Trust Strategy 2016 - 2021

Working “Beyond Boundaries” to be the preferred choice for sustainable integrated care

Version 11 – Approved at Trust Board on 30/3/16
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<th>Strategy and Operational Planning</th>
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<tr>
<td><strong>Strategy</strong> (from Greek στρατηγία stratēgia, is a high level plan to achieve one or more goals under conditions of uncertainty.(^1))</td>
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<td><strong>Operational planning</strong> is the process of planning strategic goals and objectives to tactical goals and objectives. It describes milestones, conditions for success and explains how, or what portion of, a strategic plan will be put into operation during a given operational period, in the case of commercial application, a fiscal year or another given budgetary term. An operational plan is the basis for, and justification of an annual operating budget request.(^2)</td>
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1. EXECUTIVE SUMMARY

1.1 Much has changed both locally and nationally since we published our last Trust strategy, called “Beyond Boundaries”. We need to adapt to meet growing challenges and take advantage of new opportunities.

1.2 Nationally, the NHS published a document in 2014 which sets out how health services across England need to change in future. This document, called the NHS Five Year Forward View\(^3\), was created after talking to patient groups, clinicians, local communities and frontline NHS leaders. It provides a long-term view of how services must change to keep up with growing demand and to help encourage our patients, carers and our community to look after themselves better and live healthier lives.

1.3 On the Isle of Wight, the My Life a Full Life programme\(^4\) has been successful in attracting new national funding. This funding is to be used to further develop how organisations on the Island can work more closely together. Both these national and local developments mean that the time is right to look again at how the Isle of Wight NHS Trust will provide services across these local and national we have taken the opportunity to review our current strategy, “Beyond Boundaries”.

1.4 We need to review our strategy to make sure we are concentrating on the right priorities and to make sure we are still working in the same direction as the organisations that buy and plan health services (our commissioners). Importantly, we also need to make sure that we are always listening to what our service users, carers, staff and stakeholders (people who have an interest in what we do) want.

1.5 If we make sure that what we are doing lines up with what other organisations are planning to do, we will be better prepared to take advantage of the opportunities from the My Life a Full Life programme and outlined in a key document which we recently agreed with the Isle of Wight Council – the Strategic Partnership agreement. By all working in the same direction, all the organisations that make up the Island’s health and wellbeing system, including social care and housing, will benefit.

1.6 Our strategy must include the ways that the Trust is working to drive up the quality of our services. Our plan for improving the quality of services is called our Quality Improvement Framework. We need to make sure that this work fits with and helps us to deliver our strategic priorities. Our Quality Improvement Framework is used to make sure we all work towards

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\(^3\)The NHS Five Year Forward View (https://www.england.nhs.uk/ourwork/futurenhs/) was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care

\(^4\)My Life a Full Life (http://www.mylifeafulllife.com/) is collaboration between Isle of Wight NHS Trust, Isle of Wight Council, NHS Isle of Wight Clinical Commissioning Group and the Voluntary Sector on the Isle of Wight. The aim is to change the face of health and social care on the Island, helping people live life to the full
the organisation’s vision, values and strategic objectives.

1.7 When looking at how to update this strategy, we have thought about ‘Our Vision’ which sets out our ambitions, ‘Our Values’ which underpin everything we do and how we expect staff to behave, ‘Our Goals’ which have been shared and understood across our organisation, ‘Our Priorities’ which set out our plans and the ‘Quality Improvement Framework’ which explains how we will improve the quality of our services.

1.8 Over the past three months, we have undertaken an examination of the factors impacting on and influencing the delivery of good quality, safe, sustainable, efficient and effective services to people and we understand the factors limiting or inhibiting the delivery of these.

1.9 As a result of the work we have done, we can now state our strategic direction for the next five years like this: - Working ‘Beyond Boundaries’ to be the preferred choice for sustainable integrated care.

1.10 We have defined our strategic priorities, the things we will do, as follows: -
   1. Align sustainable services to the needs of our patients, carers and people who use our services by
      a. Designing efficient and effective treatment and care pathways
      b. Maximising the person’s experience
      c. Providing 24/7 community services for the range of people with mental health needs
      d. Providing services across the seven days of the week
   2. Become a centre of excellence for the care of older people
   3. Provide excellent end of life care
   4. Become excellent in the provision of dementia services
   5. Become excellent in the provision of health and care services to children and young people

1.11 And we have stated what our strategic enablers, what we will put in place, are: -
   1. A workforce embracing integration
   2. Efficient processes with minimum waste
   3. An IT Infrastructure and Processes geared to enabling effective delivery and support, aligned with the My Life a Full Life priorities
   4. Land and buildings which are fit for purpose

1.12 This document is owned by the Trust Executive Committee and approved by the Trust Board. It is intended to guide all service and operational plans on the strategic direction of the Trust with clear links to the Island’s overarching My Life a Full Life programme.
2. INTRODUCTION

The drivers for reviewing our strategy

2.1 Our strategy, 'Beyond Boundaries' was revalidated in early 2014. One year on from the publication of the NHS Five Year Forward view and the success of My Life a Full Life in attracting development funding, we have taken the opportunity to review 'Beyond Boundaries' so that it is fit for purpose for the next 5 years.

2.2 We need to ensure we are ready to embrace the opportunities that My Life a Full Life will bring to the wider health and wellbeing system, including social care and housing, so we need to be sure we are concentrating on the right strategic priorities and getting the basics right.

2.3 In the current climate, and with the many challenges we face, 'more of the same' is not an option. To meet the challenges will require new ways of working, involving the whole health and social care system in the change process developed with service users, carers, staff and stakeholders. These stakeholders include the Island’s Health and Wellbeing Board, IW Council and the Island’s Town and Parish Councils. Whilst there is much we can do on the Island there will be services which for clinical and financial reasons service users will need to travel for, as is the case on the mainland.

Some of these challenges include:

- A chronic national shortage of doctors, nurses and some allied health professionals across the UK, magnified on the Isle of Wight which faces unique challenges in recruitment and retention of skilled staff

- A £22 billion deficit across the NHS impacting on our own services locally which means we need to change. Locally it is estimated that the health and care economy will be in £51.93m deficit by 2019/20 if nothing is done to address the challenges. With the developments envisaged under the My Life a Full Life programme supported by the NHS England New Care Models initiative estimated that the deficit position will be reduced to £19.69m by 2019/20.

- Socio-economic factors, with 20% of children living in poverty and the Isle of Wight ranking amongst the 40% most deprived local authorities in the country and significant variations across the Island.

- Our geographic isolation which means we are less able to call upon mutual support from neighbouring organisations at times of pressure on our acute services.

- Our under-utilised, ageing and dispersed buildings and land that do not fully support the needs of our services and people.

2.4 Some of the considerations informing the review of our strategy are:
- The NHS Five Year Forward View (https://www.england.nhs.uk/ourwork/futurenhs/) and the acceleration of the My Life a Full Life Programme (http://www.mylifeafulllife.com/). The aim of this strategy is to fully align the Trust with the MLaFL programme.

- The potential to work with partners in the public (we have recently signed a strategic partnership agreement with IW Council), private, third and voluntary sectors in recruitment to and the delivery of services across 7 days per week and in providing the functions that support them.

- The ‘Requires Improvement’ assessment of our 2014 CQC inspection (http://www.cqc.org.uk/provider/R1F) and our responses to that.

- The commissioning intentions and strategies of Isle of Wight Clinical Commissioning Group (www.isleofwightccg.nhs.uk), NHS England (www.england.nhs.uk), Isle of Wight Council (www.iwight.com) and of other commissioners.

- The complexity in our integrated service and care models.

- The requirement for both clinical and financial sustainability to be present in all our plans for the future

- The lack of standardisation in the core processes that deliver and support our services.

- The opportunities for improving the quality of our services that are presented by deploying new ways of working, using feedback from service users, carers, staff and stakeholders, and using evidence based research

- The NHS Outcomes Framework\(^5\) and the NHS Mandate\(^6\).

- The Trust’s role in Island life as a force for good beyond providing healthcare.

2.5 In summary, in order to meet the needs and expectations of our island population, we need to think and work differently and be innovative in our approach to delivering sustainable services.

\(^5\) Sets out the outcomes and corresponding indicators that will be used to hold NHS England to account for improvements in health outcomes

\(^6\) The NHS Mandate between the government and NHS England sets out the ambitions for the health service.
3. BACKGROUND

Who we serve

3.1 The static population of the island is one of the oldest in the country with over 65s expected to increase by 47% and account for 36% of the total population by 2037 (vs England 24%).

3.2 Currently we have 50% more people over the age of 65 compared to the England average and in 20 years we predict we will still have significantly more people over the age of 65 compared to the England average. At the same time, compared to the national average, we have fewer under 50s.

3.3 These factors influence the type of care we need to deliver and who we can call upon to deliver it.

Isle of Wight Population Profile versus National Average

3.4 The Isle of Wight ranks among the 40% most deprived local authorities in England, with 20% of our 16,000 children living in poverty. Earnings are lower than the national average, there is higher than average long term unemployment and there is low GCSE attainment.

3.5 Deprivation is reflected in worse than average rates for smoking, alcohol consumption and obesity and there are worse than average early deaths from cancer, diabetes prevalence and incidence of malignant melanoma.

3.6 Local health needs are skewed towards illnesses associated with age and frailty. The majority of over-65s have 2 or more chronic conditions, and the majority
of over-75s have 3 or more chronic conditions. Fifty-four percent (54%) of patients have at least one chronic condition requiring management.

3.7 There is significant variation across the Island as can be seen in the following charts:

Who we are

3.9 The Isle of Wight NHS Trust is an integrated acute, community, mental health, learning disability and ambulance service provider – the only fully integrated provider of these services in England.

3.10 Our workforce of around 3,000 colleagues delivers and supports our services and as a by-product of our complexity and integrated set-up, our island population and visitors receive care that is delivered across traditional professional boundaries.

3.11 Our clinical, care and support services are designed, delivered and managed by colleagues in five clinical business units and our support and other services are delivered by a variety of corporate and infrastructure functions.

3.12 Our colleagues are committed to delivering our Vision of ‘Quality care for everyone, every time’ and we are supported in the delivery of our Vision by our Values – ‘We Care’, ‘We Are a Team’ and ‘We Innovate & Improve’. Our Values guide us in the delivery of our Vision, they define who we are and they have helped us determine the outcome of this review of our strategic direction.

3.13 **Our Values** are:

- **We Care** about everyone’s safety and well-being, by valuing and respecting every person, by being open and honest, by finding time.

- **We Are a Team** working in partnership with others, building high trust relationships, striving for excellent communication, acting professionally.

- **We Innovate & Improve** by continuously developing and learning, maintaining competency, by giving, welcoming and using feedback to improve, by trying new things, simplifying and being more efficient.

Our Goals

3.14 **Excellent Patient Care**: To achieve the highest quality standards of care for all our patients and service users through the safe delivery of treatments. This will be borne out by our patients and service users enjoying a good personal experience of their interactions with us and in the outcomes of the services delivered to individuals and their families.

3.15 **Work with others to keep improving our services**: To deliver the Trust’s clinical and support strategies and build resilience into our services through the use of effective partnerships with other providers from the statutory, voluntary, commercial and third sectors.

3.16 **A positive experience for patients, service users and staff**: To build feedback mechanisms to allow us to listen to our patients, carers and people who use our services about how those services are delivered and how we are performing on delivering them. To build effective platforms and relationships for dialogue.
between colleagues and partners so that we can recognise opportunities for quality improvement and identify potential roadblocks to achieving them.

3.17 **Cost effective sustainable services:** To improve productivity and efficiency within the Trust, working with partners creating financial sustainability and maintaining cost effectiveness.

3.18 **Skilled and Capable staff:** To develop our staff, our culture and our workforce competencies in order that we can implement our Vision of Quality Care for Everyone, Every Time.

3.19 Quality is the golden thread that runs through each of our Goals and the Quality Improvement Framework is the primary enabler for driving change across our organisation.

3.20 Our **Quality Improvement Framework** is used as the basis to drive the organisation’s Vision and Strategic Objectives and in line with our Values, has our patients, carers and people who use our services at the centre of what we do.

3.21 As a result of the work we did, we were able to refine our aims and to state our strategic direction, quite simply, like this - **Working ‘Beyond Boundaries’ to be the preferred choice for sustainable integrated care.** This means that staff will work across and beyond traditional professional and organisation boundaries to provide services which are sustainable (i.e. affordable and can be staffed) which service users and carers choose to make use of, remembering always that our customers have a choice as to where they go for their treatment and commissioners can decide to ask alternative providers to treat Islanders.

3.22 Communicating our goals, our values and our priorities (outlined in the next section) in a visual and straightforward way led us to develop, in collaboration with staff and volunteers, what we have termed ‘The House’. We have also developed a visual representation showing how our goals, our values and our priorities align with the My Life a Full Life programme. These are shown in Appendix D.
4. Our Strategic Priorities – what we will do

Following internal and external discussion we have determined that the following are our strategic priorities for 2016 to 2021.

4.1 Align sustainable services to the needs of our patients, carers and people who use our services

What are we trying to accomplish?

To gain a clear understanding of the services we offer in terms of quality of delivery, value for money, return on investment, and comparison with competitors. This will enable informed decision-making about how we respond to the needs of our people. Work being undertaken in the My Life a Full Life Programme, in the shape of the redesign of services will inform this piece of work. Further information on this can be found at http://www.mylifeafulllife.com/wisr.htm.

Implications and considerations
- We need to be ready to quickly assess and refine the recommendations from this work in order that we maximise the potential benefits of service redesign
- Time must be prioritised to consult with colleagues, our staff and the public in order that proposals are explored in open forums where issues can be explored fully
- Change management support must be provided for colleagues in order that change is effected with maximum involvement of our expert staff and minimum disruption to the public and the range of people we serve
- Services should be developed with service users, carers, staff and stakeholders.

4.1a Design efficient and effective treatment and care pathways

What are we trying to accomplish?

To design treatment and care pathways that enable efficient and effective treatment which may extend beyond the traditional NHS boundaries of healthcare. To be able to predict when we might deviate from that and to have mechanisms in place to prevent this. To blur traditional professional boundaries and design innovative ways to deliver treatment and care pathways.

Implications and considerations
- We must be open to researching best practice and embracing care pathway elements that have already been proven to deliver good quality, effective and person centred services elsewhere
- Where necessary it should be acknowledged that we cannot maintain entire pathways on the mainland and for some care pathways will need to be extended to mainland providers.
Innovation and trying new things will be encouraged so openness to change and to embracing new ways to deliver sustainable care and treatment will be required. People must be ready to embrace new ways of working and be ready to try things that haven’t been tried elsewhere.

- Change management mechanisms will be deployed to support existing service users though the changes that will result in pathway redesign.
- HR processes will need to be nimble and innovative in order to support new and revised role descriptions for colleagues and to support colleagues through periods of change.
- Services should be developed with service users, carers, staff and stakeholders.

4.1b. Maximise the person’s experience

What are we trying to accomplish?

To use feedback from patients, carers and people who use services, as well as from staff engagement and different data sources to design high quality, sustainable, integrated services, ensuring we are an excellent and trusted provider of integrated, patient/person-focused services that are locally and globally admired. These may extend beyond the traditional boundaries of NHS healthcare.

Implications and considerations

- We will adopt a range of mechanisms and tools, including digital, in order to get feedback from people who use our services and this will require investment in training, communication and, potentially, in handling real-time feedback.
- It will be important to develop a mechanism for evaluating feedback that is easy to maintain and quick to determine trends.
- Public engagement and education and support for people, patients and carers who use our range of services will be required in order to maximise the benefit of receiving feedback.
- Services should be developed with service users, carers, staff and stakeholders.

4.1c. Provide 24/7 community services for the range of people with mental health needs

What are we trying to accomplish?

For mental health services to have parity of esteem with other services and to develop the change in culture to support that. To provide a 24/7 single-point-of-access service that will respond to people in distress and will signpost them to appropriate services in the community, no matter the provider - statutory, voluntary or private sector. Urgent assessments will be carried out by qualified professionals and appropriate care plans will be prepared so people have to tell their story only once. This will be supported with integrated IT that enables these stories to be shared in a secure environment.
Implications and considerations

- Out of hours working investments and safeguards will be required
- ‘Trusted assessment’ status will require respect across professional boundaries to be strong and mutually supportive. This requires investment in change management programmes and team building considerations
- Consideration needs to be given to 24/7 access to a range of community services, not just mental health, to ensure parity of esteem.
- Services should be developed with service users, carers, staff and stakeholders.

4.1d. Provide services across the seven days of the week

What are we trying to accomplish?

To use our facilities to deliver more of the routine work we currently carry out across the seven days of the week. To offer routine services at weekends and at different times to improve the use of resources and offer more choice to our patients and people who use our services.

Implications and considerations

- We will build on our survey of national guidelines undertaken during 2015 for the delivery of 24/7 services.
- There will be a consideration of how we can gauge quality, sustainability, performance and access to services so we can demonstrate the effectiveness of our services for patients treated at weekends and evenings.
- As part of the My Life a Full Life system redesign staff and public engagement and consultation during 2016, we will gauge the appetite for this.
- Services should be developed with service users, carers, staff and stakeholders.

4.2 Become a centre of excellence for the care of older people

What are we trying to accomplish?

The Isle of Wight has a higher than average proportion of older people and a priority will be to focus services on the care and support of older people with our range of partners and support the Island to become ‘age friendly’. We will deliver a centre of excellence on the Island where, with our partners, the care and support of older people is at the core of all of our adult services. We will support a centre of excellence where the experience of older people’s care and support will inform future best practice locally and nationally.

Implications and considerations
- We will build on current best practice in existing centres of excellence for the care of older people
- We will consider how quality measurements can be devised across all services so that they take special account of the range of needs of older people
- Considerations of older people will be part of all structural and cosmetic changes and improvements to our estate
- Joint training and education programmes with our partners will be needed to support the range of needs of older people, carers and volunteers
- Identify and implement preventative steps to support the most vulnerable to stay safe and encourage people to live well for longer
- There are opportunities for research into the care of older people that we will explore.
- Services should be developed with service users, carers, staff and stakeholders.

4.3 Provide Excellent End of Life Care

What are we trying to accomplish?
Working with Earl Mountbatten Hospice and other partners to help those with advanced, progressive and incurable illness, to live as well as possible until they die, regardless of their age or diagnosis and to avoid unwanted hospital admissions. To support people, patients and their carers through the prevention and relief of suffering by early identification and assessment, effective treatment of pain and other symptoms, and the provision of psychological, spiritual, social and practical support as outlined in the End of Life Care Strategy.

Implications and considerations
- An approach consistent with an individualised journey within an integrated system of care across health and social care and supported housing and in own homes is required
- Increased public awareness is required about end of life needs, to encourage culture change and to enable good conversations to take place
- Accessibility of information is required to allow informed discussion, recording and planning for the future
- Joint training is required to support and empower staff, carers and volunteers to give them the confidence to identify and care for those at the end of their lives
- There must be a person-held record, regularly reviewed, easily updated, easily accessed and visible to all who need to see it.
- There are opportunities for research into End of Life Care that we will explore.

Footnote:
7 The End of Life Care Strategy can be viewed here:
- Services should be developed with service users, carers, staff and stakeholders.

4.4 **Become excellent in the provision of dementia services**

What are we trying to accomplish?

To be a leader in dementia care, where communities encourage people with dementia and their carers to seek help and feel supported to go about their daily lives safely and free from stigma. Where people are empowered to have high aspirations and have the confidence to participate in meaningful activities.

**Implications and considerations** are set out in the Joint Dementia Strategy.  
- Acknowledgement of population needs on the Island with 1 in 3 over 65 likely to get dementia and to consider across communities the needs of younger people with dementia, people with learning disabilities, people from black and ethnic minority groups, people with alcohol related dementia
- Workforce development with partners and culture change will be required
- Strong links to research to ensure relevance and replicability
- Care planning will include end of life care planning and access to services
- Support for carers and family friends for those alone
- Promote dementia champions and dementia friends
- As a priority, develop creative housing and care and support solutions with partners to meet current and future needs of people with advanced dementia
- There are opportunities for research into the care of people with dementia that we will explore.
- Services should be developed with service users, carers, staff and stakeholders.

4.5 **Become excellent in the provision of health and care services to children and young people**

What are we trying to accomplish?

In the same way that parents look to an area for good educational opportunities for their children, parents also place great importance on the health of their children and having good facilities to provide care for them. This has a significant impact of whether individuals with families will choose to live and work on the Isle of Wight. We are also trying to help address issues around child poverty and improving the health of young people.

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**Implications and considerations** are set out in the IW CCG’s commissioning strategies, the NHS Outcomes Framework and the mandate from the Government to NHS England.

- The number of children on the Island means that specialist services are not sustainable on the Island
- Innovative ways to provide services need to be found which make the best use of new technologies
- An increase in mental health issues amongst children and young people requires a focus on mental health services for this group.
- The Trust should play its part in promoting a healthy lifestyle for children, young people and all other age ranges.
- The Trust has a substantial role as one of the Island’s largest employers to raise the aspirations of young people and develop career paths that are attractive.
- Services should be developed with service users, carers, staff and stakeholders.
5. Our Strategic Enablers – what we will put in place

5.1 A workforce embracing integration

What are we trying to accomplish?

A workforce that is supported and develops resilience to cope with service change.
To have services which are staffed to provide safe levels of service.
To have a workforce which is accepting and proactive in responding to feedback.
To have a flexible workforce that can react to the needs of the whole system.
To have a sustainable workforce that is flexible in how it delivers services and works beyond the traditional boundaries of NHS healthcare.

Implications and considerations
- As our services evolve and the ambitions of the My Life a Full Life programme become clearer, ourselves and our partners must be prepared to be open to radical challenge and change in the way we all work together.
- Quality improvement, leadership, empowerment, sustainability, effectiveness and efficiency will be key considerations.
- We will invest in our staff and will present them with opportunities to develop new skills. Traditional models of working will be redesigned and teams will be formed and reformed. We need to plan to support our staff and our colleagues through periods of change with excellent education, training, HR and communication support.
- We will maximise the potential of The Team approach.
- Team members will come from different professions and will have different skills.
- We will create teams from different organisations and must be ready for the challenge of blending different organisational cultures.
- We must be ready to deploy measurement systems to monitor and support the quality of service during and after periods of change.
- We must reduce our reliance on locums and agency staff; where we are unable to deliver services with permanent employees we should consider reducing the level of service offered or even not providing the service at all.
- Staff may need to be trained in how to handle service user and carer feedback.

5.2 Efficient processes with minimum waste

What are we trying to accomplish?

To take a targeted approach at identifying and driving out the quality and efficiency benefits associated with standardising processes and optimising process performance. Where possible, to identify current best practice in standard processes and adapt our processes accordingly.
Implications and considerations
- Leadership commitment to an organisation-wide learning program will be required
- Recognising our resource constraints, placing emphasis where it has most impact on the quality of care and the sustainability of services
- Adopting an approach that aims to drive out inefficiency must be recognised as a cultural shift which must be implemented as an organisation-wide change management initiative
- The time required for our staff and colleagues to participate in learning programmes must be seen as an investment and prioritised as such
- Robust quality and operational measurements must be designed and implemented in order that the impact of changes can be monitored effectively and improvements fed back
- The recently published Carter review will provide a benchmark.

5.3 An IT Infrastructure and processes geared to enabling effective delivery and support, aligned with My Life a Full Life priorities

What are we trying to accomplish?
To deliver a fit-for-purpose IT infrastructure to enable the use of effective IT tools to support key processes. To achieve the ambition to reduce or eliminate the need for paper records. To enable the sharing of information across our health and wellbeing system, including social care and housing. To enable cost effective and varied outputs from our IT systems. To develop a culture where IT tools and not paper forms are the norm in clinical and support environments.

Implications and considerations
- A culture shift is required in order that the implementation of IT tools in the clinical environment are championed by clinicians and where implementation plans are approved and supported by them
- Clinical engagement in the setting of IT priorities will be critical to success
- Quality measurements associated with IT deployment will be required in order to ensure potential quality risks are monitored
- People, wherever possible, will be owners of their own data, making choices and having control about their care via IT tools
- Development and adoption of a clinical information strategy to support Trust strategy

5.4 Land and buildings which are fit for purpose

Consideration has been given to the importance of our Estate as a strategic enabler. It is indeed an enabler of our strategy and is considered separately in a system-wide, island-wide estate strategy as part of My Life a Full Life. This strategy is being developed to include partnership solutions to create new models of care and considers solutions for housing for people with dementia and other priority needs. This is demonstrated in many papers
including ‘Impact of the built environment on health’\textsuperscript{9}.

What are we trying to accomplish?

To deliver fit-for-purpose buildings and infrastructure to support the delivery of excellent integrated health and care. The buildings and land which the Trust owns must be used to their maximum potential by working in partnership with the My Life a Full Life partners.

Implications and considerations
- A culture shift is required away from buildings towards mobile working.
- In the future with advances in science and technology more care will be provided in the service users homes and health and wellbeing centres, less in hospital. This means that the footprint occupied on the St. Mary’s site is likely to decrease and the best use made of facilities in the three localities on the Island.
- The recently published Carter review will provide a benchmark.
- Changes to buildings and the development of new facilities should be developed with service users, carers, staff and stakeholders.
- The Trust should make the best use of its strategic partnership agreements with Ryhurst Ltd through the Wight Life Partnership and the recently signed Strategic Partnership Agreement with IW Council.

\textsuperscript{9} Building Better Healthcare
http://www.buildingbetterhealthcare.co.uk/news/article_page/The_impact_of_the_built_environment_on_health/114263
6. MAKING IT HAPPEN

Ownership, Oversight and Assurance

6.1 Each of the Strategic Priorities will be led by a member of the Trust Executive Team who will be ultimately accountable for delivery. The Chief Executive Officer will have overall responsibility for delivery of the Strategy.

6.2 Active management of the implementation and routine monitoring of progress will be overseen by Chief Executive and the Executive Team.

6.3 A Charter for delivery will be agreed for each Strategic Objective and measures of successful achievement, or key performance indicators (KPIs), will be identified. In this way, there will be transparency of the improvements sought and visibility of how delivery is monitored and managed. As part of ongoing engagement, we will seek input and feedback on the proposed sequencing of the delivery of our strategic priorities and the milestones towards delivery. As well as achieving longer term aims it will be important for ‘quick wins’ to be identified and delivered to ensure that delivery momentum is maintained. Services will be developed with service users, carers, staff and stakeholders.

6.4 Assurance to Trust Board will be via exception reporting on progress towards implementation and delivery of the strategic priorities.

6.5 Delivery of the strategic priorities will be closely linked to our Board Assurance Framework and scrutiny of delivery and the achievements of agreed milestones will take place at Trust Board Meetings which are held in public.

Clinical Leadership and Effective Partnering

6.6 In committing to our Vision of Quality Care for Everyone Every Time, strong and effective leadership from clinical and non-clinical leaders will be essential to achieving our Strategic Priorities.

6.7 Each of the Strategic Priorities will be supported by a Clinical Sponsor who will in turn support the Executive Lead to achieve the right levels of clinical engagement.

Organisational Development

6.8 In exploring and understanding the factors limiting or inhibiting the delivery of our Vision, Goals and Priorities, the themes of leadership behaviour, empowerment and performance management emerged as areas for improvement focus.

6.9 We will engage our organisation in a Trust-wide development programme that is aimed at developing the behaviours and skills associated with good and effective leadership and working with our My Life a Full Life partners. Leadership competencies will be defined, skills gaps identified and training deployed to develop these skills at all levels in the organisations.
7. APPROVAL, COMMUNICATION & ENGAGEMENT AND FEEDBACK

7.1 This strategy was approved at the Trust Board held on [insert date].

7.2 It will be the role of all leaders in the organisation to support the communication and deployment of the strategy in their areas of influence and control. It will be important that the Trust’s stated strategy is a key influencer on the Trust’s business and operational plans, the Island’s Sustainability Transformation Plans (to be submitted to NHS England) for 2017/18 to 2020/2021 and the wider My Life a Full Life programme objectives.

7.3 The strategy will be communicated to the Trust and wider stakeholders:
- In writing
- Via the Trust’s website, intranet and social media
- Through the Trust’s business planning process
- Via the Trust’s internal and external newsletters and publications
- Via face to face briefings with staff and stakeholders

7.4 Feedback on the strategy is welcomed and should be sent to:

Executive Director of Strategy and Integration
Isle of Wight NHS Trust
Trust Headquarters
South Block
St. Mary’s Hospital
Parkhurst Road
NEWPORT
Isle of Wight
PO30 5TG

Isle of Wight NHS Trust
23rd February 2016
Integrated care

(Extract from ‘Population health systems, Going beyond integrated care’ King’s Fund\textsuperscript{10})

There is a long history of policy initiatives in England designed to promote integrated care, dating back at least to the 1960s. Most recently, amendments to the Health and Social Care Bill (following the unprecedented ‘listening exercise’) created legal duties to promote integrated care, a programme of integrated care pioneers has been established, and the Better Care Fund has been set up to pool some of the funding for health and social care. Health and wellbeing boards were created by the Health and Social Care Act 2012 to provide a local forum for the development of integrated care, and some areas are planning to go much further than required under national policy initiatives. The Care Act 2014 also includes a duty for local authorities to promote integrated working.

There are very clear reasons why integrated care has attracted growing attention and support. Population ageing and the changing burden of disease (especially the increased prevalence of long-term conditions) require care to be co-ordinated within the NHS and between health and social care. Nowhere is this more important than in the case of people with multiple long-term conditions (multi-morbidity), many of whom are in regular contact with several health and social care professionals as well as receiving care from families, friends and volunteers. Unless these professionals work together in responding to people’s needs, and treat the person as a whole rather than the presenting medical condition, there is a risk that care will be fragmented and deliver poor outcomes.

The experience of organisations and systems that have achieved high levels of integration illustrates the benefits of this way of working for patients and populations (Curry and Ham 2010). A well-known example in England is Torbay, where health and social care services have been working together in the community for more than a decade, delivering particular benefits for older people (Thistlethwaite 2011). Many other areas of England have followed Torbay’s example by creating integrated health and social care teams in the community aligned with general practices and, increasingly, with hospitals. A number of these areas are beginning to realise the benefits of integration by helping people to remain living independently in their own homes for longer and reducing the use of some hospital services.

Similar experiences have been reported from initiatives in other parts of the world, including Canada, the United States, Europe and New Zealand (Timmins and Ham 2013; Curry and Ham 2010). Some organisations and systems in these countries have sought to go beyond the integration of care for patients and service users to explore how they can use their resources to improve the health of the populations they serve. Examples include long-established integrated systems such as Kaiser Permanente in the United States (often referred to as a health maintenance organisation), which is described in more detail later in this paper.

\textsuperscript{10} Population Health Systems, Going Beyond Integrated Care, King’s Fund, February 2015 (http://www.kingsfund.org.uk/publications/population-health-systems)
1. **The NHS has dramatically improved over the past fifteen years.** Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients’ needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be.** This ‘Forward View’ sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health.** Twelve years ago Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded -and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million fulltime unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.
7. **England is too diverse for a ‘one size fits all’ care model to apply everywhere.** But nor is the answer simply to let ‘a thousand flowers bloom’. Different local health communities will instead be supported by the NHS’ national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a ‘new deal’ for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients’ experience of interacting with the NHS. We will improve the NHS’ ability to undertake research and apply **innovation** – including by developing new ‘test bed’ sites for worldwide innovators, and new ‘green field’ sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient
needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-
quality NHS, action will be needed on all three fronts – demand, efficiency and funding. 
Less impact on any one of them will require compensating action on the other two.

14. The NHS’ long run performance has been efficiency of 0.8% annually, but nearer to 
1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net 
efficiency/demand saving across its whole funding base each year for the rest of the 
decade would represent a strong performance -compared with the NHS' own past, 
compared with the wider UK economy, and with other countries' health systems. We 
believe it is possible – perhaps rising to as high as 3% by the end of the period -provided 
we take action on prevention, invest in new care models, sustain social care services, 
and over time see a bigger share of the efficiency coming from wider system 
improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a 
continuation of current budget protection. Flat real terms NHS spending per person 
would take account of population growth. Flat NHS spending as a share of GDP would 
differ from the long term trend in which health spending in industrialised countries tends 
to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close 
the £30 billion gap by one third, one half, or all the way. Delivering on the 
transformational changes set out in this Forward View and the resulting annual 
efficiencies could -if matched by staged funding increases as the economy allows -close 
the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament 
and government, and will need to be updated and adjusted over the course of the five 
year period. However nothing in the analysis above suggests that continuing with a 
comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that there 
are viable options for sustaining and improving the NHS over the next five years, 
provided that the NHS does its part, allied with the support of government, and of our 
other partners, both national and local.
My Life a Full Life programme – work streams summary

The My Life a Full Life programme has four main work streams and six enabling work streams as follows:

**Work streams**

1. **Prevention and Early Intervention:** In line with the 5 year Forward View, our aim is to shift care and wellbeing away from acute services to prevention and early interventions. Improving our ability to prevent illness, diagnose and intervene early before conditions become serious has been proven to improve outcomes and reduce long term costs for health and social care services. We are building on the concepts of identifying social capital to develop and deliver locally coordinated interventions and coproduced prevention strategies.

2. **Integrated Access:** Our single hub that brings together services from across the system into one place reshapes care delivery, harnesses technology, and drives down variations in quality and safety of care. By integrating health and care services, Integrated Access delivers system efficiencies and provides a model of provision that can be replicated across the country.

3. **Integrated Locality Teams:** Our new model of care delivers person-centred care closer to the home by providing integrated services within three localities. Primary Care, working in partnership with the IW NHS Trust and both voluntary and independent sectors, is driving forward integrated locality teams, to work across the whole health and social care system in a more cohesive and seamless way. There is a particular focus on the management of Long Term Conditions so that people are more effectively case managed, and skilling up the wider health, wellbeing and care workforce to provide support.

4. **Health and Care System Redesign:** The Re-Design of the Island’s health and care system will review whole system pathways and redesign them to provide better and more clinically and financially sustainable services. The WISR will provide a robust evidence base for the ‘case for change’ and provide us with an understanding of how current and future services can be delivered. A key part of the WISR is a tranche of ‘quick wins’ that will be implemented from March 2016 to build momentum and release cash savings. WISR is critical to the success of delivering our new model of care because:
   a. It will inform priorities and investment decisions in the future and ensure we deliver our future care model outcomes in a cost effective and clinically sustainable way.
   b. It will shape the design of system enablers such as IT, Estates, Workforce
   c. It will deliver cash savings through a tranche of quick wins
   d. It will act as a ‘push’ towards prevention and self care through the redesign of pathways
Enablers

1. **One Leadership & One Empowered Workforce:** The workforce work stream aims to support Organisational Development across the system. This includes,
   a. One workforce: the right resources, with the right skills in the right place
   b. One culture: empowering, inspiring and motivating people to work together
   c. One leadership team across the system: inspirational system leadership clearly paving a way forward.

2. **One Information & Technology Enabled Care, Infrastructure and Estates:** Integration of IT and Estates is a key enabler to drive integration across the whole system and deliver the wider quality and cost improvements. Our vision is to create a:
   a. Single system-wide IT infrastructure.
   b. Establish one data hub.
   c. Real time paperless record.
   d. Ability to share documents between organisations in a secure manner.
   e. Ability to use Wi-Fi technology to work from other organisations buildings.
   f. Increased use of Assistive Technology, particularly in prevention.

3. **Strategic Commissioning, Contracting & One Island £:** This work stream has an ambitious agenda as we move towards a single fully integrated commissioning function. The aims of the work stream are:
   b. A One Island £.
   c. New contracting models to enable innovation and collaboration.
   d. More effective and efficient outcomes for people along care pathways.
   e. People have greater control through integrated personal budgets.
   f. An open, transparent, collaborative and mature health and social care market which gives people choices.

4. **Organisational Integration & Form:** The aim of the work stream is to develop organisational forms that support whole system integration following and acting on the results of whole system review & redesign. This work stream will look at organisational form from the perspective of provision, commissioning and back office support functions.

5. **Evaluation & Measurement:** Our new model of care has a robust evaluation built into the design of the programme. This work stream will develop an evaluation framework and baseline for the whole system, establish a culture of continuous improvement, and develop a robust evidence base for future decision making.

6. **Communications, Engagement & Programme Management Office (PMO):** The communication work stream will engage the key stakeholders ensuring that a whole system communication is developed with local people. A centralised PMO hub will be developed to co-ordinate all the activity of the value proposition.

More information can be found at [www.mylifeafulllife.com](http://www.mylifeafulllife.com).
You will note that our strategy is inserted here as a ‘floor’ between our priorities and goals. In simple terms our strategy is the broad approach that we are taking to deliver our goals. Our Quality Improvement priorities are designated with a ‘QI’. All items with a direct relationship to the My Life a Full Life programme are ‘*’ starred.
Visual representation of how the strategy links to our vision, goals and priorities and aligns to the My Life a Full Life programme
The consultation process, respondents and changes made

How we reviewed our strategic direction

In a series of group sessions that involved approximately 70 colleagues and partners, we looked at the factors that will positively influence the delivery of our strategy. We also examined factors that might risk or inhibit that delivery.

This enabled us to identify the Responses and Mitigations to these which, in turn, helped us decide our strategic priorities.

<table>
<thead>
<tr>
<th>Impacts, Influences, Limitations and Inhibitors</th>
<th>Responses and Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity to deliver</td>
<td>Be clear about priorities, “Stop Doing”, Leaders as facilitators of capacity, Empower decision making, Fill vacancies</td>
</tr>
<tr>
<td>Commitment to deliver</td>
<td>Do what we say we will do, Coaching, Support, Engagement, Performance management, Be consistent and focused, Monitoring and Governance</td>
</tr>
<tr>
<td>Capability and skills to deliver</td>
<td>Knowing what you have got and valuing it, Doing the right thing, Develop leaders, Develop the organisation, Manage performance, Recruit the right people, Retain the right people – Job Design, Enable people to leave with head held high</td>
</tr>
<tr>
<td>Understanding our services</td>
<td>Triangulation of Information, Benchmark appropriately</td>
</tr>
<tr>
<td>Commissioning strategy and commissioning intentions</td>
<td>Working in partnership, responding to changing need, being open to new approaches, evidencing the delivery to commitment</td>
</tr>
<tr>
<td>Patient, carer and people who use services expectations</td>
<td>Engage, Communicate, User Groups, Be honest, Consult, Ongoing conversation, Learn the Lessons, Give clear messages, Realism</td>
</tr>
<tr>
<td>Financial constraint</td>
<td>Think “What can we do differently” Coaching, Challenging, “Forget the Rules”</td>
</tr>
<tr>
<td>Not being bold enough</td>
<td>Innovation, Stretch people’s boundaries, Empowerment, Kill negativity</td>
</tr>
<tr>
<td>A risk averse culture</td>
<td>Punish failure rather than reward trying, Plan Do Study Act (PDSA), Effective</td>
</tr>
</tbody>
</table>
Inability to change  
PDSA, Small changes + more small changes = large change, Empowerment, Leading by example

Apathy – reasons not to do something  
Leadership, Engagement, Performance Management

Lack of effective leadership and lack of willingness to hold people to account  
Mentoring, Coaching, Leadership Development  
Role modelling from the top.

As a result of the work we did, we were able to refine our aims and to state our strategic direction, quite simply, like this - **Working ‘Beyond Boundaries’ to be the preferred choice for sustainable integrated care.**  
This means that staff will work across and beyond traditional professional and organisation boundaries to provide services which are sustainable (i.e. affordable and can be staffed) which service users and carers choose to make use of, remembering always that our customers have a choice as to where they go for their treatment and commissioners can decide to ask alternative providers to treat Islanders.

We were then ready to state our strategic priorities and the strategic enablers that will support their delivery.

**Consultation**

We shared our draft strategy with staff and stakeholder organisations and individuals on 22nd December and asked for comments by 20th January 2016.

A press release was issued and we utilised social media. An online survey was used to collect 25 responses with written responses taking the total to 45. We also held a series of meetings as follows:

- Thursday, 7 January 2016, Education Centre, St Mary’s Hospital
- Monday, 11 January 2016, Sandown Health Centre
- Tuesday, 12 January 2016, Integrated Care Hub
- Wednesday, 13 January 2016, Ryde Health & Wellbeing Centre, Ryde
- Friday, 15 January 2016, Sevenacres, St Mary’s Hospital site
- Monday 18th January 2016, Morrisons, Newport
The issue was discussed at the Health and Adult Social Care Scrutiny Sub Committee on Monday 11th January 2016.

A number of staff and members of the public responded and the following also responded to the consultation:

- Programme Governance & Business Planning Team
- Earl Mountbatten Hospice
- IoW Public Health Team, Isle of Wight Council
- Age UK IW
- Patient Council Members, Isle of Wight NHS Trust
- Healing Arts Director, Isle of Wight NHS Trust
- Ventnor Town Council
- Podiatry Team Leader, Isle of Wight NHS Trust
- Chaplaincy, Isle of Wight NHS Trust
- Healthwatch IW
- Parkinsons IoW
- Health and Adult Social Care Scrutiny Sub Committee, Isle of Wight Council
- David Hide Asthma and Allergy Research Centre
- Cancer Services, Isle of Wight NHS Trust
- Crisis Response Home Team, Isle of Wight NHS Trust
- Pharmacy Department, Isle of Wight NHS Trust
- Hampshire Neurological Alliance
- Learning Disability Service, Isle of Wight NHS Trust

The key issues raised during the consultation period and the changes made to the document were:

- Additional priority – children & young people
- Additional enabler – building & land (estates)
- Clarity on links to Five Year Forward View, My Life a Full Life programme, NHS Outcomes Framework, NHS Mandate and the Health & Wellbeing Board
- Greater emphasis on service user, carer and partner involvement inc Earl Mountbatten Hospice, IW Council and town & parish councils
- Clarity about:
  - Meaning of ‘Working ‘beyond boundaries’ to be the preferred choice for sustainable integrated care’
  - Time frame - 5 year strategy
  - Ownership – Trust Executive Committee (TEC) approved by Trust Board
  - Purpose – to inform service and operational plans
APPENDIX F

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Trust Strategy 2016 - 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of document</td>
<td>States the Trust’s strategic direction for the next five years.</td>
</tr>
<tr>
<td>Target Audience</td>
<td>All Trust staff, stakeholders and public</td>
</tr>
<tr>
<td>Person or Committee undertaken the Equality Impact Assessment</td>
<td>Communications and Engagement</td>
</tr>
</tbody>
</table>

Equality Impact Assessment (EIA) Screening Tool

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

   If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

   If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat gender differently.</td>
</tr>
<tr>
<td>Women</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat gender differently.</td>
</tr>
<tr>
<td>Race</td>
<td>Asian or Asian British People</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Category</td>
<td>Yes</td>
<td>No</td>
<td>Note</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Black or Black British People</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat ethnic origin differently</td>
</tr>
<tr>
<td>Chinese people</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat ethnic origin differently</td>
</tr>
<tr>
<td>People of Mixed Race</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat ethnic origin differently</td>
</tr>
<tr>
<td>White people (including Irish people)</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat ethnic origin differently</td>
</tr>
<tr>
<td>People with Physical Disabilities, Learning Disabilities or Mental Health Issues</td>
<td>Yes</td>
<td>No</td>
<td>The priority focus on mental health issues should benefit individuals with those issues.</td>
</tr>
<tr>
<td>Transgender</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat gender differently</td>
</tr>
<tr>
<td>Lesbian, Gay men and bisexual</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat gender differently</td>
</tr>
<tr>
<td>Children</td>
<td>Yes</td>
<td>No</td>
<td>The priority focus on children and young people should benefit individuals in that area.</td>
</tr>
<tr>
<td>Older People (60+)</td>
<td>Yes</td>
<td>No</td>
<td>The priority focus on older people should benefit individuals with those issues.</td>
</tr>
<tr>
<td>Younger People (17 to 25 yrs)</td>
<td>Yes</td>
<td>No</td>
<td>The priority focus on children and young people should benefit individuals in that area.</td>
</tr>
<tr>
<td>Faith Group</td>
<td>No</td>
<td>No</td>
<td>The strategy does not treat faith differently</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>Yes</td>
<td>No</td>
<td>The priority focus on children and young people should benefit individuals in that area.</td>
</tr>
<tr>
<td>Equal Opportunities and/or improved relations</td>
<td>Yes</td>
<td>No</td>
<td>The strategy will help to improve relations in a number of areas but will not adversely affect any area.</td>
</tr>
</tbody>
</table>

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

<table>
<thead>
<tr>
<th>If you have indicated that there is a negative impact, is that impact:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td><strong>Legal</strong> (it is not discriminatory under anti-discriminatory law)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intended</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:

Not applicable

3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

Not applicable

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

Not applicable

<table>
<thead>
<tr>
<th>Scheduled for Full Impact Assessment</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of persons/group completing the full assessment.</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Initial Screening completed</th>
<th>Not applicable</th>
</tr>
</thead>
</table>