

Isle of Wight **NHS**
NHS Trust

*Working 'Beyond Boundaries' to deliver
Quality care for everyone, every time*

Clinical Strategy

2014/15 - 2018/19

Appendix 9 to our Integrated Business Plan



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Our corporate strategy - Beyond Boundaries

Beyond Boundaries describes an ambition to deliver health and social care radically differently to the way we do now. We want to break down the boundaries that exist within the Trust to improve quality and efficiency of what we have to do to meet the needs and expectations of patients now and in the future. This covers not only departments but also the conventional professional and vocational boundaries we all observe. We also want to break down the boundaries that exist between the Trust, Primary Care and The Council to develop a highly integrated model of Health and Social Care delivery on The Island.

The Trust is committed to delivering the widest possible range of safe, high quality, cost effective care it can in partnership with patients, public, our commissioners in particular Isle of Wight Clinical Commissioning Group, the Local Authority and other health providers. Our current range of health care services is based on ensuring appropriate access for people on The Isle of Wight to modern health care. In the absence of a fixed link to the mainland this need will still be there in 5 years and so will the same need for the fullest possible range of health services. What will evolve is how it is delivered. Fundamental to this process is the integration of the Island's Health and Social care systems which we have been working on over the last few years. Our healthcare system is almost uniquely placed to develop a highly integrated model of care and social care and through working with partners in health and social care we believe we can evolve a sustainable system which will best meet the needs of The Island for the foreseeable future.

The development of a highly integrated IT system will also massively transform what we do by revolutionising how we communicate with each other and our patients. This will break down conventional health and social care boundaries enabling the development of a very different model of care to the one we have now. All of this will be led by our clinicians, with the engagement of other partners and will be supported by aligned effective corporate services. This is detailed in our Integrated Business Plan, which outlines in greater detail how activity, quality and finance run together and will map out over the next 5 years. This strategy paper describes the clinical vision of this over the next 5 years and sets the direction of travel for the foreseeable future.

Dr Mark Pugh
Executive Medical Director

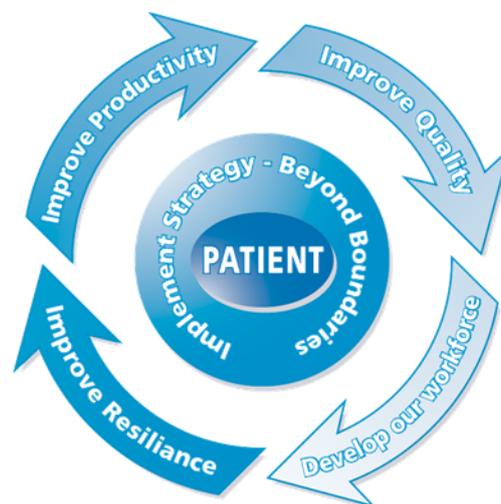
1. Background and Introduction

- 1.1 Over the next 5 years we need to develop the capacity to look after the needs of an increasingly elderly Island population with complex health needs, which we cannot hope to meet with our current health and social care model. This will be further driven by the changing expectations of the patients we serve. The NHS has been found wanting in terms of the delivery of consistently high quality care in the aftermath of The Mid Staffs scandal and we will have to continue to respond to this. Fundamental will be the need to deliver demonstrable high quality care that is sustainable in clinical and financial terms. What is exciting is that much of what we want to deliver is in embryonic form already. The development of locality capacity should provide the ability to manage more patients who currently would be referred to St Mary's Hospital, in the community. In particular we need to develop collaborative models of care which ensure patients only spend the minimum appropriate amount of time attending St Mary's hospital. All of this will be supported and innovated by the development of a groundbreaking highly integrated IT system that will allow access to a wealth of information and will produce different ways of working as we learn to harness the opportunities that this will bring.
- 1.2 Our clinical vision for the next 5 years and beyond envisages a Trust which continues to supply the fullest range of services possible, providing these services are of appropriate quality, and can be delivered within a cost the local health economy can afford. The detail of this can be found in **The Integrated Business Plan**. However, how we deliver our services will change fundamentally as we rapidly develop highly integrated services with our CCG and Council, as outlined in this **Clinical Strategy**. Services will be characterised by high quality as described in our **Long Term Quality Plan**, in a service that is led by our frontline clinicians. Our staff will be developed and empowered to work in our unique environment in a sustainable way as detailed in **The Workforce Strategy** in an environment that will be optimised for our services as outlined in **The Estates Strategy**.

2. The Trust’s Strategic Objectives

2.1 Our guiding principle of ‘quality care for everyone, every time’ is underpinned by the Trust’s Strategic Objectives as shown below

1. **QUALITY** - To achieve the highest possible quality standards for our patients in terms of outcomes, safety and positive experience of care
2. **CLINICAL STRATEGY** - To deliver the Trust’s clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective
3. **RESILIENCE** - Build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private and voluntary/third sectors
4. **PRODUCTIVITY** - To improve the productivity and efficiency of the Trust, building greater financial sustainability within the local health and social care economy
5. **WORKFORCE** - To develop our people, culture and workforce competencies to implement our vision and clinical strategy, engendering a sense of pride amongst staff in the work they do and services provided and positioning the Trust as an employer of choice



1. **To achieve the highest possible quality standards for our patients in terms of outcomes, safety and positive experience of care**

Clinically this means ...

The Island people expect and rightly deserve the best possible standard of care. All our services will need to benchmark their activity against the best standards in the NHS and beyond and openly share results with all our stakeholders, especially the public. Variation has to be explored and improvement activities used to drive up the quality of what we can deliver. Central to this will be a systematic, regular review of all our services every year to ensure the quality of what we do. External review needs to be encouraged and seen as an opportunity to develop and improve what we do. All our services will produce an annual quality report of their activity. If we cannot deliver services to a high standard, we must have the honesty to consult with our stakeholders and consider how else these services could be supplied. Our approach to quality management is detailed in our **Long Term Quality Plan**.

Over the next 5 years we will need to continue to respond to the outputs of the various health reviews that have taken place recently, such as The Francis Report, The Keogh Report and The Berwick Review. A common theme of these reports is the importance of listening to patients and carers. Therefore we need to develop services which put patients’ needs first and can be shown to really fulfil the desire of the public to have a health system that listens and responds far more positively than it does now. The Patient Voices programme has produced a set of statements

reflecting national patient wishes, which have been centrally incorporated in to the My Life a Full Life Programme, and should become central to how we plan our future Trust services too.

As we review our services we must ensure they meet the quality criteria as defined in The Darzi Review:

- Safe
- Effectiveness
- (Quality)Patient Experience

These essential aspects of care have been developed further by CQC in to 5 key questions about health care is it, safe, effective, caring, responsive to needs and well led. As long as services can meet these standards and can be delivered at a cost The Island Health and Social economy can afford, then it would be difficult to foresee why we would not want to continue providing these services.

2. To deliver the Trust's clinical strategy, integrating service delivery within our organisation and with our partners, and providing services locally wherever clinically appropriate and cost effective

Clinically this means ...

The Trust is already a highly integrated organisation combining acute, ambulance, community and mental health services. Our size has facilitated communication and trust which has driven a culture where many of the aspects of our services, which we take for granted, are held as models of service development in the wider NHS. An example of this is the Urgent Care Hub which combines 999, 111, community nurses, mental health workers, community physiotherapy and occupational therapy, a local authority warden service, and our out of hours GP service. Our plans for integration are being further realised by The My Life a Full Life (MLAFL) programme which aims to develop highly integrated, Trust, CCG and Council services for people on The Isle of Wight. The end point of this should be hospital standard care not bounded by our current geography. Our services need to reach out in to the community, local practices, and community hubs. Patients won't need to necessarily come to the hospital, for hospital directed care, because our services will be available through joined up IT and teams able to work across traditional health and social care boundaries. This will allow us to deliver hospital care beyond the boundaries of our walls.

3. To build the resilience of our services and organisation, through partnerships within the NHS, with social care and with the private and voluntary/third sectors

Clinically this means ...

Our size frequently means we deliver services with very small numbers of staff which causes problems when staff are ill, retire or take leave. The need to ensure the quality of our services or the possible development of technology delivered health care in the future may mean care will be delivered by or in partnership with new state or private providers. This requires us to develop links with larger units on the mainland, for the sake of access to technology and staff. Such links can also increase the attractiveness of hard to fill posts on the Island and can provide important development opportunities for our staff. The MLAFL programme will provide additional opportunities to link with Social Care, CCG, Public Health, and The Third Sector, and should be used as a basis to develop new staff roles, able to work across traditional boundaries like physiotherapy, occupational therapy, nursing and social care, allowing us to achieve resilience through internally derived, novel ways of working.

4. To improve the productivity and efficiency of the Trust, building greater financial sustainability within the local health and social care economy

Clinically this means ...

Productivity and efficiency gains can be delivered by doing what we do now, only better and by evolving new more efficient modes ways of delivery. Another important element of this process requires services to be properly costed and delivered within a funding envelope, The Island can afford. The development of increasingly accurate finance, activity and performance information will allow us to understand our costs. This work is being taken forward by the service line reporting project. This in turn will support us to improve our ability to manage our resources in order to deliver the model of care we want. All of this will be led by our clinicians through the directorate and team structures we have been developing. Over the next 5 years the continued development of this model will produce real ownership of the “business of healthcare” by frontline teams, with the ability to shape what they do for the benefit of their patients.

5. To develop our people, culture and workforce competencies to implement our vision and clinical strategy, engendering a sense of pride amongst staff in the work they do and services provided and positioning the Trust as an employer of choice

Clinically this means ...

Our staff are our greatest resource. Over the next 5 years we will all need to adapt how we work to deliver the changes we propose. We will need to be able to work effectively across traditional hospital and community, and health and social care divides. Over the next 5 to 10 years there is likely to be a greater role for front line Consultants and roles traditionally delivered by doctors perhaps being delivered by other staff groups. This will require us to provide different and more development

opportunities for all our staff through an Organisation Development Strategy. We need to think again about what we traditionally think different staff groups can and should deliver and where they deliver it. In addition to considering what our patient facing staff could be delivering, we need also to consider groups like medical scientists; could they take on new roles? We also need to consider whether conventionally non patient facing staff like medical secretaries could deliver other aspects of care, in the future.

“We cannot solve our problems with the same thinking we used when we created them” Albert Einstein.

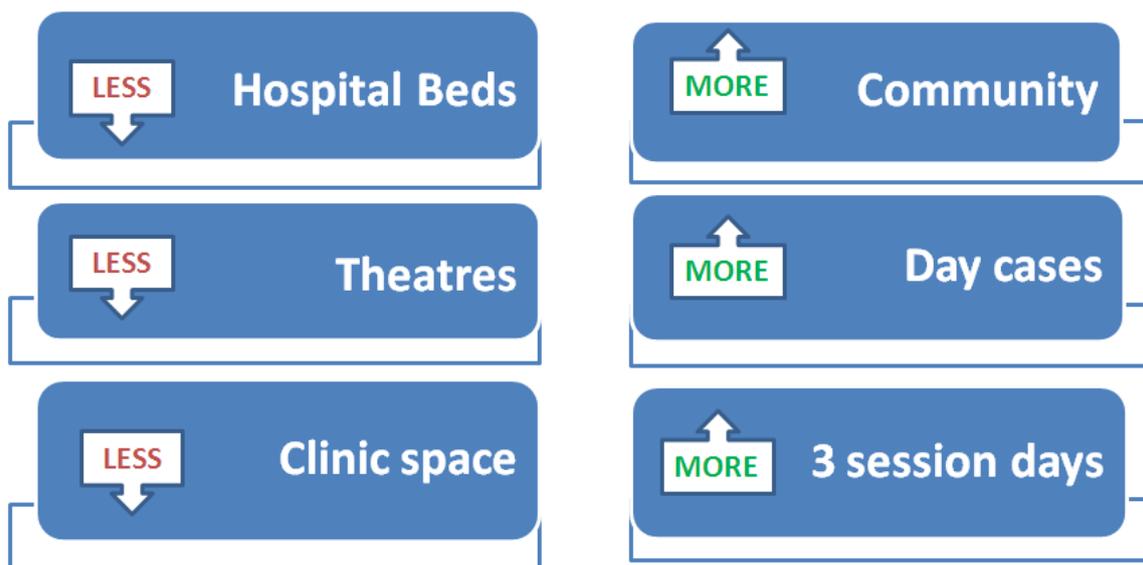
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3. Our Clinical Strategy

“To develop an NHS leading model of highly integrated health care delivering quality patient focussed care”

Clinical Redesign	<i>To continue to redesign services to develop a fully integrated community, acute, ambulance and mental health service. This will enable us to reduce admissions, reduce hospital length of stay and beds, with a resulting ‘smaller hospital, bigger community’ model of care</i>
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3.1.1 Island Healthcare need is unlikely to change significantly over the next 5 years; what will change is how this is delivered. Over this time period we need to move to a model with increased capacity to care for patients in the community to reduce the need to come to the hospital and to spend only the minimum appropriate time here when patients do need to attend hospital.



We already have an age profile on the Island that the rest of the UK is predicted to reach in 2040. Our local population will continue to age, producing a greater number of patients with complex interacting conditions which will require long term support. Hospital will play a part in the care of these people but cannot and should not supply all the health care needs. This will require the development of new community capacity, which will have to be paid for in part by reducing expenditure in the hospital. Communication will also be the key to this development and this will be changed beyond recognition as we move to a fully integrated health and social care record. For instance consider how much effort we put in to communication because the person we are communicating with cannot see the same information in front on them as we can.

How we work is in part driven by how the money flows in the NHS. Currently there is little financial incentive to avoid bringing a patient to secondary care. There is however a growing national appetite to experiment with conventional contracting mechanisms, which could support a real change in how we work and allow us to develop a more community based model of care. The continuing national and local pressures around finances will inevitably impact on how we do things over this period. We will also need to respond successfully to the tendering of further services required of our commissioners under the national “any qualified provider” policy. Fundamentally we need to ensure value for money for every penny we spend for the benefit of Island people. Savings we can make will be used to invest in the development of our services; this will be facilitated by becoming a Foundation Trust.

Pathways of Care

Patient care needs to be seen as a continuum, of which hospital care is a small although important part. Fundamentally people need to be supported in the community to minimise their need to access hospital care. When they do they need to be moved through the Trust part of the care pathway as quickly as is appropriate, with the ideal goal to get them back in to the community as soon as is safe. Once back in the community their care will continue in a joined up way to maximise clinical effectiveness. With improved support in the community it should be possible to reduce the need for acute unplanned care and increase throughput in elective planned pathways. Pathways of care have been used successfully in a New Zealand primary and secondary model of care to improve quality outcomes and reduce cost. NICE are also working on similar care pathways which will influence care delivery in the future.

3.1.2 Outpatient Activity

A move to 3 session days for outpatient clinics will allow rationalisation of the space we currently use and provide opportunities for more efficient use of staffing and resources. The use of ISIS will allow speedier communication with GPs which will reduce the need for hospital prescriptions and queries based on non-received letters. The possible development of a new reception centre, through the Strategic Business Partner programme for non-emergency patients, will provide a new modern comfortable environment to see out patients. The use of smart phone technology will be harnessed to improve communication with our patients, this could be through improved communication about appointments through to face to face communication avoiding the need to attend hospital at all. We will reconfigure clinic capacity to allow patients to be seen urgently to prevent clinical decline and avoid admission.

An innovative contract for diabetes care is already being used and the results of this should be used to influence care in other areas. The contract is based on

shared outcomes and incentivises the hospital team to support primary care through practice visits and a shared access IT platform. The Commissioners have expressed a desire to expand the use of novel contracting mechanisms to promote different models of care e.g. recognising non face to face follow up of patients via telephone, email, text etc. This is also now being encouraged by central government through an integrated care pioneer programme and support from Monitor and NHS England for novel approaches to commissioning care.

3.1.3 Inpatient Activity - Surgical

Planned surgical throughput needs to be isolated from acute unplanned activity such as medical emergency admissions, as much as possible to ensure that pathways can be run to the highest degree of efficiency possible. Optimum development of “Enhanced Recovery” will also shorten the average length of stay for patients. This has already allowed a reduction in the number of beds currently used by Surgical Specialities. Hospital capacity could be further increased by moving to 3 session days and then extending to 6 or even 7 day working, however the cost of this would need to be justified by clear benefits. There are further opportunities to move from inpatient surgery to day case surgery and maximise theatre use. For the future we need to increase access to single rooms to improve infection control and patient dignity issues

3.1.4 Inpatient Activity - Medical

Inpatient care pathways need to be optimised to ensure patients only spend as long as is absolutely necessary in hospital. This will require more organisational effort to promote timely discharge which will be facilitated by our clinical IT system, ISIS, which we started to introduce in 2013. The development of community services will also support this move, linking in with locality hubs. We have already moved to more frequent ward rounds to optimise care and discharge planning. In the future, this should move to daily review as required across the 7 day week. Over the next 5 to 10 years the Island will need to increase capacity to look after a growing elderly population. Plans are already in development to link with the 3 Locality Hubs to support people in the community with complex health needs so they can remain in their own homes, or can be supported more fully in care or residential homes.

3.1.5 Mental Health

The current model of inpatient care will be modified to reduce the need for admission. To facilitate this community support will be expanded. The movement to payment by results will continue to develop working practices. Small, specialised areas of mental health may move to mainland providers or to co-operative models of delivery to increase resilience. The introduction of PARIS will

improve IT links between the hospital, community and social services. Predictions of an increase in patients with dementia will lead to an increase in demand over the next 5 years. Our Memory Service is highly regarded and with appropriate support, should be well placed to support patients with this illness.

3.1.6 Community Services

The reduction in acute hospital capacity will be facilitated by increased community capacity to look after patients. This will require reconfiguration and investment to ensure appropriate capacity is developed. The increase in capacity will support quicker discharge of patients from hospital and the development of capacity to care for more patients in the community to prevent admission. The development of locality care models with the CCG and local authority will also require reconfiguration of services to support, develop and deliver the opportunities that exist in this area. This will also support the initiative to develop joint care initiatives between primary, secondary and social care, under the My Life a Full Life programme (see below for more details.) All of this will be supported by The PARIS IT system which is currently being rolled out in The Community and Mental Health Services and is also likely to be taken up by Social Services.

3.1.7 The Ambulance Service

The Ambulance Service continues to respond to national targets to promote speedy hand over of patients transported to hospitals. This is likely to increase pressure on The Emergency Department. The Urgent Care Hub should develop over time to become a single point of access for all urgent care services in health and this could also be expanded to include social care. The hub could also take on the role of care co-ordinator for patients in the community aligning services to optimise health and social care delivery. Further expansion could see the Hub becoming the single point of access for all urgent and non-urgent health and social care needs on The Island.

3.1.8 Isle of Wight Maternity Strategy

To increase choice in where and how women have their baby; providing continuity of care and ensuring an integrated service through network and agreed care pathways. Access to community clinics, reducing unnecessary admissions and expedite early discharges. Support access to home birth and identify improved partnership working for safeguarding and Public Health indicators eg. Smoking Cessation and improved Breastfeeding Support.

3.1.9 Our Staff

The near future is likely to see more front line Consultant delivered care, which is in keeping with recommended models. This will require an increase in the number of Consultants in some areas which will in part be offset by a reduction in Staff and Associate Specialist (SAS) grade doctors and Junior Doctors. We will require new staff models to take on roles in the future. We need staff who can work across primary and secondary care and health and social care. Some of these staffing models do not exist presently and we need to work through the Local Education and Training Boards (LETB) to influence the evolution of appropriate training programmes. For instance, a new cohort of Health Visitors would look after elderly patients in the community. As well as training staff to work in different ways we will also need to invest in more personnel to support our ambitious information system plans.

3.1.10 Third Sector

There will be an increasing role for the third sector (charities) to deliver health and social care. Over the next 5 years we will work increasingly closely with various organisations to collaboratively deliver care and in some cases hand over things we currently do, to these organisations.

3.1.11 Chaplaincy

We need to develop the full potential of those who we already work alongside. For instance in Birmingham a community Chaplaincy service has been established, to extend the work of the conventional hospital service, in to GP surgeries and the community, to support patients.

3.1.12 IT, Telemedicine and Telehealth

Why would you write to someone to tell them you had seen a patient when they could just access a common health record? In a centre in Europe, each day primary care doctors are sent a list of all the patients who have attended their local hospital. The doctor can then access the care record for these patients for information. If something needs doing urgently the hospital sends an email or text to the primary care doctor. Likewise primary care doctors can ask for input to community patients as hospital doctors can read GP notes. Our ISIS system is on the verge of delivering such functionality. What we will shortly have will improve the quality of what we do by improving speed of acquisition of information and by making that information more widely available to health and social care staff. However, the biggest gain from such a system will be the transformation in how we manage our patients. The effort and inefficiency that a paper record brings, with a potential 30 + such records per patient alone in St Mary's, could be rationalised to huge benefit with a single electronic record. Accessible across

health and social care a single electronic record which can be easily accessed by the appropriate staff groups will significantly improve health care, as it has in centres in the USA and more recently the UK,

Telemedicine may be used increasingly in certain situations like prison settings or for the delivery of certain specialities like dermatology. Improved communication between primary, secondary and social care and other care settings such as prisons may also benefit from low tech video links via smart phones and tablet computers. These links could also be used for certain patients, in their own home. However, thus far the use of community pathways to look after specific conditions through Telehealth has not demonstrated significant health improvement, suggesting the need to think carefully about how this could be deployed in the future.

Increasing patients' access to health information will inform them about health choices but will also increase patient expectation. Informed patients are to be welcomed, as research confirms better health care outcomes for patients more able to contribute to their own care. ISIS has the capacity to allow patient access to their medical record.

All these developments will move the Trust towards a paper free working environment. Initially this will start with the record being part computer based and part paper based, so called "paper light", but the benefits of being paper free should be sought as soon as possible.

3.1.13 Medical Advancement

Any medical advances which could significantly impact the bulk of provision of health services on the Island over the next 5 years should already be visible, even if they are not currently in widespread practice. Whilst the practice of medicine changes all the time, and we cannot afford to fall behind, there are no significant developments that we can see that will cause major changes to how we deliver health care over the next 5 years. That does not mean however, that for certain types of condition we will always be able to deliver the best care on The Island. The increasing specialisation of care will require us to inevitably treat increasing numbers of patients off Island. In the absence of a fixed link with the mainland it will not be possible to guarantee Island residents the same standards of care they could expect were they to live on the mainland. Traditionally Island residents have accepted this health gap, however for the future better informed patients and more stringent health regulators may be less tolerant of this situation.

Locality Working

To align our integrated service with the three GP localities established by the Isle of Wight CCG, increasing the proportion of care delivered in community settings including nursing homes. (see appendix B for a summary of the CCG Strategy)

3.2.1 The strategy for the next 5 years proposes the establishment of 3 hubs which will cover the whole Island, to deliver local services for patients. These will improve the linkage of primary, secondary and social care by using the locality hubs as bases for shared care. This will require our Trust to align community workers such as nurses, physiotherapists and occupational therapists with these teams. Primary and Secondary Doctors should also be aligned to support these groups to improve communication and team working, by breaking down traditional boundaries of care. An important element of this will be to develop a hospital without boundaries, so that patients can have access to hospital level skills in their community. If it were easier to get a hospital level opinion in the community than come to St Mary's, we would be able to support more patients with more complex conditions in the community. A move to support the treatment of more ill patients in the community, through easier availability of i.v. antibiotics or fluids at home or in nursing homes could also help reduce admissions to hospital.

Integration

To integrate across health and social care. We will integrate health and social care delivery through partnerships with the Local Authority and the third sector

3.3.1 This will be delivered through the My Life a Full Life (MLFL) programme> A collaboration between the IWNHS Trust, CCG, Council and the Voluntary Sector. It will deliver integrated approaches to health and social care services and support for people of the Isle of Wight.

Three priority areas have been identified:-

- Self care and self management and personalised care planning
- Crisis response and re-ablement
- Locality working

As the programme develops it will identify other areas across the health and social care interface, working with local people and key organisations, that would benefit from this approach. One of the primary aims of the programme will be to provide the opportunity to change skills sets and cultures within organisations and to be proactive in the community around engaging Island residents in thinking about planning for their health and wellbeing.

The MLFL programme is provides a structure to develop a common approach to health and social care delivery as well as promoting innovative solutions to community healthcare, reporting to the Island's Health and Wellbeing Board.

The development of enhanced community, capacity and resilience will promote care and support closer to home, reducing need for inpatient admission and the duration of inpatient stay.

Resilience

To increase our clinical resilience, developing partnerships to maintain accessible, safe and effective secondary care services on the Island. Acute and Mental Health services cannot provide care in isolation. We will grow existing and establish new clinical partnerships and explore alternative delivery models with the 'best in field'

- 3.4.1 We already have a number of successful partnerships with mainland providers which support the range of care we provide locally. In the future it is likely we will have more posts which we share through such arrangements. This will enable us to continue to recruit top quality staff, who could be shared with mainland services including hospitals. **This does not just apply to clinicians but should include all staff who work at our Trust.**

Some of Services Already Supplied In Partnership with Mainland Providers

1. Renal Medicine and dialysis
2. Neurology
3. Oncology
4. Vascular surgery
5. Cardiology
6. Paediatric surgery
7. ENT cancer surgery
8. Dermatology

4. How Island Healthcare will be delivered in the future

Below are 4 scenarios that describe how an integrated service could deliver healthcare in the future. Some of the elements of this exist already. The rest could be worked on over the next 5 years. Some of this is about trusted working across traditional boundaries and some is about realigning incentives so that the flow of money facilitates doing the right thing.

Mrs Attrill needs a new hip



Having identified that her progressive groin pain and limited mobility was due to an osteoarthritic hip, her GP has discussed her case on-line with an Orthopaedic Surgeon, as the GP is unsure if she should have surgery. Surgery is felt to be the only option and she is placed on the admission pathway by her GP. As per protocol her pre-op medical condition is assessed by her GP and her BP medication is modified accordingly. She has downloaded her consent form from the hospital website and joins a hip class to prepare for surgery and post operative recovery. She has an uneventful operation and is discharged after 48 hours back to the community care team, who manage her wound and encourage early mobilisation through the multifunction community care team. Post op outcome data is also gathered by the community team and fed back into the ISIS system, where results are audited by the orthopaedic team.

Mr Caine has a flare up of his rheumatoid arthritis



Mr Caine closely manages his own arthritis monitoring, his own blood tests and clinical condition via email and phone with the rheumatology clinic and his GP. Mr Caine recognises his arthritis is getting worse and arranges to have a blood test and books in to the rheumatology clinic the following day. The clinic visit results in an urgent prescription for prednisolone, which is sent by email to his pharmacy and his GP is notified of this and a change in his regular medication. His disease state is recorded on the Island Common Health record, available to Mr Caine, his GP and St Mary's Hospital. One week later the Rheumatology clinic ring Mr Caine to check all is well. He has examined his own joints and recorded a drop in his active joint count. Blood checks show an improvement as well and he is moved back to community management. Although monitored via the web and phone Mr Caine now only attends the hospital clinic when he has a flare up.

Mrs Ryland age 72 attends the Emergency Department following a fall during which she sustained a head injury



Her injury requires a few stitches and she can go home. However an integrated falls risk assessment has predicted a high risk of another fall. Her details are passed onto the community team which includes social services, who assess her home circumstances and recommend a falls alarm, which is fitted by a local charity. Her falls risk has been linked to medication, triggering a drug review by her pharmacist. Her case is passed to her locality hub and her falls risk is further investigated. All the information from the ED, ambulance, pharmacy, locality hub, GP, can all be accessed through one source, which ensures her case is managed in a holistic manner. Mrs Ryland however, is only aware of helpful assistance from a number of quarters to minimise her risk of coming to harm from a fall in the future. She knows next time the ambulance team could stitch a wound like she has sustained at home, hopefully preventing her having to attend hospital.

Mr Jones is concerned for his son and needs advice from the Mental Health team



The 111 hub received a call from Mr Jones stating that his son was 'not well'. He reported that James had been hearing voices and had become frightened and agitated. The call was passed to the Mental Health Advisory Team (MHAS). During the phone call it became evident that James needed further urgent assessment. An assessment by the Mental Health Team was organised immediately. Home Treatment was considered but due to risks identified James was offered informal admission to the acute mental health ward. In addition to a risk assessment, the inpatient team carried out a full holistic assessment of his needs. Due to his mental state, prior to admission James had dropped out of college, neglected his physical state and was malnourished with a BMI of 16. Ward staff were able to refer him immediately to the dietician who came the following day to review him on the ward. Nutritional supplements were then prescribed. Medication was given to reduce psychotic symptoms. Regular reviews were held with James and his family and the decision was made to refer him to a Community Care Co-ordinator and for therapeutic group work in the community. Occupational Therapy staff also supported James by visiting the college to explore the support he needed to continue his education. James was then transferred to the Home Treatment team so that he could be supported in his home environment. With regular follow up from the Community Team, OT's, group work and clear contingency plans in place in case of relapse, James could be safely discharged from hospital with the best chance of continued recovery.

And what of the future?

Genetic analysis will allow accurate prediction of the likely illnesses and therefore health needs in the future. The same analysis will be used to provide the best medication for the individual. People will be empowered and supported to look after their own health through feedback from sensors, which will constantly monitor various health metrics like blood pressure, blood levels of substances like glucose in patients with diabetes. Feedback could be streamed in real time to a monitoring team, who use head up displays in glasses and reported on to the person's health care co-ordinator, who could book relevant further investigations and treatment at the nearest health care facility. Using a GPS chip patients with lung disease could be fed environmental data on things like pollen or air pollutant counts. Sound a bit farfetched? It's all in development now!

5. Conclusion

- 5.1 The next 5 years will see significant pressure on the current model of care due to increasing demand and decreasing funding. None the less, the Island has a fantastic opportunity, through our historical approach to health and social care integration

and the revolutionising potential of the benefits of our local IT programme, to not just mitigate the pressures but to develop a world leading model of care. In the absence of a fixed link with the mainland there is an over-riding argument to continue to supply as much quality based and cost effective care on the Island as we can. This will require continuing optimisation of our services and the development of innovative health delivery models, particularly linking with community providers.

- 5.2 Overall, we will need to shrink the footprint of the acute hospital and increase community based care over this period. The opportunity to deliver integrated care, combining seamlessly primary, secondary, social care, and third sector will allow the Island to continue to deliver high quality care and future proof ourselves to deal with the health care needs of the future. The Island is uniquely placed to successfully build such a model ensuring we fulfil our **quality care everyone every time** pledge.
- 5.3 The successful realisation of this will fulfil our aspiration to become a globally admired leader of integrated care, building a reputation as a provider of innovative healthcare solutions in spite of our size, which will be seen as a model for future delivery of NHS care.

6. Clinical Strategy: 5 year framework

	<i>Goal</i>	<i>Enabled by...</i>	<i>Outcome...</i>
1.	A single point of contact for all urgent care will allow a streamlined and appropriate response.	...our local 111 service will be developed to maximise the opportunity for an integrated care response.	...our patients will receive the right response every time they have a healthcare crisis.
2.	Patients will spend the minimum time necessary in hospital before discharge	...an expanded community capacity.	...a smaller acute hospital, routinely using one less theatre, with the fourth now available for emergency work and other non routine work, less surgical and medical than we currently have, working 3 session days and at weekends
3.	Fewer patients will attend clinics at the Trust.	...contact by phone, email and image communication systems like Facetime, either directly with patients or through their General Practitioner.	...patients attending clinic will reduce overall by up to one third, based on available evidence
4.	Patients will move seamlessly between traditional care providers using a trusted referral process, facilitated by one seamless record spanning primary, secondary and social care.	...by the development of the My Life a Full Life Programme, which will integrate health, social care, the third sector and other local providers and an integrated IT systems spanning all parts of health and social care.	...patients will be supported to remain successfully supported in their communities
5.	Our care will be delivered by a skilled and sustainable workforce.	... by closer links with mainland providers through shared posts and other networking opportunities. We will also become less dependent on conventionally delivered care models as we develop our own staffing models.	... outcomes for Island patients will be recognised as some of the best in the NHS, with a sustainable workforce