A Guide to the Local Care System, Local Care Plan and

My Life a Full Life New Care Model for the Isle of Wight

September 2017

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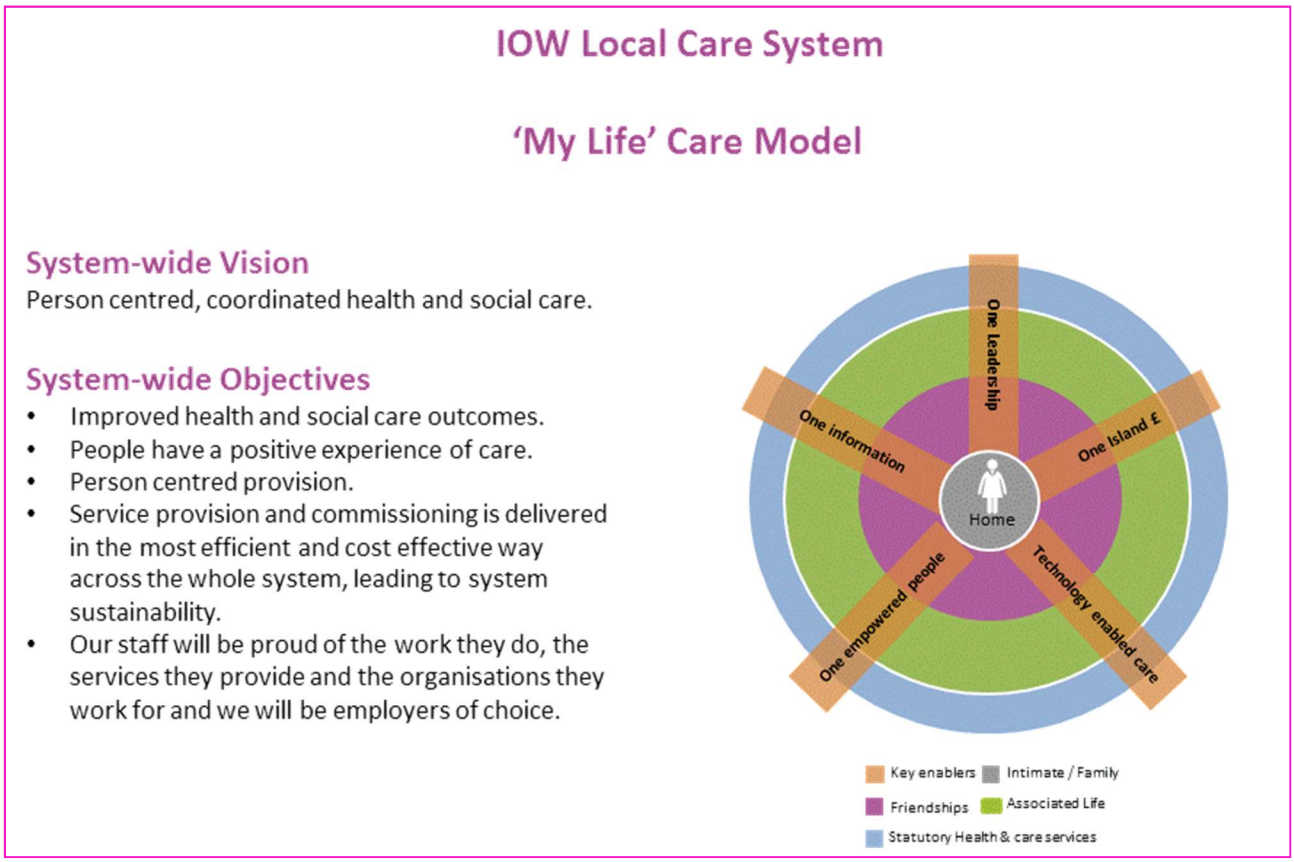
1. WHAT IS THE LOCAL CARE SYSTEM, LOCAL CARE BOARD AND LOCAL CARE PLAN

Our Local Care System

Our Local Care System is the mechanism by which the Isle of Wight will bring together the Council, Clinical Commissioning Group (CCG) and the NHS Trust along with wider partners and stakeholders to deliver the vision outlined below.



The Local Care System has agreed to streamline, speed up and prioritise the way we work and what we do – with a focus on the few things that will make the biggest difference to the population we serve.

Our Local Care Board

To help us to do that we have established a Local Care Board bringing together all the key partners to unite efforts to improve the overall quality of health and social care on the Isle of Wight. This will build on the partnership agreements that we have already committed to and ensure that we put patients, communities and taxpayers' interests above those of our individual organisations. In our discussions at the Local Care Board we have also identified a need for a clearer governance structure to help us remove duplication, ensure clear accountability and responsibility and monitor delivery of our Local Care Plan (see Appendices). As with our Local care plan, this has been streamlined and simplified from previous arrangements.

Our Local Care Plan

A Local Care Plan is being developed and agreed by the Local Care Board and by the Health and Wellbeing Board. This plan has identified and prioritised those changes required to improve care across the Island building on the Island's shared vision for person centred care, delivered closer to home. (See page 5 for the Local Care Plan Priorities).

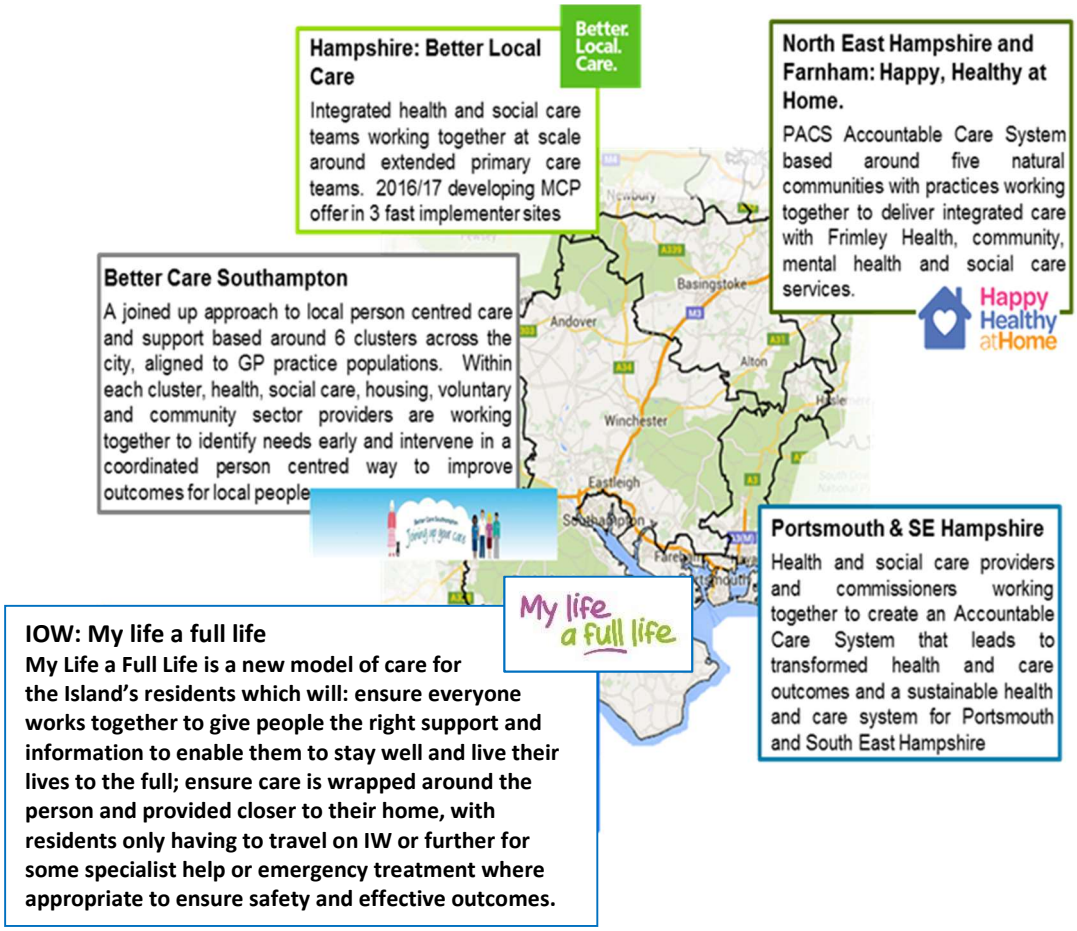
The Island has been working across a large number of initiatives to help implement the My Life care model. This work continues across the Island with the support of the System-Wide Transformation Team and the funding secured through the Department of Health's New Care Models Vanguard programme. The work to date and future planned work is shaping the development of our Local Care Plan.

The following standing groups have been agreed with the appropriate membership to drive forwards changes across the system; IT/Information Governance, Estates, HR and workforce, Finance and Quality.

How does this fit with the Hampshire & Isle of Wight STP?

Our local Care Plan- to deliver our new model of care; My Life a Full Life - has formed the basis of a wider plan with health and care organisations facing similar challenges across the South (see diagram below). These plans are all focused on empowering people to help them stay well and providing safe, high quality, consistent and affordable healthcare for everyone.

Our local care plan and local care system will continue to meet the needs of local people. By working together with other care systems across our region we can also benefit from sharing best practice and ensure we are better co-ordinated across the region to support local changes. The STP also gives us scope for sharing expertise and resources to make sure we can offer the best care to Island residents. You can read more about the HIOW STP on our website via http://www.mylifeafulllife.com/about-my-life-full/working-across-our-region



Initiative	Description
Acute Service Redesign (ASR)	Complete acute re-design including modelling options. Integrate output of acute redesign into whole integrated system redesign, including NHS Assurance processes and consultation.
Co-ordinated Access	Extended scope of existing integrated hub by adding in further functions and services, including review and implementation of required 111 changes and GP Out of Hours.
Integrated Locality Services – Phase 1	Implement integrated and co-located community health and care services in Island's 3 localities, incorporating Primary Care and case management and care planning of "most at risk" populations, ensuring redesign of current services within agreed financial envelope.
Redesign of Community Rehabilitation	Bring together community rehabilitation, recovery and reablement services across Health and Care, ensuring redesign of current services within agreed financial envelope in phase 1. In phase 2 incorporate within Integrated Locality Services.
Frailty	Define and implement end to end frailty pathway to improve care and outcomes for people who are frail, minimise time spent in bedded care settings and improving dementia and older people's mental health pathway.
Hospital to Home	Minimise the negative impact associated with prolonged hospital stay by making sustainable improvements to services and process focusing on timely appropriate assessments and admissions, improving 'in-hospital' patient flow and application of standardised discharge pathways, and ensuring the correct capacity to care for patients in more appropriate and cost-effective settings.
Mental Health Recovery	Development of blueprint for IOW Local Care Plan Mental Health Services and implementation of the following 3 initiatives:
Rehabilitation and Reablement	Recovery and rehabilitation pathway redesigned including implementation of new models of inpatient provision.
Acute Pathway Redesign	Ensuring appropriate 24/7 access to correct care setting including implementation of Safe Haven and the development of an in-reach/outreach acute model of care which supports people in the most suitable environment.
Community pathway re-design	Delivering appropriate integrated models of community provision which shifts the focus to early intervention and takes an holistic approach to Mental Health & Wellbeing.
Transforming Learning Disabilities Care	Transforming services and outcomes for Islanders, reducing reliance on institutional care.

2. WHAT IS MY LIFE A FULL LIFE – OUR NEW CARE MODEL

My Life a Full Life is a new model of care which defines the way in which health and care services will be planned and provided on the Island.

It has been developed by the Island, for the Island.

It is not an organisation or a project, but a new way of working across our local health and care system. The Local Care Plan, described previously, enables further implementation of the new model of care.

To make the idea a reality, there are four focal points of the My Life a Full Life new care model:

1. Helping to prevent people from becoming ill in the first place by providing access to information, advice and support so that people can take control and manage their own health and care more easily.
2. Changing the way we work in the local community so that everyone involved in delivering health and care services works together as a team, to support people to manage their health and wellbeing.
3. Making sure, across the Island, that people can get the right support, at the right time and place from the most appropriate service.
4. Changing the way we provide health and care services on the Island so that we can provide a better quality of care for the people of the Isle of Wight in the next decade and beyond, with the money and people we have available.

People from a variety of organisations support the new model of care and are working together to make it become a reality for people on the Island. This includes a wide range of voluntary, community and independent organisations that provide help and care on the Island, the Clinical Commissioning Group (the group of NHS staff choosing and buying health services on the Island), the Isle of Wight NHS Trust (providing ambulance, community, hospital, mental health and learning disability services on the Island), the Isle of Wight Council (providing a range of services including public health support, social care, education and housing) and One Wight Health (a GP group).

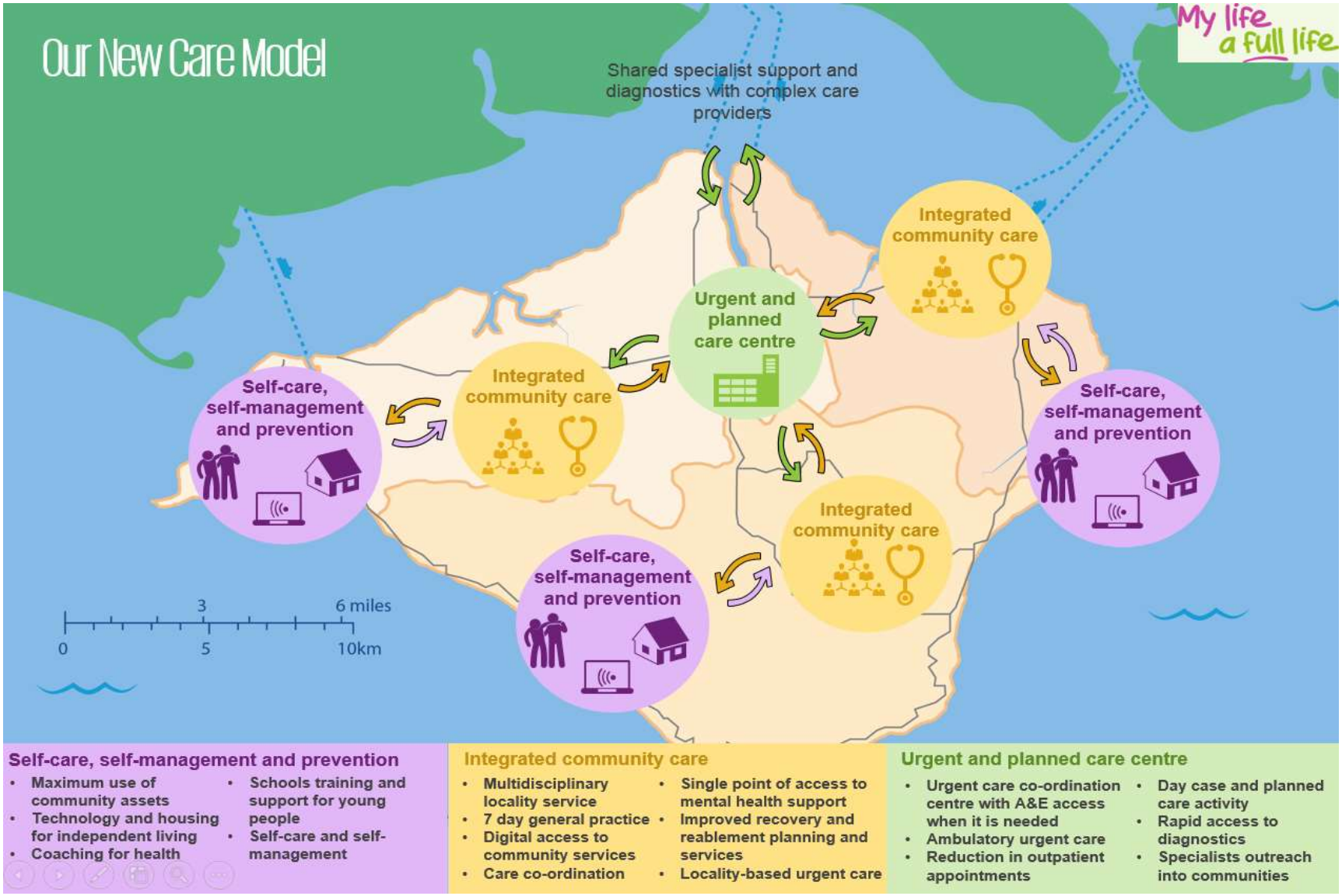
It requires all organisations to work together to enable the implementation of the new model of care.

The diagrams on the following two pages illustrates our new model of care and the future care setting for services to enable them to wrap around the person.

Our New Model of Care

- Key enablers
- Intimate/Family
- Friendships
- Associated Life
- My Life, A Full Life – care services

Our new care model – care settings



2.1 WHY DO WE NEED A NEW CARE MODEL? – THE CASE FOR CHANGE

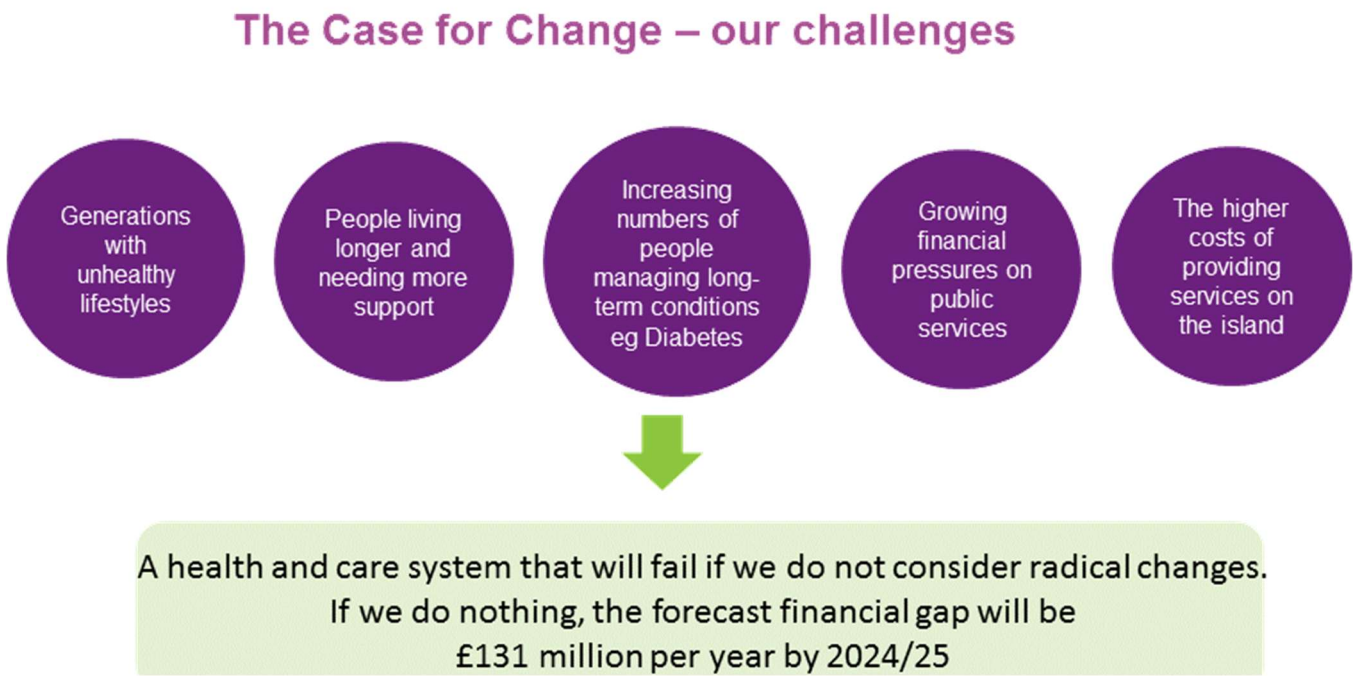
The following is an extract from the 'case for change' documentation used during the public engagement last summer (you can read the full document on our website here http://www.mylifeafulllife.com/time-to-act.htm). This articulates the need for change, to ensure the Island continues to have a safe, cost effective and sustainable health and care system able to meet the needs of its population in the future.

Healthcare needs are changing: Technological and medical improvements mean faster and more accurate diagnoses, and more effective treatment means that life expectancy is increasing. Whilst this is obviously good news, it also means more people are now living with long-term conditions and can have several different health issues to manage. It's particularly relevant on the Island as almost a quarter of our population is over 65, and many are dealing with two or more health conditions and this is only going to increase.

We struggle with our workforce: As an Island community, we also have issues around our workforce. We lose many young people to the mainland and find it difficult to attract health and care professionals. It also isn't always financially viable for new healthcare providers to come to the Island, and getting mainland support can be expensive because of the travel involved. This, as well as a shortage of doctors and nurses, mean we just can't sustain traditional workforce models.

We have financial issues: All statutory organisations within the health and care system are facing significant financial challenges so, we need to save tens of millions of pounds every year to continue delivering care the way we traditionally have. As a health and care system we must consider radical changes and make the best use of taxpayers' money. If we do nothing the forecast financial gap, as at March 2016, was predicted to be £131 million per year by 2024/25.

We have quality issues: Some services are at risk of being clinically unsafe in the way in which they are currently designed and delivered and some clinical processes and health outcomes for patients are not as good as they are in other comparable areas. We need to improve patient safety and results for Island patients.

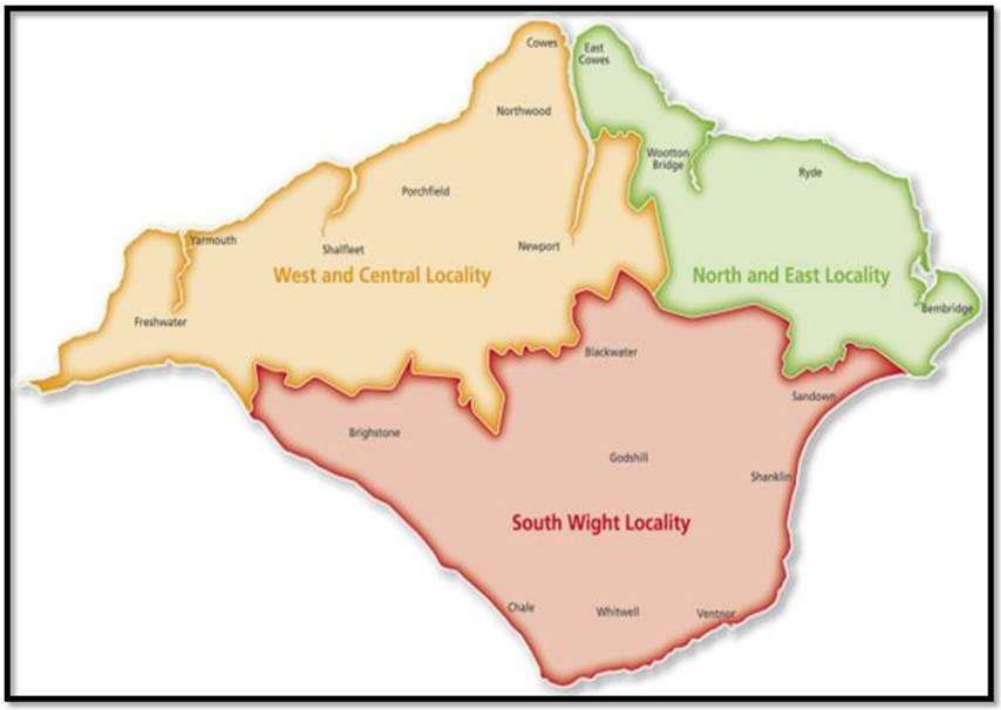


2.2 HOW IS THE MY LIFE A FULL LIFE MODEL OF CARE BEING IMPLEMENTED?

The My Life a Full Life new care model is being implemented by all the core partners involved; the Isle of Wight Council, Isle of Wight NHS Trust, Isle of Wight Clinical Commissioning Group (CCG), One Wight Health, voluntary and independent sector.

The Islands future community service model focuses on bringing together services around the local population in a locality model which enables services to be shaped to meet local needs. The purpose of locality services are: "To bring valued and skilled workforce together with the community and *empower* local people to be **active** participants, maintain independence **and** lead full and healthier lives".

The proposed locality model is based on three principles; shared ownership, shared responsibility, and shared benefits. There are three localities: West and Central, South and North East – see map below.



Other partners are also supporting this new way of working including; Hampshire Constabulary (particularly through the Serenity Mental Health programme), town and parish councils (through the locality lead parishes; Ryde – for the North East, Freshwater – for West & Central and Ventnor – for South Wight) and the Solent Acute Alliance; an alliance with Southampton and Portsmouth hospital trusts.

The Local Care Plan has been developed to help all organisations on the Island collectively implement changes to embed the My Life a Full Life model of care. This plan is made up of a number of initiatives which, when implemented, will change the way services are provided on the Island in order to move to the My Life a Full Life new model of care.

The System Wide Transformation Team is in place to support the delivery of the Local Care Plan. They provide the tools and leadership to support all partner organisations in the delivery of changes to Islands services. The team is made up of Programme/Project Managers and support staff and the team is led by the My Life a Full Life Programme Director who is held accountable by the Chief Executives of the IW Council, NHS Trust and CCG through the Local Care Board. Additional specialist expertise is brought in to the System Wide Transformation Team, when required, to provide capacity or capability where not available on the Island. Examples of areas where this additional resource has been used includes communications, stakeholder engagement expertise, and system redesign. This is essential to enable us to drive forward the delivery of the programme at the required pace.

3 HOW IS SYSTEM TRANSFORMATION FUNDED?

The development of the My Life a Full Life model of care and initial system wide transformation programme was funded in 2013-2015 by the IOW Council, IOW Clinical Commissioning Group and the IOW NHS Trust.

In 2015-16 the Island was successful in a bid to the NHS New Care Models Programme and was allocated NHS Vanguard Funding to implement the Islands My Life a Full Life model of care at pace. The Island became a national Primary and Acute Care Systems (PACS) vanguard along with nine other similar vanguards across the UK. You can read more about what it means to be a vanguard and more about the New Care Models programme on the NHS website here https://www.england.nhs.uk/ourwork/new-care-models/

In 2015-16 the Island used £1.9 million of the NHS Vanguard Funding (of the £3.399M initially allocated, not all of allocation used due to delay in receipt of funding). In 2016/17, the Island was allocated £4.74 Million of NHS Vanguard Funding (of the £14.4 million requested for 16/17) and this was allocated within year as described in the paper tabled at the Health & Adult Care Scrutiny Committee in March this year (see link below) https://www.iwight.com/Meetings/committees/Health%20and%20Adult%20Social%20Care%20SSC/20-3-17/PAPER%20B%20-%20APPENDIX%20B.pdf

A further bid for funding was placed for 2017/18 and the Island has been awarded £3.3m of transformation funding. This has been awarded in two halves with an initial sum of £1.685m for quarters 1 and 2 and a review point half way through the year which, subject to having met the required progress, will release the second half of the funding for quarters 3 and 4.

The Vanguard funding is NHS funding and comes with conditions including restrictions around what the money can be used for. The conditions state funding can only be spent on things that support and drive system transformation and cannot be spent on providing existing local services or business as usual. The central New Care Models team, who hold the Island to account regarding delivery and monitor funding, ensure that the funds are spent in the areas agreed and only spent on transformation of services.

A system wide process was in place historically and included representatives from partner organisations, to agree where the Island invested its transformation funds. In 2017/18 all investment of transformation funds is aligned with the delivery of the Local Care Plan.

4 WHAT IS A PACS VANGUARD?

The Isle of Wight is one of nine Primary and Acute Care Vanguards across the UK that have been awarded funding by NHS England under their New Care Models Programme. As a Vanguard, we are at the forefront of developing the new care model for primary and acute care systems and sharing that learning to help others develop their systems of care.

What is a PACS?

A PACS is a model for the delivery of Primary and Acute Care

What is the PACS framework?

It is a framework that outlines the current thinking on how a PACS care model should be commissioned and provided (see diagram on the next page)

It has been developed by NHS England, working with the nine primary and acute care vanguards and based on existing, recognised best practice

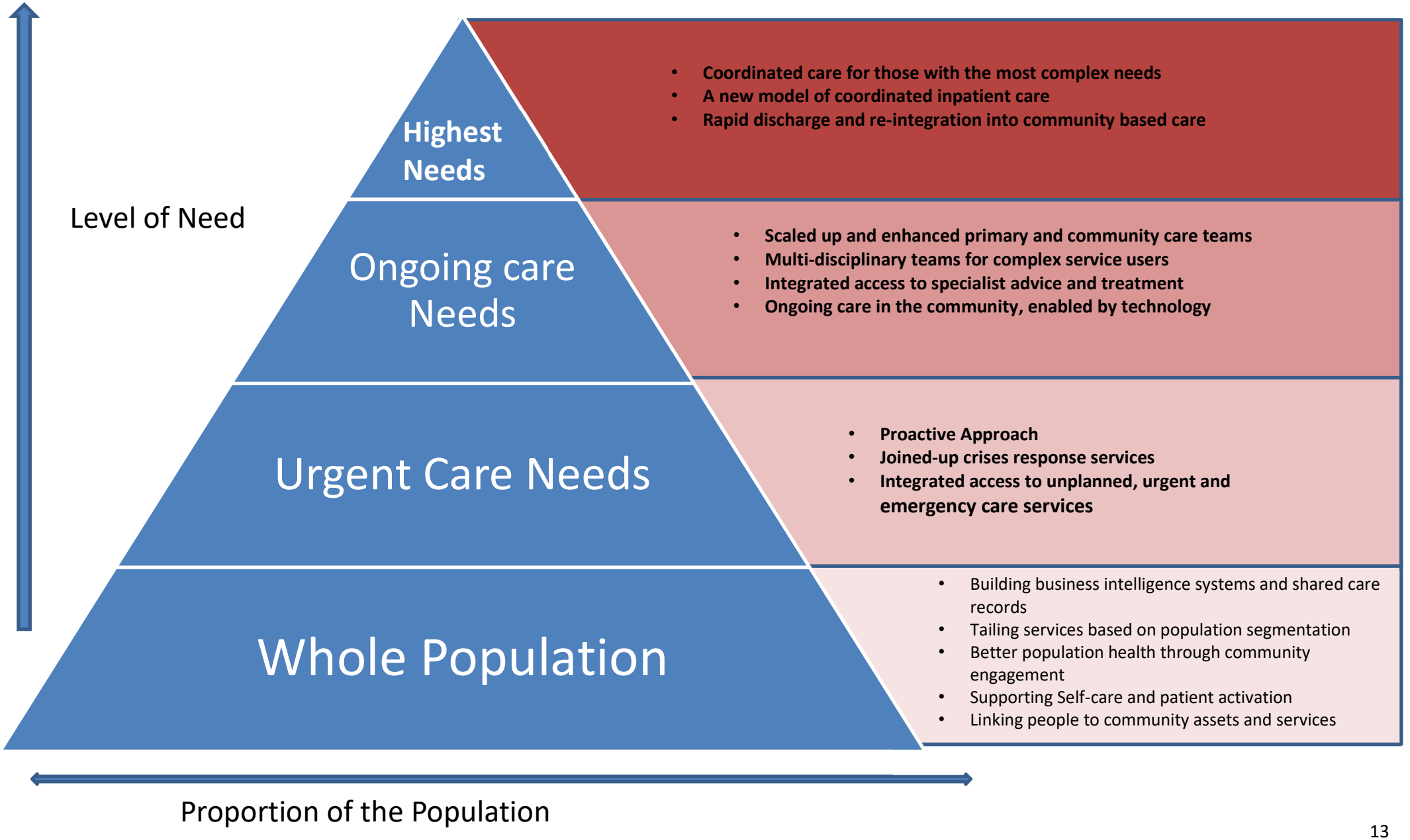
It identifies the range of interventions that, when wrapped around a local population in a coordinated manner, can make the biggest difference.

These interventions are not necessarily new but are known to work

Why do we have a PACS framework?

To support the roll out of best practice across England by defining a model that other places can implement.

Key elements of the PACS Care Model



The PACS framework is built around a matrix which has eight core areas. The chart below shows recent local initiatives which evidence our implementation of the best practice. The full PACS matrix is available for anyone wishing to study in detail the local provision which is in place to meet the needs of the local population and the framework.

PACS Matrix Care Element	Local Initiatives aligned to PACS framework	
Whole population – prevention and population health management	• Isle Find It • Isle Help • Prevention & Early Intervention strategy • Family Well Being Service • Big White Wall • Patient Activation Measure Tool • Care Navigators • Local Area Coordinators • Community Navigation	• Community Roles assessment • Pharmacy First • Market Development • Town & Parish Council Engagement • **Acute Service Redesign** • **Promoting Independence (BCF/IBCF)** • **Employment Support (BCF/IBCF)** • **Carers Programme (BCF/IBCF)**
Urgent care needs – integrated access and rapid response service	• Integrated Care Hub & Co-ordinated Access • Crisis Team • Ambulatory Care • Patient Flow and discharge	• Mental Health Serenity Street Triage • Falls Clinic • Paediatric Assessment Unit • **Co-ordinated Access** • **Mental Health Acute Pathway Redesign**
Ongoing care needs – enhanced primary and community care	• Primary Care Federation pilot projects • Primary Care Strategy & Plan • 7 day social work provision • Integrated Locality Service • Safe Haven • Technology Enabled Care – in Care Homes • Rally Round	• **Integrated Locality Services** • **Development of Locality Management Groups - Ongoing** • **Mental Health Community Pathway redesign** • **Transforming Learning Disabilities Care** • **Living Well (BCF/IBCF)** • **Care Closer to home (BCF/IBCF)** • **Support for**
Highest care needs – coordinated community based and inpatient care	• Case Management of highest risk including Microsoft 365 – IT sharing platform pilot • Shared packages of care (EM Hospice) • Facilitated Discharge & Interim Support • Support at Home team (Hospital) • Integrated End of Life Training & Dementia Training	• **End of Life Co-ordination Centre** • **Frailty & Older people with Mental Health Needs** • **Hospital to Home** • **Redesign of Community Rehabilitation** • **Mental Health Recovery**

5 IMPLEMENTATION TO DATE OF THE MY LIFE A FULL LIFE MODEL OF CARE?

5.1 SERVICES IN THE COMMUNITY

We are transforming community services by developing a new way of working, improving access to information and support, delivering more care closer to home. The following are examples of service transformation that has been delivered since 2013 to support the implementation of the My Life a Full Life model of care.

Integrated Locality Services

Implementing joint working in each of the three localities for health, social care, voluntary and independent sector health and care professionals to come together to work in a more coordinated, collaborative way to the benefit of local people. To date two community hubs are in place in Ryde and Sandown which enable joint working and co-location. Work continues to implement this in the third locality.

New community based roles

Care Navigators who work with people aged 50+ to help them navigate the care system to enable them to stay safe and independent at home. On the Isle of Wight, the Care Navigators are a team of nine employed by Age UK Isle of Wight. Originally part-funded through My Life a Full Life Vanguard funding, they are now commissioned by the Isle of Wight Clinical Commissioning Group.

Local area Coordinators who work with people of all ages to identify what a 'good life' looks like, supporting them to make the most of what's on offer in their local community. On the Island, nine Local Area Coordinators have been recruited through a fully inclusive interview process within each area. They work within the community from a variety of locations with within population areas of 10-12,000 people

Care Navigators – Impact 2014-16:

3740 people have been seen by a care navigator since early 2014.

Of the people supported, 75% were female and the average age was 79.1 years old.

82% of people's wellbeing scores improved.

Local Area Coordinators – Impact at May 2017

Local Area Coordinators working alongside 752 people

The main presenting issue (20%) is mental health.

Between 60 and 100 new introductions each month.

66.4% of people seen by LACs are economically inactive (retired, unemployed, under 18 years old).

Positive effects for all: "More confidence to control my own health care;" "Feel less isolated;" "Visit GP less;" "Attended new community groups."

Positive effects for some: "More active;" "Able to manage my medications;" "Able to manage my long-term condition."

Technology enabled care

A pilot in care homes since May 2016 which uses technology to monitor biometric health data and the risk indicators. This data improves health monitoring and the ability to share the data with GPs, community nurses and ambulance crews.

TEC Pilot in two care homes and two nursing homes – Impact:

- *24% reduction in emergency admissions compared to baseline data.*
- *24% reduction in associated activity including 111 calls and A&E activity.*
- *Saved GP time primarily through the avoidance of GP visits to homes for face-to-face contact.*
- *Residents' families report that they feel better supported due to increased monitoring*

I**mproved access to information and advice**

Support for the voluntary sector to develop and promote a central information portal for health and care advice (Isle Help https://www.islehelp.me/), a community directory (Isle Find it www.islefindit.org.uk) and an online networking/support tool (Rally Round www.rallyroundme.com/iow).

Community based mental health safe haven

Developed a community based mental health safe haven to provide out of hours professional and peer support to those in need. This is due to go live in summer 2017.

Supporting people who are most at risk

We have implemented a new way of working to support our residents with more complex needs, by bringing professionals from different disciplines together to better plan and manage the individual's care.

Supporting Primary Care

Piloted new ways of working in General Practice e.g. enhanced practitioner roles (professionals other than GPs who can treat and care for people), piloting remote consultation (e.g. Skype/app/email) services and piloting a clinical triage service to signpost people to appropriate services, to help tackle their workforce challenges.

Supporting End of Life Care

Investing in Earl Mountbatten Hospice to develop and share knowledge and skills to hundreds of care staff across the health and care system to support those working in the community to care for people and their families who are at the end of life.

Developing community engagement

Working in partnership with town and parish councils to develop community engagement around health and care in each locality.

In addition to those outlined above, My Life a Full Life funding has also helped fund a number of transforming community services initiatives and pilots, some of which are now either standard working for organisations within the health and care system or being evaluated to inform ongoing development work within the system. Examples of these include: Falls prevention, Facilitated discharge, Seven-day social work provision, Adult Safeguarding, online mental health support tools e.g. Big White Wall.

5.2 HOSPITAL BASED SERVICES

Integrated Care Hub

An integrated care hub has been established, based at St Mary's. It handles ambulance 999, NHS 111, rehabilitation, district nursing, adult social care and warden assisted housing alarm calls (Wightcare).

The team within the hub takes the calls and refers people to the most appropriate service, whether that is delivered by statutory, voluntary or independent services. Staff are co-located and work alongside each other. 999 and 111 call handlers are trained across both disciplines.

In the initial period (Jan 2014-May 2015), this resulted in 901 interactions and helped avoid 442 admissions to hospital.

Crisis response Team

A multi-disciplined Crisis Response Team has been implemented including District nurses, coronary care nurses, clinical assessors, paramedics, occupational therapist, social workers and Age UK working together as a team. Their focus is on wrapping 72 hrs of care around elderly and frail patients to enable them to stay in their home environment and only be admitted to hospital when necessary.

Between April 2015 and September 2016, the crisis team had seen 1444 patients, of which only 156 were admitted in to hospital. (11%)

Acute Frailty Service

The development of an acute frailty service - which would provide specialist frailty assessments, treatment and discharge with appropriate support to frail older people who didn't need hospital treatment and could recover better at home/in their local area e.g. with additional support. A pilot for the Acute Frailty service is underway and continues into 2017/18.

Ambulatory Emergency Care

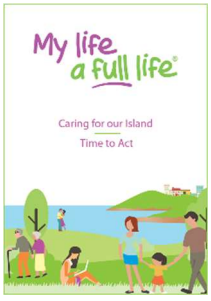
Since the 1st Nov 2016, a new service has been operating five days a week providing ambulatory emergency care (AEC) to people attending A&E. The aim is to provide same day care to people at the hospital so that they are assessed, diagnosed and treated and able to go home the same day without needing to be admitted for hospital care. So far, up to mid-March 2017, 176 patients have been through the AEC service resulting in:

- 87% of patients being discharged home thereby avoiding an admission.
- 80% of patients were seen by a Consultant within 4 hours.
- 80% of patients were discharged within 4 hours.

The service has now become part of the standard operating model in the Isle of Wight NHS Trust.

Services Redesign

In March 2016, we began a process called 'Whole Integrated System Redesign' to look at how we need to change and improve services right across the health and care system. You may recall receiving our 'Time to Act' booklet which set out why we needed to change services and asked you for your views on how we could improve them. We used the feedback we received from this survey and from the large number of events and contacts we had with our community groups and representatives and worked with health and care staff to look at some solutions to these challenges and to implement those that we could.



This current phase is about looking in more detail at acute services to develop a service model that will describe the range of urgent and planned care clinical services to be provided on-Island by the IW NHS Trust, the services that will be provided on the Island by other providers within the Solent Acute Alliance (an alliance formed with partner hospital trusts across the Solent area) and those that will need to be provided off-Island by our alliance partners.

It is necessary for the following key reasons:

- Some acute services are at risk of not being clinically safe and are unsustainable in their current form.
- Workforce recruitment challenges prevent development of appropriate skills and clinical cover
- Clinical outcomes are variable and benchmark unfavourably against peer Trusts
- The unique Island setting requires careful consideration of patient safety when considering patient transfers
- Certain services are unaffordable in their current configuration
- Future proofing against rising demand of an ageing population
- Care does not always take place at the right time and in the right place with people ending up in hospital who could be treated at home or in the community

As part of this work, we are looking in depth at the following specialties: ENT, Ophthalmology, Orthopaedics, Acute Medicine, General Surgery, Urology, Haematology, Radiology, Paediatrics, Anaesthetics, Speciality Medicine and Obstetrics and Gynaecology and developing options against the key criteria; clinical quality and safety, affordability, access (impact on staff and patients) and sustainability. Clinical and non-clinical staff from these and associated services, together with patient representatives have been involved in the process so far and we are working towards further stakeholder and public engagement in the latter part of 2017, with formal consultation, as required, in 2018.

6 WHAT DIFFERENCE HAS IMPLEMENTING THE NEW CARE MODEL MADE?

The following provides a summary of a selection of information evidencing impact to date of the implementation of the new care model.

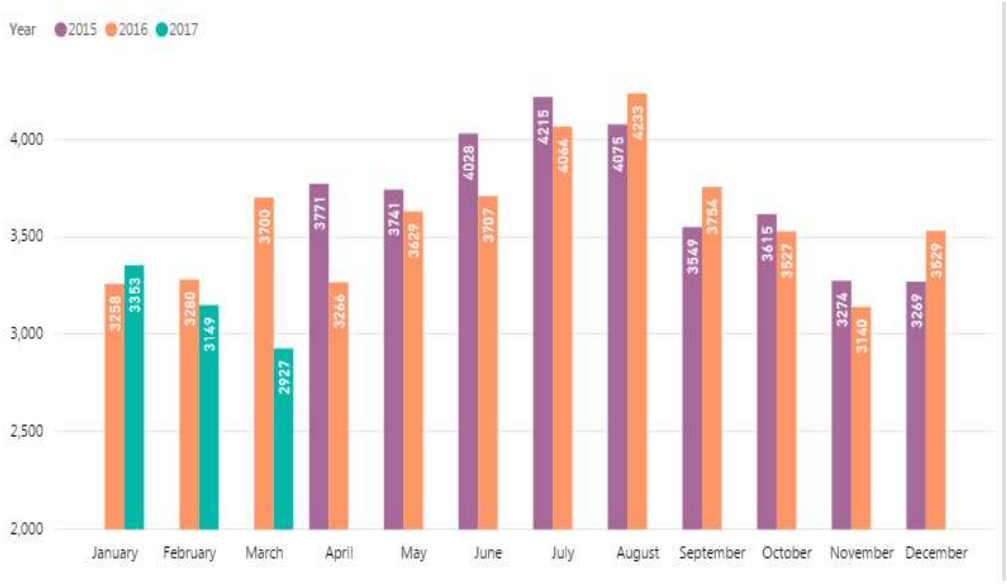
Accident and Emergency avoided admissions

The graphs below show impact since 2012 on Accident & Emergency (A&E) Admission data. The blue line shown is modelled on historic data and is showing a prediction of what A&E admission activity would have been like if we had not made any changes to Island services – i.e. the 'do nothing' scenario. The red line is showing actual A&E admission activity and therefore the yellow area represents volume of emergency admissions 'avoided'. This equates to an estimated total of 1,919 avoided admissions in 2016/17 and an average admission avoidance of 14% per quarter since 2015-16 Quarter 1.

This is as a result of many of the changes across health and care which divert people away from emergency services in the first instance. For example, Increased usage of 111, Crisis Team, MDT, Falls Clinic, Isle Help, Pharmacy First, Serenity Integrated Monitoring (Mental Health), Acute GP, Care Navigators and Local Area Coordinators which have all contributed to diverting people away from Emergency Services in the first instance.

Reduction in Accident and Emergency attendances

This graph below shows details of the Islands A&E Attendances figures for 2015-17. The data shows that we continue to see fewer attendances in 2016 compared with 2015, and 2017 appears to continue this trend. A&E attendances are down by approx. 3% from 2015-16.



More appropriate use of Accident and Emergency department

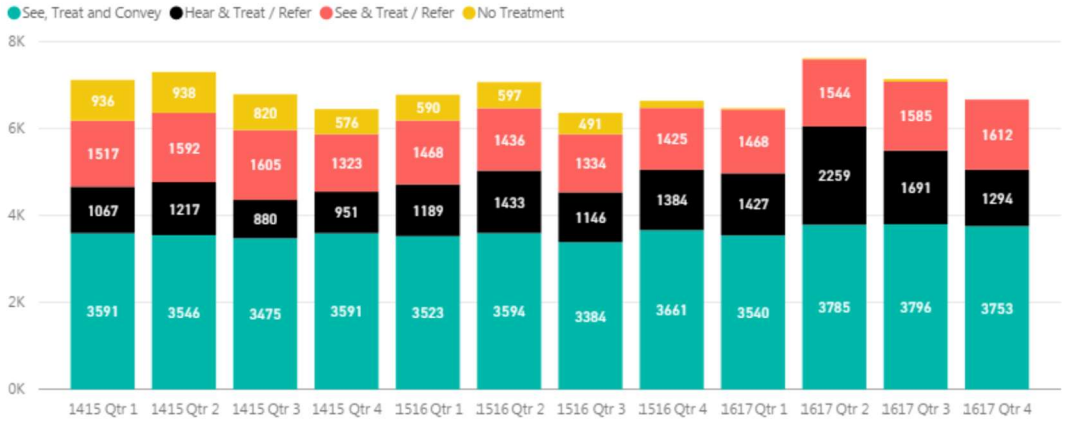
	2015/16	2016/17	% Change
A&E Attendances Total	19,831	18,898	- 4.7
Non-Elective Admissions Total	3,677	4,103	11.6
Conversion from attendance to admission %	18.5	21.7	3.2

The number of people who attend A&E who go on to be admitted to hospital has gone up by 3% - indicating a more appropriate use of A&E.

Ambulance Call Outcomes indicate more efficient use of the service

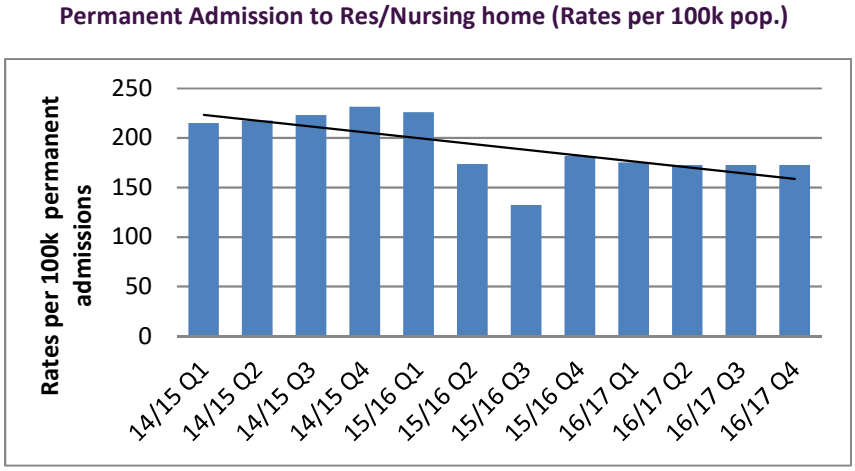
Figures for those people who have been seen, treated and then brought into hospital are up approximately 6% from 2014-15. However, the percentage of overall activity has remained constant as a larger proportion of demand has been met by a more cost-effective telephone triage service. This telephone triage service activity has increased from 14% in 2014-15 and 19% in 2015-16 to 24% in 2016-17. Calls resulting in no treatment have been reduced to virtually zero indicating more efficient use of service. See chart on the next page.

Ambulance See, Hear & Convey Activity levels by Quarter 14/15 – 16/17



Reducing level of Permanent Admission to Homes (ASC)

The graph below summaries the Island's adult social care data - Permanent Admission Rates (per 100k) to Nursing/Residential Homes since 2014/15. The data shows a reducing level of admission rates since first quarter of 2015/16.



The Island enabled this change through the use of more reablement and short term residential service options. This enables people to return and remain in their own home for longer. Better signposting and improved coordination by care navigators and local area coordinators to help people access the most appropriate services and support networks is also being used.

Financial impact - Cost avoidance

The table below shows:

- An overall cost avoidance of £2.1m for the 2016/17 financial year. This is based on A&E admission avoidance, A&E attendance reduction and better, more appropriate use of ambulance services.

Original Financial Impact Plan	Q1	Q2	Q3	Q4	Total
	£000's	£000's	£000's	£000's	£000's
Demand Management	0	0	0	450	450
Operational Efficiency	0	0	0	225	225
Total	**0**	**0**	**0**	**675**	**675**

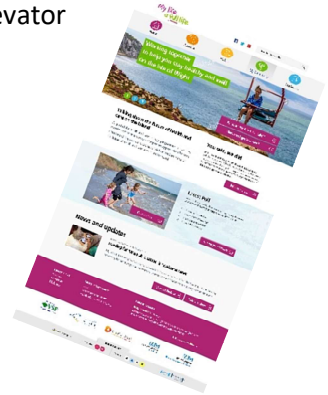
Description	Full Year Financial Impact		Comments
	Period	CCG £000's	
A&E Admissions avoidance	Apr 16 - Mar 17	2,058	Fewer admissions in last quarter than originally projected
A&E Attendances reduction	Apr 16 - Mar 17	99	Reduction in attendances (potentially avoidable) as anticipated
Ambulance - change in service profile	Apr 16 - Mar 17	18	Reduced estimated cost avoidance due to increased conveyance
	Annual Cost avoidance	2,175	

Monitoring of the impact of transformation continues to be a priority for the Isle of Wight Local Care System.

7 HOW ARE WE COMMUNICATING WITH AND ENGAGING PEOPLE IN THE NEW CARE MODEL?

We are currently using a range of communication tools to help us key people informed about our new care model and its progress:

Toolkit: We have developed a toolkit which is on our website and has been circulated to staff and volunteers across the system for their use. This includes presentations, case studies, basic summaries (e.g. elevator speech), plan on a page, national context, case for change etc. We are keeping this under review and adding to it all the time.



Website: We have a website www.mylifeafulllife.com which we use to communicate news and information updates to the public, staff and volunteers. We are in the process of recommissioning this to make it more public facing and making use of separate collaborative platforms for staff across the system. (See initial designs right).

Briefings/presentations:

We have conducted a number of face-face briefings/presentations with different stakeholders throughout the process so far. Our aim has been to go to where stakeholders are rather than making them come to us. We have also used our voluntary sector partners to help us reach community groups and so called 'hard to reach' groups. We have also conducted a number of briefings/presentations, both informal and formal, for IW Councillors and prepared written briefings for various stakeholder groups.

Events: We have held public events for people to come and meet with us and talk to us about the new care model and share their views. 400+ attendees at 21 public events, 317 people involved in community discussions, 230 community groups contacted, 160 people involved in working groups. We have also used roadshows to take our

'story' out to various locations around the Island and to deliver health and care advice and signposting in conjunction with partners.

Media: News announcements are issued as appropriate via press releases to all media via the Trust's media distribution software. We also have a Facebook and Twitter account which we use to disseminate information, news and updates. We have also hosted several successful press visits which have given us good coverage e.g. on the BBC (Inside Out), Guardian and The Sun.

Newsletter: We have a bi-weekly newsletter which features updates on the implementation of the My Life a Full Life model of care. This is issued directly to NHS Trust staff, through E-Bulletin to Trust, CCG and GP practice staff and it is also sent to all the communications leads in the various partner organisations for use in their regular internal communications e.g. for the Vine (for IWC staff and councillors). It is also sent to a health and care provider group who signed up to receive regular communications and is now going to our town and parish council locality leads and our stakeholder reference group.

Video: We have created video material which we have hosted on our website and sent out through social media including a series of video 'shorts' 2-3mins in length which highlight key aspects of the care model and programme which are in the process of being disseminated widely. We are also undertaking videos to highlight different initiatives e.g. Care Navigators and Local Area Coordinators to help make these roles easier to understand.

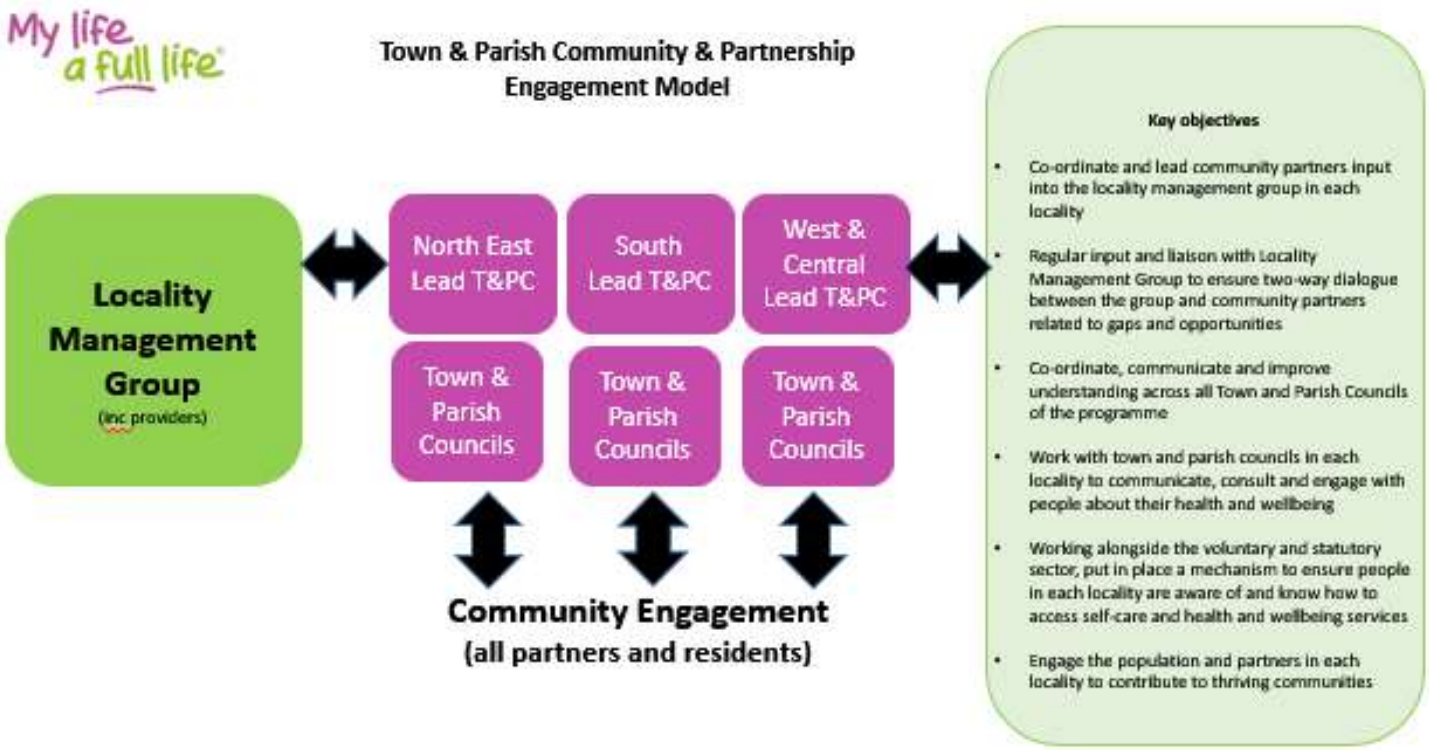
Illustrations and case studies: We are commissioning some illustrations to support the work around the Acute Services Redesign to help bring to life the target operating models in a more user-friendly way. We have also put together a number of case studies to help illustrate the impact of the work around the new care model and we continue to add to these.

Advertisements and Advertorials: Both mediums have been used to illustrate different parts of the transformation work to implement the My Life a Full Life new model of care and to communicate key messages as required. We have also used branded merchandise, where appropriate, to reinforce and promote some simple messaging.

Posters: We have also produced posters to communicate key messages or to publicise key events as relevant for different stakeholder groups. We are also currently looking at a poster campaign for internal and external stakeholders focusing on the impact of aspects of the changes to date e.g. reduction in hospital admissions, A&E attendances etc.

Direct mail: We also used a direct mailshot to all 69,000 households to communicate the Case for Change and encourage feedback to some initial questions about health and care services to help inform the first phase of the redesign. We also use direct email for specific groups of stakeholders e.g. clinicians involved in the Acute Service Redesign.

Town and parish council communications: We have developed a community partnership model with town and parish councils and now have a lead town and parish council for each locality area to help ensure a two-way dialogue between the community and their Localities statutory providers. The diagram on the next page shows the key objectives that we are working together to achieve.



Key visits: We have hosted several other key visits from other vanguard sites e.g. City & Hackney CCG, Symphony (Somerset & Yeovil) and NHS England e.g. National Director of Operations and Information Matthew Swindell. They all have been keen to learn about our work and its achievements and have helped publicise this on a wider platform.

National events – key speakers: We have attended national and regional events to profile the new care model, the work to deliver it and its achievements and progress.

We have also sought to engage and involve our community both informally and formally in various aspects of our new care model development.

Stakeholder reference group

We have a stakeholder reference group which meets quarterly to check and challenge aspects of the programme and its progress. This group has an open invite to anyone representing different groups of stakeholders and the agenda is formed by the group with a 'You said, we Did' action log maintained around key feedback and quarterly reports to the programme board. We have also developed a clinical reference group to help inform aspects of clinical service redesign and development.

Patient and Public involvement

We have sought to involve patient representatives and members of the public at key stages in the development of the new care model and its various transformation programmes/projects. For example, service users and members of the public formed a regular, core part of the working groups formed to review the Whole Integrated System Redesign and the current Acute Services Redesign.

We also work closely with Healthwatch IW to inform our consultation and engagement planning and have commissioned them to undertake training with key staff around co-producing service redesign solutions and developing a forum for GP practice participation groups in conjunction with the CCG.

We have also funded a part-time post within Community Action IW for two year's running to improve and build our engagement with the community and voluntary sector which has proved very successful.

We have also prepared a consultation strategy and will be undertaking more formal consultation, as required, with the local community in relation to aspects of the New Care Model.

8 KEY CONTACTS – SYSTEM WIDE TRANSFORMATION TEAM

The System-Wide Transformation Team are based downstairs at South Block, St Mary's Hospital. The team can be reached via Trudie Little, Team administrator 01983 822099 x 3172.

Public enquiry line is 01983 822099 x 3085.

Website: www.mylifeafullllife.com

Twitter: @mylifeafullllife

Facebook: www.facebook.com/iowmylifeafullllife/

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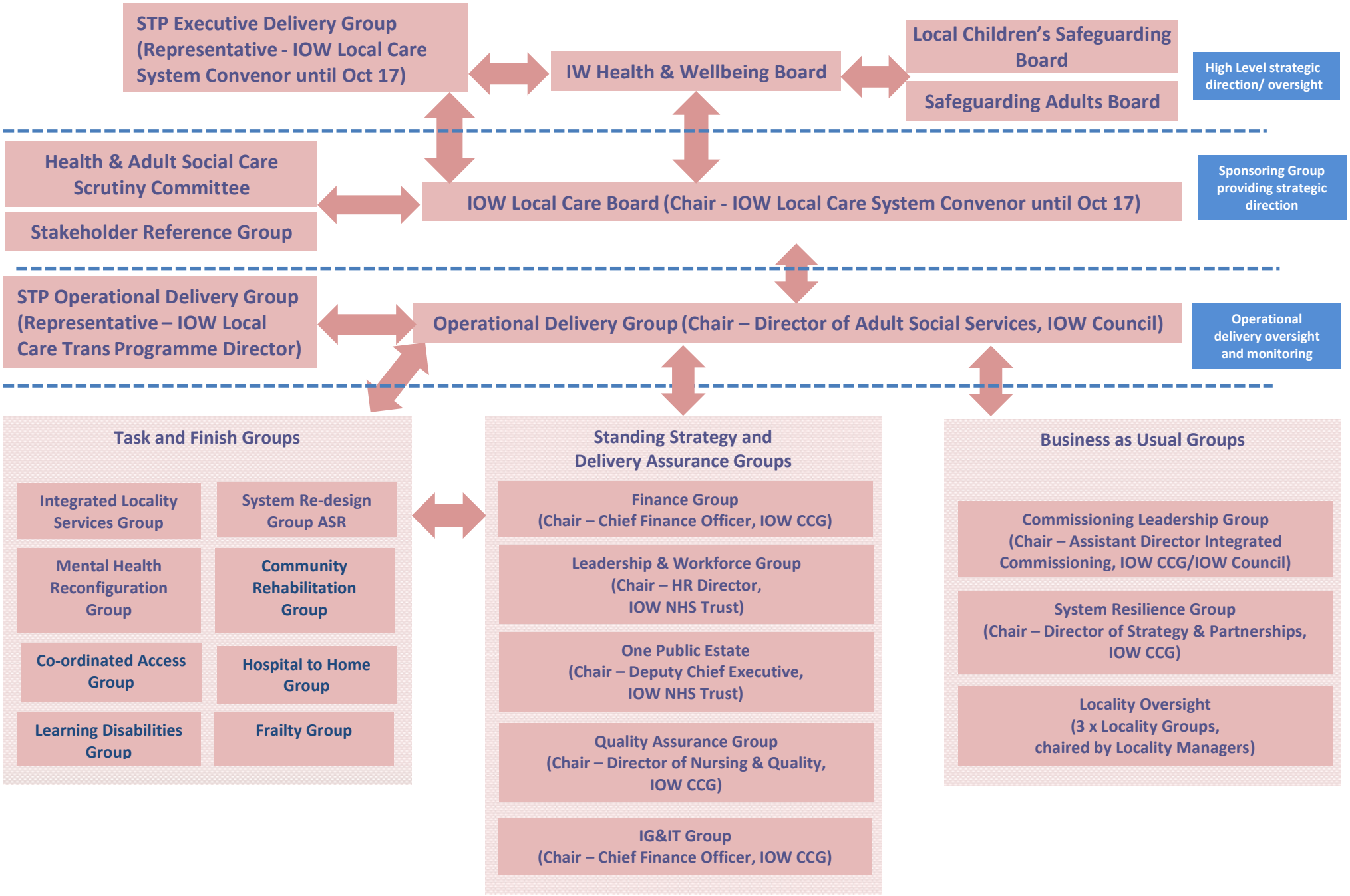
STP Executive Delivery Group (Representative - IOW Local Care System Convenor until Oct 17)
IW Health & Wellbeing Board
Local Children's Safeguarding Board
Safeguarding Adults Board
High Level strategic direction/ oversight
Health & Adult Social Care Scrutiny Committee
Stakeholder Reference Group
IOW Local Care Board (Chair - IOW Local Care System Convenor until Oct 17)
Sponsoring Group providing strategic direction
STP Operational Delivery Group (Representative – IOW Local Care Trans Programme Director)
Operational Delivery Group (Chair – Director of Adult Social Services, IOW Council)
Operational delivery oversight and monitoring
Task and Finish Groups
Integrated Locality Services Group
System Re-design Group ASR
Mental Health Reconfiguration Group
Community Rehabilitation Group
Co-ordinated Access Group
Hospital to Home Group
Learning Disabilities Group
Frailty Group
Standing Strategy and Delivery Assurance Groups
Finance Group (Chair – Chief Finance Officer, IOW CCG)
Leadership & Workforce Group (Chair – HR Director, IOW NHS Trust)
One Public Estate (Chair – Deputy Chief Executive, IOW NHS Trust)
Quality Assurance Group (Chair – Director of Nursing & Quality, IOW CCG)
IG&IT Group (Chair – Chief Finance Officer, IOW CCG)
Business as Usual Groups
Commissioning Leadership Group (Chair – Assistant Director Integrated Commissioning, IOW CCG/IOW Council)
System Resilience Group (Chair – Director of Strategy & Partnerships, IOW CCG)
Locality Oversight (3 x Locality Groups, chaired by Locality Managers)