Council all have ambitious savings programmes, of which the BCF forms a component part. The Trust will therefore be monitoring closely the
achievement of savings programmes across the system and how they impact on and contribute to overall system sustainability. This will be monitored alongside achievement of performance targets to ensure that quality of provision is not compromised.

To mitigate risk the IOW CCG and IOW Council will share risk through the BCF pooled budget contingency and all three organisations intend to develop a system wide risk sharing agreement to ensure system stability.

The Trust supports the local health economies vision to reduce non elective admissions by 1.5%. Further modelling is required to fully understand how the planned savings will materialise from each of the BCF Schemes as described above. This is particularly relevant in understanding how the Trust can realise the savings from its current cost base. It will be not be possible to realise full cost savings from a reduction in emergency admissions due to the fixed costs within the organisation.

The Trust has undertaken basic modelling on the potential impact of the proposed reduction in non-elective admissions. Current plans indicate a further 1.5% reduction over and above that already achieved and planned to be achieved in 2014, in income terms we expect this to equate to reduced income in the region of £250-300k. It is however anticipated that this reduction could be offset by an increase in the average value of the activity that is currently being undertaken because of resulting changes in the acuity of admitted patients. As the detailed plans are developed the Trust will seek to ensure that any costs incurred in the provision of additional capacity within the community setting will be funded appropriately to prevent these admissions.

The IOW NHS Trust is actively involved in QIPP planning within the Isle of Wight health economy and works with the IOW CCG in an attempt to develop QIPP Plans that are mutually beneficial. The IOW NHS Trust is closely working with the IOW CCG to ensure the planned 1.5% reduction in emergency admissions is not duplicated by existing QIPP schemes or Trust cost improvement programmes.

The projects listed within the BCF and the planned developments do not appear to have a negative impact on mental health services.

**Sharing of CCG Operational Plans**

The narrative above gives the position with regard to plans for the emergency activity reduction. The IOW CCG Operational Plans (CCG COMM trajectory submission) contained the trajectory for reduction of Avoidable Emergency Admissions (CCGOIS HSCIC) and these were shared with the Provider at the time of submission.
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Annex 1
Scheme 1 – Mental Health Reablement

Strategic objective
Deliver parity of esteem to identified high risk group, to reduce current anticipated life reduction of twenty years, by ensuring that there are long term health conditions are addressed via a number of initiatives including:

1. National Schizophrenia CQUIN.
2. Cluster 11 shared care agreement pilot, to ensure that individuals who are stable, are transferred into a shared care agreement with their GP to provide their support in their locality.
3. Ensuring the provision of an Isle of Wight enhanced and integrated (health, social care, housing and third sector) mental health reablement pathway that achieves sustainable and improved outcomes for people with complex mental health problems and evidences quality of life improvements via Camberwell assessment.
4. Improve the availability of, and enhance the provision of, local health and social care supports available to people with complex mental health problems, and enable the repatriation of those placed out of area, support the prevention of expatriations and reduce inpatient admissions.

Overview
In its simplest form, the mental health reablement pathway is an enhanced addition to the existing PbR mental health pathways for people with complex mental health needs and who are accessing secondary mental health treatment and services (mainly those in Cluster groups 12, 13, 15, 16 and 17).

Its design operates as a whole system that brings together health, social care and housing (IOW NHS Trust and IOW Council) through a Section 75 pooled agreement alongside third sector organisations and DAAT which are currently separately commissioned. The IOW NHS Trust will be the lead Provider of the integrated service.

The pathway helps ensure the provision of a holistic and comprehensive health and social care pathway. This is devised through a jointly agreed service specification and dedicated workforce structure which supports individuals to make incremental improvements in their everyday life and social functioning, and to successfully take on increasing levels of responsibility in managing as many aspects of their own life as possible.

Pathway redesign provides person-centred and intensive recovery-focused support as well as access to sustainable housing options, employment and third sector community support, to enable individuals to live as independently as possible and achieve a good quality of life.

Phase 1 of the pathway commenced delivery 1 January 2014.

The delivery chain
The IOW CCG, as Lead Commissioner, will oversee and monitor the delivery of the pathway (service specification) via the mental health and learning Disabilities Officer Level Meeting. This will be also be reported and monitored through the Mental Health and Learning Disabilities Reablement Board and exceptions will be reported to the Joint Adult Commissioning Board.

The mental health service specification and Section 75, brings together the IOW NHS Trust (commissioned to deliver and be responsible for implementing the health components of the pathway) and the IOW Council (joint partner responsible for delivering the social care and housing components). The IOW CCG has separately commissioned mental health employment support (integrated within the IAPT service and
Community Mental Health Teams and No Barriers Team) and local third sector provision will be commissioned to support the pathway further during October 2014.

The evidence base
Best practice guidance for mental health recommends commissioning of rehabilitation/reablement services to support people with complex mental health needs in achieving successful community living:

- Around 10% of service users presenting to mental health services for the first time with a psychotic illness will go on to require rehabilitation services due to the severity of their functional impairment and symptoms.
- Studies have also shown people are eight times more likely to sustain community living if supported by reablement services than general mental health services.
- 80% have a diagnosis of a psychotic illness (schizophrenia or schizoaffective disorder), and many will have been repeatedly admitted to hospital prior to referral to rehabilitation services.
- Many experience severe “negative” symptoms that impair their motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking etc) and place them at risk of serious self-neglect.
- Most have symptoms that have not responded to first-line medications and require treatment with complex medication regimes. Around 20% have co-morbidities such as other mental disorders, physical health problems and substance misuse problems that complicate their recovery further most require an extended admission to inpatient rehabilitation services and ongoing support from specialist community rehabilitation services over many years.
- People with complex mental health problems often require a large proportion of mental health resources. Around one half of the total mental health and social care budget is spent on services for people with longer term mental health problems. Half of this (one quarter overall) is spent on rehabilitation services and specialist mental health supported accommodation.
- People using the rehabilitation services are 'low volume, high needs' group.
- There is good evidence that rehabilitation services are effective.
- Investment in local rehabilitation care pathway is cost effective.
- Commissioning a good rehabilitation service includes components of care provided by NHS, Social Care, Supporting People and Voluntary sector.
- Quality and effectiveness can be assessed with simple indicators and outcome tools. The Joint Commissioning Panel for Mental Health “Guidance for commissioners of rehabilitation services for people with complex mental health needs” cites a number of papers as the evidence base for the guidance:


**Investment requirements**

The amount of funding identified for this scheme is £1,918,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

**Impact of scheme**

1. Despite being relatively small, this group absorbs around 25% of the total mental health budget. It is anticipated that by focusing on this cohort, the % of the current budget spend will be reduced, allowing additional resource for upstream interventions (*Securing our Future Health: Taking a Long-Term View, Final Report, D Wanless, 2002, HM Treasury*).

2. Despite developments in mental health interventions and services that provide early intervention to people presenting with psychosis, around 10% of people entering mental health services will have particularly complex needs that require rehabilitation and intensive support from mental health services over many years. At any time, around 1% of people with schizophrenia are in receipt of inpatient rehabilitation, these interventions are anticipated to reduce length of stay in inpatient service provision.

3. Out of area treatments are expensive, costing, on average around 65% more than similar local services. Historically, the IOW PCT/ IOW CCG have followed best practice commissioning guidance and evidence base and to date have secured £660K recurring savings on out of area placements. Currently there are 21 individuals who are in IOW CCG-funded placements on the out of area totalling a cost of £1.8m per annum. Investment into this pathway will improve the health and social care support available to these individuals and, therefore, will enable some to be repatriated. In addition, the pathway will support the prevention of expatriations. In reviewing this, the pathway anticipates the savings to be potentially gained as shown below:

<table>
<thead>
<tr>
<th>Current Service Costs</th>
<th>Budget position</th>
<th>Year 1 (current year)</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Area Placements (Specialist)</td>
<td>No CCG Budget - Any saving would need to be negotiated with Specialist</td>
<td>-</td>
<td>Year 2 – 1 patient repatriated. Value with Specialist negotiated at £50k (estimated)</td>
<td>Year 3 – 1 patient repatriated. Value with Specialist negotiated at £50k (estimated)</td>
</tr>
<tr>
<td>Out of Area Placements (CCG)</td>
<td>Current Budget £1.829m - average cost across 21 clients is £87,116</td>
<td>2 Mainland Placements avoided (bed per day £357.20)</td>
<td>2 patients repatriated – (average cost of £87,116 each)</td>
<td>2 patients repatriated – (average cost of £87,116 each)</td>
</tr>
<tr>
<td>Saving*</td>
<td>-</td>
<td>£260,756</td>
<td>£224,232</td>
<td>£224,232</td>
</tr>
<tr>
<td>Recurrent investment</td>
<td>-</td>
<td>£121,950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total recurrent saving</td>
<td>-</td>
<td>£138,806</td>
<td>£224,232</td>
<td>£224,232</td>
</tr>
<tr>
<td>Total cumulative saving</td>
<td>-</td>
<td>£138,806</td>
<td>£363,038</td>
<td>£587,270</td>
</tr>
</tbody>
</table>

* Saving from repatriation assumes individuals would have remained in the service long term. If patients require readmission the recurrent saving would be reduced.

There is no nationally agreed service specification within the UK for mental health rehabilitation (herein referred as reablement). However the Royal College of Psychiatrists’ Faculty of Rehabilitation and Social Psychiatry has produced a template for which commissioning guidance is based. This guidance, “Joint
Commissioning Panel for Mental Health: Guidance for commissioners of rehabilitation [reablement] services for people with complex mental health needs, Vol two Nov 2012,” sets commissioners of mental health services a number of key messages which will support the aims of the mental health strategy, “No Health without Mental Health” and in delivering the best possible outcomes.

It is suggested that when services follow the guidance they tend to produce the following outcomes:

- Helps ensure the provision of a holistic and comprehensive health and social care pathway that supports individuals to make incremental improvements in their everyday and social functioning, and to successfully take on increasing levels of responsibility in managing as many aspects of their own life as possible.
- Provides person-centred and intensive recovery-focused support as well as access to sustainable housing options to enable individuals to live as independently as possible and achieve a good quality of life.
- The workforce model places more emphasis on community and psychosocial intervention that will underpin the pathway provides a robust and resilient, health and social care structure to support the needs of individuals with the most complex long term mental health issues.
- More people who are currently accessing mental health services will benefit from the intensive support provided by the pathway. This means, for the Isle of Wight, that for those in Cluster groups 12, 13, 15, 16 and 17, a total of around 198 individuals would benefit from the pathway.

The enhanced pathway will produce greater efficiencies through the increase in resource allocation to support those with high level mental health needs. As a result, pathway outcomes will also contribute to:

- Reduced hospitalisation and readmission rates (financial and efficiency gains)
- Improved discharge rates from services
- Greater access to housing options
- Community integration for people living with a mental health problem
- Patient focused and best practice delivery model

The health and social care gains will include an increase in the number of individuals:

- Taking up a personal budget and accessing daily activities
- Managing self-care and developing personal networks of support
- Addressing and manage addictive behaviours and developing life skills
- Entering into employment, training and/or voluntary work

Reduce:

- Number of inpatient admissions
- Length of stay of all admissions
- Number of Section 136 presentations
- Number of expatriations

To ensure an increase in people with complex mental health needs who are:

- Receiving an enhanced service (in addition to payment by result cluster tariff/block provision (shadow))
- The number of people who accept a wellness recovery action plan (WRAP) and who are supported to implement this
- Appropriate and timely referral to housing services
- Supported into appropriate stable and sustainable housing
- Referred to Adult Social Care for an assessment of their needs and numbers who take up a Personal Budget
- An increase in accessing daily activities, as identified from their assessment, and that these are incorporated into their care plan.
- An increase in number living independently
An increase in number repatriated
Manage their own budget
Manage Self-care
Develop personal networks of support
Address and manage addictive behaviours
Develop and maintain life skills
Develop and maintain personal relationships
Engage in daily activities, employment, training voluntary work
Understand and apply rights and responsibilities principles in their lives

There is no cumulative effect to the outcomes but they aggregate to the ambitions.

The pathway builds from consultation previously undertaken by the IOW CCG, in identifying a way forward for the redesign of mental health services on the Isle of Wight, which include:

- Consultation with relevant public and third sector organisations as well as people using the service and their carers and People Matter sub groups.
- Review of the model of delivery at Woodlands Rehabilitation Unit, capital and revenue investment to increase capacity to 11 beds and additional staffing to deliver a new mental health rehabilitation/reablement community model.
- Desktop review of people currently placed out of area.
- Feasibility study of providing an intensive lockable inpatient unit (not viable due to small numbers).
- Workshops to consider what redesign might be required including addressing the need to provide flexible accommodation/services.
- Examination and modelling of investment/reinvestment of potential savings from service redesign into future services.
- Service redesign options appraisal.

To undertake:
- On a quarterly basis, a joint health, social care and housing ‘patient experience’ survey with each person on the pathway, to evaluate and provide evaluation findings.

Feedback loop
The pathway has successfully established an Implementation Group comprising health, social care, housing, drug and alcohol services, employment and third sector representatives. This group will review project progress, the integrated model and its outcomes and will report exceptions, issues and good news stories to the Isle of Wight Mental Health Reablement Board (whose members are senior officers of the IOW CCG, IOW NHS Trust and IOW Council).

A jointly prepared and approved service specification clearly defines the project aims and objectives and the outcomes to be monitored and measured (quarterly). A final project evaluation will summarise the successes and lessons learnt from the pathway and build the case for ongoing sustainability (assumes financial and person centred outcomes from the pathway are realised). Evaluation will be overseen by the IOW CCG and led by the Implementation Group.

Key success factors
Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It
is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.

- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

We can confirm that this scheme has a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have access to a range of support that helps me live the life I want and remain a contributing member of my community</td>
<td>Positive impact on the health and wellbeing of people who are older frail and people with long term conditions&lt;br&gt;People make a positive contribution to their communities</td>
</tr>
<tr>
<td>I have access to a range of easy-to-understand information about care and support which is consistent, accurate, accessible and up to date</td>
<td>People empowered to take individual responsibility in making daily choices about their lifestyles&lt;br&gt;People plan for their future housing, care and support needs</td>
</tr>
<tr>
<td>I have care and support that is directed by me and responsive to my needs</td>
<td>People are supported to take responsibility for their own health and wellbeing&lt;br&gt;People’s health and wellbeing is improved by personalised care and support&lt;br&gt;People are supported to develop contingency plans to detail their wishes at times of crisis</td>
</tr>
<tr>
<td>My support is co-ordinated, co-operative and works well together</td>
<td>People are enabled to maintain their independence within their home environment&lt;br&gt;Integrated care and support is available and delivered close to home</td>
</tr>
<tr>
<td>Outcome</td>
<td>Measure</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| I have considerate support delivered by competent people               | - People will experience seamless care and support delivered by a skilled workforce within their communities  
|                                                                        |   - Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
|                                                                        |   - Workforce work flexibly across the Island adopting flexible and integrated approaches  
|                                                                        | • Increase in number of training courses available to focus on quality of care, customer service and dignity and care  
|                                                                        | • Increase in the numbers of change workshops for MDT integrated teams including commissioners  
| I can plan ahead and keep control in a crisis                          | - People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas  
|                                                                        |   - People are supported to develop contingency plans to detail their wishes at times of crisis  
|                                                                        |   - People will be supported and be enabled to return home whenever possible  
|                                                                        | • Reduction in the number of unnecessary visits to GPs and A&E  
|                                                                        | • Reduction in unplanned admissions  
|                                                                        | • Reduction in GP contact time  
|                                                                        | • Reduction in residential care placements  
|                                                                        | • Reduce length of stay within acute environment  
|                                                                        | • Numbers of people taking up seasonal flu vaccination  
| I can decide the kind of support I need and when, where and how to receive it. | - People will use the full range of resources available to them to maximise their independence and wellbeing  
|                                                                        |   - People’s care and support is personalised to meet their health and wellbeing outcomes  
|                                                                        | • Reduction in the number of unplanned admissions  
|                                                                        | • Reduction in GP contact time  
|                                                                        | • Increased use of personalised care planning  

Mental Health Reablement
Learning Disability Reablement Bed: Ryde House Group

Strategic objective
The prevalence of mental health problems in people with learning disabilities is considerably higher than the general population commissioning for mental health problems must therefore be informed by a Joint Strategic Needs Assessment (JSNA) which takes into account the needs of people with learning disabilities. In addition to mental illness, people with learning disabilities often have coexisting autistic spectrum disorders, behaviours that challenge services, offending behaviour, or physical health conditions.

While there is no universally agreed commissioning model for mental health services supporting people with learning disabilities, the NHS Mandate states that an NHS England objective is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities, and that a substantial reduction should occur in the reliance on inpatient care for these groups of people. It is often hard to distinguish between these conditions, especially when people have more severe intellectual impairments, the JSNA must therefore provide detail about the number and needs of people with learning disabilities who have mental illnesses, as well as autism and behaviours that challenge services.

It is often difficult for people with learning disabilities to access generic and specialised mental health services. Consequently:
- Reasonable adjustments are a legal requirement and should be put in place to enable access to all mainstream services where appropriate.
- Learning disability services should be provided alongside mainstream mental health services so that the skills and expertise from both services can be utilised in order to respond to individual need.
- There should be clarity with regard to commissioning arrangements between learning disability and mental health commissioners, with a presumption of accessing generic services wherever possible and there should be protocols setting out clear pathways between mainstream and specialist services.

There are a number of national drivers and policies:
- DH Winterbourne View Review (DoH 2012)
- DH Winterbourne View Review Concordat: Programme of Action (DoH 2012)
- Nothing About Us Without Us, Valuing People, DoH, 2009
- Payment by Results
- Joint Commissioning Panel for Mental Health (2013). Mental health services for people with learning disabilities
- Mencap (2010) Getting it right
- The Challenging Behaviour National Strategy Group developed a Challenging Behaviour Charter which many organisations have signed up to
- Equality Act 2010
- NHS and Social Care Act 2012
No Health Without Mental Health: a cross government mental health outcomes strategy for people of all ages. DoH 2012.

The IOW CCG, IOW NHS Trust, IOW Council and Third Sector partners are working together to deliver the actions of the Winterbourne Concordat and ensure the services commissioned, provide the highest quality and safety of care and proper clinical governance and reasonable adjustments.

Overview
The scheme shall ensure the provision of one reablement bed and provide continuity of care for people who have profound to multiple learning and physical disabilities, promoting the wellness and recovery models within this client population in a community based facility. The scheme shall offer the reablement bed as respite support, in preventing an emergency admission or in facilitating timely discharge from an acute bed.

The scheme shall provide personalised support and treatment, aimed at promoting wellness and recovery, on a short-term basis as part of an integrated pathway. The scheme shall provide support through the provision of care that is concordant with treatment plans and evidence based practice.

The scheme shall work jointly with the IOW Council, IOW NHS Trust and others in a way that enables the individual to return to their community as quickly and as safely as possible, as well as reduce the need to refer the individual to an inpatient bed on Island or out of area.

The scheme shall ensure an integrated approach and shall ensure the involvement of the Community Learning Disabilities Team (CLDT) in completing assessments and in providing ongoing support, with the Support Workers from the service. Such assessment may include a social care assessment.

The scheme shall provide an individualised pathway of care and develop a personalised care plan, based on a thorough understanding of the individual. The pathway shall be person-centred and consist of a coordinated assessment of need, agreement of expected outcomes and provision of care and treatment followed by a joint review with the individual and their carer(s). Figure 30: Components of pathway of care.

The delivery chain
The IOW CCG will be the lead commissioning organisation for the scheme and ensuring regular monitoring and performance reporting is carried out. This will be shared at the Mental Health and Learning Disabilities Reablement Board where joint partners, IOW CCG, IOW Council and IOW NHS Trust, are members. Exceptions will be reported to the Joint Adult Commissioning Board.

The evidence base
There is no one agreed model for mental health services for people with learning disabilities, and a wide variety of provision of both community and bed-based services. Due to an absence of a national policy, numerous service models have been developed locally. These include jointly provided services where local mental health and learning disability services share facilities, teams and expertise and agree on outcomes.
to be achieved. Nationally there is recognition that there is still poorly developed local services with a high reliance on out-of-area inpatient placements.

In an influential report for the Department of Health, Mansell (2007) recommended a model consisting of local services including small scale housing, work, education and day placements, with skilled staff backed up by specialist advice and support from multi-professional teams and access to the full range of mental health and learning disability services. This also emphasised the need for practical support and training for family and other carers, including the availability of short breaks which this scheme supports.

A significant number of people with learning disabilities display behaviour problems that are described as challenging. These include aggressive behaviour directed towards others, self-injurious behaviour, and a range of socially unacceptable behaviours. Some of these behaviours may be sufficiently severe to lead to contact with the criminal justice system. Behaviour described as challenging should not be confused with mental health problems, although people may have both. There is also a high prevalence of autistic spectrum disorders in people with learning disabilities who have mental health and behavioural problems.

A recent systematic review reported that there is no evidence that a comprehensive system of mental health care can be provided by hospital-based services or by community services on their own. However, a balance is necessary which includes both hospital and community components (the ‘balanced care’ model). The relevance of this for people with learning disability needs to be explored and needs to address:

- Delivering direct specialist interventions and specialist advice
- Reducing health inequalities
- Supporting health professionals in general and mental health services
- Reducing out-of-area placements
- Supporting personalisation
- Safeguarding
- Supporting transition between teams (eg children and older people)
- Working with the criminal justice system
- Preventing people from dying prematurely
- Reducing premature death in people with learning disabilities
- Enhancing quality of life of people with long-term conditions
- Enhancing quality of life for people with mental illness
- Employment of people with mental illness

Research Papers;

Investment requirements
The amount of funding identified for this scheme is £35,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan, under the Crisis Response heading as it sits across both schemes, i.e. responding to a crisis, but also with a strong reablement focus.
Impact of scheme

Delay in detection, assessment and treatment can lead to a progressive deterioration of mental health and behaviour. This can lead to the need for more intensive services for a longer period of time, often in a more restrictive and distant setting. As well as causing unnecessary suffering to the individual and their family, this can increase costs significantly. It is anticipated that the cost of services that meet people’s needs and provide good outcomes is likely to reduce over time by:

- Creating sufficiently skilled resources in community services.
- Supporting the development of skilled provider services.
- Agreeing the principle of seeking to reduce costs of individual services once they are firmly established – but in the context of demonstrable outcomes and safe practice, and not as a fixed or arbitrary figure per year (it should also be recognised that for some people the costs will not reduce, as it is the level of support provided which keeps the person stable, and which will vary depending on the outcome which can fluctuate).
- Adopting flexible contracting systems that can rapidly respond to changes in the needs of people being supported. Use of mainstream local services may reduce stigma and negative professional attitudes, as people are more likely to become part of their local community, and staff can see what may be achieved.

The scheme responds to an unmet need identified on the Isle of Wight and will be commissioned in line with best practice guidance. In the development of the scheme, a number of national standards were consulted and are reflected in the service specification, including those listed below:

- Utilisation of local clinical expertise in the assessment and treatment of individuals
- Partnership and integrated working with the service, CLDT, IOW NHS Trust and IOW Council
- Individuals shall receive high quality care in their local community
- Meeting the needs of individuals, their families and carers
- Focusing on personalisation and prevention
- Ensuring high level of support and care to people with complex needs or challenging behaviour
- Improved safety in a facility supported by well-trained care workers
- Availability of a local, priority, service that can delivery of treatment and care plans
- Improved patient experience and care pathway
- Better value for money
- Improved family support

The Providers of the scheme will report scheme progress to the IOW CCG, on a quarterly basis, comprising the following information:

a) No of individuals referred to the reablement bed
b) No of individuals from a) who accessed and used the reablement bed
c) Length of stay per individual
d) Whether the reablement bed was used as respite or crisis intervention
e) No of individuals from b) who were assessed jointly with the CLDT
f) No of individuals from b) with an up to date Health Check
g) No of individuals from b) referred for a Health Check
h) Patient satisfaction survey to be carried out (eg PREM) per individual to capture:
   - No of individuals stating they were involved in planning their treatment
   - No of individuals stating they were always treated with dignity and respect
   - No of individuals stating they definitely understood their care plan
   - Survey to include feedback from families and/or carers
Usage of the reablement bed will be audited and monitored at quarterly intervals by the Care Co-ordinator from the CLDT, through a site visit and from the data provided above. The Care Co-ordinator will report their findings to the CLDT team leader, who will report to the IOW CCG.

Ryde House Group will log bed occupancy and this will be shared on a monthly basis with the Care Co-ordinator from the CLDT.

Feedback loop
The service specification clearly states the outcomes that are to be measured and reported (as above). The IOW CCG will oversee scheme monitoring and progress and will report to the Mental Health and Learning Disabilities Reablement Board.

Key success factors
Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.

- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

We can confirm that this scheme has a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

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<td>I can plan ahead and keep control in a crisis</td>
<td>People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas</td>
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<td>People are supported to develop contingency plans to detail their wishes at times of crisis</td>
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<td>People will be supported and be enabled to return home whenever possible</td>
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<td>Reduction in the number of unnecessary visits to GPs and A&amp;E</td>
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<td>Reduction in GP contact time</td>
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<td></td>
<td>Reduction in residential care placements</td>
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<tr>
<td></td>
<td>Reduce length of stay within acute environment</td>
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<td>Numbers of people taking up seasonal flu vaccination</td>
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<td>I can decide the kind of support I need and when, where and how to receive it.</td>
<td>People will use the full range of resources available to them to maximise their independence and wellbeing</td>
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Scheme 2 – Crisis Response

Strategic objective

The IOW NHS Trust, IOW Council and IOW CCG have clearly identified the need and desire to further develop integrated Health and Social Care working on the Isle of Wight within their respective strategic documents. This is further affirmed by the development of the My Life a Full Life Programme and the Five Year Health and Social Care Vision, which promote longer, healthier and more independent lives for the people of the Isle of Wight.

In response to national guidance and local drivers for change, extensive work has been carried out on the Isle of Wight to develop new ways of integrated working. Central to this is the My Life a Full Life Programme. The overarching strategic objective of the My Life a Full Life Programme is to ‘Ensure that valuable resources are used effectively to get the best outcomes for people, community and society for now and for future generations’. The vision for all short term services is to develop a one service approach across crisis, rehabilitation and re-ablement.

In order to achieve this the objectives within Crisis Response are to review the use of direct access beds for GPs, develop 7 day a week community service, consider the need for GP direct access nursing home beds, respite service, deliver an integrated crisis response service and improve take up and monitoring of Assistive Technology. This scheme supports the strategic vision of a holistic approach to urgent care for the Island population.

The crisis response work stream is one of the three work streams which sit within the MLAFL programme. Crisis Response aims to ensure that a co-ordinated and tailored response is provided to people in times of crisis.

Stakeholders from all areas of the Island have been brought together through various means to identify the gaps in the current system, and to identify actions for change. For the development of the crisis response model, stakeholders from health, social care, independent sector, voluntary sector and the public have been engaged.

To enable the overarching strategic aim of My Life a Full Life the specific objective are:

- Provide the right care, in the right place and at the right time.
- Reducing nursing and residential care home placements.
- Prevent unplanned hospital attendances and reduce/prevent admissions and readmissions where appropriate, through proactive management of patients at risk of a crisis and the provision of rapid response services during a crisis.
- Reduce length of service interventions where appropriate through efficient patient flow through the system, and provision of appropriate services in the community.
- Improve quality and satisfaction of care for people, through clear service navigation, easy access to integrated coordinated services closer to home.
- Ensure people are supported to reach a level of functional independence acceptable to them, preventing, where possible, avoidable deterioration and a crisis.
- Ensure commissioned services are sustainable, provide value-for-money and meet the needs of the Isle of Wight population.

Overview

The Isle of Wight has a challenging demographic profile with over 24% being over the age of 65. The My Life a Full Life integrated care programme consulted with local residents who confirmed that people
wanted to plan ahead and keep in control when in a crisis. A number of services and support have been implemented to support this.

Crisis Response Team
The crisis response team is a multi-disciplinary team consisting of health and social care professionals who will provide up to 72 hours of care and support to enable an individual to remain at home. They liaise with the ambulance service, community matrons, occupational therapists, physiotherapists, re-ablement and adult social care. The team also have members of the voluntary sector who ensure and facilitate a smooth transition of care post the end of the 72 hour crisis team intervention and onto longer term support networks and services.

The main objectives of the services are to reduce admissions to hospital and nursing and residential placements with a variety of responses delivered closer to people’s homes. The operational hours are 08.30 – 16.30 hrs, 7 days a week. Referrals into the service are usually made via 999, 111 and via a GP referral.

The defined criteria for access to the service are:
- Any person over the age of 65 that is not managing their own health or social care needs and at risk of admission to hospital or residential/nursing care.
- People that are frequent emergency department admissions and have multiple GP visits.
- People who are at high risk of falling and frequent fallers.
- Identified people that would benefit from short term monitoring due to an exacerbation of an existing medical condition with the use of telemedicine.

The team provide up to 72 hrs of support to people to maintain them in their own homes. This is undertaken by a holistic assessment of the person, environment and support they have available. This is to ensure that not only the needs from the current crisis are addressed, but also to prevent future crisis by putting mitigation plans in place.

Since the team became operational in the latter part of January 2014, they have attended over 400 people and are seeing an average of 60 – 65 people per month. The team are based within the Urgent Care Hub which coordinates and delivers 999 and 111 calls, patient transport services, hospital bed management services, hospital switchboard, community nursing referrals and access to an integrated hub pharmacist, social care first response team, Wightcare (IOW Council’s community alarm services) and monitoring of assistive healthcare technologies.

The intention is to possibly expand this scheme to assist in discharges from A & E, following the evaluation of a pilot utilising Red Cross Trusted Assessors as part of the Operational Resilience and Capacity Plan funding in 2014-15.

Direct access respite beds
GP’s currently have direct access to two Local Authority residential care homes on the Island. The criteria for access to the service is any person not managing their own health or social care needs who are at risk of an emergency hospital admission, which could be mitigated by a short term residential placement.

7 day a week working
There is currently work underway to support a number of services across the community ie physiotherapy, occupational therapy, community nursing. These services will be developed to extend the existing working hours.
Respite Care
Access to respite care is through social care. Within social care the First Response team supports carers and people to access short term respite when in crisis. The carer’s assessments also identify the longer term requirements for respite.

Assistive Technology/Telehealth
The aim of the service is to reduce emergency admissions and facilitate early discharge and activity promoting the patient sense of independence. Patients are supplied with equipment in their home delivered through the Integrated Community Equipment Service (ICES). This is monitored by the Crisis Response Team daily. Patients are referred directly from Clinicians.

Assistive technology/Telehealth currently has 50 patients monitored with the aim of prevention through early alerts to medical services.

This service is expanding and working with GP practices to attract more patients onto this scheme.

The delivery chain
The IOW CCG and IOW Council are commissioning all elements of the service schemes including healthcare, delivered by the IOW NHS Trust and social care which is provided by the IOW Council.

The crisis response work stream is led by the Head of the Isle of Wight Ambulance with project support. A multi-agency steering group meets monthly with representatives from the provider organisations and commissioners along with primary care input. The steering group is accountable to the My Life a Full Life Programme Board which is chaired by the Clinical Commissioning Group and has senior management representatives from all stakeholders.

The evidence base
Stakeholders from all areas on the Island were bought together through various means to identify the gaps in the current system, and to identify actions for change. Figure 31 shows the service development areas, which the crisis response model overlaps, and the elements identified as integral to a new crisis response service.

For the development of the crisis response model, stakeholders from health, social care, independent sector, voluntary sector and the public have specifically been engaged through:

- MLAFL: Crisis Response Workshop and meetings
- Frail Older Persons Workshop and Group meetings
- Long Term Conditions Focus Group (Patients Group)
- IOW CCG Strategy and MLAFL Workshops
- 1:1 engagement
Hospital non elective admissions increased significantly in the spring of 2012 but overall admissions were in line with the anticipated demand plan. Despite having an ageing population, overall admission rates have been maintained and benchmarking data indicates the Island as having one of the lowest emergency admission rates per 1,000 population and also low levels of emergency admissions that are categorised as avoidable.

Re-admission rates have improved significantly over recent years following investment in a number of reablement and case management schemes. Averaging around 5% the re-admission rate needs further improvement to meet national targets.

An analysis of non-elective admissions on the Isle of Wight in 2013 shows the following key points:

- Frequent Fliers: 419 non-elective admissions were for 240 patients, who were over the age of 18 (not mental health specific admissions) and had more than 1 admission per year over 4 years. Within this, 62 patients were responsible for 344 of the admissions, costing £700k. The top 5 out of 6 conditions are Atrial Fibrillation, COPD, Heart Failure, Heart Disease and Hypertension (NHS South CSU, 2013).
- People 65 years and over: Over 55% of non-elective admissions were for observation only (Excluding frequent fliers) amounting to 2040 admissions.
- A 10 week clinical review conducted in St Mary’s Hospital identified 69 admissions in MAAU that could have potentially been avoided though support from: IV medication at home; an Acute Team in the persons home; an Anticipatory Care Plans; holistic out-of-hours support for frail older people.
- Benchmarking against other areas showed that the IOW District Nursing Team were seeing an average of 196% more activity per annum (Sedgwick-Igoe et al, 2013).

The research and evidence base for the scheme was based on established Crisis Response Services across the country, which showed a shift towards prevention and early intervention and integration of services across health and social care was of benefit. Best practice examples areas include: Nottingham City, South Salford, Salford and Bristol (see table below – figure 32).

Based on the identified cohort of people within the best practice areas, and their proven savings and quality benefits, the IOW has identified an opportunity to reduce non-elective admissions and social care residential admissions. It was estimated that a 20% reduction of non-elective admissions for frequent fliers and patients over 65 years would be seen (See evidence from other areas in the table below – figure 32). A Crisis Response Service pilot is underway on the IOW, which will evidence the patient cohort, quality improvements, efficiencies across services and reductions in admissions to health and social care. To date
(January to September 2014), the initial data is showing that 510 patients have been treated by the IOW Crisis Response Service and emergency admissions are reducing. The largest cohort of patients seen were over 65 years old (94%), with 32% falls, 24% mobility issues and 15% self-care issues. As the service is established, it is expected that the number of patients seen, and the admissions avoided, will increase.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cohort</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nottingham City CCG</strong></td>
<td>• Total population: 325,000 of which 39,000 people are over 65 yrs (12%)</td>
<td>• 12 month pilot in two localities saw 1091 patients treated</td>
</tr>
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<td>• Largest cohort of patients treated by this service were over 65 years</td>
<td>• 1.3% non-elective admissions saved (505 patients), saving £1.5m</td>
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<td>• 39k non elective admissions in 08/09, 11,000 of which were patients over 65 (28%)</td>
<td>• 119 care home admissions avoided</td>
</tr>
<tr>
<td><strong>Salford PCT and Salford City Council (Jointly funded and managed)</strong></td>
<td>• Total population: 220,000</td>
<td>• In 07/08 868 patients were treated</td>
</tr>
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<td></td>
<td>• Total non-elective admissions 29,000</td>
<td>• Budget: £614k (80% costs met by PCT)</td>
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<td>• Savings: £3m (65% health, 35% social care)</td>
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<td>• 100% patient satisfaction</td>
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<tr>
<td><strong>Bristol</strong></td>
<td>• Total population: 459,000</td>
<td>• Budget: £2.8m (70:30 NHS/SC)</td>
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<td></td>
<td>• Used primarily by older people (COPD, UTIs etc)</td>
<td>• £3.6m net savings (832,600 per 100,000 pop) from hospital admission avoidance</td>
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<td>• Total non-elective admissions 39,000</td>
<td>• Additional £0.7m estimated savings to social care (Reduction in long term costs, nursing homes etc)</td>
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<td>• Improved safety eg by reducing falls in unfamiliar hospital or care home settings.</td>
</tr>
<tr>
<td><strong>South Salford CCG</strong></td>
<td>• Over 65 years of age</td>
<td>• Budget: £1.5m recurrent investment</td>
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<td></td>
<td>• Target of 20% reduction of non-elective medical admissions for over 65 yrs over 3 years</td>
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<td></td>
<td>• Target net saving of £3m over 3 years</td>
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<td>• Caseload of:</td>
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<td>- 400 patients for Virtual Ward</td>
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<td>- 50 patients for Urgent Care Team at any one time</td>
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<td></td>
<td>- GP Practices refer patients through the SPA at a rate of 3-4 per 1000 population every 12 weeks (This equates to 2461 patients per annum for the IOW)</td>
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</tbody>
</table>

*Figure 32: Examples of reductions in admission due to crisis response service*

**Investment requirements**

The amount of funding identified for this scheme is £1,885,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

**Impact of scheme**

People are enabled to maintain their independence within their home environment, reducing placements in residential admissions. People will receive a streamlined response to an urgent call for help, reducing their need for emergency admissions to A&E and acute admissions. The evaluation matrix below details the full impact of the scheme for patients and carers.
Feedback loop
Evaluation metrics have been developed and are an integral part of the overall My Life a Full Life programme and also the work stream as a separate entity. The methods of collection and type of metrics are detailed below:

**My Life a Full Life metrics**
- Emergency Readmissions within 30 days of discharge from Hospital (Public Health Outcomes Framework 4.11)
- Proportion of older people (65+) who are still at home 91 days after discharge from hospital into rehabilitation/reablement services (Adult Social Care Outcomes Framework 2b, NHS Outcomes Framework 3.6i)
- Permanent readmission to residential; and nursing homes, per 1,000 population (Adult Social Care Outcomes Framework 2A)
- Overall satisfaction of people who use services with their care and support (Adult Social Care Outcomes Framework 3A)

**Evaluation metrics**
- Reduction in the number of non-conveyed ambulance journeys (against tariff)
- Reduction in the number of prevented ED admissions (against average tariff)
- Decrease in unplanned and preventable admissions to hospital or nursing/residential placements post crisis interventions (calculated by review of patients activity 3 months pre and post crisis)
- The cost of the prevented admission to residential care
- Number of prevented social care bed days

**Workstream cost benefit metrics**
- The cost (saving) of the prevented admission to hospital based upon HRG code
- The cost (saving) of keeping people with dementia at home if their carer is in crisis
- The cost (saving) of reduced bed days within residential care homes

**Health and social care professionals – qualitative evaluation**
- Interviews with patients
- Patient questionnaire
- Health professional questionnaire

As the evaluation process has been an integral part of the scheme, the processes are in place to ensure the information is collected and verified by the crisis response steering group.

**Key success factors**
Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.
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People plan for their future housing, care and support needs |
| I have care and support that is directed by me and responsive to my needs | People are supported to take responsibility for their own health and wellbeing  
People’s health and wellbeing is improved by personalised care and support  
People are supported to develop contingency plans to detail their wishes at times of crisis |
| My support is co-ordinated, co-operative and works well together         | People are enabled to maintain their independence within their home environment  
Integrated care and support is available and delivered close to home |
| I have considerate support delivered by competent people                | People will experience seamless care and support delivered by a skilled workforce within their communities  
Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
Workforce work flexibly across the Island adopting flexible and integrated approaches |

- Increase numbers of people supported to identify their own health and social care outcomes
- Voluntary organisations providing support to older people and people with long term conditions in a timely manner and appropriate location
- Reducing the number of GP consultations
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- Increase usage of risk stratification tools to identify those at highest risk via localities practices
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### Crisis response service project timelines

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Scheme 3 – Rehabilitation/Reablement

Strategic objective
The vision of NHS IOW CCG and IOW Council is that adult residents requiring physical rehabilitation/reablement should receive it in a timely manner and an appropriate setting to enable them to reach the individual person’s optimum level of functional independence. It will be particularly relevant to people with Long Term Conditions, Dementia and the Frail Elderly.

The scheme will undertake a review of current rehabilitation (CCG funded) and reablement (council funded) services to establish whether this vision is being achieved. The review will also investigate and explore commissioning options for future provision including the possible option of an integrated provision of service across the IOW CCG, IOW Council and third sector. It will also investigate and explore how the potential integration of services with the My Life, A Full Life locality teams could further enhance service provision.

Overview
The target patient cohort includes adults, registered with an IOW GP, who have a physical health rehabilitation/reablement need.

An estimated 4000 people per year currently use these services but it is acknowledged that there are gaps in service provision and some hundreds of additional people could benefit from a revised and integrated service.

The service would be delivered on the Isle of Wight across hospital and community settings. In exceptional cases mainland providers might be commissioned to provide individual rehabilitation if appropriate skills and/or resources were unavailable on the Island.

The scheme will:
1. Undertake a review of the objectives of the commissioned elements of the Rehabilitation Service to establish whether they are being achieved.
2. Undertake a review of the use of non-weight bearing beds.
3. Benchmark the Rehabilitation Service against services provided by other similar CCGs.
4. Identify if there are any elements missing from the Rehabilitation Service.
5. Undertake a review of the objectives of the commissioned elements of the Reablement Service to establish whether they are being achieved.
6. Benchmark the Reablement Service against services provided by other similar Local Authorities.
7. Identify if there are any elements missing from the Reablement Service.
8. Consider whether the current services represent “value for money”.
9. Review access criteria to services.
10. Investigate and explore commissioning options for future provision including seven day a week services and the possible option of an integrated provision of service across the IOW CCG and IOW Council.
11. Investigate and explore how the potential integration of services with the My Life, A Full Life locality teams could further enhance service provision.

The scheme will include review of:
1. Use of hospital and community rehabilitation beds
2. Stroke rehabilitation including Early Supported Discharge
3. SPARRCS (single point of access and co-ordination service)
4. Out-patient and community rehabilitation
5. Reablement Service including the service relationship between domiciliary homecare and the Resource Centres
6. GP contracts for community rehabilitation beds
7. Neuro-psychology assessments undertaken by mainland provider
8. Mainland special placements for complex rehabilitation cases
9. Integrated Community Equipment Service/Red Cross contract
10. Disabled Facilities Grants/use of Occupational Therapists
11. Support grant to Stroke Association
12. Falls prevention and falls training

The interface with other services will also be considered, to include:
- Acute hospital rehabilitation
- Crisis Response
- Technology Enabled Care Services (Assistive Technology)
- Care Management
- Community services eg District Nursing
- Independent Living Centre
- Mental Health Outreach
- Memory Service

Once the learning from the review has been analysed, then part of the scheme will be to commission a revised integrated service, support the change management required through via active engagement and commissioning support; whilst ensuring that any revised service meets the required quality standards and overarching performance indicators.

The delivery chain
Currently the services are commissioned and provided as follows:

IOW CCG commissions services from
- IOW NHS Trust
- Red Cross
- Independent Sector Nursing Home Provision
- Colville Care
- Island Healthcare
- Autism Diagnostic Research Centre
- Stroke Association
- GP Practices
  - St Helens
  - Esplanade
  - Sandown
  - Brookside
  - Medina Healthcare

IOW Council commissions services from their internal services:
- Domiciliary homecare
- Resource Centres

The following members of staff have been tasked with undertaking this review and producing a report and recommendations:
- Jackie Raven, IOW Council
- Alison Geddes, IOW CCG

The evidence base
- Initial stakeholder event July 2014
- IOW Disease Profiles - Public Health England August 2014
Investment requirements
The amount of funding identified for this scheme is £6,642,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme
Anticipated additional outcomes:
- Increasing the proportion of people feeling supported to self-manage their condition(s) and corresponding care needs
- Improving functional ability and ability to work in people
- Reducing serious deterioration in people with ambulatory care sensitive conditions leading to reduced emergency admissions to hospital
- Improving health and social related quality of life for carers
- Managing patients in the community wherever possible
- Promoting self-management and provision of information, advice and support
- Ensuring value for money is achieved

Feedback loop
The initial outcome of the scheme will be the production of a joint IOW CCG/IOW Council report.

If the proposals within the report are agreed by the IOW CCG and IOW Council and services are re-developed then it is anticipated that feedback on the integrated services will be monitored using some of the My Life, A Full Life “I” and “We” statements:

- I will no longer be a patient or a client; I’ll be a person.
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I have access to easy to understand information about health, wellbeing, care and support which is consistent, accessible and up to date.
- I am able to get skilled advice to plan my care and support.
- I can plan ahead and keep control at times of crisis.
- I have considerate support delivered by competent people.
- We will enable people to promote their own health and wellbeing supported by self-care and self-management.
- We will see people as people and deliver co-ordinated support to individuals, their families and carers.
- We will support people at times of crisis to have the right support as soon as possible, to enable people to return home and to their communities.
- We will develop the infrastructure to deliver truly co-ordinated care and support.
- We will support people with long term conditions and the elderly frail locally, based around GP practices.

In addition evidence-based rehabilitation outcome goals will be used throughout the new integrated service. Details of these will be determined during the review process.
Key success factors

Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.

- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and we” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

We can confirm that this scheme has a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

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<td>Positive impact on the health and wellbeing of people who are older frail and people with long term conditions</td>
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<td>I have access to a range of easy-to-understand information about care and support which is consistent, accurate, accessible and up to date</td>
<td>People empowered to take individual responsibility in making daily choices about their lifestyles</td>
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<td>People are supported to take responsibility for their own health and wellbeing</td>
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<td>People’s health and wellbeing is improved by personalised care and support</td>
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<td>People are supported to develop contingency plans to detail their wishes at times of crisis</td>
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| My support is co-ordinated, co-operative and works well together | • People are enabled to maintain their independence within their home environment  
• Integrated care and support is available and delivered close to home |
| I have considerate support delivered by competent people | • People will experience seamless care and support delivered by a skilled workforce within their communities  
• Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
• Workforce work flexibly across the Island adopting flexible and integrated approaches |
| I can plan ahead and keep control in a crisis | • People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas  
• People are supported to develop contingency plans to detail their wishes at times of crisis  
• People will be supported and be enabled to return home whenever possible |
| I can decide the kind of support I need and when, where and how to receive it. | • People will use the full range of resources available to them to maximise their independence and wellbeing  
• People’s care and support is personalised to meet their health and wellbeing outcomes |

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| Reducing inefficiencies, such as duplication of assessments and recording  
• Reduction in residential care placements  
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| Increase in number of training courses available to focus on quality of care, customer service and dignity and care  
• Increase in the numbers of change workshops for MDT integrated teams including commissioners |
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• Numbers of people taking up seasonal flu vaccination |
| • Reduction in the number of unplanned admissions  
• Reduction in GP contact time  
• Increased use of personalised care planning |
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Scheme 4 – Integrated Locality Working

Strategic objective

The IOW NHS, IOW Council and IOW CCG have all clearly identified the need and desire to further develop integrated Health and Social Care working on the Isle of Wight within their respective strategic documents. Under the principles of the House of Care framework, older people with co-morbidities, including dementia, would benefit most from integrated locality working. This is further affirmed by the development of the My Life a Full Life Programme and the Five Year Health and Social Care Vision which promote longer, healthier and more independent lives for the people of the Isle of Wight.

In response to the national and local drivers for change, extensive work has been carried out on the Isle of Wight to develop new ways of integrated working. Central to this is the My Life a Full Life Programme. The overarching strategic objective of the My Life a Full Life programme is to “Ensure that valuable resources are used effectively to get the best outcomes for people, community and society for now and for future generations”. The Integrated Locality work stream is one of the three work streams which sit within the My Life a Full Life programme.

This scheme will develop delivery of integrated care in three locality teams across the Island, and will be implemented in four phases. A first step will be to remove complexity by delivering a simple pattern of services from the community and hospital settings.

Phase 1: Integrated community teams working with GPs, specialist services and the voluntary sector will assist those people living in their communities who have long term conditions or are frail due to disability or age.

Phase 2: Integrating Adult Social Care teams into locality teams.

Phase 3: Redesigning the Dementia Intensive Treatment Service (DITS) to deliver dementia support and advice within the integrated locality teams.

Phase 4: Integrating Memory Service provision and delivery of the Dementia Care Pathway within the integrated locality teams.

Stakeholders from all areas on the Island have been brought together through various means to identify the gaps in the current system, and to identify actions for change. For the development of the crisis response model, stakeholders from health, social care, the independent sector, the voluntary sector and the public have specifically been engaged.

To enable the overarching strategic aim of My Life a Full Life to be met the crisis response team has the following work stream specific strategic objectives:

Aims and Objectives

- Improve quality and satisfaction of care for people, through clear service navigation, easy access to integrated coordinated services closer to home.
- Ensure people are supported to reach a level of functional independence acceptable to them, preventing, where possible, avoidable deterioration and crisis leading to non-elective admission to hospital.
- Ensure commissioned services are sustainable, provide value-for-money and meet the needs of the Isle of Wight population.
- To build multidisciplinary teams for people with complex needs, including social care, Mental Health and voluntary services.
- To reduce the complexity of services.
- To create services that offer an alternative to hospital stay.
- To wrap services around primary care.
To develop the capability to harness the power of the wider community.

Drivers for Change

In 1901 there were just over 60,000 people aged 85 and over in the UK. Today there are 1.5 million, a 25 fold increase. By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million to 8.7 million, while those aged 85 and over, the projected increases from 1.5 million in 2011 to 3.3 million in the same period. The number of people in care homes is projected to rise from 345,000 in 2005 to 825,000 in 2041. As a result of this demographic change public expenditure on long-term care is projected to rise by more than 300% in real terms over that period.

The demographics of the Island demonstrate that the percentage of residents over 65 is already above national average and will increase going forward. This will result in an inverse age ratio by 2031 if the ONS projections are correct.

Older people are disproportionately high users of health and social care services. Moderate to severe depression occurs in 3 to 4% of the older adult population. The highest prevalence of depression is found in those over 75. Indeed contrary to some perceptions the majority of the morbidity in older people is not dementia but other functional illnesses such as depression and psychosis and that these can, and frequently do, coexist with dementia and physical health comorbidities. Depression is often difficult to diagnose and treat these groups require sustained, expert management. To address parity of esteem it is essential that all schemes address both the emotional and mental health as well as physical health conditions that people may have.

The increasing incidence of dementia in our older population is another driver for change, for example:

- **Hospital care** - 70% of acute hospital beds are currently occupied by people over the age of 65 and half of these may have a cognitive impairment including dementia. Hospitals are particularly challenging environments for people with dementia and they experience worse outcomes in terms of length of stay, mortality and institutionalisation compared with those without dementia for comparable illnesses, this is estimated to cost £6 million per year.
- **Care homes and care at home** - An estimated one third of people with dementia live in residential care with two thirds living at home. Based on the Islands estimated prevalence of dementia, 724 people live with dementia in a care home on the Island. If our proportion of people living in care homes remains the same, by 2024 this will have increased to 894.
- **Economy** - Dementia costs the UK society an estimated £23 billion a year, more than the costs of cancer, heart disease or stroke.
- **Carers** - An estimated 21 million people in our country know a close friend or family member with dementia – that is 42 percent of the population. There are around 550,000 carers of people with dementia in the England. It is estimated that one in three people will care for a person with dementia in their lifetime.

On the Isle of Wight we have the highest percentage of the population living with dementia compared to the rest of the UK, mainly due to our higher than average elderly population. It is estimated that in 2013 there were 2954 people living with dementia, this is predicted to increase by 23 percent to 3651 by 2024.

Overview

The proposal on the Island is the creation of three integrated locality teams working across the Island and linking closely with Primary Care. The 17 GP practices on the Island had already formed themselves into three localities to enable them to work more closely together to deliver services. Following this model the Community Nursing teams, Health Visiting and Midwifery have also arranged their services into these locality teams. To take forward the aims of the Five Year Health and Social Care vision the next steps will

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8 Source ONS 2008 based sub-national population projections
be to work with colleagues in Adult Social Care to create multi-disciplinary integrated Health and Social Care Locality Teams.

Integrated community teams working with GPs, specialist services and the voluntary sector will assist those people living in their communities who have long term conditions or are frail due to disability or age. A first key step will be to remove complexity by delivering a simple pattern of services delivered by a multi-disciplinary team based around localities and primary care supported by specialist services from the community and hospital setting. This will offer Island residents a more complete and less fragmented service. To be successful each locality will need to undertake systematic, targeted case-finding using risk stratification tools.

A four phase business case to create fully integrated health and social care teams is currently being progressed. Phase 1 has been agreed, and this will enhance the leadership within the 3 Community Nursing Teams. Phase 2 is in the process of being drafted and will focus on the integration of adult social care with health provider community teams. Phase 3 will be the redesigning of the current Dementia Intensive Treatment Service (DITS) to deliver dementia support and advice within the integrated locality teams to families, residential and nursing homes and the locality teams. Phase 4 will integrating Memory Service provision and delivery of the Dementia Care Pathway within the integrated locality teams.

The voluntary sector will also be a major contributor to the success of locality working and are already involved with the MLAFL programme on the Island. A pilot programme using Care Navigators based in GP surgeries has commenced in the North East Locality and following evaluation this scheme will be extended to the other two localities.

The delivery chain
The IOW CCG, as Lead Commissioner, will oversee and monitor the delivery of the four phase Integrated Locality Teams scheme. A business case is currently in development and once approved contracts will be modified and a service specification will be put in place. This will be monitored contractually but will also be monitored at the JACB.

The IOW CCG is currently commissioning Phase 1 of the business case for the Integrated Locality Teams. Phases 2 and 3 will be commissioned jointly by the IOW CCG and IOW Council. The intention is to develop outcomes based contracts for these new services.

The Integrated Locality Implementation Work Stream is led by an Associate Director, with project support, working across the organisations. The work stream is accountable to the My Life a Full Life Programme which is chaired by the Chairman of the IOW CCG and has senior representation from all of the stakeholders.

There is also an Island wide Dementia Steering Group involving all stakeholder organisations who will continue to drive for improvements over the next 5 years enabling people to live well with dementia on the Isle of Wight and ensure integration with other services.

The evidence base
Best practice examples, such as Sweden, the Netherlands and Torbay, show that integrated locality working promotes efficiencies in the way people work and reduces cost while also making quality improvements in care. For example, Torbay's Integrated Health and Social Care working showed:

- The daily average number of occupied beds fell from 750 in 1998/99 to 502 in 2009/10.
- Emergency bed day use in the population aged 65 and over is the lowest in the region.
- Emergency bed day use for people aged 75 and over fell by 24 per cent between 2003 and 2008 and by 32 per cent for people aged 85 and over in the same period.
Delayed transfers of care from hospital have been reduced to a negligible number and this has been sustained over a number of years.

Torbay Care Trust was financially responsible for fewer people aged over 65 in residential and nursing homes.

Central Manchester estimated the following benefits from integrated working over 5 years:

- 10% - 30% reduction in bed days
- 20% - 40% reduction in emergency admissions
- 10% reduction in readmissions
- 9% - 20% reduction in care home admissions

The Kings Fund *Making our health and care systems fit for an ageing population* proposes a model (pictorially highlighted below) of care which is structured around nine components, followed by a final, overarching component (integrated care centred on the individual’s needs) that binds the others together. On the Island we are taking a person-centred, whole system approach, initially focusing on people with multiple needs. To achieve this we need to undertake a redesign of the care model for these people which will incorporate primary care, adult social care and acute and community health services.

For the model to be successful the wider determinants of health also need to be included in the modelling of the care needs of older residents. Many of these services, such as housing, will be within the remit of the council, other key services are also provided by the voluntary sector on the Island the key to this approach is how we ensure this support and services work together for better outcomes on the Island.

*Figure 33: annual cost* by age and service area for Torbay (population 145,000) 2010/11
It is essential that in order to deliver the quality of care required that we configure an effective and adequately skilled and resourced community nursing workforce. Key to this is establishing the right style of leadership. It would be the aim of the enhanced leadership of the community nursing team that they would work collaboratively with colleagues to deliver person centred care in partnership with the patient and their carers. A working group convened by The King’s Fund recommended that teams of community staff should be developed around groups of practices and forge very close working relationships with them.10

**Investment requirements**
The amount of funding identified for this scheme is £5,140,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

**Impact of scheme**
It is anticipated that by working in an integrated way, at the right time and location that we will see:

- Pathway alignment through integrated locality teams, which will provide person-centred support as well as access to third sector community support, to enable individuals to live as independently as possible and achieve a good quality of life.
- Provision of holistic and comprehensive health and social care that supports individuals to make incremental improvements in their everyday life and social functioning.

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10 Edwards N (2014) COMMUNITY SERVICES How they can transform care: The Kings Fund
Increase efficiencies through:
- Reduced hospitalisation and readmission rates (financial and efficiency gains)
- Improved discharge rates from services
- Greater access to tele-care to support people in their own homes
- Reduction in admissions to residential care.
- Increased self-management and the development of networks of support.

Feedback loop
Other than the metrics detailed below moving aside from the clinical metrics the anticipated benefits of the scheme will be working to reduce social isolation for older people, encouraging self-management and self-care and ensuring good links into the community. The preventative agenda feels like it has not had a high profile for older people and this will now form the basis of the programme in collaboration with Island residents.

My Life a Full Life Metrics
- Emergency Readmissions within 30 days of discharge from Hospital (Public Health Outcomes Framework 4.11).
- Proportion of older people (65+) who are still at home 91 days after discharge from hospital into rehabilitation/reablement services (Adult Social Care Outcomes Framework 2b, NHS Outcomes Framework 2A).
- Permanent readmission to residential; and nursing homes per 1000 population (Adult Social Care Outcomes Framework 2A).
- Overall satisfaction of people who use services with their care and support (Adult Social Care Outcomes Framework 3A).

Key success factors
Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.
- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

We can confirm that this scheme has a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.
<table>
<thead>
<tr>
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| • I have access to a range of support that helps me live the life I want and remain a contributing member of my community | • Positive impact on the health and wellbeing of people who are older frail and people with long term conditions  
• People make a positive contribution to their communities | • Increase numbers of people supported in identify their own health and social care outcomes  
• Increase in numbers of voluntary organisations providing support to older people and people with long term conditions  
• Reducing the number of GP consultations  
• Delaying the need for longer term support from health and social care organisations  
• Numbers engaged in public health services (smoking cessation, weight management) |
| • I have access to a range of easy-to-understand information about care and support which is consistent, accurate, accessible and up to date | • People empowered to take individual responsibility in making daily choices about their lifestyles  
• People plan for their future housing, care and support needs | • Increase in the number of people using support websites (NHS Choices, Information Prescriptions, Directory of Services)  
• Increase in the number of people access information services (ie, Age UK, People Matter, ILC and voluntary groups)  
• Reducing the number of GP consultations  
• Delaying the need for longer term support from health and social care organisations |
| • I have care and support that is directed by me and responsive to my needs | • People are supported to take responsibility for their own health and wellbeing  
• People’s health and wellbeing is improved by personalised care and support  
• People are supported to develop contingency plans to detail their wishes at times of crisis | • Increase in the use of self-help and self-management support via locality practices  
• Increase usage of risk stratification tools to identify those at highest risk via localities practices  
• Increase take up of local support networks and healthy lifestyle services to enable local community responses at times of crisis |
| • My support is co-ordinated, co-operative and works well together | • People are enabled to maintain their independence within their home environment  
• Integrated care and support is available and delivered close to home | • Reducing inefficiencies, such as duplication of assessments and recording  
• Reduction in residential care placements  
• Reduced rate of admission |
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| - I have considerate support delivered by competent people | - People will experience seamless care and support delivered by a skilled workforce within their communities  
- Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
- Workforce work flexibly across the Island adopting flexible and integrated approaches | - Increase in number of training courses available to focus on quality of care, customer service and dignity and care  
- Increase in the numbers of change workshops for MDT integrated teams including commissioners  
- Increase in the numbers of voluntary, private and independent accessing training to support the My Life a Full Life Programme |
| - I can plan ahead and keep control in a crisis | - People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas  
- People are supported to develop contingency plans to detail their wishes at times of crisis  
- People will be supported and be enabled to return home whenever possible | - Reduction in the number of unnecessary visits to GPs and A&E  
- Reduction in unplanned admissions  
- Reduction in GP contact time  
- Reduction in residential care placements  
- Reduce length of stay within acute environment  
- Numbers of people taking up seasonal flu vaccination |
| - I can decide the kind of support I need and when, where and how to receive it. | - People will use the full range of resources available to them to maximise their independence and wellbeing  
- People’s care and support is personalised to meet their health and wellbeing outcomes | - Reduction in the number of unplanned admissions  
- Reduction in GP contact time  
- Increased use of personalised care planning |
Timeline for Phase 1 Timeline and Model

- Review of Community Nursing / Community Matrons
- Stakeholder Model Development
- Workforce Development
- Risk Stratification - Rollout of Paris
- Business Case
  - PID Agreed
  - Business Case Development
  - Organisational Change
  - Adult Social Care Development
- Implementation
- Case Load Allocation
- Workforce Development
- Care Navigator
- Review of Risk Stratification

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Scheme 5 – Enhanced Hospital Discharge

Strategic objective
Over the last ten years a growing body of national and international evidence has emerged, that links poor outcomes, including a higher risk of death, for patients admitted to hospital at the weekend around the world. The historical five day service model no longer meets justifiable patient and public expectations of a safe, efficient, effective and responsive service.

In constructing this scheme we are conscious that in December 2012 NHS England published *Everyone Counts: Planning for patients 2013/14*. It included a number of offers to NHS commissioners, to give them the insights and evidence they need to produce better local health outcomes. It stated, for the first time, that the NHS will move towards routine services being available seven days a week. Professor Sir Bruce Keogh, established the *NHS Services, Seven Days a Week Forum* ("the Forum") to consider the consequences of the non-availability of clinical services across the seven day week.

The Forum tells us that patients’ experiences of care are particularly affected at weekends by a lack of integration across all health settings and with social care services together with the need for co-ordination across primary, secondary and community based services.

This particular scheme supports the Acute Hospital Team to facilitate from Adult Social Care:
1. Improvements in the patient experience.
2. Appropriate and timely discharges.
3. Prevent delays ensuring people are discharged to promote their recovery in a more appropriate community environment.
4. Robust and comprehensive discharge planning to ensure safe discharges and patient wellbeing.
5. Reduce breakdown at ‘home’.
6. Reduce readmission to hospital.

Overview
The enhanced hospital discharge is an extension to the Adult Social Care Social Work service within the Hospital (St Mary’s). An additional to the existing team, 4 x FTE qualified social workers have been provided so that the service operates 8am - 8pm Monday – Friday and 9am – 4pm Saturday and Sunday. This ensures there is appropriate social work cover to all of the wards both in hours and out of hours.

It has also facilitated multi-disciplinary working with specific staff dedicated to specific wards. The service is provided to all patients across the hospital as well as to their families/carers.

With the reduction in length of hospital stay, which is a joint health and social care agenda, the volume and complexity of referrals for discharge is demonstrated. Patients frequently have very high social care needs and comprehensive liaison with ward staff and community health staff is essential.

The staff are based within the hospital and by maintaining dedicated ward links, ensure referrals and assessments are progressed within agreed timescales. Frequently they are completed on the same day.

The service commenced in March 2014 when recruitment and training was completed.

The delivery chain
The Hospital Social Work Team is provided by Adult Social Care and all other posts within that team are fully funded by the IOW Council.
The additional 4 posts have been funded previously via NHS Support for Social Care.

The service is managed by the Group Manager of the Hospital Team who ensures the overall performance of the team and oversees the individual staff delivery. The Group Manager is responsible both quantitatively, ensuring referrals are actioned appropriately, and also qualitatively, ensuring person-centred, multi-disciplinary assessments.

The additional 4 social work posts represent a significant increase to the team and have supported the whole team in terms of planned and unplanned absences.

The evidence base
Data for one month in 2014 showing the activity for weekend and out of hours through the enhanced hospital discharge scheme:

- 55 interventions
- 42 assessment completed
- 17 people discharge on the same day avoiding an unnecessary overnight stay in hospital
- 5 Continuing Health Care reports completed
- 4 safeguarding cases explored

Investment requirements
The amount of funding identified for this scheme is £2,969,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan. This includes care packages.

Impact of the scheme
This scheme has been developed to ensure a positive impact on the number and quality of discharges from St Mary’s Hospital.

- Impact on quality of life for people who have had an acute health episode necessitating hospital stay.
- Ensuring all discharges are planned in the context of multi-disciplinary working with ward staff and key professionals both inside and outside the hospital.
- Ensuring the ‘patient’ is at the centre of discharge planning and assessment.
- The patient’s representatives/families are involved and contribute to the discharge process.
- Ensuring appropriate services are accessed on discharge – that these are planned and there is monitoring and review on discharge.
- There is good evidence that timely, appropriate discharges which involve Adult Social Care are effective, preventing readmission to hospital.
- Recovery is promoted outside of the hospital setting.
- Supports our joint agenda to reduce length of stay for all admissions.

The service was designed with input from partners in the hospital and the IOW CCG which reflects best practice.

Feedback loop
To ensure effective delivery of this scheme, metrics will be developed and monitored by the JACB and the Adult Social Care management team on a regular basis.

We will be looking at metrics such as:
- Number of social care assessments completed
- Length of stay in hospital
- Improved timeliness of discharge
Key Success Factors

Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.

- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

We can confirm that this scheme has a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

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• People are supported to develop contingency plans to detail their wishes at times of crisis  
• Increase in the use of self-help and self-management support via locality practices  
• Increase usage of risk stratification tools to identify those at highest risk via localities practices  
• Increase take up of local support networks and healthy lifestyle services to enable local community responses at times of crisis |
| My support is co-ordinated, co-operative and works well together | • People are enabled to maintain their independence within their home environment  
• Integrated care and support is available and delivered close to home  
• Reducing inefficiencies, such as duplication of assessments and recording  
• Reduction in residential care placements  
• Reduced rate of admission |
| I have considerate support delivered by competent people | • People will experience seamless care and support delivered by a skilled workforce within their communities  
• Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
• Workforce work flexibly across the Island adopting flexible and integrated approaches  
• Increase in number of training courses available to focus on quality of care, customer service and dignity and care  
• Increase in the numbers of change workshops for MDT integrated teams including commissioners |
| I can plan ahead and keep control in a crisis | • People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas  
• People are supported to develop contingency plans to detail their wishes at times of crisis  
• People will be supported and be enabled to return home whenever possible  
• Reduction in the number of unnecessary visits to GPs and A&E  
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• Numbers of people taking up seasonal flu vaccination |
| I can decide the kind of support I need and when, where and how to receive it. | • People will use the full range of resources available to them to maximise their independence and wellbeing  
• People’s care and support is personalised to meet their health and wellbeing outcomes  
• Reduction in the number of unplanned admissions  
• Reduction in GP contact time  
• Increased use of personalised care planning |
Scheme 6 – Supporting Information, Advice and Self-Management

Strategic objective
The scheme will introduce and promote the concepts of self-care and self-management and will be particularly relevant to people with Long Term Conditions, Dementia, Mental Health problems and the Frail Elderly.

The scheme will introduce and promote the concepts of self-care and self-management. This will involve
- People being encouraged to proactively take responsibility for their own health and wellbeing.
- Supporting people when required through advice and information.
- Ensuring the right support is available to respond to their needs in a timely and accessible manner.
- Providing support with a good level of safety and quality.
- Delivering within the resources we have as an Island community.

Overview
Self-care and self-management support will be made available for the whole population of the Isle of Wight through a variety of formats to ensure maximum coverage. Existing support mechanisms will be strengthened and new methods developed.

Self-care and self-management campaigns will encourage people to seek appropriate advice and information and the use of an Island-wide care plan will be key to developing personalised information.

In addition risk stratification, using information from primary and secondary care data to identify risk of resource utilisation, will be used to identify patient cohorts and ensure that they are targeted appropriately (see figure 34 below).

- **Very High risk** patients will be able to receive self-management support from primary, secondary, tertiary and social care - in particular Community Matrons, Specialist Nurses, Care Managers and telehealth monitoring as well as self-management literature, peer support groups, the Support Group Development Officers, local Pharmacists, the Independent Living Centre, Good Neighbourhood Schemes, Care Navigators, Café Clinics, the Island’s new Information Hub and have all this information coordinated into a Personalised Care Plan

- **High risk** patients will be able to receive self-management support from primary, secondary, tertiary and social care - in particular Care Managers and telehealth monitoring as well as self-management literature, peer support groups, the Support Group Development Officers, local Pharmacists, the Independent Living Centre, Good Neighbourhood Schemes, Care Navigators, Café Clinics, the Island’s new Information Hub and have all this information coordinated into a Personalised Care Plan

- **Moderate risk** patients will be able to receive self-care and self-management support from primary, secondary, tertiary and social care and also condition-specific education, health coaching and lifestyle management advice, peer support groups, the Support Group Development Officers, local Pharmacists, the Independent Living Centre, Good Neighbourhood Schemes, Care Navigators, Café Clinics, the Island’s new Information Hub and have all this information coordinated into a Personalised Care Plan

- **Low risk** patients will be able to receive self-care support from primary, secondary, tertiary and social care and also health education, health promotion and prevention strategies and lifestyle change programmes, self-care literature, peer support groups, the Support Group Development Officers, local Pharmacists, the Independent Living Centre, Good Neighbourhood Schemes, Care Navigators, Café Clinics and the Island’s new Information Hub
The delivery chain
Currently the services are commissioned and provided as follows:

IOW CCG commissions services from
- Red Cross
- People Matter (the Island’s User Led organisation)
- Community Action IOW (voluntary sector lead organisation)
- IOW NHS Trust
- Age UK IOW
- West Wight Sports Centre
- Help and Care
- Action on Hearing Loss

IOW Council commissions services from
- Age UK IOW
- Citizen’s Advice Bureau
- Law Society
- IOW Council
- Action on Hearing Loss

The following members of staff have been tasked with undertaking this scheme:
- Martin Johnson, IOW Council
- Alison Geddes, IOW CCG

The evidence base
- Feedback from Long Term Condition Patient Group
- Feedback from Support Group development events
Investment requirements
The amount of funding required for this scheme is £106,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

<table>
<thead>
<tr>
<th>Area</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Lifestyles</td>
<td>People take their health seriously throughout their lives, have a lifelong plan for wellbeing, and are adopting healthier lifestyles as a result.</td>
</tr>
<tr>
<td>Information and Advice</td>
<td>Good local information is easily available, both to help people make healthy choices and to signpost them to sources of help and advice about their health.</td>
</tr>
<tr>
<td>Peer Support</td>
<td>People with long-term conditions are able to manage their own condition well, getting support from peers (or expert patients), and knowing when to seek professional help.</td>
</tr>
<tr>
<td>Public Involvement</td>
<td>People are confident in expressing their views, and they know that their voice is at the centre of local service planning and delivery.</td>
</tr>
<tr>
<td>Personal Budgets</td>
<td>Many people have joint health and social care personal budgets, and these are an important way of having greater choice and control.</td>
</tr>
<tr>
<td>Carers</td>
<td>The role of carers is valued, and carers are supported to carry out their caring role with information and practical support.</td>
</tr>
<tr>
<td>Community Support</td>
<td>Communities are supportive places for frail older people and people with long term conditions to live – good neighbours or local businesses will always notice and step in if people are in danger of becoming isolated.</td>
</tr>
<tr>
<td>Promotion of Wellbeing and Independence</td>
<td>All services actively promote wellbeing and independent living, working to avoid crisis, but if they do occur, responding quickly to resolve them, and making sure that the person is able to return to independence as soon as they can.</td>
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Feedback loop
It is anticipated that feedback on the integrated services will be monitored using some of the My Life a Full Life “I” and “We” statements:
- I will no longer be a patient or a client; I’ll be a person.
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community.
- I feel valued for the contribution I make to my community.
- I have access to easy to understand information about health, wellbeing, care and support which is consistent, accessible and up to date.
- I am able to get skilled advice to plan my care and support.
- I can plan ahead and keep control at times of crisis.
- I have considerate support delivered by competent people.
- We will enable people to promote their own health and wellbeing supported by self-care and self-management.
- We will see people as people and deliver co-ordinated support to individuals, their families and carers.
- We will support people at times of crisis to have the right support as soon as possible, to enable people to return home and to their communities.
- We will develop the infrastructure to deliver truly co-ordinated care and support.
We will support people with long term conditions and the elderly frail locally, based around GP practices.

Specific monitoring tools have been developed to obtain this feedback in conjunction with the University of Southampton and our Public Health department.

**Key success factors**

Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.

- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

We can confirm that this scheme has a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

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• Voluntary organisations providing support to older people and people with long term conditions in a timely manner and appropriate location  
• Reducing the number of GP consultations  
• Delaying the need for longer term support from health and social care organisations  
• Numbers engaged in public health services (smoking cessation, weight management) |
| Positive impact on the health and wellbeing of people who are older frail and people with long term conditions  
People make a positive contribution to their communities | |
| I have access to a range of easy-to-understand information about care and support which is consistent, accurate, accessible and up to date | • Increase in the number of people using support websites (NHS Choices, Information Prescriptions, Directory of Services)  
• Increase in the number of people access information services (ie, Age UK, People Matter, ILC and voluntary groups)  
• Reducing the number of GP consultations  
• Delaying the need for longer term support from health and social care organisations |
| People empowered to take individual responsibility in making daily choices about their lifestyles  
People plan for their future housing, care and support needs | |
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| I have care and support that is directed by me and responsive to my needs | People are supported to take responsibility for their own health and wellbeing  
People’s health and wellbeing is improved by personalised care and support  
People are supported to develop contingency plans to detail their wishes at times of crisis | Increase in the use of self-help and self-management support via locality practices  
Increase usage of risk stratification tools to identify those at highest risk via localities practices  
Increase take up of local support networks and healthy lifestyle services to enable local community responses at times of crisis |
| My support is co-ordinated, co-operative and works well together | People are enabled to maintain their independence within their home environment  
Integrated care and support is available and delivered close to home | Reducing inefficiencies, such as duplication of assessments and recording  
Reduction in residential care placements  
Reduced rate of admission |
| I have considerate support delivered by competent people | People will experience seamless care and support delivered by a skilled workforce within their communities  
Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
Workforce work flexibly across the Island adopting flexible and integrated approaches | Increase in number of training courses available to focus on quality of care, customer service and dignity and care  
Increase in the numbers of change workshops for MDT integrated teams including commissioners |
| I can plan ahead and keep control in a crisis | People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas  
People are supported to develop contingency plans to detail their wishes at times of crisis  
People will be supported and be enabled to return home whenever possible | Reduction in the number of unnecessary visits to GPs and A&E  
Reduction in unplanned A&E admissions  
Reduction in GP contact time  
Reduction in residential care placements  
Reduce length of stay within acute environment  
Numbers of people taking up seasonal flu vaccination |
| I can decide the kind of support I need and when, where and how to receive it. | People will use the full range of resources available to them to maximise their independence and wellbeing  
People’s care and support is personalised to meet their health and wellbeing outcomes | Reduction in the number of unplanned admissions  
Reduction in GP contact time  
Increased use of personalised care planning |
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Scheme 7 – Carers

Strategic objective

The evidence suggests that we will make a significant difference to the lives of carers and to those they are caring for on the Island by investing in them. The argument for supporting carers is clear and irrefutable. People who may be sacrificing their needs to care for a friend or relative deserve support through the Islands BCF.

This scheme demonstrates how using these allocations to increase support for carers also benefits the people being cared for, health commissioners, general practitioners (GPs) and councils. We believe that there is evidence which shows that increasing support for carers on the Island will:

- Improve health and wellbeing outcomes for patients and recipients of care.
- Improve health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health.
- Reduce unwanted admissions, readmissions and delayed discharges in hospital settings.
- Reduce unwanted residential care admissions and length of stays.

Spending more on breaks, training, information, advice and emotional support for carers will help us reduce overall spending on care and support as a result of reductions in unwanted (re)admissions, delayed discharges and residential care stays. We anticipate that by improving access to breaks, counselling, and training we will be successful in helping carers to maintain their health and quality of life and that of the person they care for.

The IOW Council and the IOW CCG are working together to improve the lives of carers, providing them with the opportunity to be consulted about services and involved in the decision making which affect them. One of the main aims of the strategy, in line with government policy, is to provide people with genuine control and choice over how they are supported. In the last 10 years we have seen a 14 per cent increase in the numbers of carers living on the Island with figures rising above 16,500, which is over 10 per cent of the Island’s population. The Care Act offers significant opportunities to improve support for carers. A new Isle of Wight carer’s strategy has now been drafted and focus’ on the things that make the most difference for carers.

This strategy potentially affects 16,500 carers (census 2011) on the Isle of Wight and is proposed to ensure that carers are supported in their caring role, through 10 key priorities, these are:

- Priority 1: Identifying and including carers
- Priority 2: Providing information, advice and training for carers
- Priority 3: Carers shaping policy and services
- Priority 4: Peer support
- Priority 5: Carers Breaks
- Priority 6: Access to work and training
- Priority 7: Access to benefits
- Priority 8: Crisis support
- Priority 9: Access to health and wellbeing
- Priority 10: Support for children and young carers.
Overview

The Working Together with Carers 2013 to 2016 plan has been developed based on information gathered from a wide range of individual carers and carer groups. This provided a focus point for further engagement, which was significant during the formal consultation launched on 3 January 2013 and closed on 25 February 2013. In order to engage widely with carers, 16 different events were held across the Island, for example, in local supermarkets, libraries, St Mary’s Hospital and with carers’ groups at different times of the day in order to fit in with the needs of carers. People were able to discuss individual issues and obtain information on carers support and services available on the Isle of Wight.

At these events people were encouraged to submit formal responses by completing a carers’ survey which could either be filled in at the event, taken away to complete either on line or on paper to return later. Consideration of how to engage with carers was supported by the local branch of Carers IOW which sent out survey information to 600 carers registered on their mailing list. An advertisement was placed in the Isle of Wight County Press advising people of the carers’ survey and the local networking events across the Island.

GP practices were sent information regarding the consultation events, along with printed copies of the carers’ survey. A GP survey consisting of five questions regarding the Working Together with Carers 2013 to 2016 plan, was sent to all GP practices across the Island.

Part of the delivering of the Carers Strategy will be to further scope demand, which will inform the longer term financial assessment.

Currently, carers have a statutory right to receive a carer’s assessment of need; councils also have a duty to recognise and take account of the carer’s right to work, education and a social life. Some of these services could be charged for however to do so would require further consultation with the various stakeholders.

The Care Act requires the council to have greater responsibilities to respond to a carers eligible needs; includes a whole family approach to assessment; a carers entitlement to request an assessment of their own needs will not be dependent on them providing regular and substantial care; an increased focus on supporting young carers; a duty to respond to carers eligible needs; a requirement to provide better information services for carers; a statutory obligation to provide a range of preventative services, the council will also need to make available more breaks and carers personal budgets. This will increase the statutory responsibility on the council.

Following the informal and formal consultation with carers the following has been established:

**Male Carers support Group**

In line with the consultation work undertaken when establishing the Working Together with Carers Strategy for the Isle of Wight we have Established a Male Carers support group, this enables male carers to meet with other male carers who have an understanding of their situation and provide support and some respite from their caring role.

**Former Carer – Moving on workshops**

In line with Priority: 2 of the NHS England’s commitment to carers and Priority: 5 of the Working Together with Carers Strategy for the Isle of Wight

During the consultation it was evident that we have large numbers of former carers that needed support to move on with their lives after their caring role has ended. Carers often become socially isolated and loose self-confidence. This session of creative workshops also supports with a buddy scheme to give former carers the confidence to attend new social groups and activities. The workshops are run by Carers IOW and have been very successful in that individuals attending the workshops have arranged the buddying between themselves and there has been no formal support from Carers IOW.
Carers Emergency Alert Card
In line with Priority; 7 of the NHS England’s commitment to carers and Priority: 1 of the Working Together with Carers Strategy for the Isle of Wight
The carers emergency alert card has been re-designed to attract both adult and younger carers with new alert cards and wrist bands which identify the person is looking after someone who could not manage without them.

Moving People Safely Training
In line with Priority: 2 of the NHS England’s commitment to carers and Priority: 9 of the Working Together with Carers Strategy for the Isle of Wight
Following consultation with carers they identified the need to be able to assist the person they are caring for to move safely, promoting wellbeing for them and the person they are caring for. Moving people safely training is accessible every month in order for carers not to have to wait for available training to become available. This is provided by the Back Care Team in connection with Carers IOW.

Next Steps
More work to be undertaken with GP Surgeries:
In line with Priority 5: of the NHS England’s commitment to carers and Priority 1: of the Working Together with Carers Strategy for the Isle of Wight
Carers are often presenting themselves at GP surgeries with their own health and social care needs relating to their caring responsibility and these appear not to be recognised by all Island GP practices and no clear pathway for signposting for support.

Training for carers to understand Mental Health Conditions:
In line with Priority: 2 and 3 of the NHS England’s commitment to carers and Priority 2: of the Working Together with Carers Strategy for the Isle of Wight
With regards to mental health, carers are aware of how the condition impacts on the person, but need more understanding about the diagnosis and prognosis of the condition.

Hospital Admissions
In line with Priority: 1 of the NHS England’s commitment to carers and Priority: 1 of the Working Together with Carers Strategy for the Isle of Wight
Work could be undertaken to identify and include carers as early as possible after a patient is admitted into hospital; this could be captured using a carer conversation record sheet held in the patients notes identifying;
I would like to (Carer)
Supported to (if they choose) to continue providing care for the patient whilst in hospital by;
◆ Assisting with personal care
◆ Assisting with feeding
◆ Assisting with dressing
Allowing the carer greater access to the ward outside visiting times, reduced or free parking and food in the canteen
◆ Be referred to Carers IOW for support
◆ Be referred for a Carers Assessment – In line with the Care Act 2014
◆ Be given information regarding diagnoses and prognosis

‘Think Carer Training’
In Line with Priority 2: of the NHS England’s commitment to carers and Priority 1: of the Working Together with Carers Strategy for the Isle of Wight
Establish training for all hospital staff, care management and GP surgeries.
◆ All staff understand what a carer is, what a carer is not and the difficulties carers have in identifying themselves as carers.
Carers are encouraged to identify themselves with staff and are proactively identified by staff.

Staff recognise and consider the important role carers play in maintaining patients good health and the effect caring has on the carers own health.

Consent should be obtained from the cared for patients so that information and advice about their condition can be shared with their carer where appropriate.

Carers are referred on for further information, advice and support – Carers IOW

Young Adult Carers
In line with Priority: 7 of the NHS England’s commitment to carers and Priority 1: of the Working Together with Carers Strategy for the Isle of Wight
A consultation needed to identify the needs of support for young adult carers on the Island.

Assisted Technology
In line with Priority: 7 of the NHS England’s commitment to carers and Priority: 1 of the Working Together with Carers Strategy for the Isle of Wight
We need to promote the use of assistive technology so that carers are aware of equipment that can support them.

Commission new services for carers support
In line with Priority 2: of the NHS England’s commitment to carers and Priorities: 2 and 8 of the Working Together with Carers Strategy for the Isle of Wight
It is necessary to establish new pathways of giving information and support to carers;
- One central point of contact – one telephone number
- 24 hours support.

And; In line with Priority 4: of the NHS England’s commitment to carers and Priority 1: of the Working Together with Carers Strategy for the Isle of Wight and the Care Act 2014, we need to establish:
  - Meaningful carer assessments to support carers as effectively as possible
  - Opportunity for personal budgets for carers with greater flexibility to their outcomes.

Employment and education
In line with Priority 8: of the NHS England’s commitment to carers and Priority 6: of the Working Together with Carers Strategy for the Isle of Wight:
There is a need to establish information to support family carers who are employed by the NHS and IOWC on the Island, looking at policies on flexible working; leave and employment breaks that support working staff that are carers and look at measures that prevent staff from giving up work to look after someone. We also need to ensure during carers assessments that all family carers are supported to retain or return to employment and studies if they choose to do so.

Carers discount card
In line with Priority: 7 of the NHS England’s commitment to carers and Priority 4: of the Working Together with Carers Strategy for the Isle of Wight
We need to continue to seek the opportunity to introduce a carer’s discount card for carers to access discounts at local businesses and leisure activities to promote healthy well-being and social interaction.

The delivery chain
Along with the work described above - the following services are commissioned and provided as follows:

Carer’s Assessment – provided via the First Response Team or the local Carers IOW UK

Sitting service – following assessment, carers may be eligible to receive a sitting service for up to two hours each week or the equivalent funding paid via a personal budget. The sitting service involves a paid carer going into the home to sit with the cared for person.
Crisis support – an immediate assessment is completed and appropriate support put in place.

Carer’s emergency alert card – identifies the holder as a carer and gives contact details and useful information in the case of an emergency. This is a free service provided to all carers by Wightcare.

Telecare – the IOW Council’s Wightcare Service provides a community alarm and response services which support Island residents and their carers with peace of mind to support them to remain safe and secure in their own homes.

IOW Council commission’s information, advice and support services from Carers IOW – which includes weekend respite for carers. Carer support is also provided via the Stroke Association.

The evidence base
Along with the Care Act, there is a range of legislation that deals with the needs of carers. The Carers (Recognition and Services) Act 1995 contains the core statutory responsibilities, and specifically introduced the concept of a ‘carer’s’ assessment. The Carers and Disabled Children Act 2000 extended the rights of carers to include the right to support services. The Carers (Equal Opportunities) Act 2004 extended the obligations in relation to assessments.

Policy Guidance issued under the Carers and Disabled Children Act and the Carers (Equal Opportunities) Act advises that Local Authorities and their local NHS partners, “develop a multi-agency carer’s strategy and ensure that agreed protocols are in place for support from partner organisations in providing support to carers”. This joint IOW Carers Strategy accords with the guidance and should enable the council to plan for, and discharge, its duties in relation to carers on the Isle of Wight.

The NHS England’s commitment to carers and the local Working together with carer’s strategy for the Isle of Wight have also been considered.

Investment requirements
The amount of funding identified for this scheme is £386,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme
Full details of the scheme expenditure plan for this scheme are set out elsewhere in this document. Set out below are details of our current level of expenditure in relation to supporting Carers for 2012/2013.

- Free sitting service - £196,103
- Residential/nursing crisis for carers - £6,793
- Carers UK - £3,264
- CRUSE - £1,530
- Family and carer support: Stroke Association - £58,104
- Carers’ alert cards - £1,000
- Quay Carers: carers support - £31,500
- Male carers support - £1,500
- Former carer support - £1,500
- IOW CCG Carers for Continuing Healthcare - £291,000

Part of the delivering of the Carers Strategy will be to further scope demand, which will inform the longer term financial assessment. Currently services are funded via the Adult Social Care base budget, £240,190 and £61,104 from NHS Support to Social Care funding and £291,000 from Continuing Healthcare funding.

Anticipated additional outcomes, carers will be:
Respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.

Able to have a life of their own alongside their caring role.

Supported so that they are not forced into financial hardship by their caring role.

Supported to stay mentally and physically well and treated with dignity.

Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes.

Feedback loop
We will measure the following:

- The numbers of carers’ assessments undertaken.
- Referral numbers from GP practices to carers’ services.
- The numbers of carers in receipt of a personal budget.
- The number of new carers receiving support through our commissioned carer services which we expect to increase following advertising.
- Completion of quality audits of commissioned carers services.
- Undertaking carers’ surveys every twelve months.
- Direct feedback from the Carers Reference group which will support us in monitoring progress in delivering the joint strategy.

Key success factors

- Effective joint working between IOW CCG and IOW Council.
- Provision of accurate data from existing providers.
- Good communication between all parties.
- Successful delivery of joined up carers support services.
- Most importantly that carers living on the Isle of Wight report that the five outcomes have been met.

We can confirm that this scheme will have a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

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<tr>
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<td>Reduction in GP contact time</td>
</tr>
<tr>
<td></td>
<td>Increased use of personalised care planning</td>
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</tbody>
</table>
Scheme 8 – Care Act

Strategic objective
The Care Act represents the biggest overhaul of Social Care legislation in 60 years, putting people and their carers in control of their care and support. For the first time, the Act will put a limit on the amount anyone will have to pay towards the costs of their care.

There will be a considerable increase in, amongst other things, the council’s responsibility towards carers and self-funders. Eligibility criteria will also be amended (significantly), with a minimum eligibility threshold being introduced across the country. This will be a set of criteria that makes it clear when local authorities will have to provide support to people. This, together with other significant funding reforms, will mean that the cost of Adult Social Care to local authorities is likely to increase considerably.

Particular attention should be paid to the fact that the financial support provided by the local authority will be extended by raising the upper capital limit from £23,250 to £118,000. This will increase the number of people approaching local authorities for help with their care and support. In addition, there will be a cap on the amount people have to spend on the care they need, regardless of how much they have in savings or assets. For people of retirement age the cap is £72,000, once this is reached the state will pay their care costs. Those who turn 18 with eligible care and support needs will have their needs met for free by their local authority for the rest of their lifetime. On top of this the local authority will have increased demands placed on it in terms of assessment, provision of information and advice and means testing.

Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing includes:
- Personal dignity
- Physical and mental health and emotional wellbeing
- Protection from abuse and neglect
- Control by the individual over day-to-day life
- Participation in work, education, training or recreation
- Social and economic wellbeing
- Domestic, family and personal relationships
- Suitability of living accommodation
- The individual’s contribution to society

Care Act implementation funding in the BCF (£135.9m nationally)

<table>
<thead>
<tr>
<th>Area</th>
<th>Detail</th>
<th>Allocation £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalisation</td>
<td>Create greater incentives for employment for disabled adults in residential care</td>
<td>0</td>
</tr>
<tr>
<td>Carers</td>
<td>Put carers on a par with users for assessment</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Introduce a new duty to provide support carers</td>
<td>148</td>
</tr>
<tr>
<td>Information, advice</td>
<td>Link LA information portals to national portal</td>
<td>0</td>
</tr>
<tr>
<td>and support</td>
<td>Advice and support to access and plan care, including rights to advocacy</td>
<td>45</td>
</tr>
<tr>
<td>Quality</td>
<td>Provider quality profiles</td>
<td>0</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Implement statutory Safeguarding Adults Boards</td>
<td>17</td>
</tr>
<tr>
<td>Assessment and</td>
<td>Set a national minimum eligibility threshold at substantial</td>
<td>88</td>
</tr>
<tr>
<td>eligibility</td>
<td>Ensure councils provide continuity of care for people moving into their areas until reassessment</td>
<td>14</td>
</tr>
</tbody>
</table>
Clarify responsibility for assessment and provision of social care in prisons

Veterans: Disregard of armed forces GIPs from financial assessment 0

Law reform: Training social care staff in the new legal framework 5

Savings from staff time and reduced complaints and litigation 15

Advocacy: Independent Mental Health Advocacy 42

Impact of DWP policies on councils/providers: Pressures relating to pensions auto-enrolment (provider cost) and the announced 1% increase of working age benefits in 15/16 (reduced client contributions 37

Total 359

In addition, a further £160k capital allocation in the BCF plan for the Care Act which we anticipate using primarily for software development work around the changes to the systems we will require to deliver the various elements of the Care Act. The exact expenditure is still being worked on.

**Investment requirements**

The amount of funding identified for this scheme is £1,126,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.

**Key success factors**

We can confirm that the Care Act will have a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

Part of the key success factors for the implementation of the Act can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
</tr>
</thead>
</table>
| • I have access to a range of support that helps me live the life I want and remain a contributing member of my community | • Positive impact on the health and wellbeing of people who are older frail and people with long term conditions  
• People make a positive contribution to their communities  
• Increase numbers of people supported to identify their own health and social care outcomes  
• Voluntary organisations providing support to older people and people with long term conditions in a timely manner and appropriate location  
• Reducing the number of GP consultations  
• Delaying the need for longer term support from health and social care organisations  
• Numbers engaged in public health services (smoking cessation, weight management) |
| • I have access to a range of easy-to-understand information about care and support which is consistent, accurate, accessible and up to date | • People empowered to take individual responsibility in making daily choices about their lifestyles  
• People plan for their future housing, care and support needs  
• Increase in the number of people using support websites (NHS Choices, Information Prescriptions, Directory of Services)  
• Increase in the number of people access information services (ie, Age UK, People Matter, ILC and voluntary groups)  
• Reducing the number of GP consultations  
• Delaying the need for longer term support from health and social care organisations |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
</tr>
</thead>
</table>
| I have care and support that is directed by me and responsive to my needs | • People are supported to take responsibility for their own health and wellbeing  
• People's health and wellbeing is improved by personalised care and support  
• People are supported to develop contingency plans to detail their wishes at times of crisis  
• Increase in the use of self-help and self-management support via locality practices  
• Increase usage of risk stratification tools to identify those at highest risk via localities practices  
• Increase take up of local support networks and healthy lifestyle services to enable local community responses at times of crisis |
| My support is coordinated, co-operative and works well together | • People are enabled to maintain their independence within their home environment  
• Integrated care and support is available and delivered close to home  
• Reducing inefficiencies, such as duplication of assessments and recording  
• Reduction in residential care placements  
• Reduced rate of admission |
| I have considerate support delivered by competent people | • People will experience seamless care and support delivered by a skilled workforce within their communities  
• Workforce experience a culture shift and behaviour across all organisations (private, voluntary and statutory) to support proactive integrated, personalised care  
• Workforce work flexibly across the Island adopting flexible and integrated approaches  
• Increase in number of training courses available to focus on quality of care, customer service and dignity and care  
• Increase in the numbers of change workshops for MDT integrated teams including commissioners |
| I can plan ahead and keep control in a crisis | • People will receive a streamlined response at first point of contact through the 111 Urgent Care Hub linked to locality areas  
• People are supported to develop contingency plans to detail their wishes at times of crisis  
• People will be supported and be enabled to return home whenever possible  
• Reduction in the number of unnecessary visits to GPs and A&E  
• Reduction in unplanned admissions  
• Reduction in GP contact time  
• Reduction in residential care placements  
• Reduce length of stay within acute environment  
• Numbers of people taking up seasonal flu vaccination |
| I can decide the kind of support I need and when, where and how to receive it. | • People will use the full range of resources available to them to maximise their independence and wellbeing  
• People’s care and support is personalised to meet their health and wellbeing outcomes  
• Reduction in the number of unplanned admissions  
• Reduction in GP contact time  
• Increased use of personalised care planning |
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Scheme 9 – Local Area Co-ordination

Strategic objective
As part of the Prevention work to improve the wellbeing of people on the Isle of Wight, Public Health has a set of proposals that address working with children, young people, adults and older people, in particular focussing on those people with long term conditions, dementia and mental illness in a holistic and family centred asset approach.

As a result of discussion with strategic partners, key stakeholders and research across the UK and wider, local area co-ordination is a project that has been identified as one to be scoped and assessed to ensure that the project is developed with clear focus on both short and longer term priorities that have been agreed within the overall BCF submission. The proposal is based on an ‘invest to save’ approach aimed to change behaviours and prevent the need for involvement of costly specialist services often with a long-term support programme.

Overview
LAC is a unique and innovative approach to supporting people who are vulnerable through age, learning disability, physical disability, sensory impairment or mental health issues to identify and pursue their vision for a “good life”, to strengthen the capacity of communities to welcome and include people and to make services more personal, flexible and accountable. It was originally developed in Western Australia in 1988 and subsequently developed across Australia. It is now operating or developing in multiple sites across England and Wales.

Local Area Co-ordination aims to:
◆ support local or non-service solutions wherever possible – reduce demand
◆ nurture valued and supportive relationships – reduce isolation/loneliness
◆ support and build on existing resources eg family group conferencing
◆ help people to stay strong and safe
◆ build individual and family leadership
◆ build more welcoming inclusive and mutually supportive communities
◆ Contribute to making services more personal, flexible, accountable and efficient – integration and reform
◆ Through planning approach we will ensure alignment with all BCF schemes in particular MLAFL Locality and self-help workstreams

As a single, local accessible point of contact for local citizens, it becomes the new “front end”, the place where relationships are formed and expectations set. It also offers the opportunity to simplify and integrate the service system(s) for local people (Bartnik, 2008). During the scoping and planning phase the leadership steering group will ensure the scheme is fully integrated and aligns with all work streams of the BCF in particular the MLAFL integrated locality working.

In supporting citizens to articulate their vision for a good life, recognising and making best use of individual and community resources, the LAC approach begins to “push back” more formal service approaches. This doesn’t ignore the crucial role that specialist services have to play in supporting people, but recognises that this offer should be the last resort as opposed to the first; a good life is a community life not a service life.

Local Area Co-ordination can be a key driver for supporting people and families to stay strong and connected, building more inclusive, supportive and welcoming communities and making services more personal, flexible, accountable and efficient.
The Isle of Wight vision is
‘All people on the Island live in welcoming communities that provide friendship, mutual support, equality and opportunities for everyone, including people who may be isolated, excluded or vulnerable due to age, disability or mental health needs, their families and carers’.

The delivery chain
It is important from the outset to establish that the outcomes from the LAC approach are multi layered and are built on a foundation of strong leadership, design integrity and effective working relationships with individuals, families and communities. Experience across a wide range of international jurisdictions has shown that it is most appropriate to consider LAC implementation in a number of stages:

- Initial set up phase with LAC governing group and manager.
- Implementation phase with new LACs including training, induction and systems development/community mapping.
- Operational phase year 1 (50% of full capacity with evidence of some practical outcomes for people and generation of informal and community support), sound information strategies, working protocols and a small number of key community development initiatives.
- year 2 (100% of capacity with widespread evidence of practical outcomes and a moderate number of substantial community development initiatives, some good working examples of preventative and multiplier effects of LAC investment).
- Generally, formative evaluations of LAC projects occur after 18 – 24 months and then summative evaluations after 3-5 years.

The evidence base
There have been 20+ independent evaluations and studies of Local Area Co-ordination nationally and internationally over the past 26 years.

Where designed with integrity and driven by strong, connected leadership, there is a range of consistent outcomes. These include:

- Derby City diverted costs/savings of £800k in first 12 months in 2 locations operating at 40% capacity (4)
- Costs 35% lower compared to non LAC areas (1)
- People supported to find local, low cost/no cost solutions (1, 2, 3, 4, 5, 6, 7)
- Preventing more expensive out of home/area/placements (1)
- Increased valued, informal, support relationships – reducing isolation (all)
- Service integration and co funding (Derby City and Thurrock Councils)
- Effective partnership working at individual, family, community and systems levels
- Increasing capacity of families to continue in caring role (1, 2, 3)
- Improved access to information (1, 2, 3, 6, 7)
- Better resourced communities (1, 2)
Improved access to specialist services (1, 2)
preventing crisis through early intervention (1, 2, 3, 6, 7)
changing the balance of care to the use of more informal supports and diverting people from more expensive services (1, 2)

In Derby, people supported through the project have reported:

- Increased social networks
- Feeling more in control of their lives
- Feeling more informed and able to make decisions
- Feeling more informed about their local community
- Feeling more engaged in their local community
- Feeling more confident about the future
- Feeling more in control of their health and wellbeing
- Feeling more able to share their gifts and skills with their community

Key references for above:


(5) University of Derby (unpublished)


**Investment requirements**
The amount of funding required for this scheme is £400,000. This is outlined in Part 2, Tab 3. HWB Expenditure Plan.
Impact of scheme

<table>
<thead>
<tr>
<th>Area</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Lifestyles</td>
<td>✷ Building individual, family and community self sufficiency.</td>
</tr>
<tr>
<td></td>
<td>✷ Access to services/resources only where necessary as back to local solutions.</td>
</tr>
<tr>
<td></td>
<td>✷ Better health outcomes and safeguarding through relationships/connections.</td>
</tr>
<tr>
<td>Information and Advice</td>
<td>✷ Building a long term relationship with individuals, families and their community – a single point of contact across age and service types.</td>
</tr>
<tr>
<td>Peer Support</td>
<td>✷ Helping people develop valued, supportive relationships/friendships – reduce isolation.</td>
</tr>
<tr>
<td></td>
<td>✷ Aims to keep people strong – prevent crisis.</td>
</tr>
<tr>
<td></td>
<td>✷ Assets/strengths of individuals, families, communities as solutions.</td>
</tr>
<tr>
<td>Public Involvement</td>
<td>✷ Contribution – sharing strengths (incl volunteering), mutual support, and employment.</td>
</tr>
<tr>
<td></td>
<td>✷ Supporting people to use or develop practical, non-service solutions to problems – demand reduction.</td>
</tr>
<tr>
<td>Personal Budgets</td>
<td>✷ Many people have joint health and social care personal budgets, and these are an important way of having greater choice and control.</td>
</tr>
<tr>
<td>Carers</td>
<td>✷ The role of carers is valued, and carers are supported to carry out their caring role with information and practical support.</td>
</tr>
<tr>
<td>Community Support</td>
<td>✷ Building more connected, supportive, welcoming, inclusive communities.</td>
</tr>
<tr>
<td></td>
<td>✷ Identifying, nurturing existing social capital in our local communities – building partnerships to develop new resources to further strengthen citizens/communities.</td>
</tr>
<tr>
<td>Promotion of Wellbeing and Independence</td>
<td>✷ The “front end” moving from assessment/services to: prevention, capacity building, local solutions. Reducing demand/dependence.</td>
</tr>
</tbody>
</table>

Feedback loop
Success will see Local Area Co-ordination and strength based thinking and action as the new “norm” in the way we support people.

For individuals, families, communities – there will be growing examples of
- Reduced dependence on services/the state
- People supported to find non service solutions
- Increased supportive personal relationships
- Contribution
- Leadership
- Choice and control
- Greater confidence in the future
- More supportive and better resourced communities
For system
- Change of focus from crisis to prevention and capacity building
- Cultural change – a focus on strengths, capacity building
- Increased choice/range of support and services
- Strong partnerships and joint working between LACs and services, LACs and communities, LACs and organisations/3rd sector, between services
- Build connections with and add value to existing initiatives – eg value of LAC supporting family conferencing in reconnecting individuals, families

Reform
- Connected leadership and approach
- A shared vision and action for the Isle of Wight
- More Integrated approach
- Identifying duplication
- Close gap between citizens and state

Key success factors
Success is reliant on a consistent, committed, cohesive and collaborative approach from all partners (health, social care, housing, employment and third sector) to care planning for people with complex physical/mental health needs and ensuring the model of delivery is personalised and recovery focused.

Effective commissioning enabled through robust service standards, ongoing monitoring and evaluation and high quality communication between partners are all essential components to achieving scheme success. It is also imperative that the views of people who use the service are captured and reported to the IOW CCG to help inform on patient experience on future commissioning of the scheme.
- Effective joint working between IOW Council, IOW CCG and voluntary sector and communities.
- Good communication between all parties.
- Willingness to engage in review by stakeholders.
- Ability to release funds from existing sources if necessary to development of new service.
- Provision of accurate data from existing providers.

We can confirm that this scheme will have a project initiation document, a project board with terms of reference and risk log to monitor and ensure that these key success factors are in place.

The key success factors for the implementation of the scheme can also be interpreted as the attainment of the “I and We” statements, which underpin the My Life a Full Life Programme and which have been extrapolated into outcome measures as detailed below.

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<td>• I have considerate support delivered by competent people</td>
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</tbody>
</table>
## Timeline

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Scoping and co-production of LAC plans through leadership steering group with support from inclusive neighbourhoods</td>
<td>Plans agreed and signed off by relevant boards</td>
<td>Recruitment processes started</td>
<td>X6 LA Coordinators recruited</td>
<td>Induction and training of LACs. Community asset mapping</td>
<td>LACs trained and in place starting to take introductions. Expected to achieve working with maximum level of 60 individuals and their families by March 2016</td>
</tr>
</tbody>
</table>
Annex 2

Provider Commentary
Name of Health & Wellbeing Board | Isle of Wight Health & Wellbeing Board
---|---
Name of Provider organisation | Isle of Wight NHS Trust
Name of Provider CEO | Mark Pugh on behalf of Karen Baker

For HWB to populate:

<table>
<thead>
<tr>
<th>Total number of non-elective FFCEs in general and acute</th>
<th>2013/14 Outturn</th>
<th>2014/15 Plan</th>
<th>2015/16 Plan</th>
<th>14/15 Change compared to 13/14 outturn</th>
<th>15/16 Change compared to planned 14/15 outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12,312</td>
<td>11,874</td>
<td>11,696</td>
<td>-3.6%</td>
<td>-1.5%</td>
</tr>
</tbody>
</table>

For Provider to populate:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?</td>
<td>The Trust supports the local health economies vision to reduce non elective admissions by 1.5%. Further modelling will be undertaken to fully understand how the planned savings will materialise from each of the Better Care Fund initiatives. This is particularly relevant in understanding how the Trust can realise the savings from its current cost base. It will be not be possible to realise full cost savings from a reduction in non-elective admissions due to the fixed costs within the organisation, this will leave the Trust with an additional cost pressure.</td>
</tr>
<tr>
<td>If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>Can you confirm that you have considered the resultant implications on services provided by your organisation?</td>
<td>Further modelling will be undertaken to fully understand how the planned savings will materialise from each of the Better Care Fund initiatives. This is particularly relevant in understanding how the Trust can realise the savings from its current cost base. It will be not possible to realise full cost savings from a reduction in non-elective admissions due to the fixed costs within the organisation, this will leave the Trust with an additional cost pressure.</td>
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Appendix A

Reduction in Emergency Admissions Performance Fund Ambition

The revised BCF planning guidance set out the planning assumption that each Health & Wellbeing Board area would plan to reduce the total number of emergency admissions to hospital by 3.5%. The guidance also confirmed that this planning assumption did not constitute a firm target which would have to be met by all areas, and that a case could be set for a lower level of ambition in 2015. This could depend on the variation in starting point, the demography of the population, and relative performance to date, and should also meet six Principles set out in guidance.

This appendix to the BCF Plan sets out the rationale for the Isle of Wight emergency reduction ambition setting out the ambition, the justification, the contribution to delivery by the BCF schemes, demonstration of meeting the Principles, and the methodology behind the setting of the ambition trajectory.

The appendix also provides contextual information supporting the BCF Plan Template Part 2 trajectories, including data derived from baselines, and the contribution of BCF to aggregated achievement of the emergency admissions reduction.

1. Ambition

Plan to achieve a 5% reduction (6.1% including population growth) by the end of Q3 2015/16 as follows:

2014 – 3.6% reduction on 2013
2015 – 1.5% reduction on 2014

<table>
<thead>
<tr>
<th></th>
<th>Q4 2012/13</th>
<th>Q1 2013/14</th>
<th>Q2 2013/14</th>
<th>Q3 2013/14</th>
<th>Total</th>
<th>% Change</th>
<th>Activity Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3275</td>
<td>3003</td>
<td>2869</td>
<td>3165</td>
<td>12312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4 2013/14</td>
<td>2819</td>
<td>2901</td>
<td>3081</td>
<td>3073</td>
<td>11874</td>
<td>-3.6%</td>
<td>-438</td>
</tr>
<tr>
<td>Q4 2014/15</td>
<td>3111</td>
<td>2753</td>
<td>2799</td>
<td>3033</td>
<td>11696</td>
<td>-1.5%</td>
<td>-178</td>
</tr>
</tbody>
</table>

Figure 35: Baseline and reductions in acute emergency admissions by Q3 2015/16
This equates to a total effect of a 6.1% reduction over the period from the commencement of the baseline period (Q4 2013-14) (see table above – figure 35 and 36) when taking into account absorption of population growth over calendar years 2014 and 2015 (0.8% and 0.3% respectively) (see figure 37 below).

The 1.5% reduction in 2015-16 (see figure 36 above) represents an increase in achievement against the submitted (IOW CCG Operational Plans 2014-2016: ProvComm) and together with the expected 3.6% reduction in 2014-15 realises a total reduction of 2.6% in excess of the national ambition.

Principle 4 tends to suggest that health & social care economies wishing to propose an ambition less than 3.5% reduction in 2015 would be justifying this with projections for achievement beyond 2015. The ambition set out here has justification for early achievement of a reduction in excess of -3.5%, and
from a baseline position which can be demonstrated is already showing a high level of system efficiencies in the rates of emergency admissions, despite a demography with a comparatively higher BCF target population.

2. Justification
   The following points outline a reasonable and robust justification for the levels of ambition for 2014 and 2015:
   
   ✷ The Isle of Wight has implemented a number of QIPP and NHS Health Support for Social Care over the past 18 months - the health economy already has advanced Integrated Care schemes (eg My Life a Full Life) of which the BCF forms a part.
   ✷ Trends show that the return on these investments (including QIPP savings) predict that the health & social care economy will deliver a -3.6% reduction in emergency admission in 2014 (Q4 – Q3).
   ✷ A further reduction of -1.5% is expected to be realised in 2015 (Q4 – Q3) by the full impact of the BCF schemes, following further outcomes and impact analysis.
   ✷ This is net of ONS population growth predictions and shows a real reduction equivalent to 6.1% during the period 2014 and 2015.
   ✷ This is an ambitious goal given the variation in starting point for the Isle of Wight where:
     - The Contract for acute services with the main provider is not subject to the Marginal Rate for Emergency Treatment (MRET) in the baseline, showing that the non-elective admission rate is below that of 2008/09 already (adjusted for service changes).
     - Non-elective admission rates are low (7th out of 151 PCTs, standardised)

Figure 38: Source: NHS Comparators
• Preventable admissions rates are low (834.7 compared to 1181.9 nationally, standardised) (see figure 39 below).

![Figure 39](image)

*Directly standardised rate (DSR) for all ages per 100,000 registered patients*

*Source: Health & Social Care Information Centre – Indicator Portal*

• End of Life Care in Hospital is low (45.3% versus England 50.7%) (See figure 40 below).

![Figure 40](image)

*Source: Public Health England’s (PHE) National End of Life Care Intelligence Network (NEoLCIN), April 2014*
The IOW also benchmarks high for community spend 11.5% compared to a national average of 8.5% (see figure 41 below).

![Figure 41 Source: NHS England Programme Budgeting Tool, 2012-13.](image1)

The Isle of Wight (in 2012/13) had the second highest nationally proportion of registered patients aged 75 or over – 11.48% of patients are aged 75 or over compared to 7.63% nationally (see figure 42 below).

![Figure 42 Source: NHS Comparators](image2)

- In addition, the IOW CCG has good performance (lower numbers) compared to the most similar five Health & Wellbeing Boards, for Emergency Admissions (MAR NEL G&A Admissions).

- These figures corroborate the assertion that the IOW already manages a higher than average proportion of the target population (as set out in the Case for Change) in the community, already.

- The realisation of the planned reduction in admissions has come to fruition more rapidly than was originally expected in terms of seeing a return on the investment of schemes implemented in Q3 & Q4 (eg crisis resolution within the BCF and Acute GP Assessment outside the BCF), and in effect the health and social care economy is seeing the benefits earlier than originally predicted.

- It is reasonable therefore to phase the benefit across the period from the start of baseline measurement period with 3.6% realised in 2014 and a further 1.5% realised in 2015, delivering a
real reduction in emergency admissions of 6.1%. *(Perversely, and to illustrate the justification for the level ambition being across the two years, one could consider that the IOW would have benefitted by taking no action since Q3 2013 and holding off implementing schemes so the benefit would flow through at a later stage against a higher baseline, with a lesser reduction achievement overall. The area should not be forced to reduce admissions against a baseline that has already delivered significant reductions comparatively and safe levels of admissions must be maintained.)*

Given the variation in starting point showing high achievement against benchmarks (illustrating that level of opportunity is significant different from lower quintile areas set the same national ambition); the differences in population characteristics (again illustrating the need for safe ambitions), the trend in local performance (the measurable impact of schemes implemented specifically to support integrated care already being realised with 3.6% reduction planned in 2014), a further 1.5% reduction in 2015 is a realistic, stretching but reasonable ambition, set in the context of a total reduction of 5% and absorption of population growth of 1.1% overall.

3. Delivery of the Reduction
The following schemes have been identified as reducing the number of non-elective admissions:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Mental Health Reablement| Deliver parity of esteem to identified high risk group, to reduce current anticipated life reduction of twenty years, by ensuring that there long term health conditions are addressed via a number of initiatives including:  
1. National Schizophrenia CQUIN.  
2. Cluster 11 shared care agreement pilot, to ensure that individuals who are stable, are transferred into a shared care agreement with their GP to provide their support in their locality and enhance current QOF.  
3. Ensuring the provision of an Isle of Wight enhanced and integrated (health, social care, housing and third sector) mental health Reablement pathway that achieves sustainable and improved outcomes for people with complex mental health problems and evidences quality of life improvements via Camberwell assessment.  
   Improve the availability of and enhance the provision local health and social care supports available to people with complex mental health problems, and enable the repatriation of those placed out of area, support the prevention of expatriations and reduce inpatient admissions. |
<p>| Crisis Response         | This scheme will contribute to a reduction in emergency admissions for frequent service users and observational admissions. This scheme particularly focuses on people over 65 at risk of admission or falls, fragility and frequent service users with long term conditions and conditions amenable to prevention of admission. This scheme was implemented in Q4 2013/14 and the impact of this scheme is being observed in the reduction in non-elective admissions from Q4 2013/14 and Q1 2014/15. |
| Rehabilitation/Reablement| This scheme will contribute to a reduction in emergency admissions/re-admissions by managing the risk of deterioration and increasing resilience in the initial post discharge period. |</p>
<table>
<thead>
<tr>
<th>Scheme</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Locality Working</td>
<td>This scheme will contribute to a reduction in emergency admissions of patients by preventing exacerbations of their multiple long term conditions.</td>
</tr>
<tr>
<td>Enhanced Hospital Discharge</td>
<td>This scheme will contribute to a reduction in emergency re-admissions by managing the risk of deterioration and increasing resilience in the initial post discharge period for a high resource intensity group of patients and ensuring appropriate discharge arrangements in place such that individuals are supported at home.</td>
</tr>
<tr>
<td>Supporting Information, Advice and Self-Management</td>
<td>This scheme will contribute to a reduction in emergency admissions by enabling people to take control of their long term conditions and therefore avoid deterioration of their condition which could result in an admission.</td>
</tr>
<tr>
<td>Carers</td>
<td>This scheme will contribute to a reduction in emergency admissions by ensuring the need of carers are identified early to reduce the breakdown of home placements and therefore also reducing admissions to residential care and hospital.</td>
</tr>
<tr>
<td>Local Area Co-ordination</td>
<td>The impacts of this scheme are more long term and preventative in nature. Therefore the impact during 2015 will be minimal.</td>
</tr>
</tbody>
</table>

### 4. Meeting the Principles

<table>
<thead>
<tr>
<th>Principle</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HWB should set an ambition for a reduction in emergency admissions.</td>
<td>1.5% reduction in 2015 on top of a projected 3.6% reduction in 2014.</td>
</tr>
<tr>
<td>2. Target should be ambitious and stretching, but not unrealistic</td>
<td>Based benchmarking, the reduction expected in 2014 and the number of schemes contributing to a reduction the target is a realistic, stretching but reasonable ambition.</td>
</tr>
</tbody>
</table>
### Principle 3. Take into account:
- Quintile performance
- Local trend
- Compared to peers
- Local population

<table>
<thead>
<tr>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quintile 2 based on actual percent reduction (Trends in Non-Elective Admissions, BCF Website)</td>
</tr>
<tr>
<td>• Quintile 1 based on standardised 2012/13 non-elective activity (NHS Comparators)</td>
</tr>
<tr>
<td>• Quintile 1 based on admissions that should not usually require hospitalisation (HSCIC).</td>
</tr>
<tr>
<td>• Recent trends show an improvement already in performance in 2014.</td>
</tr>
<tr>
<td>• Contracts for acute services with the main provider is not subject to the Marginal Rate for Emergency Treatment (MRET) in the baseline, showing that the non-elective admission rate is below that of 2008/09 already (adjusted for service changes) (MAR).</td>
</tr>
<tr>
<td>• Performance is good compared to similar HWBs (MAR CSU)</td>
</tr>
<tr>
<td>• The local population has a very high and increasing proportion of 75+ with multiple co-morbidities (ONS). Deaths in hospital are lower than national average (PHE). Proportion of spend on community services is already higher than national average (NHS E).</td>
</tr>
</tbody>
</table>

### Principle 4. Plan lower than 3.5% - explain how planned level contributes to longer term trajectory.

Some of the schemes have already been implemented and so the impact of these on non-elective admissions is already being observed. From baseline of Q4 2012/13 to Q3 2013/14, the expected reduction in non-elective admissions by end of Q3 2015/16 (ie 2 years) is 5%. This does not take into account the absorption of expected growth. This equates to a total effect of a 6.1% reduction over the period, when taking into account absorption of population growth (0.8% and 0.3% respectively).

This principle tends to suggest that a lower trajectory is proposed on the basis of contribution to a reduction over a longer time period. The IOW ambition is for earlier achievement, not pushing the achievement into future years.

### Principle 5. Lower than 3.5% - explicit support of council and CCG and written commentary of acute provider.

The BCF Template includes sign off by the IOW Council and IOW CCG, and includes Provider commentary, and has been agreed at the HWB as part of BCF Plan sign off. The ambition has been agreed after review of analytics (see part 5 of this Appendix) by the parties in order to set the trajectory.

### Principle 6. Contingency plan and risk sharing agreement make provision for costs of unplanned activity.

The BCF Template Section 5b sets out the Risk Sharing Contingency arrangements. These will also be incorporated into the Section 75 Pooled Fund agreement.

### 5. Setting the Trajectory

Historic MAR data was used to review the quarterly profiles of non-elective admissions over the previous four years. This activity is illustrated in the figure 43 below:
As highlighted in the figure above, the activity for Q4 2013/14 did not follow the same profile as previous years. This is thought to be due to the mild winter period and a combination of the implementation of some of the schemes.

It was identified that there was a risk if the 1.5% reduction was applied consistently for each quarter as this would amplify the Q4 decrease in admissions, especially as the template requires the input of two Q4 plans.

Therefore it was agreed to use the average quarterly profile of 2010/11 and 2011/12 to proportion the 1.5% reduction over the year using the following profile:

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11 PCT</td>
<td>23.1%</td>
<td>24.0%</td>
<td>26.1%</td>
<td>26.8%</td>
</tr>
<tr>
<td>2011/12 PCT</td>
<td>24.0%</td>
<td>23.9%</td>
<td>25.8%</td>
<td>26.4%</td>
</tr>
<tr>
<td>2012/13 PCT</td>
<td>25.9%</td>
<td>23.9%</td>
<td>25.0%</td>
<td>25.2%</td>
</tr>
<tr>
<td>2013/14 CCG</td>
<td>25.3%</td>
<td>24.2%</td>
<td>26.7%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Expected activity based on profile</td>
<td>23.5%</td>
<td>23.9%</td>
<td>25.9%</td>
<td>26.6%</td>
</tr>
</tbody>
</table>

In order to calculate the expected reduction from the actuals for Q4 2012/13 to Q3 2013/14 and the Q4 2013/14 to Q3 2014/15 a calculated volume for Q4 2012/13 was required. This is due to the MAR data relating to the PCT during this period. Therefore the Q4 expected proportion of 26.6% as applied to the CCG known volumes for Q1 – Q3 2013/14 to give an estimate CCG volume of 3275 – as highlighted in the table below.

This equates to 1.8% below the PCT activity volume. This seems reasonable given that the prison population which was included in the PCT data accounted for approximately 1% of the population. Therefore the removal of the prison population and specialist activity would result in a reduction in the activity volumes.
<table>
<thead>
<tr>
<th>Q4 2012/13</th>
<th>Q1 2013/14</th>
<th>Q2 2013/14</th>
<th>Q3 2013/14</th>
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<td>2819</td>
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<tr>
<td>Q4 2014/15</td>
<td>Q1 2015/16</td>
<td>Q2 2015/16</td>
<td>Q3 2015/16</td>
<td></td>
<td>-1.5%</td>
<td>-178</td>
</tr>
</tbody>
</table>

Figure 44

The Q4 2013/14 figure is highlighted in green in the table above (figure 44) because although this is the actual figure from MAR it is not thought to be representative of the usual volumes of activity during the winter period. However, this figure cannot be altered in the plan and therefore contributes to the baseline period.

In the template the Q1 2014/15 provided plan figure (3,090) has been replaced with the actual figure of 2,901.

The plan for the period Q4 2014/15 to Q3 2015/16 has used the quarterly profiles applied to the agreed ambitious but realistic 1.5% reduction (178 actuals) in 2015.

This has resulted in an actual increase for Q4 but a decrease for the following three quarters. This should smooth out the significant dip observed in activity in Q4 2013/14.